

ARTIKEL EN BOEKEN MET GOEDE VOORBEELDEN VAN LEIDERCHAP EN VERANDERMANAGEMENT

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INLEIDING

HIERONDER PRESENTEER IK WETENSCHAPPELIJKE PUBLICATIES OVER DE PERIODE TOT MEDIO 2016. TEN BEHOEVE VAN MIJN BOEKEN UIT 2014¹ EN 2016² HAD IK REEDS 1200 BOEKEN EN PUBLICATIES OVER GOEDE VOORBEELDEN EN ZORGINNOVATIE GESELECTEERD: DIE WAREN GESCHIKT OM IN DEZE OVERZICHTSBOEKEN TE BEHANDELEN.

Aan de artikelen ontbreekt een synthese. Die staat in de genoemde boeken.

Ik wijs erop dat in de overzichtspublicaties ook mislukte innovaties staan opgenomen. Vaak ligt dat niet aan de innovatie maar aan de omgeving. Een substitutie voorbeeld kan mislukken omdat de ondersteunende software niet functioneerde of omdat verantwoordelijkheden van professionals onvoldoende waren uitgeschreven.

Guus Schrijvers

Utrecht, 5 mei 2017.

¹ Schrijvers G, Zorginnovaties volgens het Cappuccinomodel, Thoeris, Amsterdam, 2014, 391 pagina's

² Schrijvers G, In tegrated Care: Bette rand Cheaper, Reed Business Information, Amsterdam, 2016, 291 pagina's

Kotter JP. Leading change: why transformation efforts fail. Harv Bus Rev March-April 1995, reprint number. Retrieved on April 10, 2016 from http://www.gsbcolorado.org/uploads/general/PreSessionReadingLeadingChange-John_Kotter.pdf.

In *Leading Change*, John Kotter examines the efforts of more than 100 companies to remake themselves into better competitors. He identifies the most common mistakes leaders and managers make in attempting to create change and offers an eight-step process to overcome the obstacles and carry out the firm's agenda: establishing a greater sense of urgency, creating the guiding coalition, developing a vision and strategy, communicating the change vision, empowering others to act, creating short-term wins, consolidating gains and producing even more change, and institutionalizing new approaches in the future. This highly personal book reveals what John Kotter has seen, heard, experienced, and concluded in 25 years of working with companies to create lasting transformation. A Business Week Bestseller. "A truly accessible, clear, and visionary guide."--Publishers Weekly A solid, substantive work that goes beyond the clichés and the consultant-of-the-month's express down yet another dead-end street.... Highly recommended. --Library Journal "Leading Change is simply the best single work I have seen on strategy implementation."--William C. Finnie, Editor-in-Chief, *Strategy & Leadership*

Kotter JP, Porter ME, Olmsted Teisberg E, et al. Leadership, strategy, and innovation: health care collection. Boston: Harvard Business Review Press, 2015.

How can management cure health care's ills? This digital collection, curated by Harvard Business Review, includes the ideas and best practices for transforming health care in these books and articles: *Leading Change*, *Redefining Health Care*, *The Strategy That Will Fix Health Care*, "HBR's 10 Must Reads on Leadership", *HBR's 10 Must Reads on Strategy*, *HBR's 10 Must Reads on Managing Yourself*, *HBR's 10 Must Reads on Managing People*, and *HBR on Fixing Health Care from Inside & Out*.

Cook D, Thompson JE, Habermann EB, et al. From 'Solution Shop' model to 'Focused Factory' in hospital surgery: increasing care value and predictability, Health Aff (Millwood). 2014 May;33(5):746-55.

Abstract

The full-service US hospital has been described organizationally as a "solution shop," in which medical problems are assumed to be unstructured and to require expert physicians to determine each course of care.

If universally applied, this model contributes to unwarranted variation in care, which leads to lower quality and higher costs. We purposely disrupted the adult cardiac surgical practice that we led at Mayo Clinic, in Rochester, Minnesota, by creating a "focused factory" model (characterized by a uniform approach to delivering a limited set of high-quality products) within the practice's solution shop.

