Managing *Change* in the NHS

Developing Change Management Skills

Valerie Iles and Steve Cranfield

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A RESOURCE FOR HEALTH CARE PROFESSIONALS AND MANAGERS

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Contents

Purpose of this resource

This resource aims to illustrate the practical application of selected change management theories and tools and builds on the SDO's *Organisational Change: A Review* (2001). It is the first of the SDO's resources to be aimed primarily at development.

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Acknowledgements

Many people have been involved in the research and development of this resource. Some have been interviewed for case material. Others have piloted the cases. Yet others have been critical readers. We warmly thank all of them.

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List of acronyms

A&E	Accident and Emergency
ACE	Angiotensin Converting Enzyme, and ACE inhibitors are medications that lower blood pressure
AHP	Allied health professional
BPR	Business Process Reengineering
CE	Chief Executive
CHD	Coronary heart disease
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
DAT	Drug Action Team
DIY	Do It Yourself
DMS	Diploma in Management Studies
EU	European Union
EWTD	European Working Time Directive
GP	General Practitioner
HA	Health Authority
HCP	Health Care Professional
HR	Human Resources
ICP	Integrated Care Pathway
I/V	Intravenous
LA	Local Authority
LDP	Local Delivery Plan
LIFT	Local Investment Finance Trust
LMC	Local Medical Committee
LO	Learning Organisation
MD	Medical Director
NED	Non-executive Director
NHS	National Health Service
NSF	National Service Framework
NTA	National Treatment Agency
OD	Organisational Development
ODP	Organisational defensive pattern
ODR	Organisational defensive routine
OL	Organisational learning
OT	Occupational Therapist
PACT	Prescription Analysis and CosT
PCG	Primary Care Group
PCT	Primary Care Trust
PDSA	Plan-Do-Study-Act
PEC	Professional Executive Committee
PEST	Political, Economic, Sociological and Technological
POD	Patient Own Dispensing
SDO	Service Delivery and Organisation
SLA	Service Level Agreement
SHA	Strategic Health Authority
SWOT	Strengths, Weaknesses, Opportunities, Threats
TQM	Total Quality Management
WDC	Workforce Development Confederation

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Introduction

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Background

In 2001 the SDO published *Organisational Change: A Review for Health Care Managers, Professionals and Researchers*. This set out to provide a resource and reference tool to help readers find their way around the literature on change management and consider the evidence available about different approaches to change. The Review has proved popular, and over 20,000 hard copies have been distributed. The SDO's follow-up evaluation of users of the Review found that those leading on change, or supporting others in this goal, expressed a need for further resources designed to show how different models and perspectives could be applied to a situation. *Developing Change Management Skills* is intended to help meet this need, and to complement other resources available. It draws on a similar literature base to the Review but its purpose is to provide support for readers to put into practice the approaches described in the Review, by *illustrating their use* in relation to substantive issues and problems.

Aim

Developing Change Management Skills aims to help those leading change in health care to use the literature in this field to inform their practice by:
- **describing** some of the relevant theories and approaches that have been used to guide change management
- **illustrating** the use of these theories in practice in a variety of settings in health
- **encouraging** readers to reflect on and evaluate change processes and how they might apply these to different settings.

Whom will it benefit?

This is a development resource primarily intended for managers and other professionals promoting or leading change in health care, and who wish to improve their ability to apply change management tools. The resource will also be valuable for developers, trainers and educators wishing to build capacity for organisational change. While its prime focus is the NHS, we hope the resource will also be of interest to those leading change in other organisations.

Those in search of a rapid overview of change management tools and the associated evidence base may prefer to turn first to the companion volume *Organisational Change* (2001) – included as a CD-ROM with this pack and also downloadable from the SDO website – or find it helpful to have this to hand while working through the cases.

Those who feel they need additional guidance and support in using the resource may wish to seek this from a local organisational development (OD) or training resource. (See also 'Sources and resources', page 273.)

What uses can you put it to?

