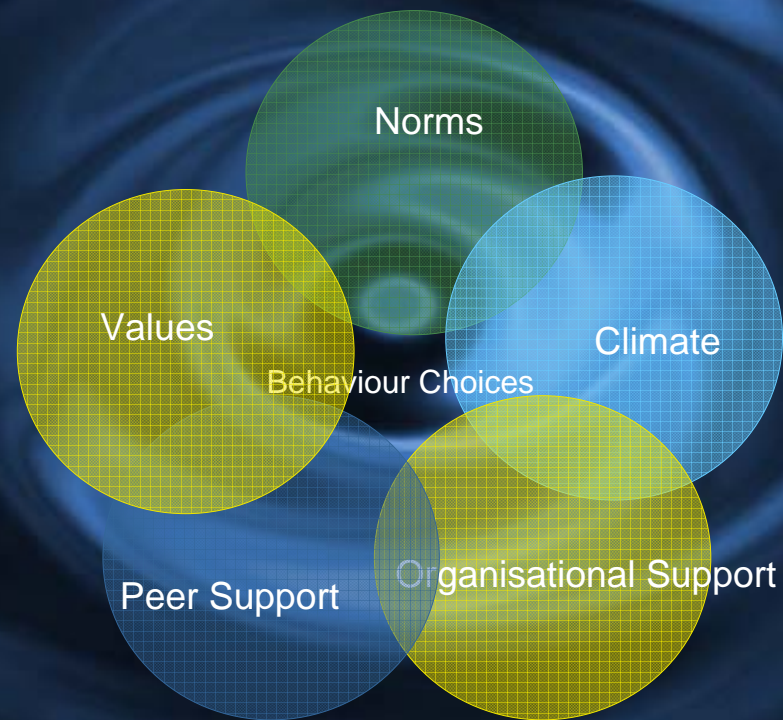


Changing a culture:
Lean Thinking and its impact
on the culture of Allied
Health Division at FMC

Josie Kitch,
Director - Allied Health Division
Flinders Medical Centre

5 Elements of Culture



Lasting success = individual initiative + cultural support

Allied Health Culture

- ❖ Historical perspective
 - ❖ Tribal warfare
 - ❖ Turf protection
 - ❖ Fighting for recognition/funding
 - ❖ Identify with own tribe, not teams
 - ❖ Expert role rather than seeing patient as expert

Reactions to Change



Case For Change

- ❖ The Case for Change:
 - ❖ Strategy to accomplish some overall goal
 - ❖ Usually provoked by some outside driving force
 - ❖ AH related to challenges of demand versus supply
 - ❖ Outpatients - we owned the processes, under tight scrutiny, feelings of this work being undervalued and under pressure re: workloads.

Process of Engagement

- ❖ Engage key stakeholders
- ❖ Define the scope
- ❖ Leadership team and commitment
- ❖ Facilitator role - benefits/challenges
- ❖ Early adopters
- ❖ Sustainability and spread
- ❖ Training

Change Management Flowchart



Change Management	Lean/RDC	AH @ FMC (examples)
Stakeholders involved	Involvement from all layers of staff	Allowed for voice of Clinicians/PMA/Admin
Scouting the environs	Mapping Tracking	Value of current state map to highlight case for change
Issues drive tools & techniques	Diagnostics – variable use of tools	Dev of booking system/outpatient system

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Change Management	Lean/RDC	AH @ FMC
Revisioning of culture	Innovation and trialing new things accepted practice Don't accept historical ways of working Question why do we do things this way?	Understand ext context Key directions - more interD thinking/planning Key enabler: embrace change

Current State

- ❖ Variety of pieces of work now across OP/IP
- ❖ Involved in variety of hospital wide projects
- ❖ Seen to be open to trial new products - i.e. outpatient booking system to be trialed in Dietetics department
- ❖ Looking at deepening the use of the methodology - workload management, staff tracking
- ❖ Move from less threatening to more threatening pieces of work
- ❖ Management with a variety of knowledge/tools/skills

Changing a culture:
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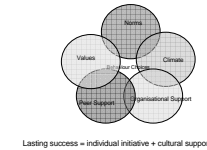
Josie Kitch,
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Culture change happens often in an insidious way and in health, as we are so busy dealing with the day to day operational business, reflecting on change processes isn't common. Health is challenging and to create a change in culture is difficult in any organisation let alone in the complex health environment.

