Office for Health management

Leading management and organisation development for the health services

Good Practice in Leading and Managing Change in Health Service Organisations

11 Irish Case Studies

Mission Statement

We contribute to a better health service by

- **supporting people development**
- **stimulating change in the way things are done**
- **helping the whole system to improve**

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Executive Summary

There are many ways of understanding change, ways borrowed from the physical and biological sciences, as well as more mechanistic or 'straight-line' approaches. It is generally accepted that the management of change has political and emotional or psychological dimensions, as well as a rational basis. Attention is usually needed to all three if change is to be effected. Managing change is, therefore, both a science and an art and it means bringing knowledge, wisdom, patience and often a good deal of trust to the task. In order to win the hearts and minds of followers, it is usually necessary for the leaders to bring both their hearts and minds to the task. Those who try to manage anything but the most straightforward of change in a mechanistic or purely rationalist fashion almost inevitably fail.

One way of representing the multi-faceted nature of change is to see it as an equation: seen this way, we are reminded that all three of the forces for change (D, V and S - see below for explanation) are necessary and, together, must exceed the amount of resistance or the cost of change.

Change = (**D**issatisfaction with the present situation **x** a **V**ision of a better future **x** Knowledge of the first **S**teps required to move) **> Cost of change/ degree of resistance**

'Nobody likes change' is a pretty commonly-held view and, in most organisational change, there is a degree of resistance to be managed. Usually, resistance arises because people simply prefer the old way of doing things, fear they will be 'exposed' in some way by the change, or fear they will lose something (physical or psychological) as a result. Sometimes people resist because they simply have a different view of the need for or rationale behind a change. In other words, most resistance is not to the change itself necessarily but to what might happen as a consequence of its introduction.

With specific regard to change in the Irish health service, there is significant expertise in relation to leading and managing change successfully and this report provides qualitative evidence of this practice. The purpose of documenting this good practice is so that it might provide guidance and insights to those managing future changes in the health service.

For the purposes of this research, health boards around the country were invited to identify changes which they considered to be representative of good practice in the general management of change. Eleven such changes are featured in this report. These eleven stories of change fall into four general categories:

- changes in the direct provision of services to patients and clients
- changes in clinical service design and delivery
- relatively discrete and time-bound changes
- overall organisation development and the development of better planning and management systems.

Several factors have a bearing, positive or negative, on the successful management of change. Many of the stories in this report share similar characteristics in terms of the factors which proved to be critical to the successful design and implementation of change. These factors included clarity of vision, communication, consultation and the need for top management support.

In general, the experiences of health service managers and clinicians in leading change is consistent with that which is documented in the seminal articles and writings from all walks of business and organisational life on the subject of change.

All of the examples of good practice in this report provide evidence of the positive contribution of at least one of the following factors.

- The establishment of a project steering or change management group which has a multi disciplinary membership, and the active involvement of credible, senior people (clinicians and/or managers) in leading and championing the change.
- Human qualities such as resilience and patience, persistent and consistent attention, a tolerance for uncertainty, and a bias for solving.
- An open and transparent consultation process 'amongst equals', i.e. where those who invite views acknowledge the uncertainty that is inherent in the management of change, and where those who offer views accept that they do not have a veto, and where there is as much clarity and transparency as possible in relation to the criteria used for decision-making.

- Communication in advance of the change and at several points throughout the change was particularly important. Focused awareness-raising and (re-)training workshops and events were also helpful in many cases.

- Active resource management: resources alone will not make the change happen but their absence can be an inhibitor. In this regard, resources can be considered a hygiene factor in managing change (Herzberg, 1966), that is, necessary conditions but not motivators.

- The adoption of an 'inclusion strategy' or approach based on seeking to engage the participation of a wide range of stakeholders and interested parties in the thinking through, planning, design and implementation of the change.

- Support systems to help problem solving, in particular, ideas gained from working in health in other countries or in other fields of public service (seemed especially useful in relation to areas of health care with little precedent in Ireland, such as primary care).

- The active engagement of people who resist or express concerns about the change.

- Compelling external pushes or forces for change (economic, social, business, demographic, political, etc.).

- The involvement of facilitators with expertise in organisation development who can help managers to appreciate the system effects of 'isolated' change, i.e. the impact on the structures, cultures and working practices of the area directly concerned by the change and other areas within the organisation.

Each of the organisations which contributed a good practice change story to this report was asked to rate the change it managed according to 20 criteria. These criteria were drawn up using Kotter's (1996) work on managing change, combined with a further 12 variables in effective change management which were identified by Upton and Brooks (1995). The 20 criteria are

- generating an appropriate sense of dissatisfaction with 'the way things are'
- a clear and common vision/inspiration about how things can be better
- creating or securing knowledge about the first steps needed to deliver the change
- securing appropriate top management support
- communication and consultation – in advance of the change
- timely securing of the necessary resources
- clear goals and objectives for implementing the various phases of the change
- clear timescales for implementation of the different phases or major tasks associated with the change

- making the change concrete and visible at an early stage
- managing the unanticipated knock-on effects
- communication and consultation – throughout the change
- managing the internal politics around the change
- empowering others to act on the vision/effect the change
- establishing an appropriate level of urgency about the change
- getting a 'critical mass' of people behind the change
- dealing with resistance and obstacles in a timely way
- aligning the change with the culture of the service/organisation
- communication and consultation – following the change
- recognising and rewarding people for changing
- declaring 'victory' at the right time (i.e. claiming that the change has been 'bedded down' at the appropriate time).

In relation to each of these 20 variables, the participating organisations were asked to rate each variable in terms of (i) how important it was seen to be in the management of this change (ii) how effective the change team/manager was in dealing with this aspect of managing the change.

When the ratings of all of the participating organisations are pooled, it is possible to get an overview of the collective rating of importance and effectiveness against each variable and, from this, to identify the 'Top 5' variables in the management of change. Not surprisingly, the findings reflect the earlier identification of factors which contributed to successful implementation of changes and they also mirror the findings of writers of seminal works on the management of change.

In summary, in terms of criticality to success, the following are the top five variables in managing change, according to organisations which participated in this research:

1. a clear and common vision/inspiration about how things can be better

2. communication and consultation – throughout the change

3. securing appropriate top management support

4. empowering others to act on the vision/effect the change

5. communication and consultation – in advance of the change.

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Introduction

'Change is the new status quo'. Fortunately, there is significant expertise in managing change within Irish health service organisations. Notwithstanding the views of some of the cynics and the propensity of the media to focus on the bad news, the experience of introducing change in the health service has been, by and large, both very good and very successful. This report provides qualitative evidence of examples of this experience in leading and managing change. The purpose of this documenting of good practice is to provide guidance and insights to other potential leaders and managers of change in the health service.

The methodology for this research was very simple: health boards were invited to identify, for inclusion in this report, changes which had been managed in their regions/areas which they considered to be representative of good practice in the general management of change. Eleven such changes are featured in this report. Many of the organisations which contributed to this report were able to identify multiple examples of good change practice but, for practical reasons, there was a limit to the number which could be included in this report.

These stories fall into four general categories:

- changes in the direct provision of services to patients and clients
- changes in clinical service design and delivery
- relatively discrete and time-bound changes
- overall organisation development and the development of better planning and management systems.

Many of the stories share similar characteristics in terms of the factors which proved to be critical to the successful design and implementation of change, factors such as clarity of vision, communication, consultation and the need for top management support. In general, the experiences of health service managers and clinicians in leading change is consistent with those which are documented in the seminal articles and writings from all walks of business and organisational life on the subject of change.

The following table is a summary of the eleven accounts of successful change management which are included in this report. The accounts are listed in alphabetical order according to the health board in which they occurred.

Title of Change Initiative	Health Board
1. A Process of Organisational Development	**ECAHB**
2. Training and Development Services in the Eastern Region	**EHSS**
3. Establishment of the 'Home First' Programme	**ERHA**
4. Establishment of an Enhanced Complaints Procedure	**ERHA**
5. New Approach to Planning and Delivery of Child Care Services	**MHB**
6. New Approach to Quality Improvement	**MHB**
7. Closure of Single-Consultant Maternity Services	**NEHB**
8. Improving Services for Patients with Dyspepsia	**NWHB**
9. New Approach to Service Planning and Development	**SHB**
10. Transfer of Services from St. Loman's Hospital to AMNCH	**SWAHB**
11. Improving Services for Obstetrics Patients	**WHB**

What is Change Management?

If you have ever been involved in a badly-managed change you will know that there are better and worse ways of managing change. Rationalists know that there is a science to planning for change and to using those plans to control the schedule, extent and cost of change. Humanists know that good change management is much more than good planning and control: it also means attending to the emotional and even political dimensions of most change. They know, for example, that people need assurance and inclusion, support, and communication in change and they know that a natural reaction to proposed change is to seek to minimise loss.

Managing change is, therefore, both a science and an art and it means bringing knowledge, wisdom, patience and often a good dollop of trust to the task. In order to win hearts and minds, it is necessary to bring both hearts and minds to the task. Those who try to manage anything but the most straightforward of change in a mechanistic or purely rationalist fashion will almost inevitably fail.

> *There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to institute a new order of things.*
>
> Machiavelli

One metaphor for managing change which reflects the dynamic nature of the activity is that managing a change is like balancing a mobile over a baby's cot (one of those toys which hangs over the cot and has several suspended parts, so that it is impossible to touch one part without disturbing the balance of the others). 'The key to the change effort is not attending to each piece in isolation; it's connecting and balancing all the pieces. In managing change, the critical task is understanding how pieces balance off one another, how changing one element changes the rest, how sequencing and pace affect the whole structure' (Duck, 1993).