Depending on need, you can use this resource:
- **for individual briefing and study** – e.g. reading through the explanatory material to inform or help consolidate your understanding of key concepts
- **as a practitioner** – e.g. exploring how models can be applied, and comparing your own views with 'model answers', to give you a greater understanding of them in your practice

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- **as a self-development tool** – e.g. using the fictional cases to experiment safely with modelling the kinds of thinking and behaviour you may wish to engender in your own setting
- **as a guide when helping others** – e.g. 'Have you thought about using Model X? Here's a case study which helps explain it which you/we could work through together'
- **as an aid to teaching and capacity-building** – e.g. in programmes on change, quality improvement, team development, and many other topics
- **as an aid to problem-solving** – e.g. with teams faced with particular problems/issues
- **as a resource/development tool** – e.g. using the cases in a coordinated way with a number of teams to support OD programmes.

Planning your time

Developing your skills by using this resource will require a considerable investment of your time, and we have tried to make it easier to use by helping you schedule this time. It is our conviction that setting aside such time to think systematically about the uses to which change management tools can be put will yield disproportionately valuable results.

Reading in sequence. Because the material sets out to show the weaving together of theory and practice, and takes readers through a change process that occurs cumulatively, over time, each case is likely to yield maximum benefit when read as a whole.

Estimated timings. For estimated times of reading cases see 'Overview of cases' on pages 11-13. Each case lends itself to being worked through in stages to allow for activities, analysis and reflection. In addition, places where these is a logical break in the material are indicated in the main text by the icon.

Level of material. Presentation of the theory concentrates on the core principles. Cases 1 and 2 introduce a total of 10 models whose basic ideas are arguably less complex. Cases 3, 4 and 5 introduce a total of 6 models and all of these contain more complex propositions. Each of the theories and their corresponding illustration and analysis sections are indicated by boxes in the bottom left hand corner of the page. You may want to quickly thumb or scroll through these sections in advance to give you an idea of the length and level of the material.

Equipment. In order to make use of the interactive elements that are an integral feature of the electronic version you will need access to a computer and/or a printer (see 'Using the resource interactively' on page 10).

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What does it contain?

The resource contains:
- this Introduction
- five complex case studies – each made up of fictional incidents in separate episodes, interwoven with theory and analysis into a realistic whole
- reflections on the cases – including ideas for applying models across cases and a discussion of evaluating change processes
- links to other sources and resources.

Cases

Cases are stand alone and can be read individually and in any order. Cases are intended to reflect a range of organisations within the NHS (see Table 1). Key players within these organisations include: individual team members, service leaders, and executive and non-executive board members. Settings and players have been chosen to ensure that issues affecting different levels of the organisation are covered and to encourage readers to explore how different parts of the service approach their own and others' problems.

It should be stressed that all the characters, places and incidents are fictional. They are made up of scrambled versions of people, dynamics, incidents and histories which we have learned about in our interviews. We hope they feel real, but any resemblance to people or situations that readers feel they recognise is entirely coincidental. Our discussion of models invariably relates to the fictional setting only.

We are not being prescriptive when we apply a concept within one setting. Many of the concepts can be applied in almost every part of the NHS as well as outside.

Working though cases should enable you to learn about:
- the strengths and limitations of change management approaches in different situations
- how to group approaches together to increase their usefulness
- the importance of applying approaches rigorously, perceptively and creatively
- how different results arise when approaches are used by people with different world views
- how to draw on knowledge and evidence from other fields which were excluded from the remit of *Organisational Change* (2001)
- experiences and perspectives of parts of services you are not otherwise familiar with.

If you are interested in how different change models can be combined at different stages of a change initiative, you may find it helpful to look at the Matrix in Case 1, page 71.

The cases contain a wealth of detail, not all of which is used in the analysis or approach to change discussed. The reason for this is twofold. First, sifting miscellaneous information, including 'soft' data, in the kinds of messy situations most managers face, and then using this to create a realistic agenda for action, are important managerial skills. Cases present readers with opportunities to try out these skills for themselves and then compare their analysis with that of the

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individuals and teams described. Secondly, material which may appear extraneous in one case can be used to apply models illustrated in the other cases, or indeed concepts from other strands of theory.

