NHS
Institute for Innovation
and Improvement

Thinking

In the middle of difficulty lies opportunity.

Albert Einstein

Thinking Differently

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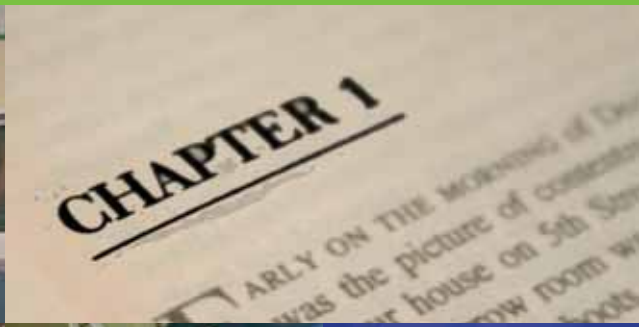




We need to have imagination and courage in order to seize the opportunities there are to transform the provision of care in the NHS.

David Nicholson, Chief Executive of the NHS

How to use this guide

The book you have in your hands is a practical, introductory guide to thinking differently. It is not a comprehensive blueprint nor is it designed to make you an expert in thinking. But it will get you started on a journey of thinking differently, and therefore doing things differently, that we hope continues well into your future.

We have selected concepts and thinking tools that have proven their value, ease, and applicability in a variety of industries and in over five years of experience with front line teams in various NHS organisations.

We'll provide you with just enough background theory to help you see why the various thinking tools ask you to do certain things that might seem a bit odd at first. But the emphasis here is not on dry theory or abstract concepts. Rather, it is on developing new thinking that leads to new ways of doing.

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If you're sceptical of the value of guides such as this in light of heavy work pressures within the health service, then we invite you to begin with the section: **Thinking Differently? Why Should I?** It will only take you a few minutes. If, after that short section, you are not convinced of the value of reading any further… well then, fair enough, pass on this guide to a colleague and get back to work.

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If, on the other hand, you are intrigued, then we suggest you read the short theory section entitled **What's Involved in Thinking Differently?** which will give you some of the basic concepts. Follow this with a quick read of the introductory pages of the three sections that describe the overall process:

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- **Stop Before You Start**
- **Generating Lots of Ideas**
- **Selecting and Testing Ideas to Make a Difference**

With this small investment of about 15-20 minutes you will get a good overview and can decide for yourself about whether to invest more of your time.

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You should then let your learning style dictate next steps. ***If you learn well through examples***, you might want to read the section on **case studies**. Use these as a starting point from which you can go back and read the details of the specific tools used in each case.

If, however, you are more of a "learn by doing" person, identify a current problem or challenge that you'd like to think differently about and dive directly into the tools. Quickly skim the first few paragraphs for each tool in a section and select one that seems like it might help with your issue. Assemble a small group of colleagues or friends, or simply work on your own, to follow the directions given and see where it takes you. Don't be discouraged if the first tool you select doesn't seem to give you any new insights; simply select a different one and give it another go. The only strong advice that we would give you here is that you follow the three-phase process in sequence, as described in the tools section of this guide. Specifically, resist the urge to jump right into **Generating Lots of Ideas** (phase 2) before you *first,* **Stop Before You Start** (phase 1)… and resist the urge to jump prematurely to **Selecting and Testing Ideas to Make a Difference** (phase 3) before you have *generated lots of ideas*.

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If your primary job role involves service improvement, you might want to read the **appendix: Linking Thinking Differently Tools to Improvement Work** early on in your exploration of this guide. If this is not your main job role, consider this section optional reading.

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Finally, if you are the sort of person who wants to learn in more depth, you'll find some recommendations to start you on a learning journey on the subject in the **appendix: References for Further Study**.

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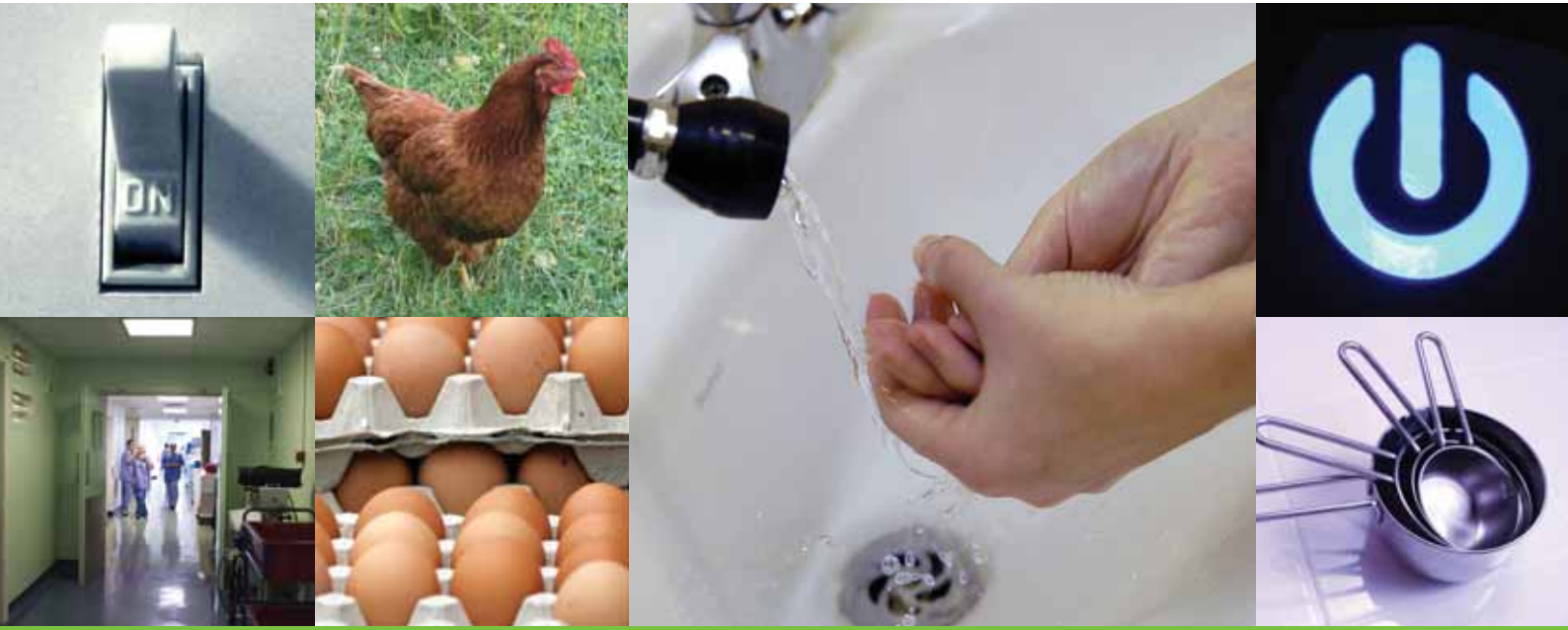
I can't understand why people are frightened by new ideas I'm frightened of the old ones.

John Cage

The only limits to our realisation of tomorrow will be our doubts of today.

Franklin D Roosevelt



Thinking Differently? Why should I?

You are a busy, hard-working staff member, clinician, manager, or leader. You may sometimes wonder if you have time to think at all. Now, along comes this guide encouraging you to **think differently**. Isn't this just the latest set of buzzwords; yet another fad?

We don't think so.

Those who have dared to think differently have changed the face of many industries, and society in general.

- Thomas Edison thought that the streets of New York could be lit at night by electricity, but he had to persevere against tremendous opposition (including attacks on his character and death threats) from the then thriving gaslight industry.
- Watson and Crick won a Nobel prize for being able to think differently, in three dimensions instead of the two dimensions of traditional chemistry, about bonding structures in DNA.
- A development team at CitiBank thought differently about bank buildings and queues at the teller window and hit upon the idea of the now ubiquitous Automatic Teller Machine (ATM).
- The innovators who have started various low-cost airlines in the US and Europe (e.g., easyJet) re-thought service delivery in that industry and have made travel accessible to significantly more people.

Apple, one of the most innovative companies in the world, has virtually made a brand out of thinking differently. They have transformed themselves from a computer hardware company to a service business that has challenged nearly everything we ever thought about how music is distributed. Forget record stores, cassette tapes, and even CDs... where is your iPod and broadband connection?

Now that's thinking differently!

It was also **thinking differently** that gave birth to the NHS nearly 60 years ago. Thinking differently led to the creation of NHS Direct, increasing access to care for millions of people. Thinking differently led to the transition from traditional surgical methods to keyhole surgery, dramatically reducing lengths of stay and discomfort for patients. Thinking differently freed engineers from the concept that a telephone needed a wire, giving birth to the mobile phone and a host of subsequent wireless products that are now routinely used within the health service. Numerous other innovations from private sector industries such as pharmaceuticals, diagnostic equipment, and IT, have also led to significant improvements in healthcare.

Equally important, at the front line of care, is the fact that every day some members of NHS staff take the opportunity to think differently about their work. For example, a receptionist in a GP surgery notes that patients sometimes do not turn up for appointments and wonders if sending text message reminders would help. She finds that it does indeed help as several patients tell her that they were both surprised and grateful for the reminder. After a search on the internet and a conversation with a mobile phone provider, she learns that there is software that can link to the practice's appointment calendar on her PC and send out the text messages automatically. She has simultaneously helped reduce the Do Not Attend (DNA) rate, reduced her workload, and pleasantly surprised the patients! Often, when we think differently, everyone wins.

In every era, those who have cared passionately for the ideals of the NHS have seen the need to think differently to meet the challenges of an ever-changing environment. Today is no different.

The recent reforms in the health service have given us different structures and different points of focus that we need in order to thrive in the new world. For example, NHS teams are striving to change services in order to reduce or eliminate unnecessary waits and delays, provide care in the most appropriate place for the patient, reduce waste and increase safety. However, it is thinking differently - the necessary prerequisite for doing differently - that will, in the end, determine whether these reforms actually make a difference for patients and the public. If we - the staff, clinicians, managers and leaders within the NHS - continue to think as we have always thought, we are likely to get the same results we have had before, regardless of the new structures and priorities that surround us.

NHS Reform is creating a different world which is more about prevention than delivery, where patients drive their own care, and services are delivered closer to home. In this brave new world, Thinking Differently will be a core capability of every NHS leader.

Helen Bevan, Director of Service Transformation, NHS Institute for Innovation & Improvement

Thinking differently is the only real and sustainable bridge to get us from where we are now, to where we would like to be.

Further, it is the extent to which we are willing to think differently that determines how great a difference we can really make. We can make incremental improvements, which of course are good, but if we stand back and challenge more deeply how we do things, the gains could be much larger in terms of effectiveness and efficiency.

For example...

Receptionists in GP surgeries have been booking appointments over the telephone for years. But are there ways, other than the telephone, to interact with patients?

A Surgery in Cheltenham already has the facility to allow patients to book appointments via a website. Now, it is making the most of new technology by giving patients the opportunity to book GP and phlebotomist appointments through their TV set. The facility is available through the local authority microsite, which provides interactive public services on digital television. This service can be accessed via SKY, NTL, Telewest, Netgem (Freeview), Kiosk and also on mobile phones.

> *'We currently have over 750 patients who book appointments online and patients have commented on how much they like it and that it is easier than making a telephone call. We hope that this new facility, (booking appointments through the TV set) will benefit those who have not got ready access to a computer at home.'*
> Dr Martin Nicholas, GP.

Now that is thinking differently!

And now that we have stretched our thinking to include interactive TV as a potential tool in care delivery, how else might we use it? For example, could we more effectively and efficiently provide patient and carer education for chronic conditions? Could patients complete evidence-based assessment questionnaires before they even book an appointment, thereby perhaps reducing some unnecessary visits? There are lots of possibilities.

Thinking differently to use new technology such as interactive television to change care processes… It's so obvious… in hindsight. Good ideas are always obvious, after someone thinks of them. Before that happens, we are stuck with our thinking… just doing what we have always done and getting the same results we have had before.

Reflecting on the example above, and all the examples from other industries, raises the question: *how many more possibilities for thinking differently might there be in health care?*

Using the approaches outlined in this guide, NHS teams are beginning to realise that if they fundamentally rethink pathways of care and service delivery methods, they could provide access and diagnosis in a matter of days for many conditions. We should not see the current 18-week target[1] (Department of Health 2006) as a constraint; rather we should set our improvement ambitions higher. For example, practice-based commissioning teams are realising that if they commission voluntary sector organisations and local handymen to improve safety in the home for the vulnerable elderly, they might reduce the likelihood of falls and save millions of pounds as well as improve quality of life for those people. Front-line staff and teams are finding many ways to make work life better and safer while improving care for patients by simply asking, "Why do we do it this way?" and not accepting "Because we have always done it that way!" as an answer.

[1] For examples of how to use Thinking Differently tools to help achieve 18 week target, see www.institute.nhs.uk/nodelaysachiever and go to section: An Overview of Creativity Tools

As the NHS evolves and changes to face the new realities of the 21st century, it puts stresses and strains on our staff. But it's good to know that many of our health professionals will walk that extra mile to achieve their dreams.

David Peat, CEO, East Lancashire PCT

Leisurely Health in a One Stop Shop!

Get your dental check-up, see a demonstration of the latest home aids for your arthritis, make an appointment to quit smoking, take your prescribed exercise class in a dance studio... and then relax in the pool!

A vision to provide Burnley residents with better access to healthcare services while simultaneously encouraging a more healthy lifestyle has become reality with the opening of a state-of-the-art facility in the centre of the town. The new centre is the result of an innovative partnership between the PCT, local council, resident and patient groups, a construction firm and Sport England.

A comprehensive range of medical services – including some previously provided in hospital – shares accommodation (and even staff!) with a new sports and leisure facility, thereby switching the focus of care from sickness to health and wellbeing.

No More Blushes...

Too shy to face your GP or your local GUM clinic? Log on to DrThom.com!

DrThom.com, founded by a doctor specialising in sexual health who realised that traditional clinics don't suit everyone, is a new service that uses the internet, post and telephone in care delivery.

The web based service aims to make it easy for people to get information, testing, and treatment without the embarrassment and inconvenience many people associate with going to a genito-urinary medicine (GUM) clinic or to their GP.

In June 2006, DrThom.com became the first 'online' medical service to register with the Healthcare Commission. All the doctors involved are sexual and/or reproductive specialists.

The website provides information and advice on a range of conditions. You can also order tests, post onto a message board to share experiences with other patients, obtain contact details for NHS and private clinics, and even receive anatomy lessons!

Tests, treatments and emergency contraception are dispatched by post, and consultation and counselling are also available by email or phone. Treatment is even available in some cases without the need to see anyone face-to-face.

Now that's thinking differently!

Thinking differently has contributed enormously to the success of our trust over the last few years. The techniques have helped unblock barriers and, as importantly, the approach has supported our culture of continuous improvement. It has also been hugely rewarding for staff as well as patients.

Stephen Ramsden, CEO Luton & Dunstable NHS Foundation Trust

So, **thinking differently** is here to stay. It is both an immediate and an on-going need. Further, it has something for everyone...

- **Thinking differently** can help clinical staff focus on the most rewarding work of patient care.
- **Thinking differently** can help the busy chief executive and finance director support better services and achieve financial and service targets.
- **Thinking differently** can help reduce the stresses of daily work for NHS staff, while actually improving the care they deliver.
- **Thinking differently** can bring more energy and satisfaction in work.
- **Thinking differently** can mean better care and greater well being for patients, carers and members of the public.

Why would you want to just keep thinking the way you always have?

Everyone thinks of changing the world, but no one thinks of challenging himself.

Leo Tolstoi

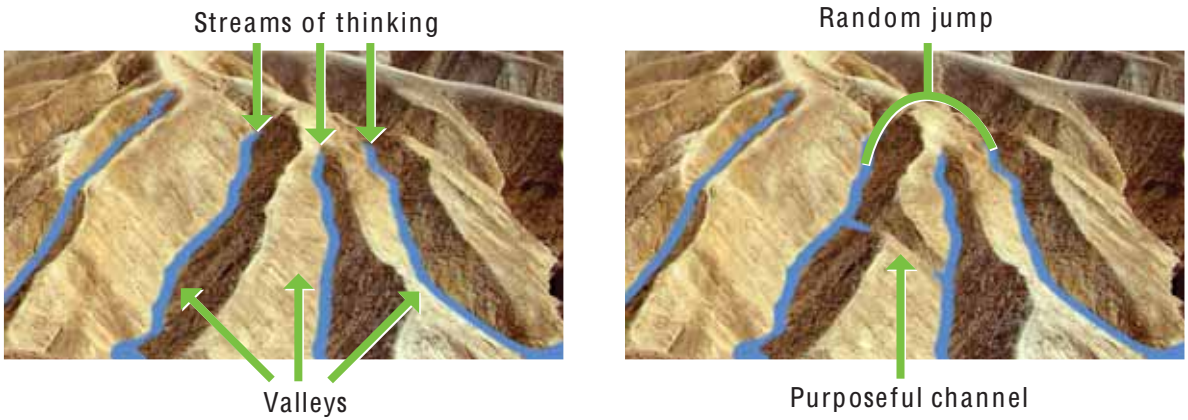
What's Involved in Thinking Differently?

Before you can effectively use the tools we describe in this guide, it is important to understand some basic concepts behind both usual thinking and thinking differently.

Natural thinking as mental valleys

While there are many complex explanations of how we think, Edward de Bono's simple model of mental valleys and streams of thought provides a good illustration. Hills and valleys in nature organise the rain that falls randomly over an area into flowing streams. In a similar way, the mind organises words and phrases - "language" - into streams of thought.

Edward de Bono's Mental Valleys Model for Thinking



The terms *mental models, assumptions, paradigms, simple rules, the way we do things, mental boxes,* and similar words and phrases are roughly equivalent to what we are calling a mental valley.

As we learn the language of the world we live and work in, a metaphorical valley is created in the mind to hold concepts that tend to flow together in our thinking. For example, in the mental valley of "A&E" we hold and link together the concepts of a physical space... with a car park and separate ambulance bays... with a main entrance and reception desk where you must register... with waiting areas... with examination rooms ... where the nurse does an initial triage and tells you that the doctor will see you later... etc. We have learned that all of these concepts naturally go together. They flow in what we sometimes call a stream of thought. That is just the way it is; it is the "usual" way to think about A&E. Simply saying "A&E" naturally puts us in this mental valley and activates the stream of thought. The same thing happens when we think of a "GP Surgery", "Patient", "Medical Record" or any other of the many words that are common in the language of health care.

We spend most of our time thinking as we have been taught to think. The mental valley is comfortable. It is also very efficient in that all one has to say is "A&E" and all these other thoughts just come streaming along. There is nothing wrong with that. That is, there is nothing wrong until we need to think differently.

We might ask for new ideas for A&E redesign, but if everyone remains in the usual valley of "A&E" all we are likely to get are slight variations on existing themes (for example, "let's put a television and drinks machine in the waiting area").

Thinking differently is about making "***creative connections***". It involves challenging, connecting and rearranging information in our mental valleys. We might challenge the usual stream of thought that uses reception and triage as control gates before gaining access to a doctor, and simply have a process where a doctor sees everyone who comes into A&E immediately, in order to begin the process of care. We might connect to the valley of "fast food restaurants" and rearrange our thinking by borrowing the idea of a drive-through window as a way to provide some hospital services. Or we might imagine some sort of hand-held GPS device to guide patients through our physical space because someone has suggested that we think for a moment about the randomly selected word "automobile".

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Benchmarking: **108**

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Picture or Object: **86**

Note that laughter is a natural physiological reaction to a novel connection in the mind.
In fact, someone initially laughing at an idea is often a good signal that it is, indeed, creative!

The difference between first-order and second-order change

Another set of terms that you may hear is first-order and second-order change. First-order change occurs when we make an improvement, but stay firmly within, the current mental valley; for example, a voluntary worker to greet patients in the A&E waiting area or reducing the time it takes to register at the reception. There is nothing wrong with that; first-order change is good.

Having a doctor as the first person you see when you come to the A&E, providing some hospital services via a drive-through window, or providing patients with a hand-held navigation device instead of relying on signage, are examples of fundamentally different approaches: second-order change. In general, second-order change often has more impact, creates more satisfaction, and has more beneficial effects than first-order change.

	First-order change	Second-order change
Underlying mental model	Unaltered	Altered
Specific way we do something	Changed	Changed
Relationship to improvement	Predominent current approach to improvement	Enhanced approach; thinking differently to make things even better
Example	Counsel high-risk patients on complex medication regimens on the importance of remembering to take their tablets correctly	Work with specialist pharmacy to create individualised multi-dose calendar packs for high-risk patients

Thinking differently requires: Attention, Escape and Movement

In his book *Creativity, Innovation and Quality*, Paul Plsek notes that the process of rising out of and exploring mental valleys to get more ideas for second-order change relies on three deliberate mental activities: Attention, Escape, and Movement. Thinking differently involves managing these three mental processes.

Attention - When you take the time to list some of the current mental valleys, assumptions or simple rules in the system, you are practicing mental attention. *("Patients who come to A&E must first report to reception").* Attention involves looking closely, observing with fresh perspective, and really noticing things.

Escape - When you challenge or block an existing rule, you are encouraging escape from the current mental valley. *("The government has made it illegal to have a receptionist and desk in the A&E!").* We often describe this as "blue sky thinking" or "thinking outside the box" that purposefully moves away from the existing situation.

Movement - When you then play imaginatively with this suggestion and generate several ideas from it without judgement or criticism, you are encouraging mental movement. *("Let's try to generate at least seven ideas for ways to manage patient arrivals in the A&E without a receptionist and a desk")* Mental movement is free association that is just allowed to flow in any direction it wishes without constraints for the moment.

While usual thinking involves mental movement, it rarely takes the time to pay explicit attention to underlying assumptions, and rarely challenges "the way we do things around here" or escapes from the comfortable mental valley. You will notice that all of the tools for thinking differently that we present in this guide involve some combination of these three mental activities.

Thinking is of better quality when we put some structure around it

Often, our mind becomes a jumble as we try to think, particularly when we try to think differently. We are trying to come up with new ideas and we can see some benefits from that... but there is also the downside and risk... and we wonder if there is any data or experience to support the idea... and perhaps we feel that this is scary, and we each wonder what others will think of us... and so on.

This jumble occurs whether we are thinking alone or in a group. Some people are their own worst critics, while others experience the worst criticism in groups. Some people are naturally positive in their outlook, while others are naturally more negative. Some people are naturally analytical ("The facts are..."), while others are more intuitive ("I feel that...").

When you want to think differently, it helps if you minimise the mental jumble and focus on one aspect of thinking at a time. For example, you might want to loosely structure your individual thinking, or that of a team along the following lines:

- Generate new ideas and possibilities without judgment. **(Imagination)**
- Think first about the positives and benefits of each idea generated or selected for further consideration. **(Positives)**
- Think about the negatives, risks, and pitfalls. **(Negatives)**
- Review or consider gathering facts, data and information to either support or rule out the ideas. **(Facts)**
- Express feelings and intuitions about the ideas. **(Feelings)**

These five aspects are essential to comprehensive thinking. The important point is that it helps to take them one at a time, rather than allowing them to become a jumble.

While this structure may at first seem limiting, it has been shown repeatedly to lead to better thinking - both in individuals, but especially in groups. The structure is formalised in **Edward de Bono's Six Thinking Hats®**[2], a tool that we will describe in a later section.

[2] © The McQuaig Group. For more information contact: www.holstgroup.co.uk

Simple rules for better idea generation

The seemingly paradoxical notion that thinking differently benefits from a little bit of structure applies even to times when we want to be our most free-thinking - during idea generation.

In the 1930s, psychologist J. P. Guilford identified characteristics of individuals and groups that were able to generate the best new ideas. Advertising executive Alex Osborn, in whose industry effective idea generation was particularly important, built on this work and coined the term "brainstorming" to describe the process of deliberate idea generation. Osborn suggested that idea generation sessions would be more successful if everyone agreed to a few simple rules. These have since been restated and enhanced by many others (for example, Tom Kelly, the chief executive of IDEO and author of *The Art of Innovation*) and can be stated as follows:

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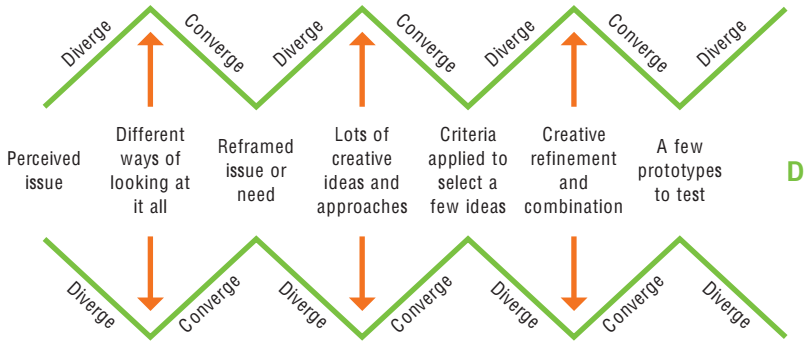
- **Criticism is ruled out** — There are no bad ideas at this point. There will be plenty of time to judge later.
- **Go for quantity** — Don't settle for 3 or 4 ideas; aim for 10-20.
- **Encourage wild ideas** — It's the wild ideas that often provide the breakthrough insights. These insights might lead to further ideas that are not so far fetched.
- **Build on the ideas of others** — What can you add? What else? What other ideas does it bring to mind?
- **One conversation at a time** — This way all ideas can be heard and built upon.

Cycles of divergent and convergent thinking

A final important concept for thinking differently is another one of J. P. Guilford's insights involving the importance of deliberately alternating between divergent and convergent thinking.

- **Divergent Thinking:** Expanding the list of possibilities; purposefully looking for more, or looking at the issue from a variety of directions. Divergent thinking stresses quantity of thought, imagination, long lists, and many different ways. Divergent thinking is necessary in order to challenge "the way we have always done it". The downside of divergent thinking is that it can go on forever and we end up with lots of new ideas but never actually do anything about them.

- **Convergent Thinking:** Reducing the list of possibilities; purposefully looking to condense, summarise, focus or select. Convergent thinking stresses quality of thought, good judgment, short lists, and a few selected ways. Convergent thinking is a necessary prerequisite to action, and without action ideas are not valuable. The downside of convergent thinking is that we might miss a possibility, or prematurely discard one and end up being very focused on an idea, but not on the best one.



Divergence / Convergence cycles

You may know individuals who tend to favour one mode over the other, or you may work in an organisational culture that tends to emphasise one over the other. For example, some people are naturally full of ideas when faced with challenges and offer lots of alternatives (divergent thinkers), while others prefer to select a single idea and start to work on it (convergent thinkers). However, cycling between **both** divergent and convergent thinking is more effective when we want to think differently.

As illustrated in the figure, we might start with a specific issue, but it is useful to spend some time looking at it from a variety of angles. This may bring a new perspective, which leads to a different statement of the issue and a refocus of our work rather than the same old way of looking at it. We might then generate lots of ideas, initially without judgment, but in the end we will need to apply some criteria to select those ideas that we wish to take forward. And so it continues, alternating cycles of divergent and convergent thinking that get the benefits of both while avoiding the pitfalls of either.

Tools Phase 1: 33
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This is a practical guide to thinking differently. It is not our intention to make you an expert on thinking. However, if you keep the few concepts described above in mind, you will have better success in thinking differently and guiding others to do so. From time to time as you use the **tools** described in this guide, return to this section on concepts for a refresher. It will help you understand better what is working and what is not; why it is working and why it is not. If you would like to explore any of the concepts presented here in greater depth, refer to the **appendix, References for Further Study**.

If we can occasionally be prepared to let go of our cherished beliefs about the rules and hierarchies of healthcare we may find there's a better way of doing things. In our case, accepting patients as equal partners in designing services has opened up a repository of knowledge and experience that would not otherwise have been available to us.

John Pickles, Consultant Head & Neck Surgeon, Luton & Dunstable NHS Foundation Trust

Introduction / Concepts Notes

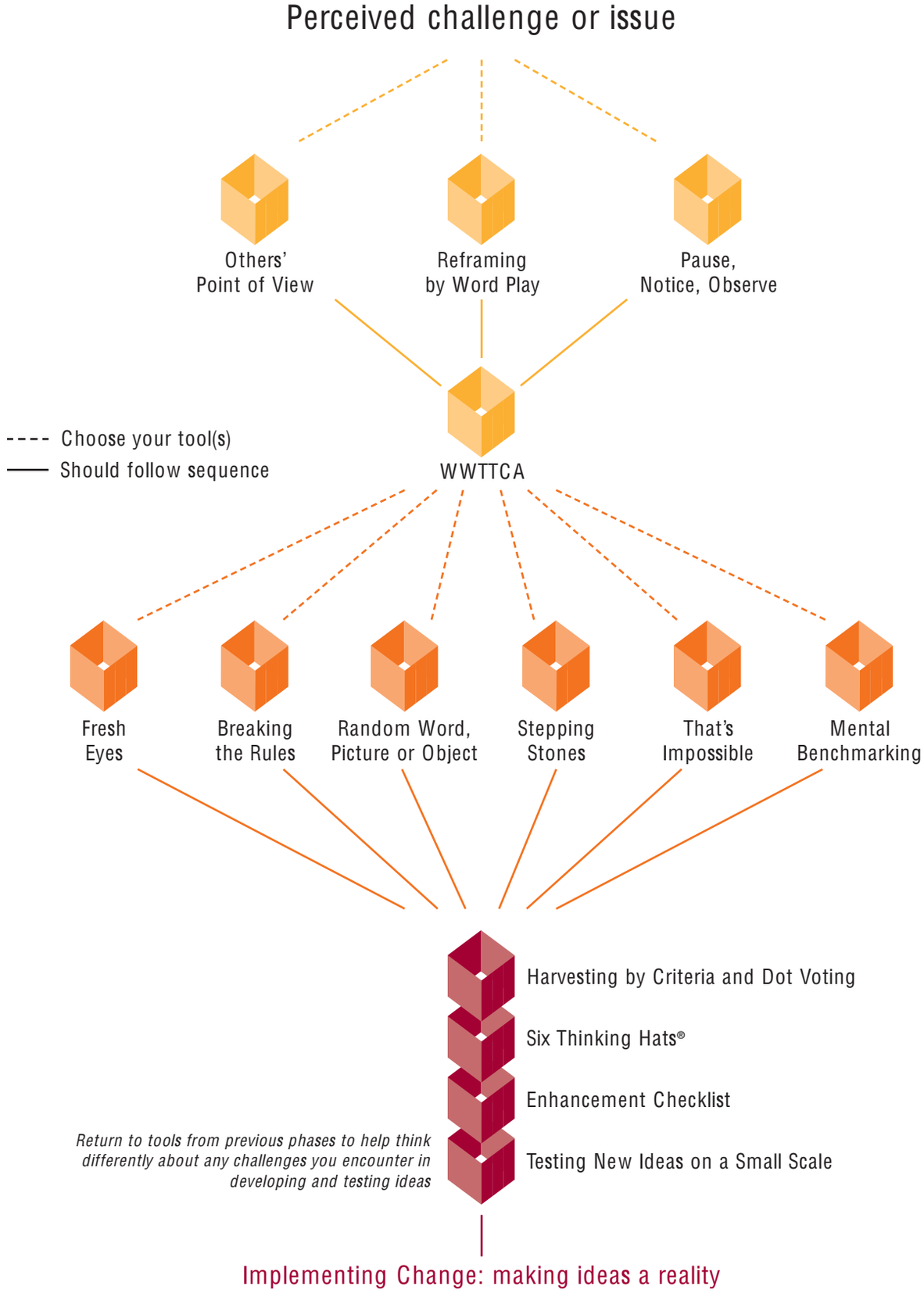
A Process for Thinking Differently

In using the tools for thinking differently, the only strong advice we would give is that you should follow the three-phase process ***in sequence***, as shown in the flowchart below. Specifically, resist the urge to jump right into **Generating Lots of Ideas (phase 2)** before you *first,* **Stop Before You Start (phase 1)** in order to really understand the issue you want to work on… and resist the urge to jump prematurely to **Selecting and Testing Ideas to Make a Difference (phase 3)** before you have actually Generated Lots of Ideas.

The main point is to not race ahead. But, on the other hand, it is fine and quite natural to loop back in the process. For example, after a few rounds of generating lots of ideas, you may want to take a quick step back to the reframing tools in the previous step just to see if you can generate even more ideas. And, you will often find that as you get into testing your ideas you may need to both reframe the issue and generate even more new ideas to meet the challenges that will inevitably arise. If thinking differently were easy then we wouldn't be stuck with some of the problems we are currently facing.

A Process for Thinking Differently

Use this framework to guide you through the ***Thinking Differently*** process from your challenge or issue through to making ideas a reality. Note where you have a choice of tools and techniques ---- and where we recommend you undertake specific actions ——

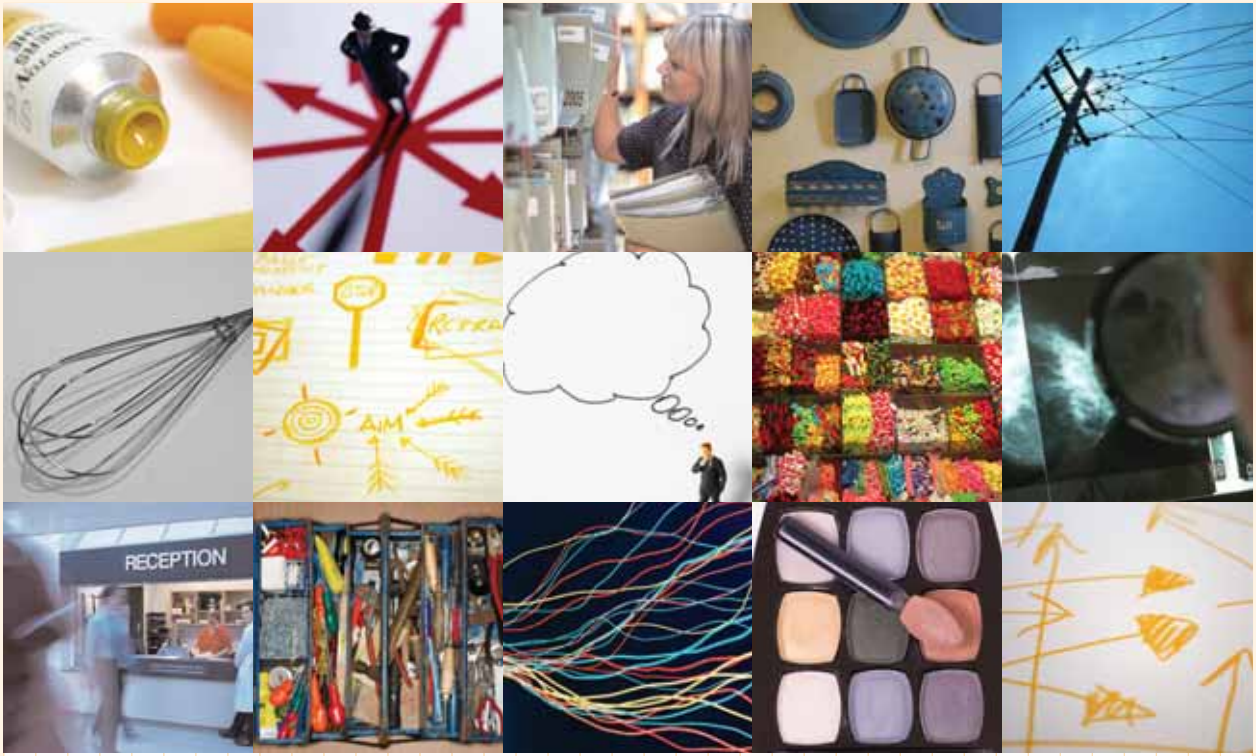


Tools Phase 1

Stop Before You Start

Introduction to Phase 1

- Others' Point of View (OPV)
- Reframing by Word Play
- Pause, Notice, Observe
- WWTTCA (We Want To Think Creatively About...)



