Process Excellence at Bolton NHS Foundation Trust

Process Excellence Network Case Study
2012 Europe Process Excellence Award Winner
“Winner – Best Process Improvement Programme”
CASE STUDY: BOLTON NHS FOUNDATION TRUST

INSIGHT FROM EUROPEAN AWARD WINNING “BEST MATURE PROCESS IMPROVEMENT PROGRAMME”

CONTEXT & PROGRAMME OVERVIEW

In 2004, the former Bolton Hospitals NHS Trust, now Bolton NHS Foundation Trust, was facing challenges faced by many healthcare organizations across the United Kingdom: high rates of mortality, hospital infections, financial difficulty, and staff dissatisfaction.

Despite examples of good practice in certain areas of service, there was no coherent system to address the challenges and make sure that examples of best practice were spread.

Introduced in 2005, the Bolton Improving Care System (BICS), a process improvement programme based on Lean principles, aimed to change that. Under the leadership of the then-Chief Executive David Fillingham after a year of trying Lean in a number of areas, BICS was established to improve patient care by “reducing wasteful processes in the system (e.g. duplication, errors and work-round solutions) in order to provide safe and high quality services.”

Since its inception, BICS has resulted in major improvements for the Trust including reduced mortality rates, shorter stays for patients and many other initiatives which have ultimately saved lives.

For their work and results achieved to date the Trust won PEX Network’s 2012 European award for Best Mature Business Process Excellence Programme (running for longer than 2 years), a pan-European award judged on operational and business results as well as clarity in execution throughout and sustainability of change.
Defining ‘Value’ from the patient’s perspective was a key component of BICS

Lean process improvement, a technique honed in Japan’s automotive industry, has at its centre the concept of continuous improvement and constantly striving to eliminate unnecessary expenditure of resources (“waste”) - defined as anything that the customer does not value.

Although the technique was honed in manufacturing, it has spread widely to other industries where its focus on iteratively improving processes has proven useful. For Bolton NHS FT the challenge in introducing the technique to its wards and services was contextualising Lean for healthcare and demonstrating that it wasn’t just a guise for eliminating jobs.

The Lean team gained the trust of employees by demonstrating that Lean process improvement was ultimately about improving quality of care. They demonstrated this through best practice site visits in the US, external speakers talking to staff, and most importantly, by getting results that led to better outcomes for patients.

Trauma was one of the first pathways selected for improvement. Using the Lean approach the team was able to redesign the trauma pathway and very quickly achieved improvements in both mortality rates and health outcomes. Demonstrating results to clinicians was key to getting their further support and buy in.

“This wasn’t just ‘tweaking’ around the edges, but a real step change in improvement,” says Joy Furnival, Associate Director of Transformation at Bolton NHS FT. “So the belief that ‘maybe this lean thing - this weird thing that’s come from automotive - could have benefit in healthcare’ began to grow”.

But it wasn’t a quick process, she cautious. Instead, there was gradual realization of what the goals of the programme should be: “Really after about a year of “playing” with Lean - just trying it out wherever we could - a consensus started to grow about how to take Lean forward.”

Putting the patient at the centre was – and remains - the critical component of Bolton’s Lean programme. In all process improvement work undertaken, the team has strived to define “value” from the patient’s perspective. Whilst all healthcare organizations may aim to put patient care at the centre, one of the distinguishing features of the Bolton Improving Care System (BICS) approach was that patients were often involved in the design of processes.
For instance, using something called *Patient Experience Based Design* (combined with their Lean programme) the Trust involved patients in process improvement work on the pathway for hip replacement. The patients were approached and invited to participate in surveys - which asked basic questions about satisfaction levels – and were also asked to keep diaries to record their whole experience of the process.

Those diaries helped the Lean team identify the emotional “touch point” for patients – things that might have seemed superfluous to the process but really mattered to the patient. In the end they invited selected participants to come and recount their stories on camera.

