# Leading change, adding value: A personal journey of leadership development

Many phrases are created in healthcare, perhaps in order to direct interest and motivation towards a particular strategy. "Leading change, adding value" has been a phrase used in nurse leadership to help organise services that address the triple aim of promoting health and wellbeing, improving care and quality, and improving efficiency whilst operating within existing resources (Cummings and Bennett, 2012). As a senior nurse in a new leadership position, I found it challenging trying to direct service improvements with this triple aim in mind when services already feel overstretched. This article will describe how a DSN service at an acute hospital trust has started to lead change and add value, whilst keeping within existing resources.

In October 2015, members of the diabetes multidisciplinary team in Coastal West Sussex Clinical Commissioning Group met as members of a steering group and embarked on working towards an integrated diabetes service, to align with NHS England's strategy of the Five Year Forward View (NHS England, 2015). Whilst we already operated in an integrated way, this next step proposed closer working between the hospital and community and primary care. Underpinning any service change was ensuring that each patient was seen in the right place, that they received the right care and that this care was timely (NHS RightCare, 2016). Applying these principals helps ensure that any adaptation of existing services meets current needs, and that the transformation plans are sustainable.

It soon became apparent that transformation of services is by no means a straightforward process, as changes proposed can have a wider impact than first anticipated due to the complex and detailed organisation of the NHS, and also because the people affected, both service users and providers, are wide ranging. Therefore, strong strategic leadership has to be in place to drive large-scale service change. Driving change forward was slow because the strategic local leadership was still forming. However, the DSN team at Western Sussex Hospitals NHS Foundation Trust had already developed an ability to review their service delivery, in order to utilise finite resources as effectively and efficiently as possible. I have identified leadership, communication, service planning and pastoral care as key enablers for DSN service review.

## Leadership

*"Management is doing things right; leadership is doing the right things"* (Drucker, 1954). Those who lead services will appreciate this statement and realise that achieving the "right things" can require a period of reflection and planning, ensuring that data and information are understood prior to proposals of change and that stakeholders are involved. Whilst a leader's intrinsic character influences the style of leadership employed, it is also necessary to be able to adapt leadership styles depending on the task. Stephen Covey (1989) has also contributed to our understanding of innate qualities of people in leadership, proposing that we should *"seek first to understand before being understood"*. As a DSN in a leadership position, I have found reflection, communication and gathering information to be key to leading change.

## Communication

Apart from communicating with colleagues and patients on a daily basis, other forums of communication have been an important vehicle for change. We have trust-wide daily Safety Huddles, in which the whole team meets at the start of the day to discuss issues affecting safe patient care and continuity. Weekly DSN meetings and Senior DSN meetings ensure flow of communication. A service development meeting was introduced for the whole diabetes team, to enable proposals of service innovations to be widely shared, including

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**Citation:** Middleton N (2018) Leading change, adding value: A personal journey of leadership development. *Journal of Diabetes Nursing* **22**: JDN036

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with service managers. Clinical supervision remains core to our clinical practice and is protected time to share complex cases. This learning can then be disseminated widely, shared between the team, clinicians in the hospital trust and also primary care and community colleagues.

It is well documented that change is often resisted, and it would seem that this is human nature (Curtis and Cullen, 2017). As healthcare is intrinsically a "human" business, it makes sense to operate in a human way. Communication is a human characteristic, should be valued highly and should be seen as a key enabler. Whilst meetings can earn a reputation as a "waste of time", it is my experience that, using the time allocated economically, they provide an essential forum of efficient communication and are an inclusive means of decision-making.

