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Leadership Practices and Behaviours that Enable and Inhibit a Continuous Improvement Culture in an NHS Trust

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Abstract

Background Healthcare providers and systems globally are increasingly recognising the benefits of adopting continuous improvement methods to transform hospital services. Creating a continuous improvement culture, relies on giving frontline staff the support and freedom to identify opportunities for positive, sustainable change and the skills to enable action. This paper analyses the leadership behaviours and practices that support or inhibit the adoption of a continuous improvement culture, drawing on a qualitative evaluation within the outpatient directorate at one NHS trust.

Objective Identify key leadership behaviours and practices that enable and inhibit a continuous improvement culture in healthcare settings.

Methods Results from the 2020 NHS staff engagement survey informed the development of an original survey and interview protocol aimed at uncovering factors that enable or inhibit a continuous improvement culture in this directorate. All staff within the outpatient directorate at all NHS banding levels were invited to take part.

Results 44 members of staff took part: 13 members of staff were interviewed, and 31 members of staff completed a survey. Of the factors that are perceived to inhibit a continuous improvement culture, 'Not feeling listened to or supported to find the right solution' was the most frequently occurring theme. Conversely, the most common enabling factors were 'leaders and staff solving problems together' and 'leaders making time to understand the challenges of their staff'. The findings suggest that the most important behavioural changes leaders can make are: proactively taking the time to listen to and understand the challenges staff face; and supporting them to find the root cause of problems.

Conclusion Continuous improvement cultures depend on high staff engagement; leaders who show curiosity, invest time in listening, and act as partners in problem solving are more likely to elicit engagement and thereby enable a continuous improvement culture.

Key Messages

What is already known on this topic – prior studies have identified the value of continuous improvement cultures in healthcare settings as well as leadership practices that support continuous improvement cultures in other contexts.

What this study adds – we identify specific recommendations for how leaders can adopt practices and behaviours to support the creation of continuous improvement cultures in the context of NHS trusts.

How this study might affect research, practice, or policy – the findings of this study could be used to support leadership teams in NHS trusts pursuing cultural change. In addition, the findings could be used in NHS leadership development programmes and included in national frameworks for promoting continuous improvement cultures in the NHS.

Introduction

Healthcare leaders globally are facing unprecedented challenges, which range from creating an engaged workforce, delivering better value for patients, and driving forward improvement initiatives, cost reductions, or cost containment. Alongside addressing these challenges, leaders must clearly establish and communicate the organisation's objectives in a meaningful way to all levels of the organisation (Fitzgerald et al, 2019).

Recent evidence demonstrates that engaged staff deliver better healthcare outcomes (The King's Fund, 2015). Specifically, NHS providers with high levels of staff engagement (as measured by the annual NHS staff survey) tend to have lower patient mortality rates, make more efficient use of their resources, and perform better financially (West and Dawson, 2012). Furthermore, engaged staff are more likely to demonstrate compassion and empathy towards patients despite the pressures they face, translating into patients who report that they are treated with dignity and respect (King's Fund, 2015). One approach to increasing staff engagement and improving organisational performance adopted by several NHS Trusts in recent years is lean management thinking,¹ which focuses on implementing a *continuous improvement culture*. Continuous improvement cultures give frontline staff the freedom to identify opportunities for positive, sustainable change and the skills to act on these opportunities. Healthcare providers and systems globally are increasingly recognising the benefits of adopting continuous improvement methods, yet providers also underestimate the difficulty in changing behaviours and culture in an organisation, and the time it can take to achieve the necessary scale of change (Fitzgerald et al, 2019). For instance, Jenkins (2017) discusses how the new ways of working introduced with a lean management system are so different that sustaining them is impossible without cultural change. Leaders themselves must change and unlearn years of old habits to find a new way of leading. Jenkins (2017) describes three key behaviours that leaders must learn: 1) asking questions rather than giving answers; 2) digging for the root causes of problems rather than jumping to quick fixes; and 3) being able to connect future goals to the practical work of today.

This article presents the results of a qualitative evaluation that aimed to understand how leaders in one NHS Trust might best support the successful creation of a culture of continuous improvement to address cultural, performance and financial challenges.

Staff Engagement and a Continuous Improvement Culture

Each year all NHS workers are invited to take part in a staff survey. The survey allows organisations to understand what is going on within different departments and identify areas to make improvements (NHS Staff Surveys, 2021). This qualitative evaluation used the results of the 2020 staff survey covering the outpatient directorate as background to inform the survey design and interview protocol with staff.