An idea is a feat of association.

Robert Frost

Stop Before You Start

The mind is wonderfully efficient. Give it a topic to think about and the mind quickly and effortlessly creates a stream of thought. Try it. Without reading any further, ask your mind to think for a moment about providing access to care in a GP surgery.

See how easy that was? You could easily visualise a typical GP surgery… patients coming through the door… being greeted by reception staff… giving their name and what they are there for… being invited to take a seat in the waiting area with other patients who are also waiting… and so on. This stream of thought is activated by the words *"providing access to care in a GP surgery"* - it is simply what we usually mean when we say or think those words.

If we asked you now to come up with ideas to improve patient access and experience of care in a GP Surgery, your mind would similarly rise to the occasion. You could easily think of ways for improving the receptionist's greeting, changing the layout of the waiting area to increase comfort and privacy, reducing the wait before being called to see the doctor, and so on. These would all be very good things to do.

Your mind has no problem at all thinking about the current system and how to improve it. Simply saying, "Let's come up with ideas to improve patient access and experience of care in a GP Surgery" is all that is needed to start the thinking process. The mind is a marvellous thing.

However, if you stop for a moment to reflect, you'll notice that in all those ideas for change, quite a lot remains fundamentally unchanged. There is first order rather than second order change■. Patients must still physically travel to get care at the Surgery. They must first speak to the receptionist, when actually they came to speak to the GP. Even though they might have an appointment at a specific time, they may still have to wait. They cannot go into the doctor's room until their name has been called.

Concepts: 22

At this point, you might protest. *"You asked me to come up with ideas to improve flow and experience in a GP Surgery and all those things you just mentioned are simply part of what a GP Surgery is"*. Of course, that is true. These things are what your mind has been trained to think of when it hears the words *"access to care in a GP Surgery"*. Your mind is simply journeying through its mental valley down the stream of thought on which we set it.

Equally effective is the mind's ability to journey down an entirely different stream of thought when asked to do so. Suppose, for example, that we had stopped and taken the time first to think about what we really mean when we say the word, "care". We might suggest that one aspect of care is giving information to patients, upon request, that is relevant to their health issues. Now, if we ask you to come up with ideas for improving the flow of information to patients about their health issues your mind might journey down an entirely different stream of thinking. The words "flow of information" trigger thoughts about websites, television, IT networks, telephone conversations, or email exchanges.

Think about this... *Maybe some of those patients who have had to travel to come into the surgery, chat to the receptionist, and anxiously wait to hear their name every time the door opens, don't really need to be in the surgery at all. A website, phone call or email would be just as good in meeting their needs. Perhaps these alternatives would be even better for some patients, and have the knock-on effect of improving access and reducing waiting for those who really do need to be seen face-to-face.*

Think about this... *If what we mean when we say that we will "see" a patient is literally that all we really need to do is to see them or see a test result, then perhaps setting up video and telemetry links from a rural village to a GP in the town would result in just as good care. It would also reduce unnecessary travel for both patients and doctors.*

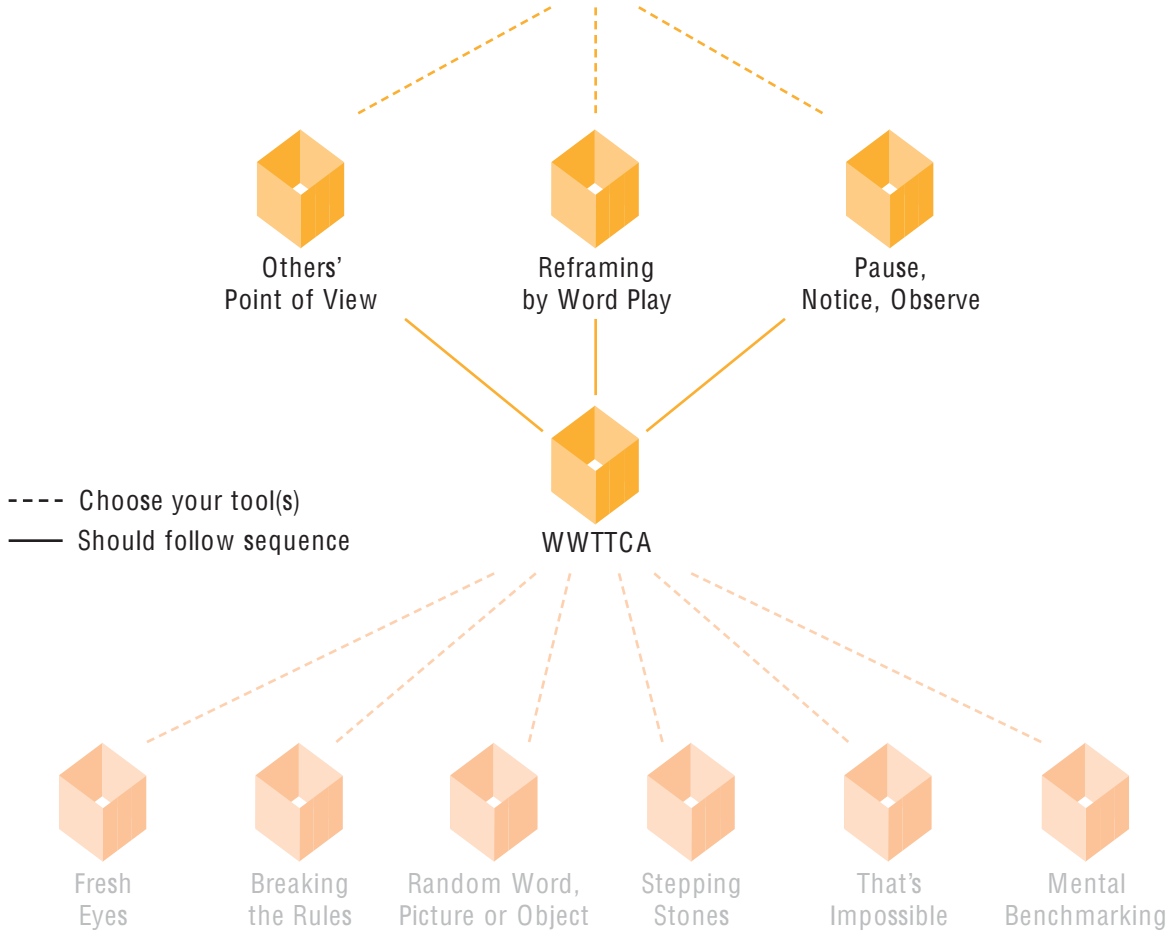
Now that is thinking differently!

The examples above are what cognitive scientists - people who do research on the mind and thinking - would call "reframing". By describing the issue or challenge in a different way than normal, different ideas naturally emerge. This of course also means that describing (or "framing") the issue in the usual way naturally leads to the same ideas that we have already had before.

That is not to say that there is necessarily anything wrong with the ideas we have already had before. They may well improve things. However, when you are struggling to achieve financial balance and meet targets; when you are already working as hard as you can and it still doesn't seem to be good enough; when patients, politicians, and the public are asking for more... only making things a bit better might not be enough. By thinking differently you can create many more opportunities to achieve significantly better health care and more efficient use of resources.

Learning to think differently must therefore begin before you start thinking too much. Our advice is: *first*, **stop before you start**. That pause before rushing ahead to generate ideas is about paying attention to how you are framing the issue, and considering ways to reframe it so that you can think differently. It is about finding different words and images to have in mind as the building blocks and triggers for your ideas. The tools we describe for this first phase will help you to do this.

Perceived challenge or issue



Starting to think in the usual way is the quickest and surest way to generate a list of the same ideas you have had before. Stopping before you start - in order to rethink and potentially reframe the issues at hand - is the quickest and surest way to generate *new* ideas.

Don't be afraid of new ideas. Be afraid of old ideas. They keep you where you are and stop you from growing and moving forward. Concentrate on where you want to go, not on what you fear.

Anthony Robbins

Tool: **Others' Point of View (OPV)**

Synopsis

Before you simply dive into an issue from the usual thinking perspective of someone who works within health care, describe the issue, opportunity or theme from a variety of perspectives. How might other people view or describe the situation?

In health care we should always consider:

- Service users
- Families and friends of service users
- Clinicians
- Staff

However, there is no need to limit ourselves to these traditional points of view. To help us think differently, it may also be beneficial to consider what perspective an observer who knows nothing about health care might bring. For example, how might the following describe the issue?

- Manager of a fast food restaurant
- 6-year-old child
- Formula 1 mechanic
- Librarian
- Sales and Marketing representative
- Leisure Centre manager
- Parents of small children
- Airline flight attendant
- Stand-up comedian
- Politician
- Newspaper distributor
- Hotel manager
- Accountant
- Head chef of an organic, vegetarian restaurant

The aim is to generate 5-10 alternative ways of framing the issue, while avoiding getting locked into the usual way we look at it. We are seeking to describe things from many different angles, using different language than what is typical. This is not about trying to find the "right" or "best" way to state the issue. We are simply striving for variety, as this may stimulate a creative connection.

Example

The manager of a mental health service writes the statement '*improve service user satisfaction'* at the top of a sheet of paper. She then works on restating the issues in a more focused way, using the perspectives of service users and their families. Some of this information has been drawn from conversations with clinicians and staff and from complaints and comments received from service users.

The new statements reflect this:

- Access is too difficult
- Medical records are often incomplete or unavailable
- We could be more empathetic to patients
- Family members need emotional support as well

Selecting a few items from the list of more unusual perspectives, the manager wonders what *other* people might say about the mental health service and what language they would use to describe some of the issues…

- **6-year-old child:** *"I'm really frightened."* Hmmm, she wonders… What could we do to explain things better and dispel myths and misconceptions about the service?
- **Stand-up comedian:** *"It's not fun to be here!"* What might we do to make the experience less anxiety-producing? How does what we do and what our users experience either enhance or interrupt their enjoyment of life?
- **Airline flight attendant:** *"What's our destination?"* Do our users and carers really know where our treatment plan is taking them, and is that really where they want to go?

After filling a page with statements that help reframe the issues, she realises that she can use some of these later with her team to help generate new ideas. For example, she might ask for creative thinking about "fright"… or explore what feelings and life needs (beside fun) are impacted by mental health treatment and ask for creative ideas about minimising or avoiding this… or focus on creative ways to help people improve goal-setting or to better understand the expected course of their condition and treatment.

While it is, of course, important to address basic issues such as access, medical records, empathy and emotional support, many of the answers to these challenges can probably be found in good practice already used elsewhere in the NHS. However, in addition, by thinking differently, this team now has the opportunity to make their service and care even better. We need both to improve our usual thinking and to think differently. **Better usual thinking helps set the minimum standard; thinking differently helps us stretch beyond that.**

The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it.

Michelangelo

When might I use this tool?

This is a good tool to use very early on in the process. It is simple to explain and use and it immediately stretches people's thinking outside the norm.

How do I use this tool?

Tools Phase 2: 70
Fresh Eyes

It's simple really. Prepare a list in advance of "other people" that you will put forward to the group *(see the list above as a starting point; you might also want to read about the related tool, Fresh Eyes)*. Suggest someone (e.g., a service user, a man from Mars) and ask for thoughts from the group as to how that person might describe some of the issues in the service, process, or topic area on which you want to focus. Ask team members to express things in the language of that person: how would they say it?

Tools Phase 2: 63
Introduction

After some time **brainstorming** (divergent thinking), you may need to review the ideas to clarify or remove any duplicates. Then, as a group, select 5-10 statements that cover the range of things you might want to explore more creatively when you move on to idea generation. You might do this through simple discussion or voting.

Tools Phase 3: 120
Dot voting

Did You Know?

OPV is one of a collection of three-letter abbreviation tools developed by Edward de Bono as part of his CoRT Thinking Programme. (Ref: de Bono E. de Bono's Thinking Course. London: BBC Books, 1982. CoRT stands for Cognitive Research Trust.) The CoRT programme is taught in schools around the world to students from children to adults.

Tips

- Spend about 20-30 minutes on this tool. Take 3-5 minutes per "other view point" and you might do 6-8 rounds of this in that time.
- Keep up a good pace. Try to avoid long explanations or problem solving at this stage; we are just seeking a variety of ways to restate and reframe some of the issues here.
- Start with something easy and obvious, such as the patient's point of view; but then intersperse some more "wacky" perspectives (e.g., comedian) as you go along. Alternating between usual and unusual points of view helps to free up thinking on the usual ones.
- If you see that team members are struggling with "why are we doing this?" take one of the more unusual examples and explain how you might use them later in idea generation, as illustrated in the examples above.
- While you do not want to get into full idea generation at this point, you also don't want to dampen spirits or lose an idea if it comes up. Have a flip chart sheet available as a "car park for creative ideas".




Tool: **Reframing by Word Play**

Synopsis

Take existing statements of the problem, issue or opportunity that you want to work on and substitute synonyms and other words or phrases. These must communicate the same thing, but in plain language, without all the jargon. The goal is to stimulate non-traditional or unusual thinking.

What on earth are you talking about?!?

Words are the shorthand we use to signify our mental valleys. If I say, "I want to design a new GP surgery" you will be tempted to go immediately to the mental valley of "GP surgery" and begin imagining a building, with a car park, a reception desk, a waiting area, and so on. In this way, my new GP surgery will end up looking very much like all other GP surgeries. Not very creative!

What if I played around with the words "GP surgery" and said instead "I want to design a new way for people to get information that will help them stay healthy". Images of Internet computers, a book kiosk, or a new television show more easily spring to mind. Now, that might be thinking differently!

Example

'Access' could be reframed as - "getting people with health needs (patients) together with those who can help (providers)."
'Medical record' could be reframed as - "specific information about individuals' health history and needs."

Statement before: "We want to improve access to care!"
New, more stimulating statement: "We want to think creatively about ways to link up people who have questions about their health with people and resources who might provide answers."

Statement before: "We want to move to a patient-held medical record... but every time we try to talk about this, we get into endless discussions about the practical problems associated with having patients carrying around large folders with their information in it."
New, more stimulating statements: "We want to think creatively about ways in which members of public could better provide certain specific information about their health history and needs when required."
Or "We want to think creatively about how certain bits of information about patients' health history and needs could be instantly available when required."

When might I use this tool?

After you have identified the list of issues to work on. This might be a result of using some of the other tools in phase one: **Stop Before you Start**, or could be your original list of issues. This tool is really helpful in creating simple statements and in identifying very specific areas to work on. A signal that this tool might be useful is the presence of "jargon" or over-used terms (e.g., *access, secondary care*, etc.) in your initial statement of your issue.

How do I use this tool?

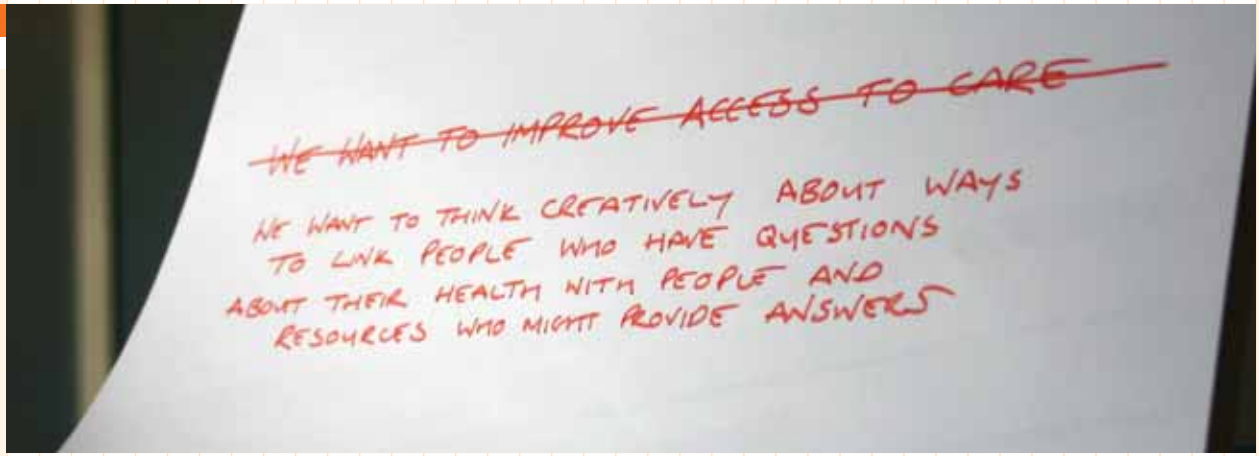
Begin with your list of previously generated statements of the issue that you wish to address. Either in discussion with your team, or alone, pick out health care jargon or over-used words and phrases.

Ask the group:

- "Please tell me what that means in plain English."
- "What other words and phrases might we substitute for that?"
- "What words might someone else use to describe what you mean by that word or phrase?" *(Maybe suggest some "other" perspectives they might use).*

Tools Phase 1: **40**
Others Point of View

Tools Phase 2: **70**
Fresh Eyes



Capture these alternative words and phrases to feed into statements in the form of "We want to think creatively about..."

Tools Phase 1: **58**
WWTTCA

Tips

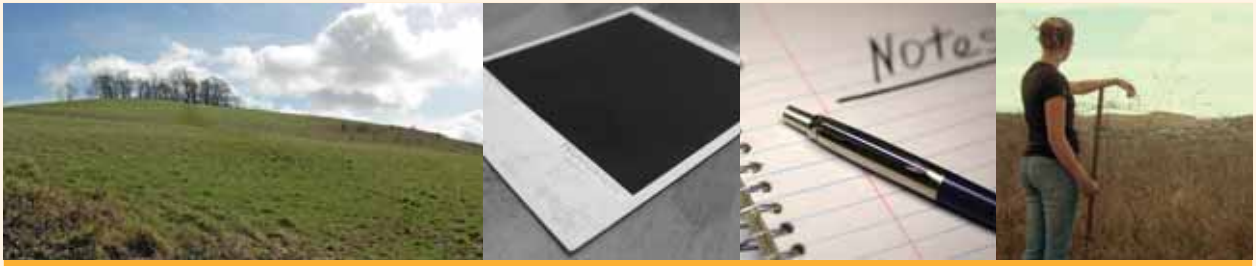
- You may need to be (playfully) hard on the group to get them out of the jargon that they are so used to using. You might:
  - Claim to be a man from Mars with only basic knowledge of English.
  - Ask them if their grandmother or a small child would know what that word or phrase meant.
  - Hand someone the flip chart pen and ask them to capture the group's alternative statements. Walk away from the group, but then come back periodically and circle new jargon or over-used words that have appeared in their restatements and ask again "What does that mean in plain English?"

Concepts: 20

- It helps if you have previously explained the concept of mental valleys.

- It also helps if team members can see where this is leading; that you are not just trying to be difficult. Use the examples above, or ones from other teams that you have worked with, to illustrate how this rewording might lead to the eventual end product of some really unique ideas and approaches to the issue.

- While you do not want to get into full idea generation at this point, you also don't want to dampen spirits or lose an idea if it comes up. Have a flip chart sheet available as a "car park for creative ideas".



Tool: **Pause, Notice, Observe**

Synopsis

Studies of highly creative people indicate that one of the things that they habitually do is pause, notice and observe. While the rest of us pay somewhat limited attention to what goes on outside our immediate sphere of interest, creative people notice more and are relentlessly curious. Taking the time to pause, notice and observe helps provide us with both understanding and inspiration; and we have more to bring to idea generation sessions.

Curiosity may have killed the cat, but where human beings are concerned, the only thing a healthy curiosity can kill is ignorance.

Harry Lorayn

Approach 1:

Randomly pause, notice and observe to store up concepts for later use

George de Mestral, the inventor of Velcro™, got the idea for the fastener by pausing, noticing and observing the cockleburs that stuck to his trouser leg during a walk in the woods. Millions of people before him had experienced the frustration of cockleburs, but de Mestral was the first to study the mechanism by which they clung so tightly to everything and wonder how that mechanism might be used productively. He wasn't really looking for ideas for a better fastener, but once he looked at the cockleburs under a microscope he could see how a new type of fastener was possible - and Velcro was the result!

We encourage you to practice similar curiosity as you go about your daily life. For example…

- *As you do your shopping, or when you travel through airports and hotels, pay attention to how you and others find your way around, how you gather information, what constitutes good and bad service, and so on.*
- *Take the time to chat to staff in shops, managers, airline flight attendants, taxi drivers, and others to understand how they do their work and, most importantly, how they think about things.*
- *Read magazines and books on topics outside your professional field.*

You don't have to be looking for anything in particular. Just notice and store it away in your mind. Someday you may find yourself using that information to help you reframe and think differently about some issue in your own work.

Approach 2:

Purposefully pause, notice and observe for a given topic

1. Begin by taking the issue that you are facing and restating it in more general terms. The Reframing by Word Play tool might be helpful for doing this, or it may be obvious enough to simply describe. For example...
   The manager of a pathology department wanted to decrease waiting time for patients who needed a diagnostic test. Data collection and conversations with staff revealed that the longest waits occurred when the waiting room was filled with patients and the two phlebotomists on duty, despite their best efforts, were unable to keep up with the workload in taking blood samples. Recruiting additional phlebotomists was out of the question given budget constraints, and the manager could not see any obvious ways that the two phlebotomists could speed up their work without risking harm to patients. His statement of the issue about which he wanted to think differently was: "How can we better handle times of peak demand?"

2. List other organisations or other contexts in which people face the same, or a very similar, issues.
   A quick hallway conversation with a couple of colleagues on this topic resulted in the following list of similar settings where systems have to handle times of peak demand:
   - *A sporting event*
   - *The city streets at rush hour*
   - *Airports at certain hours of the days, or on holiday periods*
   - *Supermarkets.*

3. Think about - or better yet, go out and observe for yourself - how others deal with issues that are similar to yours. While you do this be especially attentive to new insights and different ways of thinking.

The three colleagues agreed that, actually, the first three settings on their list did not handle peak demand all that well, or in the case of sporting events and airports, peak demands were handled simply by having more staff on duty to meet the demand.

However, the thought of the supermarket was useful. Someone pointed out that a certain supermarket in town advertised a policy saying it would open a new check out if there were more than 4 customers waiting in existing lanes. They agreed that it would be good to understand better how that system worked. Importantly, where do the extra check out staff come from (noting that supermarkets operate on very small profit margins and have to watch costs closely)?

On the way home, the pathology manager stopped in to this supermarket to observe. As the queues grew, an announcement came on the overhead pager calling for more check out staff to come up front. The manager noted that the fruit and vegetable manager and the meat department manager both came out to open a new lane. The key insight was that senior staff within the supermarket took on new roles, typically undertaken by more junior staff, as needed to help manage the times of peak demand.

4. Think about how you could apply those new insights or ideas to your own setting.

The pathology manager took this idea back to his department to work on with staff. Now, when the waiting room fills with patients, appropriately skilled individuals leave their usual posts and help the phlebotomists take blood samples. When the demand reduces everyone returns to their usual role.

You might say that this seems rather obvious and simple. But it was not obvious or simple to the people originally involved who were frustrated by budget constraints that kept them from recruiting more phlebotomists. And, judging from waiting rooms in many hospitals around the world, the idea is not so obvious to others either! It is only obvious when one takes the time to pause, notice and observe. That is thinking differently!

Example

A team at the NHS Institute for Innovation & Improvement used observation extensively while working with hospitals looking for ideas to help reduce infection rates.

They noticed that many gel dispensers were placed on the wall and watched as visitors and staff put down the bags and coats they were carrying, cleaned their hands with the gel and then picked up their belongings off the floor, thus dirtying their hands again before entering the ward.
A simple observation!

The team remedied the problem by placing a table under each gel dispenser on which visitors and staff could place their belongings while washing their hands.
A simple but effective solution!

Tips for gaining better insights from observation

Designers who create highly innovative products, solutions, and physical spaces say that observation is a purposeful skill and art. Observation inspires new ideas and can help to redefine the problem. Observation is a mindset that involves seeing beyond the surface to really understand what is going on and how a system works or fails. It is an attitude of insatiable curiosity. When you are immersed within a system, it can often be impossible to see the blindingly obvious. You need to observe because:

- People do not always do what they say they do.
- People do not always do what they think they do.
- People do not always do what you think they do.
- People cannot always tell you what they need.
- Things are not always what they seem.

(Adapted from IDEO)

If you want a definition of water, don't ask a fish.

Chinese proverb

Observation is about looking within or outside an area of work for ideas and approaches to issues that can be adapted and tested in order to improve the area.

- **Looking within an area** (for example, visiting another GP surgery or Trust to explore "good or leading edge practice") means going and looking at what people actually do in their work environment. This helps to highlight potential issues and challenges that they face. By going and observing closely yourself you might see details, critical to your ability to adapt an idea or approach within your setting, that the good practice site takes for granted and would not have thought to mention.

- **Looking outside an area** (for example, visiting a supermarket or mobile phone manufacturer) may give you even more ideas of things that you may be able to test within your area. Observing outside your usual work area is one of the main ways to help develop really innovative solutions. You may get insights and ideas that help you think about how you can *fundamentally* change a whole system or way of thinking.

Whether observing within or outside the usual setting for your issue, here are some things to keep in mind:

- Keep an open mind and observe without judging. Don't make assumptions about what you see - ask questions to find out what is behind the behaviours you observe.
- Develop a set of questions to help guide your observation and questioning.
- If you are planning to interview people as well as observe them, your questions should let the other person lead the conversation and not be directive.
- Try to get people to share their stories, not just provide answers.
- Taking photos is a really valuable way of remembering things that you have seen, and can give you and your team additional insights once you have reflected on your observations. Be mindful of the usual practices within a setting for getting individual consent when taking photos of people (this is especially important in a health care setting, but is also common courtesy in any setting).
- Sit and watch. Sometimes just sitting and watching what is going on within an environment is a great way of getting new insights that you can then talk about in your other observations.
- Ask others to think aloud. As participants perform a process or execute a specific task, ask them to describe aloud what they are thinking. This helps uncover motivations, concerns, perceptions, and reasoning.
- Learn to say instinctively, "Show me". If you are in the interviewee's environment (and you should be!), ask them to show you the things they interact with (objects, spaces, tools, etc) instead of just talking about them. Ask them to take you on a tour of their environment and capture pictures and notes to jog your memory later.

The important thing is not to stop questioning.
Curiosity has its own reason for existing.

Albert Einstein




Tool: **WWTTCA** - We Want To Think Creatively About...

Synopsis

The previous tools encourage divergent thinking about your issues. Periods of divergent thinking always need to be followed up with a little bit of convergent thinking▪ to assure focus going forward.

A useful way to summarise the group's thinking and to construct your final, reframed statements of the issues on which you wish to focus, is to complete the sentence "**We want to think creatively about...**". WWTTCA is a shorthand way to write this.

Example

- We want to think creatively about ways to link up people who have questions about their health with people and resources who might provide answers.
- We want to think creatively about how to decrease waiting times for diagnostic tests.
- We want to think creatively about ways to provide better emotional support to the patient's family.

How do I use this tool?

Review all the thinking that you have been doing using the other tools in this section. Ask yourself or a group *"which of the statements we have generated seem the most on-target for where we might need to think differently and are the most likely to stimulate new thinking?"*

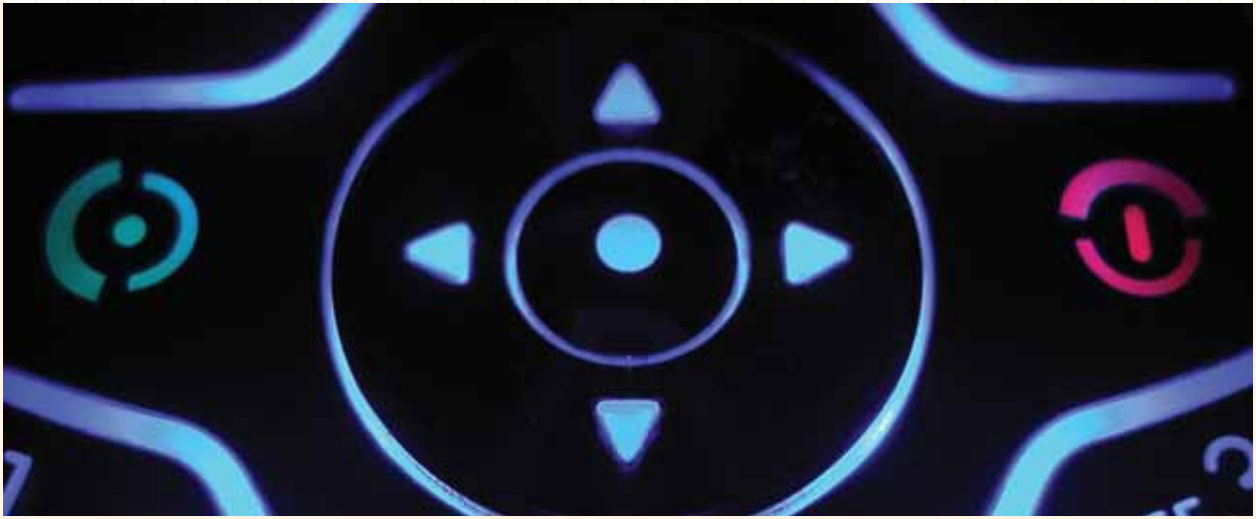
When the group have selected a few statements reconstruct these as a WWTTCA statement.

Generally speaking, 3-7 WWTTCA statements is a good number to end up with. However, there may be times when a single statement really captures it all, or there may be some issues that are so complex that you really need a dozen or more statements to cover them. Use your judgement.

Tips

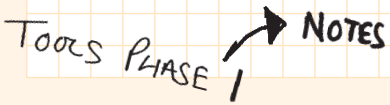
- After all the hard work that you may have done to begin thinking differently, do not allow the group to simply choose the usual, jargon-laden statements. Insist that at least some of the statements that you will carry forward for idea generation are provocative ones.

- This is a good time to pause and think ahead to the eventual effort to actually begin making real changes. If your efforts are accountable to others who will need to be the sponsors or leaders of any change efforts, it might be a good idea to ensure that they are on-board with the statements selected and the implied focus going forward. Alternatively, you might decide that it would be better to wait until you have some concrete new ideas to present to them. Just pause and think about this before you rush ahead.



I find creative thinking tools invaluable both in my own improvement work and when coaching other improvement leaders on their projects. They really help us stretch our thinking.

Liz Carter, Service Improvement Manager, NHS South West



Tools Phase 2

Generating Lots of Ideas

Introduction to Phase 2

- Fresh Eyes
- Breaking the Rules
- Random Word, Picture or Object
- Stepping Stones
- That's Impossible
- Mental Benchmarking

The way to get good ideas is to get lots of ideas and throw the bad ones away.

Linus Pauling, Nobel Prize winning chemist

Introduction

Stopping before you start - the topic of the previous section - helps you see your issue in a new light. This has probably already given you a few new ideas. **That's good!**

Experience has shown, however, that in order to get a few really great ideas, it is often helpful to first generate lots of ideas and then sift out the bad ones. In this section, we will show you some tools to help you and your team come up with lots of ideas. In phase 3, we will show you how to sort through them all in order to take a few promising ideas forward.

First, some general tips and things to keep in mind…

Concepts: 25

1. Use the rules of idea generation

Most people have heard of "brainstorming". The word is generally used as a quick way of saying, "All right then, let's have all your ideas on this issue". But did you know that there were actually rules for a good brainstorming session? These include:

- Criticism is ruled out — There are no bad ideas at this point. There will be plenty of time to judge later.
- Go for quantity — Don't settle for 3 or 4 ideas; aim for 10-20.
- Encourage wild ideas — It's the wild ideas that often provide the breakthrough insights. These insights might lead to further ideas that are not so far fetched.
- Build on the ideas of others — What can you add? What else? What other ideas does it bring to mind?'
- One conversation at a time — That way all ideas can be heard and built upon.

Keep these rules in mind when using any of the Idea Generation tools.

Did You Know?

That advertising executive Alex Osborne coined the term "brainstorming" in 1939.... It means: using the ***brain*** *to* ***storm*** *a problem or challenge... "each stormer audaciously attacking the same objective".*

These rules will actually make your idea generation more productive as they will help protect new ideas (and the people who come up with them) from any initial rejection. Further, they encourage the sort of divergent, imaginative, and supportive thinking that we need when we want to think differently. We recommend that you have these rules up on a flipchart, or make copies of them for everyone to have in front of them, whenever you want to stimulate your colleagues to think differently.

How to '*RUIN*' an Idea Generation session...

- Invite only experts
- Ask the boss to speak first
- Write everything down in great detail
- Ban any silly stuff

A new idea is delicate. It can be killed by a sneer or a yawn. It can be stabbed to death by a joke or worried to death by a frown on the wrong person's brow.