Managing and Leading Change – Some Recipes for Success

There are many eminent writers, among them John Kotter, who contend that both management and leadership are necessary in volatile environments. Kotter (1990) believes that the two are very different and complementary processes, not simply gradations of the one. Management, according to Kotter, is deductive and is about coping with complexity. It arises, by and large, out of the need in large organisations for a degree of order and consistency. Much about the stories of change in this report can be classified as falling within this category, that is, managers seeking to implement change as a way of avoiding a possibly more chaotic reality.

Leadership (according to Kotter), on the other hand, is about coping with change, particularly change that is made necessary by shifting environmental forces (such as socio-economics, politics, technology, globalisation). Leadership is inductive and is much more about envisaging a new reality rather than a reorganisation of the existing features of the organisation. Some of the changes in this report fall predominantly into this category in that they describe significant re-orientations of services and even of organisations due to changes in the external environment.

Whereas Kotter distinguished between management and leadership on the basis of the *ends* (coping with complexity versus coping with change), he also recognised that, in practice, both management and leadership are key *means* to bringing about change. The closed-ended questionnaire that was used as a framework for collecting some of the research data that form the basis of this report is based, to an extent, on Kotter's work (1996). Kotter identified eight broad steps in realising change, and these steps cover both the management and leadership aspects (including establishing a sense of urgency, constant communication, creating a vision, building coalitions and planning for short-term wins).

Pettigrew and Whipp have identified five competencies of organisations which successfully manage change, and there is a good deal of congruence between these competencies and Kotter's work. For example, Pettigrew and Whipp begin with the ability to assess the environment (the key to deciding whether management or leadership is needed) and to lead even when there is no precedent. Two other competencies which they believe to be critical are related to bridging the [potential] gap between leadership and management by linking changes to the operational plans and HR management practices of the organisation. Finally, they point to the need for alignment and coherence at all levels to ensure lasting change.

Understanding Change

There are many ways of understanding change, ways borrowed from the physical and biological sciences to more mechanistic or 'straight-line' approaches. (For a good, comprehensive guide to the different approaches, see Iles and Sutherland's (2001) review of organisational change in the NHS.) It is accepted that the management of change has political and emotional or psychological dimensions, as well as a rational basis. Attention is usually needed to all three if change is to be effected. With regard to the change stories that are included in this report, it is easy to note how much attention has been paid to the political and emotional dimensions of the changes and this has contributed, in no small way, to their success.

Rational

- Use of project management techniques such as defining and scheduling the major phases and the tasks that are required to bring about change.

- Clarification of costs and benefits, advantages and disadvantages of changing and of staying the same.

- Mapping the change – clearly delineating the end point of the change, including what will be different and what will have stayed the same.

Political

- Mapping the stakeholders – making efforts to show different stakeholders what the future might hold for them in the new structure/system, and dealing explicitly with power balances and 'winners and losers'.

- Assessing the readiness and capability for change of different stakeholder groups.

Emotional

- Communicating constantly about the change and encouraging people to participate in the design and implementation of the changes to systems, structures, practices, etc.

- Dealing with fears, concerns and difficulties that individuals might encounter in their consideration and/or implementation of the change.

- Providing the right type of support to individuals at the right time (for example, there is a lot of evidence that peoples' emotional reaction to change follows a relatively typical pattern (Kubler-Ross, 1969): in the very early and usually short-lived stages they may be in a situation of shock and denial. They may then move to anger, blame and self-doubt, and only then to a

measure of acceptance and problem-solving. To some extent, this is a self-managing process and external support may not make any difference unless requested by the individual involved. Support 'mechanisms' which can be helpful are peer support, buddying, making it safe to express anger but not letting someone get stuck in it, encouragement and reassurance along with evidence of capability (when dealing with self-doubt), facilitation of problem-solving and delegation).

Another way of representing the multi-faceted nature of change (Gleicher in Beckhard and Harris, 1987) is to see it as an equation: seen this way, it reminds us that all three of the forces for change (D, V and S: see below for explanation) are necessary and, together, must exceed the amount of resistance or the cost of change. It is worth noting that, when the organisations which participated in this research were asked to rank twenty factors in terms of their criticality in the successful management of change, each of the three elements of this equation came in the top eleven, with the creation of a vision of a better future coming first (see Appendix 1 to this report).

Change = (**D**issatisfaction with the present situation/ circumstances **x** a **V**ision of a better future **x** Knowledge of the first **S**teps required to move towards that future) **>** **Cost of change/ degree of resistance**

This change equation also reflects the need to win both hearts and minds in order for change to be successfully and willingly implemented, something that is reflected in several of the change stories in this report.

Managing Resistance to Change

'Nobody likes change' is a commonly-held view. In most organisational change, there is a degree of resistance to be managed. Usually, resistance arises because people simply prefer the old way of doing things, fear they will be 'exposed' in some way by the change, or fear they will lose something (physical or psychological) as a result. Sometimes people resist because they simply have a different view of the need for or rationale behind a change. In other words, most resistance is not to the change itself necessarily but to what might happen as a consequence of its introduction. Bridges (1995) distinguishes between change and transition: change is situational (i.e. a new process, new team, new location, new structure) but transition is the psychological process that people have to go through in order to come to terms with change. Managing resistance is about managing this psychological process.

Resistance needs to be attended to if change is to be successfully implemented. In many cases, this means dealing with the 'defensive routines' which are, frequently, the most common way in which resistance to change will be expressed and which are such barriers to organisational learning (Argyris, 1990). Such defensiveness is often sparked by managers and leaders who try to implement change by surprise, or without giving appropriate honour and value to the way things were and are done now. The most effective antidote to defensiveness is (usually) building trust and openness and this is usually achieved through involvement and collaboration. The stories of change in this report abound with evidence of this inclusive approach.

> *People responsible for planning and implementing change often forget that while the first task of change management is to understand the destination and how to get there, the first task of transition management is to persuade people to leave home. You'll save yourself a lot of grief if you remember that.*
>
> William Bridges

Buchanan and Boddy (1992) write very insightfully about what happens in organisations when change is mooted. They describe eight 'countermoves' to change which typify some of the political manoeuvring that occurs when people want to stymie change, such as dissipating resources and energies, staying vague on the goals and the inevitable difficult people issues, killing things off by committees and spreading rumours. In order to counteract these displays of resistance, Buchanan and Boddy suggest that leaders and managers of change work to establish very clear direction, objectives and programmes, adopt a fixer/facilitator/negotiator role (reason will never be enough!) and actively seek out and respond to resistance. They, like Kotter (1995), also suggest relying on face-to-face communication and consultation, building coalitions and support networks from the beginning, and establishing meaningful steering groups/project groups. Again, the stories of change which are included in this report are remarkable for their demonstration of the power of these approaches in dealing with resistance and getting 'ownership' of the change amongst key stakeholders.

Factors which Contribute to the Effective Implementation of Change

There are many factors which have a bearing, positive or negative, on the successful management of change. Many of the factors which contribute to the effective design, planning and implementation of change are mentioned in the various stories which are included in this report. Some of them are to be expected (in other words, they could be said to be 'textbook' contributing factors) and some of them are possibly specific to the sector and timing of the particular changes (most were conceived and implemented in 2000 and 2001, a time of unprecedented 'boom' in Ireland and a time of heightened demand and expectation in the health sector). Some of the contributing/facilitating factors which are mentioned by those who were overseeing the changes described in this report are listed below (the names (in alphabetical order in italics) at the end of each bullet point indicate Boards where there is particularly strong evidence of the contribution of specific factors).

- Establishment of a project steering or change management group which has a multi-disciplinary membership and the active involvement of credible, senior people (clinicians/managers) in leading and championing the change. *(ECAHB, MHB, NEHB, NWHB, SHB, SWAHB)*

- Human qualities such as resilience and patience, persistent and consistent attention, a tolerance for uncertainty, and a bias for solving problems (especially those problems which emerge after the change implementation has begun and which might stop it in its tracks or inhibit its full implementation). *(ECAHB, ERHA, MHB, SWAHB)*

- Communication, transparency and consultation 'amongst equals', i.e. where those who invite views acknowledge the uncertainty that is inherent in the management of change and where those who offer views accept that they do not have a veto, and where there is as much clarity and transparency as possible in relation to the criteria used for decision-making. Communication in advance of the change and at several points throughout the change was particularly important. Awareness-raising and (re-)training workshops and events were also helpful in many cases. *(All Board stories demonstrate the contribution of at least one facet of this factor)*

- Active resource management: resources alone will not make the change happen but their absence can be an inhibitor. In this regard, resources can be considered a hygiene factor in managing change (Herzberg, 1966), that is, necessary conditions but not motivators. *(EHSS, ERHA, MHB)*

- The adoption of an 'inclusion strategy' or approach based on seeking to engage the participation of a wide range of stakeholders and interested parties in the thinking through, planning, design and implementation of the change. *(ERHA, SHB, NWHB, WHB)*

- Support systems to help problem solving, in particular ideas gained from working in health in other countries or in other fields of public service (seemed especially useful in relation to areas of health care with little precedent in Ireland, such as primary care). *(ERHA, SWAHB)*

- The active engagement of people who resist or express concerns about the change. *(ERHA, WHB)*

- Compelling external pushes or forces for change (economic, social, business, demographic, political, etc.). *(ERHA, NEHB)*

- The involvement of facilitators with expertise in organisation development who can help managers to appreciate the system effects of 'isolated' change, i.e. the impact on the structures, cultures and working practices of the area directly concerned by the change and other areas within the organisation. *(ECAHB, WHB).*

Different Aspects of Leading and Managing Change – Performance Ratings

Each of the organisations which contributed a good practice change story for this report was also asked to rate the change it managed according to 20 criteria. As mentioned earlier, these criteria were drawn up using Kotter's (1996) work on managing change, combined with a further 12 variables in effective change management which were identified by Upton and Brooks (1995). The 20 variables are

i. generating an appropriate sense of dissatisfaction with 'the way things are'
ii. a clear and common vision/inspiration about how things can be better
iii. creating or securing knowledge about the first steps needed to deliver the change
iv. securing appropriate top management support
v. communication and consultation – in advance of the change
vi. timely securing of the necessary resources
vii. clear goals and objectives for implementing the various phases of the change
viii. clear timescales for implementation of the different phases or major tasks associated with the change
ix. making the change concrete and visible at an early stage
x. managing the unanticipated knock-on effects
xi. communication and consultation – throughout the change
xii. managing the internal politics around the change
xiii. empowering others to act on the vision/effect the change
xiv. establishing an appropriate level of urgency about the change
xv. getting a 'critical mass' of people behind the change
xvi. dealing with resistance and obstacles in a timely way
xvii. aligning the change with the culture of the service/organisation
xviii. communication and consultation – following the change
xix. recognising and rewarding people for changing
xx. declaring 'victory' at the right time (i.e. claiming that the change has been 'bedded down' at the appropriate time).