## Service planning

As it became apparent that we could not progress service transformation as quickly as initially thought, through reflection on the current service, Senior DSNs were able to lead on service changes within our department. A recurring theme was ensuring the DSNs were seeing the right person, in the right place, at the right time. As our setting is secondary care, it was important that we reserved our resources for the most complex of cases, and we reviewed the work that seemed inappropriate. Service delivery was also reviewed against skill sets within the DSN team, ensuring adequate education going forward, not only for team members but also sharing skills and knowledge with other healthcare professionals. A transformational style of leadership is required, empowering others with the knowledge and skills to deliver safe patient care. This is also relevant when interacting with patients; an empowerment approach is recognised as economical and necessary in times of limited resources. Empowerment is also core to our practice, through structured education and a Year-of-Care style of consultation, both of which are evidenced-based (Carey and Doherty, 2012).

## Pastoral care

Perhaps undervalued – I have never read this cited as an aspect of leadership – is the pastoral care of team members from a leader. An important function of a leader is to ensure the wellbeing of team members, ensuring continuity of care. Without a skilled workforce, there is no service to deliver; therefore, staff are the most important asset to an organisation. Again, the human aspect should be remembered in our core business. A service should recognise the elements that motivate people to come to work: autonomy, mastery and purpose (Dewhurst et al, 2009). Ensuring a leader works among the team and communicates regularly allows a reality check on the wellbeing of the team and, therefore, productivity and willingness to work. Self-care impacts on self-worth and, in turn, impacts on patient care. This type of "soft" leadership intervention is vital to future-proof and protect an already scarce workforce.

## Small changes, big difference: "Quick wins"

As a senior team, we have reviewed the appropriateness of some aspects of our service in light of the demand on secondary care for complex care and increasing use of technology. As admission avoidance and length of stay have been a trust priority, for some time our service assigned two DSNs to the Emergency Floor each morning, to review all patients with a diagnosis of diabetes who had been admitted in the past 24 hours. Recently, we realised that many of these patients were managing their condition with diet or a simple treatment regimen, negating the need for specialist review. This is partly due to the education we have provided over the years, both within the trust and to community colleagues, empowering them with diabetes knowledge. It is also due to the population of people with an early diagnosis of diabetes who do not yet require treatment, as a result of screening for prediabetes in primary care. We therefore were able to reduce the service to one DSN each morning, to review only those patients with complex, unstable diabetes control. This has released five DSN sessions a week to provide the following services, which are deemed a more appropriate use of specialist skills in the secondary care setting:

- One extra insulin pump clinic.
- One extra rapid-access clinic.
- One extra session of the DSN helpline.

- One extra session for ward education.
- New DSN input at podiatry clinics for blood glucose advice.

## Discussion

An understanding of the strategic plans for the NHS nationally and locally has been necessary to assess current service delivery and evaluate effectiveness. I believe the Nurse Consultant role has been a key enabler of this and ensured the senior nursing voice was heard when strategic decisions were discussed. We have found that, through an inclusive approach, working with commissioners and the whole diabetes multidisciplinary team, we have been able to take a unique perspective of the value of our service delivery against how care delivery would best meet the needs of our population and limited resources.

The people with type 1 diabetes and complex type 2 diabetes are increasingly requiring a high level of understanding of complex treatments, the use of technology and management of comorbidities. It is essential to work with diabetologists to facilitate clinical supervision and escalate clinical cases, but it is also increasingly important for DSNs to experience the primary care setting to gain experience in newer treatments in the management of type 2 diabetes, and to offer clinical supervision to primary care colleagues. For this reason, the DSN leadership team is advocating a pathway of care across the whole care setting – both primary and secondary care – in order to gain and maintain the necessary skills and competencies (TREND-UK, 2015). This adds value to the workforce, allowing the sharing of a broad knowledge base through close clinical supervision with consultants. This knowledge and skills are then shared with other clinicians across the whole pathway of diabetes care. The patient has the convenience of access to specialist skills in the primary care setting, if the practice considers this enhanced level of care necessary, saving an appointment at the acute hospital trust. This model has been in place since 2004 and has delivered these benefits.