Charles Browder

Concepts: 25

2. Use the three mental activities of Attention, Escape, and Movement

These are the keys to generating lots of ideas. It all ties back to that frequently used phrase to "think outside the box":

- We need to pay **attention** to the ways that we usually thinking about things. You can't think outside the box until you realise that your past thinking might have been constrained within a proverbial box.

- Then we need to **escape** the box. This might come through a deliberate challenge to the underlying concept, assumption, or rule that has now been called to our attention.
  For Example... we might challenge a group to come up with ideas *given the following scenario*: "All GPs have a highly contagious virus and are unable to work directly with patients for the next 6 months... How will we now handle patient flow to specialists?"

  Idea: Develop questionnaires that can be administered over the internet or telephone to screen and refer a percentage of patients with common and easily diagnosed complaints.

  Warning - when ideas are put forward you might find some people immediately jumping in to say that they will not work. For example: "we could not possibly have patients going directly to specialists". At this stage of 'divergent thinking' all ideas should be viewed as good ideas and must be protected. Refer back to the rules of idea generation and remind the team that 'criticism must be ruled out'. Synthesis or selection of ideas is very important, but it is a stage that comes later.

  The above scenario draws attention to the fact that we normally think of the GPs as being naturally part-and-parcel of the process of getting patients to specialists. By saying that they are unavailable to perform this function due to an illness, or anything else beyond our control, we are required to escape that particular mental box to see what new ideas might be generated.

Tools Phase 2: 94
Stepping Stones

Problems cannot be solved by the same level of thinking that created them.

Albert Einstein

- Alternatively, the **escape** might be coupled with the original attention-getting process. **For example...** during a session focused on improving patient flow in A&E, a team is handed a clothing catalogue opened randomly to a page that displays a jacket and asked to use this image to stimulate ideas.

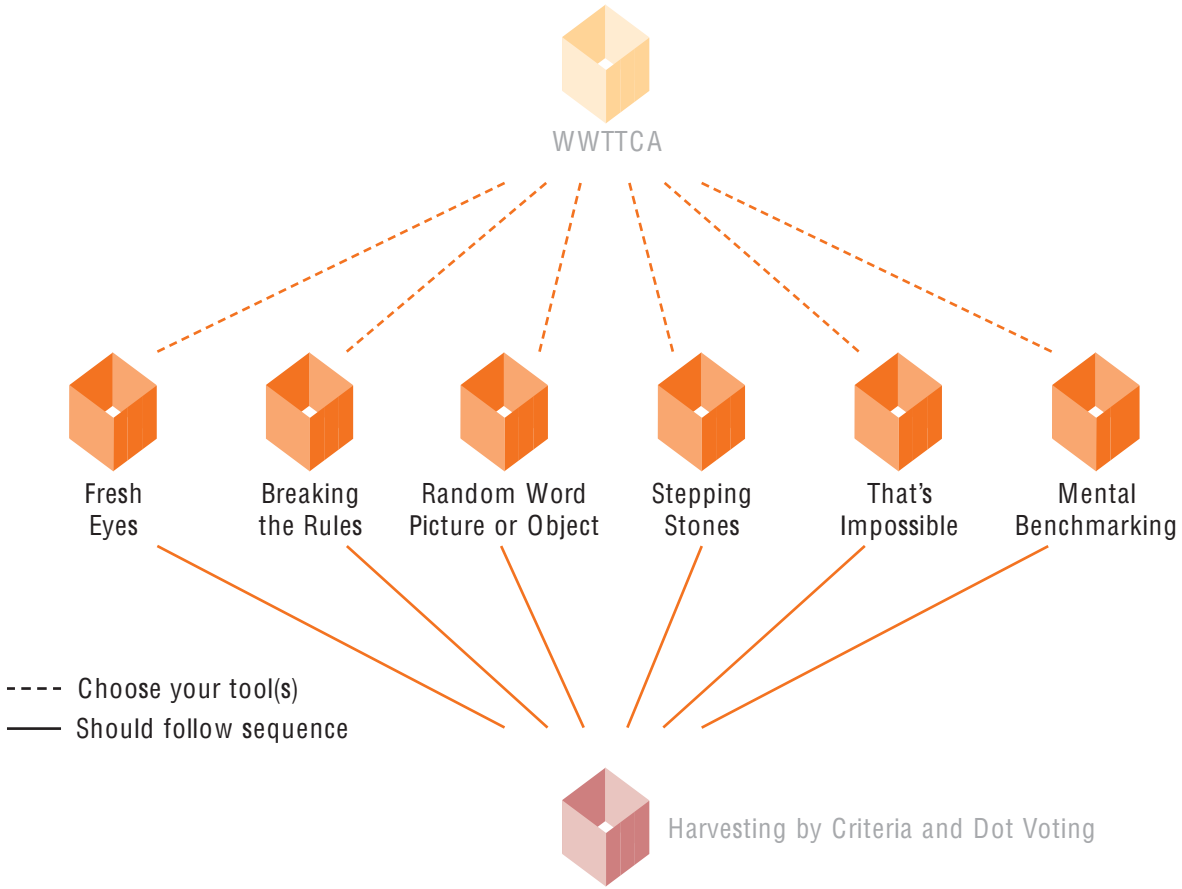
  Idea: Create a jacket with embedded sensors that make taking and monitoring vital signs easy.

- Attention and escape need to be followed up by mental **movement**, letting the mind run free, without self- or group censoring. Otherwise, the mind and the group dynamic will simply re-enforce the usual thinking and push us back into that old box outside which we are supposed to be thinking. The rules of idea generation described above aid this mental movement.

You'll be amazed at the number of ideas you can generate when you allow these three mental activities to flow. The tools described in this idea generation section provide various combinations, direction and tips for bringing this about. If you stick with them, you will find that thinking differently is not really so hard.

Ideas are like rabbits. You get a couple and learn how to handle them, and pretty soon you have a dozen.

John Steinbeck


WWTTCA
Fresh Eyes
Breaking the Rules
Random Word Picture or Object
Stepping Stones
That's Impossible
Mental Benchmarking
---- Choose your tool(s)
—— Should follow sequence
Harvesting by Criteria and Dot Voting

Tool: **Fresh Eyes**

Synopsis

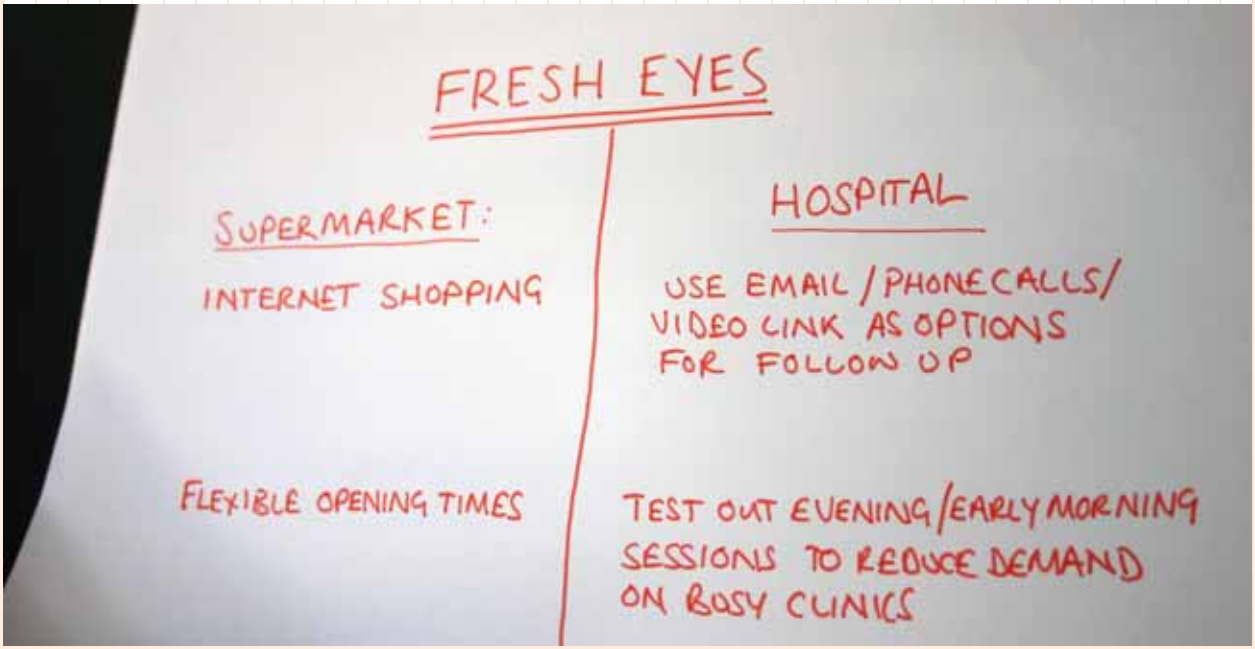
Since others will have different ways of thinking and approaching challenges, we might be able to make a novel connection▪ by using "Fresh Eyes" and thinking like another person, or making links to another industry.

New ideas come from differences.

Nicholas Negroponte

Summary of Steps:

1. Define the issue/problem.
2. Randomly select alternative viewpoints (see box below) and think about how the associated individuals would respond to the issue:
   - What would be important to them in the situation we have described?
   - What aspect of the topic would they focus on?
   - What ideas and approaches might they have?
3. Reflect on these and think about how some of these ideas could be adapted for use in your own context: Which are worth exploring further in health care?



An example of Fresh Eyes:

Issue: *John is once again waiting for hours in Wednesday's orthopaedic follow-up clinic. He thinks he should have an x-ray but no one has given him a form. Last time he came to the clinic, he waited to see the doctor who then wrote the form for the x-ray. He went along and queued for the x-ray, after which he had to queue again to see the doctor. There have been some improvements in the service because John can now book his outpatient appointment, but no matter what is done, waiting times always seem to be the same.*

Look at this issue through the fresh eyes of a ***child***, who might ask:

- *Why do we have to come to this place?*
- *Why do we have to wait?*
- *Why do we have to have the test?*
- *Why do we have to see the doctor again?*

"Walk" through the process. Someone could even act into the role of the curious child, and make a note of all the questions *'why?'*. Then take each 'why' question, (banning the easy response: "because that is the way we do things") and use them to stimulate thinking of several alternatives to existing process.

How might someone from another industry look at this?
By looking at this issue through fresh eyes from another industry, we might ask: "How would a ***manager of a supermarket*** manage demand at peak times in order to reduce waiting at checkouts?"
They might...
...promote internet shopping with home delivery
...flex opening times so that people can shop in the evenings instead of at peak times
...open a smaller store in the business district so that people can drop in for small purchases on their way home from work and so on...

This then encourages us to make creative connections we might not otherwise have made, and to look at the applicability of some of these suggestions to our own context.

For example….

- *Internet shopping:* Does all follow-up have to be face-to-face, or could we use a different method, such as via telephone or email?
- *Flex opening times:* Can we run follow-up clinics at different times to reduce demand at this particular clinic?
- *Set up shops in other places:* Can we agree protocols with our local GP practices to assess the viability of patients being followed up elsewhere?

How might we describe this from a completely different viewpoint, another pair of "fresh eyes"? If I think about skiing:

- *I make sure I have all the things I need before I go out onto the slopes. For example, I might go over a mental checklist for my gloves, skis, and ski pass.*
  For John, the patient waiting in the clinic, this might translate to us thinking about all the things he might need for this visit and creating appropriate checklists and processes to support that. For example, he might need an x–ray, blood test, and physiotherapy report. Let's set in place a process to get all of that done prior to John's appointment, in order to ensure that the consultation will be effective and comprehensive first time.

- *As a skier I will always have a map of the mountain that identifies the most appropriate route for me to go and includes 'stop off' points for lifts, restaurants etc.* We could send a map to John, along with the relevant test forms, to indicate in what order he should go through the clinic process. For example, x-ray as a first stop, then the blood test, before finally seeing the doctor with all the results available.

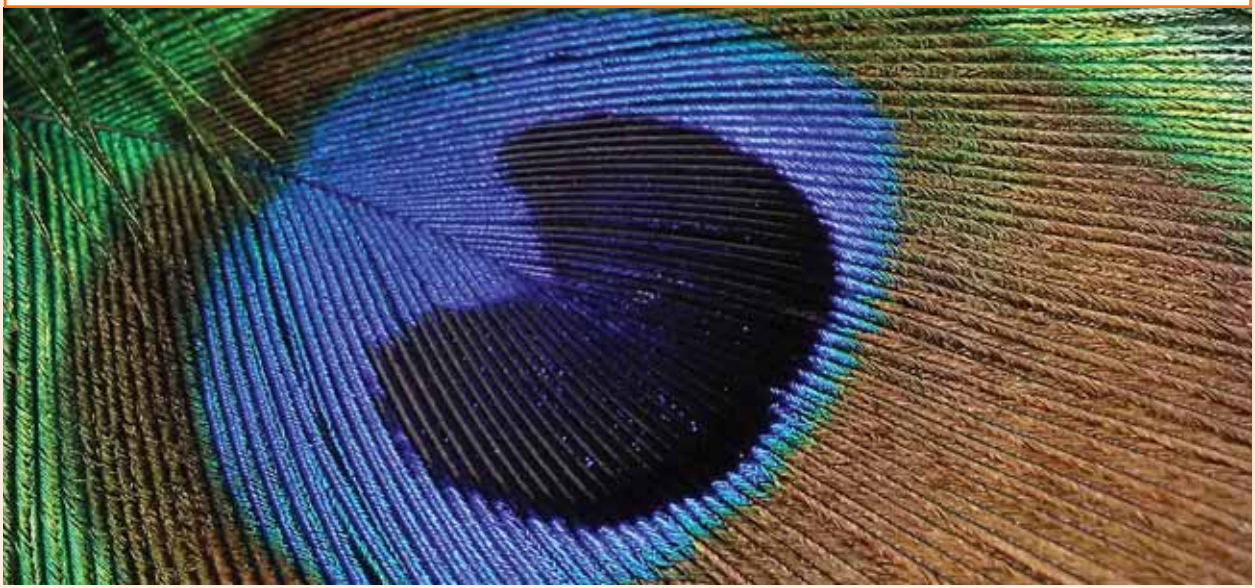
Below is a list of "Fresh Eyes" perspectives you could explore:

Accounting
Acupuncture
Animal kingdom
Architecture
Airline
Astrology
Astronomy
Ballet
Basketball
Biography
Biology
Birds
Books
Bowling
Carpenter
Chemistry
Cardiology
Cartoons
Child
Coin collecting
Comics
Computers
Dance
Deserts
Dentistry
Economics
English
Entertainment
Evolution
Fast food
Farming
Fishing
Fine cooking
Funeral homes
Finance
Football
Flying
Geology
Geography
Government
Golf
Grocers
Garbage
Hunting
History
Hotel
Igloo
India
Inventions
Interior decorating
Insects
Japan
Jungles
Journalism
Korea
Law
Librarian
Law enforcement
Mafia
Maths
Medicine
Manufacturing
Military
Mining
Meteorology
Monuments
Moon
Monasteries
Music
Mythology
Movies
Nutrition
Nuclear physics
Oceans
Olympics
Parks
Pharmacology
Photography
Polo
Philosophy
Physics
Planets
Painter
Political science
Politics
Plumbing
Printing
Religion
Restaurants
Race team
Resorts
Sculpture
Seminars
Sailing
Skiing
Soap operas
Shakespeare plays
South America
Space
Sociology
Stars
Steel
TV news
Tabloids
Tall buildings
Television
Tennis
Transportation
Terrorism
Theatre
Travel industry
Sun
Unions
Vatican
Wine
Warehousing
Zoo

Example

- We want to think creatively about (WWTTCA)... Improvements in Primary Care.
- Perspectives randomly selected... **Airline, Librarian, Supermarket.**
- Some ideas generated:
  - Establish "frequent flyers" club for patients with chronic or re-occurring conditions. Patients can order prescriptions, schedule tests, or complete self-assessments with minimal staff involvement.
  - Train librarians to help patients find health information and book appointments on-line using computers in the library.
  - Take patients with diabetes on a "healthy eating tour" of their local supermarket with a dietician. Show them how to interpret the labels and make the best food choices for their condition.

Surprise! Each of these ideas has actually been implemented somewhere in the NHS.



An example of using “Fresh Eyes” on a problem....

Great Ormond Street learns from Formula 1 Team

It was after what he described as "a particularly bad day at the office" that Prof Elliott, the head of cardiac surgery at the Great Ormond Street Hospital for Children, and his colleague, Dr Allan Goldman, in charge of paediatric cardiac intensive care, slumped into chairs in front of the television.

On the screen was a motor racing grand prix and, as they watched, the two men became aware of the similarities between the handover disciplines from theatre to intensive care and what they were seeing in the pit of a Formula One racing team. From that moment began a collaboration between the leaders of Great Ormond Street's surgical and intensive care units, first with the McLaren F1 racing team and then with Ferrari's team chief Jan Todt, technical guru Ross Brawn and, in particular, race technical director Nigel Stepney. They worked together at their home base in Modena, Italy, in the pits of the British Grand Prix and in the Great Ormond Street theatre and intensive care ward.

What resulted from this work was a major restructuring of the patient handover procedure, resulting directly from the input of the F1 pit technicians. "It is not too early to say that, when we look at the number of critical instances we encounter, they have reduced markedly since we introduced the modified training protocol developed from what we have learned from Formula 1," said Prof Elliott.

The single A4 sheet of paper, which contained the flow diagram of Ferrari's pit procedure, became several pages of twice that size when Mr Stepney and his colleagues at Ferrari were confronted with the critical transfer from operating theatre to recovery room at Great Ormond Street. “They were quite shocked at the complexity of what we did and the kind of kit we had at our disposal," said Prof Elliott

We had all being doing our jobs for years and we thought we were pretty good at it," said Dr Nick Pigott, the consultant in paediatric cardiac intensive care, who has worked alongside Prof Elliott and Dr Goldman throughout Operation Pit Stop. "Then, after we had been with the Ferrari team, we watched videos of ourselves at work and it was quite a shock to realise the lack of structure in what we were doing."There is no doubt that it is our research with Ferrari that has honed our transfer from theatre to intensive care to the level of silent precision it is today." said Dr Pigott.

Daily Telegraph, 29/08/2006

Tips on using this tool yourself or with others

- Before you try to engage others in using this tool share some of the examples given in this section on how healthcare has used ideas from other industries. This helps people to see the connections and application of the tool.
- The list of perspectives, on page 74, should not be restrictive. Add to, change or modify the list as you go.
- Try not to censor the choice of perspectives, just select them at random. Obviously, some will work better than others and some will stretch the participants more; but all are valid. Even if you can't see an immediate connection, others might.
- Spend around 30-40 minutes on this tool using 4-5 different perspectives.
- If you feel stuck in trying to make a connection, just select another perspective and move on.

Eliminate something superfluous from your life. Break a habit. Do something that makes you feel insecure.

Piero Ferucci

Tool: **Breaking the Rules**

Synopsis

Identify the underlying assumptions, mental models, unwritten rules and thinking that maintain the status quo, and then deliberately think around them to create new ideas for service delivery.

Tell me more please...
In complex systems, rules or underlying mental models (we will use these terms interchangeably) drive much of the behaviour in the system. We need to pay attention to these rules by identifying and observing exactly what is happening.

There are no rules here, we are trying to accomplish something.
Thomas A. Edison

Example...

Consider the mental model that patients with long term conditions must have regular check ups and diagnostic tests carried out in a health care facility. This generates many corresponding actions that we take for granted. Since check ups and tests are carried out in a specific place, we therefore must create patient flow processes that enable patients to move in and out of that place. We also need decision-making processes to decide which professional should see the patient and how frequently. When you think about it, a rule like "care has to be delivered in a specific place" drives many processes and patterns of behaviour in health care organisations.

Innovation is a violation of the current rules!
To get innovative ideas, we need to think differently.

Example...

One idea is that patients could check their own blood pressure, at their convenience, without seeing any clinicians, by using a static blood pressure machine within their doctor's surgery, providing a print out that can then be put in their record.

Another innovative idea is to consider enabling patients to have a check up and perform diagnostic tests in the comfort of their own home and access services when they decide, based on information that has been provided, rather than being constrained by a fixed schedule that might not meet their needs. This could be achieved through near patient testing devices that are remotely monitored through a high-speed data network connection or through the use of telephone, internet webcam or e-mail consultations when the patient chooses.

Rules maintain the status quo. We can improve the system within the constraints of the current simple rules (for example, streamline patient flow through clinic and diagnostics). This is first-order change. But we can also innovate by explicitly breaking a rule and see where our imagination takes us. This is second-order change.

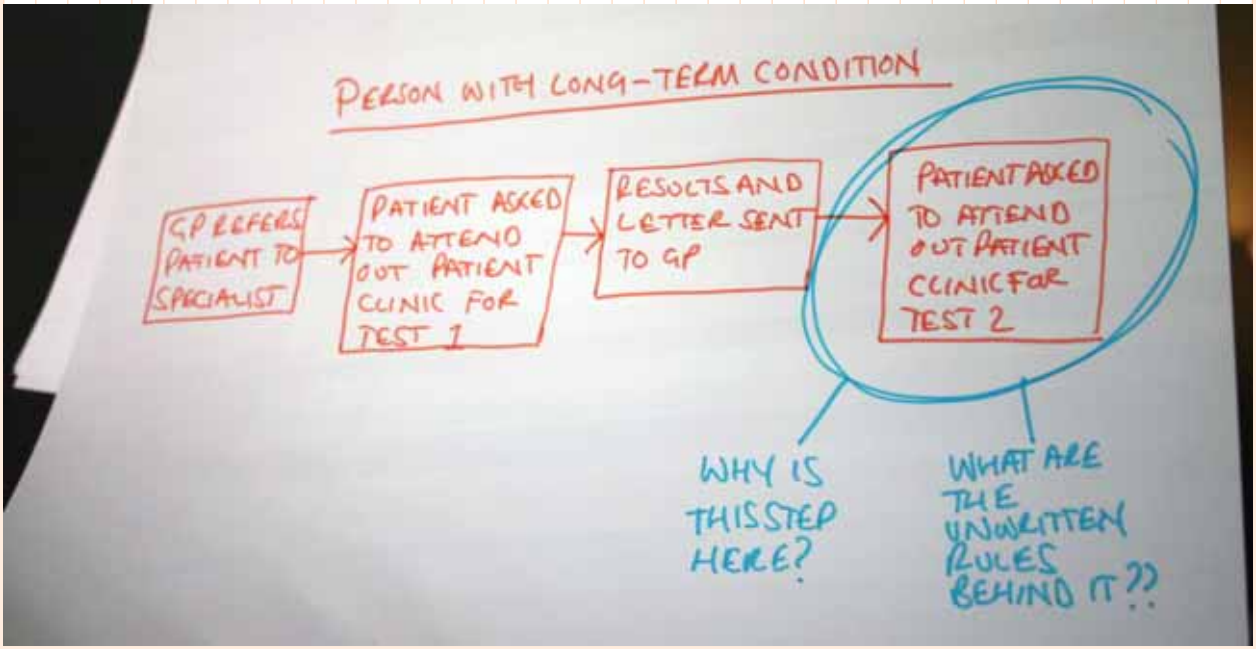
Concepts: 22

A way to stimulate different thinking for idea generation is to...

1. Identify the underlying rules

There are a variety of ways to do this:

- Simply list them through group discussion.
- Step through a process map and at each step ask, "Why is that step here?" or "What seem to be the underlying mental models or unwritten rules behind what is going on here?"
- Actually spend some time in the system to watch what happens on a daily basis and ask the questions in the previous point.
- Tell stories of normal occurrences within the system and ask the questions above.



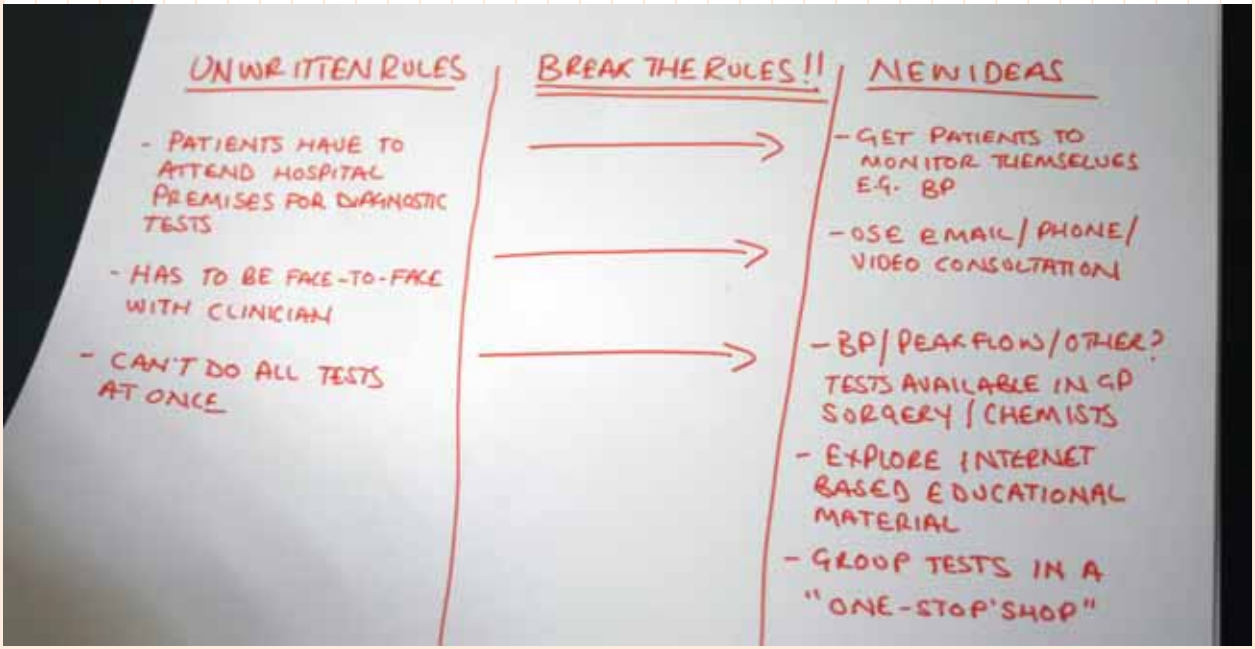
2. *Creatively challenge the rules*

There are several ways to do this:

- Ask questions:
  - What aspects of this rule can we break?
  - What aspects of this rule would we want to keep and why?
- Propose an alternative simple rule.

3. *Walk around in the "new world" and see what new ideas you can generate*

Play out the scenario as to what you would do if the rule were suddenly altered: what could you do differently? What would that look like? Draw the new process and / or capture ideas as you go.



Example...

Unwritten rule: only a healthcare professional can take and record an accurate blood pressure (BP)

Breaking the rules: A medical centre in Bewdley lends patients BP machines with printers for a couple of weeks so they can self-test and ascertain whether or not they are hypertensive or have another problem. This avoids medicalisation and inappropriate drug expenditure for those who those are found not to be hypertensive. Patients who do have hypertension are offered a discounted BP machine for ongoing self-monitoring. They can send results to the medical centre via the internet and can also access their management plan on line. This enables patients to check whether their BP is within normal limits, or if it is raised and they need an appointment with the GP.

When might this tool be useful?

- When things have been done the same way for a long time.
- On a topic where there are repetitive structures and processes that everyone knows about (*Example... In A&E there is always a reception desk where you have to go first. Why is that? What is the "rule" here?*)

Like lots of breakthroughs, the Fosbury Flop (now the standard in Olympic high jumping) looked strange the first time you saw it. Really strange.

Tom Kelly IDEO

Tips: Breaking Rules

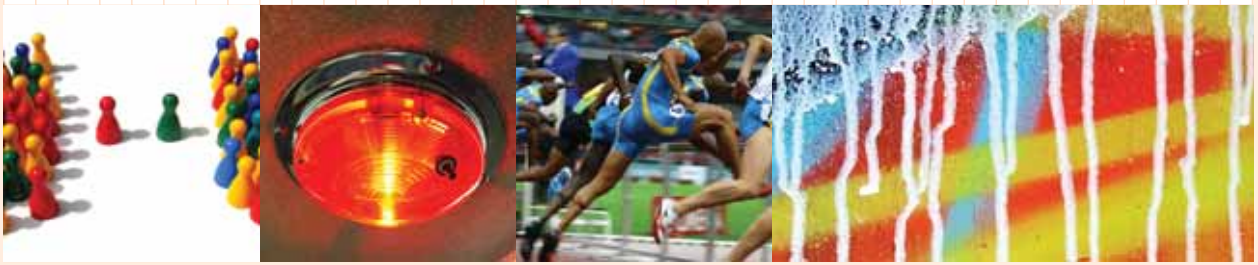
- Give several examples of simple or unwritten rules in daily life and ensure that participants understand the basic concept. For example:
  - Traffic in a city centre. Trying to describe the movement of individual cars would be enormously complex. But we all know that what is really going on is that individual drivers are just following a few simple rules regarding which side of the road we drive on, what to do when you approach a roundabout, the distance to keep from the car in front and so on.
  - The Institute of Medicine in the USA has described the future health care system as a transition from one set of simple rules to another. (See box on the next page)
  - A common unwritten rule in health care is that "Patients must pass through low cost resources before gaining access to high cost resources". Talk this through in terms of who the patient first sees upon going to the GP surgery or A&E. Note that many A&Es have been innovative in putting a medically trained person closer to the beginning of the process in violation of this rule.
  - Consider also giving the group you are working with an example that you think is an unwritten rule for their particular topic or system.

- Avoid simply being sarcastic or clever. (*Example… "If the doctor is cross with the nurses he will hide the patient's notes."*) It is OK if there are a few such items on the list in the name of fun. However, the point is to describe the functioning of the system, not simply its dysfunction. The test of a well-worded rule is that when you show it to others their reaction is: *"Yes, that makes sense, nothing wrong with that."*
- Note that some rules are, in fact, formal rules in the sense of laws or regulations. But even these might be challenged to see if there are some creative things that one can do within the limits of the rule.
- Not all unwritten rules need to be changed, but it doesn't hurt to think about them.
- Many participants may find it hard initially to identify unwritten rules in their own work practices. We get so used to "the way we do things around here" that it can be hard to step back and see them more objectively. Involving people in the group who do not work in the immediate topic-area (including patients) can be helpful as they are more likely to ask, *"Why do you do it like that?"*. This can help identify the underlying mental models or unwritten rules.

Simple Rules for Better Health Care System in 21st Century

Current Approach	New Rule
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patients' needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continually decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

Source: Institute of Medicine Committee on Quality of Health Care in America.



Tool: **Random Word, Picture, or Object**

Synopsis

How can a randomly selected word, picture or object possibly help me think differently?!?

The very words and images we use to talk about a topic bring us into our usual ways of thinking (our mental valleys"), resulting in ideas that are not very different from what we already have. A randomly introduced word, picture, or object activates thoughts that we do not usually associate with the topic and therefore gives the possibility of a new connection and new ideas.

Example...

A group working on improving the transport of samples to a hospital's pathology department has generated several ideas to speed up the process, but none are very creative. The team leader introduces the randomly selected word "umbrella" (or sees a picture of an umbrella in a magazine, or notices one in the corner of the room).

The group talks about "umbrellas" for a moment and someone notes that looking up into an umbrella you see a central post with metal arms coming out from it. This leads to discussion of the fact that in some laboratory equipment there is a sample compartment that is connected by wires to a processing computer within the same piece of equipment that does the analysis. Why not keep the central processing computer in the pathology lab, but place sample compartments out on various wards and connect these in via wires?

The Pathology manager approves a plan to test this idea by disassembling an old laboratory analyser, relocating the sample compartment on a ward, and connecting it via a cable. No need to transport the sample!

When might this tool be useful?

- This is a general-purpose tool that can be used on any topic at any time; either by an individual or a group. Try a random word, picture or object to get you started!



How do I find a word, picture or object?

a) The best words to use are nouns and there are a number of different ways that you can find one:

- Use the random word list below. Simply close your eyes and put your finger on the page. The word that you are pointing to is your random word.
- Bring in a book (a report, letter, or any page of text will do), open to a random page, close your eyes, put your finger on the page, and select the noun that is closest to where your finger lands.

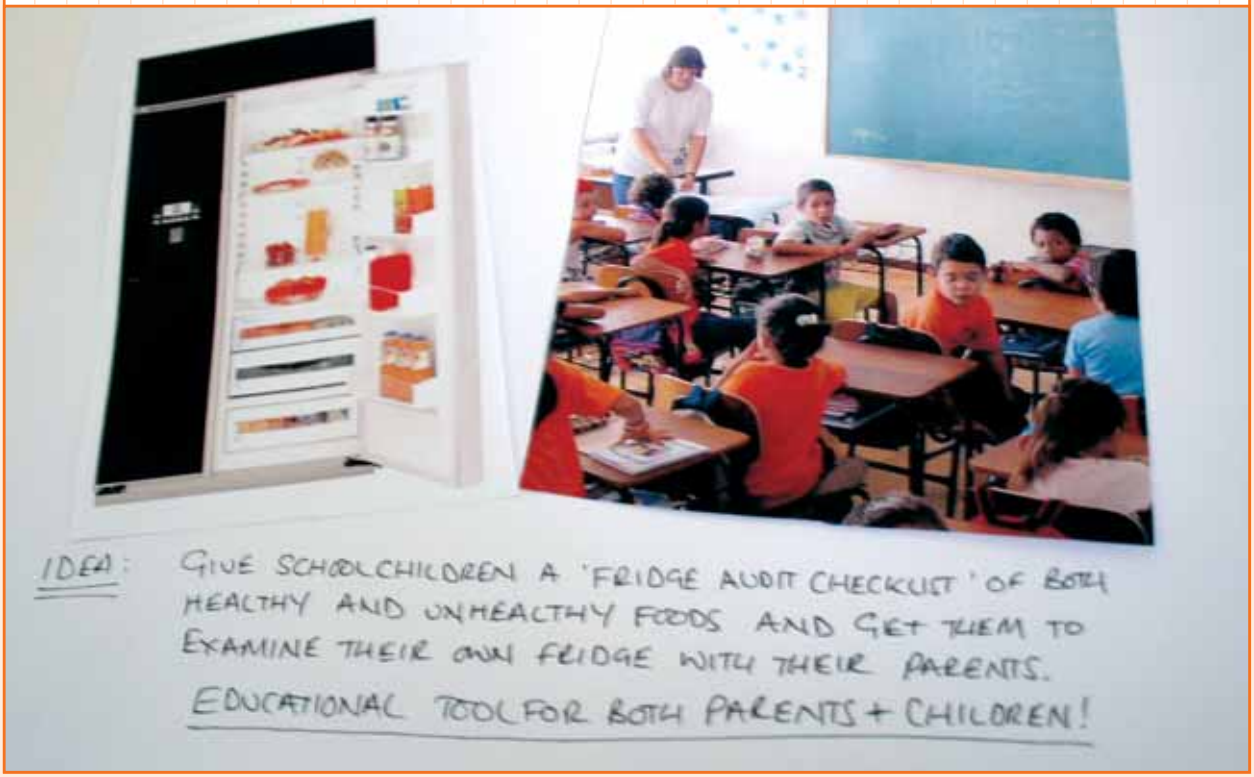
Random Nouns...