In relation to each of these 20 variables, the participating organisations were asked to rate each variable (from 1 to 5) in terms of (i) how important it was seen to be in the management of this change (ii) how effective the change team/manager was in dealing with each.

When the ratings of all of the participating organisations are pooled, it is possible to get an overview of the collective rating of importance and effectiveness against each variable and, from this, to identify the 'Top 5' variables in the management of change (based on the experiences of

the organisations which contributed to this research). Not surprisingly, the findings reflect the earlier identification of factors which contributed to successful implementation of changes and they also mirror the findings of Kotter, Buchanan and Boddy, Duck, and Pettigrew and Whipp (mentioned above). These are the top five variables:

1. a clear and common vision/inspiration about how things can be better
2. communication and consultation – throughout the change
3. securing appropriate top management support
4. empowering others to act on the vision/effect the change
5. communication and consultation – in advance of the change

Appendix 1 to this report shows a graphical representation of combined ratings of the 20 variables, along with the full list of the relative rank of each.

Good Practice in Managing Change: 11 stories

The 11 accounts of good practice in managing change begin overleaf. They are all presented in the same format to make navigation within and between them more easy. They are presented in alphabetical order according to the Board in which they occurred.

Again, grateful thanks to each of the Boards and the people who presented these examples of good practice.

1. East Coast Area Health Board
A Process of Organisational Development

1. Please describe the nature of the change

The change in question was not a discrete one in this instance, but rather the development of the organisation, that is, the East Coast Area Health Board which was established in 2000 (along with two other area health boards in the old 'eastern health board' region). This OD change programme was begun so that staff of the newly-created Board could develop an allegiance to their new employer and so that there would be a sense of a unified identity and ethos within the new organisation. There was a strong sense that people didn't want the new organisation simply to be a name change, they also wanted its creation to be the start of new ways of working across sites, across disciplines and across grades. To this end, the OD change programme was about giving people in the new organisation an opportunity to address barriers to and enablers of more effective involvement in making the ECAHB a more attractive place for people to work and a better provider of health and personal social services.

It was decided early on, based on informal soundings with staff, that the approach taken should be participative, inclusive, cross-sectoral and action-based. The main vehicle for implementing this OD change programme was the formation of a number of Action Teams, based on self-selected membership according to particular interests (the Teams were based on areas for action which were identified in January 2001 and which covered areas such as Communications, Mentoring, Induction, Recruitment, Accommodation, Care Group Planning, Client Participation, and Staff Facilities).

2. Who were the intended beneficiaries of the change?

The change was intended to have a direct impact on staff of the newly created Board and, through staff, on patients and service users. There was a desire to make it easier for staff to innovate, to take more responsibility for effecting change in their own units and parts of the organisation, and to improve the general working conditions for staff and encourage more participation and partnerships across the organisation. In addition to the benefits derived from simply working on common problems across disciplines, the work of the Action Teams was undertaken in many instances to be of direct benefit to staff (for example, through improving communications, accommodation, facilities, recruitment and development) and to help the Board to meet its commitments to clients (through better planning and client participation).

3. Who else had a stake in the change?

The main stakeholders in this change were the 3000+ staff of the ECAHB. Given that the change was about changing old ways of working and bringing in new values and a new culture, the change genuinely was Board-wide in its scope. As is to be expected, some people chose to engage much more fully in the change actions than others, but it is recognised that this programme will continue indefinitely (although the issues to be addressed will change over time) and, in this way, will become akin to a continual quality improvement process.

The primary initiator of the change was the Director of Human Resources. He was supported in managing the change by an external facilitator and by a dedicated Change Programme Co-ordinator. The Action Team members are the main 'designers' of change and managers and staff are/will be the principal implementers of changed ways of working. In addition, a number of people volunteered to act as Change Agents (advocates for the new culture) and the Board is also in the process of training a cohort of twenty-one Change Facilitators to ensure the availability of an in-house facilitation resource and to support the ongoing work of the OD Programme and other change initiatives, e.g. *Quality and Fairness*.

4. How did resistance manifest itself (if at all) and how was it managed?

There was little overt resistance to the change programme in general. However, there was some cynicism, fear and apathy at the beginning, with people believing that change wouldn't happen, that people were too ingrained in their ways of working and that there was little real commitment to 'changing the ways things are around here'. To begin with, people also resisted the change, or simply ignored it, because they were content with doing the best job they could do in their given areas or because they were already fully occupied just 'doing the day job'. In addition, as is often the case, some of the change Action Teams lost momentum mid-way through their work because 'initiative fatigue' set in or because they discovered that they had 'bitten off more than they could chew'.

Resistance (negativity) was managed in a number of ways:

- by involving people in diagnosis of what needed to be changed, and in design and delivery of the changes – in other words, by giving people within the Board a chance to make a difference

- by making the process voluntary (no-one was compelled to get involved in an Action Team) and transformational (based on a vision of where people want to get to)

- by involving people in interactive and creative workshops to precipitate the change

- by communicating with people on a regular basis, making participation enjoyable, and by celebrating the progress and achievements of the individual Action Teams

- by inviting people to become Change Agents and to act as conduits of information between the Action Teams and the wider organisation

- by giving a large degree of autonomy to the Action Teams and by providing them with support and facilitation when their enthusiasm or commitment flagged or when they ran into problems in addressing issues as complex and as broad as communication and recruitment

- by the persistent championing of and commitment to the change programme by the senior managers of the Board, including the CEO.

5. How were the timing and scheduling of the change agreed and managed?

The timing and scheduling of the change was primarily informed by the creation of the ECAHB and by the appointment of the Director of HR in September 2000. The change programme has been moving forward ever since then, with the Action Teams setting their own pace and scheduling their own activities. In November 2001, a progress report on the first year of the change programme was produced and widely disseminated to the Board and beyond. The programme continues.

6. What were the critical activities associated with delivering the change?

- Communication and involvement of staff – kick-starting the programme with the engagement of the senior managers and heads of discipline and getting them to generate the common vision of the sort of Board they wanted the ECAHB to be. Listening to staff and respecting their opinions.

- Championing of the change from the top, especially by the Director of HR and the CEO.

- Involvement of a trusted external facilitator.

- Persistent and consistent attention to the change and the recognition that it is an ongoing programme rather than a one-off initiative (since November 2000 there has been at least one event a month designed to support and/or progress the change programme).

- Getting 'real' people to identify the changes and to commit to addressing them.

- The opportunity presented by the creation of a new Board and a (largely) new management team – a chance to reflect from the beginning on how things might be.
- Self-selection of Action Team members and support to/facilitation of the Action Teams.
- The appointment of Change Agents who acted as conduits of information between the Action Teams and the wider organisation.
- Early successes and achievements of the Action Teams and celebration of these.
- Creation and effective operation of a Programme Review Group to 'project manage' the initiative and ensure progress is on target.
- Mainstreaming the model of collaboration and participation into the work of the Board (e.g. using the same model of facilitated workshops to come to a decision on resource adjustments).
- Seeing the impact of the Board's work on the wider health services management stage (e.g. similar initiatives being started in other Boards or adoption of some of the ideas at national level).

2. Eastern Health Shared Services

Training and Development Services in the Eastern Region

1. Please describe the nature of the change

This change centred on the development of a new approach to the design and delivery of training and development in the three area Health Boards and the Health Authority of the Eastern Region. In particular, the change was intended to ensure greater efficiency and effectiveness in this function through the establishment of a dedicated specialist training facility (in St. Mary's Hospital, Phoenix Park) and the related establishment of a team of experienced professionals, drawn from the health services, to ensure a high level of customisation to the needs of the client organisations.

It was intended that both the new facility and the support of an expert team would transform the manner in which training is both planned and delivered across the three Area Health Boards, ERHA and Eastern Health Shared Services (five agencies, approximately 15,000 employees). The new team, consisting of four Development Officers, was established in February 2002 and the facility opened in September 2002. It is expected that the facility will be self-sufficient within approximately two to three years. The key advantage of the Development Team is the ability to capitalise on the internal or health expertise of the team in designing training interventions.

2. Who were the intended beneficiaries of the change?

The initiative is intended to provide improved resources to every employee of the five agencies already listed (the 'customers'), through improving the approach to training and development delivery and through evaluation of service improvement. Specifically, the HR Directors and the ERHA Director of Nursing Midwifery Planning and Development are now availing of the facilities on offer, whilst also benefiting from the increased number of purpose-built programmes on offer from the development team.

The end users are ultimately the various course participants and their line managers who have assisted in designing the training programmes with a view to directly improving service delivery.

3. Who else had a stake in the change?

There were a number of stakeholders or key players involved in this project. It is more practical to consider the stakeholders from two perspectives in terms of the capital work and the team development.

Capital Project

The change in respect of developing a training centre was planned originally about four to five years ago, prior to the arrival of the current Training and Development Manager. Funding and the confirmation of an available site did not emerge until late 2001-early 2002. The Northern Area Health Board made part of the Nursing Home at St. Mary's Hospital available for renovation on condition that the Special Olympic World Games Committee would be allowed to use the centre for two months in 2003. Funding for the project was made available through Eastern Health Shared Services.

