

THE SYMBIOTIC RELATIONSHIP BETWEEN LEAN AND LEADS

**A discussion paper for Canadian Health
Leadership Network Partners**

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A DISCUSSION PAPER

Lean Health Care Transformation in Saskatchewan

Saskatchewan's Health System is in the midst of an ambitious plan to alter the way it strategizes and delivers health care across the province.

If it is successful, the province will be the first in Canada to introduce the so-called "Lean" system of management to all of its 43,000-plus health care workers and managers.

Dan Florizone, former Deputy Minister of Health, calls the approach a "game changer" and says Lean has the potential to "turn the system on its head." He says the 50-year project will include everyone from the nurse practitioner in a remote northern clinic to dozen member teams in big-city operating rooms.

"This is transformational," Florizone said. "No state or province that I'm aware of in the world has attempted it on this scale."

INTRODUCTION

To stimulate change, leaders often employ innovative management techniques to accomplish key goals. In Saskatchewan, the Ministry of Health (MOH) and individual health authorities (HAs) have endorsed the *Lean management system* to accomplish the twin goals of improving health system effectiveness and efficiency in delivering high quality, safe patient care. The use of Lean as a new management system and a change tool lays out a challenge for all leaders in Saskatchewan. In tandem, Regional Health Authorities (RHAs) are using the *LEADS in a Caring Environment* capabilities framework as a common leadership language to guide the development of their leaders through the Saskatchewan Leadership Program (SLP) in understanding how to implement change effectively.¹

Quality-improvement literature provides considerable proof of Lean's effectiveness. When implemented as an entire management system, Lean can become a catalyst for behaviour changes in both management and staff as well as shift a leadership culture (O'Mara et al., 2014; Toussaint et al., 2013; Doolen et al., 2012; Sobek, 2011; Dellifrairie et al., 2010). Experience is showing that "Although the lean system philosophy and tools have been introduced successfully in some hospital organizations, the complete impact of the adoption has not been widespread mostly because of a lack of the appropriate leadership and management infrastructures" (Steed, 2012, p. 49). Lean implementation in Saskatchewan has had its controversies, given the media attention and public voice (Star Phoenix Newspaper, 2014). However whether that controversy is a natural resistance to change, five years into the implementation plan, or exacerbated by leadership practices

¹ Both Lean and LEADS are defined and interpreted further in this paper.

inconsistent with that change, is not for this paper to explore. It is clear that for Lean implementation to be successfully adopted and sustained over the long term, high quality leadership is essential (Dibia et al., 2014; Blakley, 2012; Steed, 2012).

Lean and LEADS are mutually supportive; therefore the fit between the leadership expectations of Lean (i.e. leadership skills to ensure a deep respect for people as well as the discipline works as intended) and the leadership expectations of LEADS must be identified to maximize the potential for success.

THE LEAN IMPLEMENTATION CHALLENGE

Lean and LEADS need to be complementary in the same way that in an organ transplant, the organ and the health conditions of the recipient need to be as complementary as possible in order for the transplant to be successful.

For example, an individual is not a good candidate for an organ transplant if he or she is not healthy for other reasons such as infection, uncontrolled heart disease, or a drug or alcohol problem. In most of these instances, a transplant is not attempted. Even when transplantation is undertaken, the transplanted tissue can be rejected by the recipient's immune system, destroying the transplanted tissue. Transplant rejection can be lessened by determining the molecular likeness between the donor and recipient and by use of immunosuppressant drugs after transplant.

In essence, Lean is the organ to be transplanted into the organizational and system dynamics of the health sector of Saskatchewan, with a particular set of competencies, attributes, assumptions, and techniques associated with it in order for its benefits to be realized. Leadership becomes the “key ingredient to successfully implement and sustain a lean management system...and requires a unique set of leadership behaviours” (Blakley, 2012, p. 25).