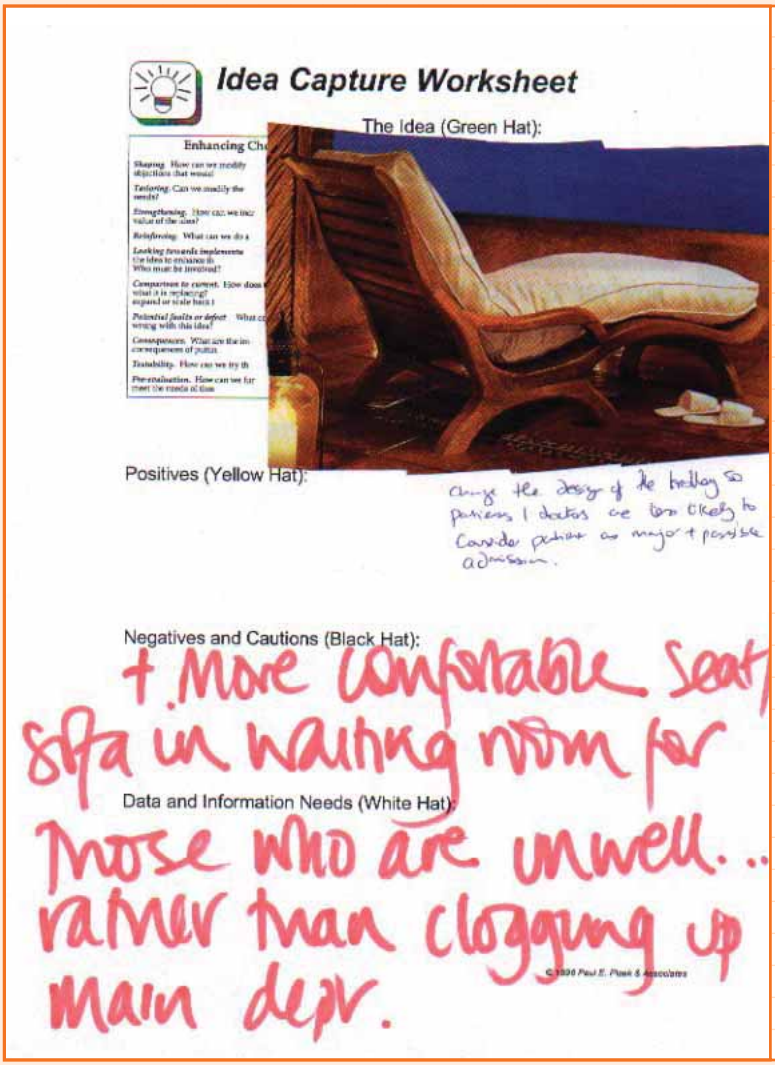
tongue plastic wrench star gourmet money flashlight dice windsurfer ribbon camera can pencil pin watermelon soda tape necklace mould gutter jewel house gully fuel music wastebasket x-ray cup paint lamb stomach rain telescope knee pole champagne top beans angel student lips salmon lungs gasoline tub fox chimney bikini prison tax igloo fireplace axe smoke referee cork stream strip jellyfish vines bomb umbrella cone flood frog rib table flower towel window locker toy podium saucer rainbow amoebae disk snail rice grass fence horse shed leaves bird tractor Olympics straw mirror chapter vacuum bread cyclone gravy emerald gang pliers binoculars studio parakeet fingernail meadow bat curb zipper gutter outlet elbow weeds paper wig road sauna cord duck floor book announcer nappy cake terrorist sandwich lightning candle crown jelly fossil pet ruler circus plug coach wallpaper ham envelope actor riot clay train television garage stadium fork detective magazine medal refrigerator sonar planet hostage car salad....

b) *Old magazines, particularly ones that have nothing to do at all with health care, are good sources of pictures. Open to a random page that has a picture or advertisement on it. Explore what is in the picture and talk about what it makes you think.*

For example...

A team working to come up with ideas for public health campaigns came across a picture of an open fridge in a magazine. This generated discussion about healthy eating and how a professional could tell a lot about someone's health by looking into his or her fridge. When one of the group also noticed a picture of schoolchildren that someone else had cut out and left on the table, the idea was born for creating a checklist for children to bring home to explore the contents of the family fridge with their parents.





For example...

The picture of a recliner chair made them realise that putting patients on trolleys instantly reinforced a certain severity of illness in the minds of staff and patients. In addition to this trolleys are actually not the most appropriate seating option for many patients.

They wondered if a more chair like design, while being comfortable and allowing the patient to rest, might help retain elements of wellness for both patients and staff.

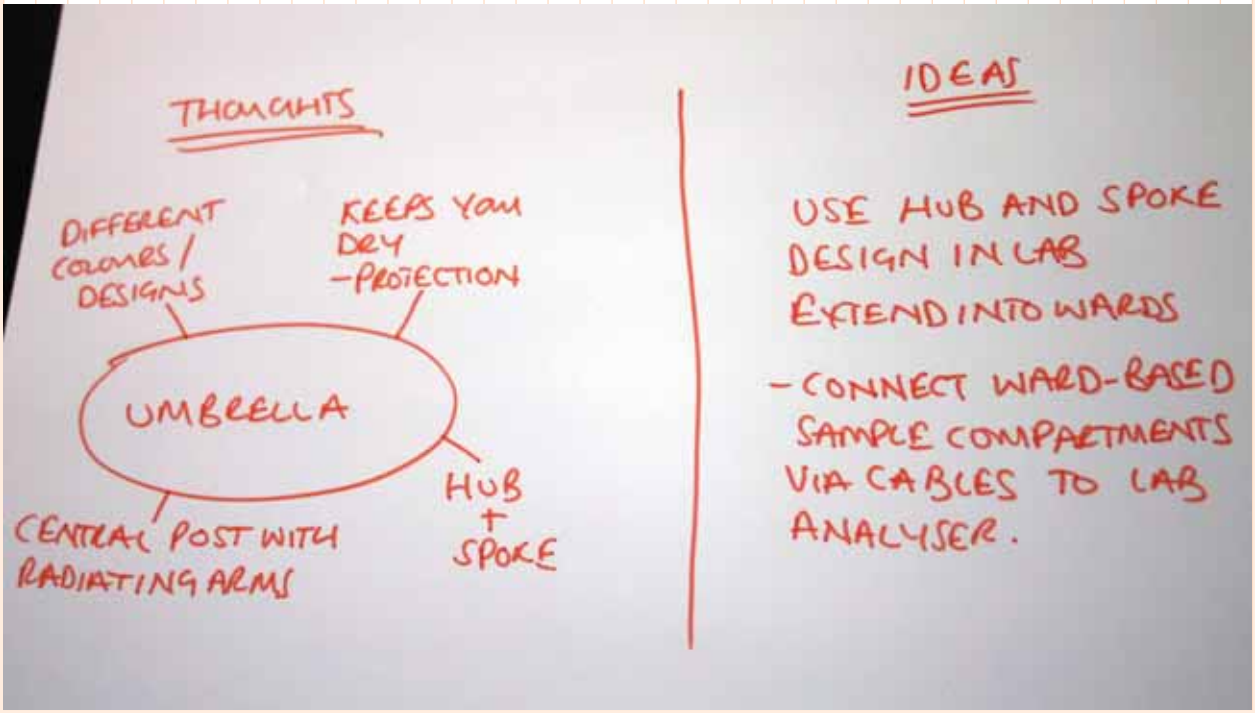
c) Look around you for objects, bring in objects from home, or ask your partner or children to give you an object, but don't tell them what it is for.

This guide is full of words, pictures and images of various objects!

Use it as an immediate resource for this tool.

How do I use this tool?

- Draw a vertical line on flipchart paper to separate it into two columns.
- Select a word, picture or object at random.
- Discuss in the group whatever this prompts people to think about.
- Make a note of these in the left-hand column of the flipchart paper.
- Then ask how some of these items can relate to your issue or topic and write those ideas down in the right-hand column of the flipchart paper.
- Spend about 10 minutes on each random word, picture or object.



Tool: **Stepping Stones**

Synopsis

Offbeat ideas and somewhat wild scenarios can serve as catalysts or mental "stepping stones" to help us make an intuitive leap to a really good idea. By starting with the outrageous, we are able to suspend judgement and think more freely, provoking connections or associations between seemingly unrelated pieces of information in the mind.

How might I use it?

There are two basic types of stepping stone provocations ...

Type 1 - State an extreme or outrageous approach to the issue at hand

The purpose is to jolt the thinking (escape), step back and see what concepts emerge (attention), and then return to somewhat more practical suggestions that stem from the concepts (movement).

Concepts: 23

Example A

Issue at work: *I can't seem to find the time to focus on improvement.*
Outrageous idea: You must do all of your work using improvement tools.

What are the **underlying concepts** within the idea?

- Improvement is work
- Use an improvement technique for everything you do
- Streamline tasks
- Think about things that do not need to be done at all
- Learning/improving new skills is part of everyday activities
- Challenges are opportunities for change.

Making **connections** between using improvement techniques and your 'usual' routine, how might the above concepts be applied in the workplace?

Change ideas:

- *Using improvement techniques:* During the initial handover at the beginning of your shift ask your self and the staff handing over how this process could be made more efficient without compromising the information exchange. Come up with at least three alternative ideas at each shift change for 3 days.
- *Streamline tasks:* Every time you do a task think how many steps are involved (even create a rough process map). Identify at least one way that you can simplify the process to make it better.
- *Identify things that do not need doing:* Be aware of things that you really do not need to do. Ask "does it need doing at all or who else could help?" This might even be something that patients could do for themselves. This creates more time for doing other things like improvement work.
- *Learning/improving new skills is part of everyday activities*: every time you learn something new about the service you provide make a note of it and review with your team to see if it can lead to general improvement.
- *Challenges are opportunities for change:* Every time something seems to be a challenge think about how it could be different, what is making it such a challenge and how could it be overcome?

Example B

Issue at work: *staff morale is very low.*
Outrageous idea: send everyone on a skiing holiday.

What are the **underlying concepts** within the idea?

- Time out of the workspace
- Learning/improving new skills
- Presenting people with a challenge
- Doing something staff wouldn't normally do
- 'A change is as good as a rest'
- Energising activity
- Alternative modes of transport (skis!)
- Reward of good food after a hard day's skiing

Making **connections** between the skiing holiday and improving staff morale, how might the above concepts be applied in the workplace?

Change ideas:

- *Time out:* Open forum for staff to bring ideas during lunch hour; access to reading materials through improved library service; aerobics/exercise facilities on site.
- *Learning/improved skills:* Improved access to educational and experiential learning opportunities. Swap roles for a day to see a service through new eyes
- *Presenting people with a challenge:* How can we make this the best organisation in the country for XYZ?
- *Alternative modes of transport:* Look at broader issues relating to staff. Is parking sufficient? Can we organise taxi services for night nurses? Can we get staff subsidised theatre tickets through our local Chamber of Commerce?

It is not because things are difficult that we do not dare, it is because we do not dare that they are difficult

Seneca

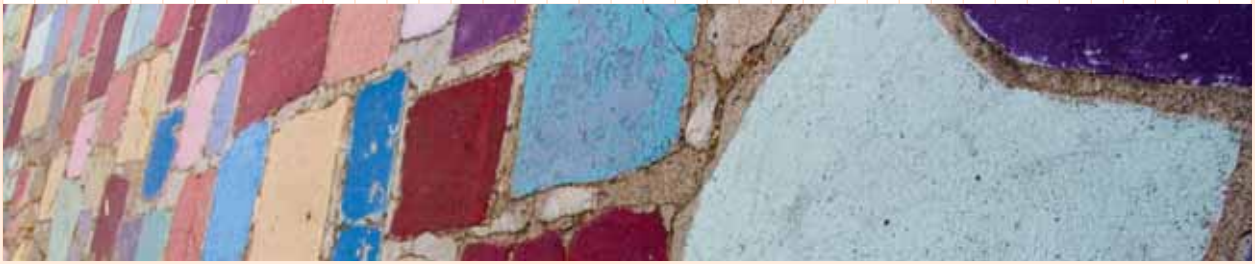
Type 2 - State an extreme or outrageous scenario that makes it necessary to completely redefine how we approach the issue at hand

Here we are using the same sequence of *escape, attention,* and *movement*, plus we are applying the old adage that "necessity is the mother of invention."

a. Select elements of the system that are central to the way people currently think about the issue. For example: "we simply must have more beds", "we cannot possibly do this without more nurses" or "we need another x-ray machine, Laparoscope, or BP machine before things will improve".

b. Suddenly eliminate or drastically modify these elements in a scenario that describes a new situation and makes it seem real.
Be imaginative! You could: pass a new law or regulation, invent a mysterious and selective virus that means that certain people cannot be involved in the process, discover some environmental hazard that forces facilities closure or prohibits the use of certain resources or equipment, create a crisis of any sort!

c. Include a statement of what you want the thinking to focus on in the new scenario.



Example

Creative focus: *We want to think creatively about how patients access emergency services.*

Elements of the system that are central to the way we currently think about the issue:

- GPs
- A&E consultants
- Nurses
- Diagnostic equipment
- A&E as a place
- Ambulances
- Etc.

Write a **scenario** and include a **statement of focus:**

- *A mysterious virus has affected every GP in the UK so that they are unable to work. Everyone else is completely unaffected.*
  How can we design a direct and speedy flow to A&E that sorts only those patients who really do need the skills and expertise available in A&E and directs the rest to other resources? What other resources could be used ?
- *An inspection agency has noted the presence of a mysterious chemical in A&E and has ordered it to shut down and be sealed off for an indefinite period of time. The nearest alternative A&E is 200 miles away.* You are in charge of the Emergency Services Network that serves this community. What are you going to do to provide access to emergency care?
- *The manufacturer has discovered an extremely serious defect in the brakes of all Ambulances in operation in the UK. They are such an immediate danger to public safety, that they have all been banned from the roadways - with immediate effect! Parts to repair the problem will not be available for 6 weeks.* You are the in charge of the Emergency Services Network that serves this community. What are you going to do?

When might I use it?

When you feel that you or a group is stuck, or is simply coming up with variations on the same old themes.

Whenever you notice that the current thinking seems to depend too heavily on certain resources or assets in the system.

Tips

- Have a good bit of fun with this tool. It is meant to be playful and tongue-in-cheek. But this is play with a purpose. The goal is to explore the outrageous suggestion or scenario, but to come back to reality with some new ideas on the topic at hand.
- Keep in mind the sequence: escape, attention, movement.
- This is a popular tool with health care teams because they are usually experienced in dealing with crisis.
- Stepping Stones of the first type are best done spontaneously. Either suggest something yourself off the top of your head, or ask the group for some really far-out and outrageous ideas; then just go with it as described above. The spontaneity of it adds to the climate of purposeful play and freethinking.
- Stepping Stones of the second type are best prepared in advance and used as a set. Take time to think through a good list of things in the system that people think are central to approaching the issue, and take time to carefully craft the statement of focus to avoid making the new approach too obvious. Use several of these Stepping Stones to make sure that the ideas don't just substitute one taken-for-granted resource for another.
- If you are working with others when using Stepping Stones of the second type, be prepared for initial incredulity; group members may simply stare back at you blankly and say things like, "That can't possibly happen". Stick with it; insist that they deal with it: "No really, it did just happen, now what are you going to do? You can't just sit there, 'you' have to do something". You might want to point out to the group that this reaction is exactly what many people experience in times of crisis, but then they have to get on with it and do something.

Tool: **That's Impossible!**

Synopsis

Often, we take as a given that something is impossible. Maybe it is simply that we were not able to do it in the past and we have not recently thought about the possibilities. Once you think about it, it is possible to do (or at least come close to doing) many 'impossible' things.

How often - even before we began - have we declared a task "impossible"? A great deal depends upon the thought patterns we choose and on the persistence with which we affirm them.

Pierro Ferrucci

How do I use this tool?

1. Make a list of things that are currently accepted as being impossible

Example... It is impossible to.... make sure everyone uses hand gel before they enter the ward. It is impossible to... know that a patient is going to turn up for an appointment until they actually present at reception.

2. Ask: "How could we actually make that possible?" "How could we come close to doing that?" "How could we do that at least some of the time?"

Continuing the example...

- Make sure everyone uses hand gel before they enter the ward:
  - Have a video camera and motion detector pointing at people as they walk near to the ward. This triggers a voice recording reminding people to wash their hands.
  - Only by using the hand gel will the ward door unlock. For example, wire the button that unlocks the ward door to the hand gel dispenser.
  - Each time hand gel is dispensed a coloured, timed label is dispensed with it so that people are easily identified if they have not got the right label.
- Patient turning up for appointment:
  - We ring them up to see if they are coming.
  - Place large sign near a telephone in the car park asking patients to call us to let us know that they are in the car park so that we can begin preparation for the appointment.
  - Give patients a swipe card or PIN number to key in for a special car park or clinic entrance. When they swipe the card or key the number to get in, a signal alerts us that they are on the way.

Example

Perform major surgery without making an incision? That's impossible!
Removing a brain tumour through the nose; performing an appendectomy through the mouth; removing a gall bladder through the vagina…. It may sound impossible but it's been done! Doctors in France, the US and in India have all performed surgical procedures such as these using ultra-slender instruments and tiny video cameras inserted into the body's natural orifices. Using the body's own channels prevents the need to cut through sensitive tissue and muscle, avoiding major scaring, and providing faster recovery time and less pain.

Over 15 years ago, it seemed impossible to have an operation without a large, invasive incision… until someone thought differently and laparoscopic (key hole) surgery was born. The natural orifice approach marks another step change and the chance of eliminating the need for any incision at all.

"Getting rid of them (incisions) completely is going to be not an evolutionary step, but a revolutionary step," said Dr. Marc Bessler of Columbia University Medical Center.

Original story at: www.nytimes.com/2007/04/20/health/20surgery.html

The world is moving so fast these days that the man who says that it can't be done is generally interrupted by someone doing it.

Harry Emerson Fosdick

Example

"Get your heart to call your doctor and report how it's doing". What?!? Don't be ridiculous! That's impossible!

Oh no it's not....
Technology which enables doctors and patients to have "virtual consultations" via the internet now exists.

For example, patients with chronic heart disease who have an implanted cardiac device can collect their own data by holding a small antenna over the implant and transmit it straight to their doctor via a standard telephone line. The physician can review the data on a special web site and the patient can also check their own condition online.

Patients with diabetes can transmit their blood glucose readings to a web-based database, which can analyse the data and provide immediate feedback to both patient and doctor, along with two way messaging of insulin schedules, advice and reminders.

Other remote monitoring opportunities now available include brain activity, blood pressure, ECGs, oxygen saturation, sleep apnoea... all via wireless transmission to mobile phones, PDAs, laptops and computers!

When might I use this tool?

- When you sense that people are reluctant to set ambitious goals for improvement.
- When people say things like, "Well, there is no way that you can..." or "It is simply not possible to..."

Tips

- Because you are addressing directly something that is widely held to be impossible, you should not be surprised at stronger than usual negative thinking as you begin to use this tool. Be sure to emphasise the rules of idea generation to suspend judgment, go for quantity, build on others' ideas, etc.
- Capture all ideas for possible later development; don't allow laughter to result in rejection. Suggesting that one tries something thought to be impossible always brings out laughter... until someone actually does it!
- This tool might result in some 'outrageous' ideas. Be careful not to let them be dismissed. Ask the group to ask: *"how might we really make this happen?"*

Tool: **Mental Benchmarking**

Synopsis

Many of the basic issues we face are common to other industries and settings▪, if we state them in plain English and remove the jargon▪. For example, in health care we talk about "access," or "patient flow," or "matching up the correct patient with his or her medications." But these are really common issues across many industries. Those in other industries will have different mental models from us – McDonald's deals with "access" by providing a drive-through window; Disney World deals with waiting time for its rides by providing stimulating visual input to make the time pass more quickly; and FedEx certainly knows a thing or two about how to match up packages with the correct delivery lorry.

If we can connect our issues and those different mental models, we might generate a creative idea!

Tools Phase 1
Pause, Notice, Observe: **50**

Reframe by Wordplay: **46**

The best innovators aren't lone geniuses. They're people who can take an idea that's obvious in one context and apply it in not-so-obvious ways to a different context.

Harvard Business Review

How to do Mental Benchmarking

The tool involves four steps:

1. **Frame the issue in its plainest or most general terms.**
   Example... We want creative ideas on providing faster service to customers.

2. **Select an industry or business at random, or one that also deals with a similar issue.**
   Example... Fast food restaurants, banks, shops etc.

3. **Describe how that industry naturally thinks about the issue.**
   Example... Fast food restaurants have drive-through windows, a limited menu, "combos" where you just give the menu number, etc. Banks provide services via ATMs (kiosks) or on the internet, etc.

4. **Borrow and adapt concepts to your issue.**
   Example... What health care services could we offer via a drive-through window? *E.g. prescription refills, lab sample drop offs, flu jabs, quick consultations...* How can we bundle or combine services, maybe for those with long term conditions? What could we do with a health kiosk? Etc.

Laughter is a natural physiological reaction to a novel connection in the mind. Expect that others may initially laugh at ideas borrowed from other industries or settings *("A drive-through window in a hospital like the one in those fast food restaurants!?! You must be joking!)* Rather than being discouraged, take this initial reaction as a signal that the idea is potentially creative! Stick with it, really think about it, and you may find that it is not such a crazy idea after all.

If at first the idea is not absurd, then there is no hope for it.

Albert Einstein

Drive-through flu jabs? You must be joking!

Actually, it's already happening in the US and Canada....

Service with a jab and a smile

For more than 10 years Beatrice Zastrow has received her flu shot.

Last year, Zastrow discovered an easier way to get the vaccine - by pulling into a full-service flu drive-through.

"We just drove in, filled out some paperwork, and got the shot. It took probably a total of 15 minutes," Zastrow said.

It was so convenient that she and her husband, Orville, are getting their flu shots by drive-through again this year in Shady Grove, Md., she said.

"I can go any weekend for the next three weeks, and I know it won't take up my whole day," Zastrow said.

One nurse compared the process to picking up dinner at a fast-food restaurant only "you don't get the fries."

As patients pull into a drive-through clinic, nurses begin handing out paperwork consisting of medical history reviews and consent forms. Once the paperwork is filled out, patients stop at a fee station before receiving the vaccination.

Lisette Osborne of the Howard County Health Department in Maryland said the vaccination process was easy.

"You roll down the window, roll up your sleeve, and get the shot," she said.

The Howard County drive-through was the second largest in the country, servicing 2,100 people in one day.

Not only do patients take advantage of the drive-through, but the county benefits as well, by practicing the kind of quick treatment that might be necessary in case of a large-scale medical emergency.

Another purpose to this process is to see how quickly we can perform in case of an emergency. We get better at it every time because we learn lessons about how to do it more efficiently," Osborne said.

The vaccines are the same as what you would receive in the doctor's office. You have a choice between the flu shot or nasal flu vaccine.

"I find it all so interesting," Zastrow said. "At the doctor's office, I would have to wait in the waiting room before seeing the doctor and then wait 15 minutes after the shot to make sure everything was OK. But with this drive-through, if you've had a flu shot in the past, there's not much of a wait to see the doctor and you can drive off immediately."

ABC News, Oct. 17, 2006 - http://abcnews.go.com/Health/story?id=2575478&page=1

TOOLS PHASE 2

NOTES

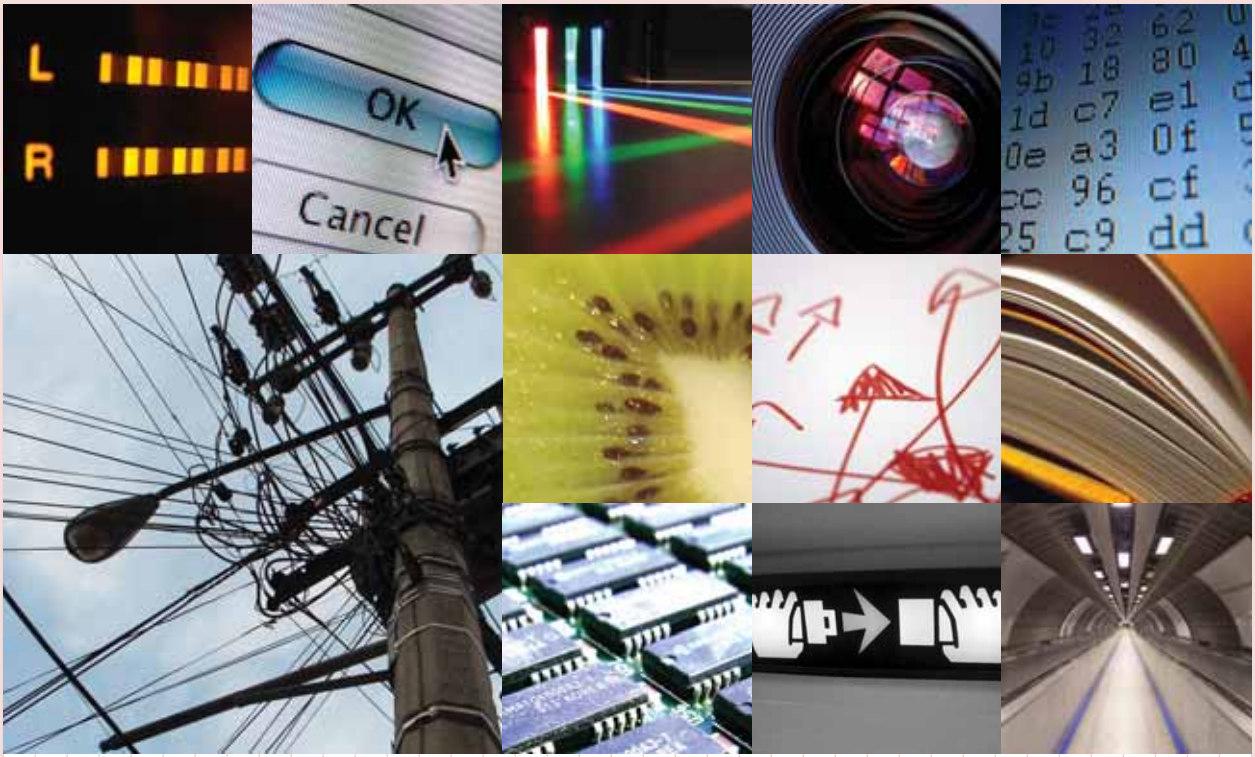
Tools Phase 3

Selecting and Testing Ideas to Make a Difference

Introduction to Phase 3

- Harvesting by Criteria and Dot Voting
- Six Thinking Hats®
- Enhancement Checklist
- Testing New Ideas on a Small Scale

Implementing Change: making ideas a reality



It is better to have enough ideas for some of them to be wrong, than to always be right by having no ideas at all.

Edward de Bono

Introduction

If you have followed the process and used the tools that we describe in the previous sections you should now have lots of ideas. The key to the previous phases of the thinking differently process was *divergent* thinking: expanding your options... getting outside the box of 'usual thinking'... challenging the way things have always been and the ways that you have been taught to think about them... suspending judgement... exploring widely.

Now it is time to balance all that with some *convergent* thinking: selecting the most promising options... thinking more concretely about how you might adapt new ideas to your current circumstances... applying judgement... doing something in the here and now... making something happen.

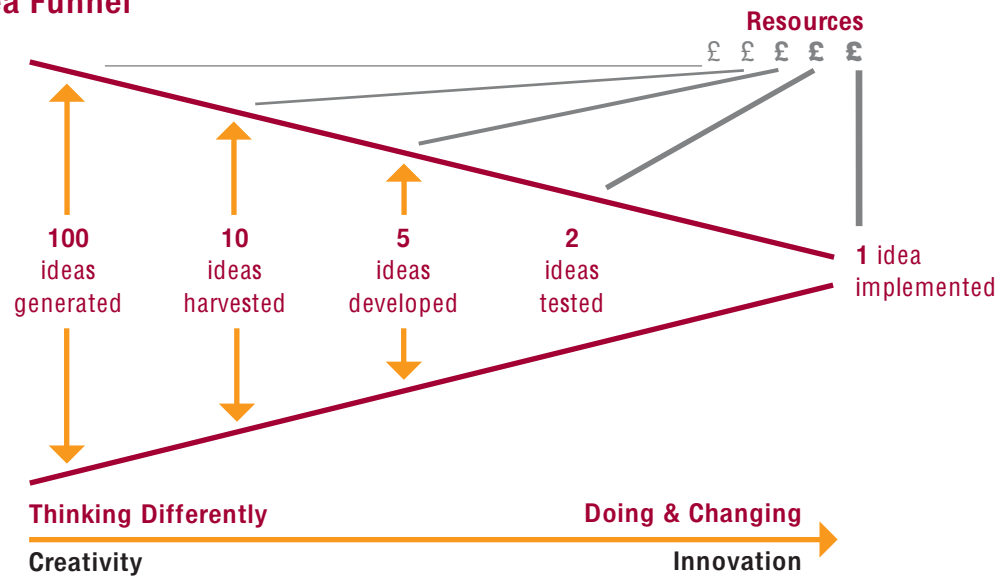
Concepts: **20**

It is important to acknowledge this shift in emphasis. A common pitfall for potential innovators is to go around talking with wild-eyed enthusiasm about all the great ideas they have, only to meet cynicism from colleagues who say things like "Look here, be practical" or "That will never work". Perhaps this has even happened to you?

And so, this final phase of the process of thinking differently is just as important - and requires just as much deliberate effort - as the other phases.

Experience across many industries suggests that the process of *convergent* thinking that is required to get ***one*** new idea implemented (such as a new product, service, or internal procedure) begins with around 100 ideas that have come out of idea generation sessions and proceeds through a process that can be illustrated by a funnel. This process of harvesting or selecting, further developing, and testing ideas is critical to success.

The Idea Funnel



Numbers depicted are illustrative only, but are based on typical ratios across a variety of industries

Note especially that this funnelling process helps us manage resources better when thinking differently. If you are truly thinking differently, then the ideas that you come up with are unlikely to have been tested before in your setting.

It's important to accept that not all ideas generated are equal; yet all are important to the process of thinking differently

Sometimes ideas that "look good on paper" really don't work when put into practice. That is simply the nature of any innovation. It is a risky business.

So, it would be imprudent to take an idea directly from a freewheeling brainstorming session and implement it fully in just one giant step. You could waste a lot of resources that way; not to mention making it very hard for anyone to get support for another new idea in the future!

As the sizes of the arrows illustrates in the Idea Funnel diagram, it takes little resource to brainstorm 100 ideas (a group can easily come up with 100 ideas in a hour or two using the tools we describe in phase 2). You might then spend a little more time in selecting perhaps the 10 best ideas and thinking a bit more about them. Next, you might gather a small team to further develop and think about both the strengths and weaknesses of each idea. In this section, we describe some tools to help with all of this.

But with all the time and effort that you have put in to get to this point, still all you have are ideas on paper. You won't really know how they work until you try them out. Here is where the larger resource commitment starts. We suggest that you first try out an idea on a small scale before you ask for commitment to full implementation; and we'll give you some tips to help you think through and plan all of that.

This entire development and testing process might unfold in just a few days for a small idea in a single team or department, while it might take months to play out for a larger-scale idea such as developing a new service or a fundamentally new way to access care. However, in either case, thinking it through and managing the risks and resources associated with the change is critical.

Case Study: 155

For example...

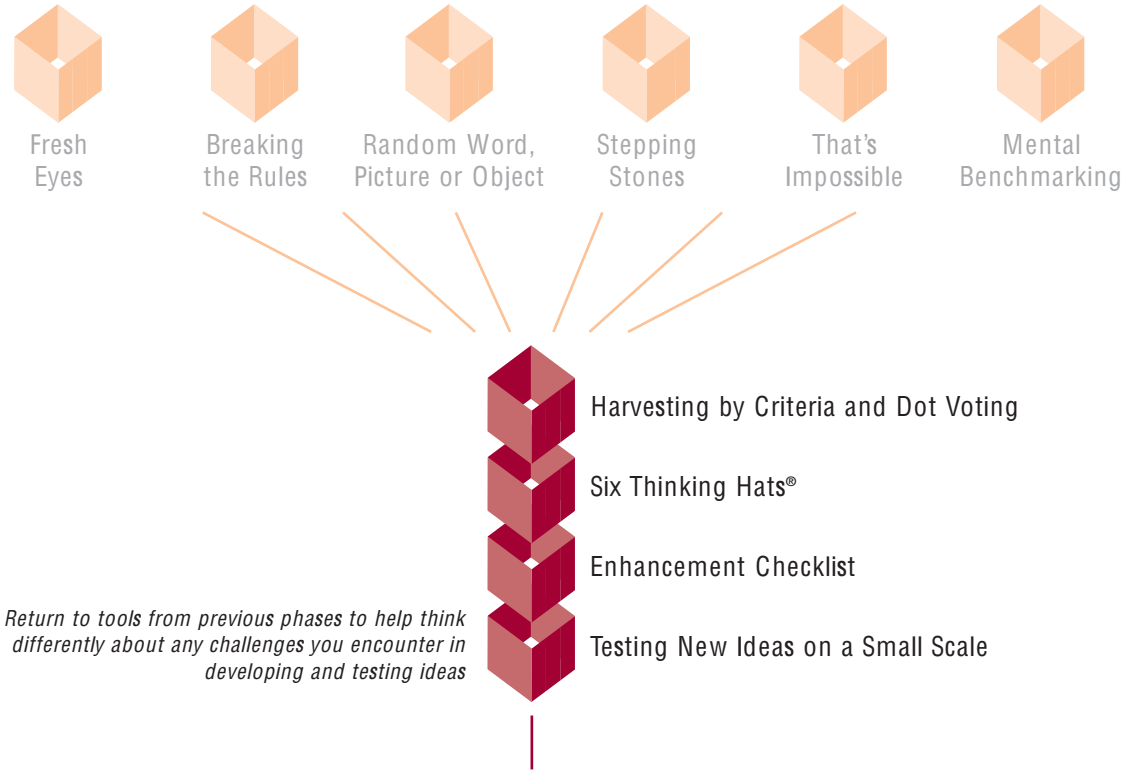
As described further in the case study Award Winning Thinking Brings Better Care to a Diverse Community, a group of 120 people assembled to think differently about out-of-hours care in Northeast London generated 180 ideas in just two hours. The group then quickly voted to get down to 11 ideas. These were further subjected to a short analysis that resulted in rejection of some and combination of others into just 6 ideas. Teams were then commissioned to further develop and test these over several months, resulting in 2 being abandoned, 2 subsumed under other initiatives, and 2 going on to broad and successful implementation. That is the typical process of thinking differently!

