Response to NHS Chief Executive’s Open Call for Evidence and Ideas

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5 key messages and 11 recommendations for promoting the adoption and spread of innovation at scale and pace in the NHS

1. The adoption and spread of innovation in the NHS is about leading large scale change at pace. Research suggests that whilst only 30% of large scale change programmes succeed, it is possible to increase the rate of success through the application of evidence based approaches (see appendix). There needs to be a greater emphasis on promoting the adoption and spread of innovation as core business for NHS bodies.

Recommendation: Leaders of all NHS bodies should have an understanding of the latest evidence base for leading large scale change and be held to account for the application of this methodology for improving the quality and cost of health care within their local system.

Recommendation: The NHS Commissioning Board (NHSCB) should place a requirement on Clinical Commissioning Groups (CCGs) to evidence their approach to promoting the adoption and spread of innovation at scale and pace as part of the accreditation and authorisation process.

Recommendation: The Provider Development Agency should ensure that all aspiring FTs can evidence their approach to promoting the adoption and spread of innovation at scale and pace across their organisation and wider system.

Recommendation: Health Education England should be required to ensure that all Local Education and Training Boards ensure that all undergraduate and postgraduate training and education programmes include a work based learning component on leading large scale change/adoption and spread of innovation in the NHS.

Recommendation: The National Institute for Healthcare Research should develop a stronger focus on supporting applied research in promoting the adoption and spread of innovations at scale and pace – perhaps working with Health Education England to develop a Bridging the Gap programme to enable clinicians and managers at a local level to undertake applied MPhil and Doctorate level programmes to support the adoption and spread of high impact innovations at a system level.

Recommendation: The Office of Life Sciences should support the NHSCB and the NHS in developing a clear pipeline for promoting the adoption and spread of innovative technologies through the commissioning and procurement process.

Recommendation: Quality Observatories and Public Health Observatories should continue to develop their role in supporting CCGs in translating the national evidence to support the adoption and spread of innovation at a local level.
2. The QIPP challenge calls for innovation at pace and scale. Experience of QIPP delivery shows that there is no shortage of locally-led innovation projects and pilots. However, efforts are being spread too thinly, with insufficient attention to evidence of what works, lack of clarity about implementation milestones with a consequent risk that initiatives will not have the desired big impact in terms of improving quality and productivity. **Recommendation:** The centre needs to provide leadership and focus to ensure that where there is compelling evidence of interventions that work these are implemented in a more systematic way. The centre needs to identify two or three things (no more) for “industrial-scale” implementation. An example of this is the management of long-term conditions which presents one of the biggest challenges and opportunities for change. Whilst allowing scope for local innovation on LTC management the centre should set a clearer requirement about the minimum common platform that all Clusters/CCGs should be implementing systematically by a given timescale (eg risk profiling; personalised care planning; telehealth; integrated primary, community and social care teams). This should be supported by all CCGs participating in a mobilisation programme on the lines developed by Sir John Oldham.

3. There needs to be greater clarity and agreement on what constitutes best practice for spread and adoption across the NHS. **Recommendation:** The NHSCB should work with other national bodies e.g. Royal Colleges, Clinical Directors, NICE to provide greater clarity and consistency on what constitutes best practice for spread and adoption across the NHS and introduce a “comply or explain approach” to focus leadership attention on the adoption and spread of innovation to deliver improved outcomes.

4. The definition of adoption and spread of innovation in the NHS needs reframing. The adoption and spread of innovation is about promoting the uptake of an idea, service or product which when applied, significantly improves the quality of health and care. By its very nature, the adoption and spread of innovation is not about doing something that is new to healthcare it’s more about making best practice somewhere, best practice everywhere. **Recommendation:** The centre should produce a refreshed innovation strategy for the NHS to clearly define the importance of focusing leadership attention on the adoption and spread of innovation and to set out the expectations on all NHS bodies within the emerging NHS landscape.

5. Patients have a vital role to play in creating a pull for the spread of innovation in the NHS (see appendix). **Recommendation:** HealthWatch England should work with patients and professionals in developing evidence based information that should be routinely available to all patients as part of their pathway of care that sets out their role and responsibilities in managing their health and wellbeing and what they should expect from their local NHS to enable them to remain as healthy and independent as possible.
Appendix 1

Learning from elsewhere about adoption and spread

What can the NHS and NHS commissioning Board learn from local, national and international best practice to accelerate the pace and scale of adoption of innovation in the NHS? [Please indicate relevant examples, published papers or other evidence you have found useful.]

The adoption and spread of innovation in the NHS is about leading change at scale and pace.

The evidence base demonstrates that only 30% of large scale change programmes are successful in delivering their goals. In their article, The Inconvenient Truths about change management: why it isn’t working and what to do about it, (Keller and Aiken 2008 - attached) identify key factors associated with increasing the success of large scale change programmes and Plsek et al (due for publication Sept 2011) offer an evidence based model for accelerating the adoption and spread of innovations in the NHS.

The Institute for Healthcare Improvement (IHI) have published a series of Innovation White Papers to promote the adoption and spread of innovations in healthcare e.g. a Framework for Spread: From Local Improvements to System-Wide Change (2006 attached) and The Seven Leadership Leverage Points for Organisation-Level Improvement in Health Care (2008 attached). The papers have emerged from the IHI’s direct experience of working with healthcare systems in accelerating the adoption and spread of innovations at scale e.g. the 100k Lives Campaign which exceeded their goal of saving 100k lives in 2 years by promoting the adoption of best practice in 6 key areas to prevent an estimated 122,300 avoidable deaths in 18 months.

The campaign was considered to have been a success for a number of reasons including leadership from the highly credible, respected, clinical leader and CE of IHI – Don Berwick, who was able to share a compelling vision for success through the skilful use of public narrative and a well constructed evidenced based programme of action, with clear metrics and an “in time” approach to tracking and celebrating success. The IHI talk of the importance of Will, Ideas and Execution – we often focus on building the case for change but tend to overlook the need to design for “execution”. The Primary Care Collaborative, North East Transformation System, Productive Series and the Choose Well campaign have been highlighted by colleagues as examples of where we have got the “execution” design right and have been successful in accelerating the adoption and spread of innovation in the NHS.

The Jönköping County Council in Sweden is often cited as an example of a health system that has achieved notable success in improving the quality and cost of healthcare through the adoption and spread of best practice e.g Baker et al (2009 - attached) and Bevan et al (2008 – attached) . Baker et al, in their publication Quality by Design, provide insight into how the leadership
community in Jönköping have developed a system level approach to creating a culture of innovation to deliver quality and cost improvements. Success factors include inspirational leadership, the co-production and clarity of vision (to create value for the patient), the embedding of the dual role of staff as improvers and service providers in job descriptions, personal objectives and performance reviews, the provision of innovation and improvement training for all staff, the use of clear methodologies to accelerate change e.g. participation in the 100k Lives Campaign and Pursuing Perfection programme, the use and alignment of metrics from frontline teams to the Board of the County Council to track progress in delivery and to encourage peer review and a focus on recognising and celebrating improvement effort whether this results in success or not. Some of our CCGs are linking into the Jönköping Community to support them in their leadership work in developing as high performing systems.

Patients have a vital role to play in accelerating the adoption and spread of innovation in the NHS. We have some powerful examples of where patients have been enabled to create a pull for innovation in healthcare e.g. people newly diagnosed with diabetes in Barnsley being supported by their PCT to know exactly what “best practice" to ask for from their GP Practice and people in Leeds being supported by the Local Authority to access information on line akin to Amazon to enable them to make choices about their home support requirements. Some of the best Innovations in mental health have come from service users often from countries such as Holland or the US who are working on creative and innovative solutions to mental healthcare often sitting outside the main stream. The development of Soteria projects is an example, there is a national Soteria network in the UK including Bradford. Service user pressure can drive change and using existing support or pressure groups can be very effective and could be used more often to support the adoption of best practice. (see http://www.soterianetwork.org.uk/)
A Framework for Spread
From Local Improvements to System-Wide Change
We have developed IHI’s Innovation Series white papers to further our mission of improving the quality and value of health care. The ideas and findings in these white papers represent innovative work by organizations affiliated with IHI. Our white papers are designed to share with readers the problems IHI is working to address; the ideas, changes, and methods we are developing and testing to help organizations make breakthrough improvements; and early results where they exist.

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A Framework for Spread
From Local Improvements to System-Wide Change

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Executive Summary

A key factor in closing the gap between best practice and common practice is the ability of health care providers and their organizations to rapidly spread innovations and new ideas. Pockets of excellence exist in our health care systems, but knowledge of these better ideas and practices often remains isolated and unknown to others. One clinic may develop a new way to ensure that all diabetics have their HbA1c levels checked on a regular basis, or one medical-surgical unit in a hospital may develop a consistent way to reduce pain for post-operative patients. But too often these improvements remain unknown and unused by others within the organization. Organizations face several challenges in spreading good ideas, including the characteristics of the innovation itself; the willingness or ability of those making the adoption to try the new ideas; and characteristics of the culture and infrastructure of the organization to support change.

In 1999, the Institute for Healthcare Improvement (IHI) chartered a team to develop a “Framework for Spread.” The stated aim of the team was to “…develop, test, and implement a system for accelerating improvement by spreading change ideas within and between organizations.” The team conducted a review of organizational and health care literature on the diffusion of innovations, and interviewed organizations both within and outside of health care that had been successful in spreading new ideas and processes, including Luther Midelfort Health System, Mayo Health System, Virginia Mason Medical Center, and Dean Health System.

Since then, the Framework for Spread and our deeper understanding of its content have continued to evolve. This white paper provides a snapshot of IHI’s latest thinking and work on spread. It is divided into two parts:

The first part of the white paper describes the major spread projects that IHI has supported through early 2006, and harvests the lessons we have learned about the most effective ways to:

• prepare for spread;

• establish an aim for spread; and

• develop, execute, and refine a spread plan.

The second part of the white paper is a reprint of an article published in the June 2005 issue of the Joint Commission Journal on Quality and Patient Safety, describing how the Veterans Health Administration (VHA) used the Framework for Spread to spread improvements in access to care to more than 1,800 outpatient clinics.

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IHI Spread Projects: 1999–2006

Since IHI first began working to develop a Framework for Spread in 1999, both the framework and IHI’s deeper understanding of its content have continued to evolve, especially regarding the role of leadership in planning and guiding spread, understanding and utilizing the structure and culture of an organization in developing an initial plan for spread, and the importance of developing a clear spread aim.

In addition to the Advanced Clinic Access initiative within the Veterans Health Administration (described in the accompanying article), IHI has supported, guided, or studied a variety of spread projects. (Note: While not all of these projects have explicitly applied the Framework for Spread, our reflections about the factors that have contributed to effective spread in each of these examples have both helped us refine our thinking and increased our confidence that the Framework for Spread can be helpful in guiding organizations as they plan for and support the spread of improvements.)

IHI’s 100,000 Lives Campaign

The 100,000 Lives Campaign is an initiative to engage US hospitals in a commitment to implement changes in care that are proven to improve patient care and prevent avoidable deaths. Begun in December 2005, this national campaign has enrolled over 3,000 hospitals in a coordinated effort to prevent unnecessary deaths in hospitals by implementing six interventions that have been shown to reduce hospital mortality.

For more information, see www.ihi.org/IHI/Programs/Campaign/

Bureau of Primary Health Care

The Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC), in partnership with the Institute for Healthcare Improvement, has embarked on a nationwide initiative to improve care for people with chronic conditions. Since 1998, IHI has worked with the BPHC to design, launch, and support the Health Disparities Collaboratives, which use IHI’s Breakthrough Series Model, the Model for Improvement, and the Chronic Care Model to make rapid, significant improvements in care. With the goal of involving every federally qualified health center in the country, the BPHC has sponsored successive waves of Collaboratives to spread the Chronic Care Model so as to improve care for all its patients, especially those with chronic disease.

For more information, see www.ihi.org/IHI/Topics/Improvement/SpreadingChanges/Literature/HealthDisparitiesCollaboratives.htm
IHI’s IMPACT Network

Through its Leadership Community and front-line Learning and Innovation Communities, IMPACT helps organizations develop improvements in specific clinical and operational areas and then spread these improvements throughout their organizations.

For more information, see www.ihi.org/IHI/Programs/IMPACTNetwork/

US Department of Health and Human Services, Division of Transplantation

In partnership with IHI, three successive Collaboratives to increase the conversion rate of organ donors (the number of actual donors divided by the total number of eligible donors) and to increase the number of organs procured from each donor have saved the lives of thousands of people since 2003. Hundreds of hospitals and Organ Procurement Organizations have worked together to design and implement the best methods of partnering with each other and with donor families to ensure successful organ transplants.

For more information, see www.ihi.org/IHI/Topics/Improvement/SpreadingChanges/Literature/SpreadingtheGiftOfLifeOrganDonationBreakthroughCollaborative.htm

Tula and Tver Oblasts (administrative districts) within the Russian Federation

From three demonstration projects begun in 1998, new systems of care for patients with pregnancy-induced hypertension (PIH) have spread from 3 to 40 hospitals; for patients with neonatal respiratory distress syndrome (NRDS), from 5 to 43 hospitals; and for patients with arterial hypertension (AH), from 5 to 442 clinics.

For more information, see www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/ToRussiawithHealthCareImprovement.htm

Tuberculosis Treatment in Peru and HIV/AIDS Treatment in South Africa

IHI has expanded its mission to help in the world’s most resource-poor countries. Following three years of exploratory activity to expand treatment for tuberculosis in Peru and HIV/AIDS in South Africa, IHI is now specifically devoting its energies to the work in South Africa. The IHI team is currently supporting local partners in five projects to expand antiretroviral treatment for AIDS in South Africa, applying an approach that utilizes collaborative improvement methods, diffusion of innovation theory, and the chronic disease management model. This work in South Africa also aims to create high-functioning, interdependent “wedges” of the health care system comprising tertiary, secondary, and primary facilities that act as nodal points for subsequent waves of expansion.

For more information, see www.ihi.org/IHI/Topics/DevelopingCountries/
California Improvement Network

The California HealthCare Foundation, in partnership with IHI, is building the California Improvement Network (CIN) to spread improved chronic illness care among the state’s physician office practices and clinics.

For more information, see www.chcf.org/topics/chronicdisease/index.cfm?itemID=112543&subtopic=CL351&subsection=reports

End Stage Renal Disease Networks

From winter 2002 to summer 2005, the Centers for Medicare & Medicaid Services (CMS) engaged IHI to support the End Stage Renal Disease (ESRD) Networks in an initiative to increase rates of arteriovenous (AV) fistula placement and use for dialysis patients in the US. The use of fistulas has been shown to decrease mortality and morbidity for patients and reduce the cost of care. The use of fistulas in the ESRD Networks increased from 33 percent in September 2003 to over 40 percent at the end of 2005.

For more information, see www.ihi.org/IHI/Topics/ESRD/

Kaiser Permanente

IHI is currently partnering with Kaiser Permanente to spread innovations across their system, drawing on the concepts and ideas presented in this white paper. Improvements being spread include the Nurse Knowledge Exchange (NKE) at change of shift, and innovations in primary care redesign leveraged by information technology.

For more information, see www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm

Key Issues in Developing a Spread Plan

Each of the above examples has enriched IHI’s understanding of how health care organizations can use components of the Framework for Spread most effectively to help plan and guide their spread activities. Most recently, IHI has observed that organizations often benefit from specific guidance in applying the components of the Framework for Spread. We encourage organizations to consider the issues below when developing and carrying out their initial plans for spread.

Preparing for Spread

Health care leaders and improvement teams often ask, “How do I know if I’m ready for spread?” The answer is that it’s never too early to plan for spread, but that certain things should be in place before
actually carrying out the plan. These factors include the widespread acknowledgement by leadership that the improvement project is a key strategic initiative of the organization; the designation of both executive sponsorship and day-to-day leadership; and the existence of successful sites that are the source of the specific ideas to be spread, as well as evidence that the ideas result in the desired outcomes.

The role of leadership cannot be emphasized enough in both initiating a plan for spread and being actively supportive once the plan is underway. The assessment of the organization’s readiness for spread is also an excellent time to consider some initial communication so that others in the organization can understand the reasons for the initiative, become aware of the improvements being made at the successful site, and learn how they might contribute to the effort. (Activities that should be considered as part of an organizational assessment of readiness for spread are discussed in more detail in the accompanying article on page 341 under the “Leadership” and “Better Ideas” subsections.)

Establishing an Aim for Spread

The development of an aim for spread is an important outcome of the initial spread planning process. A spread aim addresses the “who, what, and where” of spread and should include the following components:

- The population (e.g., clinics, units, facilities) that is the target of the spread activities (identifying the target population is discussed in more detail on pages 341 and 342 under “Set-up for Spread” in the accompanying article);

- The specific goals that are expected to be achieved (e.g., access to primary care within 24 hours of the request, eliminating ventilator-associated pneumonia in an ICU, etc.);

- The specific improvements that will be made in the target population (e.g., the principles and methods of advanced access in primary care, the use of the Ventilator Bundle in an ICU, etc.); and

- The time frame for the effort (e.g., 6 months, 12 months, 2 years).

Developing an Initial Spread Plan

The spread aim is the foundation for an organization’s spread plan. A spread plan addresses the “how” of spread and includes communication methods and channels to reach and engage the target population; a measurement system to assess progress in meeting the spread aims; and anticipation of the actions needed to embed the changes into the organization’s operational systems. (The communication and measurement activities associated with spread are discussed on pages 342 and 343 of the accompanying article.)

We have found in our recent work that addressing the following questions is helpful for determining how best to reach and engage the target population in the spread activities:
1. *Can the organization or community structure be used to facilitate spread?*

The specific characteristics of an organization will determine the most effective way to assign responsibility and utilize existing or new communication methods to attract and engage those in the target population to try the new ideas. Some organizations may be characterized by a nested structure (i.e., where one unit is directly related to other units within a centralized organizational structure), while other organizations may be more decentralized. In a nested structure, planning for the involvement of successive waves of organizational units is often a way to rapidly reach the maximum number of units. For example, starting with 1 unit, moving to 5 units (that are connected to the first), then to 25 units (that are connected to the previous 5 units), etc.

2. *How are decisions about the adoption of improvements made?*

In some organizations, decisions are made in a centralized, directed manner, while others may rely on a consensus-building process. These elements of an organization's culture contribute to the timetable and expectations that are set by leadership for spread.

3. *What infrastructure enhancements will assist in achieving the spread aim?*

Each organization should consider the extent to which infrastructure changes can be utilized to speed the adoption of the improvements. Some changes by definition are more dependent upon individual adoption decisions (e.g., prescribing a new medication or use of a new treatment regimen), while others are more tied to infrastructure or system-level changes (e.g., roll-out of a new computer system). Most improvements lie somewhere between these two poles of the adoption decision continuum, but the more infrastructure changes can be used to support adoption (e.g., establishing an electronic decision-support system for chronic disease management), the more quickly improvements can be spread throughout the target population.

4. *What transition issues need to be addressed?*

Lack of knowledge of using an electronic health record (EHR), for example, might delay adoption of a new approach to panel management in a clinical office practice. The absence of a reliable communication system for a nurse on a medical-surgical floor to use in requesting assistance from the ICU might slow the adoption of Rapid Response Teams in a hospital. Such issues need to be addressed early in the spread plan to facilitate the transition to a new system.

5. *How will the spread efforts be transitioned to operational responsibilities?*

A spread effort is successful only when the new ideas or practices become the way an organization “does its business.” Transferring the responsibility for facilitating the adoption decision from a
project leader to a line manager can help make this transition. Some issues that need to be addressed in planning for spread include training and new skill development, supporting people in new behaviors that reinforce the new practices, problem solving, and assignment of responsibility.

Executing and Refining the Spread Plan

Establishing methods for obtaining feedback on the progress of the spread process is central to a successful effort. *(The role of knowledge management is discussed on page 343 in the accompanying article.)* Some methods for obtaining information from those involved in spread and making adjustments in the process may include formal and informal reports from those in the target units; regular communication between those individuals with experience in the organization and those trying to implement the improvements for the first time; and using data to assess progress and making changes in organizational responsibility to ensure that the gains are maintained.

The Framework for Spread and the aforementioned components of developing a successful spread plan have been shown to be effective in helping to guide spread across different types of organizations and for different types of improvements. Going forward, IHI is interested in finding ways to identify the most effective spread strategies and methods for organizations with specific structures and cultures. We encourage organizations to apply the elements of the Framework for Spread, and to share their insights with IHI as to which activities contribute to the successful spread of innovative ideas in health care. This continues to be a pressing need for the continued improvement of health care, nationally as well as internationally.

Refer to IHI’s website for more information on spreading improvements in health care (www.IHI.org/IHI/Topics/Improvement/SpreadingChanges).

References


Organizational Change and Learning

Using a Framework for Spread:
The Case of Patient Access in the Veterans Health Administration

Kevin Nolan, M.A.
Marie W. Schall, M.A.
Fabiane Erb, R.H.I.A.
Thomas Nolan, Ph.D.

The experiences of four Veterans Health Administration (VHA) clinics in spreading operational changes and achieving improved access for veterans are discussed in detail elsewhere. Much has been written about the problem of and reasons for the lack of widespread implementation of evidence-based innovations in health care. Such innovations would include not only new drugs or equipment but an operational system, such as one that orders, dispenses, and administers medications. The lack of implementation makes it clear that strong evidence for an innovation is necessary but not sufficient to result in its adoption.