Some of the key players at this point were the CEO of the NAHB, the three HR Directors of the Area Health Boards, the Chief Officer of the EHSS, the Director of Employee Services of the EHSS and the Training and Development Manager of the EHSS. A point of note with regard to this aspect of the project was that it was not a very direct line of decision-making in terms of agreeing to proceed with the initiative, because five separate agencies had different vested interests and needed convincing of its merits. Any one of the five key players at this point could have jeopardised the project if they were unwilling to proceed.

Development Team

The decision to proceed with the Development Team was somewhat more straightforward, in that the decision to recruit specifically four Development Officers was made internally at EHSS, once more, however, with the backing of all five agencies.

4. How did resistance manifest itself (if at all) and how was it managed?

There was little enough actual resistance to the project because the stakeholders agreed such facilities and resources were much needed and, in particular, key people believed that investment was also badly needed in certain frontline service areas. However, given the number of competing demands for HR attention in 2001-2002, getting the project to a sufficient level of priority for the key decision-makers was difficult at times. Any overt resistance that did manifest itself related to agreement on the location of the centre and funding of the project. There was some tentativeness in the initial stages as a result of the lack of certainty about the roles of the different players.

Following lengthy negotiations between key stakeholders, agreement was reached to proceed with the capital works. Once approval was reached to deliver on the capital works and recruit the team there was little difficulty with proceeding with the further phases of the project. The challenge was then focused on utilising the facility to a level that satisfies the needs of key customers in tandem with upskilling and developing the capability of the development team.

5. How were the timing and scheduling of the change agreed and managed?

Managing various stages of the capital project depended on meeting construction deadlines, which were managed by EHSS's Architectural Surveying and Engineering Department. A number of pilot programmes took place between May and September, the timing ensured that the team was ready to deliver when the facilities were opened. The co-ordination of delivery was principally managed by the Training and Development Manager.

6. What were the critical activities associated with delivering the change?

As previously outlined, securing agreement to use the accommodation and achieving agreement to increase the employee complement were fundamental to proceeding with the plans. Fortunately, with some manoeuvring, these two critical decisions were made around the same time. The capital project was managed as would any other capital works with the key difference that each stage was critically monitored by the stakeholders and the summertime deadline had to met to enable the Irish National Special Olympics to use the centre this year in preparation for the World Games in 2003.

Selecting the right candidates for the Development Team was also critical. The successful candidates were chosen on the basis of a number of criteria, which focused on their health experience, training exposure/experience and their determination to want to work in this specialised area. The rate at which the team has progressed is very much a reflection of the members' willingness to succeed in making a real change in the manner in which Training and Development is both managed and delivered.

The change in the way Training and Development is being planned and delivered is happening through negotiating with key line managers as to what they would expect as a reasonable outcome from their intervention and using these expectations to benchmark our effectiveness. Working with line managers is, therefore, thought to be key to success.

3. Eastern Regional Health Authority
Establishment of the 'Home First' Programme

1. Please describe the nature of the change

The change was one of a range of initiatives targeting older people and designed to enable them to stay at home and look after their health at home (or as close as possible to home or in 'home-like' circumstances). In this case (the "Home First" project), a pilot project was established to facilitate the discharge of older people from hospital (Beaumont) directly to their own homes, with community health services support (from the Northern Area Health Board), rather than to nursing homes. In order to effect the change (enable people to move home with appropriate care), there was a significant need to improve and integrate community services.

2. Who were the intended beneficiaries of the change?

The change was intended to have a direct beneficial impact on patients, i.e. older people in acute hospitals – research has proven that people prefer to return home and do much better (attain better health status more quickly) when they return home (obviously, with the right expert clinical support) rather than have to experience further institutional care. The change had the secondary benefit of making more acute hospital beds available because it reduced the impact of the limited capacity of Dublin nursing homes to accept patients from hospital.

3. Who else had a stake in the change?

The change was initiated by the Eastern Regional Health Authority (ERHA) and involved working closely with the Northern Area Health Board (NAHB) and with Beaumont Hospital (BH) to ensure that discharges were appropriately planned and managed from both the hospital and the community services sides. The primary 'owners' of the change were the Commissioners of the ERHA – this ownership was transferred to the NAHB and BH as the project progressed.

The main groups of staff to be affected by the change were nurses and health and social services staff in both the hospital and community. In the hospital setting, the primary staff stakeholders were nurses and geriatricians who wanted assurance that their patients' care and recuperation would not deteriorate if they were discharged to home rather than to further nursing care (nursing home). In the community, it was care staff (home helps and care attendants), nurses and therapists who were most affected by the change – these groups of staff were concerned about their capacity and ability to take on new ways of working and the extra work of caring for older people discharged from hospital to home (given that they already had long waiting lists for community OT services).

The main 'makers and breakers' of the change were

- nursing and other clinical care staff who had some misgivings about the ability of the health services in general to provide appropriate post-acute hospital care for older people in their homes

- managers (including clinicians with a management role in both the hospital and community) who needed to work differently, to interface more across non-traditional boundaries, who had to create new ways of managing resources, and who had to develop new systems for delegating work (including sub-contracting)

- consultant geriatricians, whose support for the initiative was a significant enabler of the change

- carers and families of older people who could resist discharge to home if not assured that their relatives would receive the necessary health and social care following discharge

4. How did resistance manifest itself (if at all) and how was it managed?

Resistance was manifested in a number of very overt ways:

- There was a need for radical change to some mind-sets and attitudes, a need to change the strong tendency to ultra-caution and to only looking at the problems rather than to trying to find solutions (a 'can't do' approach rather than a 'can do' one). People wanted evidence-based assurances that things would be better or, at least, no worse for patients under the new regime. (This became something of a chicken-and-egg issue because the evaluation of the Home First project was to provide the evidence for/against the new regime.) There was also a suggestion (not unusual!) of the 'not invented here' syndrome whereby people are not really interested in supporting other people's ideas for change. As the change began to take effect, mind-sets began to unfreeze and there was growing acceptance that patient care and safety was not compromised by their discharge to home.

- Professional and sectoral silos – people are very used to working in their own way (the way they have learned in their professional schools, be they nurses, therapists or doctors) and in their own system (hospital or community) and there needs to be a lot of attention paid to supporting people to work in inter-disciplinary and cross-sectoral systems. Consistent attention was required to help and encourage people (clinical staff) to move out of their habitual ways of working and to getting them to promote the take-up of the new service to patients.

- Resources – people wanted the additional resources (money, equipment, staff, etc.) in place

before they began to change because they did not trust that additional resources would arrive after the change had begun and, in some cases, even operated in ways to protect current levels of resources rather than use them to further the change. In addition, people had very different ideas and assessments of the amount of resources that would be needed to effect the change and it became very clear that the lack of activity-based or unit-based costings was an impediment to agreeing resource requirements. Finally, the environment of the time was marked by serious recruitment difficulties and this became a stumbling block in some areas. Support from the centre (the ERHA) was an important factor in helping to resolve these issues, especially where new (in Ireland) ways of working were required, such as sub-contracting services to non-statutory providers.

5. How were the timing and scheduling of the change agreed and managed?

The timing and the pace of the change were set by the ERHA in the first instance – the change was initiated on foot of the publication of the Action Plan for Older People (which identified the need for older people to be/stay at home in so far as possible) and consultations with the Area Boards. The Authority/Area Boards were interested in making a difference, especially because it was a relatively short time since they had been established. The hospitals were interested in the change and encouraged a fast pace too because nursing home/step-down beds were in very short supply in Dublin.

6. What were the critical activities associated with delivering the change?

- Tri-partite involvement of senior people from the ERHA, NAHB and BH and the appointment of a Steering Team whose members had the right levels of enthusiasm, resilience, seniority, credibility and teamworking and problem-solving ability.

- Constantly 'selling' the change at local level to people (staff members) who thought it might not/would not work and keeping up the attention and drive for change.

- Convincing community services to allow subcontracting of basic care services.

- Patients' reactions to the change were largely positive from the beginning which meant that good news started to spread and was further disseminated via PR activities, conference presentations, and general communication.

- Appointment of a Care Organiser (who took up the role of planning, negotiating and coordinating care packages for the thirty older people involved in the pilot project) and the subsequent appointment of a social worker to complement the care.

- Development of protocols for care packages for older people.

- Experience of ERHA project leaders of similar ways of providing care in the UK (meant that they were familiar with a working model and could provide some conviction about its feasibility).

- Solving the problems as they arose, not admitting defeat, and having central support (ERHA).

- Using publicity (or the threat of negative publicity) as a lever for further change.

- Consultation – based on initial consultations with the Area Boards and other agencies, the need for the change was identified. The consultation did not stop here, though – a proposal was drafted and made very concrete through further local consultation and this helped gain the 'buy-in' of key stakeholders.

- Securing and providing the necessary resources (in economic terms, the project was not very costly overall).

4. Eastern Regional Health Authority

Establishment of an Enhanced Complaints Procedure

1. Please describe the nature of the change

The change concerned the way in which complaints about health services are received and dealt with by the thirty-nine health service provider agencies within the Eastern region. Whilst acknowledging that the vast majority of health service users are satisfied with their experience, a number of people (inevitably) will not be fully satisfied and it is important for these service users, as well as the particular provider agency and relevant staff, that there is a process by which they can make their views heard and have their dissatisfaction addressed and even redressed.

Of course, some of the provider agencies have long had their own procedures by which service users could make complaints: this initiative was designed to review, enhance, and make these procedures more effective and more people-centred. In short, the change concerns a change of culture (attitudes and values) as well as of practice and procedures.

The full scope of this initiative has not at the time of writing (Autumn, 2002) been implemented and therefore the full benefits have not yet ensued. A major review has been undertaken and has identified a number of areas of difficulty, including the need for further enhancement of the ethos of customer service and some legislative changes designed to make complaints procedures more effective in the handling of complaints.