Structure
Each case is broken down into a number of separate sections, consisting of:
- overview, with guidelines on how to approach the case
- introduction to the relevant theory
- case material, divided into episodes
- experimenting with the theory/case
- illustration and analysis
- conclusions and references.

Depending on the case, theory is introduced before, during and/or after case material. Each case includes several opportunities to engage in interactive learning (see 'Using the resource interactively' on page 10).

Choice of models
Models illustrated in the resource include many but not all of those introduced in *Organisational Change* (2001). The choice is pragmatic and does not indicate the superiority of those included over those left out. We have aimed to show models being applied in realistic situations, in the depth that will allow readers to consider how to use them themselves. Some comprehensive concepts, e.g. Soft Systems methods and action research, are difficult to illustrate to this depth in the space available. Others are similar to models we do illustrate, so Weisbord's Six-Box Organisational Model gives way to the Seven S Model. Some, like OD and project management, are sufficiently familiar or have a good, accessible literature of their own, so these are omitted.

In general we have used the models in one case only (with some cross referencing). For an alphabetical list of models see Table 1 on page 10. However, many could be used in several of the settings (see Table 3.1 in Section 3 'Reflections on the cases', page 267).

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Table 1: Models illustrated

Model	Setting and case
Adding value	Acute trust hospital, Case 5
Articulating a mission	Woodville Hospital Pharmacy, Case 1
Business Process Reengineering (BPR)	Acute trust hospital, Case 5
Commitment, enrolment and compliance	Woodville Hospital Pharmacy, Case 1
Content, Context and Process Model	Strategic Health Authority (SHA), Case 4
Five Whys	Community Drug and Alcohol Service, Case 2
Force field analysis	Community Drug and Alcohol Service, Case 2
Ladder of inference	Community Drug and Alcohol Service, Case 2
Organisational learning and the Learning Organisation	Primary Care Trust (PCT), Case 3
PEST	Woodville Hospital Pharmacy, Case 1
Readiness and capability	Woodville Hospital Pharmacy, Case 1
Seven S Model	Woodville Hospital Pharmacy, Case 1
Stakeholder analysis	Community Drug and Alcohol Service, Case 2
SWOT analysis	Woodville Hospital Pharmacy, Case 1
Total Quality Management (TQM)	Acute trust hospital, Case 5

You may find it helpful to have access to *Organisational Change* (2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Using the resource interactively

As a reader you are encouraged to take opportunities to apply the tools before comparing your thinking with that of the authors. In doing so you can develop skills you can apply within your own and other settings.

An electronic version of this document can be downloaded from the SDO site at www.sdo.lshtm.ac.uk and can be saved to your hard disk.

Wherever you see the (HIDE | SHOW) icon on the electronic version, you will note that immediately following there is a blank space or incomplete text/table. This gives you the opportunity to pause, reflect, make notes, discuss. To reveal hidden text, click on the 'Show' button. To conceal text again, click on the

'Hide' button. After you click on the (HIDE | SHOW) buttons you will need to click the cursor on the main text in order to be continue scrolling through the document.

The document's default setting is 'Hide'. This means that whenever you open the electronic version all the relevant parts are hidden. You cannot save the document in 'Show' mode. However, you can print out a hard copy when the text is in either 'Hide' or 'Show' mode.

Using the (SHOW ALL | HIDE ALL) button: if you prefer to display all the hidden text for a particular case, click on the 'Show all' button situated in the Overview section of the case; similarly, if you wish to hide all the text of a case, click on ''Hide all'.

Overview of cases

Case 1: Leading a service through change

Setting: Pharmacy Department in an acute trust

A newly-appointed head of department in Pharmacy tries to decide on the top priorities for change over the ensuing twelve-month period. Episode 1.1 leads to an illustration of the benefit of using the *Seven S*, *PEST* and *SWOT* frameworks, in a disciplined way, to arrive at a small number of key change priorities. Tools for analysing the stakeholders involved and their ability to help or hinder the change process – *Commitment, enrolment and compliance* and *Readiness and capability* – are also demonstrated. In Episode 1.2 a look at what has happened in the department fifteen months later allows us to consider the value and limitations of using these tools. The introduction of a matrix, drawing on the insights of three different schools of thinking, allows us to reflect on when and how to use which kinds of approach.