Experience indicates that an effective operational system, such as those suggested above, will spread much more slowly than, for example, a new antinausea drug. No press releases will announce the approval of the medication system by the Food and Drug Administration. Patients will not demand its installation. No army of persons knowledgeable of the system will be dispatched to explain it. The spread of operational systems presents significant challenges—not faced by a drug company spreading an antinausea drug—for the following reasons:

- Operational systems are often large or complex and thus difficult to describe and communicate.
- The systems are usually not services for sale. Thus, well-developed marketing and sales processes are not available to create demand for them.
- Even if the new system was desired, the transition from the current system to the new system may be difficult.

Because these challenges seem difficult to overcome without purposeful leadership, we focus our attention on

Article-at-a-Glance

Background: Experience indicates that an effective operational system will spread much more slowly than, for example, a new antinausea drug. The Veterans Health Administration (VHA) used a Framework for Spread to spread improvements in access to more than 1,800 outpatient clinics between April 2001 and December 2003. The framework identifies strategies and methods for planning and guiding the spread of new ideas or new operational systems, including the responsibilities of leadership, packaging the new ideas, communication, strengthening the social system, measurement and feedback, and knowledge management.

Applying the Framework for Spread: Following a collaborative for reducing waiting times for patients without the large-scale addition of resources, each of the participating 22 Veterans Integrated Service Networks (VISNs) used the framework to expand improvements in access to care to six additional targeted clinics (for example, primary care, eye care, cardiology).

Results: During the VHA’s spread initiative, waiting time for a primary care appointment decreased from 60.4 days at the end of fiscal year (FY) 2000 to 28.4 at the end of FY 2002. Results were sustained. Waiting time was < 25 days at the end of FY 2004.

Discussion: The Framework for Spread suggests areas that organizations should consider when developing and executing a strategy for a spread initiative. Further study is needed to determine the specific activities that should be emphasized to accelerate spread.
spread within organizations. This does not preclude the spread of such systems between organizations if an appropriate umbrella organization such as a professional association exists.

In 1996, the Institute for Healthcare Improvement (IHI; Cambridge, MA) initiated the Breakthrough Series Collaborative in an attempt to reduce the gap between available knowledge and its use in practice in areas such as waits and delays, end-of-life care, and chronic disease care. A collaborative is an improvement method that brings together multiple similar sites with a common aim to adapt and spread existing knowledge. Collaboratives are particularly useful to hone an operational system, to document its advantages, and to begin the spread process.

Although collaboratives proved successful, a more general approach to the spread of operational systems was needed to reach a wider audience. In 1999, the authors began a literature review and conducted interviews with organizations successful in spread. In 2000, testing of an approach to spread began in projects in health care and in industries such as chemical, landscape maintenance, and building products. Figure 1 (above) presents the Framework for Spread that evolved. The framework is founded on Everett Rogers's definition of diffusion and draws both from the literature and from the experience of organizations actively involved in spreading improvements from a local site to their entire system.

The Framework for Spread identifies the following components for planning the spread of new ideas:
- The responsibilities of leadership (including set-up)
- Identification of better ideas
- Communication
- Strengthening the social system
- Measurement and feedback
- Knowledge management

The framework is not meant to be prescriptive nor considered as a specific intervention but rather it is meant to suggest some general areas to consider as a large spread project is undertaken. Factors such as an organization's infrastructure, culture, size, strength of its underlying social system, and the operational system being spread will influence how the components of the framework are applied. Check lists for spread appear in sidebars throughout the article to help in planning a strategy.

The section that follows describes the components of the Framework for Spread and the application of the framework in the VHA, which has attempted other spread projects with varying degrees of success, as an example.

Applying the Framework for Spread to the VHA
The VHA partnered with the IHI to conduct a collaborative from July 1999 through March 2000 on reducing waiting times for patients without the large-scale addition of resources. The collaborative included teams from 134 facilities from the then 22 Veterans Integrated Service Networks (VISNs). Following the collaborative, each VISN was asked to expand the improvements in access to care to additional clinic sites within six performance clinics (primary care, eye care, audiology, cardiology, orthopedics, and urology) with large patient volumes and long waiting times for appointments. The clinics care for approximately 3.8 million patients per year in more than 1,800 sites (Figure 2, page 341). This strategic effort was referred to as the Advanced Clinic Access (ACA) initiative.
Veterans Health Administration (VHA) Organizational and Clinic Structure for Spread of Improved Access

<table>
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<tr>
<th>VA Central Office</th>
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<tbody>
<tr>
<td>21 VISNs</td>
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<tr>
<td>140 Facilities and 500 Community-Based Outpatient Clinics</td>
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<tr>
<td>1,800 Clinic Sites in the Six Performance Clinics</td>
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<td>4,600 Providers in the Six Performance Clinics</td>
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<td>3.8 Million Patients in the Six Performance Clinics</td>
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Figure 2. This chart shows the multiple levels of the organization that were utilized by the VHA in building a plan to spread improved access across its system. VA, Department of Veterans Affairs; VISN, Veterans Integrated Service Network.

Each of the then 22 networks (VISNs) within the VHA used the Framework for Spread to guide its efforts. VISN 2, the VA Healthcare Network of Upstate New York (VISN 2), consists of 5 medical centers and 27 community-based outpatient clinics (CBOCs) or access points for care. VISN 2’s work in attempting to achieve the VHA standard of < 30 days average wait time for an appointment is presented in terms of the Framework for Spread components.

Leadership

Leaders at many levels in VISN 2—including the network director, chief medical officer, facility directors, and network and local care line managers—“set the agenda” for change through the following actions:
- Embraced improved access as a key strategic initiative and set waiting time goals. This was communicated through facility leadership meetings, the VISN 2 Web site, and publications. Leaders also committed funding and staff time.
- Aligned goals for improved access with two existing incentive programs, the Provider Compact and Goal Sharing. The Provider Compact funded provider educational activities depending on the level of attainment of a set of measures. The Goal Sharing Program allotted dollar awards of graduated amounts to teams achieving certain levels of performance.
- Established a multifunctional steering committee to lead the spread effort.
- Supported a VISN 2 point of contact (POC) and facility POCS to manage the day-to-day activities of the VISN spread strategy. One of the barriers faced was the time commitments required from the POCS and others to facilitate spread. VISN 2 staff members do this work in addition to their regular duties, which caused several to drop out over time. This required the VISN core group, which does remain intact, to develop a system to recruit and train staff members to support the work.

Better Ideas

A key attribute of ideas that influences their rate of spread is their benefit to all adopters relative to other ideas. The concepts and ideas to improve access adopted in the VHA are consistent with the advanced or open access approach currently used with success in a number of health care settings. The VHA assembled these ideas into an easy-to-use booklet and developed them into a Web format for the national VHA Web site (available at the IHI Web site). Two primary care and three specialty care areas in VISN 2 demonstrated during the national collaborative that adopting these ideas to improve access can provide benefits not only for patients but also for providers. It was determined that the ideas could be replicated in other primary and specialty care units.

Set-up for Spread

Once the better ideas are documented and successful sites identified, leaders should initiate the set-up for spread by identifying the target population. Consideration should be given to the different audiences (for example, physicians, nurses, technicians) within the target population. Leaders should also
oversee the development of an initial plan for spread, which could include ways to attract those in the target population willing to adopt the improvements. Ways to attract these early adopters might include the planning of broad-based communication about the new system’s advantages, developing a process to identify persons influential with their peers, or developing a plan to share comparative data with adopters. The initial plan might also include the infrastructure changes, such as in information technology and distribution systems, and the realignment of functions within the organization needed to achieve the goals of the initiative.

VISN 2 used a general communication campaign to attract adopters, which was followed by a series of meetings to showcase the work of the successful clinics. VISN 2 focused on a group of clinics at a time. Clinics willing to be part of the initiative would constitute the initial waves. Improvement in the national scheduling system aided VISN 2 in its work.

General Communication and Knowledge Transfer in the Target Population

Because communication is at the heart of spread, the day-to-day manager of a spread initiative needs to organize a communication campaign. Many different channels of communication can and should be used to raise awareness and share technical knowledge. However, technical knowledge that focuses on the “how to” is best communicated through interaction with colleagues. Persons who are influencers or opinion leaders in the social system serve as the best messengers.

VISN 2 used a number of communication strategies to spread the ideas to improve access to the targeted clinics and strengthen the social system. Three successive “waves” of learning initiatives were launched in March 2000, March 2001, and January 2002. By making the successes of colleagues visible, the vast majority of clinics joined voluntarily. However, some staff members (physicians especially) refused to listen or to consider adopting the principles. Engaging them and spreading the access improvements to their clinics became a significant challenge for the access coaches and the leaders in VISN 2. It took extra effort to educate them and then have them put the concepts into practice and then see the benefits for themselves.

Sidebar 1. Checklist for Spread—Leadership, Better Ideas, and Set-up

- Is improvement in this area a strategic initiative within the organization?
- Is there an executive(s) who is responsible for the spread?
- How will this executive be involved on an ongoing basis?
- Is there a person or team who will manage the day-to-day spread activities?
- What are the positions of the key people who will make the adoption decision?
- Has the relative advantage of the changes been documented for all adopter audiences?
- Are the changes packaged so that they can be easily understood and tested by the adopters?
- Is there a successful site that has implemented the new system?
  - Are the changes implemented scalable to the entire target population?
  - If there is no successful site, what is the strategy to create a good example?
- Has an initial plan for spread been developed?
  Consider:
  - Ways to attract early adopters
    - Planning broad-based communication
    - Developing a process to identify people in the target population who are influential with their peers
    - Developing a plan to share comparative data with adopters
  - Potential infrastructure changes needed

In 2002, VISN 2 also incorporated the use of “road shows”—events held at each of the five medical centers and at several large CBOCs. Physicians, nurses, and schedulers from successful sites met with staff. Part of the discussions were held in peer groups, for example, physicians meeting with physicians, schedulers with schedulers. In addition, articles about improving access and success stories appeared in VISN 2 newsletters.
Monthly video conferences, conference calls, team reports, and frequent e-mail exchanges were used to transfer knowledge. Personal coaching was available to sites that attended the VISN 2 meetings. In 2001, information was included on the VISN 2 intranet Web site. VISN 2 also communicated with patients. “No show” posters were designed to enlist patients’ help in reducing the number of scheduled appointments cancelled.

VISN 2 took advantage of resources developed at the national level such as a theme (“Providing quality care when veterans want and need it”), a logo, a poster, messages for each adopter group, and information posted on the VHA national Web site. Other important resources for communicating both broad awareness and technical information about improving access included two nationally produced videos. One video, “The Time Has Come,” showed patients, leaders, and providers from the VHA talking about the benefits of improving access. A second video featured Mark Murray, M.D., explaining the key ideas for improving access. Many providers also took part in national conference calls hosted by Dr. Murray and national e-mail groups.

Measurement and Feedback

Measurement is an integral part of improvement. It provides information about whether the changes made in a system are having the desired effect. Two different types of measures are useful: measures that demonstrate the extent of the spread of the recommended changes, and a set of measures that demonstrate the outcome of the changes implemented.

A strong measurement system was in place in VISN 2 before the spread initiative began. Wait times data are now, however, included in the monthly VISN 2 report, reviewed at steering committee meetings, and used to give feedback to sites and to refine the VISN 2 spread strategy. The rate of spread (the percentage of clinics that have implemented the ideas to improve access) is also measured. A clinic using ≥ 75% of the 33 ideas to improve access for a period of ≥ three months is considered to have implemented the ideas. Clinics self-report these data quarterly on a standard data collection form. VISN 2 ACA coaches validate the data through observation within the clinics. The data are summarized and plotted twice a year with help from contacts at the facilities.

Sidebar 2. Checklist for Spread—General Communication and Knowledge Transfer

- How will awareness of the initiative be communicated?
  - Have the benefits for different audiences been documented?
  - Have comparative data been shared?
  - What channels will be used to raise awareness in the target population?

- How will technical knowledge be communicated to facilitate the adoption of the changes?
  - Are peer-to-peer interactions planned?
  - Are potential adopters influential in the social system willing to be involved?
  - How will successful units be involved to supply technical support?

Knowledge Management

As ideas are adapted to a local system during a spread initiative, adopters generate knowledge about the ideas and how best to improve outcomes. Day-to-day managers need to develop systems to capture this knowledge and make it available to others on an ongoing basis. In VISN 2, knowledge was formally captured during face-to-face meetings and road shows. The day-to-day manager would make decisions on what information would be posted on the VISN 2 intranet Web site. The VHA national Web site also served as a mechanism to share tips, tools, success stories, and other information to assist others in making changes to improve access.

Results

During the spread initiative’s time frame, the waiting time for a primary care appointment in the VHA decreased from 60.4 days at the end of fiscal year (FY) 2000 to 28.4 at the end of FY 2002. Waiting times at the end of FY 2004 were < 25 days (Figure 3, page 344). These results were based on waiting time data from all patients and are available from the VHA scheduling system. VISN 2 achieved similar results. The waiting time for all primary care patients decreased from > 50 days in April 2000 to < 20 days in April
2003 (Figure 4, page 345). Through the continued efforts in VISN 2, the waiting times in FY 2004 averaged approximately 16 days. In addition, all specialty care performance clinics were averaging < 30 days for their next available appointment. Figure 5 (page 345) shows the rate of spread in VISN 2. As of September 30, 2002, the ideas had spread to > 90% of the performance clinics and 78% of all clinics. The largest reduction in waiting times coincided with the successive waves. In VISN 2 during FY 2001 and FY 2002, there was a slight increase (5%) in the number of unique patients cared for and no increase in the overall and clinical FTEs. In addition, VISN 2 had no patients on waiting lists for entry into the system. The percentage of patients seeking primary care who were seen within 30 days increased from 74% in May 2002 to 92% in September 2004 (Figure 6, page 346).

**Discussion**

The work to spread improved access in each VISN within the VHA was guided by the Framework for Spread and supported by the infrastructure developed at the national level. Because this work was a strategic objective, many other areas, such as the scheduling system and referral guidelines, were focused on for improvement at the national level to support the spread initiative. Addressing issues—at the individual, unit, or organizational level—that could inhibit adoption is essential to any spread effort. One of the challenges faced by the national leadership in leading the spread of ACA was building leadership commitment and involvement at the VISN and facility levels. Tying ACA goals to annual performance reviews, using national meetings of VHA administrative and clinical leadership groups to build awareness as well as share effective leadership methods to support access improvement, and providing direction through the national steering committee all helped to guide, encourage, and acknowledge the role of regional and facility leaders.

The leaders in VISN 2 supported the day-to-day manager of the spread initiative in organizing a multifaceted communication campaign, allowing awareness...
Improvement in Average Next-Available Appointment Waiting Times for Primary Care in Veterans Integrated Service Network (VISN) 2

Figure 4. This graph shows the reduction in waiting time for a clinic appointment in VISN 2 that coincided with the implementation of its spread plan.

Rate of Spread of Advanced Clinic Access in Veterans Integrated Service Network (VISN) 2

Figure 5. This graph shows the increase in the number of clinics over time that implemented specific recommended changes to improve access as part of the Advanced Clinic Access project in VISN 2. ACA, Advanced Clinic Access; PM, performance.
and technical knowledge to improve access to be communicated throughout the VISN. Because of the succinct packaging of ideas and the coaching of their peers, clinics could readily test changes to their systems. The rate of spread accelerated as a new wave of clinics was reached in face-to-face meetings and follow-up. The social system strengthened as physicians, nurses, and schedulers interacted at meetings, road shows, and other scheduled VISN events. Celebrating successes and shining a spotlight on the top performers had a positive effect on participation levels and led to greater physician involvement. The VISN 2 and national Web sites continue to serve as key resources for information. Data on wait times, which are available from the scheduling system, continue to provide a key source of feedback.

The Framework for Spread suggests areas that organizations should consider to develop and execute a strategy for a spread initiative. VISN 2 undertook a certain set of activities within the framework. Other VISNs undertook some different activities to provide leadership for the project, communicate ideas, strengthen the social system, or provide feedback. Further study is needed to determine the specific activities that should be emphasized to accelerate spread. This might depend on the characteristics of an organization and the ideas being spread.

The VHA and VISN 2 are actively pursuing the initiative to improve access. The existence of a VHA systemwide database enables demonstration of sustained reduction of waiting time for an appointment. The veterans—and other patients—deserve no less.

References

White Papers in IHI’s Innovation Series

1. Move Your Dot™: Measuring, Evaluating, and Reducing Hospital Mortality Rates (Part 1)
2. Optimizing Patient Flow: Moving Patients Smoothly Through Acute Care Settings
3. The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement
4. Improving the Reliability of Health Care
5. Transforming Care at the Bedside
6. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care
7. Going Lean in Health Care
8. Reducing Hospital Mortality Rates (Part 2)
9. Idealized Design of Perinatal Care
10. Innovations in Planned Care
11. A Framework for Spread: From Local Improvements to System-Wide Change

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Innovation Series 2008

Seven Leadership Leverage Points

For Organization-Level Improvement in Health Care

Second Edition
The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. IHI helps accelerate change by cultivating promising concepts for improving patient care and turning those ideas into action. Thousands of health care providers participate in IHI’s groundbreaking work.

We have developed IHI’s Innovation Series white papers as one means for advancing our mission. The ideas and findings in these white papers represent innovative work by IHI and organizations with whom we collaborate. Our white papers are designed to share the problems IHI is working to address, the ideas we are developing and testing to help organizations make breakthrough improvements, and early results where they exist.
Seven Leadership Leverage Points

For Organization-Level Improvement in Health Care

Second Edition

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Foreword to Second Edition

It is almost three years since we published the First Edition of our white paper, Seven Leadership Leverage Points for Organization-Level Improvement in Health Care, and in that time we have learned a great deal about what it takes to achieve results in quality and safety at the level of entire organizations and care systems. A primary source of our learning has been the application by committed leaders of one or more of these leverage points in the 100,000 Lives and 5 Million Lives Campaigns, in the course of which hundreds of organizations have achieved major improvements in system-level measures such as mortality rates and prevalence of harm. The Campaigns continue to be an extraordinarily rich source of learning to improve and extend our theory—and it is a theory—of “leverage” for leaders.

In addition to the Campaigns, the Institute for Healthcare Improvement (IHI) has also learned a great deal about what works (and, importantly, what doesn’t) from a diverse set of sources ranging from our involvement in national initiatives such as the The Health Foundation’s Safer Patients Initiative in the UK, large-scale collaborative programs such as the 200+ organizations in IHI’s IMPACT network that are participating in Learning and Innovation Communities, in-depth work with IHI’s Strategic Partners, and direct fieldwork and interviews with health care clients as well as industry leaders outside health care. We have noticed, for example, that many of the leverage points work well in the field without much modification, whereas others seem to need some reframing, or a special emphasis on particular elements within the leverage point, or even substantial revision.

Much of this ongoing learning about the role of leaders in quality has been distilled into three IHI white papers that deal either directly or indirectly with one or more of the original Seven Leadership Leverage Points. The 5 Million Lives Campaign’s “Get Boards on Board” intervention, for example, expands Leverage Point One, on the adoption and oversight of aims at the highest levels of governance, into the exceptionally detailed Governance Leadership “Boards on Board” How-to Guide. Leverage Point Six, on engaging physicians, has been the subject of intense interest, which in turn has led to the publication of IHI’s white paper, Engaging Physicians in a Shared Quality Agenda. And the work of Tom Nolan and the IHI Innovation Team has resulted in a very thoughtful new framework and white paper on the critically important issue of Execution of Strategic Improvement Initiatives to Produce System-Level Results, which has relevance to several of the original leverage points, particularly Leverage Points One (adopting aims), Two (developing and overseeing the execution of a strategy to achieve breakthrough aims), and Seven (building improvement capability).

Finally, as with any organically growing set of interconnected leadership theories, there is a constant need for “sensemaking.” In particular, many leaders have expressed the need for a “cross-walk” between frameworks, so that they can place their understanding of elements of various frameworks into some sort of meaningful context. For example, how does the IHI framework for strategic improvement (Will, Ideas, and Execution) relate to the Seven Leadership Leverage Points? What is the fit between the Framework for Execution and the leverage points?
Because we have gained a lot of new knowledge and field examples, and are also faced with questions about relationships among various IHI frameworks, we thought this would be a good time to write a Second Edition of the *Seven Leadership Leverage Points* white paper. In doing so, we aim to:

- Propose “Version 2” of the Seven Leadership Leverage Points, incorporating our learning since the original white paper was published in 2005, particularly the learning on the subject of execution.

- Provide a number of specific examples of the field application of each leverage point (rather than the extended “for example” of the 100,000 Lives Campaign that we employed in the First Edition).

- Describe the relationship between the Seven Leadership Leverage Points and other IHI leadership frameworks.

Finally, it is important to point out that this new and improved set of leverage points is still a theory, and a theory at the “descriptive” stage of development, at that. By “descriptive” we mean that we are able to describe *associations* between each leverage point and results, but we are NOT able to ascribe specific *cause and effect*. In other words, the leverage points theory is not yet a “normative” theory, in that we cannot make the following statement: “If you as a leader do these seven things, you will get dramatic system-level results.” But we can say, with perhaps greater confidence than three years ago, “Where organizations *are* getting significant results, several of these leverage points appear to be strongly in place.”