A comprehensive training programme has been developed (for staff handling complaints) and put in place and will be offered more widely in the coming months. A customer service action plan (called 'People Matter') and an advocacy framework are about to be launched and significant training in customer service and complaints handling has already taken place throughout the region.

2. Who were the intended beneficiaries of the change?

The change to the way in which complaints are treated by agencies in the Eastern region was (and is) primarily intended to benefit service users, particularly the 20% of clients/patients who 'thought about' making a complaint about their experience of health service delivery, 33% of whom did make a complaint. The providers of health services were also intended beneficiaries as no-one wants to provide unsatisfactory service and a complaints system that enables service users to make their views known in a fair, 'no-blame' and measured way is one of the best ways of getting to deliver quality services.

3. Who else had a stake in the change?

In addition to service users, staff were the main stakeholders. In many cases, it is staff on the delivery side who first hear complaints (for example, ward-based nurses) and these complaints are typically passed on to designated managers who investigate the nature of the service users' dissatisfaction (50% of complaints centred on communication and 30% on aspects of behaviour of staff, according to the preliminary review; other complaints concerned lack of service provision/access/health system shortfalls).

For this reason, all staff with a customer-facing role and all staff involved in the investigation and handling of complaints were critical stakeholders in this change.

4. How did resistance manifest itself (if at all) and how was it managed?

The primary manifestation of resistance came in the form of defensive attitudes: complaints about service delivery and/or about specific members of staff are, by their nature, highly sensitive and can lead to significant defensiveness. In addition, it seemed as if agencies and their staff were fearful about what would happen if the complaints system was centralised (under the ERHA) or changed in such a way as to lead to a higher level of complaints. People needed to be convinced that the system would support the perception that complaints would be viewed as valuable feedback.

Resistance was managed, by and large, by communication and involvement. Staff were involved in reviewing the systems and in making recommendations for change. Staff from across the region were encouraged to network and share information via conferences and workshops. A good deal of time was spent in living the people-centred ethos of the entire project by encouraging staff to participate in the activities associated with 'diagnosing' the required changes and developing approaches to improve the handling of complaints.

In addition, the ERHA appointed a Working Group, whose membership was drawn from the statutory/voluntary, acute hospital/community/disability agencies who had the expertise, the credibility and the experience to ensure appropriate attention to the process. The whole process was also well resourced and spearheaded by the ERHA.

5. How were the timing and scheduling of the change agreed and managed?

By the ERHA with the relevant stakeholders, with a schedule agreed from the start (an Interim Report was produced in September 2001 and a Progress Report was produced one year later). Further implementation of the Working Group's recommendations (as outlined in the Interim Report of 2001) will continue under the auspices of the ERHA.

6. What were the critical activities associated with delivering the change?

Communication and consultation, involvement and participation. This change is fundamentally a culture change designed to put people at the centre of the health services and recognises that from time to time things do go wrong in the delivery of the health services. The Health Strategy (*Quality and Fairness*) addresses this issue in Action 49.

Given how critical staff are in any change in the way complaints are dealt with, a conscious effort has been made throughout to put staff members at the centre of this process so that staff-centredness becomes the means and service-user-centredness is the desired end.

5. Midland Health Board

New Approach to Planning and Delivery of Child Care Services

1. Please describe the nature of the change

The change was designed to enable the Midland Health Board to develop and deliver a modern and effective service to meet the needs of children and families in the region. It was also intended to resolve some of the concerns that were evident within the area of child care generally (nationally, as well as in the region) including the need to re-think models of residential care; the search for greater alignment and clarification of roles and responsibilities in an increasingly complex and specialist area; growing regulation and accreditation of services relating to children; and the need to structure service around three relatively distinct and different needs:

- child protection (relating to abuse and treatment/follow-up)
- care for children (foster care and residential care)
- family supports.

The first part of the change process was the development of an all-encompassing strategy for child care. A high-level Steering Committee was established and was charged with overseeing the development of this Strategy, including ensuring appropriate consultation and evaluation. An Implementation Team was also established to ensure implementation of the different actions.

2. Who were the intended beneficiaries of the change?

The development of this new approach to planning and delivering these services is intended to benefit the end-users of these services: the children, the families and the carers of children. It was also intended to be of benefit to the service providers in that it was hoped that the new structures and greater clarity of purpose and approach would enable the Board to improve its retention of key scarce staff (such as social workers).

3. Who else had a stake in the change?

In addition to service users, staff of the MHB were the main stakeholders (in the past ten years, most non-statutory providers of child care services have withdrawn from this type of work). In particular, it was staff on the 'front line' of service delivery that were critical to the change, because this is where stress was most keenly felt due to staff shortages, frequent changes being imposed by statute, and the growing acuity of service required by children and families.

Managers in the service were and are key to the changes being effected because their roles needed clarification and modification in many respects. The services delivered to children and families are increasingly planned and managed on a multi-disciplinary basis and so it was not only social workers who had a stake: other disciplines, both residential and community-based, also had to change the way they delivered services to enable the changes to take effect.

4. How did resistance manifest itself (if at all) and how was it managed?

Resistance was 'surfaced' through additional consultation with key stakeholders. In one instance, a measure of resistance was 'sensed' by some members of the Steering Committee and it was agreed that it would be appropriate to check its depth and breadth. (It transpired that staff were unhappy at the pace of the changes, especially the speed at which they moved from being general principles for consideration to firm bases for the annual service plan.)

Resistance has also come from one or two disciplines who, perhaps, feared that their roles would be less central in the planning and management of services to children and families and who wanted assurances as to the reporting arrangements (management and professional accountability) suggested in the proposed restructuring.

5. How were the timing and scheduling of the change agreed and managed?

The Steering Committee (which included the head of the child care 'programme' for the Board) was an important 'mediator' in the scheduling of the change, in some cases acting to speed it up and in other cases acting to moderate it. Key factors which influenced the timing (quickened the pace) were the desire to get things done, the growing need for change, and the need to link the changes to the Board's primary means of planning and managing services, the annual Service Plan.

Other factors acted as a brake on the change and these were the staff shortages, the capacity of staff to take on more change, and the resistance from staff. The original Project Manager resigned from the post early on in the process but has now been replaced and this appointment is expected to ensure momentum in the coming months.

6. What were the critical activities associated with delivering the change?

There were a number of activities that were critical to designing and delivering the change including

- building in time for bullet-proofing and reality-checking the strategy at an early stage
- ring-fencing time for people to participate in the Implementation Team and to ensure feedback to their relevant disciplines/constituencies

- consultation and involvement of key stakeholders, especially those who might be perceived as having 'most to lose' – talking to staff throughout the process, and building good trustworthy relations through timely communication, listening, and reversing of decisions when appropriate

- good rapport within the Steering Committee and within the Implementation Team

- checking in with people when dissatisfaction/discomfort was sensed

- delegating of power and authority to stakeholders and acceptance of their power and right to be involved in the design and delivery of change

- in one case, when a significant problem arose for the Board in relation to an aspect of its child care services, a critical incident-type meeting took place at the highest level within the organisation and the tenor of this meeting was about resolving the problem and preventing it from occurring in the future: this no-blame problem-solving approach underlined for staff the message that there was senior management support for them and that change was being sought for the sake of improved service provision rather than for any other reason

- persistence – keeping the need for change on the agenda even though the environment was very busy and capacity was already stretched; not letting things 're-freeze' in their old ways

- accepting that certain factors which are outside of the control of any stakeholder will impact on the pace and even direction of change, but not letting them stop it.

7. Other factors

The full range of changes that are anticipated to arise out of this strategy has yet to be implemented (most of the changes to date have taken place within the Family Supports part of the child care service).

6. Midland Health Board

New Approach to Quality Improvement

1. Please describe the nature of the change

The overall purpose of this change related to (i) improving the management of risk and the quality of service within the Midland Health Board and (ii) coordinating the various risk management/continuous quality improvement and clinical audit initiatives and programmes which have been put in place in the Board in recent years. In order to achieve this improvement in service quality, a number of initiatives have been or will be introduced in order to

- reduce the incidence of harm/make the Board a safer place to work through risk assessment, guidelines and policies for managing known or possible risk, control of hazards, incidence reporting, etc.

- systematise quality management through standards, protocols, accreditation and control

- continue to develop a programme of clinical audit and systematic review in both the acute hospital and community settings.

Much of the work involved in bringing together this new approach to quality, audit and/or risk management has entailed awareness-raising and training of staff and line managers to be their own 'risk/quality managers'. Some new committees, with very specific terms of reference, have been created to work alongside those other committees within the Board which already have some quality-related role to ensure that risk management is coordinated at different points and levels in the organisation. In addition, there are plans to develop a knowledge management intranet to facilitate sharing of information, analysis and learning about risk and quality across the Board.

2. Who were the intended beneficiaries of the change?

Ultimately, improvements to the quality of service are designed to benefit the service users or patients/clients of the Board. However, it was also intended that staff would benefit through, for example, bringing about a safer working environment and having their work more formally validated.

3. Who else had a stake in the change?

Staff (including line managers) of the MHB were the main stakeholders in these changes. Much of the impetus behind these changes was aimed at changing the value that staff place on reviewing and learning from prior performance or incidents and on identifying areas for improvement within their own service or others. In other words, a key element of this change related to trying to clarify the boundaries of staff responsibility and authority for effecting improvements in the quality of service, and also trying to clarify the appropriate 'escalation protocol' if quality improvements could not be effected locally or immediately and, therefore, required referral to a higher level or other part of the organisation.

4. How did resistance manifest itself (if at all) and how was it managed?

To date, outright resistance has been relatively low. Whilst many people felt very uncomfortable and even fearful about clinical audit and whilst some others were unclear as to their role with regard to these quality improvement practices, they have now been successfully introduced into many of the areas of service of the Board.