This paper looks at a culture change that is occurring in AH at FMC and tries to analyze why this has occurred.

1

5 Elements of Culture



Much has been written about culture and cultural change. Culture has been analyzed to be made up of 5 elements: norms, values, peer support, org support and climate. All of these elements are important to consider when understanding how the culture interacts with the individual to influence their behaviour choices. Whenever two or more people come together with a shared purpose they form a culture with its own written and unwritten rules for behaviour. These cultures have a tremendous impact upon our behaviour as individuals.

Changes initiated in unsupportive cultural environments tend to last less than one year. In contrast, changes that are supported by the culture are likely to stick. In addition, both the desire to attempt change and the likelihood of long-term success are positively related to cultural support.

In order to achieve sustained results goals must be linked with the creation of more supportive cultural contexts. This is true whether our goal is to exercise regularly, to increase org productivity or to reduce teenage binge drinking. The culture influences our choices and determines the effectiveness of our individual initiatives. Lasting success = individual initiative + cultural support

There are many links between culture change management literature and RDC/Lean thinking methodology and in this paper I want to draw the links between these two bodies of work and use AH division at FMC as an example of how and why the methodology can create cultural change.

2

Allied Health Culture

- ◆ Historical perspective
 - ◆ Tribal warfare
 - ◆ Turf protection
 - ◆ Fighting for recognition/funding
 - ◆ Identify with own tribe, not teams
 - ◆ Expert role rather than seeing patient as expert

To give some background it is important to have a historical understanding of AH and how this has impacted on its culture. AH has grown up and has, let's face it, carved bits of work away from the medical and nursing worlds. We come, therefore, from a history of having to fight for our patch, wrestling it away from other staff groups and constantly having to prove our value. This has led to a culture of patch protection, boundary surveillance and suspicion of our colleagues and that doesn't just include medical and nursing staff, it also includes other allied health. And so we come together, but we are wary of each other and we keep fighting.

One of the significant issues for the health system is that we train separately, we learn how special we are (and that's not just doctors that I am talking about!!) and we come into the health world all puffed up with our knowledge, wanting to change the world and then we are shoved into teams and told to work together, respect each other, get along and put the patient first!! The first working years for any professional is all-consuming and they have little understanding of what they know and don't know, let alone what other professions do and know. Then we wonder why our staff are inculcated into the culture of their homes - whether that be wards/department, rather than a culture of the team and the needs of patientswell we know what's best for them don't we!!

AH are aware that hospitals can't run without nursing/medical staff and when finances are tight they attempt to run without much AH – albeit with impacts on patient outcomes so we are constantly fighting for our bit of the funding pie. AH in the acute setting have felt powerless and so have in the main tried to align themselves very strongly with medical staff ... doing this by feeling superior to nursing staff ...which we are not .. But also feeling inferior to medical staff....which we are not. And thus the unique culture of AH has grown. And with no disrespect intended I call this --- the arrogant victim culture.

3

Reactions to Change

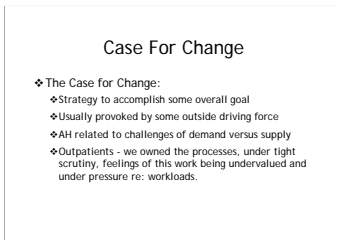


So that is my view of the AH culture – seeing this and wanting to create a space where AH could discard this and move on into a more mature cultural space. Hence a change process was needed. But we know that change does not come without significant angst for some.

We all know people who don't like change, we call this resistance and can talk about it as if it were an irrational response to be overcome with rational persuasion. In fact it is always the case that from an individual's point of view one's own behaviour is rational. Generally when people have worked in an org for very long they have absorbed a set of norms and expectations about what is expected, what is rewarded and what is least approved. They have learned the way to behave that will, at the very least keep them out of trouble. This set of widely shared beliefs is the org culture.

The RDC methodology involves staff at all layers and levels of the org - builds from a strong foundation of the current state and develops with the whole group a planned future state map. It allows for people to see the old ways of thinking and doing and understand what needs to change. This allows for people to develop a more humorous system for "catching" each other in the old ways and rewarding the new. In this way what might have become the source of serious resistance becomes a source of camaraderie and commitment to the new way of doing business. So instead of staff feeling like they have to stand and fight for their patch, they have a strong sense of working together to solve issues where the issue is the processes and the system within which we work and historical ways of working rather than the problem being the other team members.