According to Furnival, they learned many things as part of that work. “There can be quite large differences between what staff think patients value and what patients actually value,” she said.

For example, one patient talked about how she’d had diabetes all her life but when she came into hospital for replacement hip surgery, staff at Bolton Hospital had taken her medications away from her for diabetes. To the patient that meant loss of control and she had found that quite upsetting. Another, meanwhile, explained how painful it was getting back into a car after the surgery – something that made the team realise that the patient’s experience didn’t end as soon as they left the ward.

The patient feedback prompted the team to look at things differently, says Furnival, giving “us quite a lot of qualitative evidence around how we’re doing now, and also it gives us emotional ideas about how we can add to that emotional experience for a patient as well as the practical process things.”

The Lean team looked at things such as how pain relief is requested and administered on the ward, how to deal with patients who normally self care (such as the diabetic who shared her experience on camera) and understanding when patients want things. The patients themselves took action by writing the top ten tips for patients coming in for a hip replacement, which the hospital now distributes to help other patients.

*WHAT WE ARE NOT WHAT WE DO*

The Bolton Improving Care System has been running since 2004, but one of the challenges when the new Chief Executive, Lesley Doherty, took over in 2009 was that the programme still had a ways to go before it was embedded culturally within the DNA of the organization.

Doherty had previously been Chief Operating Officer and Director of Nursing and Performance at the Trust. She was herself a qualified Nurse and had experienced first hand what it was like to implement the Lean programme. “I recognised that my appointment was an opportunity to reflect on what we had achieved but move from something more than what the previous CEO had brought to the trust and enable the cultural adoption of BICS. Integral to
this was making BICS being what we ‘are’ rather than what we ‘do’,” she said.

In other words, just doing Lean was not enough – it was important to make it part of Trust’s organisational culture.

One of the difficulties is getting the balance between standardized processes but also creating the environment where employees feel empowered to make changes to those standards.

It is a perpetual challenge, says Furnival, to “create a paradigm that standard work can be improved upon- that it’s not an inflexible, rigid thing.”

The Trust established a training programme for its staff in 2007 to build leadership and improvement skills. The emphasis was on “learning by doing” where staff were encouraged to practice the application of theory and reflect on how they could use the techniques in their working environment. Basic training in improvement techniques was mandated for all staff members. The Trust also encouraged a culture of best practice and knowledge sharing so that when staff in one area identify a better way of doing something, the idea can be spread.

The programme employs typical Lean techniques such as making work visible, use of A3 Thinking & Policy Deployment, and specific techniques like Hoshin Planning in order to cascade the Trust’s high level strategic goals from the top level down to specific actions. But also important has been adapting the language and Lean approach to fit the medical environment.

“We got a bit sensitised to Lean right at the beginning,” says Dr. Ian Dufton. “So we tend to do things without some of the terminologies or some of the fancy words, and certainly we don’t use any Japanese if we can avoid it!”

Joy Furnival agrees, adding that it was necessary to adapt many of the Lean concepts – which were honed in automotive manufacturing – to the notion of patient care because in healthcare “we don’t have ‘widgets’ - we have real people with real feelings and real emotion.”

In addition to training and adapting the language to suit the healthcare environment, visible leadership commitment was critical to making the programme successful. Board level leadership often go to see for themselves (i.e. through Gemba walks) what’s really happening in order to understand for themselves the improvements made and where problems still exist.

“BICS is integral to achieving our strategic objectives, it’s how we undertake change, how we look to continuous quality improvement, how we engage staff and patients, how we learn and how we gain resilience.” - Lesley Doherty, Chief Executive, Bolton NHS Foundation Trust

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OVERCOMING CHALLENGES

It’s not all been smooth sailing, however. The programme has had its share of challenges along the way and still has a long way to go, says Furnival.

As she puts it the “Lean journey has been an emotional rollercoaster: sometimes it works; sometimes it doesn’t.”