Because of the more step-by-step nature of this phase of the thinking differently process, the tools in Phase 3 are organised and described in a different way. Whereas in the previous sections we recommended that you pick-and-chose tools that suited your needs - and didn't necessarily recommend that you use them all - in this section we suggest that you systematically work through each of the tools presented, in the order in which they are presented.

You must decide how much time and effort to expend on each tool, depending on the nature and scope of the ideas you are working with, but it is risky to skip any of the concepts that each tool represents. We will highlight the main concept behind each tool to make it easy for you to see what is essential in the process.

The critical ingredient is getting off your butt and doing something. It's as simple as that. A lot of people have ideas, but there are few who decide to do something about them now. Not tomorrow. Not next week. But today. The true entrepreneur is a doer.

Nolan Bushnell, Founder of Atari Computer



Final point: If you don't follow through on a few ideas and at least test them out, then all of your effort up to this point is really a waste. It might have been fun. It might have provided some escape from the pressures of the job, but ideas without action have no real value. Ideas without action accomplish nothing for the patients and the public we serve. The world belongs to those who do something. When those who are doing something also take the time to think differently… well, that opens the door for something really great to happen!

Tool: **Harvesting by Criteria and Dot Voting**

What do you mean by "Harvesting"?

You cannot implement everything that comes out of your idea generation sessions. Harvesting is about beginning to narrow down the list in order to identify those that deserve a bit more thinking, and perhaps a test. (Recall the Idea Funnel™.)

How many ideas should we select?

Try to harvest about twice as many ideas as you think you can reasonably expect to implement. Tip: In order to identify a consensus comfort level, ask several people what they think: "Could we implement 2-3 ideas from among the many we have come up with? or 5? 10? 20?".

Who should do the harvesting?

While you or the small group of people that you have involved in generating the ideas can certainly select a few to take forward, consider that harvesting is also a good time to get more people involved in the process. It can be done by a relatively large group of 12-20 people, or more; including organisational leaders, people who were involved in generating some of the ideas, and several people whose opinions are representative of key stakeholder groups.

By involving others, you are creating buy-in and increasing the commitment to at least test out a few of the ideas. Remember, there will be many people who will be uncomfortable with these ideas simply because they were generated by thinking differently - they do not correspond to the pre-existing mental valleys of how things ought to be done in health care.

Concepts: **20**

You will need many voices in support of at least trying some ideas; so begin recruiting those voices now.

What do you mean by "Criteria"?

If you are going to make a selection among the ideas you will need some basis - or, criteria - for that selection. You can say, *"Alright then, let's vote on the best ideas here"*, but what do you mean exactly by "best". Best might mean best for patients and carers, most efficient use of resources, most satisfying to staff, most likely to get the support of key stakeholders... or any number of other things. Don't assume that others will define "best" in the same way as you.

So, we suggest that you first give some thought to what criteria you will use for harvesting. There are a wide variety of things that you might consider in various circumstances. There is no particular right or wrong; the important thing is simply to be clear about how you will select ideas before you dive in.

Two broad criteria: Attractiveness and compatibility

In general, criteria for harvesting tend to fall into two broad categories...

- **Attractiveness** refers to an idea's impact on external and internal stakeholders - e.g. staff, patients, the public at large etc. In other words, *will people like it?*
  You must define this term more explicitly for your effort, of course. Perhaps you want something that will really be noticed and appreciated by service users... something that is especially attractive to staff or GPs...something that brings clear benefits to the service, what ever is appropriate for your situation.

- **Compatibility** refers to your assessment of your ability to implement the idea in your context. In other words, *can we do it?*
  You will want to stress that we ought to be stretching our thinking about what we can do; implementing new ideas will be hard, but we ought to stretch ourselves to do it. At the same time, we do need to be realistic and note that an idea that will require several million pounds and fundamental breakthroughs in technology might not be something that we can tackle at this time, no matter how creative the idea is.

Begin your harvesting effort with a discussion of these two broad categories and then discuss what might be the most important criteria (choose 1-4) to consider when selecting ideas from among the many generated.

For example...
The Team 5000 redesign group that is described in the case study Thinking Differently About Delivering Primary Care, used the following criteria to harvest from among the 150 ideas generated: potential effectiveness in delivering high-quality care; time required to implement; resources required to implement.

Case Study: 171

What if we can't agree criteria?

Don't get caught up disagreements at this point. Rather, simply do multiple harvests. For example, suppose you cannot agree whether it is more important to select ideas that will really impress service users or ideas that doctors will support. No problem. Do one harvest where you select the ideas most likely to impress service users and a second harvest of ideas most appealing to doctors. You might find that a few ideas appear on both lists. If so, selecting those to work on further pleases both camps. Or, you might take the top few ideas under each criterion and in the next step of further development say that one of the challenges is to think of ways to make the user-appealing ideas more appealing to the doctors, and vice-versa.

Tools Phase 3: 116
Introduction

Remember the Idea Funnel. Harvesting is not the final selection of what will be implemented, it is just the narrowing down of options on which more thinking and work will be done.

What do you mean by "Dot Voting"?

In dot voting, group members simply vote for some pre-determined number of ideas from the list that they feel best meet the criteria to bring forward for further development and test.

To use the tool:

1. Prepare flip charts with the list of ideas that were previously generated. Clarify the ideas as needed as you write them up, and eliminate or combine duplicates. Make sure the ideas are written out in a full sentence or paragraph rather than a couple of words, which might not mean very much to most people.

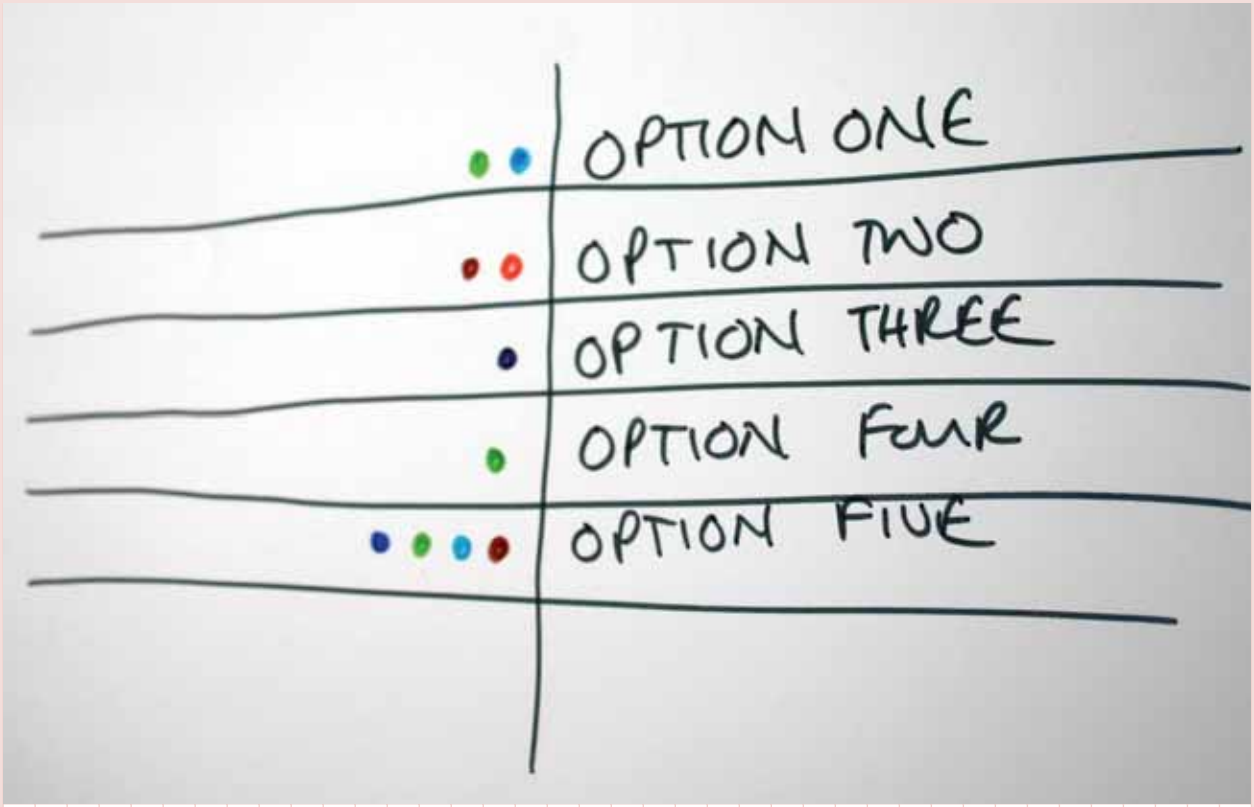
2. Review the list of ideas to ensure that everyone understands each idea. **Tip:** If you are bringing in new people who were not involved in the idea generation (as we strongly recommend!) you might do some of this briefing prior to the harvesting session.

3. Agree on the number of ideas that you would like to see come out of this harvesting process for further development. Stress that you will always have the full list to go back to later; no ideas are being thrown away.

4. Discuss and agree the criteria that you will use to select the ideas to take forward. **Tip:** Review the notes on "attractiveness" and "compatibility" on page 122.

5. Give each participant a number of "votes" roughly equal to twice as many ideas as you have agreed you want to see come out of this process. "Votes" can be coloured dots, small post-it notes, marks with coloured pens or anything that is small and will stick to the flip chart easily.

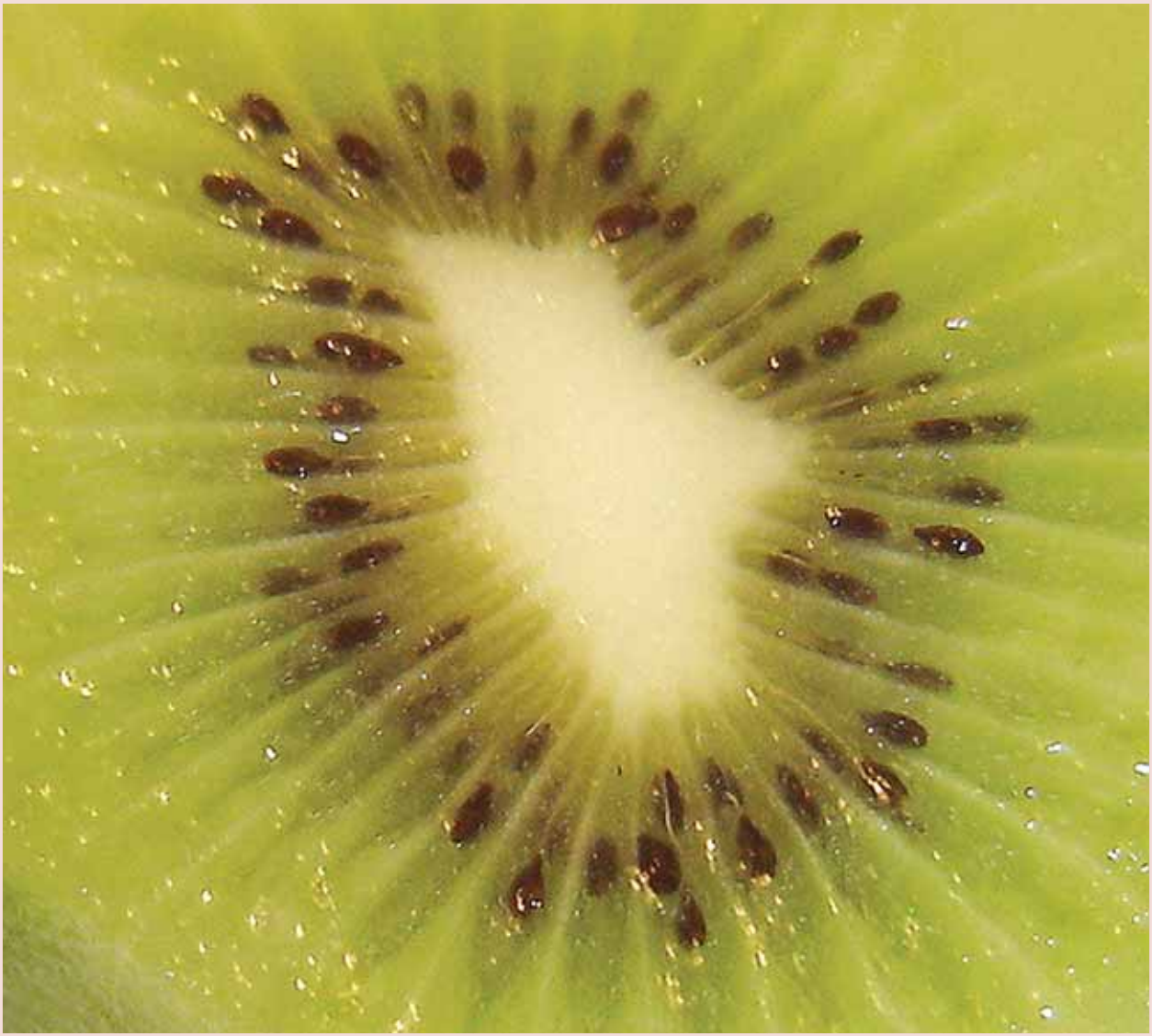
6. Ask participants to place their votes next to the ideas that they feel best meet the agreed criteria. **Tip:** The physical interaction of doing this is part of the consensus building process. You will find clarifying questions being asked and some "lobbying" for ideas going on. That is good!



7. Identify ideas that received votes from half or more of the group.

8. If this does not yield the desired number of ideas, repeat the vote. But this time only consider ideas that got at least 2-3 votes in the first round; disregard the rest. Continue this process until a consensus emerges.

9. If the first round yielded more items than were desired, discuss whether to take all the ideas forward, or which ones to hold back on for now.



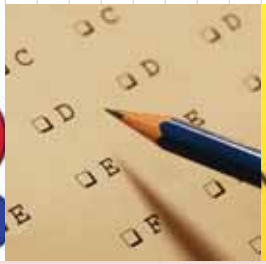
Variations on this tool

There are many different ways to use the basic concept of Dot Voting. You may have your own experience and a method that you prefer. We say, "What ever works for you." Some popular variations, with tips, are given below:

- *Assign each person a different colour dot so that you can see who voted for which idea.* This can be helpful if you want to ensure that key stakeholders see at least one of the ideas that they support make it through for further development. If you have invited someone to the harvesting meeting, but none of the ideas that they voted for make it through, that might be something that you want to discuss.
- *Give everyone fewer votes, but anticipate several rounds of voting as you eliminate items that got no (or few) votes each time round.* This takes longer, but can build better consensus. As you proceed into later rounds of voting, the list to choose from gets smaller and the chances that everyone can see at least one of the ideas that they voted for at some point make it through increases.
- *Allow a person to give an idea multiple votes.* Multiple votes allow people to express strong preferences, but has the downside that you may end up with an item that got lots of votes, but only because 1-2 people gave it all of their votes. You could use a restriction, such as "no more than three of your votes on one item". Another way is to simply ask for a show of hands of who voted for each of the winning items and see the distribution across the group.

No matter how you do it, keep these goals in mind:

- You want the process to yield a few ideas that best fit the agreed criteria.
- You want to build consensus and support among key stakeholders that will be needed as you face the challenge of taking these ideas forward and implementing them.



Tool: **Edward de Bono's Six Thinking Hats®** [3]

Synopsis

This tool enables individuals or members of a group to explore an idea or topic from a variety of perspectives, and in ways that may differ from their preferred way of thinking. Edward de Bono, an expert on thinking and the developer of the concept, suggests that by metaphorically wearing different hats, we can direct our thinking in specific ways".

Concepts: **20**

The main difficulty of thinking is confusion.
We try to do too much at once. Emotions, information, logic, hope and creativity all crowd in on us.
It's like juggling too many balls.

Edward de Bono, Six Thinking Hats®, Penguin, London 2000

[3] © The McQuaig Group. For more information contact: www.holstgroup.co.uk

The Six Thinking Hats® are:		
Hat	**Calls for...**	**Think of...**
 **White**	data, facts, and information only	white paper
 **Red**	feelings and intuitions only	fire and warmth
 **Black**	thinking about negatives, downsides, risks, cautions and warnings only	the black robes of a judge
 **Yellow**	thinking about positives, optimism, benefits, and goodness only	sunshine
 **Green**	creativity and new ideas	new growth and vegetation
 **Blue**	attention to the big picture, direction, and management of thinking process	the sky above or a police officer directing traffic

By giving each hat and the mode of thinking that it represents an equal amount of time and consideration, we can avoid prematurely jumping to a conclusion, or making a decision with insufficient information. In addition, ensuring the whole group uses the same "hat" at the same time increases the speed and efficiency of the thinking process, since everyone is thinking in parallel instead of in different, conflicting modes.

For example...

Suppose that one of the ideas that a group wants to take forward after using dot voting is that of introducing a one-stop clinic for multiple diagnostic tests. The group might further process this idea (and all the others selected in the harvest) through a discussion using the hats as follows:

Hat	Comments about one-stop clinic idea
	*Our creative idea is to implement a one-stop clinic in a service area where this has not yet been explored*
	*Beneficial for patients – only need to visit the hospital on one occasion, rapid diagnosis, coordinated care, integrated approach*
	*Possibly too fast for patients, particularly if diagnostic tests confirm a very serious diagnosis. Risk of 'carve-out' if several professionals pulled into one clinic setting to the detriment of other services*
	*Additional information about protocols for delivering 'bad news' to patients would be useful. Capacity and demand work to understand impact on other services. Survey of patient views...*
	*We are anxious about how these service changes will effect us but, despite the disadvantages, our gut response is that this will better serve our patients*
	*Let's form a small team to develop the idea further.*

When to use:

As the above example illustrates, this is a particularly useful tool during or after the harvesting of creative ideas. Six Hats thinking helps provide a well-rounded view from a variety of perspectives. A quick run through the hats enables us to broaden our understanding of the idea, thereby helping us decide whether the idea is feasible to take on to further development, or whether its challenges so far outweigh the potential benefits that it can be put aside at this point with no further expenditure of time and resources.

While the example above describes its use in a group - where, indeed it is powerful in getting everyone thinking together, rather than debating - the Six Thinking Hats® can be used by an individual as well.

Thinking is the ultimate human resource. Yet we can never be satisfied with our most important skill. No matter how good we become, we should always want to be better.

Edward de Bono

Case study: The Black Country puts on its Thinking Hat

The Black Country Health Review, "Better by Design", aimed to develop models of service provision that would meet the needs of the local population and provide the basis for financial investment. The SHA, Hospital Trusts and Primary Care Trusts wanted innovative ideas on how best to achieve this. Keen to "keep the NHS local", they felt it important to engage patients, professionals and the public throughout the decision-making process and to get these differing perspectives in a meaningful way.

Public meetings and in-depth information gathering and analysis were the starting points for a wide-ranging review of both hospital services and the interface between secondary & primary care in several key areas.

A series of key questions were then addressed through 5 one-day seminars attended by a total of around 500 people including clinicians, administrative staff, managers, patients, family members and other community stakeholders.

A professional facilitator introduced participants to creative thinking techniques. De Bono's Six Thinking Hats® were used as the framework for the sessions. Participants worked in mixed groups of 8, with table facilitators, to generate ideas for future service development in response to the key questions provided.

Tools Phase 2: **86**
Random Word, Picture or Object

The table groups first focused on the Green hat – generating as many ideas as possible, without criticism or justification. The Facilitator introduced the Random Word tool to help them do this. Participants then used each mode of thinking ("hat") in turn to develop and evaluate the ideas they had generated: Yellow to determine the benefits, Black to examine the drawbacks and risks, White to establish what data was available and needed and Red to identify peoples' gut feelings.

These thinking tools generated nearly 2000 ideas in under a week!

"90% of bad decisions are errors of perception, not logic. These sessions helped iron out initial perceptions and concentrate on contributing a range of ideas from different perspectives to be worked through as part of a group".

Workshop facilitator.

Use of de Bono's Six Thinking Hats® as a "harvesting" tool enabled the ideas generated from the sessions to impact on the decision making process rather than just remain as ideas. A core group from the Black Country Health Review assessed, selected and developed a shortlist of the ideas with the greatest potential for delivery and benefit, again using the Six Hats technique.

The most significant (and unexpected) result of the cross-community idea generation sessions was a substantial re-framing of the review itself. Having begun with a focus on how to invest in hospital-based services, it shifted to focus on how best to co-ordinate services between primary and secondary care, and to generate models of care that were integrated.

This shift came from a combination of gaining in-depth information on how services were currently performing and encouraging staff and public to **think differently**.

The SHA, Hospital Trusts and primary Care Trusts have now used the key themes and ideas that were produced across the idea generation sessions to develop new models of care, recommendations for future provision of services in the Black Country and the key steps towards implementation. (For more information see: www.dudley.nhs.uk/sites/board-papers/documents/0404/Enclosure6.PDF)

"These ideas come directly from our staff who work with patients every day and our customers in the wider community".

Paul Maubach, Review Project Director, Birmingham and Black Country SHA

How to use:

A. To use the Six Thinking Hats®, someone in the group 'puts on' the Blue Hat as the leader of the session. The blue hat leader explains the overall plan for flow to the group. We highly recommend the sequence of hats in the previous example for use on harvested ideas. The main role of the leader is then to manage the time and keep the group focussed and actively participating in the thinking associated with just one hat at a time.

"Excuse me, we are on the yellow hat now, so only positive comments about benefits and good points are allowed… we'll go on to the black hat where you can bring up those cautions soon".

B. Work through the hats in sequence. Remember that the whole group must wear or focus on the same colour hat at the same time. De Bono suggests about four minutes per hat to keep the discussion lively, focused and flowing.

C. Since, as Harvard Professor David Perkins points out, "most of us are better critics than we are creators" experience in the NHS suggests that it is useful to block the critical thinking of the Black Hat initially and instead begin with Yellow in any sequence. After a period of focussing only on the positives and benefits of an idea, the criticisms and cautions are naturally somewhat tempered. **Tip:** NHS teams have found it useful to set ground rules that balance positives and negatives; such as "spend equal time on Yellow and Black Hat", or "your list under Black Hat can be no longer than that under Yellow Hat.

D. Consider quickly returning to the Green Hat to further embellish the idea or to think of ways to enhance the benefits (yellow) and reduce the drawbacks and risks (black).

E. Return to the Blue Hat for a final vote on the idea as to whether, all things now considered, it should continue in the development process or be put aside for now.

Tips

- You don't have to actually wear hats; it is only a metaphor. However, some teams in the NHS have found it good fun to actually have a supply of inexpensive coloured caps to remind them to stay on focus.
- The Hats have natural pairings; Yellow is positive whilst Black is more negative; Red is emotion driven whilst White is data-driven. In general, if you use one hat of a pair, you should also use the other one as well for balance.
- All participants must "put on" the same colour Hat at the same time, and everyone should participate equally. The idea is to *think together*, what Edward de Bono calls "parallel thinking".
- Discourage people from characterising themselves as being a particular hat ("Oh, don't worry about me being quiet… I'm saving all my comments for when the Black Hat comes round".) Whilst people will have preferences and natural ways of being, we should encourage them to become more balanced in their practice of different modes of thinking.

Tool: **Enhancement Checklist**

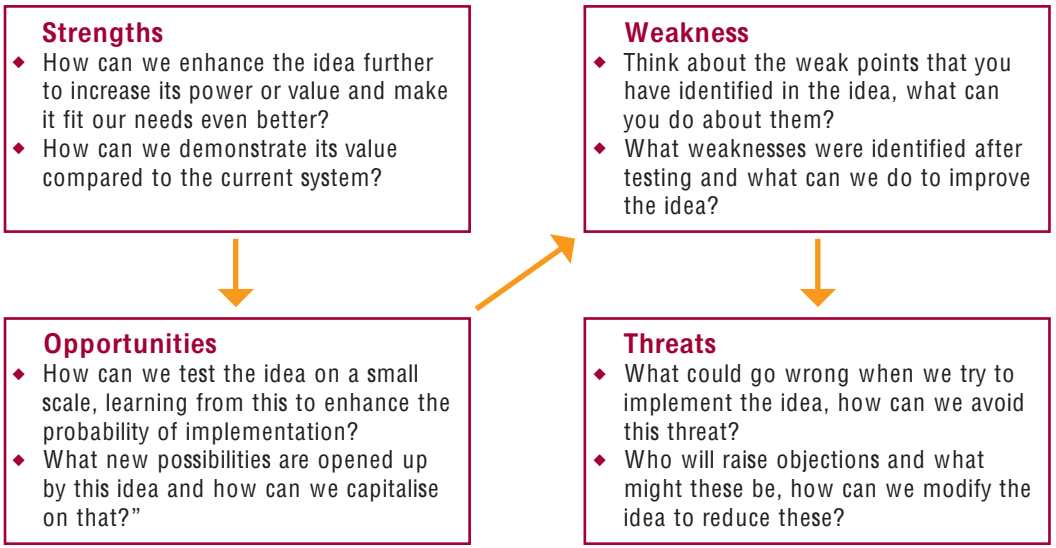
Synopsis

Edward de Bono suggests that we explore a series of questions that, in his experience, are often not asked, nor thoroughly addressed before people press on to test new ideas. Thinking through such issues early on, before testing an idea, enhances the chances for success.

An idea that is developed and put into action is more important than an idea that exists only as an idea.

Edward de Bono

Based on some of the questions suggested by de Bono, we have constructed our Enhancement Checklist in the familiar format of a SWOT analysis. The items in the checklist direct our thinking to consider emotional and people-related issues, the strengths and weaknesses of the idea, systems-effects and consequences, and the need for small-scale tests and prototypes.



The Enhancement Checklist is the necessary next step after harvesting your ideas. It will help you to:

- Enhance an idea enough to make it attractive to key stakeholders whose support you need in order to take it forward.
- Further develop an idea in order to get it to the testing stage.
- Identify any ideas that should not, at this stage, be taken any further.

How to Use It

The Enhancement Checklist is meant to be taken as a whole. Consider multiple questions at the same time, and be prepared to re-evaluate your work on earlier questions as you go along. When you think you are finished, go through the list one final time to make sure you have not missed anything.

The amount of time required for enhancement depends on the complexity of the idea. You might make it through all of the questions in an hour or two on a simple idea. A more complex idea may need much more time assigned to thinking, exploring and working with others; perhaps spread out over several meetings or in an away day.

Finally, please note that the question about testing the idea on a small scale (in the Opportunities section of the checklist) is so important that it bears special attention. The next section is devoted to this topic.

For example...

Case Study: 155

The six idea development teams described in the case study Award Winning Thinking Brings Better Care to a Diverse Community■, used the Enhancement Checklist as their guide over several months of work to develop the ideas further. They learned that time spent looking honestly at the items in the Weakness and Threats section either strengthened their idea or made it clear that further investment of effort and resources was not likely to be fruitful.

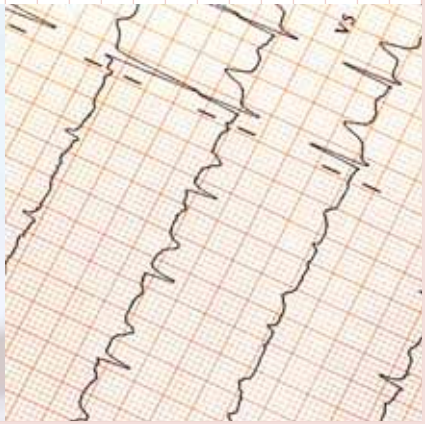
Tips

- Do not rush the work of enhancement! Many creative ideas go down in flames in the rush to try them out before they have been thought through properly.

- Recall the Idea Funnel™ concept and keep in mind that it is OK if the outcome of this process is to recommend that the idea not be taken forward. Such a decision is not a failure of the process of thinking differently; rather, it is successful outcome that indicates that you are managing appropriately the risks inherent in new ideas. However, always maintain the bias that you are striving to take the idea forward and it is your challenge to find ways to overcome potential objections and weak points. If the idea is not taken forward, remember to capture the learning from the exercise - you will always learn something.

- Engage lots of people in this thinking process. You or your small team do not have to work it out alone. For example, if you are not sure who will object and for what reasons, conduct a quick survey or focus group rather than guessing. Test out your ideas with others by simply telling them what you are thinking about doing and asking what they think. In the end, it would be great if, when you are finally ready to test the idea, everyone is saying "Well, it is about time! We have been talking about this enough, let's give it a go!" rather than "You want to do *what?!?*"





Tool: **Testing New Ideas on a Small Scale**

Synopsis

If you are really thinking differently, then you are coming up with ideas that are unusual or uncommon in your environment. Therefore, you cannot know how they will work until you actually try them out. But spending lots of organisational resource and effort in the full implementation of an idea that you are unsure will work is not appropriate.

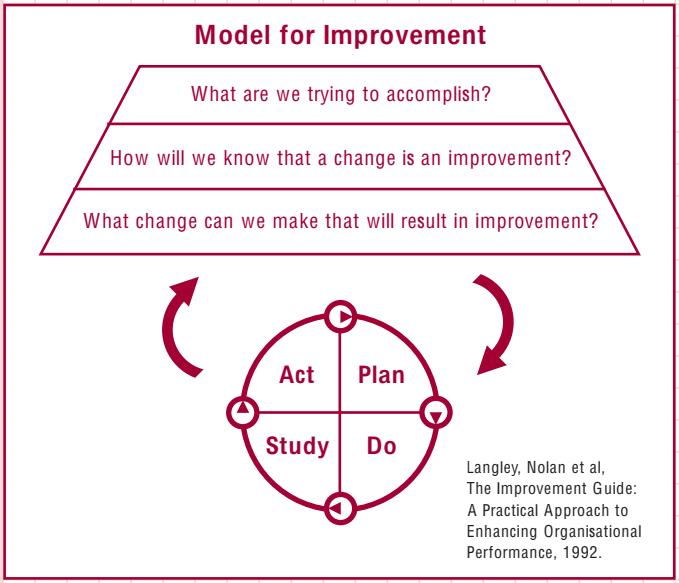
In theory there is no difference between theory and practice. In practice there is.

Jan van de Snepscheut

As noted in the Opportunities section of the Enhancement Checklist, we strongly suggest that you consider carefully developing a small trial or demonstration of the idea in order to build confidence and to work through any unexpected problems before you go to larger-scale implementation. This concept of small-scale testing is integral to all improvement work. (see Improvement Leaders Guides: www.institute.nhs.uk/improvementleadersguides).

Thinking Differently and the Model for Improvement

The model for improvement was designed to provide a framework for developing, testing and implementing changes that lead to improvement. Its framework includes three key questions and then a process for testing change ideas using Plan, Do, Study, Act (PDSA) cycles. Use of small-scale testing, such as the PDSA cycle is a way of testing an idea by putting a change into effect on a temporary basis and learning from its potential impact. This is quite different from the approach traditionally used in healthcare, where new ideas are often introduced on a large scale, without sufficient development or testing.



The basics of small-scale testing:
PLAN: specify and agree the change idea to be tested.
DO: carry out the test and measure the impact.
STUDY: review the data before and after the change. Reflect on what was learnt.
ACT: plan the next change / test cycle or plan for implementation.

Just following the Model for Improvement is not enough. The tools for Thinking Differently will ensure you have great change ideas in the first place. First, you need to **stop before you start**, question and re-frame your initial issue to help really focus on what it is you are trying to accomplish. Then you need to **generate lots of ideas** in order to end up with high quality changes to test (remember the Idea Funnel).

(For more on the Model for Improvement, see the Improvement Leaders Guide: Process Mapping, Analysis and Redesign)

Tips for Small-scale Testing:

Obviously, the details of how construct a small test of an idea will vary considerably based on the nature of the idea itself. But here are some tips to get you started in your thinking:

- If the idea involves a process modification that would change things for all time …
  - Can you get agreement to test it out for just a few hours, days, or a week? It would be important to agree up front that if it doesn't work you'll put everything back the way it was.

For example…
In a hospital in the South East, an orthopaedic team wanted to introduce weekend physiotherapy to reduce delays in discharge dates. They tested the idea on just two orthopaedic wards over two weekends and monitored the results. These showed reduced length of stay for the patients involved in the test. The team did another test cycle over the next two weekends - this time withdrawing the weekend service. The length of stay went back up, showing that it was the service change, not other factors that had caused the initial improvement. This provided them with the information and confidence to implement the weekend physiotherapy service.

- If the idea would involve and impact lots of people, or various groups of people…
  - Can you test it out on a subset of those people? For example, can you try it out with only a few patients… for just a few days or a week… with only 1 or 2 doctors or other staff who would have to become engaged?

For example…
At a hospital in south east London, one Elderly Care physician wanted to reduce routine follow-up appointments in her Falls clinic in order to free up time to see new patients more quickly. Rather than trying to influence others to do the same, she changed her own practice, collected data on the impact and made run-charts available to her colleagues. When they saw the results, the other clinicians soon followed suit.

- If the idea involves bringing in a new member of staff, or acquiring a new set of skills not currently reflected in the existing staff…
  - Can you "borrow" (or arrange a secondment for) someone with those needed skills from another area for a short time in order to evaluate what impact this might have if you could get a permanent position, or could re-train some existing staff.
  - Could you send just one member of staff on a new training scheme offered elsewhere in order to evaluate whether or not retraining others would really have the effect that you hope for?