4



I saw the need for change but needed to develop a case for change.

Change is a strategy to accomplish some overall goal but what was that goal? Saying the goal was to change culture would have signaled death to the change process, as culture is by its nature something that people hold dear to themselves.

So the goal really became “coping with demand”. The outside driving force was financial constraint, demand higher than supply, difficult politically in cutting services and a spotlight on outpatient services.



2. Process of engagement – step by step

RDC came to FMC and very rightly went into the place where the most crisis was - ED. It spread from here to other areas and some of the AH clinicians were involved in the work at a grass roots level. However, in true AH style, we looked on with envy and feeling left out – What about us?? So I commenced a series of discussion with RDC re: AH, and they quite rightly only became interested in doing a piece of work with AH that AH owned and thus the AH Outpatient RDC work began.

3. Define scope

The exercise of defining the scope and writing that down provided good discipline and required much discussion and these robust discussions were the first part of the process.

4. Leadership team and commitment RDC were clear that we needed a leadership/exec team and that there needed to be commitment from these leaders for this work. So a process was begun where we documented the piece of work to be done, agreed to how we would fund a Facilitator role, and physically signed off on the work. This approach ensured buy-in – well at least buy-in on paper. This piece of paper also gave me the authority to call people to task, if needed.

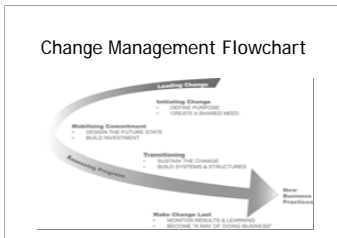
5. Facilitation role – benefits/challenges We eeked out some funding for a Facilitator as it was important to have someone on the ground who had the time/energy and responsibility to undertake a range of the tasks, gather information, support departments and provide on the ground expertise. We were also fortunate enough that the RDC Director agreed to be part of the work and mentor our facilitator – and I think also became quite intrigued with the world of AH. The challenges for this role was that the person faced a range of responses to their work from areas which embraced the methodology with passion to areas who were largely suspicious of what the “hidden agenda” was.

6. Early adopters With any change management process they discuss the role of the early adopters and this was certainly the case with this piece of work. Our Podiatry department became shining stars in regard to embracing the methodology. There were a number of reasons why they became early adopters – demand issues, mainly outpatient based and so the piece of work was relevant for the majority of their work, strong leadership, and I think it was their first experience of being in the spot light in a “positive way”.

7. Sustainability and spread across the Division

Unfortunately as is often the case, the funding for the Facilitator role was not recurrent and so the aim was to embed the methodology and gain some wins and gain some data to support the viability of the methodology within acute AH. And we did this. The issues of ongoing sustainability was concerning and the ability to spread the learning’s across the Division was also a challenge. The aim was to have change agents in every department and for departments to own their own RDC pieces of work rather than relying on a Facilitator. So the RDC Director developed a training package for the Division.

8. Training The training program included every head of department and key people from their department – folk who the HoD thought would be able to take the methodology and run with it. The aim was to broaden and deepen the knowledge across the Division of the concepts and the methodology behind RDC. It was also an opportunity to reinforce the expectation that RDC work in AH would continue and grow. Part of the training was for the departments to start working up a proposal of a piece of work and for this to be presented to the group. This created expectations that this work would happen.



So how does change management and redesigning care align? Looking at a change management flowchart reveals the similarities. RDC uses all these steps to develop new ways of working and so whilst it holds itself up as a business process reengineering methodology, the impact of using these tools also develops an ongoing change management methodology which can lead to cultural change.

Large scale org change usually triggers emotional reactions. This emotional process is exhausting and needs to be acknowledged. Using a methodology that does not blame the worker but looks critically at the system/s that have developed over time creates an environment where people are acknowledged for their hard work, their commitment and the creative ways they work with a broken system, whilst challenging the status quo. The power of producing a current state map to enable people to look objectively on their processes and truly see the complexity and the work around and the waste is very empowering. I have witnessed so many times a true engagement of “surely we can do this better”.

Change Management	Lean/RDC	AH @ FMC (examples)
Stakeholders involved	Involvement from all layers of staff	Allowed for voice of Clinicians/PMA/Admin
Scouting the environs	Mapping Tracking	Value of current state map to highlight case for change
Issues drive tools & techniques	Diagnostics – variable use of tools	Dev of booking system/outpatient system

In the next few slides I have attempted to draw the links between change management methodology, RDC/Lean methodology, and what has happened in AH at FMC.