In 2012, Blakley—who at that time was a senior leader in the Saskatchewan health system— conducted a qualitative study to determine how the Saskatoon Health Region (SHR) leadership community could build on its leadership strengths to support a Lean management system. She found that for success:

- Leaders must be effective coaches, and therefore require additional training (*Engage Others* domain of LEADS).
- Communication related to the region’s vision and intent of implementing Lean must be enhanced (*Achieve Results* domain of LEADS).
- Required leadership behaviours must be articulated. Once informed, leaders must develop and grow these behaviours (consistent with the capabilities of the *Lead Self* domain of LEADS).²

² The purpose of the LEADS framework is to articulate these leadership behaviours and encourage their ongoing assessment and development by health leaders in Saskatchewan.

- A commitment to, and desire for, a team-based, cross-functional work environment (*Engage Others* capability of LEADS) is required.
- Organizational culture must support the RHA's ability to implement and sustain the new Lean management system (the *Systems Transformation* domain of LEADS articulates the importance of creating a climate of continuous improvement—foundational to Lean methodology).
- Coaching, visionary, and democratic styles of leadership are preferred (*Engage Others* domain of LEADS). A pacesetter leadership style, “if poorly executed or used over a sustained period of time it can have a highly negative impact on an organization's climate” and therefore “can impair the region's ability to implement and sustain the new lean management system” (Blakley, 2012, p. 72).
- Coalitions with physicians must be created (*Develop Coalitions* domain of LEADS).

The above analysis suggests that the *LEADS in a Caring Environment* capabilities framework does contain the unique set of behaviours required of leaders in the recipient organization (RHA, hospital, primary care program, or community program) to introduce Lean, and also the practices of leadership required for the transplant to be successful. The greater the fit between the two—i.e. the existing leadership skills of managers and those required for the implementation of Lean (the molecular similitude mentioned earlier)—the greater the potential for success. The degree of fit is a determining factor in success, but the process of determining fit can also identify what has to be done to improve the potential for success.

This paper focuses on the needed fit between the leadership practices inherent in the discipline of Lean and the leadership language of LEADS. It does not address the degree to which current leadership practices in Saskatchewan RHAs mirror the expectations of LEADS. That is outside the scope of this paper³, but is important to gauge the potential success of introducing or sustaining a successful Lean Management System.

WHAT IS LEAN?

Lean is a disciplined method of process improvement that aims at accomplishing the following goals:

- To maximize the value proposition of health service delivery to patients (i.e. quality improvement).
- To build safety into every step of the process. (Black & Miller, 2008)
- To eliminate waste in the service delivery process, where waste is defined as: waste of overproduction (producing what is unnecessary); waste of transportation; waste of time (waiting); waste of processing; and waste of inventory (Fine, Golden, Hannam & Morra, 2009). In order to accomplish these goals, the Lean methodology:

³ For a substantive, empirical analysis of the leadership practices and changes (as of 2012) needed in those practices to support Lean, see Blakley, B. (2012). *Leading Lean: Building Leadership Capacity in the Saskatoon Health Region*. An Organizational Leadership Project Report. Victoria: Royal Roads University.

- Puts the patients, clients and residents at the center of the care and service.
- Engages all staff “who own the process” in analyzing existing methods for their contribution to the above goals, and designing new methods that will accomplish the above goals.
- Employs a disciplined and rigorous set of procedures to:
 - *define the value* to the patient in any service delivery model;
 - *arrange the value stream*, i.e. process mapping—identify all procedures employed by everyone in the service delivery stream that are currently in place to deliver patient care; obtain data to inform current state in the spirit of “no action without data; no data without action” (Mann, 2005);
 - *examine for flow*—that is, analyze existing processes from the patient’s perspective and minimize waits and handoffs (from one provider to another);
 - *ensure pull*—redesign the service delivery process backwards—so the patient is pulled through the process by demand from the back end, rather than pushed from the front end; and
 - *continually seek perfection*—that is standardize processes that are required to be systematically employed; ensure they are implemented as designed; and empower employees to identify areas for ongoing and continuous improvement (Fine et al., 2009).

There are many examples in Saskatchewan of Lean improvements (see Appendix A).

WHAT IS REQUIRED OF LEADERS IN A LEAN ORGANIZATION?