Key elements of implementing the new model were mapping the care process, segmenting the patient population, using information technology to communicate clearly defined expectations, and empowering nonphysician providers at the bedside. Using a set of criteria, we determined that the focused-factory model was appropriate for 67 percent of cardiac surgical patients. We found that implementation of the model reduced resource use, length-of-stay, and cost. Variation was markedly reduced, and outcomes were improved. Assigning patients to different care models increases care value and the predictability of care process, outcomes, and costs while preserving (in a lesser clinical footprint) the strengths of the solution shop. We conclude that creating a focused-factory model within a solution shop, by applying industrial engineering principles and health information technology tools and changing the model of work, is very effective in both improving quality and reducing costs.

Grumbach K, Lucey CR, Johnston SC. Transforming From Centers of Learning to Learning Health Systems: The Challenge for Academic Health Centers, JAMA. 2014 Mar 19;311(11):1109-10.

Health care organizations face intensifying pressure to achieve the triple aims of better patient experience, better health, and affordability.

Although all health systems grapple with these imperatives, the tripartite mission of research, education, and patient care presents particular challenges for academic health centers in responding to demands for high-value, patient-centered care and population health. In this Viewpoint, we propose that health reform offers an opportunity for academic health centers to create new synergies across mission areas to become exemplary learning health systems.

Halfon N, Long P, Chang DI, et al. Applying a 3.0 transformation framework to guide largescale health system. *Health Affairs*, 33, no.11 (2014):2003-2011.

Abstract

Implementation of the Affordable Care Act is unleashing historic new efforts aimed at reforming the US health system.

Many important incremental improvements are under way, yet there is a growing recognition that more transformative changes are necessary if the health care system is to do a better job of optimizing population health. While the concept of the Triple Aim—dedicated to improving the experience of care, the health of populations, and lowering per capita costs of care—has been used to help health care providers and health care systems focus their efforts on costs, quality, and outcomes, it does not provide a roadmap for a new system. In this article we describe the 3.0 Transformation Framework we developed to stimulate thinking and support the planning and development of the new roadmap for the next generation of the US health care system.

With a focus on optimizing population health over the life span, the framework suggests how a system designed to better manage chronic disease care could evolve into a system designed to enhance population health. We describe how the 3.0

Transformation Framework has been used and applied in national, state, and local settings, and we suggest potential next steps for its wider application and use.

Ham C. Strengthening leadership in the NHS, BMJ. 2014 Feb 20;348:g1685.

The Rose and Dalton reviews are welcome but there are no easy answers. The appointment of Stuart Rose, former boss of Marks and Spencer, to advise the government on leadership in the NHS is the latest in a long line of attempts to make use of private sector expertise in the NHS.

Rose's brief is to explore how the 14 NHS trusts placed in special measures can be helped to tackle concerns about their performance.¹ Like Roy Griffiths, Adair Turner, and Gerry Robinson before him, Rose faces the challenge of using experience in a very different sector to enable NHS organisations to put in place the leadership that can provide improved care for patients.

Arguably, the NHS has most to learn from the private sector about how to treat patients as valued customers rather than as grateful recipients of care. Despite progress in improving patients' access to care, much remains to be done to tackle relational aspects of care, including ensuring that patients are treated with dignity and respect and are able to communicate effectively with doctors and other staff. NHS organisations could also do more to support patients to manage their own health and wellbeing and involve them as genuine partners in care. If Rose can help support NHS leaders to introduce the changes in culture needed to improve these aspects of care, then he will have indeed performed a valuable service.

Rose will find that part of the answer to improving patient experience is to ensure that staff are supported to do the job for which they trained.

As research has shown, there is a close correlation between staff experience and patient experience, sometimes expressed as "happy staff mean happy patients."