Change management discusses the importance of some vital elements – the first being stakeholder involvement and lean actively engages with staff from all levels. For us this allowed the voice of our Clinicians but also importantly paramedical aides, admin staff being valued as they know our systems best and know what the work arounds are and have a fantastic solutions focus.

The second is scouting the environs which we can link to mapping and tracking tools. The value of current state maps have allowed us to learn to see the whole issues, learning to see where value is added and learning to see from the patient perspective.

In change management, the issues drive tools and techniques which align strongly with the diagnostic phase of RDC. In AH this has allowed for the development of new tools that reduce rework, improve processes and improve visibility and reduce complexity.

Change Management	Learn/RDC	AH @ FMC
Revisioning of structures Processes Governance techniques/products	RDC structures Trials of no-take, ward rounds etc	Ext. roles - PT led clinic 7 day service dev Unit based teams
Chaos & messiness accepted	PDSA No blame Systems not individual issues	Freedom to trial new things Learn as you go

Change management discusses the revision of structures and processes - we have seen many examples of this within the organization in regard to trials of a no-take system, changes in ward rounds, changes in "learning to see" via journey boards. For AH the RDC methodology has contributed to the trial of extended roles in outpatients such as the physiotherapy led orthopedics clinic, the strength of commitment for 7 day service development to ensure patient flow and more recently the development of AH structures that align such as unit based teams.

So how does RDC help this??? PDSA cycle provides a freedom to experiment without being locked in – AH often want to be perfect and do things perfectly and that has created inaction due to imperfect information/systems/data we have--- so in this context it feels less risky to do nothing than to do something that is not perfect. However RDC provided a methodology and tools to enable people to experiment, try things, review the progress and then change.

It is a very freeing methodology and this has created an environment where trying things is well regarded whilst acknowledging that we won't necessarily get it right the first time.

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Change Management	Learn/RDC	AH @ FMC
Revisioning of culture	Innovation and trialing new things accepted practice Don't accept historical ways of working Question why do we do things this way?	Understand ext context Key directions - more interD thinking/planning Key enabler: embrace change

Culture of the organization as a whole has changed. We now have a situation where there is a lack of willingness to accept historical ways of working. We question status quo more and don't defend our practices before analyzing them.

For AH it has been a journey that we are still on. Defensiveness has lessened, we understand how clunky the system is and look to change it.

At a recent strategic thinking session the group clearly articulated the need to do more interdisciplinary thinking/planning so that we get to know and trust each other more. Also the group saw a key enabler of the Division being the willingness to embrace change. Clinicians want to identify as AH workers and not just with their discipline.

This is an important first step but we have started the journey. Obviously the need is for AH to continue to place patient care as the primary objective and not spend energy on turf wars. This is still a challenge.

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Current State
<ul style="list-style-type: none"> ◆ Variety of pieces of work now across OP/IP ◆ Involved in variety of hospital wide projects ◆ Seen to be open to trial new products - i.e. outpatient booking system to be trialed in Dietetics department ◆ Looking at deepening the use of the methodology - workload management, staff tracking ◆ Move from less threatening to more threatening pieces of work ◆ Management with a variety of knowledge/tools/skills

Currently we have a variety of pieces of work happening in departments. We have moved into areas that were considered to be in the too hard basket – for example working through streamlining the processes around diet ordering and provision; working on processes re: Guardianship board.

Each department has identified hot spots and that is where they are targeting their work, however, at our monthly Clinical Governance meetings HoDs share the progress, outcomes and successes with each other. Some of the work that particular departments are undertaking will inform the whole Division, for example Speech Pathology department has recently done a range of tracking of staff that have highlighted significant issues that our staff face in regard to time spent in information gathering and processing and in communication. This is information that we have been aware of at some level but when looking at concrete data it can be very confronting when realising what staff spend time doing. The concrete data also provides a stronger impetus for change.

Lean creates rigour around decision making, it creates greater objectivity and it creates a culture where change is possible and trialling new ways is accepted and expected. This has helped us in our journey toward greater teamwork and true respect for ourselves, our colleagues and our patients.

I hope this paper has given you some food for thought about the alignment of Lean and how it creates opportunity for culture change.

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