Question marks persist in some cases about the link between clinical audit, accountability and litigation, and staff in some areas, where quality and review remained relatively unstructured, expressed some wariness about erosion of their jobs. In other areas, resistance was expressed because the changes required new skills.

By and large, resistance has been managed in a number of ways. These are primarily by providing interactive education and training, by talking to staff and line managers, asking them the right questions about the services, and clarifying their responsibility for effecting quality improvements in their areas, and by providing people with evidence of the benefits of clinical audit and other quality-centred methods in the first instance.

5. How were the timing and scheduling of the change agreed and managed?

The most critical timing issues appear to have been the appointment of members of 'technical support' staff dedicated to one or more aspects or managing risk/quality because it is these staff who provide the expert support and much of the drive to effect changes. Other factors which impact on the scheduling are relatively routine, such as people's availability and the service planning cycle.

6. What were the critical activities associated with delivering the change?

There were a number of activities that were critical to designing and delivering the change including

- appointment of credible/experienced staff to key posts (such as clinical audit)
- reorganisation of the management team and integrating risk management and quality
- involving people through facilitating discussions with them, holding local workshops, delegating the identification of problems and the solution-finding to them
- securing base funding for risk management
- accepting that people will try to use the evidence generated by risk management/audit/review processes to try to bargain for more resources and having real discussions with them about assessing risk and allocation of resources
- follow-through on commitments: when people asked for help to resolve problems, it was forthcoming or, if not, there was at least a feedback loop to the relevant people explaining why not
- championing of the approach by a few key stakeholders (such as the directors of nursing and some of the consultant hospital doctors)
- training and education as one of a number or ways of raising awareness and reducing fear.

7. North Eastern Health Board
Closure of Single-Consultant Maternity Services

1. Please describe the nature of the change

The change was designed to provide a safe system of maternity, neo-natal and paediatric services by closing two single-consultant-led maternity units (in Monaghan and Dundalk), and by transferring services to larger units at Cavan and Drogheda. The units were deemed to be unsafe by the relevant professional bodies because they had only one consultant and the number of deliveries at each of the units was such that additional consultant staff, if such were to be appointed, would be unable to maintain their levels of skill and expertise. Following on from the closure of these units as consultant-led services, it was proposed that they be re-opened, on a phased basis, as midwife-led units as part of an overall re-organisation of maternity services across the region.

2. Who were the intended beneficiaries of the change?

The change was designed to ensure that women and babies across the region had access to 'woman-centred, safe, quality, and sustainable' maternity services (obstetrics and neo-natal) and that staff would work in units which would ensure that they could maintain optimum levels of expertise.

3. Who else had a stake in the change?

The change was initiated by the CEO on foot of the recommendations of two Board-appointed expert/review groups (Condon/Kinder). The primary 'owners' of the change were the Executive of the organisation (CEO and DCEO who was responsible for Acute Hospital Services). However, since such a change represented major policy, it was a reserved function of the Board which required formal Board approval before it could be implemented.

The main groups of staff to be affected by the change were midwives and consultants involved in the obstetrics services of the Board, both within the hospital and community settings. In addition to the Board staff, GPs were also affected. All staff in Monaghan hospital (in particular) were indirectly affected, especially as the perception grew that this closure was 'the beginning of the end for Monaghan hospital'.

The main 'makers and breakers' of the change were the following.

- The Board – especially the **public representatives** who were representing affected constituencies (notably Monaghan, where the closure of the maternity unit was perceived as threatening the viability of the hospital) and some of the clinicians on the Board who did not agree with the necessity to close the units, notwithstanding the position of the Royal College of Obstetrics and Gynaecology on single-consultant units.

- **Midwives** – there was significant resistance from some midwives to the closure.

- **Insurers** – indemnity could no longer be provided to units which operated outside the accepted safe levels of consultant staff (these were the only two such maternity units in the country).

4. How did resistance manifest itself (if at all) and how was it managed?

Resistance was manifested in a number of very overt ways.

- The Board refused on a number of occasions to take a decision, and proposed alternative solutions, none of which was viable.

- There were direct appeals to public representatives at the highest level to provide alternative solutions to those recommended by the CEO, and the public representatives also believed that such an overturn was possible.

- There were many attempts to contradict the recommendations of the Review Group in the national and local media and senior clinicians were brought on board by both the pro-closure and anti-closure sides to argue the case.

- There were threats of industrial action.

- There were attempts to confuse the message with the messenger and to personalise the issue rather than address the problem.

5. How were the timing and scheduling of the change agreed and managed?

The timing and scheduling of the closure were planned and discussed in detail with the key stakeholders, with a view to ensuring minimal disruption to the business-as-usual of the maternity services. However, the imminence of a loss of insurance cover (with a two-week cut-off period)

eventually resulted in the Board adopting a formal resolution in accordance with recommendations; this meant that the change was accelerated and the original schedule substantially revised to accommodate this deadline.

6. What were the critical activities associated with delivering the change?

- Appointment of an independent Review Group.
- Involvement of the senior management team and General Managers in the closure.
- Support of certain consultants/GPs and other clinicians, both on the Board and in the service.
- RCOG's stance on safe consultant levels in maternity units.
- Support of the DoHC for the change.
- Retaining, in so far as possible, a focus on the outcome of the change (safe services).
- Withdrawal of insurance – critical external force for change.
- Opportunity to 'save face' through apportioning the 'blame' for the closure on outside influences beyond the control of the political system (i.e. the insurance industry).
- In so far as possible, ensuring that key people knew what was happening throughout and avoiding unnecessary unpleasant surprises for people.
- Ability to attract extra resources to support the implementation of the change.

7. Other factors

Imposed change versus planned change!

Very turbulent environment/backdrop in parallel with this change – this both complicated the closure change (the business-as-usual was undergoing significant increases in activity, complexity and acuity) and added to people's perception that change was needed in any event.

Highly political nature of this change and highly media-conscious political activists at all levels!

8. North Western Health Board

Improving Services for Patients with Dyspepsia

1. Please describe the nature of the change

This change falls very much within the area of improving clinical quality of service and relates to an attempt to improve the service provided to patients presenting to GPs with gastrointestinal complaints. The approach to achieving this improvement in quality was led by the Board's Public Health Medicine specialists and focused on increasing the implementation by GPs of evidence-based guidelines relating to the diagnosis and management of *Helicobacter pylori*, a microbe implicated in at least three out of every four ulcers.

It was recognised that simply disseminating such guidelines to GPs would not be enough because, in general, guidelines need to be modified to take account of 'local conditions' and systemic issues that can prevent their full adoption. That change was needed became apparent as steady increases were noted in referrals to hospital by GPs of patients presenting with dyspepsia for endoscopy testing and in increased prescribing of proton pump inhibitors.

It was decided that there were three elements to achieving the improved quality of service: (i) active participation of GPs and other health practitioners in examining and modifying the guidelines for local use, (ii) the provision of non-invasive tests for *H.pylori*, and (iii) the establishment of a gastroscopy service that could be easily accessed by GPs. The performance indicators which were used to assess the effectiveness of the change were an increase in the diagnosis and eradication of *H.pylori*, a reduction in the number of people on long-term anti-ulcer therapy (without a definitive diagnosis), and a raised awareness in general about the use of evidence-based guidelines as a quality improvement tool. The change proved to be successful on all three of these measures.

2. Who were the intended beneficiaries of the change?

As in most change in the health service, the ultimate beneficiaries are the patients or service users, in this case people presenting to their GPs with gastrointestinal complaints.

In addition to the service users of the North-West, GPs and the Health Board itself were also expected to benefit in that there was a likelihood that the improved quality would also be accompanied by more efficient use of resources including GP time, more cost-effective use of gastroscopy testing and reduced expenditure on dyspepsia medications.

3. Who else had a stake in the change?

At the outset, it was clear that a diverse group of people needed to own this change for it to happen and widespread consultation confirmed both the diversity of interested stakeholders and the desirability of the change. A project group was formed including representatives of the main interested parties (such as GPs, endoscopy clinicians, nurses, pharmacists and laboratory specialists, local hospital and Primary Care managers, and Public Health Medicine experts). The project leader was the Specialist Registrar in Public Health Medicine.

4. How did resistance manifest itself (if at all) and how was it managed?

There was very little resistance to this change, largely because of the active engagement throughout with the main deliverers of service (both the GPs and hospital-based doctors and other clinical staff). The rational case for change was well established and likely to carry weight with clinicians (the evidence clearly pointed to the increase in gastroscopy waiting lists and in prescribing of expensive therapies, and the guidelines for the management of dyspepsia were themselves based on clear clinical evidence). The exploratory work of the stakeholder group also helped dissipate resistance in that strategies and proposals for resolving problems were discussed in detail by all concerned prior to adoption or implementation.

5. How were the timing and scheduling of the change agreed and managed?

The timing of the change was governed by a clear research-oriented schedule. The change was managed according to good research practice, with a trial group, a control group, and before-and-after assessment of impact over a defined eight-month period. This implementation phase followed a three-month phase of group discussion and design of strategies for effecting improvement, strategies aimed at addressing organisational/systemic blockages and barriers (such as the need to change access protocols and to align the roles of the hospital-based and community-based clinicians) as well as strategies aimed at the health professionals.

6. What were the critical activities associated with delivering the change?

- Establishment of a multi-disciplinary stakeholder group involving representatives of the clinical staff whose work was most likely to be affected by the change, and active participation by the members of this group.

- Clear leadership of the change by the 'sponsoring department' via the Specialist Registrar in Public Health Medicine.

- Time given to enable the group to review and explore the status quo (the guidelines and the practical implications of trying to implement them) before trying to implement change (it became obvious that certain preparatory steps would need to be taken before asking the GPs to try to change the way they use the hospital-based testing services for this category of patient).

- Active communication with GPs, including the dissemination of briefing materials, explanatory memos and posters, as well as building local consensus processes and outreach visits.