Reading: allow roughly 3.5 hours

Case 2: Changing a team, from inside it

Setting: Community Drug and Alcohol Service in a community mental health trust

A new member of staff without managerial responsibilities tries to find ways of initiating change. Episode 2.1 leads into a discussion and illustration of the *Five Whys* model, to arrive at ways of exploring change in the medium to long term. Episode 2.2 provides additional material for exploring models such as *force field analysis* and *stakeholder analysis* (also considered in Case 1 as *Commitment, enrolment and compliance* and *Readiness and capability*), to assess how change can be facilitated in the immediate and short terms. A look at what has happened in the service six months later in Episode 2.3 allows us to consider the value of a tool, *ladder of inference*, associated with individual and organisational learning. Episode 2.4 shows us what has happened a further six months on.

Reading: allow roughly 4.5 hours

Case 3: Challenging a health community to change

Setting: PCT and various agencies in a local health economy
Primary Care Trusts (PCTs) are younger organisations than most others in the NHS. In a relatively short time they have had to discover the potential and limits of their role, establish their ways of operating and develop working relationships with other organisations. All this has been at a time when tiers above them in the NHS hierarchy have been preoccupied with coming into existence themselves. In many ways, therefore, PCTs have had an opportunity to learn, rather than be told, how to function effectively. Accordingly, we have chosen to explore in relation to this case the concepts of *organisational learning* and the *Learning Organisation*.

Episode 3.1 of the case introduces a series of perspectives within the PCT that allow you to diagnose the dynamics using the concepts that have been introduced. In Episode 3.2 a series of perspectives outside the PCT allows you to diagnose the dynamics at work there. Episode 3.3 looks at one character's subsequent perspective which leads to an exploration of the question 'How can I engender a culture of organisational learning?'.

Reading: allow roughly 4 hours

Case 4: Deciding how to support change as an SHA

Setting: SHA and an acute trust
A team from an SHA use a strategic management model for differentiating higher from lower performing organisations, in order to decide what approach to take to a hospital trust that is deemed to be failing.

After meeting the team and the decisions they are trying to make in Episode 4.1, you are introduced to a model – often known as the *Context, Content and Process Model* – and the *eight-factor framework* derived from this. As the team attempt to apply this framework in Episode 4.2 you have the opportunity to reflect on whether you would use it in this way, and then compare your reflections with those of the team. Episode 4.3 shows the decisions that are arrived at and the immediate consequences of these.

Reading: allow roughly 3 hours

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Case 5: Prompting change across an organisation

Setting: An acute trust, Maternity Services and Admissions Team (Surgical Services)

In Episode 5.1 of the case you see an acute trust through the eyes of people managing services on a day-to-day basis, and then from the perspective of an executive director. This allows you to explore the concept of adding value and consider how the Trust's managers are able to add value to the services in their remit, and avoid diminishing it.

You are then invited to explore how the principles of Total Quality Management (TQM) could be used by an individual senior manager to influence quality across an organisation, and by a team to improve quality within a particular service: Maternity Services.

Episodes 5.2 and 5.3 enable you to explore the theory of Business Process Reengineering (BPR) and follow the course of a pilot reengineering project within the Trust, with the opportunity to reflect on the key learning points and consider whether this approach should be rolled out organisation-wide.

Reading: allow roughly 4.5 hours

Further development

If you wish to develop your skills in using theory to inform practice, and extend those to using practice to inform theory, we encourage you to keep in touch with:
- **the SDO programme** – visit their website at www.sdo.lshtm.ac.uk
- **the Health Services Research Unit (HSRU) at the London School of Hygiene & Tropical Medicine** – visit the School's website at www.lshtm.ac.uk and the HSRU's journal website at www.rsmpress.co.uk/jhsrp.htm
- **the authors:**
  Valerie Iles – email: v.iles@reallylearning.com; website: www.reallylearning.com
  Steve Cranfield – email: steve@scranfield.demon.co.uk

You are also encouraged to complete and return the inserted feedback form, which is also downloadable from the SDO website.