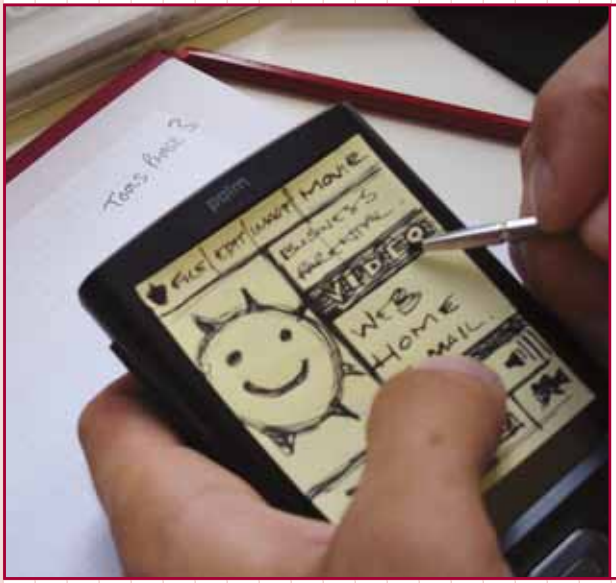
- If the idea involves altering a physical space…
  - Can you perhaps make temporary alterations, or provide temporary structures, for a test?
  - Can you maybe create a mock up in some unused space and test it there?

- If the idea involves some new gadget or fixture…
  - Could you create a mock up in cardboard, wood, or plastic that you could then use for a while to demonstrate the idea and evaluate whether the expense of constructing something more permanent is worth it?

For example…
A team from the NHS Institute for Innovation and Improvement, working on new ideas to reduce hospital acquired infections, put together a "cardboard ward" to mock up changes to ward layout, signage and fixtures. This enabled them to get a better feel for how these would work in practice and to iron out glitches before testing them in real life.




- If the idea requires changes in IT systems or other equipment…
  - Can you test the idea using a temporary computer program, or a mock-up of the functionality in some commonly available program such as a word processor or spreadsheet?
  - Could you demonstrate the new IT system with a paper-based system that could be automated as a later development effort (taking into account that the paper based system for the test will obviously be less efficient than the proposed automated system)?
  - Can you borrow a needed piece of equipment from a supplier? They are usually quite anxious to be able to demonstrate what their equipment can do.
  - Can you create a mock up of the equipment that is sufficient to show how the idea would work if only you could acquire the real equipment?



For example….

Some of the wards in a hospital in North Devon needed immediate data on length of stay, admissions and discharge in order to test out a new tool they had developed to predict discharge dates and so reduce delays. Faced with a complicated IT system that did not seem able to provide real-time information in the way they needed it, an improvement advisor handed out graph paper and pencils and showed staff how to "plot the dot". Soon, ward staff were recording their own run charts and were able to use the data to test their Predictor Tool while the IT department worked on being able to get computer generated information to them more quickly.

We can make our clinical results much, much better, simply by believing that we can, and then trying something, measuring it and learning from that.

Laurence Wood, Consultant Obstetrician, Coventry & Warwickshire Hospitals NHS Trust

The goals of testing your ideas on a small scale are:

(1) To create some confidence and momentum for the idea, if it really is a good one…

(2) To learn more about the idea so that you can further enhance it, or…

(3) To evaluate and eliminate the idea from further development without a major investment of resources, if it turns out not to be such a great idea after all.

Key Point: The measure of the success for a test is whether or not you learned something. The test is successful even if the idea itself fails, as long as you learn something. The only "failure" is a failure to learn.

I have not failed, I have merely found ten thousand ways that won't work.

Thomas Edison, inventor of the light bulb

Remember, if your idea has reached this far in the process it has already been subject to lots of critical thinking, perhaps by many people… and it was judged to "look good enough on paper" to give it a go. No one has a perfect crystal ball to see the future. There will always been unforeseen effects and unintended consequences, when you are really pushing the envelope in thinking. If all you ever do is test successful ideas, then you may not be thinking differently enough!

When you get a result that you expect, you have another result; but when you get a result that you don't expect, you have a discovery.

Frank Westheimer

Implementing Change: making your ideas a reality

So you've managed to think differently.... Now what??

It is not enough simply to have creative ideas. Ideas alone do not really change anything. Innovation only occurs when ideas are put into action.

To put one's ideas into action is the most difficult thing in the world.

Goethe

Implementing an idea takes more than good intentions; it requires change management skills. There is a vast literature about the implementation of change, and an important subset of that literature deals directly with the implementation of highly innovative change. Although the focus of this guide is on the steps before implementation – reframing the issue, generating, selecting and testing ideas - it might also be helpful to consider some of the key points that appear repeatedly in the literature on change management.

Keep these in mind as you think about how you will bring your ideas to fruition and make the changes stick:

- Effective change is born of a sense of urgency. You need to create or increase urgency.
- Amid the excitement you feel for your new ideas, do not forget to think about others who are not so close to it. You will need to address the "why should I support this?" question for those who will participate in testing or implementing the change.
- Whilst thinking differently often requires that we escape the organisation's structure and rules, implementing new ideas requires that we engage the organisation's structures, processes and rules, at least enough to gain permission to try something radically different.
- Every idea needs a guiding coalition (a group of champions or sponsors) whose members are wide-ranging and influential enough to help with necessary resources, including participation by others.
- Be prepared for resistance in response to innovative ideas. Be patient, but focus on trying out something new. Prototypes and small-scale tests, where others can see the impact of the new idea, often help as people see that their worst fears are unfounded and that there are some benefits that they had not fully appreciated.
- If you cannot state the idea clearly and compellingly in 5 minutes or less, you are not ready to proceed into implementation.
- Over communicate. You are ready to implement only when people start saying to you "Enough talk already, when are we going to do it?!?"
- Use feedback to keep the change on track. Information and feedback are important to ensure people know how the change is making a difference.
- Implementation of innovative ideas is frightening to many. Leaders have the responsibility for leading the way by their own actions in supporting and implementing new ideas.

And the journey doesn't stop there. Once you have turned your ideas into reality and implemented the necessary changes, you will need to continue to evaluate and re-focus. Inevitably, a change that was innovative when implemented will, after a period of time, become part of the status quo. We see that in healthcare and in our everyday lives: ground-breaking open heart surgery was re-thought to develop key-hole surgery, which later brought about day case surgery; the telephone was a radical invention that changed the face of communication... and then became part and parcel of everyday life until someone again thought differently and the mobile phone took the technology to a totally new level.

The concepts and tools of continuous improvement (see www.institute.nhs.uk/improvementleadersguides) will be invaluable in ensuring that your newly implemented ideas don't become stagnant but keep evolving. Then one day, you or someone else will stand back and ask "why do we do this at all?!". **That's the joy of the Thinking Differently journey: it doesn't ever stop and so the possibilities are endless!**

How do you get your group to defy the status quo and act on good ideas? It starts with vision, teamwork and some fire in the belly.

Dr Jack Silversin

Some Final Words...

This book is designed to provide you with concepts and tools to help you to stand back from the status quo, to re-frame everyday problems and issues, and to generate, select and test new ideas for change.

In the end... it is the extent to which we are willing to challenge the way we currently do things, to take the time and effort to think differently and to breathe our new ideas into life that determines how great a difference we can really make.

Whatever you can do or dream you can do, begin it.
Boldness has genius, power and magic in it.
Begin it now.

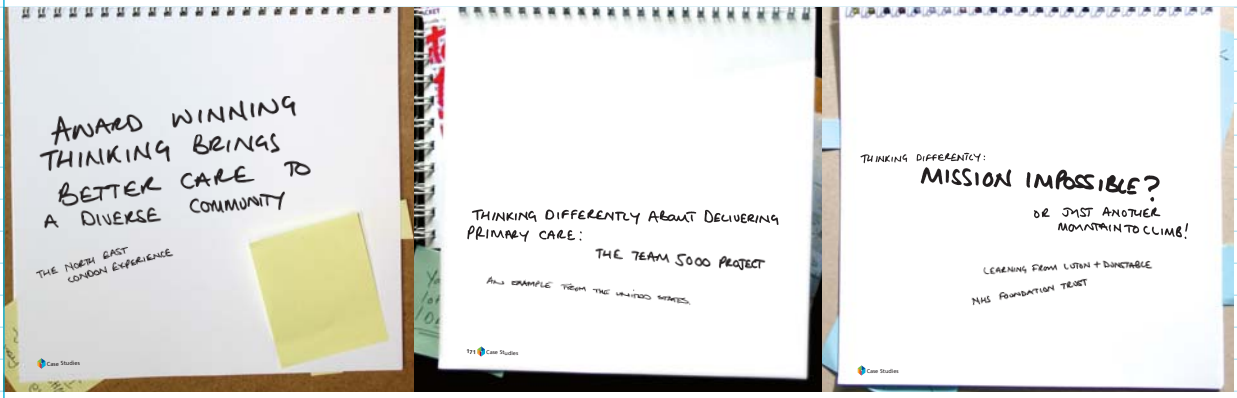
Goethe

TOOLS PHASE 3

Case studies

Practical Examples of Thinking Differently

- Award Winning Thinking Brings Better Care to a Diverse Community
  The North East London experience
- Thinking Differently About Delivering Primary Care
  An example from the United States
- Mission Impossible? Or Just Another Mountain to Climb
  Learning from Luton and Dunstable NHS Foundation Trust



Case Studies

The following case studies are included to help you see the process of **Thinking Differently** in practice within three different healthcare settings.

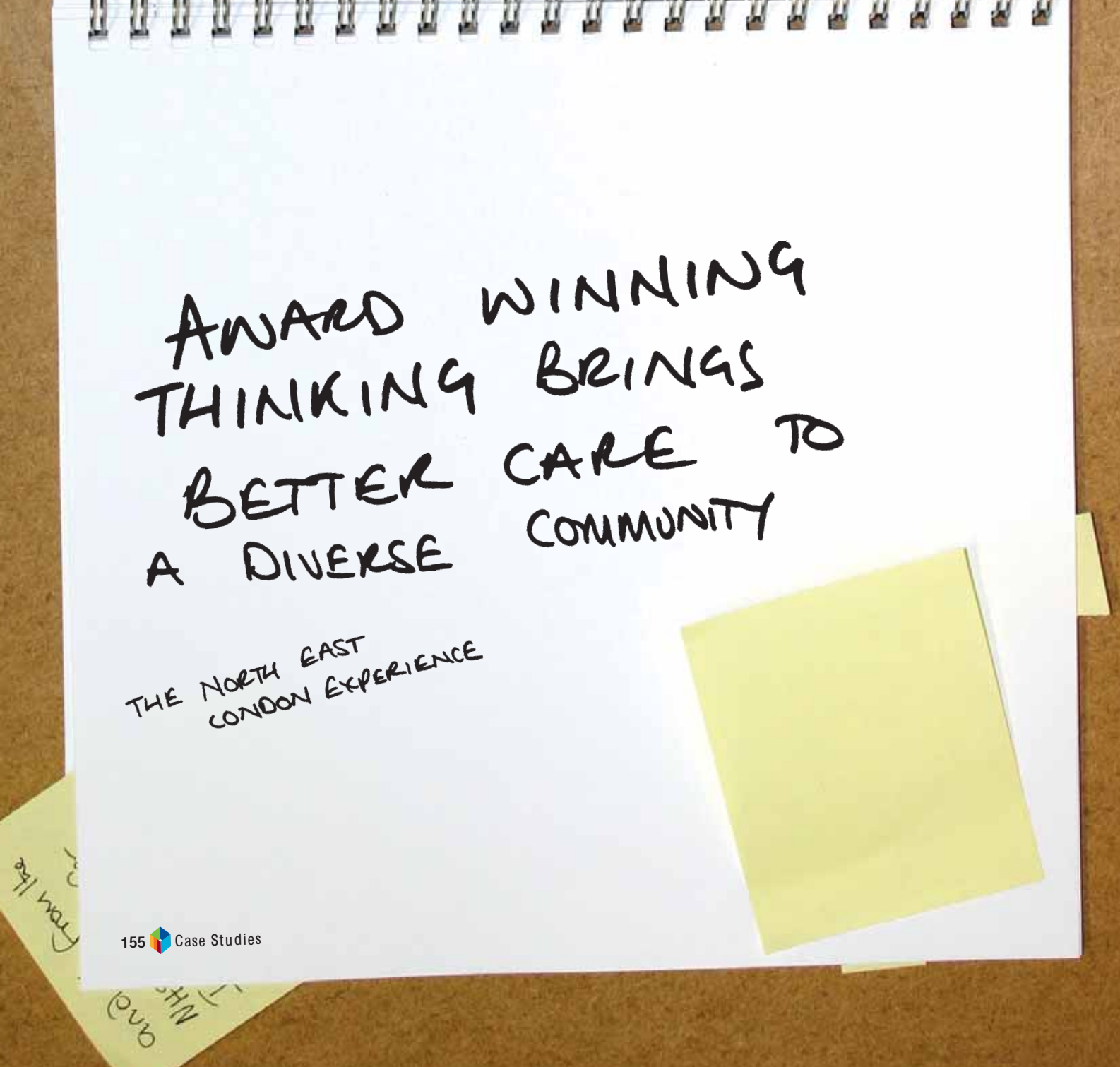
Tools Phase 1: **33**
Tools Phase 2: **63**
Tools Phase 3: **113**

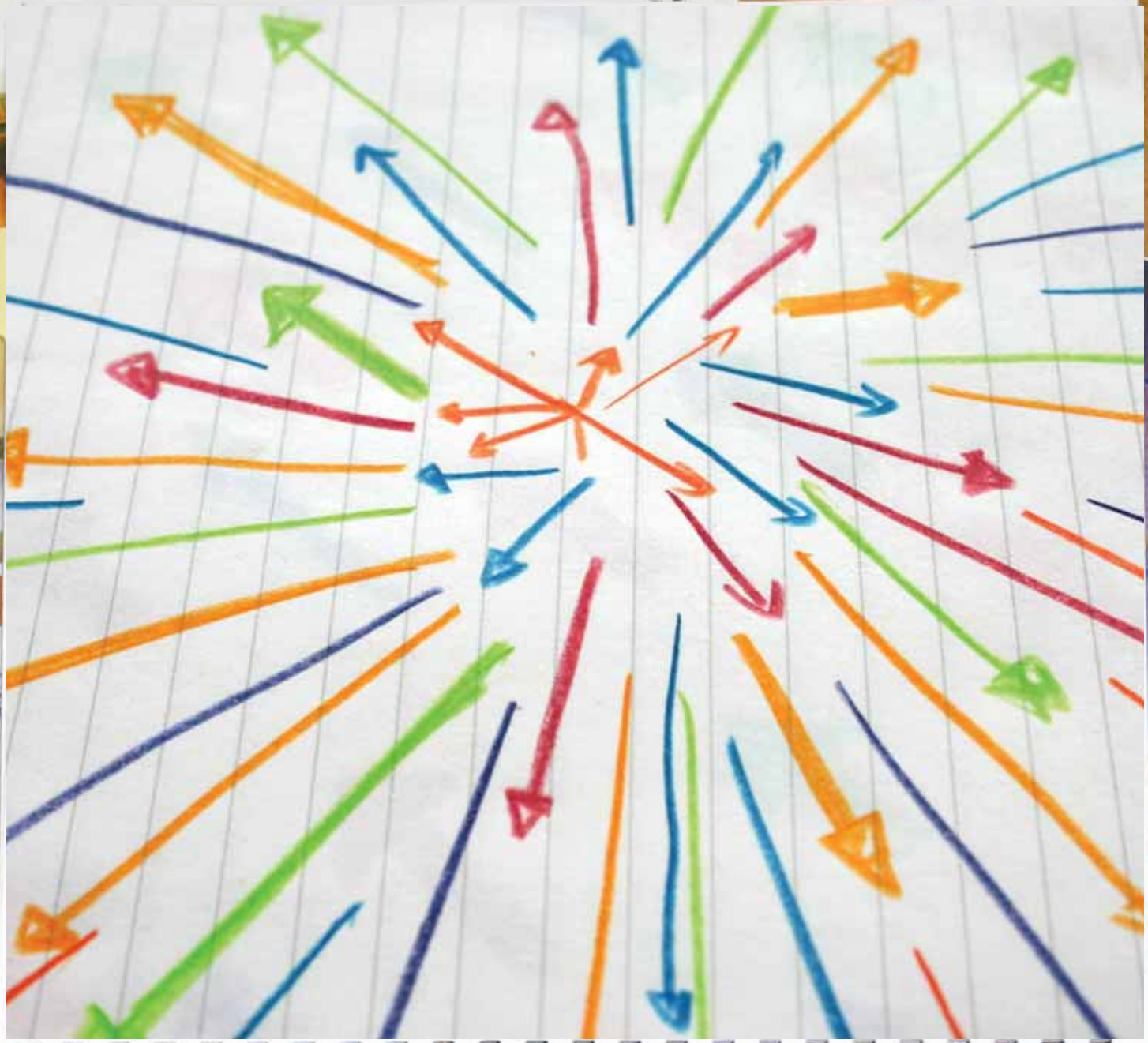
Each example will take you through the whole process, from the focus on specific issues, challenges or situations, to re-framing these issues (**stop before you start**) through **generating lots of ideas**, and on to **selecting and testing** some of those ideas for implementation.

As you work through and apply the Thinking Differently process to your own context and your own issues, we encourage you to document the journey. This will help you to keep a record of the different tools and approaches you tried, what worked well, what you learned from the experience and what you would do differently next time. We also hope that it will encourage you to share your stories and experiences with us so that we can build a wider cadre of case studies and help others within the healthcare community to be more effective on their journey of **Thinking Differently**.

AWARD WINNING THINKING BRINGS BETTER CARE TO A DIVERSE COMMUNITY

THE NORTH EAST LONDON EXPERIENCE





Award Winning Thinking Provides Better Care in a Highly Diverse Community

We wanted to see if we could do something to break the mould rather than just incremental change.

Stephen Langford, Executive Director of Service Transformation, North East London SHA

Health care is typically organised to provide services during 'normal office hours'. Patients seeking to access services 'out of hours' can often experience delays and poor co-ordination of services. Such was the case in North East London in 2003 when the chief executives of the various Trusts and the SHA commissioned the Service Transformation, Redesign and Innovation Project (STRIP) to bring about improvements.

A small steering group consisting of SHA leaders and several key individuals from primary care and acute Trusts met in mid-2003 to work out a two-pronged strategy. This first involved putting together an inventory of the many initiatives already underway in order to join these up into a better, more coherent plan. While there was a sense that many good things were happening that would certainly make a difference, the leaders also felt a need to initiate work on a second prong: **thinking differently**. They envisioned this evolving over five phases to create some new approaches to the issue of out-of-hours care that could be added to the existing suite of initiatives.

Phase	Deliverables	Who and How
Scoping	Theme, goals, targets; match with priorities; key stakeholders to involve	Small planning team
Fact gathering	Data, facts, answers to key questions that key stakeholders will raise	Small planning group, with lots of stakeholder input
Idea generation	Lots of ideas	Large group (100-120) of stakeholders across the whole system
Idea testing and development	Successful efforts that can be spread across the patch; lessons learned	Multiple small teams in pilot sites
Implementing new systems	Real, measurable and sustained change that benefits both patients and staff	Multiple organisations across the patch

AWARD WINNING THINKING

TOOLS PHASE 1

OTHERS' POINT OF VIEW

P.40

Stop Before You Start

The first two phases of the effort involved data collection to describe the magnitude and specifics of the problems and to collect the views of key stakeholders. This naturally began, as it often does, as a somewhat internally focused exercise within the health service - looking at data on A&E waits, speaking with clinical and managerial leaders, and so on - when it was noted that **Others' Points of View** might be a useful approach to add. Specifically, what did the care system look like to service users, both during 'normal business hours' and 'out of hours'? If the aim of the initiative was to help think the unthinkable and generate new ideas that were a departure from usual thinking and practice, then who better to question what we do and how we do it than the very people those systems are supposed to provide for?

It was powerful right from the beginning having patients involved. Some things were contentious but it was difficult for people to argue against when faced with "this is what patients have told us they want".

Stephen Langford, North East London SHA

The planning team commissioned someone to speak to members of the public and interview patients who had turned up at A&E outside normal GP surgery hours to collect their experiences and stories. Innovation experts point out that such efforts to **Pause, Notice and Observe** often yield fresh insights into chronic problems, and it turned out that this was the case here as well. Northeast London is one of the most culturally diverse areas in all of Europe. Mental models about health care services and how to access them are highly variable and the experiences of different cultural groups in trying to access the same services can vary tremendously.

PAUSE, NOTICE AND OBSERVE P.50 TOOLS PHASE 1

The planning team saw that all of the data - the analytical facts as well as the stories of patient experiences - could feed into the design of an idea generation session that they envisioned as the third phase of the effort.

Generating Lots of Ideas

The culmination of the planning was a day-long event at the Excel Centre in London involving over 120 people from various disciplines and organisations across the patch, individuals from the voluntary sector, and a dozen service users from the community.

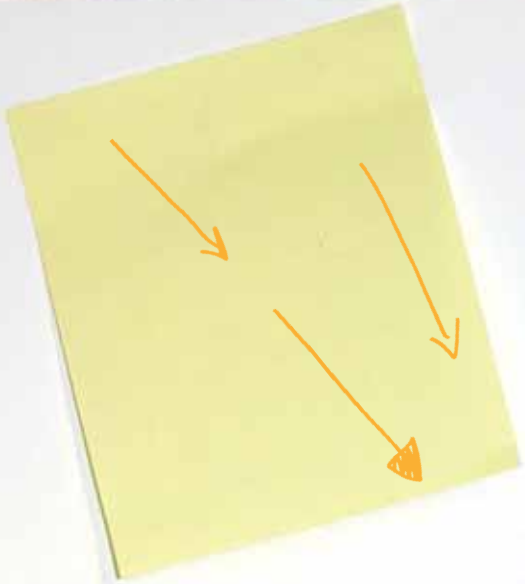
The SHA chief executive kicked off the day with a welcome, followed by a presentation from a national expert about the out-of-hours service delivery problem in North East London and across the country. The speaker challenged the group to bring some new thinking to the problem. The workshop facilitator then presented the concepts of mental valleys; first- and second-order thinking; attention, escape and movement; different modes of thinking (Six Thinking Hats); and divergent/convergent thinking as a lead-in to a series of interactive table exercises that would encompass the rest of the day.

The first exercise involved the **Fresh Eyes** tool and utilised the **Others' Point of View** material collected in the stories of patients' experiences. Table groups were randomly assigned to read two patient stories and asked to come up with ideas for new ways of working that might have improved the experience of accessing care. Starting off with this exercise, and having real patients in the table groups, served to centre the entire day around the patient.

Subsequent rounds of idea generation used the **Breaking the Rules**, **That's Impossible**, and **Stepping Stones** tools. For example, the Stepping Stones provocations included:

- A very selective virus has incapacitated all GPs in London. Now what!?!
- All our A&Es have been declared unsafe to occupy. Now what!?!
- It is illegal to have more than 10 patients in A&E queuing. Now what!?!

In each round, one person at the table captured each idea generated on a large sticky note. These were collected as the discussion went along by roving facilitators who grouped similar items and organised the ideas into themes on the wall along a corridor. Around 180 unique ideas were generated in only two hours!



Selecting and Testing Ideas to Make a Difference

CONCEPTS P.20

The idea generation during the morning clearly represented *divergent* thinking. So, the afternoon was naturally devoted to *convergent* thinking that would begin to select ideas to take forward.

During the lunch break, each participant was given 8 sticky dots and asked to browse the ideas posted on the corridor wall. The **Harvesting Criteria** to be used to conduct this **Dot Voting** were summarised in the following instructions to the group:

- Use your dots to vote for what you consider to be the "best" ideas
  - Best in sense of delivering service to patients and in helping staff do the work
  - Don't worry about cost or technical feasibility (that will come in later analysis and idea development)
- You can use your dots as you wish (e.g., all 8 on one idea; 4 each on two ideas; 3 on one, 2 on another, 1 each on three others; etc.)

TOOLS PHASE 3 P.120

This led to the selection of 11 ideas (the top vote getters), which were summarised aloud for the group and then each assigned to two tables for further discussion. Table groups were first asked to develop the idea a bit more by focusing on questions from the weaknesses, opportunities, and threats sections of the **Enhancement Checklist**. Following this shoring up of the weak points and imagining how the idea might be tested on a small scale, groups were next asked to take the idea through the **Six Thinking Hats®** sequence of yellow (positives), black (negatives), white (data), and red (feelings). In the end, the table groups expressed overall positive feelings about 8 of the 11 ideas and suggested that laying aside the other 3 as having too many challenges to overcome at this point.

P.136

P.128

The day ended with expressions of thanks from senior leaders and an evaluation, which was positive. All of the ideas and notes from the day were typed up for further review.

Several days later, a few members of the planning group met to reflect on the day and decide how to package the output for a presentation back to the chief executives who had originally commissioned the work. Some of the original 8 ideas were combined to yield 6 ideas, which were then documented on a five-part proforma:

1. A headline: something that captures the essence of the idea in an intriguing way.
2. The idea: crisply stated in attractive language in just a sentence or two.
3. This allows us to...: capture how this idea linked up with other key concepts that the decision makers would be familiar with.
4. Why we like this idea...: a list of key benefits, (yellow-hat thinking), as we believe that black-hat thinking will come naturally without listing it.
5. How we might trial it...: a brief description of how the idea might be tested on a very small scale with willing participants, to make it feel more do-able initially.

An example of one of these proformas is overleaf:

TOOLS PHASE 3

Creating a pool of Service Access Guides from within a community

Idea:
To create a cadre of people from within existing ethnic minority communities, in order to signpost the way for patients to access services more appropriately, to meet their special needs.

This allows us to:

- Bridge language or cultural barriers that prevent patients from knowing how to access services
- Relieve current bottlenecks in the system that result from misinformation about how to access services
- Engage the community itself in defining how it wishes to use services
- Get more focussed input from the community about their experience of accessing services.

Why we like this idea:

- Consistent with the direction of public involvement, patient choice and patient centred care
- Potentially relieves the demand for translator services
- Builds empowerment rather than dependency
- Can be flexibly adapted to all sorts of 'communities' and is easily replicable
- Utilises existing communication channels with existing communities rather than expensive marketing and PR campaigns
- It allows a wider range of people to signpost ways of accessing care.

How we might pilot:
Pick two specific communities who have specific health needs and find it difficult to access services because of major language or cultural barriers.

These one page proformas were presented to the chief executives at their next meeting. They agreed to charter teams to take all 6 of the ideas forward into the next phase of the effort involving further development and testing. The six ideas described below illustrate the richness and creativity of the discussion in the all-day event. Clearly, participants were thinking differently.

Insight: *It was useful to have a small group of pragmatic leaders to take the free-flowing output of the idea generation day and repackage the ideas to make them more "marketable" to senior decision makers for the next step in the process.*

Synopsis of the Ideas Taken Forward:

1. Fulfiling the needs by meeting the demand for convenient care
Idea: Offer GP surgery services (including minor emergency, chronic disease management and rotating specialist clinics) 8am to 8pm, 7 days a week

2. Creating a pool of Service Access Guides from within a community
Idea: Create a cadre of people from within existing ethnic minority communities, in order to signpost the way for patients to access services more appropriately, to meet their special needs

3. Pills on wheels around the clock
Idea: Partner with private sector companies for the provision and delivery of pharmacy services 24 hours a day, 7 days a week

4. Allowing the patient to become their own gatekeeper, creating an NHS 'frequent flyer' club
Idea: Many patients have recognised and legitimate continuing needs for specific services. For these patients the normal gatekeeper role is a bottleneck that doesn't add value; create a "club" that allows direct access to required services

5. Creating capacity while working when you want
Idea: Create pioneering examples of professionals who work non-traditional schedules but have high career satisfaction and work / life balance

6. Health Mall - A one stop shop for all your healthcare needs
Idea: Expand and extend the current trend of Walk-in-Centres by placing them in highly visible, easily accessible, high traffic areas of the community; offer extended hours comparable to commercial shopping; expand the range of services located in them

A champion and a small team of 3-10 people were identified for each idea. These groups met together twice over a 12-month period to share experiences and to receive additional guidance on project planning and testing on a small scale. Senior executives and several non-executive SHA board members attended these sessions to lend further support to the effort.

Understanding What Constitutes Success in the Journey of Thinking Differently

It is instructive to note that over the testing and development period, two ideas were abandoned, two were subsumed under other initiatives, and two went on to broader implementation. In terms of the process of thinking differently, all were successful in that something was learned from each.

The "pills on wheels" project was discontinued mainly because of the context in which it was proposed. The basic idea come from the difficulty of developing certain patient services within the framework of the existing pharmacy contract, and was therefore hard to promote as it became clear that these constraints would in effect be removed by the new Pharmacy contract from April 2005.

The "creating capacity while working when you want" project was also affected by a change in context. With the implementation of the national 'Agenda for Change' programme this proposed local change in working terms and conditions for a small group NHS employees was perceived as working against rather than with the national grain. Further, the project lacked support among the professional groups that would be responsible for testing and implementing key areas of the concept.

> ***Lessons learned:*** *New ideas depend heavily on the context in which they are introduced, the presence of a sense that the problem is big enough to warrant the effort of trying something radically different, and the active support of key stakeholders. Sometimes an idea can be a good idea, but just not in the current context.*

The "health malls" project was overtaken by similar concepts within the programme for Community Walk-in-Centres. In essence, one could say that the project proceeded, but with different sponsorship.

The "frequent flyers" project likewise found a new home under different sponsorship within the North East London Long Term Conditions Collaborative, where its scope narrowed to a focus on home monitoring of patients.

> ***Lessons learned:*** *One path for new ideas might be to join them up with other initiatives where they can gain access to other sponsors and resource pools. In the change management literature, this has been referred to as "having your idea board a train that is already pulling out of the station". As in rearing children, sometimes the best thing is to let them go off on their own!*

The "Fulfiling the needs by meeting the demand for convenient care" project group focused on developing knowledge resources to enable GP practices to successfully maintain opening hours of 8am to 8pm, seven days a week. (The project was actually re-branded as the '8 till 8' initiative.) The development team demonstrated that this could be accomplished principally by increasing the practice list size to make full use of the infrastructure already available, and by revising and restructuring their staff working hours as a team. The idea champion presented the case for this to all the PCTs and waited for volunteers to step forward to trial it.

Two practices offered to engage as pilot sites and the development team led them through the process via a series of away-days and on-site coaching. In the first three months of the pilot test, the two practices had generated an additional 2,200 GP consultation and 3,200 nurse consultation slots. Nearly 4,000 additional patients had been seen – over 2,500 of these were likely to have been seeking appointments with out-of-hours providers, either through the GP out-of-hours service or at an A&E department. The success of these pilots has led to more practices stepping forward to implement the ideas.

Lessons learned: *Often, one of the biggest barriers to initially implementing an idea that results from thinking differently is the willingness to take a risk, when lacking the evidence to know that it will work. Volunteers signal that they have already overcome this barrier and are willing to embrace the idea based on the strength of the theoretical case alone. Rather than expending energy trying to get "buy in" from everyone, use these volunteers as co-developers to work out the details of the idea and collect the data to support an evaluation. If the results are positive, the numbers will speak for themselves and others will come along. If the results of these small test don't turn out as you expected, that is good too, as you will have avoided massive disruption. It is all part of the process of* ***thinking differently****.*

Award Winning New Thinking

The final project of the six revolved around the idea of creating a cadre of people from within existing ethnic minority communities to signpost the way for patients to access more appropriately the services they need to meet their special needs. This project, renamed as "The Health Guides Project", won the Regional Health & Social Care Award ('Improving health and reducing health inequalities' category) for 2005 and was a finalist for the National Awards.

Guiding for Health

North East London has a high proportion of ethnic minority groups, and a growing range of these communities are "excluded" from mainstream society and services, partly due to language barriers (there are 200 different languages within the local population) and partly from a lack of engagement with and understanding of ethnic minority communities. The result for thousands of people, many of whom have long term conditions or disabilities, is difficulty in accessing the services and care they need, thus exacerbating local inequalities in health and reducing the effectiveness of the resources available for the local population.

The Health Guides project has been a collaboration between the local NHS, a voluntary organisation - Social Action for Health, and local communities which aims to address the issues and health consequences of the social exclusion.

Aims of the Health Guides projects include:

- Facilitating own-language access for excluded people to information and guidance about health services
- Promoting understanding and awareness of self care and self management
- Reducing health inequalities
- Increasing the effectiveness of NHS resource use
- Engaging more effectively with and empowering excluded communities.

Health Guides are... local people from a growing range of excluded local communities (such as Bengali, Somali, Congolese, Caribbean and Kurdish), trained and supported by NHS project workers to help others in their communities to improve their health and access local services.

A Health Guide...

- Runs community based, own language group sessions to address health issues and concerns
- Represents local people and feeds back to health and social care organisations
- Guides patients in accessing services
- Promotes health and well-being
- Enables people to take a stronger role in managing their own condition.

Benefits from the project include:

- A more confident and better informed patient population
- Broader and deeper social networks within and across excluded communities
- Local mechanisms for representation of excluded groups
- Better informed local service provision
- Helping people access the care they need
- Greater involvement of isolated and minority communities.

There have also been some unexpected spin-offs. For example, the project has created new access to employment opportunities for community members who have trained as health guides. In fact, 50% of the original 75 people trained secured work within 6 months. This has the dual benefit of ending long-term unemployment for many individuals and of widening participation from excluded communities in the local work force.

Due to the enormous response to the original posts advertised, the initiative has been rolled out more widely and now also includes mental health service users. The level of community involvement in the Health Guides project and the range of people involved is a key highlight for local healthcare leaders.

It is tapping a very rich vein of community interest in health in a way not done before.

Stephen Langford, North East London SHA

AWARD WINNING THINKING BRINGS BETTER CARE TO A DIVERSE COMMUNITY

TOOLS PHASE 1

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Some Final Reflection on the Process of Thinking Differently

The North East London "Out-of-Hours" initiative is a wonderful example of the entire process that unfolds when we choose to think differently. Let's recap some of the key points...