Six questions from the staff survey (Table 1) were extracted as the focus for this qualitative evaluation because they most relate to the key leadership practices required for a continuous

¹ Lean management thinking transforms the entire organisation through creating new ways of working, new forms of leadership and above all shared mind-sets and behaviours shown to transform an organisation's capabilities and performance.

improvement culture identified from the literature and summarised in Table 2. Please see Appendix 1 for the full directorate staff survey results.

The results from the staff survey suggested that staff members did not feel involved in decision making nor did they feel empowered to decide how they carried out or made improvements in their area of work. These secondary findings, combined with insights from the literature, shaped the key factors identified for inclusion in the original survey and interview protocol, which was specifically focused on what leaders could do to improve staff engagement and problem solving.

Table 1: Staff survey questions to explore further in staff interview and survey

1.	Satisfied with opportunities to use my skills (52%)
2.	Opportunities to show initiative frequently in role (54%)
3.	Involved in deciding changes that affect my role (34%)
4.	I have a choice in deciding how to do my work (40%)
5.	Able to make improvement happen in my area of work (45%)
6.	Team members have a set of shared objectives (57%)

Table 2: Key leadership practices required for continuous improvement culture (McKinsey, 2017; Dombrowski & Mielke, 2014)

1.	Asking questions rather than giving answers
2.	Digging for root cause of problems rather than jumping into quick fix solutions
3.	Connecting future goals to the practical work of today
4.	Giving employees space to experiment with their own ideas and allowing them to approach them autonomously
5.	Positioning improvement as a way of thinking and working; not as something trying to be achieved
6.	A focus on the long- term development of employees
7.	Engagement and role- modelling of line managers and frontline staff in improvement

Methods

The first author collected qualitative data using a survey and interviews to understand how staff members perceived leadership practices and behaviours that enabled or inhibited a continuous improvement culture. This was undertaken midway through 2021. The findings from the data provide a set of recommendations for leaders both within the directorate and the wider organisation.

The opportunity to participate in this qualitative evaluation was advertised to all staff in the directorate at all NHS banding levels. There was an approximate response rate of 15% with this sample including administrative staff, nurses and operational managers. Interviews were offered face to face or via Microsoft teams to encourage participation.

Participant Interviews

An interview protocol was used as a framework during the interviews. Please see Appendix 2 for a full list of interview questions.

A semi-structured interview technique (Charmaz, 2006) used to allow participants to expand on certain questions with their own experiences. Participants were also prompted throughout to describe examples of situations which allowed for deeper exploration. In addition, attention was paid not only to what participants said but also to how some of the responses were delivered, for example the participant's body language, tone of voice and emotional expression. The intention during the interviews was to provide a safe space for participants to speak openly and honestly through use of an empathetic interview style. Each interview lasted approximately one hour. Three were undertaken using Microsoft Teams and the rest were undertaken face-to-face. All interviews were recorded.

Participant Survey

Recognising that not all staff would feel comfortable undertaking an interview, an anonymous survey was designed using similar questions to the interview protocol. The project sponsor and general manager of the directorate sent an email to all staff inviting them to take part, in addition to inviting them to take part via the weekly directorate communications email.

Data Analysis

The interview recordings were uploaded and transcribed verbatim using Dovetail. The raw data from the survey was extracted from Survey Monkey and uploaded to Dovetail.

Each interview transcript and the survey data were read several times before beginning thematic content analysis, which is a process of labelling and organising the data. In some of the interviews the conversation went off topic and therefore these deviations were uncoded. Inductive coding, in which codes or themes are created based on the raw qualitative data, was used instead of predetermined codes or themes from the literature. Verbatim quotes from both the interview and survey data were also selected to contextualise the themes derived from the data. The data were labelled and then grouped into themes using Dovetail.

Ethical considerations and limitations

Confidentiality and anonymity were the key ethical issues identified and managed. All participation in this qualitative evaluation was voluntary and remained anonymous. Only the administrator who organised the interviews and the interviewer knew the staff members who volunteered to take part. Interviews were conducted one-to-one in a private room or using Microsoft Teams. Once the interviews were uploaded to Dovetail the recording was deleted.

The main limitation of this evaluation is the sample size and no doctors took part. As the survey was anonymous it is possible that staff who took part in the interviews also completed

the survey. Additionally, only 13 members of staff volunteered to be interviewed and while the survey data was useful it did not provide the level of detail the interviews allowed.

Results

44 members of staff took part in total. 13 members of staff were interviewed, and 31 members of staff completed the survey. There was a good distribution of participants from different NHS banding levels as shown in the Table 3 below.