We hope you find the Second Edition of the *Seven Leadership Leverage Points* white paper useful in your own leadership work, and we invite all readers to give us feedback from their own field observations, so that this management theory can continue to grow and improve.

James L. Reinertsen, MD
February 2008
Context and Background

Leaders of health care delivery systems are under pressure to achieve better performance. Through mechanisms such as mandatory public reporting, pay for performance, and “non-payment for defects,” regulators, payers, communities, and informed patients are pressuring leaders to produce measured performance results. These results are often framed for specific circumstances (e.g., “reduce rates of wound infections after cardiac surgery”) and sometimes specified at the system level (e.g., “reduce rates of all forms of harm during hospitalization”).

Many hospital and health system leaders have themselves become personally and painfully aware of defects in their own organizations and office practices—needless deaths, harm, suffering, delays, feelings of helplessness, waste, and inequities—and with a lot of hard work, some have become quite skilled at achieving project-level reductions in these defects (e.g., lower rates of central line infections in a particular ICU). But it is much harder to achieve organization-level results—for example, reduced rates of all hospital-acquired infections, across all units and services. Increasingly, it appears that while health care CEOs and other leaders want to make these changes happen, they don’t have a tried-and-true method by which to bring about system-level, raise-the-bar change. Specifically, health system leaders often say that they are pretty clear about what they should be working on, but far less clear about how they should go about that work.

Leadership models and frameworks can provide a roadmap for leaders to think about how to do their work, improve their organizations, learn from improvement projects, and design leadership development programs.* The core of the comprehensive IHI strategic improvement framework is Will, Ideas, and Execution: in order to get organization-level results, leaders must develop the organizational will to achieve them, generate or find strong enough ideas for improvement, and then execute those ideas—make real improvements, spread those improvements across all areas that would benefit, and sustain the improvement over time. And when this Will-Ideas-Execution framework is fully fleshed out with the addition of two other core components, “Set Direction” and “Establish the Foundation,” 24 specific elements emerge into an overall leadership system for improvement called the IHI Framework for Leadership for Improvement (see Figure 1).
Leaders can be daunted by the breadth and depth of this sort of comprehensive model. Even though the 24 individual elements are quite clear, many of them are still fairly broad in scope (e.g., “Plan for Improvement” or “Review and Guide Key Initiatives”). So leaders often look at comprehensive models such as this and ask questions such as “But how exactly do I ‘Plan for Improvement’ or ‘Review and Guide Key Initiatives’?”

The Framework for Execution is a superb example of an answer to the “But how...?” question. This framework expands and explains a system for execution of large-scale change, and provides concrete and specific examples of what leaders do and how they do it, in organizations that are highly capable of execution (see Figure 2).
The Seven Leadership Leverage Points framework, on the other hand, was developed in large part to answer a second type of question that leaders were asking:

- “This is a very broad framework; are there one or two places where I could get started, where my actions might have the greatest effect?”

- “We can’t work on 24 things at once. If we had to place our bets on a few specific leadership actions within this framework that would be highly likely to bring about system-level results, what would they be?”

Executives appeared to be asking about “leverage”: specific activities for leaders, and specific changes in leadership systems, in which a small change might bring about large, positive, system-level results. This white paper is an attempt to answer that question—that is, where leaders might place their bets to achieve system-level results.
The foundation for our answer about leverage comes from at least four different sources:

1. Complex Systems Theory: Complex adaptive systems such as health care organizations and communities cannot be specified and managed in detail. It is highly likely that small changes in certain critical aspects of these systems might bring about surprising and unpredictable amounts of improvement or deterioration in overall system performance. If leaders could choose the right system attributes (“leverage points”) and make small, perhaps difficult, but important changes, very large performance change might result.

2. Observed Performance of Leaders and Health Systems: We have been able to watch the actions of leaders in organizations participating in IHI’s Pursuing Perfection and IMPACT initiatives, as well as in the 100,000 Lives and 5 Million Lives Campaigns, and simultaneously to observe the performance of those systems. Where system-level change has occurred, we have attempted to infer from these sources what some of the leadership leverage points for improvement might have been. For example, we have observed that system-level improvement does not occur without a declared aim to achieve it, and that how the aim is declared and adopted by leaders appears to be very important. These leverage points are based largely on qualitative data—more anecdotes and stories about the work of leaders than a solid research base. Nevertheless, these stories are powerful, and serve to support and refine the theory.

3. Hunches, Intuition, and Collective Experience: The authors come from a variety of backgrounds in health care and have tapped into our collective experience to postulate some of these leverage points—particularly those that surface as recurrent “difficult moments” for leaders. For example, it is our sense that the business case for quality is still fragile in many health care organizations, and therefore that if the chief financial officer (CFO) were somehow to become a champion for system-level improvement in quality, dramatic improvement would become much more likely.

4. Ongoing Research and Development of Management Theories and Methods: In the three years since the First Edition of the Seven Leadership Leverage Points white paper was published, we have learned a lot about topics such as execution, governing boards, transparency, and physician engagement, to mention just a few. We have attempted to weave this learning into the Second Edition of the Seven Leadership Leverage Points white paper, with a particular focus on the several areas of synergy between the IHI Framework for Execution and the Seven Leadership Leverage Points.
It might be helpful to note what these leverage points are not:

• The leverage points are not intended to be a comprehensive framework for the leadership of organizational transformation. That is a much broader subject, addressed by approaches such as The Baldrige National Quality Program.

• The leverage points are not a substitute for a coherent quality method such as the Toyota Production System or the Model for Improvement. In fact, the organizations in which the leverage points would be applied are assumed to have adopted a coherent quality framework.

Finally, we would emphasize that we have framed these as leadership leverage points. In other words, we believe that these activities are the particular responsibility of the senior leaders of organizations.

This paper has three sections:

1. A detailed explanation of the Seven Leadership Leverage Points and specific examples of their application in health care, where available


3. A self-assessment tool (Appendix A) to help administrative, physician, and nursing leaders of health care organizations design and plan their work using the Seven Leadership Leverage Points

**Leverage Point One: Establish and Oversee Specific System-Level Aims at the Highest Governance Level**

A broad quality aim is part of the mission statement of most health care organizations. But if leaders are to achieve new levels of performance at the system level, we believe that governing boards must:

• Establish solid measures of system-level performance—for example, hospital mortality rate, cost per adjusted admission, adverse drug events per 1,000 doses—that can be tracked monthly, if not more frequently;

• Adopt specific aims for breakthrough improvement of those measures;

• Establish effective oversight of those aims at the highest levels of governance and leadership; and

• Commit personally to these aims and communicate them to all stakeholders in a way that engenders heartfelt commitment to achieving them.
Establishing system-level performance measures helps to answer the questions, “What are we trying to achieve, and how are we doing at it?” Sometimes referred to as the “big dots” (a reference to the visual display of critical data points for important measures that reflect the quality of care delivered), well-chosen system-level measures collectively define what is ultimately important to the stakeholders of the organization. Collectively, they provide an answer to the question, “How good are we?”

To help measure the overall quality of a health system and to align improvement work across a hospital, group practice, or large health care system, IHI and colleagues developed the Whole System Measures. For each measure, IHI set an ambitious goal that would represent breakthrough performance—performance that exceeds previous believed “limits”—referred to as the “Toyota Specification.” The Whole System Measures provide an excellent example of a balanced set of world-class, system-level (“big dot”) quality performance measures from which an organization’s leaders might choose a few dimensions in which to seek breakthrough performance. The measures are intended to complement an organization’s existing balanced scorecard, measurement dashboard, or other performance measurement system.

The tables below list the Whole System Measures, the relevant Institute of Medicine (IOM) Dimension of Quality, and the Toyota Specifications. Table 1 shows the performance (“Toyota”) specifications for system-level measures, while Table 2 shows the performance specifications for specific components of the care system.

Table 1. Whole System Measures and Toyota Specifications: System Level

<table>
<thead>
<tr>
<th>IOM Dimension of Quality</th>
<th>Whole System Measure</th>
<th>Toyota Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered</td>
<td>Patient Experience Score</td>
<td>[Response to the question in the How’s Your Health database, “They give me exactly the help I want (and need) exactly when I want (and need) it.”]</td>
</tr>
<tr>
<td>Effective and Equitable</td>
<td>Functional Health Outcomes Score</td>
<td>5% of Adults Self-Rate Their Health Status as Fair or Poor [Self-rating will not differ by income]†</td>
</tr>
<tr>
<td>Efficient</td>
<td>Health Care Cost per Capita</td>
<td>[Surrogate measure: Medicare Reimbursement per Enrollee per Year]‡</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Due to the lack of nationally available data using the Functional Health Survey-6+, IHI used self-reported health status data from the Centers for Disease Control and Prevention Health-Related Quality of Life Surveillance report.
‡ Due to difficulty with calculating Health Care Cost per Capita, a surrogate measure of Medicare Reimbursement per Enrollee may be used for ease of collection.
Several aspects of Leverage Point One deserve emphasis, based on what has been learned over the last three years:

- The responsibility for adopting aims and overseeing measures cannot be delegated by the board. What the governance board pays attention to gets the attention of management, physician leaders, and, ultimately, the entire organization.

- Aims must be focused. It is unrealistic to set breakthrough aims across the entire spectrum of performance. In fact, it is highly unusual for any organization, in or out of health care, to achieve breakthrough levels of performance in more than one or two dimensions during any one year.

- It is impossible to overemphasize the importance of the data feedback loop that boards use to oversee the achievement of system-level aims. For strategic breakthrough aims, the primary question that the data must answer for boards is “Are we improving? Are we on track to achieve our aim(s)?” To allow boards to answer this question, measurement of performance must:
  - Use consistent operational definitions so that the board can track the trajectory of performance over time;

<table>
<thead>
<tr>
<th>IOM Dimension of Quality</th>
<th>Whole System Measure</th>
<th>Toyota Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Rate of Adverse Events</td>
<td>5 Adverse Events per 1,000 Patient Days</td>
</tr>
<tr>
<td>Safe</td>
<td>Incidence of Nonfatal Occupational Injuries and Illnesses</td>
<td>0.2 Cases with Lost Work Days per 100 FTEs per Year</td>
</tr>
<tr>
<td>Effective</td>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>HSMR = 25 Points Below the National Average</td>
</tr>
<tr>
<td>Effective</td>
<td>Hospital Readmission Percentage</td>
<td>30-Day Hospital Readmission = 4.49%</td>
</tr>
<tr>
<td>Effective</td>
<td>Reliability of Core Measures</td>
<td>10^7 Reliability Levels</td>
</tr>
<tr>
<td>Patient-Centered</td>
<td>Patient Satisfaction with Care Score</td>
<td>60% of Patients Selected the Best Possible Score</td>
</tr>
<tr>
<td>Timely</td>
<td>Days to Third Next Available Appointment</td>
<td>Primary Care: Same-Day Access Specialty Care: Access Within 7 Days</td>
</tr>
<tr>
<td>Efficient</td>
<td>Hospital Days per Decedent During the Last Six Months of Life</td>
<td>7.24 Hospital Days per Decedent During the Last Six Months of Life</td>
</tr>
</tbody>
</table>
o Be timely (no more than a month’s lag between data and review); and

o Not necessarily be risk-adjusted or use “rates of events per number of interactions.” (These sorts of measurements tend to be more complex, can delay feedback loops, and are primarily used to answer a different question, “How do we compare to other organizations?”)

• It is not enough for boards to review performance measures. When they hear stories of the patients and families whose lives have been affected by quality and safety events, boards will drive for improvement with a much greater sense of urgency and commitment.

• Boards must develop the capability to oversee quality and safety. The best boards are bringing in members who are experts in quality methods in manufacturing and other industries, and are investing in education of all the trustees.

• It is often helpful to develop specific scorecards of measures to track progress on efforts such as a hospital’s work on the 5 Million Lives Campaign, or its major strategic goal to reduce hospital-acquired infections, rather than have key data elements related to these initiatives simply reported out and mixed together with all other quality and reporting metrics. Initiative-specific scorecards create context, which facilitates both understanding and monitoring of progress.

• When boards start holding management accountable for achievement of breakthrough aims, the trustees start asking tough questions. This sends signals throughout the organization that can be a powerful force for culture change.

Ascension Health’s board provides us with an excellent example of the practices described above. In 2003, the board of this 70-hospital system adopted a specific, focused breakthrough aim: zero preventable deaths and injuries by the end of 2008. The boards in each region have incorporated review of patient stories about preventable deaths into their meeting agendas, and the boards must approve the action plan to prevent similar events in the future. Furthermore, the regional boards do not simply accept every action plan passively, but often send the management team back to develop more robust solutions to serious safety risks. The Ascension system tracks the risk-adjusted mortality rate on a monthly basis, and has built the achievement of their aim—zero preventable deaths and injuries—into the management performance expectations. The results at the system level are shown in Figure 3.
Figure 3. Example of Board Oversight of Performance Measurement for System-Level Aims at Ascension Health

Leverage Point Two: Develop an Executable Strategy to Achieve the System-Level Aims and Oversee Their Execution at the Highest Governance Level

Execution tends to be the weakest link in the Will-Ideas-Execution triad. As depicted in the Framework for Execution in Figure 2 above, and as described in detail in IHI’s Execution of Strategic Improvement Initiatives white paper,* there are four critical steps for leaders who wish to achieve breakthrough results:

1. The senior team and board must adopt a few focused breakthrough quality and safety aims (as described in Leverage Point One, above).

2. The senior executive team must develop a plan—a “rational portfolio of projects”—with the scale and pace needed to achieve their aims.

3. Key projects must be resourced with capable leaders, both at the large project level and at the day-to-day microsystem level.

* Execution of Strategic Improvement Initiatives, Institute for Healthcare Improvement, 2005.
4. The management team must monitor and respond to data from the field at multiple levels in order to steer the execution of the strategy. Leaders must get answers to the questions, “Are we executing our strategy?” (data about the progress of the portfolio of projects) and “If we’re executing the strategy, is it working?” (data about the system-level measures that the organization is trying to move to a new level).

From field observations over the past three years of how senior executives go about building executable strategies and getting results, we emphasize the lessons that follow about the four critical steps to successful execution.

- Just as the board cannot delegate the adoption and oversight of system-level quality aims, the executive team cannot delegate the building and execution of a plan to achieve the aims. The era when quality aims could be delegated to “quality staff,” while the executive team works on finances, facility plans, and growth, is over. System-level breakthrough aims are by their very nature strategic, and require the energy and attention of the entire organization, led by the CEO and the entire executive team.

- One good way to build a rational portfolio of projects is to develop a cascaded series of goals and drivers (see Figure 4). In this method, the senior executive team adopts one or two breakthrough goals and for each goal posits up to three “drivers”—structures, processes, or cultural patterns that would need to be put in place, or changed, in order to achieve the goals. Each of the chosen drivers is assigned to an individual member of the senior executive team as a goal to be achieved, and that executive then brings a group together at the next level to address a new driver question, “What would have to be changed or put in place in order to achieve this goal?” The conversations about goals and drivers then cascade in a similar fashion through additional levels of the organization, until the answer to the driver question looks like a project—i.e., something that could be executed by a specific team in a focused manner over, say, 90 days. The result of this cascaded series of goals and drivers is not only a good project plan, but also a highly visible, well-communicated logic of the plan wherein each person, at every level, knows their part and how those parts fit into the whole.

- IHI’s experience in the field keeps reinforcing the old truth: “Culture eats strategy for lunch.” When thinking through drivers of major system-level quality and safety aims, cultural drivers should be near the top of any leader’s list. Patterns of behavior that are driven by underlying values, habits, and beliefs—the organization’s culture—will dominate every other possible driver and may jeopardize changes to processes and structures unless they are explicitly addressed. Some examples of such patterns of behavior around safety practices might be the following:
“We follow the safety rules…unless we’re really busy.”

“Those are good rules for infection prevention, but they really don’t apply to me.”

• The Framework for Execution describes other methods by which an executable project portfolio can be developed, but all effective methods seem to share the two features described below.

1. A good method for execution ensures that the system-level aims have a powerful influence on choices of projects throughout the organization. Managers are not being asked, “How does what you’re already working on in your department support the system-level aim?” Instead, the primary question is, “What do we need to do in order to accomplish the aim?” The first question results in what one frustrated manager reported: “We do all this strategic planning, and set these grand goals, and then the plan to accomplish the goals looks pretty much like every department simply rationalized its pet projects.” The second question results in a portfolio of projects with the scale and pace needed to accomplish the stated aim.

2. A good method forces focus. The example in Figure 4 depicts the logic chain for only one driver at each organization level. In reality, a cascaded set of conversations, with two or three drivers at each level, will branch many times, resulting in a fairly large number of projects once the process has played out to the project level. If leaders do not focus on one or two aims, supported by three or fewer drivers, then the cumulative burden of projects that results is overwhelming for front-line staff (especially when added on top of their daily work!).

• Large, complex projects must be led by capable leaders who are given the time to do the projects or the projects will not be successfully executed. Outside of health care, in companies capable of execution, the individuals chosen to lead a project of strategic importance are carefully chosen, and given time (for example, 50 percent to 100 percent of their time for six months) to complete a major strategic project. In contrast, health care organizations often ask leaders to take on major projects as “add-ons” to already daunting workloads.

• Even with careful attention to developing a logical portfolio of projects, creating focused aims, and enabling well-resourced and supported project leadership, a plan to achieve system-level breakthrough aims requires guidance and oversight from the senior executive team. A successful leadership system for execution has two critical components: 1) obtain data and feedback regularly on whether a) the strategic project portfolio is being executed, and b) the strategy is working; and 2) have senior executives regularly review and respond to timely, useful data on these two questions. This type of system ensures that leaders take timely action to resolve issues that may be prohibiting execution (e.g., break down barriers, provide resources for project leaders, or replace project leadership). If projects seem to be executed well, but little progress on system-level measures is seen, the senior team then takes action to revise the strategic project portfolio or ramp up the scale and pace of implementation.
Figure 4. Example Cascading Series of Goals and Drivers

<table>
<thead>
<tr>
<th>Key Drivers to Achieve Goal</th>
<th>Leader's Goal</th>
<th>Leader Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician/nurse teamwork</td>
<td>Reduce mortality rate by 20% in 2 years</td>
<td>CEO</td>
</tr>
<tr>
<td>• End-of-life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital-acquired infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Handwashing</td>
<td>Reduce hospital-acquired infections by 50% in 12 months</td>
<td>Chief Medical Officer, Chief Nursing Officer</td>
</tr>
<tr>
<td>• Lean processes: Flow management, reduce wasted time and effort of staff to give time to barrier precautions, handwashing, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bundles: Ventilator, Central Line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adopt common pre-operative order sets for the same conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Learn and use “Level 2” reliability principles in all critical care areas and surgery suites</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fully deploy Ventilator Bundle and Central Line Bundle to all units within six months</td>
<td>Department Chairs, Nursing VPs</td>
</tr>
<tr>
<td></td>
<td>Project: Achieve 10^2 reliability in the Ventilator Bundle and Central Line Bundle within three months</td>
<td>ICU Unit Manager, Medical Director</td>
</tr>
</tbody>
</table>

Leverage Point Three: Channel Leadership Attention to System-Level Improvement: Personal Leadership, Leadership Systems, and Transparency

The currency of leadership is attention. What leaders pay attention to tends to get the attention of the entire organization, and all potential resources for channeling leadership attention, whether formal or informal, should be connected to the aim: personal calendars, methods of data display, meeting agendas, project team reviews, executive performance feedback and compensation systems, hiring and promotion practices, to name a few. We have begun to notice three key ways in which effective senior leaders channel attention to system-level improvement: personal leadership, leadership systems, and transparency. In concert, these three methods form a powerful leverage point for achieving system-level results.

Personal Leadership

The staff pay attention to the organization’s senior executives and, in particular, to what they do with their time. If an organization establishes a new breakthrough safety aim (e.g., “eliminate
hospital-acquired infections”) as part of its strategic planning process and the CEO and other senior executives continue to do exactly what they did the year before—attend the same meetings, visit the same project teams, read and ask questions about the same reports, ask for data about the same performance measures—then the staff’s interpretation of this new goal is, “Well, it’s a nice thing to aim for, but they don’t really take it seriously, so why should we?”

Executives are constantly sending signals about what they believe to be important. Some signals are negative (e.g., arriving late to the meeting, not asking questions, taking a phone call during the meeting, and leaving early). Other signals tell the staff that executives really care about achieving the stated quality aim. Examples of positive signals might include the following:

- **Prioritize Calendars:** Leaders can change their personal schedules to make time for data review, meetings with project leaders, and other activities that support the work.

- **Conduct Project Reviews:** Senior executives can send powerful signals by personally performing reviews with project teams—asking about their project aims, connecting the work of the team to the overall organization aims, focusing on results, helping the team to overcome barriers, and providing encouragement.

- **Tell Stories:** Positive organizational “buzz” can be created by the stories that executives tell in their formal and informal communications. If the stories reinforce the cultural changes and practices needed to achieve breakthrough aims (e.g., a story about a manager’s willingness to do multiple rapid tests of change and the great results achieved), they will encourage more rapid adoption of the needed patterns and practices.