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Case Studies

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Case Study 1:

Leading a service through change

Woodville Hospital Pharmacy

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Overview

A newly-appointed head of department in Pharmacy tries to decide on the top priorities for change over the ensuing twelve-month period. Episode 1.1 leads to an illustration of the benefit of using the *Seven S*, *PEST* and *SWOT* frameworks, in a disciplined way, to arrive at a small number of key change priorities. Tools for analysing the stakeholders involved and their ability to help or hinder the change process – *Commitment, enrolment and compliance* and *Readiness and capability* – are also demonstrated. In Episode 1.2 a look at what has happened in the department fifteen months later allows us to consider the value and limitations of using these tools. The introduction of a matrix, drawing on the insights of three different schools of thinking, allows us to reflect on when and how to use which kinds of approach.

Approaching this case

The case is designed to be read in the following sequence. We suggest some places for taking breaks in the material, with indicative times.

Episode 1.1 Changes on the horizon – the arrival of a new head of department prompts reactions and reflections	30 minutes
Articulating a mission – a discussion of the uses of a mission and an illustration of the different missions held by the new and old heads of department	15 minutes
Seven S Model – an overview of the model and an opportunity to apply it to the case	45 minutes
Illustration and analysis – an opportunity to compare your thinking with ours	15 minutes
	Total 105 mins
PEST analysis – an overview of the tool, an opportunity to apply it to the case and to compare your thinking with ours	15 minutes
SWOT analysis – an overview of the tool, and another opportunity to apply it to the case and compare your thinking with ours	60 minutes
	Total 75 mins
Readiness and capability assessment – an introduction to the tool, and an opportunity to apply it to the case	15 minutes
Enrolment, commitment and compliance – an introduction and opportunity to apply it	10 minutes
Episode 1.2 The best laid plans ... events one year later	10 minutes
Schools of thinking about change – an introduction to a matrix that enables you to reflect on uses and limitations of these tools	20 minutes
	Total 55 mins

You may find it helpful to have access to *Organisational Change* (Iles and Sutherland, 2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Note:
The (HIDE | SHOW) icon refers to those parts of the electronic PDF version of the document where readers have the option to hide or show the text, depending on whether they want to stop and think before comparing their own ideas with ours.

If you prefer to display all the hidden text for the case, click on the 'Show all' button; similarly, if you wish to hide all the text for the case, click on 'Hide all'.

(SHOW ALL | HIDE ALL)

Main characters

Pharmacy staff

You will find organisation charts on pages 30-32:
Jacqueline – recently retired Chief Pharmacist
Ashok – newly appointed Chief Pharmacist
Karen – Assistant Dispensary Manager (C grade pharmacist)
Stuart – Senior Technician, Dispensary Manager
Anne – Principal Pharmacist, Clinical Services
Jayesh, Nicki and Bola – three of the Technicians
Penny – Principal Pharmacist, Patient Services
Hina – Senior Technician
Azim – Pharmacist (D grade), with responsibility for medicines information
Charles – Chief Technician (Procurement)
Roy – Pharmacist who has worked in the Department for 15 years

Other people at Woodville Trust

Sheila Elliott – Medical Director
Paul – Director of Clinical Support Services, line manager for Chief Pharmacist
Sally – Director of Education and Training
Maria – Sister, Suffolk Ward

Local PCT

Elaine – the local PCT's new Director of Pharmacy Services

Location

Woodville Hospital NHS Trust

Time

Episode 1.1: takes place in the present over a one-week period
Episode 1.2: is one year on.

Perspective

A new Chief Pharmacist has just arrived at Woodville Hospital and it is through his eyes that we will analyse the situation. The information needed for the analysis is conveyed through a number of voices within and outside the department.

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Episode 1.1:
Changes on the horizon

Tuesday morning – To and from the wards

As the door closed behind her and she left the hustle and bustle of the dispensary Karen experienced that familiar feeling of freedom. She knew it would be short-lived and that within an hour she would be rushing round her last ward, anxious to get back to the dispensary, aware of the pressure that would be mounting in her absence. But she always enjoyed making her way onto the first ward.