That was certainly the experience of Dr. Ian Dufton who has been a staunch supporter of Lean process improvement, despite his first experience with Lean being a self-described “disaster.”

For various reasons - stemming from people and external factors in addition to process problems - “Lean itself didn’t really move us forward,” explained Dr. Dufton. “If anything, it set us back bit because the staff became sensitised to Lean, believing it hadn’t been a useful process. We realised there were a number of things that had to change first before we could use it effectively.”

But, he said, he was glad that they persisted with Lean, explaining that the approach gave them both the tools and space in which to really make a difference in the work they were doing.

“[Lean] gave us a platform on which to build, which was different from how we tried to build things before,” said Dr. Dufton.

In 2009, BICS itself suffered a setback. It was named as among the worst performing healthcare trusts in the country for mortality levels. More patients were dying than the national average – a fact that threw into sharp relief the importance of the work the process improvement teams were undertaking, and the difficulty of the task that faced them.

According to Furnival it was a challenging time.

“We’d been doing all this improvement work for three or four years, some of which was on mortality work in specific pathways. So how could it be if we’d done all this improvement work, we were still really not very good? We had to face up to the fact that we’d done some good work, but we hadn’t done enough yet.”

The Trust’s hospital standardised mortality ratio (HSMR) was measured at 124.7 in 2008/2009 - higher even than the 2004/2005 period when the improvement programme first started (when it was measured as 122.3).

British newspapers reports in 2009 named the Royal Bolton hospital one of the worst in the country.

The team did a lot of work to understand the causes of high mortality - how it was measured, the way that medical coding works and looking at key care pathways (notably in high mortality areas - the foundation’s HSMR for congestive cardiac failure was at 141.5, and 115.6 for pneumonia versus 91.3 for fractured neck of femurs, and 88.5 for heart attacks).

By 2010/2011 the mortality measure was down to 103 - in line with national averages – earning Bolton the label of “Most Improving Trust in
England” from an official body.

Furnival attributes the turnaround to date to being about both team work and visible leadership from the Trust’s medical director. But in addition to that, she says, “there is another facet and that is really facing up to reality. We had to look in the mirror and see how it really is now - even if it’s not something you necessarily want to see.”

Furnival stresses, though, that the Trust still has a long way to go. “You have to be very tenacious, you have to accept that stuff will go wrong and take the flak and keep going around the cycle of PDCA to keep improving things. We’re six years into our journey but, like anyone, we’re still facing a lot of challenges even now.”

With public sector austerity measures in the UK set to bite in the next few years the challenge for healthcare organizations is to continue to provide high quality service to patients with the limited resources available to them.

Next on the horizon, Bolton NHS FT says it will be looking to continually adapt, spread and sustain BICS across whole integrated pathways, work with their Social Care teams to enable true “end-to-end” improvements, and partner with patients to really deliver the services that matter most.

Lessons from the Bolton Lean Journey:

- It has to involve a cultural change
- Board and lean team must lead by modelling behaviours
- It has to be values and behaviourally led built on engagement
- It requires leaps of faith
- It requires leadership courage
- **It saves lives**, ...and money
- **Lean is all about people and all about quality**
IMPROVING HEALTHCARE PROCESSES: A DOCTOR’S VIEWPOINT

INTERVIEW WITH DR. IAN DUFTON, CHILD AND ADOLESCENT PSYCHIATRIST AND THE CLINICAL LEAD OF THE BOLTON CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Dr. Ian Dufton has been clinical lead at Bolton NHS Foundation Trust since 2009 and has led the service through a challenging period of process redesign and continuous improvement work. Over that time the service has been shortlisted and won a number of awards and he himself won the BMJ group Clinical Leader of the Year Award in May of last year. He is an advocate of LEAN management principles and believes that they support the effective engagement of clinicians resulting in the delivery of quality clinical services.

HOW DID YOU FIRST REACT TO THE IDEA OF LEAN PROCESS IMPROVEMENT AND WHAT WAS YOUR FIRST ENCOUNTER WITH IT ACTUALLY LIKE?