**Leadership Systems**

Personal leadership is a powerful way to channel attention, but even the best personal leadership needs to be supported by good leadership systems—the interrelated set of structures and processes by which leaders work. It’s a great beginning for a senior executive to remake her calendar to include project meetings, conduct project team reviews, and tell great stories that reinforce the desired culture changes and behaviors. However, if senior executive meeting agendas, data reviews, messages communicated at quarterly staff meetings, and featured items in the weekly newsletter do not all support the quality and safety aims, these defects in the “leadership system” will lessen the effect of that executive’s individual efforts.

A simple way to test the effectiveness of leadership systems is to find out what performance data are “top of mind” for senior executives and other managers. In most health care organizations, the vast majority of executives will know the last month’s operating margin and service satisfaction scores. But very few will know the last month’s mortality rate, or number of hospital-acquired infections, or number of decubitus ulcers. This is because the leadership systems are different for finance than
they are for quality and safety—the reliability and timeliness of measurement and reporting, the frequency and depth of management reviews, and so forth.

In organizations that achieve system-level results, the key data related to quality and safety tend to be “top of mind” for executives, not just for the quality staff. The COO of an extremely high-performing community hospital—when asked about the most recent data for several key performance measures, which he quickly rattled off without reference to documents or other support—said the following about the basic elements of a good system for channeling leadership attention to system-level improvement:

“We get the key measures updated monthly. At each weekly management meeting we go over one of the categories—safety, for example—in depth, and take actions to make sure we’re on track. We post the numbers each month on every bulletin board in the hospital, so I get a lot of questions about them as I walk around. Besides, I just finished up our quarterly staff communication meetings where the main priority is to explain these numbers to all the staff. After all, a portion of my paycheck, and of all the staff’s paychecks, depends on how we do against these numbers!”

Transparency

Perhaps the most powerful method of channeling leadership attention is to harness the power of transparency. (In fact, this is such a potent tactic that we debated whether “Harness the Power of Transparency” might stand alone as a new Leverage Point Eight.) The fundamental force behind this method is simple: if the public (regulators, media, community, patients) are paying attention to all of your quality and safety performance data (and not just the numbers that you’re proud of), then those people inside the organization will tend to work with greater urgency to improve performance (especially the numbers they aren’t proud of). Or, put more memorably: “If you’re going to be naked, it’s good to be buff.”

The Wisconsin Collaborative for Healthcare Quality provides an excellent example of the power of transparency. A group of health care systems worked with employers to design and publicize a 40-item quality and safety report. The systems agreed to report all the data they had, good or bad, and also agreed that they would not use any of the data for marketing. When the first reports went to the public, each organization was the best in the state in at least one of the 40 measures, and each was also the worst in the state in another of the 40 measures. John Toussaint, CEO of ThedaCare, a participant in the Collaborative, describes the internal reaction at ThedaCare to having publicly displayed data they were not proud of:

“Within hours, the doctors in that department were in my office angrily asking me, ‘How dare you send out those numbers to the public? We look bad!’ After I calmed them down a bit, I said, ‘Well, maybe the numbers are bad because we are bad.’ It took about a week to solve the problem and make dramatic improvements in the numbers. We had been working on that
issue for a couple of years, without getting anywhere. And once it went to the public, we solved it in a week."

Health system leaders often express reservations about transparency because they fear that patients will choose other hospitals or medical groups if they see unflattering data. The past few years of experience, along with the limited data from formal studies of public transparency, should reassure hospital marketing departments that, in general, public reporting does not lead to shifts in market share and volumes, even when the reports show the hospital in a bad light.

Other hindrances to transparency include fear of malpractice suits and worry that philanthropy will dry up if donors hear about poor performance measures. Neither of these fears appears to be valid. The vast majority of malpractice suits have nothing to do with errors or actual performance data, but rather are the result of broken trust relationships. And our experience with donors suggests that they recognize that no hospital is perfect, and they feel valued and respected when they are treated with honesty about hospital performance.

**Leverage Point Four: Put Patients and Families on the Improvement Team**

The most commonly cited reason for failure of organizations to reach breakthrough aims is the failure of the senior leadership group to function as an effective team, with the appropriate balance of skills, healthy relationships, and deep personal commitments to achievement of the goals. CEOs who want to achieve quality and safety goals must constantly ask themselves, “Do I have the right senior team in place to get the job done?” Getting this difficult judgment correct, and acting on it, is a critical task for the CEO, and is therefore a key leverage point for system-level performance improvement.

We recognize that while getting the senior leadership team right is extremely important, this challenge is fairly broad and universal (i.e., every CEO faces this question, for every kind of strategic aim). We therefore reframed Leverage Point Four to make it less “generic” and much more focused. Instead of “Get the Right Team on the Bus,” we have zeroed in on team members who usually aren’t even considered candidates to be on the bus—patients—and have restated Leverage Point Four as “Put Patients and Families on the Improvement Team.”

Our rationale for this change is straightforward. Quite simply, we have observed that in a growing number of instances where truly stunning levels of improvement have been achieved, organizations have asked patients and families to be directly involved in the process. And those organizations’ leaders often cite this change—putting patients in a position of real power and influence, using their wisdom and experience to redesign and improve care systems—as being the single most powerful transformational change in their history. Clearly, this is a leverage point where a small change can make a huge difference.
What does Leverage Point Four look like in action? The following are four examples.

**Daily Patient Conversations with Senior Executives**

The entire senior management team at McLeod Regional Medical Center in Florence, South Carolina, starts each day by gathering outside the CEO’s office and then going to a patient care unit. Each member of the senior team visits three or four patient rooms, talks with the patients and nursing staff, asks patients about their experiences, and gives patients the daily newspaper. The whole process takes about 30 minutes, including a standing debrief with the entire team. Patients and staff see the senior team as personally engaged in making the care system better, and the senior executives hear ideas and concerns directly from patients in ways they have never done before.

One powerful consequence is the effect these conversations have on the executives themselves, who typically feel energized and inspired to improve the care system with much greater urgency and commitment than they would without the patients’ words ringing in their ears every morning. The results at McLeod’s 550-bed hospital are spectacular: a 40 percent drop in mortality rate, some of the very best CMS Core Measure scores in the nation, and a dramatic drop in adverse drug events—including a seven-month run with zero harm from medications.

**Family-Centered Rounds**

At Cincinnati Children’s Hospital in Ohio, it has become routine to give parents the choice to be full participants in the daily “work rounds” as nurses, house staff, and teaching faculty give progress reports, do examinations, discuss differential diagnoses, and make treatment plans. The process provides parents with direct, unfiltered communication about everything that is happening with their child, and also invites parents to provide information and participate in decisions in an unprecedented fashion. Parents are involved in ensuring that medication orders are correct and helping to create discharge goals. Families routinely say they now feel they are truly part of the care team. In the words of Steve Muething, a pediatrician and Assistant Vice President of Patient Safety: “Family-centered rounds began as a flow initiative and there was much resistance. Five years later it is a core value of our organization. Nurses and physicians believe care is better and safer and the teaching improves when parents are active participants in rounds. Teams are now uncomfortable when parents aren’t involved in rounds.”

**Structural Integration of Patients and Families**

Stimulated in part by a well-publicized patient death from an overdose of chemotherapy, Dana-Farber Cancer Center in Boston, Massachusetts, began asking patients and families to participate in the design of safer care processes. This institution now has over ten years of experience inviting patients and families to become full members of virtually every committee, task force, and improvement team in the organization. Over 400 patients and families are now actively involved as volunteers in these roles at any one time, as full participants in decisions about care design, safety improvements,
facility planning, operations management, and strategic issues—essentially everything important about the organization. Although many internal staff members were skeptical about this change at the beginning, they now wonder how they ever ran Dana-Farber without having patients and families deeply involved. Two “results” stand out among many performance highlights: There have been no more fatal medication safety events in the 11 years since they began this structural and cultural change, and philanthropic support (by many of the same volunteers who help to run the organization) reached the astounding level of $160 million in 2006—without a major capital campaign.

Patient Stories at Board Meetings

Every meeting of the Board Quality Committee at Delnor-Community Health System in Geneva, Illinois, features a patient story about a harm event, helping the organization “put a face on the problem” rather than just seeing abstract reports of measurements. Typically, a patient (or family member) is invited to tell what it was like for them to experience a surgical site infection, or some other quality defect. Board members then ask questions to clarify their understanding of the experience. Although these conversations take only 20 to 30 minutes during the actual meeting, there is a lot of preparation involved—to invite a patient or family member (not all want to participate), prepare the patient and family for the meeting, discipline the board not to get into ad hoc problem-solving during the meeting, and so forth. The effect on the board members has been powerful. They now ask questions of the medical staff and administration with greater passion and urgency, and they expect results. It might be a coincidence, but it is over a year since Delnor has had a ventilator-acquired pneumonia or a central line infection, and the mortality rate at Delnor has dropped some 40 percent in two years. There are other ways in which boards and senior leaders can hear patient stories, but none are as powerful as having the patient in the room.

The principles behind Leverage Point Four are nicely articulated in the “Patient- and Family-Centered Care” approach of the American Hospital Association, as follows:

• All people (patients, families, and staff) will be treated with dignity and respect.

• Health care providers will communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.

• Patients and families participate in experiences that enhance control and independence.

• Collaboration among patients, family members, and providers occurs in policy and program development and professional education, as well as in the delivery of care.

The most important learning from the last three years of experience is that these principles must be translated into specific structural and process changes if they are to have an effect on the organization’s culture. The most powerful of these structural and process changes—the one with the most
leverage—is to “Put the Patient in the Room.” At least four things happen when patients and families work alongside health care professionals to improve quality and safety:

- **Self-Serving Conversations Cease:** Many complaints (e.g., “We can’t do it that way because that would require us to cooperate with that other cardiology group with which we compete”) sound unseemly when patients and families are in the room.

- **The Whole System of Care Comes into Play:** Patients experience care across multiple departments, medical groups, and organizations. They want solutions that work for them, not just for one part of the system.

- **Better, More Innovative Ideas Come Forward:** Patients and families are a tremendous wellspring of ideas for improvement and redesign, if we listen to their voices.

- **Physicians and Nurses Feel Supported and Inspired:** When patients are on committees and task forces, they become a source of energy and positive reinforcement for care professionals.

For all these reasons, we believe that Leverage Point Four—Put Patients and Families on the Improvement Team—is not only an important force in driving the achievement of measured results, it is also the leverage point with the greatest potential to drive the long-term transformation of the entire care system.

**Leverage Point Five: Make the Chief Financial Officer a Quality Champion**

One particular member of the senior executive team stands out, in our view, as a critical leverage point for large system change: the CFO. The connection between quality improvement and business performance is still weakly made in most health care organizations, but that is changing. The combination of pay-for-performance programs, major changes to the Medicare payment system, and the elimination of increased payment for eight “never events” has put quality and payment on the radar screens of many health care CFOs. Additionally, a number of organizations have begun to try to understand the true financial impact of harm events such as falls, medication errors, and delayed care. Others are examining the comparative cost of care when evidence-based care protocols are utilized. CFOs are finding significant opportunities to improve patient care margins by reducing and eliminating error and clinical waste.

Traditionally, the successful health care CFO is a master of the revenue stream, able to maximize contracts and payment systems. Cost-reduction efforts have generally been in reaction to external changes in the market or payment systems and are mostly one-time events focused on reducing the cost of labor, supplies, and vendor contracts (i.e., the inputs to the processes of care). But when compared to CFOs in other industries, health care CFOs have typically not focused on improving the processes themselves—taking out wasted time and effort, eliminating defects that require rework,
and so forth. To a large extent, the core processes of health care—diagnosing, treating, communicating with patients, etc.—have been something of a “black box” and off limits to health care CFOs.

Leverage Point Five reflects our belief that health care organizations would be far more likely to achieve dramatic improvement in system-level measures of both financial and quality performance if health care CFOs were to become strong drivers of quality-based elimination of waste, and if their commitment were translated deeply into the budgeting, capital investment, and innovation and learning systems of an organization.17

The strongest examples of Leverage Point Five in action tend to come from organizations such as Virginia Mason Medical Center in Washington, Park Nicollet Health Services in Minnesota, ThedaCare in Wisconsin, and McLeod Regional Medical Center in South Carolina that have adopted lean management principles (in particular, the Toyota Production System).18 In these health care systems, efforts to both reduce costs and to improve quality are primarily focused on the processes of care. Any reduction in input costs (supplies, personnel, etc.) comes about as a result of having removed waste from the process, not as a new constraint on an unimproved process. Examples of what these organizations are achieving by engaging the CFO in improvement of core care delivery processes include the following:

• Improving time available for care delivery: McLeod has eliminated 112 minutes of wasted nursing documentation time per cardiac patient, freeing up nurses to provide higher levels of quality and safety.19
• Improving throughput and avoiding capital costs: By using lean techniques to manage flow, Park Nicollet now routinely processes 64 patients per day through the same endoscopy facility that once struggled to care for 30 to 32 patients per day, with less strain and effort on the part of nurses and physicians. Patients and staff are delighted, and $3 million in capital expenditures were avoided.²⁰

• Making more secure long-term financial plans: ThedaCare has seen so much reduction in waste from their first couple of years of widespread application of the lean methodology that the CFO has built a long-range financial plan that does not require any price increases.²¹

Some patterns are emerging from these examples and others like them:

• **Organizations with CFOs who are engaged in improvement efforts have adopted quality as the strategy, not one of many strategies.** The key marker of this strategy is seen when times get tough: these organizations invest more, not less, in quality when they are under financial pressure.

• **These CFOs take a personal role in process improvement and waste removal.** It isn't enough to cheer on the sidelines; CFOs must be teachers and practitioners of quality methods, and actively seek out process improvement opportunities. A good example at Park Nicollet has been the huge reduction in administrative waste that resulted from the elimination of the entire budgeting process—three months of management time and energy expended every year in what the CFO realized was pure waste.²²

• **These CFOs encourage serious investment in development of improvement capability.** When quality is the strategy, organizations recognize the significant investment that must be made to develop capable leaders of improvement at all levels and they make the commitment to build this capability (see Leverage Point Seven).

• **CFOs are beginning to shift their focus to cost per unit as opposed to revenue per unit.** Because most hospital payment systems involve a fixed form of payment (e.g., DRGs, case rates, bundled outpatient rate, Ambulatory Surgical Center rate, per diem rate), many CFOs are making the connection that eliminating infections, medication errors, falls, and delays in care are strategies for reducing their average per unit cost of production and increasing the margin on care delivery. Taking it one step further, some CFOs are beginning to ask what it should cost to treat pneumonia, replace a hip, or deliver a baby, for example, establishing a per-unit cost standard for various high-volume reasons for admission. Rather than asking managers to cut dollars from a budget, these organizations are asking managers to decrease the cost per unit of production by eliminating clinical and administrative waste.
Leverage Point Six: Engage Physicians

Clearly, all members of the health care team need to be engaged if leaders are to succeed in making quality and safety improvements. So why single out physicians? This leverage point arises from the reality that whereas physicians by themselves cannot bring about system-level performance improvement, they are in a powerful position to stop it from moving forward, and therefore their engagement is critical. Simply stated, leaders are not likely to achieve system-level improvement without the enthusiasm, knowledge, cultural clout, and personal leadership of physicians.

“Yes, but how do we engage physicians?” Since the First Edition of this white paper was published, this has been the most common question asked by hospital and health system executives. IHI’s answer to this question is structured around the framework depicted in Figure 6 and is described in detail in the Engaging Physicians in a Shared Quality Agenda white paper. That white paper builds on the principles articulated in the initial Seven Leadership Leverage Points and utilizes continued learning from organizations that have achieved breakthrough levels of performance with a high degree of physician engagement (e.g., McLeod Regional Medical Center and Immanuel St. Joseph’s–Mayo Health System in Minnesota).

Figure 6. IHI Framework for Engaging Physicians in Quality and Safety

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Each of the six elements of this framework is important by itself, but physician engagement is more likely when leaders work across all the elements. Specific examples of how hospital and health care system leaders are using the framework to engage physicians are described below.

**Discover Common Purpose**

The key idea here is to learn what the physicians' quality agenda is, and to harness your quality efforts to their agenda. “Physicians' quality agenda” is not an oxymoron. Doctors care deeply about their patients' outcomes, and they also care deeply about wasted time (especially their own). In contrast, doctors are less excited about improving the hospital's publicly reported quality scores, reducing length of stay, or removing waste in the supply chain—all of which they tend to think of as “the hospital’s problem, not mine.”

Hospital leaders can address this gap by how they frame aims and measure results. Physicians care about mortality and harm—quality and safety outcomes—much more deeply than they care about process measures, and one way to engage them is to make sure that the organization's aims focus on outcomes that are meaningful to doctors. For example, instead of aiming to “be in the top tenth percentile of CMS Core Measures,” a hospital might establish an aim to “reduce the risk of needless deaths in the hospital.” One strategy to accomplish this aim might be to improve the reliability of CMS Core Measures for acute myocardial infarction and pneumonia.

**Reframe Values and Beliefs**

Both administrators and doctors need to reexamine and reframe some of their core values and beliefs if true engagement in quality and safety is to occur. Administrators must begin to think of doctors as partners rather than as customers. Doctors must begin to see their responsibility for the system's quality results, and not just for their own personal quality performance. These sorts of deep cultural changes do not happen overnight, and won't happen just because we wish them to. One example of process that might be redesigned to help drive changes in values and beliefs is the traditional “Morbidity and Mortality Conference.” Typically in these conferences it is the doctors who ask, “Did someone make an error of judgment or of technique in this case?” The redesigned process would focus on doctors and administrators asking a very different question: “What were the systems factors—culture, structure, processes—that contributed to this death, and what could we do together to change these factors?” Over time, as this question is repeatedly asked and addressed with real action, physicians will start to feel more like valued partners in the hospital's operations, and they will also begin to work on the system of care, not just in the system of care.
Segment the Engagement Plan

One of the most immediately practicable elements of the IHI Framework for Engaging Physicians in Quality and Safety uses the principle of segmentation. Not all physicians need to be engaged in any particular quality initiative, and those that must be engaged do not need to be engaged in exactly the same way. The idea is to develop a segmented plan for engaging physicians—one plan for a few physician champions, another plan for the physicians who might be members of the actual improvement team, yet another plan for the structural leaders of the medical staff who might need to adopt a new hospital policy based on the work of the team, and so forth. It is important when designing each of these segmented plans to include a plan to engage those physicians who are likely to block recommendations that emerge from the project team or policies recommended by the structural leaders.

Use “Engaging” Improvement Methods

Executives realize that doctors have often been cynical about quality improvement in the past because the methods—ways of involving physicians in improvement work, data reporting, etc.—are almost guaranteed to disengage them. For example, asking busy doctors to join an improvement team that meets every two weeks during the time doctors would otherwise be making rounds; using the vast majority of the meeting time for activities that don't require physician input; gathering data month after month without testing any changes, then sending out flawed performance data on quality measures to individual doctors and asking them to improve.

The process for standardizing clinical processes is another example where redesign is needed to better engage physicians. Typically, when doctors are asked to standardize their approach to a clinical situation, they design a protocol, care pathway, or guideline—a specification of what should be done, using the best evidence. Visually, the process looks something like Figure 7—a series of conference room meetings, often stretched out over months, during which the evidence is debated and different doctors and specialties argue their favorite points—all about what should be done, in theory. There is little discussion about how, who, when, where—the practical aspects of actually executing a guideline in any given clinical setting—and no testing of any of the ideas in the real world to see whether any of this works. Is it any wonder that few doctors choose to use the final product, when it is eventually sent forth into the clinical world with the hopes that the doctors will “opt in”? 
A much better way to standardize clinical processes, one that engages physicians, is to spend no more than one meeting on the *what* of a guideline and use small tests to refine the design for the local setting (see Figure 8). There is usually a good “starter kit” for a clinical protocol or guideline available from a national, reputable source—good enough for most clinical settings as an initial protocol. The main work of the standardization team is not to reinvent the science behind this protocol, within each hospital. Rather, their focus is on how to make the existing protocol work within the local context. The team tests various methods for *how, who, when, where,* initially on a very small scale, making frequent changes to improve implementability. Tests of change increase in scale, until most doctors find themselves able to use the protocol in their patient care. At that point, the guideline or protocol is adopted with the expectation that doctors *opt out* if they don’t wish to use it. After all, through its testing the team has demonstrated that the vast majority of doctors can use the protocol and it works well in daily practice.
Show Courage

Change is required to make improvements in quality and safety; this change is not easy, especially when one powerful voice speaks out against it. Physicians are among the most powerful voices in health care organizations and their collegial nature makes them reluctant to challenge other doctors. “Monovoxoplegia,” or “paralysis by one loud voice,” is a common phenomenon that occurs in doctors’ meetings, improvement teams, executive team meetings, and even in board rooms, where lay board members often sit silent when one doctor speaks up against a proposed change.

There is no simple answer to overcome “monovoxoplegia,” but the basis of an effective approach relies on building an organizational culture of courage—the courage to ask questions, to challenge the status quo, and to support the doctors and nurses who do wish to make improvements. Courage of this sort is beautifully illustrated by Donna Isgett at McLeod Regional Medical Center, and the question she now asks physicians when they balk at using evidence-based practices: “Are you saying that you value your individual autonomy more than you value your patients’ outcomes?” Knowing that they will be supported all the way to the board enables all clinicians, including doctors, to ask tough questions. Courage is infectious.