Table 3: Participants' banding

NHS banding	Number of participants
Band 2	11
Band 3	6
Band 4	6
Band 5	9
Band 6	1
Band 7	4
Band 8	7
Total participants	44

Leadership practices that enable a continuous improvement culture

Five leadership practice themes emerged in the data that would enable a continuous improvement culture: staff and leaders solving problems together, leaders making time to understand, honest transparent communication from leaders, leaders visible and curious, using objective data. The radar plot in figure 1 shows the number of times each theme arose in the data.

[Figure 1 here]

'Solving problems together' and 'making time to understand' were the strongest enabling themes arising 25 and 22 times in the data, respectively. Staff reported what a positive impact it had on morale and motivation when leaders used their knowledge and expertise, didn't take problems at face value and worked with staff to look deeper into things no matter how small the problems or improvement ideas appeared. Staff in management positions described feeling very valued because of the leadership style within the directorate. They described feeling they were always involved in working through problems and supported if they needed help resolving a problem as demonstrated in this quote: *"She asks for our advice and our wisdom and our knowledge. She's not the sort of person who says you need to do this and you need to do it now, or I want this and I want it now. She always wants to understand."* This staff member described how experiencing this leadership style from their own manager enabled them to be the caring manager they wanted to be.

Our thematic analysis suggests that the linchpin of the enabling factors is this theme of leaders proactively engaging with members of staff around problems that they have raised. The other factors – such as leader visibility and curiosity, were closely related to this key factor. For example, one staff member commented about a senior leader: *“He makes a point of going to speak to people to see how they are and how they are getting on and he’ll say if you need to come to me then come to me no matter what area it relates to or what the problem relates to.”* Staff particularly highlighted that leaders must be visible **and** curious; simply walking around without taking the time to listen and understand issues was seen as a tick-box exercise.

Leadership practices that inhibit a continuous improvement culture

Four leadership practices that inhibited a continuous improvement culture emerged from the data: staff not feeling listened to or supported to find the right solution, staff not involved in problem solving, unclear priorities and reactive short-term demands. The radar plot in figure 2 shows the number of times these themes arose in the data.

[Figure 2 here]

In direct inverse to the enabling factors, ‘Not feeling listened to or supported to find the right solution’ was by far the most frequently occurring theme, arising 41 times in the data and referenced by many staff in both interviews and the survey. Several staff provided examples of where they have tried to make suggestions for improvements, but they are never considered by their managers, causing them to withdraw from making suggestions despite being much closer to the reality of the work. Several senior managers reported there are often directives from senior leaders outside of the directorate, and from their perspective, these leaders displayed little appetite to want to spend time exploring the right solution. This quote illustrates the perceived impact of this: *“There have been massive misunderstandings, lots of assumptions and wasted time focusing on things that either aren’t issues or focusing on the wrong things.”* This was echoed by another staff member: *“if you don’t feel valued or appreciated, or you feel like you’re doing work, which is either pointless or nobody’s appreciating it, it can be really demoralizing.”*

A closely related theme which was reported 20 times in the data mainly by junior staff (band 2-3) was ‘not being involved in problem solving or generation of new ideas’ with their immediate managers. Several staff reported feeling completely excluded and because their ideas are pre-emptively dismissed, they have stopped suggesting improvement ideas which they believe negatively impacts their team and patients. Another staff member went on to express how frustrating this is because ultimately it can lead to patient experience being negatively impacted as the solutions which are designed by managers often don’t work in reality and they then bear the burden for these missteps: *“when things go wrong patients look to us to vent their frustrations”*.

Discussion

Dombrowski and Mielke (2014) identify the leadership practices needed for a culture of continuous improvement. They emphasise the importance of leaders giving their staff space to experiment with their own ideas and allowing them to approach this autonomously by not intervening directly with problem solving and instead asking a set of questions to support the problem-solving process.

However, in this qualitative evaluation, we find the most important factors diverged somewhat from pre-existing recommendations about how a continuous improvement culture can be achieved. We did not hear a strong narrative from participants that they wanted more autonomy and space; instead, the findings suggest that in an acute NHS Trust, given resource constraints and conflicting priorities, staff members wanted more visibility, active participation, and proactive engagement from leaders. Not feeling listened to or supported to find the right solution was the most frequently occurring theme in the data. Many of the senior staff described feeling listened to within the directorate but often not feeling listened to by senior leaders outside of the directorate with a directive approach often being the default. This was echoed by staff in more junior roles who are directly patient-facing, who feel frustrated that solutions have been designed by managers too far away from the detail, and additionally burdened by the perceived negative impact these solutions have on patient experience.