My reaction to the ideas were very positive. They seemed extremely intuitive and for some time I’d been looking for a management methodology that both made sense and had clear evidence of success within other organisations. But, our first encounter in trying to use Lean in the Child and Adolescent Mental Health Service was a disaster.

We started Lean at a point when our services were experiencing a number of difficulties. Some of those difficulties were based on professional relationships and more HR-type issues and some of those difficulties were based around escalating demand - in terms of number and types of activity our service was being asked to do.

With all this change and challenges confronting our organisation, it made it difficult for us to identify what really needed to be done. At this point Lean itself didn’t really move us forward. If anything, it set us back bit because the staff became sensitised to Lean, believing it hadn’t been a useful process. We realised there were a number of things that had to change first before we could use it effectively.

WHAT WOULD YOU SAY WERE SOME OF THE THINGS THAT HAD TO CHANGE IN ORDER TO USE LEAN EFFECTIVELY?

First, we really needed to settle down in our commitment for change and in our commitment to Lean. Next, we had a number of factors come together that meant we really had to do something. In addition to leadership changes, we had a number of staff leave (for a variety of reasons) and we moved into a period of financial adversity. All of these factors put together created the right environment for us to move on with Lean.

Simply put: no money and no staff meant that we really had to do something different. And with escalating levels of demand, we recognised that we just couldn’t stay the same.

After we recognised that, it enabled us to recruit
new people who were also on board with improvement right from the beginning. As a result, our next experience with Lean was more positive and we were lucky enough to win an award based on the work that we did. That started us moving in the right direction.

YOU WON CLINICAL LEADER OF THE YEAR IN 2011 AND WERE QUOTED SAYING THAT “WINNING THE AWARD WOULD BE A JUSTIFICATION OF OUR EFFORTS TO PUT LEAN INTO CAMHS AND SPUR US ON”. IN WHICH WAYS DO YOU THINK LEAN HELPED IN THE ACCOMPLISHMENT?

I think it helped to a large extent. Often when it comes to service aims or mission statements, managers sit quietly in a room and write them up - usually cut and pasting from the last set of mission statements – and say “these are our mission statements”. These statements are distributed among the staff. Everyone looks at them and says “all right, okay, fair enough”. Then nothing happens.

This time round we actually tried to do things from the bottom up. Lean gave us a method and time to our approach. In really simple terms it allowed us to sit down as a team for somewhere between three to five days thinking about what we were doing, whether it was the best that we could do for the patients and whether it was the most efficient. Actually having the time to think it through rather than always doing things on the hoof – or worse thinking that someone would go into a darkened room and come up with a solution and impose it on us – was absolutely critical.

Lean gave us time to think based on a clear direction of what we were trying to do, involving as many of our staff group or the people who were delivering it as we could - even involving young people and their families - to actually try and create the next steps or the redesign of this or the new way we might do that. That is what I think has really made a difference.

We’ve had to be a bit careful because we got a bit sensitised to Lean right at the beginning so we tend to do things without some of the terminologies or some of the fancy words, and certainly we don’t use any Japanese if we can avoid it. But people have really embraced the underlying aims of what we’re trying to do. That’s why I think Lean has made a difference; it gave us a platform on which to build, which was different from how we tried to build things before.

The challenge we face now is that the goal posts never stay in the same place. It’s one thing to attack a static problem, it’s another thing to try and create a real sense of continuously improving and redesigning your service to meet demands that are constantly changing.

The last 12 months have been really challenging because here in the UK and within child and adolescent mental health services in particular, the climate has changed: the referral rates have changed, the services that were there to support young people have dramatically diminished over a very short period of time, the whole landscape is shifting at a pace that’s really quite difficult to keep up with.

THERE ARE SOME WHO PERCEIVE DOCTORS AS BEING QUITE RESISTANT TO ANY CHANGES IN THE WAY YOU’RE WORKING. WHAT DO YOU THINK IS BEHIND THAT, AND WHAT DOES IT ACTUALLY TAKE TO WIN DOCTORS OVER?