Adopt an Engaging Style

To achieve the best improvement results, leaders must keep in mind certain characteristics in the physician professional culture, including their focus on individual patients, a deep sense of individual responsibility for patient outcomes, the tendency to overestimate the risk of changes in practice, and valuing individual experience over data and formal studies. Below are some ideas, more fully described in the Engaging Physicians in a Shared Quality Agenda white paper, for developing a “style” that engages physicians in improvement.

• **Involve Physicians from the Beginning:** Don’t hand them a final or near-final version of proposed changes.

• **Work with the Real Leaders:** In most groups of physicians, there are typically one or two opinion leaders. They might not be the “titled” leaders within the organization, but they have earned the respect of their peers and can influence others. To facilitate change and improvement, these real leaders must be involved in the improvement work.

• **Choose Messengers and Messages Carefully:** Physicians often give credibility in part to who delivers the message, so it is important to plan how a proposed change is described and by whom (e.g., a specialist, a general practitioner, a physician with specific specialty qualifications, etc.). Furthermore, terms such as “accountability” and “performance reports” can have unintended meaning, and communication should be designed to be engaging rather than inflammatory.
• **Be Transparent, Especially with Data:** Physicians generally don’t trust interpreted data, so give them access to the raw data. Even if they never look at the data, they will value knowing that you trust them to do so.

• **Value Their Time with Your Time:** If an executive leader asks physicians to take time to engage in a “critical strategic initiative” but can’t be bothered to attend meetings himself, then the doctors feel manipulated and undervalued, and physician engagement will suffer accordingly.

**Leverage Point Seven: Build Improvement Capability**

Three years of field experience have reinforced the critical importance of Leverage Point Seven. It would do little good for an organization to implement Leverage Points One through Six—adopt aims at the board level; develop brilliant plans to achieve the aims at the executive level; channel attention to the aims with transparency and executive time; engage patients in designing changes to achieve the aim; link financial and clinical improvements to the aim; and engage physicians in the aim—if no one in the organization were technically capable of making, sustaining, and spreading improvements (Leverage Point Seven).

To effectively execute improvement projects throughout an organization, leaders must devote resources to establishing capable leaders of improvement in every microsystem. If successful projects are to scale up, spread, and change the performance of the entire system, then leaders must build a system of leaders capable of rapidly recognizing, translating, and locally implementing change concepts and improved designs. The list of capabilities required of senior leaders to drive system-level improvement is long, but includes at a minimum the ability to know, use, and teach the following:

• The Model for Improvement and small-scale rapid tests of change\(^{23}\)

• A coherent improvement strategy such as the Toyota Production System\(^{24}\)

• Concepts and practices of high-reliability organizations\(^{25}\)

• Sophisticated practices in flow management\(^{26}\)

• Concepts and practices of scale-up and spread of improvements\(^{27}\)

• Concepts and practices of safety systems\(^{28}\)

Park Nicollet Health Services provides an example of the level of investment in improvement capability that might be required if quality is to be the strategy for an organization, rather than just a strategy. In an organization of approximately 5,500 full-time equivalent employees, CEO David Wessner has taken 39 of his best managers “off the line” to become deeply trained process improvement leaders, with a full-time focus on facilitating rapid, sustained improvement in quality and safety. He plans to grow this
group of leaders to at least 100 people, over and above the normal complement of staff in areas such as infection control, Joint Commission accreditation, and other typical quality and safety functions.

Over the past three years since the initial leverage points were developed, one of the most consistent findings has been that senior executives tend to overestimate the capability for improvement within their organizations. Simply sending a few staff to a couple of conferences and adding “quality and safety” to job descriptions will not begin to address the critical need for capable improvers at every level in health care organizations.
### Summary of Changes to the Seven Leadership Leverage Points

The table below provides a brief overview of the changes to the Seven Leadership Leverage Points, based on IHI’s learning between publishing the First Edition of the white paper in 2005 and this Second Edition in 2008.

|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **One** Establish and Oversee Specific System-Level Aims at the Highest Governance Level | • Emphasis on the critical role of the board in quality  
• Learning about the power of stories and data at the board level                                                                                                                                                                      |
| **Two** Develop an Executable Strategy to Achieve the System-Level Aims and Oversee Their Execution at the Highest Governance Level | Learning about what it takes to execute change on a large scale:  
• Focus on one or two major aims  
• Rigorous steering of the execution plan using good data from the field  
• Resourcing strategic improvements with capable improvers and change leaders as their primary job responsibility                                                                                                         |
| **Three** Channel Leadership Attention to System-Level Improvement: Personal Leadership, Leadership Systems, and Transparency | • Confirmation and examples of the power of leadership attention to improvement aims  
• A major new emphasis on the power of transparency to drive improvement and change                                                                                                                                                     |
| **Four** Put Patients and Families on the Improvement Team | • Original leverage point focused on establishing the most effective senior leadership team  
• Revised leverage point focuses exclusively on the transformational role of patients and families on leadership and improvement teams                                                                                                           |
| **Five** Make the Chief Financial Officer a Quality Champion | • Learning about the potentially powerful role CFOs can play in improvement once they see “reduce waste in core processes” as the primary driver of cost reductions, rather than the traditional approach of “reduce inputs to (defective) core processes”                                                                 |
| **Six** Engage Physicians | • Developed an entirely new framework for engaging physicians in a shared quality agenda, with extensive examples                                                                                                                                                       |
| **Seven** Build Improvement Capability | • Continued reinforcement of the critical need to build capable improvers at every level as an important underpinning for the other six leverage points                                                                                                                                 |

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Appendix A:  
**Leadership Leverage Points Self-Assessment Tool for System-Level Results**

The self-assessment is a discussion and action tool designed to help the administrative, physician, and nursing leaders of a health care organization design and plan their work in order to lead to a significant reduction in one or two system-level measures (e.g., mortality rate, harm rate, nosocomial infection rate, or chronic disease outcome measure). The self-assessment should be completed by the senior leadership team of the organization, first as individuals and then together as a group to review the results and plan actions that will address any leadership leverage points that need attention.

<table>
<thead>
<tr>
<th>Leadership Leverage Points</th>
<th>Action Needed / Action Planned</th>
<th>By Whom</th>
<th>By When</th>
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<tbody>
<tr>
<td><strong>1. Establish and Oversee</strong></td>
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<tr>
<td><strong>Specific System-Level Aims</strong></td>
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<td><strong>for Improvement at the</strong></td>
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<tr>
<td><strong>Highest Governance Level</strong></td>
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- Senior leadership team has developed specific "how much, by when" aims for system-level measures of quality and safety.
- Board has adopted the aims and is overseeing their achievement using system-level measures of progress against the aim.
- Patient stories about harm or quality issues (either in person, by videotape, or as told by front-line personnel) are part of every board meeting.
- Accountability for achieving the aims is clearly established in the board’s executive performance feedback system.
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<th>Leadership Leverage Points</th>
<th>Action Needed / Action Planned</th>
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<tbody>
<tr>
<td>2. Develop an Executable Strategy to Achieve the System-Level Aims and Oversee Their Execution at the Highest Governance Level</td>
<td>Senior leadership team has developed a plan to achieve the aims that is focused on the right drivers, and has the necessary scale and pace.</td>
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<td></td>
<td>Senior leadership team has resourced the projects that are necessary to achieve the aim with effective leaders.</td>
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<td></td>
<td>Leadership team is steering and adjusting both the strategy to achieve the aim and its execution, based on weekly and monthly review of measures.</td>
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<td>Leadership Leverage Points</td>
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<td><strong>3. Channel Leadership Attention to System-Level Improvement</strong></td>
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<td>Senior executives personally do executive reviews with key project teams working on the aims.</td>
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<td>Measures of progress on each project, and on the overall aims, are widely distributed throughout the organization and the community, even if you aren’t proud of the measures (transparency).</td>
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<td>Leaders are given sufficient time to work on key projects (the work is not just added on to an already busy schedule).</td>
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<td><strong>4. Put Patients and Families on the Improvement Team</strong></td>
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<tr>
<td>Patients and families are deeply involved in all improvement and redesign teams.</td>
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<tr>
<td>Each member of the senior executive team is engaged and committed to achieving the aim, and views this as part of his or her core work.</td>
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<td>Leadership Leverage Points</td>
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<td>5. Make the CFO a Quality Champion</td>
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<td>CFO can articulate the business case for each improvement initiative and is a primary driver of quality improvement.</td>
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<td>Finance representatives are integrated into improvement project teams to support the business case needs.</td>
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<tr>
<td>When times are tough, we invest more in quality since it is our primary strategy for removing waste and improving efficiency.</td>
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<td>Leadership Leverage Points</td>
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<td><strong>6. Engage Physicians</strong></td>
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<tr>
<td>The executive team</td>
<td>understands and shares the</td>
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<td></td>
<td>medical staff’s intrinsic</td>
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<td></td>
<td>motivation for quality (outcomes, wasted time…).</td>
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<td>The medical staff are</td>
<td>regarded as partners in the</td>
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<td></td>
<td>delivery of care, not as</td>
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<td></td>
<td>customers of the hospital.</td>
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<td>There is a clear plan for</td>
<td>developing physician</td>
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<td></td>
<td>engagement that recognizes</td>
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<td>the multiple “segments” of the</td>
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<td>physician staff (champions,</td>
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<td></td>
<td>structural leaders, others).</td>
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<tr>
<td>We use quality methods</td>
<td>that encourage physician</td>
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<td></td>
<td>engagement in quality rather</td>
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<td></td>
<td>than drive them away (sensible use of data, make the right thing easy to do).</td>
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<tr>
<td>Executive, physician, and</td>
<td>nurse managers are confident</td>
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<td></td>
<td>of support all the way to the</td>
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<td>board level, and have the</td>
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<td></td>
<td>courage to engage physicians</td>
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<td></td>
<td>in difficult conversations and</td>
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<td></td>
<td>avoid “monovoxoplegia” (paralysis by one loud voice).</td>
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<tr>
<td>Capable physician leaders</td>
<td>have been appointed to each</td>
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<td>project, and are supported</td>
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<td>with good data and analytic</td>
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<td>resources.</td>
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| **7. Build Improvement Capability** | The entire senior leadership team (including CEO and senior managers) knows and uses the technical and change leadership knowledge required to achieve the aims and execute the strategies:  
- Content knowledge for each strategy  
- Model for Improvement and rapid tests of change  
- A coherent improvement strategy  
- Scale and spread  
- Reliability science  
- Flow management  
- Safety systems | | |
| | The senior leadership team can, and does, teach the technical and change leadership knowledge to others in the organization. | | |
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15. Execution of Strategic Improvement Initiatives to Produce System-Level Results
16. Whole System Measures

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The Inconvenient Truth About Change Management

Why it isn’t working and what to do about it

by Scott Keller and Carolyn Aiken
The Inconvenient Truth About Change Management
Why it isn’t working and what to do about it

The Idea in Brief

In 1995, John Kotter published research that revealed only 30 percent of change programs are successful. Fast forward to 2008. A recent McKinsey & Company survey of business executives indicates that the percent of change programs that are a success today is... still 30%. The field of ‘change management’, it would seem, hasn’t changed a thing.

Digging deeper into why change programs fail reveals that the vast majority stumble on precisely the thing they are trying to transform: employee attitudes and management behavior. Conventional change management prescriptions addressing these behavioral and attitudinal changes by putting in place four basic conditions: a) a compelling story, b) role modeling, c) reinforcement systems, and d) the skills required for change.

These prescriptions are well grounded in psychological research and make good common sense – which, we believe, is precisely where things fall apart. The inconvenient truth of human nature is that people are irrational in a number of predictable ways. The prescription is right, but rational managers who attempt to put the four conditions in place by applying their ‘common sense’ intuition typically misdirect time and energy, create messages that miss the mark, and experience frustrating unintended consequences.

In the same way that the field of economics has been transformed by an understanding of uniquely human social, cognitive and emotional biases, so too the practice of change management is in need of a transformation through an improved understanding of the irrational (and often unconscious) nature of how humans interpret their environment and choose to act.

The Idea in Practice

A) CREATING A COMPELLING STORY

#1: What motivates you doesn’t motivate (most of) your employees. Research confirms that there are at least five sources of meaning for humans at work: impact on society, the customer, the company/shareholder, the working team, and “me” personally. What’s more, workforces are evenly split as to which of these is a primary motivator. “Telling five stories at once” is the key to unleashing maximum energy for change.

#2: You’re better off letting them write their own story. Research indicates that when employees choose for themselves (versus “being told”), they are more committed to the outcome by a factor of almost five to one. Time communicating the message should be dramatically rebalanced towards listening versus telling.

#3: It takes both “+” and “−” to create real energy. Deficit-based approaches (“solve the problem”) to change can create unproductive fatigue and resistance. Constructionist-based approaches (“capture the opportunity”) generate more excitement and enthusiasm, but lead to risk-averse solutions. By moving beyond this dichotomy and pursuing both approaches simultaneously, managers can neutralize these downsides and maximize impact in mobilizing the organization.

B) ROLE MODELING

#4: Your leaders believe they already “are the change.” Most executives have the will and skill to role model, but don’t actually know ‘what’ they should change due to their self-serving biases (if they didn’t think what they were doing was right, they wouldn’t be doing it). Smart use of concrete 360-degree behavioral feedback can break through this barrier.

#5: Influence leaders aren’t that influential. It is not enough to invest in a few rather than in many as a way of catalyzing desired changes, no matter how appealing the idea is. New research shows social ‘contagions’ depend less on the persuasiveness of “early adopters” and more on how receptive the “society” is to the idea. While influence leaders are important, we warn against overinvesting in them – your effort is better spent elsewhere.

C) REINFORCING MECHANISMS

#6: Money is the most expensive way to motivate people. A change program’s objectives should be linked to employee compensation to avoid sending mixed messages. Little upside is gained, however, due to a number of practical considerations. There is a better, and less costly, way. Small, unexpected rewards have disproportionate effects on employees’ motivation during change programs.

#7: A fair process is as important as a fair outcome. Employees will go against their own self-interest if the situation violates other notions they have about fairness and justice. Careful attention should be paid to achieve a fair process and fair outcomes in making changes to company structures, processes, systems and incentives.

D) CAPABILITY BUILDING

#8: Employees are what they think. Behaviors drive performance. Mindsets (the thoughts, feelings and beliefs held by employees) drive behaviors. Capability building should focus on technical skills as well as shifting underlying mindsets that enable the technical skills to be used to their fullest.

#9: Good intentions aren’t enough. Even with good intentions, it is unlikely employees will apply new skills and mindsets unless the barriers to practice are lowered. The odds can be improved by using ‘field and forum’ approaches linked to trainee’s day-to-day accountabilities reinforced by quantifiable, outcome-based hurdles along the way.

Show me the money!

Where we have tested these inconvenient truths in practice versus more rational, conventional approaches to influencing behavior we have found they achieve significant positive results. For example, in 18-month longitudinal studies using control and experimental group methodologies we achieved a 19 percent lift in profit per banker versus 8 percent and a 65 percent reduction in call center customer churn versus 35 percent with conventional approaches alone.
Conventional change management approaches have done little to change the fact that most change programs fail. The odds can be greatly improved by a number of counterintuitive insights that take into account the irrational but predictable nature of how employees interpret their environment and choose to act.

The Inconvenient Truth About Change Management

Why it isn’t working and what to do about it

In 1995, John Kotter published what many consider to be the seminal work in the field of change management, *Leading Change: Why Transformation Efforts Fail*. Kotter’s “call to action” cited research that suggested only 30 percent of change programs are successful. His work then goes on to answer the question posed in its title and to prescribe what it takes to improve this success rate.

Kotter is perhaps the most famous purveyor of change management wisdom, but in fact he is one of many who have a point of view regarding how managers and companies can best manage change. In the last two decades, literally thousands of books and journal articles have been published on the topic. Today, there are more than 1,800 books available on Amazon.com under the category of “Organizational Change.” The field has developed to the extent that courses dedicated specifically to managing change are now part of the curriculum in many major MBA programs.

With so much research done and information available on managing change, it stands to reason that change programs today should be more successful than those of more than a decade ago, right?

The facts suggest otherwise. McKinsey & Company recently surveyed 1,546 business executives from around the world, asking them if they consider their change programs “completely/mostly” successful: only 30 percent agreed. Further investigation into a number of similar studies over the last 10 years reveals remarkably similar results. The field of change management, it would seem, hasn’t really changed a thing.

This failure to live up to its promise is why many senior executives today recoil at the mere mention of the words ‘change management’. Memories come flooding back of significant time and effort invested in “the soft stuff” that, in the end, yielded little tangible value.

The focus of McKinsey’s applied research over the last four years has been to understand why change management efforts consistently fail to have the desired impact and, most importantly, what to do about it. At this point in our research we don’t claim to have all the answers. We have, however, developed and tested a set of perspectives in real-life application that senior managers have found genuinely insightful and that have consistently delivered business results far beyond expectations.
SUCCESSFUL CHANGE REQUIRES UNCOMMON SENSE

Digging deeper into why change programs fail reveals that the vast majority stumble on precisely the thing they are trying to transform: employee attitudes and management behavior (versus other possible sources such inadequate budget, poorly deployed resources and poor change architecture).  

Literally thousands of prescriptions are put forward in various change management publications regarding how to influence employee attitudes and management behavior. However, the vast majority of the thinking is remarkably similar. Colin Price and Emily Lawson provided a holistic perspective in their 2003 article, *The Psychology of Change Management*, that suggests that four basic conditions have to be met before employees will change their behavior:

A. **A compelling story:** They must see the point of the change and agree with it, at least enough to give it a try

B. **Role modeling:** They must also see colleagues they admire modeling the desired behavior

C. **Reinforcement systems:** Surrounding structures, systems, processes and incentives must be in tune with the new behavior

D. **The skills required for change:** They need to have the skills to do what is required of them.

This prescription is well grounded in the field of psychology and is entirely rational. Putting all four of these conditions in place as a part of a dynamic process greatly improves the chances of bringing about lasting changes in the mindsets and behaviors of people in an organization—and thus achieves sustained improvements in business performance.

One of the merits of the approach above is its intuitive appeal, so much so that many managers feel that, once revealed, it is simply good common sense. And this, we believe, is precisely where things fall apart. The prescription is right, but rational managers who attempt to put the four conditions in place by applying their "common sense" intuition typically misdirect time and energy, create messages that miss the mark, and experience frustrating unintended consequences from their efforts to influence change.

Why? In implementing the prescription, they disregard a scientific truth of human nature: people are irrational in many predictable ways. The scientific study of human irrationality has shown that many of our instincts related to understanding and influencing our own and others’ motivations push us towards failure instead of success. We systematically fall victim to subconscious thought processes that significantly influence our behavior, even though our rational minds tell us they shouldn’t. How many of us drive around looking for a close parking place to “save time” for longer than it would have taken to walk from the available parking spaces? How about falling into the trap of spending $3,000 to upgrade to leather seats when we buy a new $25,000 car, but finding it difficult to spend the same amount on a new leather sofa (even though we know we will spend more time on the sofa than in the car)? Are you willing to take a pencil home from work for your children to use, but are not willing to raid the company’s petty cash box for the money to buy a pencil for the same purpose? These examples point to how all of us are susceptible to irrationality when it comes to decision making.

The scientific study of human irrationality has shown that many of our instincts related to understanding and influencing our own and others’ motivations push us towards failure instead of success.

In the same way that the field of economics has been transformed by an improved understanding of how uniquely human social, cognitive and emotional biases lead to seemingly irrational decisions, so too the practice of change management is in need of a transformation through an improved understanding of the irrational (often unconscious) way in which
humans interpret their environment and choose to act.

In what follows we will describe a number of counterintuitive insights regarding human irrationality and implications for putting the four conditions for behavior change into place. We will also offer practical—if inconvenient—advice (as it calls for investing time and effort in areas that your rational mind will tell you shouldn’t matter as much as they do) on how to improve the odds of leading successful change. We illustrate these approaches through concrete examples of how various companies have, either by conscious awareness, intuition, or simple luck, leveraged predictable employee irrationality to great effect in making change happen.

Dealing with the human side of change is not easy. As Nobel Laureate Murray Gell-Mann once said, “Think how hard physics would be if particles could think.” All told, we don’t expect our advice to make your life as a change leader any easier. We are convinced, however, it will have more impact.

**A. THE INCONVENIENT TRUTH ABOUT CREATING A COMPELLING STORY**

Change management thinking extols the virtues of creating a compelling change story, communicating it to employees and following it up with ongoing communications and involvement. This prescription makes sense, but in practice three inconvenient truths often get in the way of this approach achieving the desired impact.

**Inconvenient Truth #1: What motivates you doesn’t motivate (most of) your employees**

We see two types of change stories consistently told in organizations. The first is the “good to great” story along the lines of “Our historical advantage has been eroded by intense competition and changing customer needs; if we change, we can regain our leadership position once again, becoming the undisputed industry leader for the foreseeable future and leaving the competition in the dust.” The second is the turnaround story along the lines of, “We’re performing below industry standard and must change dramatically to survive; incremental change is not sufficient—investors will not continue to put money into an underperforming company. We are capable of far more based on our assets, market position, size, skills and loyal staff. We can become a top-quartile performer in our industry by exploiting our current assets and earning the right to grow.”