Patients receive better care when it is delivered by staff working in teams that are well led and where staff report they have the time and resources to care to the best of their abilities.

This highlights the crucial role of team leaders, often experienced nurses, who develop a culture in which patients are treated with dignity and respect, and motivate their colleagues to do the same.

2 Another part of the answer can be found in studies of how high performing healthcare organisations in other countries deliver great care to patients. These organisations benefit from continuity of leadership, organisational stability, and consistency of purpose—characteristics that are in short supply in many parts of the NHS. This purpose is often expressed as providing the best care possible with the resources available, with quality and outcomes being at the forefront.

High performing organisations pursue this purpose by setting ambitious goals, measuring progress towards their achievement, and providing staff with the skills to improve care.

3 Analysis undertaken by The King’s Fund concludes that leadership in NHS organisations needs to be collective and distributed rather than located in a few people found at the top of these organisations.

The involvement of doctors, nurses, and other clinicians in leadership roles is also essential, particularly in the clinical microsystems that comprise the basic building blocks of hospitals and other healthcare providers.

Organisations in which skilled clinical leaders work with experienced managers draw on different sources of expertise as they aspire towards higher standards of performance. The size and complexity of healthcare organisations suggest the need for caution in adapting approaches used in other sectors, such as the appointment of “superheads” to run several schools, in the NHS.

4 This caution is directly relevant to the review led by David Dalton, chief executive of Salford Royal NHS Foundation Trust, to explore how NHS providers can collaborate in networks or chains. The government established this review to build on an initiative last autumn in which high performing NHS hospitals were invited by health secretary, Jeremy Hunt, to provide support to hospitals placed in special measures.**1** The interest in developing chains takes this idea much further to explore what incentives are needed to persuade high performing hospitals to work across different parts of England.

Although it is too early to form a judgment, buddying successful hospitals with those that are struggling carries a substantial risk that standards in high performing NHS organisations will fall if their leaders are distracted by the work involved in lending support to others.

5 The decision by the government to set up these reviews is a welcome, albeit belated, recognition of the crucial role of leaders in improving NHS performance.

At a time when there are growing difficulties in recruiting experienced people to top leadership roles in NHS organisations, it is hoped that the reviews will report expeditiously on what needs to be done to attract more talent into the NHS and how existing expertise can be used more effectively. A good start would be to redouble efforts to attract clinicians into leadership roles at all levels, as Roy Griffiths advocated in 1983, and to value the role of managers instead of constantly criticising them.

Ministers must play their part by bringing an end to constant reorganisations, which serve only to distract leaders from their core purpose of improving patient care.

The leadership role of politicians also needs to be recognised through an unwavering focus on patient safety and quality as the real priorities for the NHS.

Pronovost Understanding that there are no easy solutions either in the private sector or the NHS is the first step on the road to strengthening leadership in the NHS for the longer term.

Pronovost P.J., Enhancing Physicians' Use of Clinical Guidelines, JAMA. 2013 Dec 18;310(23):2501-2.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported receiving grant or contract support from the Agency for Healthcare Research and Quality, the Gordon and Betty Moore Foundation (research related to patient safety and quality of care), and the National Institutes of Health (acute lung injury research); receiving consulting fees from the Association of Professionals in Infection Control and Epidemiology Inc; receiving honoraria from various hospitals, health systems, and the Leigh Bureau to speak on quality and patient safety; receiving book royalties from the Penguin Group; and serving as a board member for the Cantel Medical Group.

Kellerman B. *The end of Leadership*, New York: HarperCollins publishers, 2012.

From one of the pioneers in the field of leadership studies comes a provocative reassessment of how people lead in the digital age: in *The End of Leadership*, Barbara Kellerman reveals a new way of thinking about leadership—and followership—in the twenty-first century. Building off of the strengths and insights of her work as a scholar and a teacher, Kellerman critically reexamines our most strongly-held assumptions about the role of leadership in driving success. Revealing which of our beliefs have become dangerously out-of-date thanks to advances in social media culture, she also calls into question the value of the so-called “leadership industry” itself. Asking whether leadership can truly be taught, Kellerman forces us to think critically and expansively about how to thrive as leaders in a global information age.