That’s a really tricky one because I’m a doctor who doesn’t feel that way and I have several colleagues who work with me in our department who also don’t think or feel that way.

I think the overarching bit is that most doctors have a real sense of looking after patient care and we don’t want to do anything that might compromise that in anyway. The real challenge is how to manage that in a real scenario where we’re going to have to do what we can with what we’ve got to the best that we can - there’s only so much resource to go round.

As doctors, we would like our service to be absolutely perfect every time and I think there is the tendency to resist change believing we’re advocating on the patient’s behalf, even if there is sometimes evidence to suggest
a different way of doing things might be better.

I think the way to overcome that is to include early in our medical training things such as service delivery, service design, and methodologies that look at effective service designs because actually sometimes we get very focused on what goes in the syringe but we look very little at whether the syringe is actually the right design.

**WHAT WOULD YOU SAY IS THE FUNDAMENTAL THING THAT THOSE WORKING TO IMPROVE PATIENT CARE, WHETHER USING LEAN PROCESS IMPROVEMENT OR OTHER KINDS OF CHANGES, REALLY NEED TO KEEP FRONT OF MIND?**

That’s really straightforward; it’s the patient experience. That’s the thing to keep front of mind: if we do this what will be the impact on a patient’s experience of the service? If we can keep that in mind then most of the time we do reasonable things because we’re always trying to improve that process.
ADAPTING LEAN FOR IMPROVEMENT IN HEALTHCARE

INTERVIEW WITH JOY FURNIVAL, ASSOCIATE DIRECTOR OF TRANSFORMATION AT BOLTON NHS FOUNDATION TRUST

Joy Furnival is the Associate Director of Transformation at Bolton NHS Foundation Trust. She joined Royal Bolton Hospital in September 2008 and leads the innovative Bolton Improving Care System (BICS), based on the creative application of lean thinking within healthcare to deliver transformation. She has worked in the healthcare sector since 2006 and prior to that she worked in internal management consultancy and improvement. She worked with a number of external clients throughout the chemicals and petrochemicals sector worldwide, delivering operational excellence programmes and realising safety, quality, productivity and financial improvements.

BOLTON NHS TRUST HAS BEEN ONE OF THE REAL INNOVATORS IN INTRODUCING LEAN THINKING TO HEALTHCARE WITHIN THE UK. WHAT HAS THE JOURNEY BEEN LIKE SO FAR?

Our story really began in 2004/5 when the trust got a new chief executive, David Fillingham. He had been the national lead for the NHS Modernisation Agency implementing much of the early reform for the NHS plan. For us, medium-sized district general hospital in northern England, it was a bit of a shock that a big national name was going to lead Bolton. He had a lot of knowledge, contacts and global awareness of what was going on in the improvement business in healthcare.

We picked our fractured neck trauma pathway to work on first. To some extent it was an inspired choice because a lot of work had gone on in the past through traditional quality improvement approaches such as clinical audit. And although there had been a lot of effort and a lot of people really trying to improve mortality rates, it wasn’t really changing - we still had significantly high mortality rates in that pathway.

Then we tried using lean on this pathway with clinicians. We asked questions like: what could we do? What’s causing these errors? Why are we getting more harm than we’re expecting? Using the lean approach we were able to redesign the trauma pathway - including the trauma stabilisation unit - and very, very quickly the results, in terms of mortality rates and health outcomes, were beginning to show significant improvement.

This wasn’t just “tweaking” around the edges, but real step change in improvements. So the belief that “maybe this lean thing - this weird thing that’s come from automotive - could have benefit in healthcare” began to grow.

I think for the organisation that this felt scary to begin with. Some may have felt that with all the change going on there was a hidden agenda there. But it was showing results leading to much better outcomes for patients – so staff gave it a go.