- Revision and clarification of professional roles and responsibilities for patients across the community and hospital boundaries.

9. Southern Health Board

New Approach to Service Planning and Development

1. Please describe the nature of the change

This change relates to the way in which the Southern Health Board (SHB) approached the strategic development of its services through organisation-wide corporate planning. This new approach began in 1993 when the SHB undertook a staff survey, the results of which prompted a process of modernisation of the organisation. One of the major tangible outputs from this process was a Corporate Development Plan (CDP).

The CDP was originally devised to cover the period 2000-2003 and has now been updated for the period 2002–2005. The updating of the CDP was necessary to reflect both internal and external changes in the SHB environment and to ensure that the strategic direction of the organisation properly reflected the national health strategy, *Quality and Fairness.* The purpose of having a CDP is to provide clear focus and direction to the organisation. The CDP draws heavily on consultation and dialogue with staff and senior managers. This consultation has been conducted in a variety of ways, including staff surveys, submissions received during the consultation process for the new national health strategy, focus groups and workshops.

The CDP is based on an agreed mission ('Caring for People'), a set of values expressing how staff and service users are treated, and a vision for the organisation ('to improve the health and quality of life of the individuals and communities we serve'). The CDP sets out the overarching corporate objectives and goals, as well as the actions to be taken to deliver on these goals and forms the guiding and integrating framework for the annual service plans and related work plans. Progress relating to the achievement of the goals is monitored by a tracking process which gathers performance information at programme and function level.

2. Who were the intended beneficiaries of the change?

The ultimate beneficiaries of any effective corporate development planning process are the customers or patients or service users and this is the case here too. Of no less importance are the staff and managers of the organisation: the staff who deliver the services and the managers who are accountable for resource usage. The staff survey of 1993 was a major catalyst for change in the SHB. The output from the survey led directly to much greater staff involvement in the planning, development and delivery of services, as well as providing staff with assurance regarding the purpose, direction and unity of the organisation.

The consultation processes which underpin the CDP have probably been the biggest and most tangible change for a large number of staff in the organisation and have led to the organisation being much better able to re-orient itself at relatively short notice to take account of national strategy developments. In addition, the definition of corporate objectives, goals and actions gives managers clear guidance as to the overall corporate mission and vision and assists them in prioritising the use of resources and in the preparation of annual service plans.
The trust and good working relations that are being built through staff involvement are helping the organisation to transform the way it delivers existing services as well as to develop new services. However, it is acknowledged that consultation processes have their own learning curve and it is important to manage the process well so that it is meaningful and so that it does not lead to 'unfulfillable' expectation.

3. Who else had a stake in the change?

Service heads and managers were and are critical to the corporate planning process because the process cannot lead to real change unless they own the outputs and manage their resources within the agreed parameters (mission, vision, values, objectives, goals and actions).

4. How did resistance manifest itself (if at all) and how was it managed?

There was relatively little overt resistance to the change to a more structured corporate planning and development process, possibly because the process was instituted as a result of a staff survey, the results of which were shared within the organisation and provided an impetus for change. Covert resistance was evident in pockets, resistance which found expression in cynicism and, at a slightly more benign level, in people 'sitting on the fence' rather than committing themselves to the change. Some staff members felt threatened because they saw the process as being 'another management agenda' rather than one which was designed to improve working relations and service delivery.

The primary way in which resistance (including cynicism) was managed was through face-to-face dialogue and involvement of staff, including workshops (with senior manager participation, led by the CEO) where the process and its implications were openly discussed and debated. In the consultation exercise for the first CDP, all members of staff received a letter informing them of the process and inviting their views and this widespread personal communication reinforced the message concerning the commitment of the organisation to change. A staff magazine was introduced in the mid-1990s to provide staff with information on the planning process as well as to improve intra-organisation communication in general.

Reassurance and validation of the process and the Plan itself came from the fact that the national health strategy of 2001 adopted a similar consultation-based approach, and came up with many very similar recommendations as were contained in the SHB's own CDP.

5. How were the timing and scheduling of the change agreed and managed?

This particular change process has been underway since 1993 and was not scheduled as such. It began with senior managers sensing a level of frustration and conducting a staff survey to check this sensing. The early part of the organisational change process coincided to some extent with the publication of the first national health strategy (Shaping a Healthier Future, 1994). The work of updating the CDP for the period 2002-2005 was linked to the need to interpret what the publication of *Quality and Fairness* meant for us. The national health strategies, as well as the broader modernisation agenda in the public service, have underlined the need for adopting a more strategic approach to the planning and management of health services.

6. What were the critical activities associated with delivering the change?

In the decade since this change was first conceived, there have been hundreds of critical activities. The following list is an attempt to summarise the learning of the SHB in relation to this organisation development over the past number of years.

- Accept that it takes time to get consultation right and that it has to be carefully managed so that it is based on two-way dialogue, leading to collaborative decision-making, based on the reality of service planning and management, and not simply a process of vetoing or developing wish-lists.

- Feedback (to staff and to those who were consulted) is a critical feature in learning to consult and in delegating control and accountability for performance against plans (in the SHB, a Microsoft Project-based tracking tool is now being used by functional heads to help them monitor progress against workplans and service plans).

- Give sufficient time to enable real consultation.

- Make the 'agenda for change' a transformational one, one that focuses on changing the way things are done (and not just focusing on doing more).

- Target your effort – it is not possible to consult with everyone in a large organisation. Make sure you get the buy-in of those who are going to manage the changed ways of doing things and make sure to communicate and inform others about the change.

- In so far as possible, make the process a multi-disciplinary one and encourage people to get together and share experiences and learn from each other.

- Make sure that senior managers are very visibly involved and persist with the change even though progress might seem slow (even risky) at times.

10.South Western Area Health Board

Transfer of Services from St. Loman's Hospital to AMNCH

1. Please describe the nature of the change

The change concerned the transfer, in 1999, of acute psychiatric admission services from St. Loman's Hospital (SLH) in Palmerstown to the new Adelaide & Meath incorporating the National Children's Hospital (AMNCH) in Tallaght. The transfer involved the closure of three acute wards in SLH (totalling 55 beds) and the commissioning/opening of a new 50-bedded unit in AMNCH[1].

Although the three SLH wards and the new AMNCH unit could all be classified as acute psychiatric units, very different cultures and ways of working operated in SLH, a thirty-five-year old specialist mental health service with a heavy emphasis on rehabilitation and community care, and AMNCH, a new large acute general hospital. So the change was both a geographical re-location and a culture re-orientation.

2. Who were the intended beneficiaries of the change?

The change was intended to have a direct beneficial impact on patients, i.e. service users of the psychiatric/mental health services in the South West of Dublin. It was widely acknowledged that SLH had run down into a state of considerable disrepair and that a new unit was not only desirable but necessary for service users.

3. Who else had a stake in the change?

In addition to patients/service users, the main stakeholders in this change were staff in SLH. The main cohort of staff was nursing but others too were heavily involved including therapists and doctors. Nurses were concerned about the implications for them and for service users of the incorporation of a mental health service into an acute hospital setting. The move to AMNCH also meant changes for some of the staff on the general side of Tallaght, for example those working in admissions and in anaesthetics.

The primary 'drivers' of the change were the Clinical Director for the area (a consultant psychiatrist with a national reputation for service development) and the SLH management team which, in effect, became the steering group for the project. Other major players in the change were the decision-makers at Health Board and Department of Health and Children level because this was where the decisions concerning the timing of the move and the size of the unit in AMNCH were being taken.

[1] The final number of beds in the new unit was 50 but this number varied at different points in the planning process from 12 at the beginning (when the psychiatric unit was conceived as a unit to service AMNCH only) to 90 (based on estimated need for the whole of the SW Dublin catchment area).

The main 'makers and breakers' of the change were

- nursing and other care staff who had some misgivings about the nature of service that would be available to service users in an acute hospital setting (loss of community care ethos); in addition, some nurses were concerned about their status as psychiatric nurses in a large acute hospital; others were concerned about the possible de-skilling of psychiatric nurses in an highly protocol-driven general hospital environment

- staff members who just did not want to relocate from Palmerstown to Tallaght or who did not want to be based in a large acute hospital

- staff who saw the move to a far superior facility as an opportunity to rethink and develop new approaches to practices, treatment and therapy

- consultant psychiatrist/Clinical Director, whose support for the initiative was a significant enabler of the change.

4. How did resistance manifest itself (if at all) and how was it managed?

Resistance was manifested in a number of ways.

- People were openly sceptical about the change, given that it had been mooted on several occasions without any action, and that the size and scale of the unit were changed so often. In some cases, this scepticism became outright disbelief, a sense that nothing would actually happen.

- Some people refused to move because they simply did not want to and also because they wanted to ensure that they were appropriately compensated for moving.

- People seemed to prefer to point out all of the problems and reasons why the change couldn't or shouldn't happen rather than to concentrate on finding solutions and ways forward.

- There were many, many robust discussions and debates on the nature and ethos of mental health services when based in a general hospital, with people expressing very real fears about increasing medicalisation of care.

Resistance was managed by involving people in the planning and decision-making processes, through communication, and through negotiation (in formal Industrial Relations arenas).

5. How were the timing and scheduling of the change agreed and managed?

The timing and scheduling of the change were difficult to manage in that the decisions about when to move were taken, by and large, outside the steering group. Once the decision had been confirmed, the steering group took over the planning and scheduling of the transfer of services.