Many staff expressed their frustration about not being part of the problem-solving process, with a common perception that leaders, including senior leaders outside of the directorate, default to a directive approach and impose what they believe to be the best solution without taking time to understand the challenges and realities. It was the belief of staff that this led to a 'workaround culture' and a focus on the wrong things.

The management literature offers several concepts and frameworks for how leaders, and organisations, might better realise a culture of continuous improvement. First, research on psychological safety in healthcare contexts (Nembhard and Edmondson, 2006) suggests that when leaders are inclusive and invite contributions from lower-status members, they are more likely to elicit engagement in improvement efforts. The idea that leaders should proactively elicit participation neatly links with our data, which shows the key problem reported by respondents is 'not feeling listened to' and the key intervention would be for leaders to 'take time to truly understand.' Similarly, Halaychik (2016) describes participative leadership as a human-orientated approach which involves followers in the decision-making process. This has many benefits for both the follower and the leader with the style often recognised for creating a more engaged workforce, employee retention and greater teamwork in the organisation. Because of this engagement, followers often take ownership of the organisation's objectives and view themselves as playing a key part in achieving them. This is supported by our data, with staff describing a greater sense of accountability and motivation when involved in decision making and when leaders want to understand their challenges so they can support them in resolving them sustainably.

With respect to how these leadership behaviours might actually be implemented in NHS Trusts, we suggest that the culture change framework offered by Denning (2011) is a useful

tool for organisations seeking to evolve in the direction of continuous improvement cultures. Denning argues that culture is a system of interrelated goals, roles, processes, values, communications, practices, attitudes, and assumptions; these interlocking elements form a system and reinforce each other making single-fix changes work in the short term but eventually these interlocking elements take over and often the change is drawn back into the existing culture. Denning (2011) believes the most fruitful culture change strategy is to begin with a vision or story for the future which is cemented in place using management tools including role definitions, measurement and control systems. In the context of NHS Trusts, the idea is that unless leaders buy into the vision, it will be difficult for specific behavioural changes to be implemented. Therefore, NHS Trusts should invest time into developing a story for the future which motivates and incentivises leaders.

Although this evaluation was carried out in a directorate of one NHS trust and did not include doctors, it is plausible that the findings and recommendations would apply across the entire Trust due to the consistency with a cultural diagnostic recently undertaken at this Trust (please see appendix 3). Several issues were highlighted in this diagnostic including an appetite from staff to learn and improve individually and collectively but a frustration that attempts to do so are not supported by leaders creating the conditions for learning. In addition, low psychological safety and fear of speaking up were highlighted which may have impacted on willingness of staff to participate in this evaluation.

The findings of this qualitative evaluation and the available best practice literature provide compelling evidence that leaders themselves must change some of their deeply engrained habits and behaviours if they are to enable a culture of continuous improvement. The table below summarises the top two enabling leadership practices and behaviours which were highlighted by this evaluation.

Table 4: Recommended leadership practices and behaviours to enable a culture of continuous improvement

Leadership Practices	
1	When presented with a problem avoid jumping in with a solution or directive; instead use a set of questions to support staff to find the root cause of the problem and to identify their own potential solutions.
2	Take time to understand the challenges staff face by going to their place of work, walking in their shoes, and being curious.
Specific Behaviours	
2	Take time to really listen and understand. Involve staff in the problem- solving process in a respectful, curious, and supportive way.
4	Where possible, be honest and transparent about what you need and why you need it - particularly when a directive approach feels necessary.

Conclusion

This qualitative evaluation aims to help leaders at NHS Trusts to identify how they can influence the successful implementation of a continuous improvement culture through their

own behaviours and practices. Leaders who show curiosity, invest time in listening, and act as partners in problem solving are more likely to elicit engagement and thereby enable a continuous improvement culture.

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Statements

a. Contributorship Statement: Claire Benjamin planned and conducted the data collection and analysis. CB obtained ethical approval from City, University of London, and support from managers to collect data. Daisy Chung contributed ideas related to culture, change management, and leadership to inform the framing of the data. CB submitted the study to *BMJ Leader*.

b. No funding to report.

c. No competing interests to report.

d. CB would firstly like to acknowledge study participants for sharing their time and experiences. Secondly CB would like to thank the chairman for her support in sharing the findings of this evaluation with senior leaders in the organisation to drive cultural change