- Thinking differently has its place alongside existing initiatives. It can complement these efforts and be "in addition to". There is no need to debate "either we continue to think as we always have, or we think differently". Rather, we can say, "Yes, let's keep doing all the good things that our current thinking tells us we should do... AND let's also do a bit of new thinking as well".

- The case illustrates the importance of **thinking a bit before** diving into idea generation. The refocus on patient experiences, the deliberate collection of their stories, and the effort to plan for active involvement of service users in the idea generation event clearly changed the course of what might have evolved otherwise.

TOOLS PHASE 3 INTRO P.116

- The process naturally proceeded along the lines suggested by the **Idea Funnel.** Let's see... 180 ideas generated, 11 initially harvested, 6 taken forward for development, 4 actually field tested, and 2 now more widely implemented. If you refer back to the illustration of the **Idea Funnel** you will see that these numbers track the general experience pretty well. The ideas that did not make it all the way through to final implementation are not failures nor wastes of effort; they are simply part of the natural process of thinking differently.

The way to get good ideas is to get lots of ideas and throw the bad ones away.

Linus Pauling, Nobel Prize winning chemist

- Finally, the case illustrates the point that simply having a brainstorming session is not enough when it comes to thinking differently. Generating the ideas is actually the easiest part. The hard part - and clearly most important part - comes after that and involves the courage and conviction to stick with it to see some of the ideas through to implementation.

AWARD WINNING THINKING BRINGS BETTER CARE TO A DIVERSE COMMUNITY

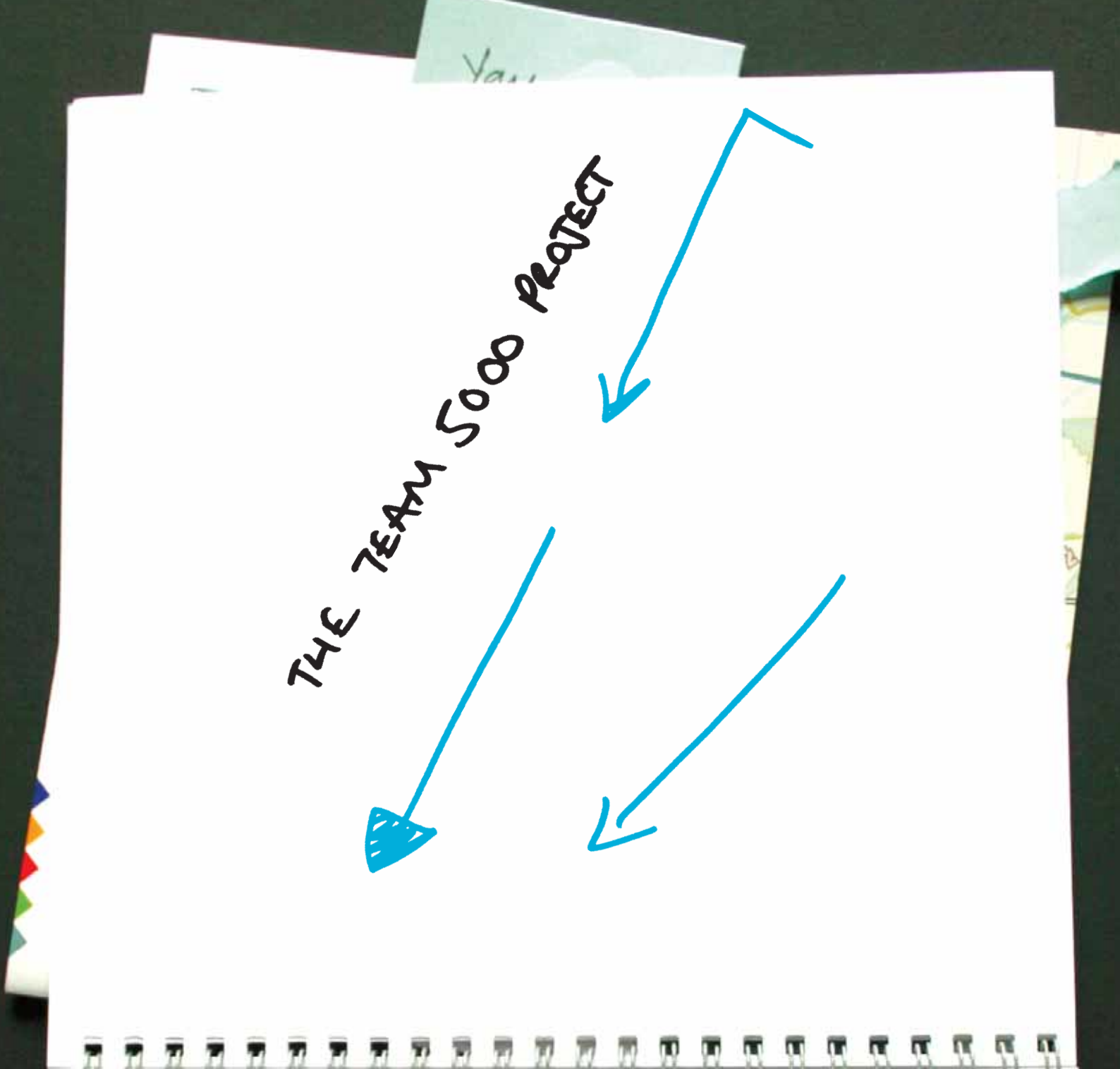
AWARD WINNING THINKING BRINGS BETTER CARE TO A DIVERSE COMMUNITY

THE NORTH EAST LONDON EXPERIENCE

THINKING DIFFERENTLY ABOUT DELIVERING PRIMARY CARE:

THE TEAM 5000 PROJECT

AN EXAMPLE FROM THE UNITED STATES.


THE TEAM 5000 PROJECT

How Can a Primary Care Doctor Be Expected to Cope With a Three-Fold Increase in Number of Patients?

The Virginia Mason Medical Centre, a hospital and primary care delivery system in Seattle in the US, faces financial pressures from declining revenue streams associated with the on-going issues of health care funding in the States. Projections by the finance department suggested that primary care operations would run massive deficits unless the status quo assumption regarding the number of patients on a primary care doctor's list was challenged.

Primary care lists in the US normally range from 1200-1500 patients per doctor (they are called "panel sizes" in the US and this ratio of patients-to-doctor is about the same in the UK). Without getting too deep into the details of US health care funding, suffice it to say that total annual revenues into a primary care practice is roughly correlated to the size of the list. That is, in order to double revenues, the practice would need to roughly double its list. But if delivering care to twice as many patients using the current thinking means that twice as many doctors, staff, and facilities are required, the net result would still be financial shortfall.

Clearly, this presented the need for ***thinking differently****!*

The organisation is heavily engaged in using "lean thinking" - a concept adapted from general industry that emphasises attention to flow in all processes, and the dramatic reduction of waste of all kinds. In additional to using this new thinking borrowed from other industries to help increase efficiency, senior leaders recognised that they needed some fundamentally new models for primary care delivery. So, they asked the organisation's Innovation Centre to help design workshops for groups of staff to generate new ideas. The Centre's director, along with an outside consultant who had been appointed as chair of the Centre, used a process similar to the one outlined in this Guide.

TOOLS PHASE 2

FRESH EYES

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TOOLS PHASE 1

OTHERS' POINT OF VIEW

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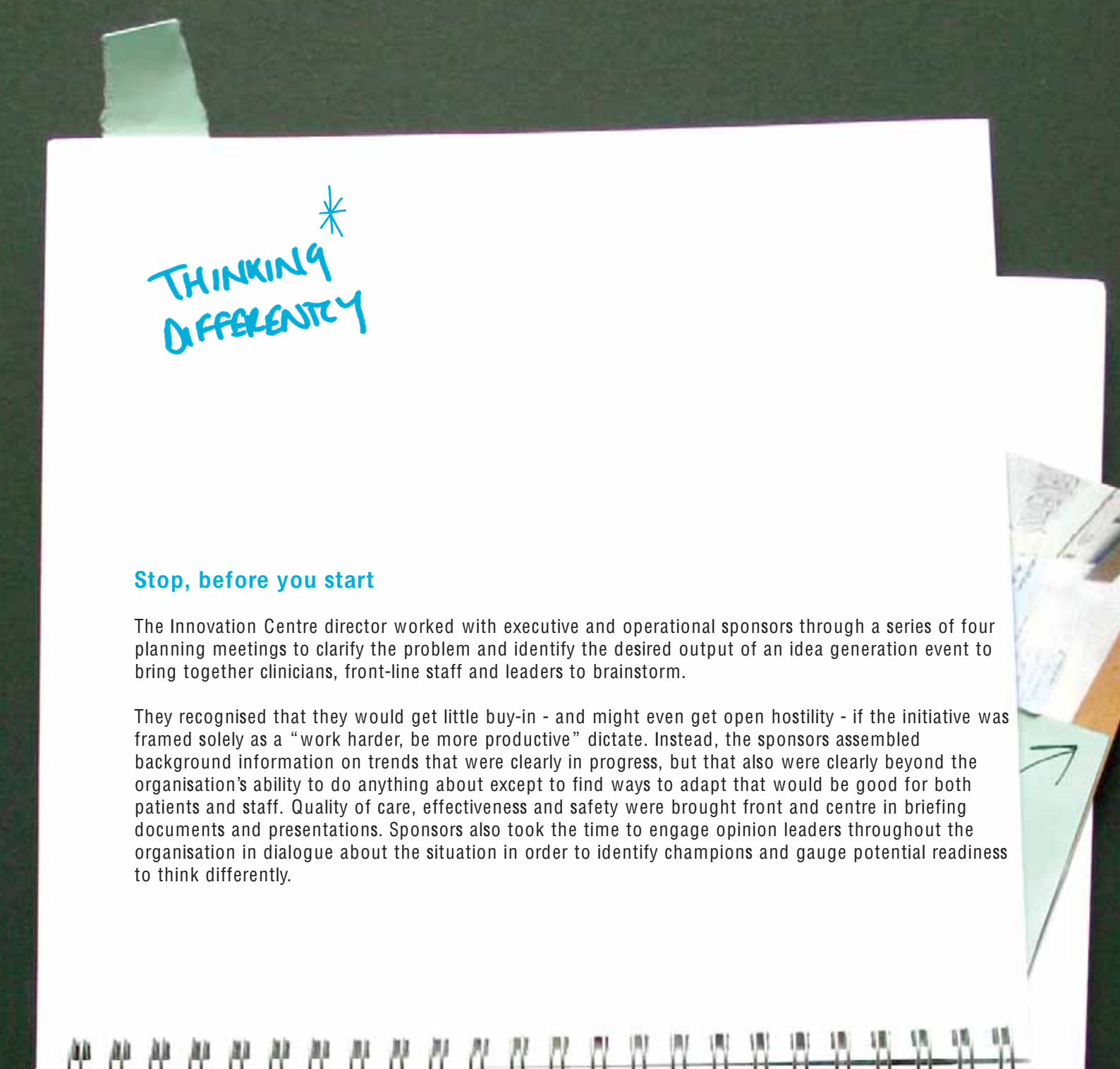


Stop, before you start

The Innovation Centre director worked with executive and operational sponsors through a series of four planning meetings to clarify the problem and identify the desired output of an idea generation event to bring together clinicians, front-line staff and leaders to brainstorm.

They recognised that they would get little buy-in - and might even get open hostility - if the initiative was framed solely as a "work harder, be more productive" dictate. Instead, the sponsors assembled background information on trends that were clearly in progress, but that also were clearly beyond the organisation's ability to do anything about except to find ways to adapt that would be good for both patients and staff. Quality of care, effectiveness and safety were brought front and centre in briefing documents and presentations. Sponsors also took the time to engage opinion leaders throughout the organisation in dialogue about the situation in order to identify champions and gauge potential readiness to think differently.

TOOLS PHASE 1

In short, rather than rushing directly into idea generation, they took two months to carefully build the compelling case for the need for some new thinking. While one can only imagine how it might have gone had they not done this, as you will see, when the session with front-line clinicians and staff was finally held, assumption-busting ideas flowed quickly and easily.

p.58

Over the course of these planning meetings and conversations, the following **'We want to think creatively about (WWTTCA)...'** statement emerged:

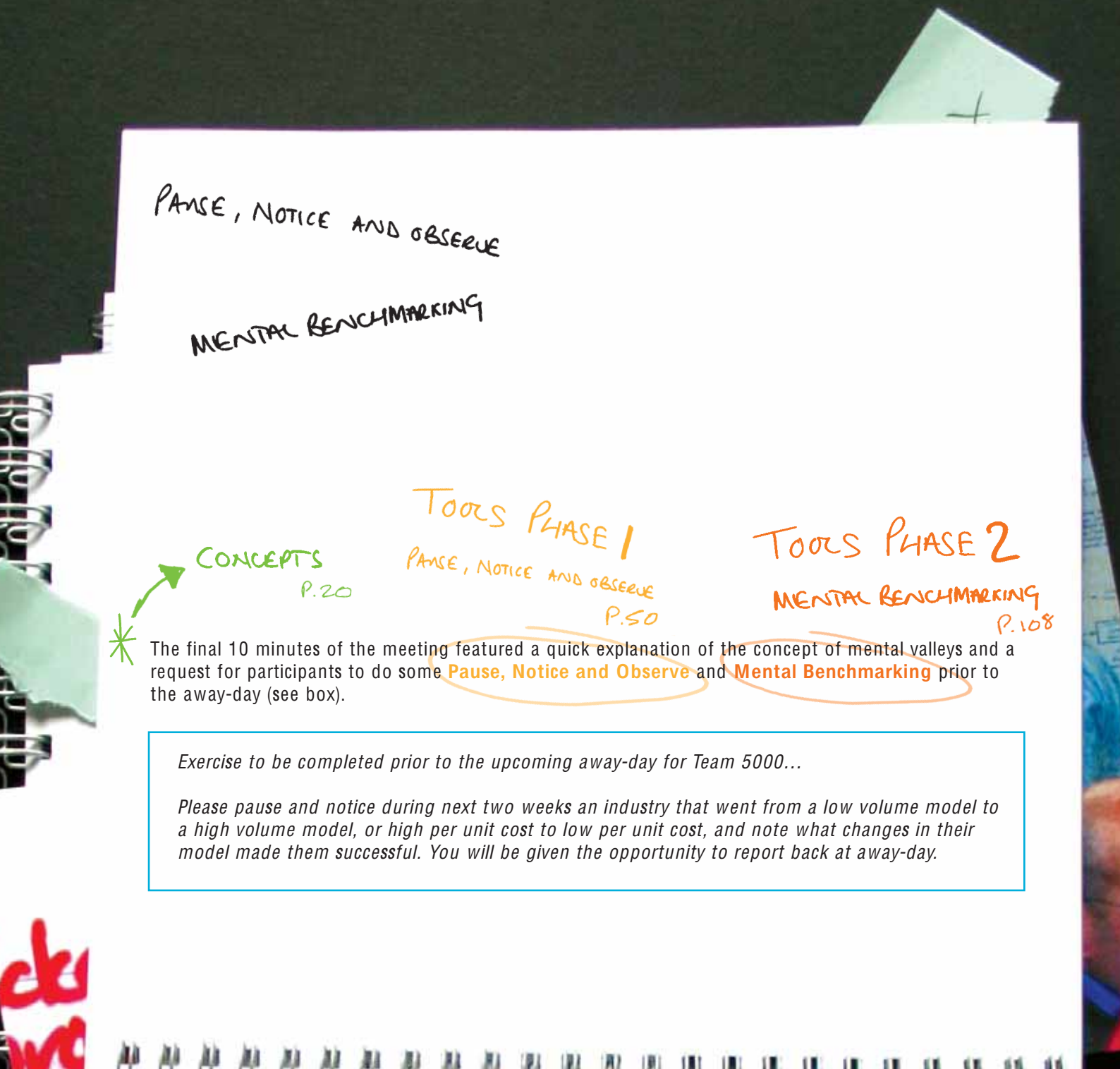
> ***WWTTCA...*** *How to develop a health care delivery model that delivers high-quality care to a 5000 patient panel, without increasing the direct patient care resources needed.*

The somewhat arbitrary goal of 5000 patients was selected on the basis that it would satisfy financial needs under most projections about future payment schemes, it was a nice round number, and it clearly signalled a need for radically new thinking (i.e., it is not simply a 10-20% workload increase over present, but 3-4 times the workload!). Innovation research has shown that declaring such "stretch goals" often stimulate more creative thinking than the more usual "let's be reasonable" targets. The effort was dubbed "Team 5000" and this provided a simple, engaging message to spread throughout the organisation to start everyone thinking about how things might be different.

About 40 people representing a cross-section of clinicians, staff, managers, key opinion leaders, and individuals who were seen as naturally creative thinkers were asked to mark their diaries for a future away-day, and to attend a 1-hour preparatory meeting to learn more. The preparatory meeting featured a concise presentation by senior clinicians and executives of the compelling reasons for new thinking; summarised as "the 10 myths of primary care". This was followed by examples from the organisation itself that reminded participants of small-scale innovations that had successfully challenged current thinking in the past. The idea was to create both the feelings of "we must do this" and "we can do this" among the participants. Sponsors also saw this short meeting as a way to gauge readiness to think differently prior to the investment in a longer away-day.

> ***Insight:*** *This is a great example of how leaders can manage the risks and uncertainties naturally associated with thinking differently.*

Questions were challenging, but appropriate and positive, and several clinicians and opinion-leaders who had had the opportunity to mull things over following their previous conversations with sponsors offered supportive comments. This preparatory meeting was videotaped and copies were sent to any invitees who were not able to attend.



The final 10 minutes of the meeting featured a quick explanation of the concept of mental valleys and a request for participants to do some **Pause, Notice and Observe** and **Mental Benchmarking** prior to the away-day (see box).

> *Exercise to be completed prior to the upcoming away-day for Team 5000...*
>
> *Please pause and notice during next two weeks an industry that went from a low volume model to a high volume model, or high per unit cost to low per unit cost, and note what changes in their model made them successful. You will be given the opportunity to report back at away-day.*

Generating Lots of Ideas

The away-day began with kick off comments, introductions, and a brief recap of the background information. Participants then broke into table groups to discuss the **Pause, Notice, and Observe** (or **Mental Benchmarking**) exercise and report key findings. Based on past experience with away-day pre-meeting exercises where only a handful of people actually do the exercise, the facilitators hoped nervously that at least 1-2 people per group might have done the work in advance and that would be enough to stimulate others to add additional examples spontaneously. In fact, many participants pulled out notes and magazine articles that they had brought with them to describe their insights from other industries that had faced similar challenges. This was a pleasing result that reassured the sponsors that the two months of effort in preparing for the brainstorming session had indeed been a good investment. There was a high level of engagement and openness to new ideas. An example of one of the seven main themes that emerged from the report back was:

Consider self-service as service

- *Train the customer to do the basics; e.g., pump your own petrol, check in yourself for the airline, scan your own groceries*
- *Customer manages and sorts their own information*
- *Security that allows the customer to self-manage even very sensitive information 24 x 7 x 365; e.g., bank account*
- *Make self-service a desirable "want"*

As the groups reported back, two facilitators wrote ideas on sticky notes and posted them on a blank wall. This allowed the facilitators to introduce what they called the "Wall Mart of Ideas". This is humourous play on the name of a retail superstore chain in the US and created the image of a place where one could go "shopping" for ideas later in the session (we will say more about this momentarily).

The facilitators then divided the group into 6 multi-disciplinary teams of approximately 7 participants each for several rounds of idea generation. After a short presentation about mental valleys; the principles of attention, escape and movement; convergent and divergent thinking; and the rules for idea generation, each team was handed a card to guide them through a specific tool for thinking differently. Example of tools and idea generation exercises are described in the table overleaf.

Tool to stimulate Thinking Differently	Example of specific instructions given to a team
Reframing by Wordplay	Take each word in the "We want to think creatively about (WWTTCA)..." statement and talk about all its possible meaning and connotations. Using these alternative words to trigger your thinking, capture new ideas for how we might handle a panel size of 5000 patients.
Fresh Eyes	If you gave a team of movie theatre managers the task of delivery healthcare to 5,000 patient panels, how would they go about it?
Stepping Stones	How would you provide primary care without doctors - they have been banned by law.
That's Impossible	How would a care team with only one doctor provide care for a list of 15,000 patients!

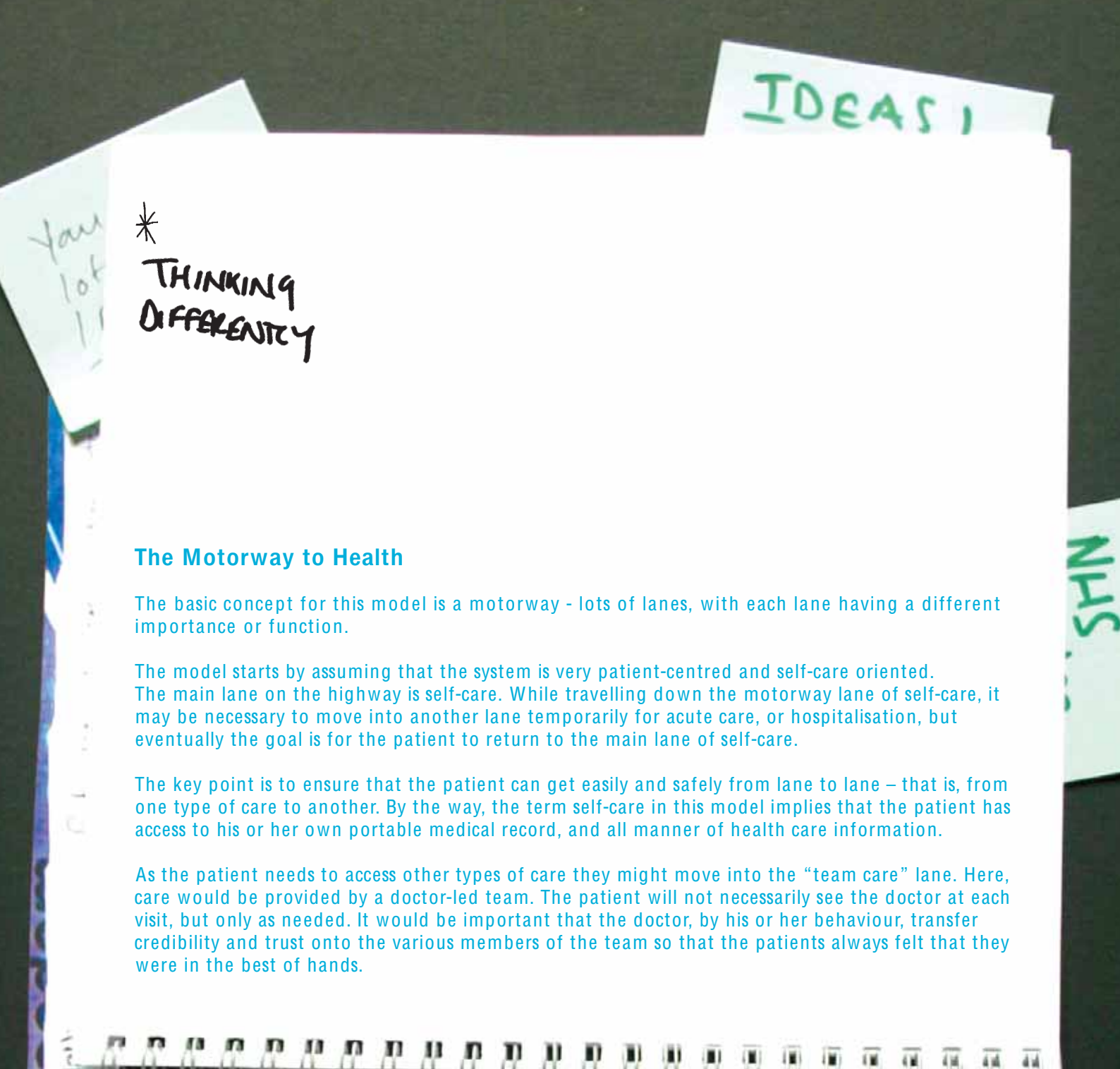
In each of three rounds, each team generated 10-30 ideas. At the end of each round, teams were asked to choose the top two or three ideas in several categories that the sponsors wished to highlight—for example: most innovative, ideas that emphasise team delivery of care, new ways to access care, and so on. Top ideas were written on post-it notes and added to the Wall Mart (an idea could be selected in multiple categories). In this way, each round combined both divergent thinking (via the idea generation exercise) and convergent thinking (via the harvesting criteria).

CONCEPTS P.20

As the teams worked, the facilitators and sponsors organised the Wall Mart by grouping similar ideas under themes, eliminating duplicates, and going back to teams to clarify what they had written so that the ideas would be understandable to anyone who read them. In the end, the Wall Mart contained around 150 ideas. And that was just the morning's work at the away-day!

> ***Insight:*** *With proper preparation and some tools, front-line clinicians and staff are quite capable of thinking differently about the challenges they face.*

In the afternoon, new teams were formed and given 90 minutes to "go shopping at the Wall Mart" in order to design an overall model of high-quality primary care for 5000 patients, using the ideas generated in the morning as elements. Teams then gave 3-minute reports, which were videotaped to allow details to be captured later. An excerpt from one of the reports is provided on the next pages.



The Motorway to Health

The basic concept for this model is a motorway - lots of lanes, with each lane having a different importance or function.

The model starts by assuming that the system is very patient-centred and self-care oriented. The main lane on the highway is self-care. While travelling down the motorway lane of self-care, it may be necessary to move into another lane temporarily for acute care, or hospitalisation, but eventually the goal is for the patient to return to the main lane of self-care.

The key point is to ensure that the patient can get easily and safely from lane to lane – that is, from one type of care to another. By the way, the term self-care in this model implies that the patient has access to his or her own portable medical record, and all manner of health care information.

As the patient needs to access other types of care they might move into the "team care" lane. Here, care would be provided by a doctor-led team. The patient will not necessarily see the doctor at each visit, but only as needed. It would be important that the doctor, by his or her behaviour, transfer credibility and trust onto the various members of the team so that the patients always felt that they were in the best of hands.

As a patient moves through the system, for example, with a chronic disease such as hypertension, the patient might move into the "credentialed patient" lane. Here, the patient receives training and a sort of "certification" that allow him or her to do some health care items themselves, such as order their own lab tests (haemoglobin A1c levels if they are diabetic, or basic metabolic profile if they are hypertensive).

The patient would move in and out of self-care, team care, and credentialed patient lanes on the motorway of health as they go along their journey.

Another concept in our model was the "community care" lane. For example, one aspect of community care might be the elderly patient who is in and out of the hospital with heart failure. A family member or friend who takes on the role of care giver can become credentialed by the primary care practice to do a variety of checks and report results into the practice. Another aspect of this lane on the motorway might be establishing community clubs (for example, diabetes support groups) that meet and are supported with knowledge resources by the practice.

In summary, the idea is that of dipping in and out of various types of care as needed, with the real drive - the main lane on the motorway - for the patient being self-care.

Insight: *Allowing the teams to concentrate on designing their models and embellish verbally, rather then having to fuss over capturing details on flip charts, made the group work lively and kept the creative side of the brain, rather than the analytical, more fully engaged.*

After all the reports, each team did a **Six Thinking Hats®** exercise on their model to identify both positive points and issues or barriers that would need to be addressed in taking them forward. Sponsors offered final comments and thanked everyone for a good session. Evaluations of the session were very positive, with several participants commenting that they now thought it was entirely possible to get to the goal of 5000 patients per doctor.

THATS THINKING DIFFERENTLY!

* TOOLS PHASE 3 P.128

Selecting and Testing Ideas to Make a Difference

The facilitators and sponsors met the following day to review the output of the session and begin the process of planning next steps. A review of the videotaped reports identified nine general themes and several ideas that were repeatedly selected by the various teams in their models (an indication of a potential high level of acceptance and readiness to test these ideas if they were to be taken forward). The leadership group constructed a high-level model by combining the best elements from the various reports, identified three sites that had come forward to serve as test sites for some of the ideas, and selected two physicians to champion the next phase of the work. Following the meeting, the facilitators compiled all the ideas generated into an "idea notebook" that was 42 pages long - it had indeed been a productive day!

The two physician champions worked with the facilitators, sponsors, and pilot sites over the next several weeks to clarify the overall model and further harvest specific ideas to test. The main **harvesting criteria** that emerged from these discussions were:

- potential effectiveness in delivering high-quality care for 5000 patients
- time required to implement
- resources required to implement

TOOLS PHASE 3
HARVESTING BY CRITERIA P.120

A total of 43 ideas were identified and put into four categories:

- Foundational elements:
  ideas and processes that need to be in place first in order to support the more innovative elements of the model
- Tier One:
  Ideas to be tested immediately
- Tier Two:
  Later, medium-range ideas to be tested over the next 6-18 months
- Tier Three:
  Future developments requiring significant resources.

The facilitators developed a table on one side of paper that captured the 43 ideas and could serve as a "traffic-light system" for the three pilot sites. A green dot would indicate that the idea had been fully tested and implemented, a yellow dot would indicate that the idea was currently under test, and a red dot would indicate that the idea was not yet planned for testing. This simple table became an on-going reporting vehicle for the project and was reviewed frequently by the sponsors, champions, and facilitators, in concert with the teams at each pilot site. The facilitators also worked with each of the sites to coach them through the concepts described in the section in this Guide on **Testing New Ideas on a Small Scale**.

At the time of this writing, this is a work in progress. The pilot site teams have met for another away-day one year on from the original one to share progress. During the session, additional ideas were generated by the use of the **Breaking the Rules** and **Stepping Stones** tools focused on generating new thinking on some of the challenges that the pilot sites reported were holding them back from even more progress.

> ***Insight:*** *The tools and various stages of the process of thinking differently can be used flexibly over time. During testing of ideas new ways to frame the original issue or entirely new ideas might emerge - thinking differently often begets further thinking differently as individuals get more comfortable with breaking out of what once was their comfort zone.*

The teams and leadership of the organisation are confident that they are well on their way to the goal of panel sizes of 5000 patients per primary care doctor and they are already turning attention to planning for the spread of new ways of working to other sites, and for sustaining the gains.
(for more detail on spread and sustainability, see **www.institute.nhs.uk/improvementleadersguides**)

THINKING DIFFERENTLY

ABOUT DELIVERING

PRIMARY CARE:

THE TEAM 5000 PROJECT

THINKING DIFFERENTLY:

MISSION IMPOSSIBLE?

OR JUST ANOTHER MOUNTAIN TO CLIMB!

LEARNING FROM LUTON + DUNSTABLE

NHS FOUNDATION TRUST


A+E
WARD
HOSPITAL
HOME
HRS BOSS
TIMELY
"WE ARE GUESTS IN PATIENT'S LIFES"
EQUITY
EFFECTIVENESS
SAFETY
EFFICIENT
SEAMLESS SERVIC


ONE STOP HEALTHCARE
KFC

Thinking Differently: Mission Impossible? Or just another mountain to climb!

The Luton & Dunstable NHS Foundation Trust has a history of embracing new ideas and experimenting with different ways of thinking and working. When they weren't chosen as one of the four pilot sites for the experimental whole systems initiative, *Pursuing Perfection,* in 2002, they decided to "do it anyway" and learn alongside the official sites. They have been involved in a range of national programmes and collaboratives and were one of the first sites for the Safer Patients Initiative. The Trust's commitment to making improvement mainstream is demonstrated by its Changing the Way We Work (CWWW) team of improvement facilitators, led by a full time Associate Director. As a consequence, many members of staff have been involved in service improvement activities.

Fertile Ground:
There is a very strong Board-led modernisation culture throughout the Trust, and it is difficult to come across a member of staff who does not use the current language of healthcare improvement. They have a genuine desire to push boundaries.
Bedfordshire and Hertfordshire SHA

In 2003 the Trust joined a national pilot to test creative thinking tools and training materials in a healthcare setting, with a view to helping teams and individuals build new thinking into their improvement activities and optimise the potential to achieve significant change.

The expert facilitators took them through a process similar to the one described in this guide.

Getting Organised to Think Differently

Leadership Team

A leadership team, formed to support the initiative, included the Chief Executive, Director of Nursing, Director of Operations, Associate Director CWWW, and Emergency Services Collaborative Programme Manager. The team was joined by an active patient representative along with members of the SHA and two Primary Care Trusts, as partner organisations.

Frontline Teams

Three frontline healthcare teams came together to learn more, each chosen to think differently for a reason and with some distinct characteristics:

Imaging: Eight members - two consultant radiologists, ward sister, receptionist, radiographer, service redesign co-ordinator, patient representative, general practitioner.

The imaging service had a real issue with waiting times. A wait of more than six months for MRI scanning and a traditionally hierarchical team meant that the service needed some fundamental change and was ripe for different thinking.

Patient safety: Five core members - head of nursing practice, matron, patient safety manager, head of quality development, doctor with expertise in reducing mortality rates. Pharmacy, theatres and intensive therapy unit staff were also engaged in discussions.

This project brought together a group of people who were not yet a team. Newly signed up to the Patient Safety Initiative and with a Patient Safety manager appointed but not yet started, here was an opportunity to think differently right from the outset of the work.

Paediatrics: Six members: senior paediatric sister, two consultant paediatricians, clinical nurse manager, booking project co-ordinator, matron.

A very inclusive, non-heirarchical team with a history of trying to improve services and strongly linked into the Pursuing Perfection work within the trust. Learning new thinking tools would enable them to go even further.

Stop Before You Start

An initial full day workshop was run in September 2003 by expert facilitators and attended by the three project teams, the leadership team and representatives from the partner organisations. The teams were asked to do some preparatory process mapping to help identify some of the issues they wanted to address.

The workshop was opened by the Chief Executive who showed his own commitment to creative thinking by playing the opening sequence to the film, "Mission Impossible", which depicts Tom Cruise scaling an impossible-looking mountain top! The analogy to what the teams were doing (it's a big challenge but it can be done) helped set high energy levels for the day.

The facilitators gave a brief overview of the evidence from other industries on why innovation – thinking differently – is important, and showed its links with healthcare improvement work. Participants were then introduced to the key concepts behind thinking differently: mental valleys; first- and second- order change; the three mental processes of attention, escape and movement; different modes of thinking and divergent / convergent thinking cycles. Participants were also given an overview of the Thinking Differently process: framing and re-framing the issues; generating lots of ideas; harvesting, enhancing and testing ideas.