Bason C. *Leading Public Sector Innovation. Co-creating for a Better Society*, The Policy Press, University of Bristol, 2010.

In a time of unprecedented turbulence, how can public sector organisations increase their ability to find innovative solutions to society's problems? "Leading public sector innovation" shows how government agencies can use co-creation to overcome barriers and deliver more value, at lower cost, to citizens and business. Through inspiring global case studies and practical examples, the book addresses the key triggers of public sector innovation.

It shares new tools for citizen involvement through design thinking and ethnographic research, and pinpoints the leadership roles needed to drive innovation at all levels of government.

"Leading public sector innovation" is essential reading for public managers and staff, social innovators, business partners, researchers, consultants and others with a stake in the public sector of tomorrow.

"This is an excellent book, setting out a clear framework within which the practical issues involved in public sector innovation are explored, using insights drawn from extensive practical experience of implementing and supporting it. It draws on an impressive range of research and relevant wider experience in both public and private sectors and is written in a clear and persuasive style.

The book offers an excellent synthesis of principles, practices and tools to enable real traction on the innovation management problem - and it ought to find a place on any manager's bookshelf." John Bessant, Director of Research and Knowledge Transfer and Professor of Innovation and Entrepreneurship, University of Exeter Business School

Loop F.D., Leadership and Medicine, Fire Starter Publishing, 2009.

A great medical organization is first and foremost its talent base. Leadership at every level protects and advances the mission and becomes a magnet for recruitment and retention of the best staff. The Cleveland Clinic is a model of integration, quality and value for patients worldwide. That s the message that shines through every page of Leadership and Medicine. Author Floyd D. Loop, M.D., an accomplished physician leader, provides a compelling inside look at what it takes to run a major medical system. Along the way, he teaches readers some valuable lessons about the art and science of leadership.

As chief executive of the Cleveland Clinic, Dr. Loop led a transformation from a financially troubled enterprise known mainly for its heart care into one of the world's most successful healthcare organizations. Under his 15-year tenure, the Clinic grew into a fully integrated medical delivery system, a renowned medical school and an industry blueprint for growth and innovation. Dr. Loop was able to build an integrated system to benefit the patient. He has successfully built what others are looking to create today.

This book will inspire and enlighten leaders who work for every type of healthcare organization at every level of the organization. Dr. Loop s personal philosophy serves as a prism through which he examines, with disarming honesty, the trials and triumphs of medical leadership. And he offers a wealth of practical advice to future generations the rising stars who must solve the problems plaguing our nation's healthcare system.

Leadership and Medicine is an excellent resource for physicians, administrators, academicians and students anyone and everyone with a vested interest in the future of healthcare in America.

Berry LL, Seltman KD. Management Lessons from Mayo Clinic; inside one of the world's most admired service organizations, New York: McGraw-Hill professional Publishing, 2008.

Management Lessons from Mayo Clinic reveals for the first time how this complex service organization fosters a culture that exceeds customer expectations and earns deep loyalty from both customers and employees. Service business authority Leonard Berry and Mayo Clinic marketing administrator Kent Seltman explain how the Clinic implements and maintains its strategy, adheres to its management system, executes its care model, and embraces new knowledge - invaluable lessons for managers and service providers of all industries. Drs. Berry and Seltman had the rare opportunity to study Mayo Clinic's service culture and systems from the inside by conducting personal interviews with leaders, clinicians, staff, and patients, as well as observing hundreds of clinician-patient interactions. The result is a book about how the Clinic's business concept produces stellar clinical results, organizational efficiency, and interpersonal service.