The research is clear that the potential for health care to significantly increase the quality of its service through the reduction of waste will require a highly self-conscious and intentional leadership agenda (Berwick & Hackbarth, 2012). In addition, it will require a different set of leadership skills, attributes and competencies than many leaders currently may not hold (Mann, 2005; Doss & Orr, 2007; Toussaint & Gerard, 2010; Blakley, 2012). The following table outlines what Jim Womack (2012), arguably one of the thought leaders on leading in a Lean environment, has identified as the difference between traditional management and Lean management. Based on leaders experience in the Saskatchewan Health Systems adoption of Lean and Blakley’s study in 2012, the third column outlines what is evolving as the leadership required to implement Lean in complex systems such as health care.

THE SYMBIOTIC RELATIONSHIP BETWEEN LEAN AND LEADS

Traditional Management <i>James Womack -Gemba Walks (2011)</i>	Lean Management <i>James Womack -Gemba Walks (2011)</i>	Lean Leadership <i>Bonnie Blakley -Lead 2 Lean Solutions (2015)</i>
Authority – managers seek authority to take action by referring to the organizational chart	Responsibility – lean managers seek responsibility to address important issues by leading as if they have no authority	Accountability – lean leaders regardless of title take accountability to address important issues. Everyone sees improvement as his or her business not requiring formal authority to work towards improvement. [Aligns with <i>Achieve Results</i> domain of LEADS]
Decisions own by managers - Managers make decisions	Decisions informed by staff - Lean managers seek input from staff and make decisions	Decisions made by those doing the work - lean leaders in formal management roles work with their teams to build problem-solving skills. Those doing the work make decisions, where appropriate. [Aligns with <i>Engage Others</i> domain of LEADS]
Results – managers manage by results	Process – lean managers manage by deeply understanding the process	People & process – lean leaders, regardless of title, have a deep understanding of the strengths of their people and their processes. [Aligns with <i>Engage Others</i> domain of LEADS]
Give answers – managers give answers to their direct reports	Ask questions – lean managers pose questions to their problem owners transferring responsibility for the problem to the lower manager, who is closer to the problem	Ask questions and listen deeply – lean leaders ask good questions and listen deeply to their teams to understand the problem and determine action to address. Team members feel valued as their input is heard. [Aligns with <i>Lead Self</i> domain of LEADS]
Plans – managers make detailed, lengthy, grand plans	Experiments – lean managers treat every plan as an experiment with a rigorous Plan-Do-Check-Act cycle built in	Innovates and takes risk – lean leaders encourage thinking outside of the box and utilize a fail-forward-fast philosophy as part of the Plan-Do-Check-Act cycle. [Aligns with <i>Achieve Results</i> domain of LEADS]
Formal education – managers seek formal education to advance their careers often outside the organization	Gemba learning – lean managers pursue gemba learning within their organization	Leadership development – lean leaders develop their capacity through a combination of formal education, gemba learning and leadership training. A balance of technical training on the gemba or through formal training programs is complimented with leadership training. [Aligns with <i>Lead Self</i> domain of LEADS]