Really after about a year of “playing” with Lean - just trying it out wherever we could - a consensus started to grow about how to take Lean forward.

Since then, it’s been an emotional rollercoaster: sometimes it works; sometimes it doesn’t. You have to be very tenacious, you have to accept that
stuff will go wrong and take the flak and keep going around the cycle of PDCA to keep improving things. We’re six years into our journey but, like anyone, we’re still facing a lot of challenges even now.

**WHAT WERE SOME OF THE OTHER CHALLENGES YOU’VE FACED ALONG THE WAY?**

I would say the other big challenge is about leadership continuity. David Fillingham eventually left us to take on a new opportunity. Taking on a new chief executive is a risky time for big change programmes because often they’re so connected with the vision and commitment of a certain leader.

We were very lucky here that our new chief executive, Lesley Doherty, didn’t change direction in terms of the fundamental commitment; she renewed it and re-evaluated it. We became a new organisation and needed to adapt to that “newness” but the fundamental principles didn’t change.

**YOUR TRUST WAS RATED ONE OF THE WORST PERFORMING IN THE COUNTRY WITH REGARDS TO PATIENT MORTALITY JUST 18 MONTHS AGO. NOW IT’S BROUGHT UP TO NATIONAL PERFORMANCE LEVELS. WHAT DO YOU THINK HAS BEEN KEY TO TURNING THIS AROUND?**

On the mortality reduction it’s definitely about teamwork and very visible leadership from our medical director. Within that, then I suppose there is another facet and that is really facing up to reality. We had to look in the mirror and see how it really is now - even if it’s not something you necessarily want to see.

In 2009 we had extremely high mortality rate published nationally - one of the worst in the country - and yet we’d been doing all this improvement work for three or four years, some of which was on mortality work in specific pathways. So how could it be if we’d done all this improvement work we were still really not very good? We had to face up to the fact that we’d done some good work, but we hadn’t done enough yet. We had to face up to that. It didn’t mean it didn’t work; it just means we haven’t done it at scale.

We also had to do a lot more work on engagement really: we asked ourselves how can everybody have a role in improving mortality, not just a small member of an improvement team or a particular clinical team? How can all staff - at that time numbering 3,500 and now 6,000 - be involved in improving mortality at all levels?

We did a lot of work to understand the causes of high mortality - how it was measured, the way that medical coding works because that had an impact on the mortality rate - but also changing care pathways (notably in key mortality areas like respiratory).

We’ve attempted to set up Lean cells within wards, and focussed on flow in the sense of the flow of a clinical decision being made about what’s going to happen next in terms of diagnosis or decision-making for what’s going to happen the next day or in the following week. We focussed on flow from that perspective and how do you pull a patient based on clinical decisions, whereas in a more industrial environment flow is much more about the widget. In our situation we’ve got to adapt that because obviously we don’t have “widgets” - we have real people with real feelings and real emotion.

**IF YOU COULD POINT TO ONE THING THAT YOU’VE LEARNT ALONG THE WAY, WHAT WOULD IT BE?**

It’s is critical to have robust action plans for following up on what you say you’re going to do and evaluating what you’ve actually achieved. It’s very easy to say and very tough to do, especially for us in healthcare. The number of priorities and indicators you are dealing with are huge, so it’s sometimes very difficult to prioritise. Things can get lost, actions are not always being done in the timeframe you initially envisaged or new incentives come in that make the current action a bit irrelevant. Keeping focus is tough.
And the other thing is that getting adherence to standard work is very tough. You can involve a lot of people in developing standard work. The theory says that if you involve people in creating standard work then it will help people follow procedure. But when you have 6,000 staff – and it’s impossible to engage 6,000 people in creating standard work - how do you create that environment where people accept that not everybody could be personally involved and yet still create an environment where standard work can be improved upon. That’s a perpetual challenge. How do you have standard work but still create a paradigm that standard work can be improved upon- that it’s not an inflexible, rigid thing.