By examining the operating principles that guide every management decision at this legendary healthcare institution, the authors;

Demonstrate how a great service brand evolves from the core values that nourish and protect it;

Extrapolate instructive business lessons that apply outside healthcare; Illustrate the benefits of pooling talent and encouraging teamwork;

Relate historical events and perspectives to the present-day Clinic;

Share inspiring stories from staff and patients An innovative analysis of this exemplary institution, *Management Lessons from Mayo Clinic* presents a proven prescription for creating sustainable service excellence in any organization.

Kotter JP, Schlesinger LA. Choosing Strategies for change, Harvard Business Review 2008.

The rapid rate of change in the world of management continues to escalate.

New government regulations, new products, growth, increased competition, technological developments, and an evolving workforce compel organizations to undertake at least moderate change on a regular basis. Yet few major changes are greeted with open arms by employers and employees; they often result in protracted transitions, deadened morale, emotional upheaval, and the costly dedication of managerial time. Kotter and Schlesinger help calm the chaos by identifying four basic reasons why people resist change and offering various methods for overcoming resistance.

Managers, the authors say, should recognize the most common reasons for resistance: a desire not to lose something of value, a misunderstanding of the change and its complications, a belief that the change does not make sense for the organization, and a low tolerance for change in general.

Once they have diagnosed which form of resistance they are facing, managers can choose from an array of techniques for overcoming it: education and communication, participation and involvement, facilitation and support, negotiation and agreement, manipulation and co-optation, and both explicit and implicit coercion. According to the authors, successful organizational change efforts are characterized by the skillful application of a number of these approaches, with a sensitivity to their strengths and limitations and a realistic appraisal of the situation at hand. In addition, the authors found that successful strategic choices for change are both internally consistent and fit at least some key situational variables.

Xyrichis A, Lowton K. What fosters or prevents interprofessional teamworking in primary and community care? A literature review, Int J Nurs Stud. 2008 Jan;45(1):140-53.

Abstract

BACKGROUND:

The increase in prevalence of long-term conditions in Western Russel societies, with the subsequent need for non-acute quality patient healthcare, has brought the issue of collaboration between health professionals to the fore. Within primary care, it has been suggested that multidisciplinary teamworking is essential to develop an integrated approach to promoting and maintaining the health of the population whilst improving service effectiveness.

Although it is becoming widely accepted that no single discipline can provide complete care for patients with a long-term condition, in practice, interprofessional working is not always achieved.

OBJECTIVES:

This review aimed to explore the factors that inhibit or facilitate interprofessional teamworking in primary and Community care settings, in order to inform development of multidisciplinary working at the turn of the century.

DESIGN:

A comprehensive search of the literature was undertaken using a variety of approaches to identify appropriate literature for inclusion in the study. The selected articles used both qualitative and quantitative research methods.

FINDINGS:

Following a thematic analysis of the literature, two main themes emerged that had an impact on interprofessional teamworking: team structure and team processes. Within these two themes, six categories were identified: team premises; team size and composition; organisational support; team meetings; clear goals and objectives; and audit.

The complex nature of interprofessional teamworking in primary care meant that despite teamwork being an efficient and productive way of achieving goals and results, several barriers exist that hinder its potential from becoming fully exploited; implications and recommendations for practice are discussed.

CONCLUSIONS:

These findings can inform development of current best practice, although further research needs to be conducted into multidisciplinary teamworking at both the team and organisation level, to ensure that enhancement and maintenance of teamwork leads to an improved quality of healthcare provision.

Russell RF, Stone AG. A review of servant leadership attributes: developing a practical model. Leadership & Organization Development Journal 2002;23(3):145-57.

Purpose

This paper seeks to apply discriminate analysis to determine principal's leadership styles differences between genders in USA Midwest public schools.

A distinction is to be made between "servant" (seen as aligned with emotional intelligence) and "traditional" (or top-down) leadership. The debate between the traditional (or, top-down) leadership approach, versus the servant (which is seen as aligned with emotional intelligence) leadership approach is ripe for investigation.