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Staff improve processes – managers outsource problems to staff or consultants	Line managers and teams improve processes – lean managers improve processes by directly leading improvement activities in dialogue with everyone touching the process. Staff and consultants only brought in as necessary.	Teams improve processes – lean leaders are responsible to understand the problem, articulate the vision for what the outcome is required, then get out of the way and let the team figure out the how. Lean leaders hold all involved, including themselves, accountable for outcomes. [Aligns with <i>Achieve Results and Systems Transformation</i> domains of LEADS]
Decisions made remotely with data – managers analyze information away from gemba	Decision made on the gemba with facts – lean managers make decisions at the location of the problem	Decisions made on the gemba with facts by the team – lean leaders work with teams to understand problems and enable them to make decisions in alignment with the overall goals/outcomes required. [Aligns with <i>Achieve results</i> domain of LEADS]
Standardization by staff – managers standardize processes by relying on staff experts	Standardization by line managers and teams – lean managers standardize processes through hands-on engagement with all of the people touching the processes; using outside expertise only when necessary	Standardization by teams – lean leaders have their teams standardize processes through involving all those who touch the processes and experts where appropriate. [Aligns with <i>Develop Coalitions</i> domain of LEADS]
Go fast to go slow – managers typically do not fully understand the problem. Putting quick countermeasures in place does not address the real issue and leads to time-consuming rework	Go slow to go fast – lean managers take the time to fully understand the process and its purpose; establish root cause and seek the most promising countermeasure before taking action	Set the pace just right – lean leaders coach their teams to effectively understand root cause and act on putting countermeasures in place at the pace required to ensure due diligence and meet system demands. [Aligns with <i>Achieve Results and Systems Transformation</i> domains of LEADS]
Vertical focus – managers focus on vertical teams with all the functions and silos orientated toward the CEO at the top	Horizontal focus – lean managers focus horizontally on the flow of value across the organization – from product/service to customer	System focus – lean leaders focus on the entire system ensuring both strong vertical and horizontal focus occurs [Aligns with <i>System Transformation</i> domain of LEADS]
Heros – managers typically swoop in to ‘fix’ the problem when something not working to achieve results	Farmers – lean managers understand the work they are responsible for and tend to it as a farmer tends to his crop to achieve results	Coaches – lean leaders understand the work their team is responsible for and coaches the team to achieve results. [Aligns with <i>Engage Others</i> domain of LEADS]

*Adapted from comparison of modern and lean management taken from James Womack’s book *Gemba Walks (2011)* and Bonnie Blakley’s Royal Roads University Master’s Paper: *Leading Lean: Building Leadership Capacity in the Saskatoon Health Region (2012)*

WHAT IS LEADS?

The *LEADS in a Caring Environment* capabilities framework is a set of capabilities successful leaders can employ to accomplish meaningful change in the Canadian health system. LEADS—like Lean—is accepted by many professional bodies (e.g. Accreditation Canada; Canadian Medical Association) and by many national, provincial, and regional health organizations (e.g. Alberta Health Services, Saskatoon Health Region, and the Ontario Association of Community Care Access Centers, to name a few) as a set of standards to strive for in the practice of leadership, regardless of one’s personal leadership role in the health system.

LEADS consists of five domains—i.e. five broad areas of action that leaders should employ to address the challenges of change.

The first letter of each domain, in sequence, spells the LEADS acronym. The five domains are:

Lead Self
Engage Others
Achieve Results
Develop Coalitions
Systems Transformation

Each domain has four capabilities associated with it to guide the leader in what to do to be successful. The five domains and 20 capabilities of LEADS are outlined in detail in Appendix B to this paper.

The LEADS framework was created through a highly rigorous qualitative research process and is grounded firmly in the leadership literature (Dickson, 2008; Dickson, Briscoe, Fenwick, Romilly & MacLeod, 2007). An articulation of how it can “come to life” in health organizations—that is how leaders can practice behaviour consistent with LEADS capabilities—are outlined in a book entitled, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, by Dickson & Tholl (2014).

LEADS can also be viewed as a model to assist the leader to lead change. It emphasizes three key expectations of leaders to be effective in carrying out change: *relationship building* (Engage Others and Develop Coalitions); *creating conditions to support and lead change* (Lead Self and Systems Transformation); and a clear, unequivocal *commitment to producing desired results* (Achieve Results) (Dickson & Tholl, 2014). In addition, the building blocks of LEADS—Being (WHO) + Caring (WHY) + Doing (HOW) reinforce the philosophy of the commitment of putting the patients, clients, and residents at the center and hence very consistent with the underpinnings of Lean.

THE DEGREE OF FIT BETWEEN LEADERSHIP PRACTICES OF LEAN AND LEADS

Based on the above explication of Lean and LEADS, it is valuable—as both have been endorsed as guides to achieve health system transformation—to determine how similar they are in philosophy, purpose, and approach.