These stories both seem rational, yet they too often fail to have the impact that change leaders desire. Research by a number of leading thinkers in the social sciences, such as Danah Zohar, Chris Cowen, Don Beck and Richard Barrett, has shown that stories of this nature will create significant energy for change in only about 20 percent of your workforce. Why? The stories above all center on the company—beating the competition, industry leadership, share price targets, etc.—when in fact research shows that there are at least four other sources of meaning and motivation that can be tapped into to create energy for change. These include impact on society (e.g., making a better society, building the community, stewarding resources), impact on the customer (e.g., making it easier, superior service, better quality product), impact on the working team (e.g., sense of belonging, caring environment, working together efficiently and effectively), and impact on “me” personally (my development, paycheck/bonus, empowerment to act).

**What the leader cares about (and typically bases at least 80 percent of his or her message to others on) does not tap into roughly 80 percent of the workforce’s primary motivators for putting extra energy into the change program.**

The inconvenient truth about this research is that in surveys of hundreds of thousands of employees to discover which of these five (society, customer, company/shareholder, working team, “me” personally) sources of meaning most motivates them, the result is a consistently even 20 percent split across all dimensions. Regardless of level (senior management to the frontline), industry (healthcare to manufacturing), or
geography (developed or developing economies), the results do not significantly differ.

This finding has profound implications for leaders. What the leader cares about (and typically bases at least 80 percent of his or her message to others on) does not tap into roughly 80 percent of the workforce’s primary motivators for putting extra energy into the change program. Those people leading change should be able to tell “five stories at once” and in doing so unleash tremendous amounts of organizational energy that would otherwise remain latent in the organization.

By way of practical example, consider a cost-reduction program at a large U.S. financial services company. The program was embarked on with a rational change story that “ticked all the boxes” of conventional change management wisdom. Three months into the program, management was frustrated with the employee resistance inhibiting impact. The team worked together to re-cast the “story” around the cost program to include an element related to society (to deliver “affordable housing”: we must be most affordable in our services), customers (increased simplicity, flexibility, fewer errors, more competitive prices), the company (expenses are growing faster than revenues, which is not sustainable), working teams (less duplication, more delegation, increased accountability, faster pace), and individuals (bigger, more attractive jobs created: a great opportunity to “make your own” institution).

This relatively simple shift in approach lifted employee motivation measures from 35.4 percent to 57.1 percent in a month, and the program went on to achieve 10 percent efficiency improvements in the first year—a run rate far above initial expectations.

Inconvenient Truth #2: You’re better off letting them write their own story

Well-intentioned leaders invest significant time in communicating their change story. Roadshows, town halls, magazines, screen-savers and websites are but a few of the many approaches typically used to tell the story. Certainly the story (told in five ways!) needs to get out there, but the inconvenient truth is that much of the energy invested in communicating it would be better spent listening, not telling.

In a famous experiment, researchers ran a lottery with a twist. Half the participants were randomly assigned a lottery ticket. The remaining half were given a blank piece of paper and a pen and asked to write down any number they would like as their lottery number. Just before drawing the winning number, the researchers offered to buy back the tickets from their holders. The question researchers wanted to answer is, “How much more do you have to pay someone who ‘wrote their own number’ versus someone who was handed a number randomly?” The rational answer would be that there is no difference (given a lottery is pure chance and therefore every ticket number, chosen or assigned, should have the same value). A more savvy answer would be that you would have to pay less (given the possibility of duplicate numbers in the population who write their own number). The real answer? No matter what geography or demographic the experiment has taken place in, researchers have always found that they have to pay at least five times more to those who wrote their own number.

This result reveals an inconvenient truth about human nature: When we choose for ourselves, we are far more committed to the outcome (almost by a factor of five to one). Conventional approaches to change management underestimate this impact. The rational thinker sees it as a waste of time to let others self-discover what he or she already knows—why not just tell them and be done with it? Unfortunately this approach steals from others the energy needed to drive change that comes through a sense of ownership of “the answer”.

When we choose for ourselves, we are far more committed to the outcome (almost by a factor of five to one).

Consider another practical example in Barclays’ Personal Financial Services CEO, David Roberts, who employed a fairly literal interpretation of the above finding. He wrote his change story in full prose, in a way that he found meaningful. He then shared it with his team, getting feedback on what resonated and what needed further clarification. He then asked each of his team members to “write
their own lottery ticket”: what was the change story for them, in their business, that supports the bigger PFS-wide change story? His team members wrote their change story, again in full prose, and shared it with their teams. Their teams gave feedback and then wrote their own story for their area/department, and so the process continued all the way to the frontline. It took twice as long as the traditional roadshow approach, but for a five-times return on commitment to the program, it was the right investment to make.12

Sam Palmisano, current CEO of IBM, in spearheading a change effort to move IBM towards a values-based management system, enabled thousands of employees to “write their own lottery ticket” regarding IBM’s values. During a three-day, online discussion forum (dubbed ValuesJam), over 50,000 employees were empowered literally to rewrite IBM’s century-old values.13

Other applications need not be so literal. At a global consumer goods company the CEO brought together his top 300 for three two-day “real work” sessions over three months where they created the story together. Again, this invested significant time, but having the top 300 five-times committed to the way forward was considered well worth the investment. At BP, to develop a comprehensive training program for frontline leaders, a decision was made to involve every key constituency in the design of the program, giving them a sense of “writing their own lottery ticket.” It took a year and a half to complete the design using this model, but was well worth it. Now in implementation, the program is the highest rated of its kind in BP. It involves more than 250 active senior managers from across the businesses willingly teaching the course, and, most importantly, has resulted in managers who have been through the training program being consistently ranked higher in performance than those who haven’t, both by their bosses and by the employees who report to them.14

At a minimum, we advocate that leaders leverage the “lottery ticket” insight by augmenting their telling of the story with asking about the story. Consider David Farr, CEO of Emerson Electric, who is noted for asking four questions related to his company’s story of virtually everyone he encounters in the organization: 1) how do you make a difference? (testing for alignment on the company’s direction); 2) what improvement idea are you working on? (emphasizing continuous improvement); 3) when did you last get coaching from your boss? (emphasizing the importance of people development); and 4) who is the enemy? (emphasizing the importance of “One Emerson”/no silos, i.e., he wanted to emphasize the “right” answer was the competition and not some other department!).

On a final note, many executives are surprised not only by the ownership and drive for implementation that comes from high-involvement approaches, but also by the improved quality of the answers that emerge. As one CEO told us, “I was surprised how people stepped up during the direction-setting process — I was worried about everything getting ‘dumbed down,’” but in the end we got a better answer because of the broad involvement.”

Inconvenient Truth #3: It takes both “+” and “–” to create real energy

In 210 B.C., a Chinese commander named Xiang Yu led his troops across the Yangtze River to attack the army of the Qin (Ch’in) dynasty. Camped for the night on the banks of the river, his troops awakened to find their ships on fire. They rushed to the boats ready to take on their attackers, only to find that it was Xiang Yu himself who had set their ships ablaze. Not only that, but he had also ordered all the cooking pots crushed. Xiang Yu’s logic was that without the pots and the ships, they had no other choice but to fight their way to victory or die trying. In doing so he created tremendous focus in his troops, who battled ferociously against the enemy and won nine consecutive battles, obliterating the main-force units of the Qin dynasty.

The above story is perhaps the ultimate example of creating a “burning platform” to motivate action—a message that says “We’ve got a problem, we have to change!” This model is often referred to as a deficit-based approach to change. It identifies the problem (what is the need?), analyzes causes (what is wrong here?) and possible solutions (how can we fix it?), and then plans and takes actions (problem solved!). Advocates of this approach point out that its
linear logic and approach to dissecting things to understand them is at the heart of all the scientific progress made by Western civilization. They also cite examples like that of Xiang Yu, where it has a profound effect. Given the case for the deficit-based approach, it has become the model predominantly taught in business schools and is presumably the default change model in most organizations. At success rates of 30%, however, the vast majority of change leaders are not enjoying the same success as Xiang Yu did. Why is this?

Research has shown that a relentless focus on “what’s wrong” is not sustainable, invokes blame and creates fatigue and resistance, doing little to engage people’s passion and experience, and highlight their success. This has led to the rise of what many refer to as the constructionist-based approach to change. In this approach the change process is based on discovery (discovering the best of what is), dreaming (imagining what might be), designing (talking about what should be) and destiny (creating what will be).

Consider a study done at the University of Wisconsin where two bowling teams were recorded on video over a number of games. Each team received a video to study. One team’s video showed only those occasions when it made mistakes. The other’s showed only those occasions when it performed well. The team that studied its successes improved its score twice as much as the other team. The conclusion is that choosing the positive as the focus of inquiry and storytelling is the best answer for creating change. Whereas the deficit-based change approach is well suited for technical systems, research into the constructionist-based approach shows that in human systems a focus on “what’s right” can achieve improved results. So should enlightened change leaders shift their focus exclusively to capturing opportunities and building on strengths instead of identifying and solving problems? We think not.

Humans are more risk averse when choosing among options framed as “gains” than when they choose among those framed as “losses.” For example, what would you do if given the choice between a sure gain of $100 and a 50 percent chance of gaining $200? If you are like most individuals, you are risk seeking in this case and choose a 50 percent chance of losing $200. A single-minded focus on “what’s possible,” with its bias towards more conservative choices, flies in the face of achieving radical change. The reason for this is that, as humans, we inherently dislike losses more than we like gains.

The inconvenient truth is that both the deficit-based and constructionist approaches to change have their merits and limitations. It is clear that a single-minded focus on today’s problems creates more fatigue and resistance than envisioning a positive future. But it is also clear that when it comes to behavioral change some anxiety is good, and that an over-emphasis on the positive can lead to watered-down aspirations and impact.

We believe the field of change management has drawn an artificial divide between deficit-based and constructionist-based approaches. The best answer is an “and” answer. While it is impossible to prescribe generally how the divide should be split between positive and negative messages, as this will be specific to the context of any given change program, we strongly advise managers not to “swing the pendulum” too far in one direction or another. Consider Jack Welch at GE, who took questions of “what’s wrong here?” (poor-performing businesses, impending bankruptcy, silo-driven behaviors, bureaucracy, etc.) head on, as well as “imagining what might be” (number one or two in every business, a “boundaryless” culture of quality, openness, accountability, etc.).

Revisiting the University of Wisconsin bowling team experiment mentioned above, we suspect that a team that studied its successes and mistakes would outperform teams that studied only either/or.
B. THE INCONVENIENT TRUTH ABOUT ROLE MODELING

Conventional change management suggests leaders should take actions that role model the desired change and mobilize a group of influence leaders to drive change deep into the organization. Unfortunately, this prescription rarely delivers the desired impact because it neglects two more inconvenient truths about change management.

**Inconvenient Truth #4: Your leaders believe they already “are the change”**

Most senior executives understand and generally buy into Gandhi’s famous aphorism, “Be the change you want to see in the world.” They, often prompted by HR professionals or consultants, commit themselves to “being the change” by personally role modeling the desired behaviors. And then, in practice, nothing significant changes.

The reason for this is that most executives don’t see themselves as “part of the problem,” and therefore deep down do not believe that it is they who need to change, even though in principle they agree that leaders must role model the desired changes. Take for example a team that reports that, as a group and as an organization, they are low in trust, not customer-focused and bureaucratic. How many executives when asked privately will say “no” to the questions, “Do you consider yourself to be trustworthy?” and “Are you customer focused?” and “yes” to the question “Are you a bureaucrat?” Of course, none.

The fact is that most well-intentioned and hard-working people believe they are doing the right thing, or they wouldn’t be doing it. However, most people also have an unwarranted optimism in relation to their own behavior.

Typically, insight into “what” to change can be created by concrete 360-degree feedback techniques, either via surveys, conversations or both. This 360-degree feedback should not be against generic HR leadership competency models, but instead against the specific behaviors related to the desired changes that will drive business performance. This style of feedback can be augmented by fact gathering such as third-party observation of senior executives going about their day-to-day work (e.g., “You say you are not bureaucratic, but every meeting you are in creates three additional meetings and no decisions are made”) and calendar analyses (e.g., “You say you are customer focused but have spent 5 percent of your time reviewing customer-related data and no time meeting with customers or customer-facing employees”).

Consider Amgen CEO Kevin Sharer’s approach of asking each of his top 75, “What should I do differently?” and sharing his development needs and commitment publicly with them. Consider the top team of a national insurance company who routinely employed what they called the “circle of fire” during their change program: Every participant receives feedback live in the room, directly from their colleagues on “What makes you great?” in relation to “being the change” and
“What makes you small?” Consider the leadership coalition (top 25) of a multi-regional bank who, after each major event in their change program, conducted a short, targeted 360-degree feedback survey regarding how well their behaviors role modeled the desired behaviors during the event, ensuring that feedback was timely, relevant and practical.

While seemingly inconvenient, these types of techniques help break through the “self-serving bias” that inhibits well-meaning leaders from making a profound difference through their actions to the ultimate impact of the change program.

Note that some readers may be thinking, “But surely there are a few people who are fully role modeling the desired behaviors—what does this mean for them?” If the purpose of senior executive role modeling is to exhibit the behaviors required that ensure the success and sustainability of the change program (e.g., collaboration, agility in decision making, empowerment), then the answer is “keep up the good work!” If the answer, however, is expanded to include role modeling the process of personal behavioral change itself, there is more to do. Recall that Gandhi also said famously, “For things to change, first I must change.”

We often cite Tiger Woods’ reaction to his astonishing, 18-below-par victory in the Masters tournament in 1997: he chose to rebuild his swing. As he practiced many of its 270 elements, he endured a period of awkward performance. The press deemed him a one-Masters wonder. Four years later, he won the world’s four major golf tournaments in one year, an unprecedented accomplishment. At one point, Woods’ lead over the second-ranked player was larger than the gap between No. 2 and No. 100.21 The lesson is clear: continued success requires critical self-examination and growth. Few senior executives would suggest they are less in need of personal learning than Tiger Woods.

**Inconvenient Truth #5: Influence leaders aren’t that influential**

Almost all change management literature places importance on mobilizing a set of “influence leaders” to help drive the change. Typically guidance is given to find and mobilize those in the organization who either by role or personality (or both) have disproportionate influence over how others think and behave. We believe this is sound and timeless advice – indeed having a cadre of well-regarded people proactively role modeling and communicating the change program is a “no regrets” move. However, since Malcom Gladwell popularized his “law of the few” in his best-selling book, *The Tipping Point*, we have observed that the role of influence leaders has moved from being perceived as a helpful element of a broader set of interventions to a panacea for making change happen (likely an unintended consequence of Gladwell’s work which itself was directed towards marketers versus change leaders).

Influence leaders are no more likely to start a social “contagion” than the rank and file... success depends less on how persuasive the “early adopter” is, and more on how receptive the “society” is to the idea.

Gladwell’s “law of the few” suggests that rare, highly connected people shape the world. He defined three types of influence leaders that are among this select group: Mavens—discerning individuals who accumulate knowledge and share advice; Connectors—those who know lots of people; and Salespeople—those who have the natural ability to influence and persuade others. Gladwell famously illustrates his point with the example of Hush Puppies. The footwear brand was dying by late 1994—until a few New York hipsters began wearing their shoes. Other fashionistas followed suit, whereupon the cool kids copied them, the less-cool kids copied them, and so on, until voilà! Within two years, sales of Hush Puppies had exploded by 5,000 percent, without a penny spent on advertising.22 Compelling stories such as this have been interpreted by many change leaders as evidence that the lion’s share of their role should focus on getting the influence leader equation right and—voilà!—all else will follow.
Duncan Watts, a network-theory scientist working for Yahoo!, has conducted a number of experiments that help explain why “influence leaders” are not the panacea the above example implies. In the context of the Hush Puppies story, he essentially posed the more expansive question, “Given East Village hipsters were wearing lots of cool things in the fall of 1994, why did only Hush Puppies take off? Why didn’t their other clothing choices reach a tipping point too?” His research shows that influence leaders are no more likely to start a social “contagion” than the rank and file. He concludes that success depends less on how persuasive the “early adopter” is, and more on how receptive the “society” is to the idea. To start a social epidemic is less a matter of finding the mavens, connectors, and salespeople to do the infecting and more a matter of developing the “virus” that society is a fertile spreading ground for. Watts suggests a better metaphor than a virus—a forest fire—for the way social influence really works. There are thousands of forest fires a year, but only a few become roaring monsters. Why? Because in those rare situations the landscape is ripe: sparse rain, dry woods, badly equipped fire departments. In these situations, no one will go around talking about the exceptional properties of the random smoker who unwittingly tossed a smoldering cigarette butt into a patch of parched grass in the middle of a forest during a drought.23

The inconvenient truth is that it is not enough to invest in a few rather than in many as a way of catalyzing desired changes, no matter how appealing the idea is. We warn against overestimating the impact a group of influence leaders can have and, in turn, overinvesting in them in a world of scarce resource (time, money, people). We advocate that change leader attention should be balanced across all four conditions for change – a compelling story, role modeling, reinforcement systems, and the skills required for change – to ensure they are reinforcing in ways that maximize the probability of the change “spark” taking off like wildfire across the organization.

C. THE INCONVENIENT TRUTH ABOUT REINFORCING MECHANISMS

Conventional change management emphasizes the importance of reinforcing and embedding desired changes in structures, processes, systems, target setting and incentives. If you want collaboration, create cross-functional teams. If you want customer focus, make sure your systems give you a full picture of the customer relationship. If you want just about any behavior, make people’s paycheck dependent on it, and so the logic goes. Again, these are all perfectly rational until confronted with two inconvenient truths.

Inconvenient Truth #6: Money is the most expensive way to motivate people

Upton Sinclair once wrote, “It is difficult to get a man to understand something if his salary depends upon him not understanding it.”24 If a change program’s objectives are not linked somehow to employee compensation, this sends a strong message that the change program is not a priority, and motivation for change is adversely affected. The flip-side, however, is not true. When change program objectives are linked to compensation, motivation for change is rarely meaningfully enhanced. The reason for this is as practical as it is psychological in nature.

Consider the change manager who is working to link the change program with compensation. He or she is faced with existing executives’ annual compensation plan that is typically comprised of three elements: a portion dependent on how the corporation does (typically an earnings or return-on-capital number for the whole company), a portion dependent on how the leader’s specific business or function does, and a portion dependent on individual goals, often related to operations or people.

The rational change manager dutifully builds change-program impact into earnings forecasts and business unit/functional financial operating plans. Come review time, however, he/she realizes that with the myriad of controllable and uncontrollable variables that influence the
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financial outcomes, the link to specific change program implementation becomes weak at best. Operational (non-financial) impact from change program implementation creates a stronger link to outcomes and individual efforts. Unfortunately, however, the weighting of non-financial outcomes from the change program in the context of the vast array of other metrics also “linked” to rewards (e.g., compliance, safety, social responsibility, diversity, talent development, leadership competencies) renders any link to compensation hardly relevant.

The reality is that in the vast majority of companies it is exceedingly difficult to meaningfully link a change program to individual compensation. So why not just change the compensation approach? This is of course an option, but easier said than done and certainly not without risk and potential unintended consequences when considering that change must happen in real time—the organization must continue to carry out its day-to-day tasks and functions while at the same time fundamentally rethinking them. The good news is that there are easier, relatively inexpensive ways to use incentives to motivate employees for change.

In one study, researchers gave people a tiny gift and measured the increase in satisfaction with their lives. Specifically half of a group of people who used a photocopier found a dime in the coin return. How much did the gift increase their satisfaction with their lives? When asked about how satisfied they were with their lives, those with the dime were 6.5 on a 7 scale whereas those without were only 5.6. Why such a lift in satisfaction for such little reward? For human beings it holds that satisfaction equals perception minus expectation (an equation often accompanied by the commentary, “reality has nothing to do with it”). The beauty of this equation for change managers is that small, unexpected rewards can have disproportionate effects on employees’ “satisfaction” with a change program.

Gordon M. Bethune, while turning around Continental Airlines, sent an unexpected $65 check to every employee when Continental made it to the top 5 for on-time airlines. John McFarlane of ANZ Bank sent a bottle of champagne to every employee for Christmas with a card thanking them for their work on the company’s “Perform, Grow and Breakout” change program. The CEO of a large multi-regional bank sent out personal thank-you notes to all employees working directly on the company’s change program to mark its first-year anniversary. Most change managers would refer to these as merely token gestures and argue that their impact is limited and short-lived. Employees on the receiving end beg to differ. Recipients of these “dime in the photocopier” equivalents consistently report back that the rewards have a disproportionately positive impact on change motivation that lasts for months, if not years.

For human beings it holds that satisfaction equals perception minus expectation – small, unexpected rewards can have disproportionate effects.

The reason these small, unexpected rewards have such impact is because employees perceive them as a “social exchange” with the company versus a “market exchange.” To understand the difference, consider the following: Assume you are at your mother-in-law’s house for Thanksgiving dinner. She has spent weeks planning the meal and all day cooking. After the meal you thank her and ask her how much you should pay for the experience. What would her reaction be? Most people report that their mother-in-law would be horrified and the relationship damaged as a result. Why? The offer of money takes the interaction from a social norm, built around a reciprocal, long-term relationship, to a market norm that is more transactional and shallow. Back to your mother-in-law, would she have accepted a nice bottle of wine for the table as a gift from you? Likely yes, as small, unexpected gifts indicate social norms are at play.