6. What were the critical activities associated with delivering the change?

- Communication and involvement of staff and service users through initiatives such as time capsules and the 'village pump' briefing board where people could access lively and up-to-date information about the new unit and the change process.
- Involvement of able, credible senior people in the Steering Group and the persistence and resilience of the members of that Group given the fact that the commissioning of and transfer to the new unit was no-one's job, was an add-on to their existing work.
- A mix of champions from both the management and clinical sides.
- Constantly 'selling' the change at local level to people (staff members) – persistence bordering on the obsessional!
- The possibility of the move to a general hospital environment offering an opportunity for significant professional development and career enhancement.
- Heavy emphasis on service user consultation and involvement in planning and commissioning the new unit.
- Availability of resources to compensate staff for the move.
- Solving the problems as they arose, including both amending existing practices and developing new ways of working.
- Maintenance of respect and dignity for others throughout the process, even when there was significant diversity of views and opinions about what was best for people (staff/service users).
- The fact that the geographical environment in Tallaght was so far superior to that in SLH.
- Keeping up the attention and drive for change even though there was ongoing and considerable uncertainty as to the timing.

- Self-selection of project team members (relating to different aspects of the commissioning of the new unit/transfer of services).

- Loyalty and commitment of staff to making things better, to trying to stay focused on the benefit to service users.

11. Western Health Board

Improving Services for Obstetrics Patients

1. Please describe the nature of the change.

This change was one of a number of changes in the WHB that could be described as a continuous quality improvement initiative – it involved eliciting feedback and comments from the users of Obstetrics and Gynaecology services in University College Hospital Galway (NUIG) through facilitated focus group meetings which were specifically designed to obtain information about the experiences and opinions of mothers who had attended the Maternity unit, and to use this information to set the agenda for service improvement. The change was prompted by accreditation and was managed by a sub-group of the Accreditation Obstetric and Gynaecology Team in collaboration with members of the Organisational Development Team and staff midwives.

2. Who were the intended beneficiaries of the change?

There were a number of beneficiaries: the patients or end-users of the obstetric service were the principal intended beneficiaries in that the outcome which was sought was improved service as defined by service users. Service users were involved in identifying areas for improvement based on their current experience of the service – the improvements would then impact on all future users of the service.

In addition, it was intended that staff would benefit from the change through their involvement and empowerment in relation to the identification of areas for improvement and through their implementation of actions to bring about service improvement. At a more general level, it was hoped that the staff would benefit too from the strengthened links between the hospital and the community in that they would have a better understanding of total maternity patient pathway.

3. Who else had a stake in the change?

One of the core groups of staff with a clear stake in this project were the midwives: it was intended to involve as many of them as possible in the process and, in order to provide them with the necessary skills and confidence to work in focus groups, a development workshop was run for midwives by the Department of Nursing Studies at NUIG to improve their facilitation competence. In addition to midwives, some professionals allied to medicine also participated in the focus group process.

The project was initiated by the Accreditation Quality Manager and was one of a number of Quality Improvement projects suggested by the accreditation process. The accreditation project itself was intended to improve service integration and inter-disciplinary working through collaboration with the Organisational Development team. Therefore, those involved in both accreditation and OD had a stake.

4. How did resistance manifest itself (if at all) and how was it managed?

The main form of resistance came in the planning and exploratory stages when concerns were explicitly expressed by some of the midwives about the service-user consultation process (for example, the midwives wanted assurance about the validity of the process, the relevance of the questions, the criteria for selection of participants) and about the capacity of the organisation to follow-through on patient-identified improvements which were beyond the scope of current resources.

In order to try to provide assurance and clarification on these and other general fears relating to the change, significant effort was put in to including and involving staff from all areas, and to explicit discussion about how the potential findings might be dealt with, taking account of the sensitivities of people who might feel themselves criticised. In addition, at the planning stage of the project, discussions took place about how to involve nurse managers and the management team and an 'inclusion strategy' was agreed.

5. How were the timing and scheduling of the change agreed and managed?

The timing and the scheduling of the change was set out in a work plan or breakdown at the beginning of the project and this aspect of the project was managed by the OD facilitators to the group. The methodology for the Focus Group sessions was agreed and ongoing feedback was given to the Accreditation Project Manager who also participated in the planning and organisation of the Focus Group sessions.

6. What were the critical activities associated with delivering the change?

There were a number of critical activities associated with delivering this change including

- the establishment of a multi-disciplinary group to design and oversee the project
- the collaboration between the clinical staff and the Organisational Development team members/facilitators
- the explicit adoption of a participative, consensual approach to the process and to the resolution of problems

- the engagement with those who were expressing concerns about the project and who could have become ‘resisters’ to change
- making resources available to ensure appropriate attention to the logistical organisation of the focus group sessions and participant interviews
- the involvement of staff as observers in the focus group sessions
- the attention paid to the design of the questionnaire and to the analysis of the findings
- the writing up of the report and its presentation to the management team.

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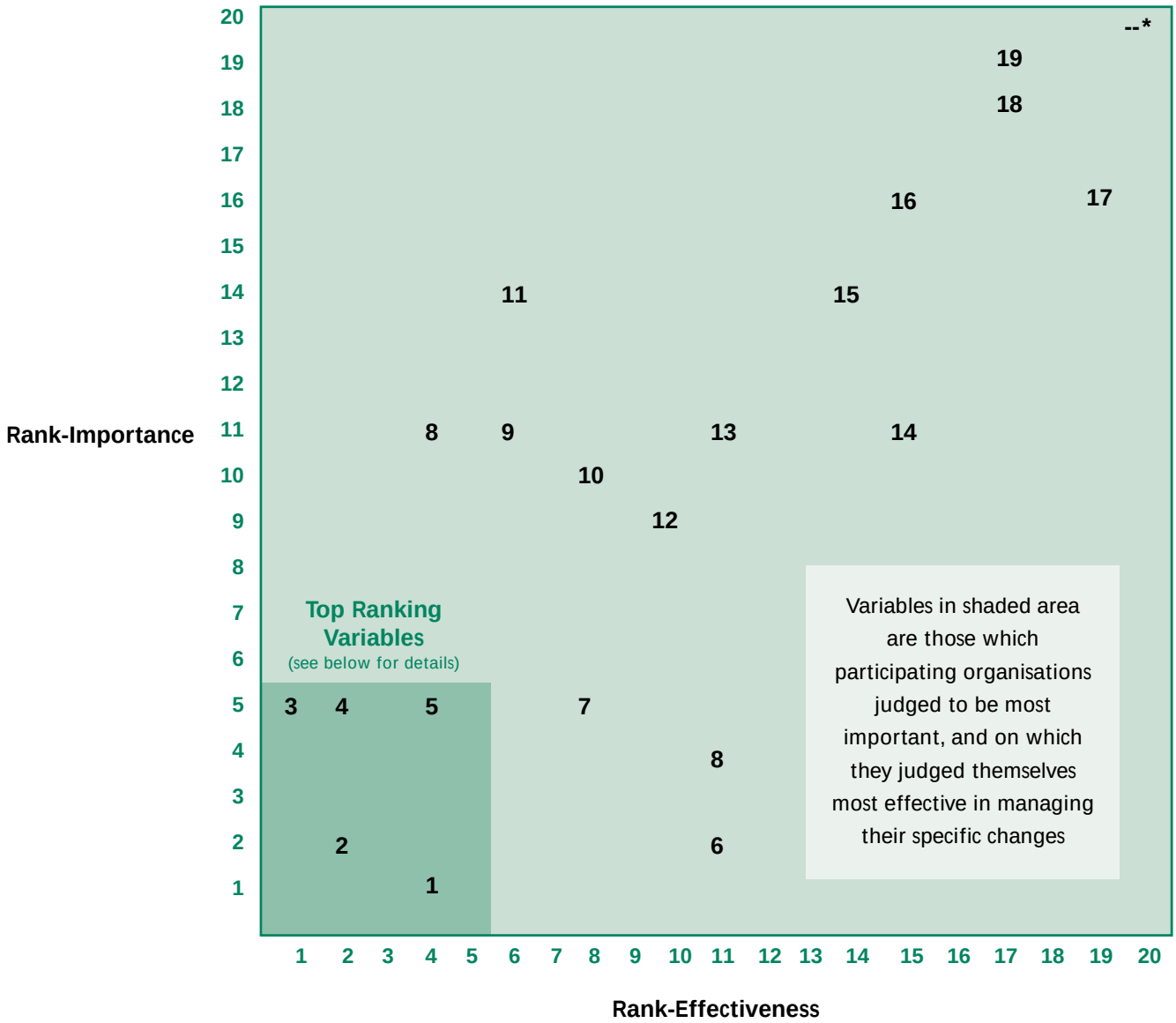
Appendix

Critical Success Factors in Managing Change

Twenty variables associated with the successful management of change were derived from literature. In relation to each of these 20 variables, the participating organisations were asked to rate each variable (from 1 to 5) in terms of (i) how important it was seen to be in the management of the change in question and (ii) how effective the change team/manager was in dealing with it. The following table is based on combining the ratings of all of the organisations in relation to both (i) importance and (ii) effectiveness and plotting them against each other to give a cross-referenced ranking of the 20 variables.



20 Variables on which Participating Organisations Rated their Change Management			
1st	A clear and common vision/inspiration about how things can be better	11	Creating or securing knowledge about the first steps needed to deliver the change
2	Communication and consultation – throughout the change	12	Dealing with resistance and obstacles in a timely way
3	Securing appropriate top management support	13	Timely securing of the necessary resources
4	Empowering others to act on the vision/effect the change	14	Clear timescales for implementation of the different phases or major tasks associated with the change
5	Communication and consultation – in advance of the change	15	Clear goals and objectives for implementing the various phases of the change
6	Making the change concrete and visible at an early stage	16	Declaring 'victory' at the right time (i.e. claiming that the change has been 'bedded down' at the appropriate time)
7	Getting a 'critical mass' of people behind the change	17	Communication and consultation – following the change
8	Recognising and rewarding people for changing	18	Establishing an appropriate level of urgency about the change
9	Managing the internal politics around the change	19	Managing the unanticipated knock-on effects
10	Generating an appropriate sense of dissatisfaction with 'the way things are'	--*	Aligning the change with the culture of the service/organisation

* not in order, because some of the changes were designed to break with the culture of the service/organisation