An important distinction is that Lean is a management discipline—to be developed organically or adopted as a way of operating to maximize efficiency and effectiveness. It is comprised of a logistical stream of disciplined procedures that must be followed, and employs processes to respect the knowledge and involve employees in the implementation of those procedures, hence enhancing staff engagement and involvement. Lean is first an innovative intervention that must be supported as a change process in its own right, and that requires a particular collaborative leadership approach to ensure the willing involvement of staff in its implementation. Once implemented, Lean then becomes the “new way of doing business.” Leadership attributes inherent in LEADS are crucial in its adoption, implementation and ongoing sustainability and evolution.

LEADS outlines what leaders do to be successful in guiding people through innovation as well as sustaining it. Therefore, the fit between the “leadership of people” processes of Lean and LEADS is vital to determine in order to use both approaches in a mutually supportive fashion. A simple way of putting it is that Lean is an approach for change to be accomplished which requires a defined set of skills, behaviours and attributes; LEADS defines the skills and capabilities of leaders required for that to happen. Learning those skills is important for all leaders, and particularly important for middle managers, who need to implement Lean (Manville et al., 2012).

Let’s now outline the similarities of the two models as they speak to leading people through the change process.

- **Overall Philosophy of Leadership:** Both Lean and LEADS have a shared fundamental value imperative—a commitment to providing the best services to patients/clients that the health system can provide (consistent with the *caring* foundation of LEADS). Both articulate that leadership of change is everyone’s responsibility in an organization, not just the formal leaders’ responsibility. Both approaches realize that each role requires people to exercise leadership relative to the responsibilities of that unique role. If there is a leadership philosophy that defines both Lean and LEADS, it is: “Follow me...and let’s figure this out together.”
- **Lead Self:** Self-leadership (the Lead Self domain of LEADS) is also fundamental to the success of a Lean initiative. As Black and Miller (2008) stated, “The most critical factor in success is your commitment and personal stewardship of the process as the health care leader. It starts with the leader's deep commitment and perseverance. You will be tested over and over again.” This quote reflects the capabilities of Lead Self (i.e. *self-aware, manages themselves, develops themselves, and demonstrates character*). The authors also state that new things will be learned about the system

in the process of implementing Lean. Leaders will have to grow and learn in order to address these new challenges. In order to transform the system, they have to actively engage in ongoing personal transformation.

- **Engage Others:** LEAN also emphasizes the importance of engaging all clinical and non-clinical staff in the redesign of the processes. Consequently, the Engage Others domain of LEADS (i.e. *fosters development of others, contributes to the creation of healthy organizations, communicates effectively, and builds teams*) is necessary for the success of Lean. As Black and Miller (2008) stated: “the key to success will be your *people*. Organizations often leverage this resource least effectively. The principles I've outlined above are aimed at gaining the greatest possible return from the skills and ideas of the people who do the work”. This emphasizes the leader’s need to be able to Engage Others in a very skillful manner.
- **Achieve Results:** The ability to exercise the four capabilities of the Achieve Results domain of LEADS is fundamental to Lean; indeed, is its *raison d'être*. Lean is about mapping the current state of processes and procedures, and designing a process map to move to a desired future state—i.e. a vision (the *set direction* capability of LEADS). Lean is then about designing processes that *strategically align decisions with vision, values and evidence* (i.e. the data and evidence that emerges from an assessment of the current state and leading practices, e.g. in other jurisdictions) of the enterprise that is undergoing the change or improvement (an Achieve Results capability). Those implementing Lean then need to be able to *take action to implement decisions*. The ability to *assess and evaluate* results—in specific and measurable terms, is fundamental to Lean being successful, and the fourth capability of the Achieve Results domain of LEADS.
- **Develop Coalitions:** The Develop Coalitions domain of LEADS emphasizes the importance of organizations (i.e. primary care, secondary care, the community) working together to serve the patient (*demonstrate a commitment to customers and service*). In addition, it emphasizes the importance of being *purposeful in building partnerships and networks*, ensuring the endeavor that is being promoted has a strong knowledge base (*mobilize knowledge*), and acknowledges that sophisticated political acumen is required to be successful (*navigate socio-political environments*). In principle, Lean endorses all of these concepts.
- **Systems Transformation:** Lean also demands capabilities of Systems Transformation. Leaders need to *orient themselves strategically to the future*—i.e. anticipate the challenges and impact of Lean for one’s area of responsibility. Leaders need to *demonstrate systems and critical thinking, encourage and support innovation and champion and orchestrate change* capabilities of LEADS. These are required to sustain the Lean initiative from inception to completion. As Black and Miller (2008) state, “It has been critical that we not ‘blink’ and that we consistently drive home the message that Lean is the organization's management system. We have to lead by example (for instance, by participating in the improvement processes).” They also