The three teams were then asked to discuss at their tables their initial perceptions of the problems they wanted to address. After a few minutes to jot down the seemingly obvious statements of the problems from the traditional point of view of health professionals, teams were introduced to the **Others' Point of View (OPV)** tool and asked to restate the problems from the perspectives of service users and other staff not represented in the team. The facilitators circled health care jargon words and phrases and asked the teams to **Reframe By Word Play** to come up with more "plain language" descriptions of the problems. After about an hour of this work, teams were instructed to select what they felt were the most stimulating statements of the problems and to phrase these as **'we want to think creatively about' (WWTTCA...)** statements. (See the left column in the box "Example Patient Safety Team" and note the broad reframing of the last three examples provided there.) This generated a lot of discussion about some of the underlying dimensions of the problems and helped teams tease out the key issues on which they wanted to focus.

Generating Lots of Ideas

CONCEPTS P.20

The rest of the day was spent by the project teams in interactive table exercises, using a variety of divergent thinking tools to help them generate ideas relating to the issues they had identified. The teams were asked to observe the **Rules of Idea Generation** - suspend judgement, accept wild and whacky ideas, build on others' ideas. Laughter and fun was encouraged and the teams were given the objective of generating as many ideas as possible.

The Thinking Tools used included: TOOLS PHASE 2

P.70 **Fresh Eyes:**
What ideas would someone from another sector bring? Who does that well? What advice or ideas would they give to us?

P.86 **Random Word:**
Nouns chosen at random (battleship; scaffolding; market): What does it make you think of? What ideas can we take from that to address our issues?

P.94 **Stepping Stones:**
Start with a wild proposition, and create solutions. E.g.: All doctors and nurses have contracted a debilitating virus that makes them unable to work; how do we continue to provide service? All hospital buildings have been declared unsafe to occupy; how do we continue to treat patients? Then... Why can't we do some or all of those things now?

P.76 **Breaking the Rules:**
Identify rules that govern behaviour and practice (example: all mandatory nurse training sessions must be booked one year in advance). What would be the implications of breaking those rules? Do we need the rules? What other approaches and solutions does this suggest?

Example: Patient Safety team

We Want To Think Creatively About...	Examples of ideas generated
• Infection control • Drug errors • Mortality rates • How we can break bad habits for everyone • Getting the right things in the right place • Ensuring patients are informed about infection and help staff to prevent it	• Surveillance, like the police • Team rewards for low infection rates • Specialist lead on each ward • Feedback following bad behaviour • Community service; staff obliged to work in a different area, supervised • Control the flow, as supermarkets do with bread always at the back of the store • Make hand wash smell nice and moisturising • Alcohol gel on notes trolley • Purpose-built design to ensure right things in right place • Formally enrol patient as part of the team, as market research focus groups do • Decontamination chamber • Red aprons for isolated patients • Each bedside has supply which relatives and patients use

Ideas from each of the exercises were captured on post-it notes and, after each round, were added to individual team wall charts. At the end of the idea generation session, each team did a clustering exercise, re-organising the post-it notes to eliminate duplications and identify key themes around the ideas. The teams had generated more than 90 new ideas by the end of the day!

Selecting and Testing Ideas to Make a Difference

In the final hour of the workshop, the facilitators presented **Dot Voting**, **Six Thinking Hats®**, and the **Enhancement Checklist**. Teams were asked to quickly select the 1 or 2 ideas that they thought they could try immediately. These were then assessed in a quick run though of de Bono's **Six Thinking Hats** to consider the perceived benefits (yellow), drawbacks and risks (black), any information they needed to gather (white) and their gut feelings about the idea (red). This was done to build confidence in the idea, or to help reject it quickly, before a quick team discussion using a few of the **Enhancement Checklist** questions. The leadership team then challenged the teams to go away and repeat this harvesting and enhancing process on more of the ideas generated, communicate more widely to their clinical teams, and try out at least one idea in the coming months.

A second workshop, four months later, re-visited the project team issues and the ideas generated at the first workshop, along with reflections on the learning that came from the tests of the ideas selected in the previous workshop.

The teams generated some more ideas but the main emphasis of the workshop was on ***convergent thinking:*** selecting more ideas to go forward and enhancing those prior to testing and implementation.

Facilitators again used **Six Thinking Hats®** and the **Enhancement Checklist** as the main tools to help the teams do this.

* This process enabled a significant number of creative ideas to be assessed, with some dropped as inappropriate, some put 'on hold' for future consideration, and others developed further for testing. This mirrored the '**funnelling**' effect typical of innovation initiatives.

Imaging Team

The Imaging team wanted to provide a 'delay free' magnetic resonance imaging (MRI) diagnostic scanning service. Several key ideas were considered for further development:

Ideas selected for development	Anticipated benefits
• One-stop back pain clinic with same day imaging • Touch-screen internet kiosk giving patients access to website information explaining the MRI scanning procedure • Patient self-diagnosis using photo-booth-style and mobile MRI units • 24-hour scanning	• Reduced MRI waiting list • Fewer orthopaedic outpatient appointments • More effective resource use • Shorter waiting time to diagnosis • Fewer hospital visits • Reduced patient anxiety • Increased multi-disciplinary teamworking

The idea of a touch screen internet kiosk with access to web-based information on MRI scanning procedures was developed further and integrated into a mainstream service. Patients can now use the PALS patient information screens in the hospital's reception to access the Royal College of Radiologists website explaining the MRI scanning procedure.

The one-stop back pain clinic with same day imaging got to the testing stage but was not implemented as not all staff were behind the change.

This wasn't a "failure"; the whole point of testing ideas is to identify issues and problems to work on prior to wider implementation. The timing was not necessarily right for this idea at the time, but it may well provide a seed that will flourish when conditions change.

Involvement in the initiative has had a wider reaching impact for the team too. Having somewhat resented the "external" change facilitators, the Imaging department has now set up its own Change Team and have continued to develop new ideas and test improvements themselves. Their success in thinking and working differently has seen major reductions in waiting times. And they now play a key role within the Trust in piloting new approaches, including a Lean Rapid Improvement event that led to significant improvements in ultrasound services.

Patient Safety Team

This group aimed to reduce hospital-acquired infections and adverse drug events. Key ideas included:

Ideas selected for development	Anticipated benefits
• Interactive CD-rom with multiple choice questionnaire and 'click on' hazard perception test • Nominate one ward 'where no patient will receive a hospital acquired infection' and learn how to achieve this • Boxes of gloves by every bed and hand rub available on trolleys • Intensive staff and patient information • Tabs that change colour on hand washing • Using bright orange gels	• Reduce cross-infections • Increase staff and patient awareness • Reduce drug errors

One of the initial ideas that came through selection to testing and then implementation was an interactive CD-ROM on hand washing to help fight health care acquired infections (HCAI). The team borrowed concepts from computer games and from the online, multiple choice theory test for UK car drivers to help develop the idea. The CD presents a series of facts about HCAI, takes the user through the steps of proper hand washing, provides a multiple-choice questionnaire and a "click on" hazard perception test, and produces a certificate for the member of staff if successful. The content of the CD has now been integrated into the Trust's intranet and has had a high uptake from ward staff.

TOOLS PHASE 2

P.70 FRESH EYES

P.108 MENTAL BENCHMARKING

Another idea was to designate one ward as 'a ward where no patient will receive a hospital acquired infection' and to test a series of measures to achieve this. These included boxes of gloves by every bed, hand rubs on every trolley, intensive staff and patient information and hand gel dispensers at the door. Uncommon in 2003, these and many other safety measures are now standard across every ward in the Trust.

This initial work of the Patient Safety team to think differently paved the way for the ongoing success of the Trust in the national Safer Patients Initiative.

Paediatric Team

The aim of the Paediatric team was to simplify the care pathway for children with chronic conditions, such as asthma and diabetes. The team held an 'appreciative inquiry' session and listed the changes they had implemented over the previous couple of years. These became the foundation for further ideas.

They focused on four in particular:

Ideas selected for development	Anticipated benefits
• 24-7 nurse-led prescribing • dedicated paediatric consultant across primary and secondary care • introduction of paediatric 'care bundles' for asthma and diabetes • paperless record using patient-held 'smart card' (CD or floppy disk), providing a shortcut to an emergency care pathway when necessary	• reduced pressure on pharmacy • reduced number of carers returning to collect drugs • reduced length of time to dispense drugs • improved linking of primary and secondary care • co-ordinated guidelines across several departments, most without paediatric specialists • up-to-date patient information available to patient, family and professional carers • improved communications between all those involved in a patient's care

The team used the concept of the 'bundle' to help them work on a variety of related issues, incorporating co-ordinated guidelines across several departments, most of which do not employ paediatric specialists. The 'care bundle' identifies the key diagnostic, admission, vital signs, and discharge procedures for all patients, giving a clear structure to care.

This gave the team a basis for further innovative changes around one of the projects on which they were focusing for the Pursuing Perfection initiative - Childhood Asthma:

1. The team developed an integrated care pathway for children with asthma, standardising various admission, management and discharge plans and developing information packs for children and their families to support this.

2. Asked to test an education pack for Asthma UK, the team thought laterally about how to do this. They chose a cohort of the children who most frequently attended hospital and identified their care team – including family members, a variety of healthcare professionals and a school teacher as well as the child – and trained them all in using the pack.

3. The team took the concept of "co-production" and involved school children in redesigning their own care. Testing ideas with one school, they worked with a group of 11-14 year olds who:
   - process mapped having an asthma attack at school and going to the GP about their asthma;
   - wrote an asthma policy for all schools in Luton;
   - developed a series of "promises to children" to help direct the Pursuing Perfection work;
   - designed an information leaflet for other children on having asthma.

The team definitely got braver. They began to be more creative and adventurous about what they might do.

Cathy Adcock, Changing The Way We Work facilitator

In a presentation on their achievements and lessons learned, the Paediatrics team answered their Chief Executive's "Mission Impossible" challenge with a rendition of ***"Ain't No Mountain High Enough!"***

Spin-offs from Thinking Differently

After the involvement of the three frontline teams in testing processes and tools for thinking differently, the Trust wanted to incorporate this work into its mainstream commitment to improvement. A selection of change agents and service improvement staff from the Trust and from some of its partner organisations were therefore trained as facilitators in order to develop local competency in the use of creativity tools. Members of the Changing the Way We Work Team in particular now use the Thinking Differently tools as part of their general "toolkit" for working with frontline staff.

For Example...

TOOLS PHASE 2 p.86

Need Pain Relief? A Random Word Provides the Answer!

The pain team were stuck in a rut. They had a long-running problem of trying to reduce pre-operative pain for their patients with fractured neck of femur (FNF). The Pain Nurse had spent much of her time educating colleagues in a variety of departments – A&E, wards, orthopaedics – and everyone understood and agreed that patients needed fast, effective pain relief. In practice however, delays in providing analgesia continued, with some patients waiting up to 290 minutes and a lot of variation in the system. The team was stuck for ideas. Previous attempts to find a solution had always produced variations on the same theme – further education and feedback to staff - with no consistent and sustained improvement for patients.

There was clearly a need to think differently.

One of the hospital's Changing The Way We Work Team was asked to help. She introduced the **Random Word** tool at one of their meetings to help them to generate new ideas. Using a table of random verbs, the group played with the 5th verb on the 5th row. It happened to be the verb "dissect". A few ideas were thrown around but nothing really flowed so they randomly picked another verb. This time, it was "eliminate", a word that really got them thinking.

"Eliminate... fractured neck of femur..."
"Eliminate... box number 3 on a drug chart" (i.e. reason for not giving patient pain relief = *the patient refused*; the group realised this may be due to the way in which patients were asked about their pain).
"Eliminate... clinicians who think it's OK not to give pain relief to a patient!"
"Eliminate... pain altogether"

The last one really resonated with the group: *"Can we do that? Can we eliminate the pain?"*

They discussed the method of patient controlled analgesia, which was effective for many patients post-operatively. Could they bring it in earlier in the patient pathway to pre-operative care? That would be a good solution for some patients, but not for a significant number of older patients, who are confused, and for others who are cognitively impaired. In addition, the strong opioids used sometimes cause confusion or make confusional states worse in the elderly. Was there another solution that would work for **all** patients?

What would eliminate actually mean? One of the group came up with the term 'blocking'.
"Aha! Blocking... a pain block! What about a femoral block? Or a sciatic nerve block?"
They discussed those solutions but came up with a number of drawbacks:

- there are risks involved which means both blocks can only be administered by an anaesthetist;
- anaesthetists would not always be available to do this. There would inevitably be delays, meaning patients still in pain.

Were there any other kinds of blocks? Something that could be administered by a wider range of clinicians? The team left the session committed to research other pain blocks and one of the anaesthetists came up with the fascia-iliaca compartment block. This was not commonly used for FNF and was normally administered by anaesthetists. However, it was a quick, safe procedure so perhaps could be used more widely and by non-medical personnel...

The team tested the new block for its ease of use and its effectiveness in eliminating pain in their patients with FNF. The benefits were clear:

- it's effective in relieving pain in most cases *(71% patients report low pain 15 minutes after the block, rising to 83% at 24 hours)*
- it works for both children and adults
- complications are uncommon and it can be used alongside other pain killers
- it lasts up to 24 hours and can be topped up so is a great option for patients with co-morbidities that delay surgery
- it reduces the need for opioids in elderly people, therefore reduces opioid-related confusion
- it means patients can be moved for bed changes and toileting more comfortably
- it doesn't require complex equipment
- it's safe and easy enough for health professionals other than anaesthetists to use, therefore a greater number of patients can benefit.

A great result from thinking differently!

Two pain nurse specialists, orthopaedic nurses and several A&E doctors have now been trained in the procedure, ensuring that patients are given effective pain relief more quickly and benefit for longer. The pain team are rolling out training to more personnel and have continued to audit the effects of their innovation.

Thinking differently has contributed enormously to the success of the L&D over the last few years. The techniques have helped unblock barriers and, as importantly, the approach has supported our culture of continuous improvement. It has also been hugely rewarding for staff as well as patients.

Stephen Ramsden, Chief Executive

Key learning from the Luton & Dunstable experience:

- It can be difficult to predict and evaluate the benefits from an initiative like this. It cannot be seen in isolation from other initiatives and ways of working and often takes reflection on the wider picture to see the effects.
- Not all good ideas will get to the testing stage and fewer will make it through to implementation. This mirrors the natural "funnelling" effect of the Thinking Differently process.
- Thinking Differently tools are a valuable addition to improvement methods. Facilitators and other staff can be quickly trained in their use and most people engage well with the tools.
- Thinking Differently tools can stimulate and strengthen existing teams which already have a successful track record of improvement and innovation. The fact that problems may be well-known, and that solutions may be already under consideration, does not prevent thinking tools from helping to generate even more innovative ideas.
- It's important to recognise participants' past achievements in improvement and innovative change and to communicate that to them.

The initial reaction of the paediatric team to their involvement in the initiative was one of anger. Their feeling was "we've already done lots of good things so why do we need this?" which prompted them to pull together 3-4 sheets of paper listing all the ideas they had already implemented.

The fact was, this was the very reason why they were being asked to get involved – they were a well-functioning team, open to change and so had the potential to really take some bold steps with their service.

This indeed proved to be the case but the learning here was how important it was to actually communicate that to them.....

Start Thinking Differently and it's hard to stop....

Once the mind has been stretched, it doesn't snap back into the same place. In Luton & Dunstable, it was sometimes hard to see a clear thread through the journey of learning new ways of thinking, from new ideas generated through to specific projects and changes implemented. There were some examples of this but, perhaps more importantly, this case illustrates the fact that the process is often not linear. The complexity of the journey means that something that starts as a project may not deliver obvious "results" on that particular issue. However, as we can see in Luton & Dunstable, unforeseen spin-offs and new ways of thinking can spring up in unexpected places and times.

Thinking Differently is not like sowing a uniform field with a predictable crop and harvest time. It's more like scattering lots of wild seeds, then watching and waiting to see what kind of diverse meadow springs to life.

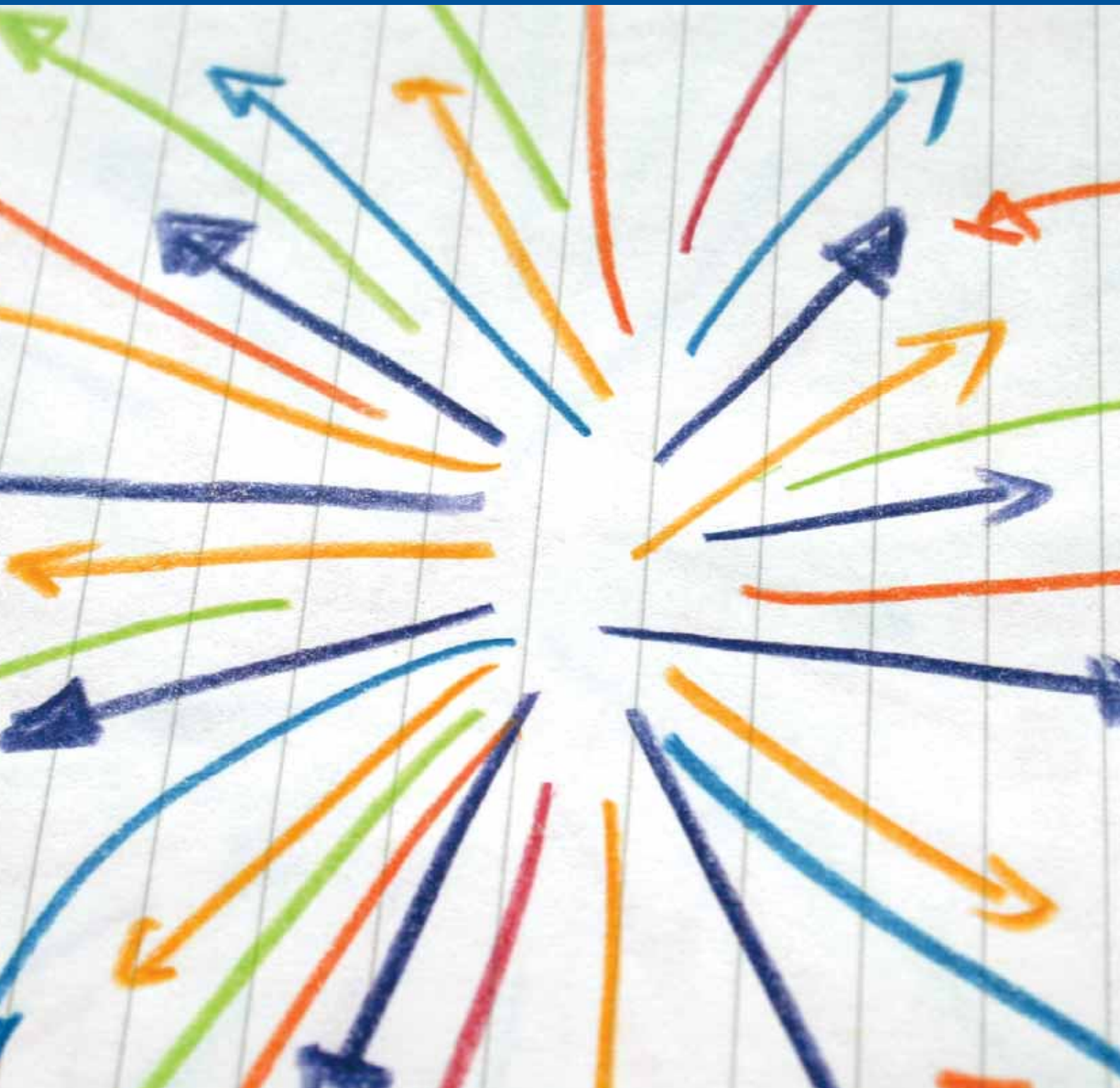
THINKING DIFFERENTLY:

MISSION IMPOSSIBLE?

OR JUST ANOTHER MOUNTAIN TO CLIMB!

Appendices

- Linking Thinking Differently Tools to Improvement Work
- Tips for Facilitators
- References for Further Study



Appendix

Linking Thinking Differently Tools to Improvement Work

The methods for Thinking Differently in this book are intended to build upon, not replace, all the improvement work that has been going on for several years now in health care.

Q: How might I use tools for thinking differently in conjunction with my existing improvement and modernisation work?

A: Below is a "starter for ten" to get you thinking.

Process mapping...

Tools Phase 2: 78

- Explore the use of the **Breaking the Rules**™ tool by asking people to identify what are the unwritten rules behind the various steps in the process.

Tools Phase 1: 46

- Look at how you label the steps in the process with words and phrases that are actually health care jargon and use the **Reframing by Word Play**™ tool to open your mind up to other ways of doing things.

Tools Phase 2: 94

- Use any of the thinking tools to come up with redesign ideas and then show the contrast with the current process by constructing before and after process maps.
- Identify the steps or stages where there are bottlenecks and use a **Stepping Stones**™ provocation to identify new and alternative options.

Tools Phase 1: 40
Tools Phase 2: 70

- Review a process map using the **OPV**™ and **Fresh Eyes**™ tools to help you look at it from a range of perspectives (e.g. nursing staff, patients, porters, family members...) in order to identify improvements.

Rapid cycle tests of change (PDSA)...

- Use the rapid cycle test of change approach to help you further enhance an innovative idea, or pilot test it on a small scale.

Tools Phase 3: 128
Tools Phase 3: 136

- Use the **Six Thinking Hats**®™ and the **Enhancement Checklist**™ tools to help you make any idea for improvement better and more likely to succeed, regardless of its level of creativity (i.e., use these tools on an idea which simply copies and adapts what others have already done, or an idea that comes from simple logic or analysis).

Capacity and demand...

Tools Phase 2: 70

- In conjunction with capacity and demand analysis, try a **Fresh Eyes**™ approach if you see a mismatch that is causing queues. Think about how a supermarket, a Disney theme park, or major sports stadium thinks about and manages queues.

Measurement and data collection tools...

- Use your experience in measuring and monitoring improvement to help you evaluate the test or implementation of an innovative idea.

Tools Phase 1: 58

- You might specifically focus on "**WWTTCA**" how to collect data", or "**WWTTCA**" how to communicate performance measurements"... and then go on to apply various thinking tools to these issues.

Human side of change...

- Everything you have learned about the human dimensions of change in doing improvement work also applies to bringing about innovative change.

Tools Phase 1: 58

- You might specifically focus on "**WWTTCA**" engaging clinicians (or staff, or senior leaders)" ... and then go on to apply various thinking tools to these statements.

Methods for patient/user involvement...

Tools Phase 2: 70

- Instead of having to use your imagination in the **Fresh Eyes** tool, actually invite service users who are bankers, race care drivers, children, etc. to contribute their points of view and ideas about how to make things better.
- Likewise, involve patients and users directly in Phase one (**Stop Before you Start**) when using tools such as **OPV**, or **Reframing by Word Play**.

Tools Phase 1: 40
Tools Phase 1: 46

Process redesign projects...

- For your next redesign project, spice up traditional Brainstorming with any of the thinking differently tools. **Breaking the Rules**, **Stepping Stones**, or **That's Impossible!** will really get team members' creative juices flowing.

Tools Phase 2: 78
Tools Phase 2: 94
Tools Phase 2: 102

Achieving the 18 Week wait...

- Use any of the thinking differently tools to help you generate ideas around reducing delays in the patient pathway. See www.institute.nhs.uk/nodelaysachiever for specific suggestions on how some of these can help and how they can be used in conjunction with other improvement tools to achieve the 18 week target.

Don't let anyone tell you that traditional improvement methods are analytical and, therefore, could not possibly mix well with a focus on thinking differently. Rubbish! It is not an either-or choice. The goal of both traditional improvement work and of thinking differently is to make things better for service users and staff. If you really want to be creative, find more and more ways to use the tools of thinking differently and traditional improvement together. After all, it is all about novel connections that lead to useful ideas.

For detailed information and advice on Improvement Methods, see the Improvement Leaders' Guides at www.institute.nhs.uk/improvementleadersguides.

Appendix: 211

A full list of all 15 guides is provided in **Appendix: References for Further Study**.

Appendix

Advice for Facilitators

Those who say it cannot be done should not interrupt those who are doing it

Chinese proverb

Concepts: 20

- As you work with groups using these tools, link back frequently to the basic concepts described in the **Concepts** section. People are better at creative thinking when they understand what they are supposed to be doing or thinking about, and why. Two especially important concepts to refer back to frequently are: mental valleys and attention-escape-movement.
- Provide an example or two as you explain a tool. Make these directly applicable to the issue they are working on, but don't steal the best idea. So, for example, if you are working with a team in Emergency Services, give an example of an unwritten rule that might apply in that setting and a creative idea that comes from purposefully escaping that rule.

Tools Phase 2: 63

- No matter which tool you are using, establish the ground rules of Idea Generation: Every idea is a good one; No judgment or criticism allowed; Aim for quantity; Build on other's ideas. Consider illustrating these on a flip chart to display in the room.

Tools Phase 3: 128

- You might also want to refer frequently to the **Six Thinking Hats®** and use these to maintain a positive (Yellow Hat) or creative (Green Hat) atmosphere in the group.
- Be patient and expect that it may take a while for a group to get rolling with a particular tool. Resist the urge to step in too soon or be too directive. Of course, answer questions and clarify instructions, just don't feel like you have to give them ideas. Let the creativity emerge from them.
- Get the groups to assign roles, such as a scribe, perhaps a chairperson and someone to feedback. Ask new people to take on these roles at least once in your session. Observe the group dynamics frequently and change roles as needed.
- Capture every idea. This is critical for the later stages of the Thinking Differently process. If working with a small group you could offer to perform this scribing function yourself. If working with a larger or multiple groups, assign a scribe and make sure they write everything down. If the scribe does not write an idea down then they are, in effect, judging. Further, participants will begin to think that they must more fully explain their idea in order to get the scribe to capture it. Either way, this violates the rules of Idea Generation and makes whatever tools you are using less effective.

- Pause on ideas that generate laughter. Laughter is a signal of an unusual connection in the mind. Make sure that the idea has been written down, then ask, "what is the main point behind that and how might we use that to generate another idea?"
- Keep the pace lively. Seek to switch to another tool or provocation before the energy runs out of the one that you are on.
- Seek physical space that lets people easily break into smaller groups with chairs clustered around a flip chart. There should also be plenty of usable wall space to keep the group's ideas visible as it works. Tables are less essential and can actually inhibit creativity if they impose formality.
- Identify the core people needed to work on a particular topic - the content experts and stakeholders - then supplement the group with some creative thinkers not necessarily connected to the subject.
- Consider how people from different demographics and perspectives can enrich the quality and depth of the ideas. For example, will the subject benefit from the ideas of younger staff just entering the workforce, or a certain role that will be significantly impacted during implementation?
- Constantly mix and match individuals so that the energy stays high. Ask people to switch groups… do some exercises in trios, whilst doing others as groups of 6-8. Use your judgment, but the idea is not to let things grow stale.
- Be aware that doing all this thinking is actually hard work for most people. They will get tired if you go on too long. Take frequent breaks. Intersperse activities with presentations or less demanding tasks. Provide refreshment!
- Even if you do not plan to do a formal idea harvesting session with the group you are working with, bring some sort of closure to any idea generation session by at least asking people to note some of the ideas that they thought were among the best.
- Be aware of your own learning style, attitude to change and willingness to think differently. Ask yourself "Am I walking the talk here?".

If you are not having fun facilitating the process of Thinking Differently, you are not doing it correctly!

Appendix

References for Further Study

Paul E. Plsek, *Creativity, Innovation, and Quality.* ASQ Quality Press, 1997
This book takes the reader through directed creativity from first principles to application. The first third of the book covers the theory of directed creativity, included the mechanics of mind and heuristics for directed creativity. The second third presents the three principles behind all tools for creative thinking and reviews the hundreds of tools available. The final third covers the application of directed creativity to re-engineering, design, customer needs analysis, and problem solving. Practical and informative. Also visit the website - www.directedcreativity.com.

Edward de Bono, *Serious Creativity.* Harper-Collins, 1992
Edward de Bono is a prolific writer on the topic of thinking in general and creative thinking in particular. Part 1 of this text will introduce you to such classic de Bono-isms as "lateral thinking" and the "self-organising mechanism of mind." Though de Bono never refers directly to the research from the cognitive sciences, you will find his work consistent with it. Part 2 covers tools and techniques for creative thinking, while part 3 discusses issues of organisation-wide creative thinking. De Bono's style is crisp, and the book is fun to read.

James M. Higgins, *101 Creative Problem Solving Techniques.* Winter Park, FL: New Management Publishing Company, 1994
This is a great catalogue of creative thinking tools. Each of the 101 tools is explained in detail; the book will provide you with plenty of food for thought. The presentation is organised around the Creative Problem Solving (CPS) model, but the translation to the the three-step process we outline in this Guide is easy.

Robert J. Sternberg, ed. *The Handbook of Creativity.* Cambridge Univ. Press, 1999
This is the most up-to-date, comprehensive scholarly reference on the topic. The 22 chapters are well written and relatively free from the repetition one sometimes finds in a collected work such as this. The contributor's list reads like a who's who of cognitive scientists, psychologists, educators, philosophers, and researchers who are currently working in the field of thinking about creativity. While the writing style is accessible, this is not casual reading. However, if you are the sort of person who likes to dig down under the surface of a topic, you'll find this book a brilliant 'one-stop shop'.

Thomas H. Davenport, Laurence Prusak, H. James Wilson, *What's the Big Idea? Creating and Capitalizing on the Best New Management Thinking.* Harvard Business School Press, 2003
Major new management ideas are thrown at today's companies with increasing frequency. Only a handful of these ideas will be a good fit for your organisation. Choose the right idea at the right time and your company can become more efficient, more effective, and more innovative. Choose the wrong one-or jump on the right bandwagon too late and your company could fall hopelessly behind. In What's the Big Idea?, Davenport and Prusak introduce a largely unsung class of managers they call idea practitioners, individuals who do the real work of importing and implementing new ideas into businesses. While gurus reap most of the credit when big ideas take flight, their research reveals that idea practitioners actually play the most important role: They turn the right ideas into action.

Various Contributors, *Harvard Business Review on Innovation,* 2001
Short chapters written by leading experts describing how creativity and innovation can give your organisation the leading edge. Case study examples of companies such as 3M provide a practical understanding of how to support creativity and innovation as well as illustrating managerial tools and techniques.

Tom Kelley, *The Art of Innovation.* Doubleday, 2001
This book is about IDEO, the organisation that has been acclaimed as America's leading design firm. It describes how the organisation has built an innovative culture so that creativity is part of the routine. The book provides a valuable insight into ways of working, teams, relationships and processes.

Michael Schrage, *Serious Play- How the worlds best companies stimulate to innovate.* Harvard Business School Press, 2000
Describes how the leading companies use models, simulations and pilot testing to innovate. Written with project leaders in mind there is a focus on how to manage innovation initiatives through to successful products and processes. The book draws on examples from companies such as Walt Disney, IBM, General Electric and IDEO.

Frances Hesselbein, Marshall Goldsmith & Iain Somerville, Eds, *Leading for Innovation - and organising for results.* The Drucker Foundation, 2002
Short chapters written to provide practical guidance for those who wish to lead their organisation to a new dimension of performance. Suggests some of the qualities required to develop a culture that promotes innovation and provokes thought about how organisations must abandon practices that no longer work or are no longer useful. Includes thought from some leading CEO's of innovative companies.

Andy Law, *Experiment at work - explosions and experiences at the most frightening company on earth.* Profile Books, 2003
A story of a business which is run like no other. Using creativity as a guiding force and putting personal development and growth at the top of its list were just two things that enabled this company to be the most successful in its field.

Dave Allen, Matt Kingdon, Kris Murrin, Daz Rudkin, *What If?- How to start a creative revolution at work.* Clapstone, 1999
Describes six behaviours, which the authors have identified within creative and high performing teams. Contains practical ideas on how these behaviours can be encouraged within teams using illustrations from companies such as ASDA, Virgin, ICI & Ben and Jerry's ice cream.

Barry Nalebuff and Ian Ayres, *Why not? How to Use Everyday Ingenuity to Solve Problems Big and Small.* Harvard Business School Press, 2003
Packed with real examples of how creative thinking has transformed many organisations this is a fun yet informative read. Their approach, inspired by Edward de Bono, is a primer for fresh thinking, reframing problems and finding creative solutions. They encourage thinking both inside and outside the box and their inherent optimism offers novelty and surprise.

CK Prahalad, Venkatram Ramaswamy, *The New Frontier of Experience Innovation*. MIT Sloan Management Review, Vol 44, No. 4, 2003
Describes the natural evolution of thinking about innovation from a focus on products and service (producing something a customer might want), to "solutions" (creating something that solves a problem for a customer), through to "experience space" (creating the capability for the customer to individualise and adapt products and services to meet his or her ever-changing needs). Experience innovation shifts the focus to the daily lives of service users. What could be more needed in health care?

John Bessant, *Challenges in Innovation Management* in International Handbook on Innovation, Ed. Larisa V. Shavinia, 2003
Professor Bessant describes some of the key issues for managers and leaders who want greater levels of new thinking and innovation in their organisations. Key topics covered include managing organisational culture, creating continuous learning, facilitating relationships, and gaining high levels of involvement in rethinking the ways we have always done things.

Andrew Hargadon, Robert I Sutton, *Building An Innovation Factory*, Harvard Business Review, May-June 2003
Business school professors describe their research on how leading commercial organisations capitalise on different thinking. The "knowledge-brokering cycle" that they describe includes how to capture good ideas, keep ideas alive, imagine new uses for old ideas, and put promising concepts to the test.

Jack Silversin, Mary Jane Kornacki, *Implementing Change: From Ideas To Reality*, Family Practice Management, Jan 2003
A concise, easy to read article on implementing new ideas and change within healthcare settings, written by two Physicians experienced in quality improvement in the US. It highlights common barriers to change and provides a helpful set of practical guidelines for building a good foundation and then applying change management skills. Download the article at: www.aafp.org/fpm/20030100/57impl.pdf

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Thank you

The development of this book has been an exciting and truly collaborative process. We would like to thank everyone within the NHS and International healthcare systems who contributed their enthusiasm, experiences and knowledge throughout the different sections and case studies. Specifically like to thank Lisa Godfrey Harris for her work on the early drafts.

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