Consider the study of a daycare center where a $3 fine was imposed for parents picking up their children late. When the fine went into place, incidents of late pickups went through the roof. Why? Before the fine was imposed, the daycare staff and the parents had a social contract—for the
parents, feeling guilty about being late compelled them to be more prompt in picking up their kids. Once the fine was imposed, the daycare center had inadvertently replaced social norms with market norms. Free from feelings of guilt, parents frequently chose to be late and pay the fee (certainly not what the center had intended!)

When it comes to change, social norms are not only cheaper than market norms, but often more effective as well. By way of example, consider the AARP (American Association of Retired Persons) which asked some lawyers if they would offer less expensive services to needy retirees, at something like $30 an hour. The lawyers said no. Then the program manager from AARP had the idea to ask the lawyers if they would offer free services for needy retirees. Overwhelmingly, the lawyers said yes. When compensation was mentioned the lawyers applied market norms and found the offer lacking. When no compensation was mentioned they used social norms and were willing to volunteer their time.

**Inconvenient Truth #7: A fair process is as important as a fair outcome**

Consider a bank which, as part of a major change program, diagnosed that its pricing did not appropriately reflect the credit risk that the institution was taking on. New risk-adjusted rate of return (or RAROC-based) models were created, and the resulting new pricing schedules delivered to the frontline. At the same time, sales incentives were adjusted to reward customer profitability versus volume. The result? Customer attrition (not only of the unprofitable ones) and price over-rides went through the roof and, ultimately, significant value was destroyed by the effort. The rational change manager scratches his or her head in confusion wondering, “What went wrong?”

“Ultimatum games” offer a compelling example of the inconvenient truth at play here. Give a stranger $10. Tell them they must split the money with another stranger however they wish. If the person accepts the offer, the money is split. If they reject the offer, no one gets any money. Studies show that if the offer is a $7.50/$2.50 split, more than 95 percent will reject it, preferring to go home with nothing than to see someone “unfairly” receive three times as much as they do. You may be thinking to yourself that with a total pie of $10 to share, unequal allocations are rejected only because the absolute amount of the offer is low. Seemingly irrationally, however, the “ultimatum game” findings are the same even when the absolute amount of the offer is equivalent to two weeks of wages.

Employees will go against their own self-interest (read: incentives) if the situation violates other notions they have about the way the world should work, in particular, in relation to fairness and justice.

The inconvenient truth is that employees will go against their own self-interest (read: incentives) if the situation violates other notions they have about the way the world should work, in particular, in relation to fairness and justice. In the case of the banking price-rise example described above, whether right or wrong, the frontline view of the pricing and incentive changes was that they were unfair to the customer, a symbol of increasingly greedy executives losing sight of customer service. Even though it meant they were less likely to achieve their individual sales goals, a significant number of bankers vocally bad-mouthed the bank’s policies to customers, putting themselves on the customer’s side, rather than the bank’s. Where possible, price over-rides were then used to show good faith to customers and inflict retribution on the “greedy” executives.

In making any changes to company structures, processes, systems and incentives, change managers should pay an unreasonable amount of attention to employees’ sense of the fairness of the change process as well as the outcome. Particular care should be taken where changes effect how employees interact with one another (headcount reductions, changes to processes such as talent management, annual planning, etc.) and with customers (sales stimulation programs, call center re-designs, pricing, etc.). Interestingly,
in the pricing example described above, the outcome is inherently fair (customers are asked to pay commensurate to the risk the bank is taking on), and therefore the downward spiral described could have been avoided (and has been by other banks adopting RAROC-based pricing) by carefully tending to employees’ perceptions of fairness in the communications and training surrounding the changes.

**D. THE INCONVENIENT TRUTH ABOUT CAPABILITY BUILDING**

Conventional change management emphasizes the importance of building the skills and talent needed for the desired change to be successful and sustainable. Though hard to argue with, in practice there are two more inconvenient truths that demand attention if one is to successfully build the needed capabilities.

**Inconvenient Truth #8: Employees are what they think**

Many managers believe in their heart of hearts that the “soft stuff”—employees’ thoughts, feelings and beliefs—has no place in workplace dialog. “All that matters is that they behave in the ways I need them to; it doesn’t matter why,” they will say. While rational—behaviors drive performance after all—this view misses the point that it is employees’ thoughts, feelings and beliefs that drive their behaviors. Ignoring the underlying mindsets of employees during change is to address symptoms rather than root causes.

Consider an analogy from operations management. When a motor burns out on a machine on the shop floor it is replaced, right? Effective managers will only replace the engine once the root causes are known: “Why did the motor burn out?” Because it overheated. “Why did it overheat?” Because it was insufficiently ventilated. “Why was it insufficiently ventilated?” Because the machine is too close to the wall. The operator then moves the machine away from the wall and replaces the motor. Not doing so would mean the fix would be short-lived (the new motor would have quickly burned out too, due to the lack of ventilation). A far better solution is achieved by addressing the root cause.

Let’s see how this applies to change management. Consider a bank that through a benchmarking exercise found that its sales per banker were lagging the competition. “Why are sales per banker lower?” the rational manager asks. Analysis shows bankers are not spending enough time with customers. “Why aren’t they spending more time with customers?” Because a significant amount of their time is spent completing paperwork. With this diagnosis the bank set about reengineering the loan-origination process to minimize paperwork and maximize customer-facing time. Not only that, bankers are provided with new sales scripts and easier-to-use tools so that they’ll know what to do with the extra time in front of the customer. Training on the new processes and tools is administered and, voilà, problem solved. Except for the fact that six months later, the levels of improvement are far lower than envisioned.

**Ignoring the underlying mindsets of employees during change is to address symptoms rather than root causes.**

What went wrong? A further investigation into “why”, with an eye to the bankers’ mindsets, provides a much fuller view of the root causes: Is there anything about how they think and feel, or what they believe about themselves and their jobs, that explains why they wouldn’t be spending more time with customers? Faced with a stalled improvement program, the bank in question proceeded down this line of inquiry. They quickly found that most of the bankers in question simply found customer interactions uncomfortable and therefore actually preferred paperwork to interacting with people (and, in turn, created reasons not to spend time with customers). This was driven by a combination of introvert personalities, poor interpersonal skills and a feeling of inferiority when dealing with customers who by and large have more money and education than they do. Furthermore,
supervisors (who had mostly been recruited from the banker ranks) were also insecure with their selling and interpersonal skills, and therefore placed more emphasis on managing paper-based activity, further exacerbating the problem. Finally, most bankers loathed to think of themselves as “sales people”—a notion they perceived as better suited to employees on used-car lots than in bank branches. Efforts to create “more sales time” flew directly in the face of their vocational identity.

Armed with these root-cause insights, the bank’s change program was enhanced to directly address the mindset challenges as well as the process and tool barriers. Training for bankers and supervisors was expanded to include elements related to personality types, emotional intelligence and vocational identity (recasting “sales” as the more noble pursuit of “helping customers discover and fulfill their unarticulated needs”). This enhancement not only put the program back on track within six months, but also ultimately delivered sustainable sales lifts in excess of original targets.

Those skeptical of the importance of mindsets are encouraged to consider the Roger Bannister story. Until 1954, the four-minute mile was considered to be beyond human achievement. Medical journals of the day went so far as to declare it an impossible “behavior.” In May of that year, however, Roger Bannister broke this barrier, running the mile in 3 minutes, 59.4 seconds. What is perhaps more amazing is that two months later it was broken again, by Australian John Landy. And within three years, 16 other runners had also broken this record. What happened? A sudden spurt in human evolution? Genetic engineering of a new super race of runners? Of course not. It was the same human equipment, but with a different mindset—one that said “this can be done.”

Bannister emphasizes in his memoirs that he spent as much time conditioning his mind as he did conditioning his body. He wrote, “the mental approach is all important… energy can be harnessed by the correct attitude of mind.”

Inconvenient Truth #9: Good intentions aren’t enough

It is well documented that after three months adults retain only 10 percent of what they have heard in lecture-based training sessions (e.g., presentations, videos, demonstrations, discussions). When they learn by doing (e.g., role plays, simulations, case studies), 65 percent of the learning is retained. And when they practice what they have learnt in the workplace for a number of weeks, almost all of the learning can be expected to be retained. Accordingly, effective skill-building programs are replete with interactive simulations and role plays to ensure time spent in the training room is most effective. Further, commitments are made by participants regarding what they will “practice” back in the workplace (“My Monday morning takeaway is…”) to embed the learnings. This is all well and good, except that come Monday morning, very few keep their commitments.

Consider a social science experiment at a Princeton theological seminary. Students were asked a series of questions about their personality and level of religious commitment and then sent across campus. Along the way, they met a person slumped over coughing and groaning and asking for medical assistance. Did self-proclaimed nice people help more? Absolutely not. Neither did religious commitment correlate to who provided help. The only predictor of the seminarians’ behavior was that half were made to think they were late for an appointment across campus, while the others believed they had plenty of time. Sixty-three percent with spare time helped, as opposed to just 10 percent of those in a hurry. When short of time, even those with "religion as a quest" did not stop to help.

Given this aspect of human nature, it is unreasonable to expect that most employees will genuinely practice new skills and behaviors back in the workplace if nothing formal has been done to lower the barriers to doing so. The time and energy required to do something additional, or even to do something in a new way, simply don’t exist in busy executives’ day-to-day schedules. Ironically, this is particularly the case in the days following training programs, when most managers are playing catch-up from their time...
away. This failure to formalize and create the space for practice back in the workplace dooms most training programs to deliver returns that are at best 65 percent of their potential.

We advocate a number of enhancements to traditional training approaches to “hardwire” day-to-day practice into capability-building processes. First, training should not be a one-off event. Instead, a “field and forum” approach should be taken, in which classroom training is spread over a series of learning forums, and fieldwork is assigned in between. Second, we suggest creating fieldwork assignments that link directly to the day jobs of participants, requiring them to put into practice new mindsets and skills in ways that are “hardwired” into to the things for which they are accountable. These assignments should have quantifiable, outcome-based measures that indicate levels of competence gained, and certification that recognizes and rewards the skills attained.

Consider one company’s approach to building lean manufacturing capabilities. The first forum offered a core of basic skills and mindsets in performance improvement. Fieldwork then followed, involving cost, quality and service improvement targets over a three-month period. Anyone delivering on these targets was awarded a green-belt certification in lean. The next forum provided much deeper technical system design skills and project and team leadership training. The fieldwork that followed involved participants redesigning entire areas of the plant floor and overseeing a portfolio of specific improvement teams—all aspects of which had quantitative targets (both in terms of financial results, and people and project leadership in 360-degree evaluations). Anyone achieving their fieldwork targets then became a black belt in lean. The final forum built more advanced skills in shaping plant-wide improvement programs in the context of pressing strategic issues, applying improvement concepts to more complex operations, and coaching and mentoring others. Fieldwork again put these lessons into practice with quantitative improvement goals attached, resulting in a set of “master black belts” emerging from the program.

**SHOW ME THE MONEY!**

So far, we have tested the incremental impact of applying these inconvenient truths in practice above and beyond more conventional approaches to influencing behavior in three longitudinal studies. Each study has employed control versus experimental group methodologies (comparing impact with like customer and employee demographics, ensuring minimal distortions of trial over a one-year test period). In each of these cases, the results have been profound.

In retail banking, for example, applying conventional change management approaches in a salesforce stimulation program achieved an 8 percent lift in profit per business banker and 7 percent per retail banker. While respectable, this was below management aspirations of achieving a 10 percent lift in both areas. Where inconvenient truths were acted on beyond conventional change management approaches, however, the program achieved a 19 percent lift in profit per business banker and 12 percent per retail banker, far exceeding management’s expectations.

In the call centers of a large telecommunications company, the results of a customer churn reduction program applying conventional change management approaches resulted in 35 percent churn reduction, falling short of management’s aspiration of a 50 percent reduction. Acting on the inconvenient truths, however, delivered 65 percent churn reduction to the delight of management, employees and customers.

An insurance back office which had implemented lean operations improvements found that performance six months after the “step change” was stagnant, not fulfilling the continuous improvement expectations of the program. Revamping the program to leverage inconvenient truths, the company has now posted more than two years of 5 percent improvement...
(above and beyond the step change) in cost, quality and service, exceeding the 3 percent continuous improvement target built into the budget.

As mentioned above, we acknowledge that our research into the impact of applying approaches based on the inconvenient truths about change management is still in its relatively early days by virtue of the fact that sustainable impact can only be measured over numbers of years. The longitudinal examples mentioned above, however, give us confidence and motivation to broadly share the thinking above.

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David Whyte once wrote, “Work, paradoxically, does not ask enough of us, yet exhausts the narrow part of us we bring to the door.”35 Our research and experience has led us to believe that the impact of conventional change management thinking is held back by exactly this paradox. More activity is undertaken, less energy is tapped into, and ultimately change impact is disappointing.

By acting on the inconvenient truths discussed above, Whyte’s paradox is at least in part resolved by tapping into motivations that are uniquely human. In doing so, tremendous individual and organizational energy for change is unleashed.
The Inconvenient Truth About Change Management

Why it isn’t working and what to do about it

Further Reading

In writing this article, the goal has been to highlight those aspects of change management that are most counter-intuitive, and therefore most likely to inhibit change program success. We have not attempted to deliver a holistic recipe for change management. For a comprehensive view of the more rational, conventional elements of successful change programs, we suggest the following reading:

A R T I C L E S

Leading Change: Why Transformation Efforts Fail
By John Kotter
Harvard Business Review
March–April 1995

Businesses hoping to survive over the long term will have to remake themselves into better competitors at least once along the way. These efforts have gone under many banners: total quality management, reengineering, rightsizing, restructuring, cultural change, and turnarounds, to name a few. In almost every case, the goal has been to cope with a new, more challenging market by changing the way business is conducted. A few of these endeavors have been very successful. A few have been utter failures. Most fall somewhere in between, with a distinct tilt toward the lower end of the scale. John P. Kotter completed a 10-year study of more than 100 companies that attempted such a transformation. Here he shares the results of his observations, outlining the eight largest errors that can doom these efforts and explaining the general lessons that encourage success. Unsuccessful transitions almost always flounder during at least one of the following phases: generating a sense of urgency, establishing a powerful guiding coalition, developing a vision, communicating the vision clearly and often, removing obstacles, planning for and creating short-term wins, avoiding premature declarations of victory, and embedding changes in the corporate culture. Realizing that change usually takes a long time, says Kotter, can improve the chances of success.

Driving Radical Change
By Josep Isern and Caroline Pung
The McKinsey Quarterly
June 2006

Genuine transformations take place on a scale different from that of routine change programs — and are much harder to pull off. Two of the most urgent challenges are setting appropriate aspirations and mobilizing energy and ideas. A transformation calls for game-changing ideas, not incremental improvements. Leaders must clarify this up front and regularly reinforce it, eliciting ideas on why change is necessary, what must change, who must change, and how to change. By creating clear expectations, leaders must initiate disciplined processes for idea generation and development. This first phase of every initiative must include time for creativity, with a challenge mechanism built in to avoid incrementalism. Many transformations kick off with a rush of enthusiasm, only to falter later. To achieve radical change, leaders must find ways to reenergize their organizations at regular intervals. They can do this by “fuel-injecting” ideas with six proven catalysts: setting high aspirations; managing pace; engaging at three levels; embedding visible change; building capabilities; and making change personal.

The Psychology of Change Management
By Emily Lawson and Colin Price
The McKinsey Quarterly
2003 Special Edition: The Value in Organization

Large organizational-change programs are notoriously difficult to run: They involve changing the way people not only behave at work but also think about work. Sometimes, however, changing individual mindsets is the sole way to improve a company’s performance. Psychologists in fields of adult development have made several important discoveries about the conditions that have to be met before people will change their behavior. First, they must see the point of the change and agree with it, at least enough to give it a try. Then the surrounding structures — rewards and recognition systems, for example — must be in tune with the new behavior. People must also see colleagues they admire modeling it and need to have the skills to do what is required of them. Applying any one of these insights on its own doesn’t have much impact. But managers now find that applying all four together greatly improves their chances of bringing about lasting changes in the mindsets and behavior of people in an organization — and thus of achieving sustained improvements in business performance.

The Role of the CEO in Leading Transformation
By Scott Keller and Carolyn Aiken
The McKinsey Quarterly
April 2007

In today’s business environment, incremental improvement is not enough — periodic performance transformation is required to get, and stay, on top. Much has been written about what it takes to transform performance successfully. But what is the CEO’s role in leading the transformation? How does the CEO’s role differ from the role of the executive team or of initiative sponsors? Surprisingly, there is little written material that addresses these questions. Guidance can be given, however, based on experience derived from scores of major transformation efforts combined with a series of intense research projects over the past decade. There is no single model for success. The exact nature of the CEO’s role will be context-specific (e.g., influenced by the size, urgency, and nature of the transformation, the capability of the organization, the CEO’s personal style). This white paper outlines four roles that successful CEOs tend to play: making the transformation meaningful, role modeling desired mindsets and behaviors, building a strong and committed team, and pursuing impact relentlessly.
End Notes


2. For a list of about 100 highly recommended books on change management see Nickols, Fred, 2006. [http://www.managementlogs.com/2006/04/change-management-books.html](http://www.managementlogs.com/2006/04/change-management-books.html). As of March 7, 2008, Amazon had 1,861 books listed under the official category "organizational change" and 8,604 books under the category of "change."


8. The leather seats and red pencil examples have been borrowed Ariely, Dan, Predictable Irrationality: The Hidden Forces that Shape Our Decisions, Harper Collins, 2008, p 20 and p 218.

9. Behavioral economics and behavioral finance are closely related fields which apply scientific research on human and social cognitive and emotional biases to better understand economic decisions and how they affect market prices, returns and the allocation of resources. Daniel Kahneman with Amos Tversky and others, established a cognitive basis for common human errors using heuristics and biases (Kahneman & Tversky, 1973, Kahneman, Slovic & Tversky, 1982), and developed Prospect theory (Kahneman & Tversky, 1979). He was awarded the 2002 the Nobel Prize in Economics for his work in Prospect theory as a psychologically realistic alternative to expected utility theory.


Cameron, Lisa, "Raising the stakes in the ultimatum game: experimental evidence from Indonesia," Economic Inquiry 1999, 37(1), pp 47–59; This assumption was also tested by having U.S. participants play the game for $100. They found no difference between play for $100 and play for $10 as reported in Hoffman, E., K. McCabe, et al., "On Expectations and the Monetary Stakes in Ultimatum Games," International Journal of Game Theory 25 (1996): pp 289-301


IBM research; Whitmore, "Coaching for Performance."


Experimental and control group clusters of bank branches were chosen that matched each other and the organizational average on the following dimensions: Performance: NPBT (growth and average over longest coherent period available), economics of customers, average income per customer, industry composition in business banks (split between service and manufacturing industry), and characteristics of centers; Staff: performance rating, tenure (+2.5 years min.); and Size: footings per banker. During the study we ensured no distortions of trial occurred in terms of change of management, restructuring of operations, test of other initiatives in an incomplete subset of trial participants. Performance was compared over 1 year between three groups: 1) No intervention, 2) Salesforce effectiveness improvement program with “rational” change management interventions, 3) Salesforce effectiveness improvement program with “rational” change management interventions. This approach is illustrative of all longitudinal studies mentioned.

The next leg of the journey: How do we make High Quality Care for All a reality?

Helen Bevan, Director of Service Transformation, NHS Institute for Innovation and Improvement

Chris Ham, Professor of Health Policy and Management, Health Services Management Centre, University of Birmingham

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The final report of the Darzi review of the NHS, *High Quality Care for All*, sets out bold policy proposals to take the NHS to its next stage. The ten Strategic Health Authorities, in creating their local visions as part of the review, have led a monumental and far-sighted effort to describe their goals for better health outcomes and better care for their local populations.

While this was, no doubt, very hard work, experience has shown that successfully executing on visionary plans is even harder work. So, as we celebrate the journey thus far and move forward on the consultation and implementation process, we cannot but wonder: Is the NHS adequately prepared for the next leg of the journey?

**Key points in this report**

1. *High Quality Care for All* and the ten SHA region reports collectively set out a compelling vision of the future NHS and provide a foundation for transformational change.

2. History suggests that implementation processes are likely to be the weakest link in turning the *High Quality Care for All* proposals into reality. Implementation needs to be managed in ways that have never been done before in order to achieve results that have never been achieved before.

3. There is a need to reflect on what has worked in the past, in the NHS and other healthcare systems. An evidence-based implementation approach should be built. This means considering not just what actions are needed to reform the system but also how to embed and institutionalise the reforms and enhance the potential for breakthrough change.

4. In the context of the UK government’s public service reform model, over the last few years, less emphasis has been placed in the NHS on building capacity and capability than on other approaches such as performance management and market-type incentives. Evidence from a range of sources suggests that many local NHS organisations and systems lack the change capacity and capability to deliver the reforms.

5. Capability building needs to be ‘hard-wired’ into the daily work of NHS staff. Initiatives such as the Productive Ward demonstrate just how much energy for change can be unleashed by encouraging front-line teams to question how they work and providing simple tools and skills development.

6. The skills and capabilities that already exist within the system should be built upon. Evidence suggests that bringing ‘outside in’ change capability (consultancies and external experts) can add momentum, new perspective and skill in the short-term. However, in the longer term it is ‘inside out’ change, the capability of the system to change itself that will create the sustainable improvements we seek.