**ANY TIPS ON HOW YOU CREATE THAT ENVIRONMENT?**

I think, like in so many organisations, it’s easy to say; much harder to do. But I believe that communication is the most important aspect. And although I must say that we’re still not brilliant at it, we do a lot of communications about what’s going on and we make it very clear who people can contact if they want to learn more or they want to get involved. We are connecting all of our work with our healthcare trust values to make it very clear that we want staff to feel valued, respected and proud.

**WHAT ARE YOUR THOUGHTS ON USING LEAN VERSUS SIX SIGMA IN HEALTHCARE?**

Six Sigma’s very data dependent and it’s quite a heavy training programme. Healthcare, whilst it has a lot of data, doesn’t necessarily have useful data from which you can create SPC charts and so on. Plus, it can be disengaging to many of the staff who don’t necessarily have access to the data or are perhaps not that way inclined in terms of using charts. But, it can be very good with other groups of staff. For example some doctors very much like the SPC-style of approach.

The other thing with Six Sigma is it’s quite defined; you have a start date, end date, etc. Many of the problems we face in healthcare are very complex and ambiguous. So perhaps in certain areas - for example, in the laboratory - Six Sigma would be a very appropriate approach. But perhaps in other areas, it may not be the most engaging approach. Lean, with its concept of looking for waste, is more inclusive and does not require that much skill or specific training: we can teach anybody to look for waste.

**WHAT ADVICE WOULD YOU GIVE TO OTHER HEALTHCARE ORGANISATIONS LOOKING AT GETTING STARTED WITH LEAN OR MAYBE EVEN ANY OTHER PROCESS IMPROVEMENT TECHNIQUE?**

Get ready for the ride. A lot of people talk to me, say, “yes, we’re going to do lean and that will sort that problem out”. Lean is paradoxical: if you remove waste you’ll find more problems underneath that waste. So sometimes it can feel like all it does is create more problems. Lean is about uncovering problems and then using a robust scientific method to solve those problems involving all stakeholders.

Lean isn’t a magic wand that you can do it for three months and suddenly everything’s fixed and I guess part of the challenge for Lean or other methods, like Six Sigma, is there can be this perception that if you’re doing it suddenly you’ll be perfect but, in fact, potentially the opposite is true.

If you’re interested in finding out more about the work of Bolton NHS Foundation Trust, there are case studies available on its website: http://www.boltonft.nhs.uk/bics/default.html

You can also listen to a podcast interview with a clinical with Michaela Bowden, respiratory specialist and departmental manager at Royal Bolton Hospital, after the department won a PEX Network award for best Project in Service and Transaction in 2011. Listen to the podcast here: Interview with Europe’s Best Process Improvement Project in Service and Transaction Winner (2011)
ABOUT PROCESS EXCELLENCE AWARDS

The Process Excellence Awards have been established to honour, recognize and celebrate projects that demonstrate true best practices. Entrants are assessed on the use of methodology, business impact, and excellence within the practice of Lean, Six Sigma & Business Process Management (BPM). Judges for the PEX Network awards are assembled of experts and business leaders working in industry.

All full list of European award winners 2012 can be obtained on PEX.Network.com.
About Us

WHAT IS THE PROCESS EXCELLENCE NETWORK?

PEX Network is an online, free to join, membership portal providing process professionals with exclusive access to a library of multimedia resources from top executives on Lean Six Sigma, BPM, Operational Excellence, Continuous Improvement and other process excellence related topics.

The Process Excellence Network has a subscribed membership of 80,000+ with an additional 20,000 connected to us via our social networks and a global contact database of over 450,000.

In addition to online resources, PEX Network organizes 30+ targeted face-to-face events globally per year with industry specific focuses on Financial Services, Telecoms & Utilities, and Energy. We also hold major cross industry summits on process excellence in Orlando, FL (PEX Week) and in London, England (PEX Week Europe) every January and April.

ABOUT THE EDITOR

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