state, “all major change is met with resistance”—and the systems transformation domain is recognizing the many sources of what appear to be resistance, but is actually a reflection of deeply seated cultural beliefs and attitudes; fear of personal change; or indeed a sense of inadequacy on behalf of clinicians to have the skill set to implement the Lean change. Leaders have to have the skills to deal with these practical challenges as well as be able to view the whole system. They have to see how their part of the process impacts the overall system—they need to “zoom in and zoom out” so that improvements in one area do not end up sub-optimizing care in another area or bringing in negative unintended consequences.

Obviously there is a strong fit between both the philosophy of leadership and skills of leadership in both Lean and LEADS. Using the latter—LEADS—to prepare managers to implement Lean, and to support them in their implementation, makes eminent sense.

CHALLENGES OF IMPLEMENTING LEAN

Lean has a strong theoretical and philosophical argument for its use. However, in practice, there are a number of challenges in implementing Lean (Jones & Mitchell, 2011). Some of the most significant are:

- Lean intends to “reduce waste.” A simplistic view of waste reduction is to reduce staff. However, Lean is better approached from the perspective of building capacity. Waste can be removed if we challenge the way we do our business, rethink the roles and responsibilities of those who do the work, and become more efficient and effective in delivering service as the demand increases. A formal leader is encouraged to approach it from this perspective. If an individual chooses to proceed, he/she must also prepare to deal with the inevitable issues that will emerge amongst unions, staff, etc. with respect to being asked to define and do their work differently.
- The potential for individual Lean projects to be done in isolation from one another. Jones & Mitchell (2011) state, “...Lean has most often been applied in relation to hospital-based approaches where there is a clear chain of policy and procedure to be examined. It has less often been applied to other elements of the health-care system: i.e., primary care reform; home and community care; etc. The principles have application, but leaders would have to adapt and adjust the traditional approaches to fit those different contexts”. Benefits of Lean initiatives take time and don’t all happen at once. Truly long-term commitment to using Lean as a vehicle for system transformation emphasizes the importance of that domain of LEADS. Remember Dan Florizone called the Lean initiative a “50-year project.”

In closing, Jones and Mitchell (2011) state: “But Lean won’t just happen on its own. It needs leadership and leaders. People willing and able to gather colleagues around them, find out how to do it and win senior management support. It needs managers with the vision to give staff licence to experiment” (p. 23). In addition, it needs staff and clinicians—doctors and others—to also master the skills of collaboration and innovation.

Conclusion

In essence, LEADS does have a symbiotic relationship to Lean. It gives leaders—at all levels—the skills to lead, in a manner consistent with the principles and practices of Lean and patient-centered care, and assists them in ensuring sustainable implementation of Lean interventions. LEADS leadership development programs can allow individuals to truly assess their own abilities in providing leadership, and to learn and practice how to do those skills well. Successful implementation of Lean is a leadership challenge, and LEADS can provide the “people” support mechanism and capacity often lacking.