Design/methodology/approach

E-mail based surveys from 445 responding public school principals comprised of men ($n=265$) and women ($n=180$) were quantitatively analyzed. The self-selected sample for the study was drawn from public schools in three Midwest states in the USA. The inventory contained 40 content items prepared on a five-point Likert scale and one demographic question.

Content and construct validity were evaluated and significant difference tests were performed. The study sought to clarify which cluster of items from the Servant-leadership Styles Inventory (SSI) best described gender membership and, thereby, proffered possibly gender oriented servant-leadership styles utilizing discriminant function analysis methods.

Findings

This study has established that SSI items identified with Servant-leadership dimension are reliable and valid; however items aligned with Traditional leadership dimensions were found to be less reliable and valid. Additionally these results have shown that Servant-leadership items can be effective in differentiating between men and women principals. It is important to note that both men and women equally reported that they were reluctant to use Traditional leadership styles. No differences between genders in Traditional leadership styles usage were found. However, there were significant differences between men's and women's Servant-leadership style usage.

Research

Current research shows that men and women operate differently. What has been lacking, however, is an instrument that discriminated between male and female leadership styles. This study is bounded by the following limitations: by location, the study is restricted to USA Midwest practicing public school principals; to the gender based perceptions of principals in Midwest USA, other factors such a training, experience and longevity are unknown; and it is also unknown as to the instrument's cultural biases when applied to other countries and regions in the USA.

However, the instrument may open opportunities for cultural and gender based leadership research studies when applied to new populations.

Practical implications

This paper reports the development of a new research instrument, the SSI. The instrument utilizes 20 traditional leadership styles and 20 servant leadership styles to query subjects. The instrument was found to be reliable and valid, especially the servant leadership items.

Originality/value

The paper shows that four Servant-leadership styles lend understanding to the field, and help begin a discussion of feminine servant-leadership style.

These four newly identified styles are: daily reflection; consensus building; healing relationships; and drive sense of selfworth. The feminine leader is more likely to hold and practice these values than male leaders.

Lippitt M. The managing complex change model. Copyright, 1987, by Dr. Mary Lippitt, founder and president of Enterprise Management, Ltd.

Wat zijn de sleutelementen voor een succesvolle verandering? Dr. Mary Lippitt (1987) ontwikkelde een model voor complexe verandering met 5 sleutel elementen: Visie, Incentives, Resources, Skills en Plan.

Vanuit de Lean literatuur zijn er meerdere artikelen en boeken welke het belang beschrijven van het hebben van een Visie en het belang van commitment van het management. 3 jaar geleden vond ik al deze voorwaarden vanzelfsprekend, omdat deze in de fabriek waar ik kwam te werken duidelijk aanwezig waren. Ik heb echter geleerd dat deze basisvoorwaarden regelmatig ontbreken bij organisaties, waardoor een Lean implementatie bij voorbaat al gedoemd is te mislukken.

In dit artikel wordt Lippitt's 'Incentives' vervangen voor 'Commitment' (wat een gevolg is van de juiste incentives), omdat commitment van het management op internetfora als belangrijkste reden tot mislukken van veranderingen wordt genoemd.

Het hebben van een **VISIE** is de eerste stap voor een succesvolle (lean) cultuur verandering. Auteurs die Lean als filosofie (Rother (2010), Liker (2004), Suzaki (1993)), beschrijven allen dat het van belang is om als organisatie te weten waar je naartoe wilt en hoe Lean principes je kunnen helpen om daar te komen.

Het klinkt vanzelfsprekend, maar ik heb het genoeg gehad om een MT te ontmoeten dat bij ons kwam kijken hoe wij lean 'gedaan hadden' na een mislukte 'implementatie' aan hun zijde. Het bleek dat het MT er zelf onderling niet over uit was wat Lean eigenlijk betekent en het het ook onduidelijk was wat zij binnen de organisatie eigenlijk met Lean wilde bereiken. Als er geen eenduidige beeld is van wat er gebeuren moet, is het dan vreemd dat dit 'wat' dan niet lukt?