7. Evidence from high-performing health systems indicates the need to invest significantly in leadership-level skills for large-scale change; to mobilise for improvement, strategically align goals, and create measures and implementation initiatives; to work explicitly with models and theories of large-scale change; and to balance short-term operational results with longer term transformation.

8. Evidence from these systems also highlights the value of using information on comparative performance to bring about improvements in care, with the focus being on clinical quality. Transparency of information on variations in clinical quality should be used as part of performance management and to inform the public about the standards of care being achieved by NHS organisations to enable the aims of *High Quality for All* to be taken forward.

9. Consideration should be given to how to frame the implementation of *High Quality Care for All* to gain wholesale staff and public engagement, not just in planning and prioritising but in the entire change implementation process. Whilst politicians and policy makers may seek a ‘once-in-a-generation’ big bang launch of major new directions, it will pay to be restrained with NHS staff, focussing on clarifying and integrating efforts.
In this paper, we offer our review of the outputs of the Next Steps Review, focusing not on the ‘what’ of the specific proposals, but the ‘how’ of executing and delivering the anticipated changes. We describe the recent evidence and experience in healthcare regarding execution of large-scale change, and provide critical recommendations of things to consider as we move on from the current milestone.

The regional reports from the Next Steps Review

The nine SHA regional reports on Our NHS, Our Future, together with the Healthcare for London Report on the Consultation and Recommendations for Change, collectively present a compelling case for change across the country. The documents are typically labelled as a ‘strategic vision’ or ‘clinical vision’ and each sets out ambitions for health and healthcare in the region over the next period. All the reports are characterised by a depth of strategic analysis, an integrated approach to health and healthcare improvement, significant clinical engagement in the development process and explicit ambitious goals for change. In fact, they represent a step-change in the ability of the NHS at its most senior level to set out a visionary case for change.

Overall, the regional reports are very strong on ‘what’ needs to change but much less strong on ‘how’ it will happen. Perhaps this is an unfair criticism since the guidance given to SHAs in developing the reports was to follow a traditional model of strategy development, with an initial ‘vision’ stage, followed by a consultation process. Yet if we examine world-class approaches to large-scale implementation of change, we consistently see two characteristics (Institute for Healthcare Improvement, 2007):

- implementation planning is an integrated part of strategy development and it is considered from the beginning of the vision setting process
- there is an explicit link made between the outcomes sought, the hypothesis on the factors (‘drivers’) that are most likely to deliver that outcome and the specific project or programme plan for delivering the improvements. This means that the specific actions that are recommended are built upon an explicit theory of change.

There is evidence of these characteristics in some of the regional plans. Examples include the North East Transformation System as an implementation vehicle in the North East SHA proposal and the comprehensive Delivering Our Vision strategy from North West SHA. However, it is hard to evaluate most of the proposals from an implementation perspective because there is insufficient evidence to make a judgement.

So what other sources of evidence should we draw on in designing an implementation strategy to deliver sustainable results?

Approaches to public service reform

A good starting point for our reflection is a quick review on approaches to public service reform to-date. We will return to them later in the report. Over the last eleven years, the Labour Government has pursued an active programme of public service reform with four main components (Figure 1). Experience in the last decade has highlighted the strengths and weaknesses of each component (Prime Minister’s Strategy Unit, 2006).
Centrally-driven performance management has contributed to improvements in performance in a number of public services through the application of targets and other interventions, such as National Service Frameworks in the NHS. Whilst this approach has delivered results, it has well known limitations, including the stifling of innovation and creativity, limiting aspiration and ambition to the level of the standard or performance target, and increased bureaucracy.

Market incentives to increase efficiency and quality of service have also played a part in performance improvement. By offering the users of public services a wider range of options from which to choose, and by requiring providers to compete for resources, competition and contestability have contributed to improvements in efficiency and quality, as in the reductions in waiting times. The limitations of this approach include its discouragement of the sharing of best practice, a risk that market forces become an alternative rather than an addition to building internal capability for improvement, and undermining of the public service ethos.

Users shaping services is a third approach and is closely linked to the use of market-type incentives. As well as offering users more choice, this approach seeks to strengthen the collective voice of citizens, empower users by giving them control over budgets, and involve them as co-producers of services, as in the Expert Patient Programme. The limitations of this approach include the risk that equity may worsen as the articulate middle-classes profit at the expense of the poor, and the weakness of voice mechanisms in changing the behaviour of public services.

Strengthening capability and capacity of public service leadership and the workforce has involved bringing in and developing talent, improving workforce development, pay and workforce reform (as in the new contracts for NHS staff), and using data on comparative performance to drive up standards. The limitations of this approach include the failure to use the opportunities offered by workforce reform to achieve performance improvements (eg the new contract for consultants in the NHS), and the uneven investment in leadership development and local improvement capability.

In practice, all four of these approaches have been used in various combinations in different public services. In the NHS, greatest reliance has been placed
on top-down performance management, supplemented by market incentives and users shaping services from below. By comparison, less attention has been given to strengthening capability and capacity. High Quality Care for All signals a change in emphasis. Lord Darzi, in presenting his recommendations, has suggested that there will be no new nationally determined targets and no large-scale restructuring of the NHS system. However, much less has been said, either nationally or regionally, about the need to build capacity and capability for large-scale change and improvement.

**NHS capability for change**

Evidence from a range of sources suggests that many NHS organisations fall short on the change capability required to deliver the proposals emerging from the Next Steps Review. For instance:

- the Office of Government Commerce study of change capability in the NHS (July 2006) scored the NHS at only two out of a possible five for seven out of nine categories assessed. The NHS got low scores in use of change management methods, staff development approaches and change leadership
- a study of NHS Trusts and PCTs by the University of Warwick (2006) looked for evidence of the kind of improvement approaches that have been used in industry for more than 50 years to improve operational efficiency and effectiveness. The researchers found strong evidence of such capacity and capability amongst high performing NHS organisations and in some of those with the greatest improvement challenges. However, they found very limited capability in evidence-based change management amongst the majority of NHS organisations that are in the middle of the performance curve
- a review by Ham et al (2007) showed a significant deficit in project management skills across the NHS, specifically in the management workforce. The report found that that this was hindering effective progress in delivering sustainable service improvement.

This evidence is backed up by recent experience by the NHS Institute for Innovation and Improvement which suggests that the biggest area of unmet need amongst local NHS organisations is in ‘hands-on’ improvement skills both for leaders and front-line teams, and how to align change capability with local strategic imperatives.

Our assessment is that in the next stage of NHS reform, there needs to be a much stronger focus on strengthening capability and capacity at all levels.

Moving from good to great in human service organisations like the NHS - to borrow the language of Jim Collins (2001) - involves understanding that many of the answers to the problems that exist lie within. This does not entail reverting to a system dominated by unaccountable professionals. Rather, it means engaging front-line staff much more fully than has been the case hitherto and supporting them through education and development to bring about improvement in care for patients and service users. In the process, there is a need to put more emphasis on measuring and comparing performance, and developing leadership skills and capabilities in the use of performance data, linked to incentives that can drive quality improvements.

In the next section of the paper, we set out some of the evidence from research into high performing organisations and provide case studies on large-scale change in healthcare. In order to make a timely contribution to the debate, we have not sought to carry out a full systemic review but to summarise some of the latest evidence.

In the final section of this paper, we develop these ideas further as an agenda for the NHS leaders considering the implementation of High Quality Care for All.

**High performing healthcare organisations**

The need to give priority to strengthening capability and capacity is reinforced by the findings of three recent global research studies into high performing healthcare organisations.

**International comparison of healthcare systems**

A two-year project led by Ross Baker at the University of Toronto (Baker et al, in press) examined the characteristics of five international systems and two Canadian systems. Based on fieldwork in each of these systems and analysis of their performance, Baker and colleagues identified the following common attributes of high performance:

- outstanding leadership
- quality and system design as a core business strategy
- significant investment in building capability for improvement
• integration of services across levels of care, sites and disciplines
• harnessing of information technology and meaningful measurement
• focus on putting patients/clients first
• engaged physicians and workforce
• strategic alignment of aims, measures and activities
• incentives and accountability.

Organising for quality
Further insights are offered by an international study conducted jointly by researchers from the RAND Corporation and University College London (UCL). Bate, Mendel and Robert (2008) selected for study nine healthcare systems in the United States and Europe. These were a variety of hospital and primary care organisations renowned for high performance and excellence in implementing and sustaining quality improvement. The research team identified six core challenges in the case study institutions:

• structural: organising, planning and co-ordinating quality efforts
• political: addressing and dealing with the politics of change surrounding any quality improvement effort
• cultural: giving quality a shared, collective meaning, value, and significance within the organisation
• educational: creating a learning process that supports improvement
• emotional: engaging and motivating people by linking quality improvement efforts to inner sentiments and deeper commitments and beliefs
• physical and technological: designing physical infrastructure and technological systems that support and sustain quality efforts.

A distinctive contribution of this study was to move beyond a list of the characteristics of high performing organisations to analyse the process for organising for quality and overcoming the above challenges. By comparing the different organisations that were selected as case studies, Bate and colleagues found that there were many routes to quality improvement. There is no one ‘right’ method or model. It was the interaction of key factors in varying contexts that helped to explain the journeys the organisations they studied had been on.

One of the implications that follow is that it is difficult for healthcare organisations as complex adaptive systems to copy or transfer experience from other organisations without understanding their own distinctive history and context (Plsek and Greenhalgh 2001). People and relationships are critically important in facilitating or inhibiting quality improvement, and a key task of leadership is to understand how to work with the people who work in healthcare organisations to tackle the challenges identified by Bate and colleagues. In the case study sites they followed, leaders did this in various ways, including through structural interventions (eg using communities of practice), cultural interventions (eg emphasising staff empowerment) and educational interventions (eg providing training in quality improvement methods).

World-class quality in healthcare
Anthony Staines (2007, see also Øvretveit and Sousa, 2008), a Swiss researcher, carried out an in-depth study of the healthcare organisations globally that have made the greatest improvements in clinical outcomes and quality. The good news, from a Next Steps Review implementation perspective, is that it is possible for healthcare organisations to make transformational improvements in clinical performance. However, even with significant resources and leadership effort, it takes a long time to create change across the board. Amongst the ‘world-class’ organisations that Staines studied, it took a minimum of ten years of sustained effort to get measurable results across the whole system or organisation. Any healthcare system that pursues such a strategy has to reach a ‘threshold’, below which investment in improvement will not yield results. The threshold will only be reached when a number of ‘infrastructure’ elements, those that create the conditions that lead to better outcomes, have been in place for a significant period of time. These elements include:

• building leadership will and commitment
• freeing up resources for clinical quality improvement
• training staff
• establishing indicators and data collection systems.
Staines notes that, in fact, performance may actually appear to deteriorate before it gets better. This typically happens because more efficient data collection systems are introduced which capture more data (and therefore illuminate more problems) before the real improvements kick in.

As Staines describes it ‘initial investment in change goes into the balance sheet, not the operating results.’ He identifies leadership tampering as a major barrier to reaching the investment threshold and achieving results. This means changing direction before the old direction had time to deliver. Equivalent examples of leadership tampering in the NHS include organisational restructuring and continuously introducing new policies and initiatives.

**Case studies: Jönköping County Council and the Veterans Health Administration**

Moving from systems level approaches to public service reform, through research on high performing healthcare organisations, the experience of two organisations that have been successful in programmes of improvement and transformations holds further lessons for change implementation in the NHS.

**Jönköping County Council**

In Sweden, Jönköping County Council is widely recognised as an organisation that has achieved and sustained a high-level of performance (Øvretveit and Staines, 2007). This is illustrated in its standing in the league tables that are used to compare performance across Sweden. In UK terms, Jönköping is an elected regional health authority serving a population of around one-third of a million and raising most of its resources through local taxes. Healthcare in Sweden is run on a devolved basis with the national government in Stockholm setting the legal framework and determining the entitlements for citizens, but the county councils have the main day-to-day responsibility for healthcare funding and delivery.

Referring back to the four approaches to public service reform described by the Prime Minister’s Strategy Unit (Figure 1), Sweden has made little use of top-down performance management because such an approach is incompatible with that country’s devolved system of healthcare. Market incentives have also been absent because in Jönköping the controlling politicians have not favoured the use of competition and contestability as drivers of reform. Users shaping services from below have received greater attention, not least through the accountability of politicians to the public through the ballot box.

However, Jönköping has relied primarily on strengthening capability and capacity to achieve improvements in care. From an NHS perspective, notable features of Jönköping’s approach include:

- **organisational stability**: in contrast to the NHS, Sweden has enjoyed a large measure of organisational stability, enabling leaders to focus their efforts on service and quality improvement, not distracted by structural changes

- **continuity of leadership**: the Chief Executive of Jönköping County Council has just retired after being in post for 19 years. Before that he was the Director of Finance. He therefore brought to the role the intimate knowledge of the business and the constancy of purpose that Collins (2001) identifies amongst characteristics of successful leaders

- **collective and distributed leadership**: Jönköping has given priority to the development of a leadership team to work with the Chief Executive, and to the development of leadership right through the organisation. This includes a strong emphasis on clinical leadership in the front-line improvement efforts (‘microsystems’) that are the focus of much of the quality improvement work in the county

- **investment in education and learning for improvement**: Jönköping has created its own in-house facility, Qulturum, which acts as a central focus for quality and culture and a centre of education and learning in quality improvement. It has made a very significant investment in building its own improvement expertise and cadre of experts in innovation and improvement. Much of the work that is done in Qulturum draws inspiration from links with international leaders in quality improvement such as Don Berwick and Paul Batalden

- **a vision of patient-centred care**: all of Jönköping’s work is directed at improving care for patients and service users. This is symbolised by Esther, a fictitious 88-year old whose experience is used to enable clinical staff to map current care pathways and explore how they can be improved to better meet her needs.

In Jönköping, quality improvement is seen as a long-term, and at times a slow, journey that is not
Amenable to quick fixes. The emphasis is therefore placed on building momentum for change rather than speed, and recognising that sustainable change depends on building capability and capacity for improvement throughout the organisation.

Veterans Health Administration

The experience of Jönköping can be compared with that of the Veterans Health Administration (VA) in the United States. The VA was widely perceived to be an organisation in crisis in the early 1990s. Following the appointment of Ken Kizer as the new Chief Executive, the VA embarked on a major programme of transformation that led the Washington Monthly in 2005 to describe it as ‘the country’s best healthcare system’.

Research into the transformation of the VA (see, for example, Oliver, 2007) has identified the following factors as being important in its turnaround:

- the move away from a fragmented system centred on individual hospitals to a system based on 22 regional service networks
- the introduction of a performance management approach focused on key targets enabling the headquarters to hold the regional directors accountable for performance
- the development of a culture of measurement and reporting centred on key performance criteria facilitating comparisons between regional networks through increased transparency
- the emphasis within the performance management approach, and the culture of measurement and reporting, on clinical quality as well as other aspects of quality
- the use of financial and non-financial incentives to support performance management and quality improvement
- the use of information technology, including the electronic patient care record, to achieve closer integration of care and to support the use of measurement and reporting as drivers of improvement
- the investment on health services research (pre-dating the appointment of Ken Kizer) and the ability to lever the capacity for research in the organisation to support quality improvement and to make the results available through the scientific community (eg through articles in the New England Journal of Medicine on the progress made in the VA)
- the strengthening of leadership at all levels of the organisation, including the involvement of doctors and other clinicians in key leadership roles.

In moving away from a fragmented system centred on hospitals to a system of regional service networks, the VA was able to demonstrate the benefits of integrated care. These benefits include achieving good outcomes for patients with chronic diseases and reducing the use of hospitals bed days by 50% in five years without adverse effects on the quality of care (Ashton et al, 2003).

Throughout the transformation, Kizer focused on quality as the overriding goal of his strategy. In using performance management, he emphasised the need to develop this collaboratively rather than to impose it top-down. This entailed working with regional directors and clinical leaders to agree the targets and measures that should be used in performance contracts. As in Sweden, the public reporting of performance data was seen as an important driver for quality improvement in the VA.

What are the implications for the implementation of High Quality Care for All?

The NHS is at a critical point in its journey. The reforms of the past ten years have clearly moved the service forward, and the national and regional plans under the Next Steps Review set ambitious goals for the future. The key question now is how we proceed from this point onward to execute on these plans.

The fundamental issue is that, as we discussed previously, the NHS is a complex adaptive system. This means that any major intervention changes not just aspects of the system, but the very nature of the system itself. This is made even more complex by the fact that the NHS is predominantly a human activity system, which introduces issues of politics and group or self-interest that are difficult to model or predict. Any large-scale strategy has to be cognisant of these realities. Drawing on the research evidence summarised above and the experience of high performing organisations, we believe that there are important implications for leaders at every level of the NHS system:

1. The biggest challenge for leaders lies in building greater capacity and capability for change within NHS organisations and the public. Research on large-scale change shows us that if services are to improve dramatically, it will be
through the engaged improvement efforts of front-line clinical and managerial staff that do the work. While over the past ten years we have seen the development of the capacity and capability for small-scale, incremental change in pockets within the NHS, a significant investment of time, resources, and leadership effort will be required to create the capability for large-scale change across the whole of the NHS.

2 The experience of high performing organisations is that they have invested their own resources in building capability among staff and promoting ‘inside out’ change, for example, through Culturum in Jönköping. The evidence tells us that bringing ‘outside in’ change capability can add momentum, new perspectives and skills in the short-term. However, in the longer term, it is ‘inside out’ change, the capability of the system to change itself that will lead to sustainable improvements for every patient and local population. As a result of the reform process over the past ten years, the NHS has tremendous organisational memory on how to implement radical change, probably more than any other national healthcare system globally. We should treasure that and build on it.

3 The evidence suggest that, on its own, wholesale formal training in quality improvement and change management techniques will not deliver the results we seek. Capability building needs to be ‘hard-wired’ into the day-to-day practice of our staff (Keller and Aiken, 2008). Initiatives such as The Productive Ward demonstrate just how much energy can be unleashed by encouraging front-line teams to question how they work and providing simple tools and skills development to support them, on the job. Across the NHS, we need to find the mechanisms to tap into and mobilise the huge pool of latent individual and organisational energy for change, as has happened in the case study systems.

4 Our research stresses the importance of planning and resourcing large-scale change implementation. We need to calculate upfront how much extra time, effort, skills and systems will be required to execute the change and create the space and resources for it to happen. We cannot just assume that people will fit it in on top of existing busy jobs. Evidence suggests that if anyone’s workload increases by more than ten per cent as a result of an implementation initiative, it is likely to run into problems (Sirkin et al, 2005). Dedicated resources need to be identified and set aside for key implementation and change management roles, including people taking on project management responsibilities (hand et al, 2007).

5 As the case study organisations demonstrate, change capability is not just about the micro-level ability to make improvements at the front-line of patient care (although this is critically important). We also need to invest significantly in leadership-level skills for large-scale change. Specifically, leaders need to know how to mobilise individuals, teams and communities to the cause of change; how to strategically align goals, measures and implementation initiatives; how to work explicitly with models and theories of large-scale change; and how to balance short-term operational results with longer term transformation.

6 The Jönköping and the VA experiences reveal just how powerful publishing and comparing variation in performance on key quality indicators can be as a lever for performance improvement. The lesson from these high performing organisations is that transparency of information on variations in clinical quality should be used as part of performance management and to inform the public about the standards of care being achieved by NHS organisations to enable the aims of High Quality Care for All to be taken forward.

7 We need to consider how we frame implementation of High Quality Care for All to gain wholesale staff and public engagement not just in planning and prioritising, but in the entire change implementation process. Paradoxically, transformational change is more likely to succeed where it is framed as a continuation of the present, starting from the organisational legacy and what people are used to (Barrett and Fry, 2005). Whilst politicians and policy makers may push for a once-in-a-generation ‘big bang’ launch of major new directions, it will pay to be restrained with NHS staff, focussing on clarifying and integrating efforts.

8 While it may be hard to admit it, we need to acknowledge that front-line staff in the NHS are much more motivated by the needs of the members of the public that they encounter daily, than they are by the pronouncements of senior leaders that they see rarely. Devoting resources to build even more capacity in members of the public to play constructive roles in driving improvement work might be the most rewarding investment the service will ever make (Reinertsen et al, 2008).
While competition can, no doubt, drive up standards of performance, when it becomes a barrier to collaboration it may have gone too far. The private sector has much to teach us here about getting the right balance between competition and collaboration. For example, while firms in the automotive industry compete fiercely, they still find ways to share for the common good breakthroughs in areas such as safety and fuel efficiency. Regional and national leaders should take responsibility for reflecting carefully on current efforts and actively working to strike a better balance between competition and collaboration.

In the wake of the release of High Quality Care for All, we invite NHS leaders to consider carefully what they will do next using the nine points above as an initial challenge. We now have new goals for the future, but we have had new goals before, have we not? We have approaches for executing on new plans and goals, but these have never quite delivered fully on what was so enthusiastically envisioned at the initial release of the plans, have they? We have been at this point in the journey before, have we not?

The question now before the NHS leadership community as we contemplate how we will execute on the changes outlined in the national and regional plans is: What will we do this time round - simply more of the same, or something different?

The NHS Institute for Innovation and Improvement will be contributing more ideas on implementing large-scale change in the autumn of 2008.

References


Institute for Healthcare Improvement (2007) Execution of strategic improvement initiatives to produce system-level results, IHI White Paper (www.ihi.org)