“Leadership is the capacity to translate vision into reality.” – Warren Bennis

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APPENDIX A

Examples of Lean successes in Saskatchewan health care

- Regina Qu'Appelle Health Region's Oncology Ward increased the time nurses spend with patients during a shift from *26 percent to 41 percent*.
- As a result of reducing the number of radiation treatments required by breast cancer patients, *235 CT appointments slots were reallocated*, freeing up the equipment for other procedures.
- Five Hills Health Region added an *extra 1/2 day capacity* to do an additional 9 scope procedures each week or *approximately 470 more scopes each year* using existing resources.
- The Prairie North Health Region undertook an initiative aimed at improving the flow of patients from admission through to discharge. In December 2009, only 55% of patients discharged were under expected length of stay (ELOS). By July 2010, *85% were discharged under ELOS*.
- Regina Qu'Appelle Health Region reduced cancelled MRIs from 12 to 1 per week, representing a *7% increase in productivity or capacity to perform an additional 650 scans/year* using existing resources.
- Regina Qu'Appelle Health Region *reduced the number of ambulance trips for patients requiring transport to receive MRIs from 9/week to 1/week* by using more appropriate transportation services.
- Staff in Prince Albert Parkland *reduced time spent in report by 42%* on the surgical unit and improved the quality of the report at the same time. Staff say they know patients better, feel they have more time to spend with patients, and can more easily identify those at risk for falls.
- Provincial Disease Control Laboratory saved *10-12 hours* of staff time per day through improving initial data entry process and returned one storage room (40 sq. ft.) to office space.
- Cypress Health Region *saved 3 months' technician time* each year through initial improvements in their laboratory.
- St. Paul's Hospital processes more than eight million medical samples annually. Through Lean, the lab *processed 27% more blood samples and 39% more chemistry samples a day, and processed more than 96% within a 60-minute target*.

THE SYMBIOTIC RELATIONSHIP BETWEEN LEAN AND LEADS

- The Prairie North Health Region examined staff scheduling processes at the Battlefords Union Hospital and determined that scheduling practices had a significant impact on the costs incurred for overtime. They were able to achieve *95% to 100% reduction* in costs due to missed meal break overtime, which resulted in *annual savings over \$200K*. They are now in the process of rolling this initiative out across the region.

APPENDIX B

The LEADS in a Caring Environment Framework

Leads Self: Self-motivated leaders...

Are Self Aware

- Is aware of their own assumptions, values, principles, strengths and limitations.

Manage Themselves

- They take responsibility for their own performance and health.

Develop Themselves

- They actively seek opportunities and challenges for personal learning, character building and growth.

Demonstrate Character

- They model qualities such as honesty, integrity, resilience, and confidence.

Engage Others: Engaging leaders...

Foster Development of Others

- They support and challenge others to achieve professional and personal goals.

Contribute to the Creation of Healthy Organizations

- They create engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities.

Communicate Effectively

- They listen well and encourage open exchange of information and ideas using appropriate communication media.

Build Teams

- They facilitate environments of collaboration and cooperation to achieve results.

Achieve Results: Goal-oriented leaders...

Set Direction

- They inspire vision by identifying, establishing and communicating clear and meaningful expectations and outcomes.

Strategically Align Decisions with Vision, Values, and Evidence

- They integrate organizational missions and values with reliable, valid evidence to make decisions.

Take Action to Implement Decisions

- They act in a manner consistent with the organizational values to yield effective, efficient public-centred service.

Assess and Evaluate

- They measure and evaluate outcomes. They hold themselves and others accountable for results achieved against benchmarks and correct the course as appropriate.

Develop Coalitions: Collaborative leaders...

Purposefully Build Partnerships and Networks to Create Results

- They create connections, trust and shared meaning with individuals and groups.

Demonstrate a Commitment to Customers and Service

- They facilitate collaboration, cooperation and coalitions among diverse groups and perspectives aimed at learning to improve service.

Mobilize Knowledge

- They employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system.

Navigate Socio-Political Environments

- They are politically astute. They negotiate through conflict and mobilize support.

Systems Transformation: Successful leaders...

Demonstrate Systems / Critical Thinking

- They think analytically and conceptually, questioning and challenging the status quo, to identify issues, solve problems and design and implement effective processes across systems and stakeholders.

Encourage and Support Innovation

- They create a climate of continuous improvement and creativity aimed at systemic change.

Orient Themselves Strategically to the Future

- They scan the environment for ideas, best practices, and emerging trends that will shape the system.

Champion and Orchestrate Change

- They actively contribute to change processes that improve health service delivery.