## Reflection

As an experienced nurse in a new leadership position, I am grateful for the development opportunities. As senior colleagues approached retirement, I benefitted from a programme of development, supported by our hospital trust, to ensure succession planning and business continuity. I have been mentored by our retiring Nurse Consultant over a period of 2 years, which has coincided with a bespoke leadership programme offered by a scholarship with The Florence Nightingale Foundation. This included a study trip to Canterbury, New Zealand, to learn about their integrated system of healthcare, which offers elements of care to which our Clinical Commissioning Group aspires.

### How I have changed as a person and influenced patient care improvements

I have become more aware of personal attributes and leadership capabilities through leadership diagnostics, and have had the opportunity to reflect and read more widely on intrinsic enablers. I received training on impact and presence from the Royal Academy of Dramatic Art, developing confidence both in meetings and presenting to a larger audience.

Building relationships is so valuable as it leads to identifying trusting partnerships and useful networks. I have built relationships internally in the organisation and externally, including overseas, all of which add to a rich tapestry of ideas and diverse solutions that might not have been discovered otherwise. I have also found these relationships are further enhanced through language, and my preferred medium of communication is face to face. Although using valuable time, face-to-face conversation enhances the relationship and the time given for the meeting is maximised to full potential, adding value to this leadership activity.

I have discovered a large project cannot be implemented in isolation or by a sole person. Therefore, it is important to identify key stakeholders and followers early on, ensuring they are apprised of project progress and can assist as necessary to advance implementation. Successful service change has been achieved by small "quick wins" which, given time, should pave the way for the direction of travel for our service and can be built upon for larger-scale change in the longer

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term. I can now appreciate the importance of aligning improvement projects with organisational strategy. This gives the project power and, in times of difficulty or obstruction when leading forward, enables decision-makers in organisations to advance the project and help prevent derailment.

The overseas visit to Canterbury was, without doubt, a career highlight. I have experienced on-the-ground knowledge and gained unique insight into new ideas and methodologies, which has added impact and influence both to me as a leader and also to the diabetes team as I share the learning. This, in time, will hopefully result in improved patient outcomes. While it is important to recognise the differences that have influenced healthcare in the UK and New Zealand, it should be acknowledged that the principles of care delivery in Canterbury can be applied to our UK setting. I was able to identify some key enablers of Canterbury's successful service transformation:

- Integrated IT, promoting efficient communication.
- High levels of engagement from the workforce, with a "can do" attitude.
- A health system built around the patients' needs.
- Healthcare professionals from primary, community and secondary care settings coming together to agree care pathways and responsibility of care delivery.
- Taking out the waste in the system and focusing on the best way to spend limited resources.
- An appreciation that time is a common currency for both patients and care providers.
- Contracting barriers have been removed to allow integration, with a belief system of "one budget, one system".
- Investment in primary and community care, enabling more care to be undertaken outside the hospital setting.

## Conclusion

As the NHS celebrates 70 years, I have found myself reflecting on how the experience of delivering healthcare, and receiving it, has changed over time. It is clear that demand has increased, as has the number of treatments alongside complex comorbidities, requiring a highly skilled workforce. We face an unprecedented shortage of nursing staff, an issue which has yet to be addressed. What is clear is that those working in the NHS have a responsibility to ensure that the skills and knowledge we have today are not only passed on to our colleagues but are used in a transformational style. This style enables others to practice safe diabetes care and share knowledge and skills to benefit the growing numbers of people with diabetes. In the words of the former Chief Executive of The Florence Nightingale Foundation, Elizabeth Robb, *"Do everything you can to make the most of everything you do"*. ■

**Acknowledgement**

The author wishes to thank The Florence Nightingale Foundation; Health Education Kent, Surrey and Sussex; and Western Sussex Hospitals NHS Foundation Trust for sponsoring the leadership scholarship experience. Thanks also to colleagues for support and development opportunities in new leadership roles, enabling continuous improvements in patient care.

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