Na een visie komt het **COMMITMENT**, wat onder anderen ontstaat door het creëren van de juiste inscentives. Wanneer je er als organisatie voor kiest om voor een cultuurverandering als Lean te gaan, moet iedereen ook daad bij het woord voegen. Kotter (1996) beschrijft in zijn traditionele 8 stappen van veranderen onder anderen het belang van het communiceren van de visie en het creëren van draagvlak voor de visie, om zo alle neuzen in de organisatie dezelfde kant op te sturen.

Maar, commitment betekent ook het goede voorbeeld geven, het zogenaamde 'walk the talk', het lopen van Kamishibai rondes en of Gemba walks (Mann, 2005) en het belangrijkste van alles: focussen op het preventief oplossen van problemen in plaats van correctief (Webers, 2010).

Alleen wanneer iedereen zich houdt aan bovenstaande afspraken kan de organisatie veranderen in een cultuur van continu verbeteren. Wanneer het management niet de daad bij het woord (de visie) voegt, blijft de cultuurverandering bij een schijn vertoning.

Wanneer je weet waar je naartoe wilt, zijn **RESOURCES** nodig. Resources komen in verschillende soorten. Aller eerst is er tijd nodig. Een cultuur verandering realiseren door 1 iemand 2 dagen in de week vrij te spelen? Dat klinkt mij als erg optimistisch. In mijn huidige functie zijn we met 2 man fulltime vrijgespeeld om de lean transformatie te begeleiden in een fabriek van ongeveer 200 man, en nog steeds zijn we naar 3 jaar nog lang niet uitgeleerd en uitverbeterd. Lean heeft ook alles te maken met bottom-up verbeteren. Dat betekent dat medewerkers tijd en ruimte moeten krijgen om hun eigen werk te kunnen verbeteren.

In onze fabriek worden op een afdeling waarbij de lean basis wordt geïmplementeerd (zie: Lean huis voor de werkvloer) maandelijkse Lean workshops gehouden waarbij medewerkers van alle ploegen uitgenodigd worden om een hele dag met Lean bezig te zijn. Ze strepen daarvoor een eigen dienst in de fabriek weg.

Verder zijn er natuurlijk ook uren nodig van de technische dienst en engineering, om verbeter ideeën uit te voeren op machines. Naast tijd is er ook budget nodig om de verbeter ideeën uit te voeren. Niets is meer frustrerend voor medewerkers als het indienen van een verbeter idee, welke vervolgens wordt afgewezen omdat deze te duur is.

Helaas lopen wij hier, ondanks een groot lean budget, nog steeds tegenaan. Het budget is nooit groot genoeg en er zullen altijd keuzes gemaakt moeten worden.

Het vierde element wat nodig is voor een succesvolle verandering is de **SKILLS** binnen de organisatie.

Zeker op het gebied van Lean zijn talloze tools die kunnen faciliteren in het veranderen van de organisatie naar een cultuur van continu verbeteren. Zonder skills ontstaat er angst en onzekerheid, met langzame verandering tot resultaat.

Als niemand weet wat voor tools je kunt inzetten in een bepaalde situatie, hoe kun je dan het 'laaghangend fruit' plukken wat nodig is om mensen te laten zien dat de nieuw ingeslagen weg een goede keuze is (Kotter, 1996)?

Tot slot is er een **PLAN** nodig. Weet welke acties je gaat uitzetten om de visie te bereiken, de zogenaamde verbeter kata (Rother 2010), en welke Lean tools je inzet om een specifieke value stream te optimaliseren.

Kies de juiste KPI's op basis van handelingsniveau (leading) om te meten of iedereen bezig is met de juiste zaken en een aantal resultaatgerichte KPI's (lagging) om te controleren of het plan inderdaad leidt tot verbetering die bijdraagt aan de organisatie visie (Webers, 2010). (zie ook het artikel over Hoshin Kanri)

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