A C grade pharmacist at Woodville, Karen was Assistant Dispensary Manager, supporting Stuart the Dispensary Manager (see Figure 1.2, page 31). She rated his skills highly. He was an experienced technician who had worked in the department for several years and who managed to keep calm whatever the pressure. And what pressure! Outpatients were routinely waiting 45 minutes or longer; and patients waiting for TTAs[1] could be held up by 4-5 hours. Naturally there were complaints. And yet, whatever the crush and noise in the waiting area, Stuart would ensure that every 'script was tackled in turn, that it was checked by a pharmacist before it was handed out, and that the pharmacy assistant, who received the 'scripts and bore the brunt of the complaints, was well provided with cups of tea and words of support.

On her way to Suffolk Ward Karen mentally checked the activities she still needed to tackle for her Diploma.[2] After last week's discussion with Anne (Principal Pharmacist, Clinical Services) she was very enthusiastic, knowing what she needed to do and confident she could do it. She hoped today she would have an opportunity to look through the case notes to identify a candidate for her next case presentation, but knew that she would have to be back in the dispensary within an hour and a half. The thought irritated her. Fundamentally she didn't believe she had chosen pharmacy as a career to spend most of her time doing something so tedious. Yes, she knew that, as Jacqueline (the recently retired Chief Pharmacist) used to say, patients relied on pharmacists to be sure their medication was absolutely safe. But she also thought (but had never mentioned this to Jacqueline) that when she got bored she wasn't particularly safe. Her mind would drift off to something more interesting and she would work on autopilot for a while. On the wards she could perform something much more like the role she thought she was taking on when she applied for the degree all those years ago. Although even there she didn't feel completely at ease. She hated it if she was asked to join a ward round. She was never sure she would have the answers to questions asked and was terrified of looking foolish in such a crowd, and of doctors too. She was conscious that she was daunted by doctors, and wasn't quite sure why. Something to do with the behaviours perhaps, the speed at which they worked led to impatience if an answer was too slow in coming.

She was pleased to see that Maria was the Sister on the Suffolk ward today, but she was disappointed that Maria wanted to complain.

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[1] Medications and supplies *to take away*.
[2] Post-graduate Diploma in Pharmacy Practice.

The dispensary was like a magnet, drawing all the resources towards it

'Karen, I know you're always in a rush but can I whinge to you about something? The I/V additives service. You know how we used to do it here on the ward and you were worried that we didn't have the backup to do it properly, so you set up the centralised service down in the pharmacy.'

'Well, Jacqueline was worried about it certainly', said Karen.

'Well, it's only open 9-5, Monday-to-Friday', Maria continued, 'so when we needed it over the weekend it wasn't available and we had to do go back to doing it ourselves. Only, because we use your service most of the time now it's ages since we've done it – and it took forever, when we were really short staffed, and we wasted several packs. I really think if you can't offer it all the time we should go back to doing it on the ward and keeping our skills up, it's more dangerous this way.'

'I'll take that back with me', promised Karen. 'Now we've got a new boss I don't know what he'll say. Jacqueline wouldn't have heard of it but you never know, I do think we can offer a safer service for the majority of cases but I see your point.'

As she left Maria, Karen reflected that that wasn't all she did not know about Ashok. He had been in post a week and was still getting to know names, faces, and the way round the department. He had seemed surprised when he had spent a morning in the dispensary; and Bola had reported the same when he had asked to accompany one of the ward technicians and she had drawn the short straw! 'I expect life is rather different here from St Luke's', she thought. Ashok had been a Principal Pharmacist at St Luke's, a teaching hospital, before taking over as Chief Pharmacist at Woodville General (see Figure 1.1, page 30). She wondered what he was making of it all. She had friends at St Luke's and knew they had a POD[3] scheme, for instance. Jacqueline had steadfastly resisted implementing such a big change. 'It will mean finding money for all those new lockers, getting the ward staff to think differently, a big training programme for our own staff, *and* it's risky too', she had said.

Karen thought fondly of Jacqueline, who had been fiercely protective of her staff, always maintaining that the safety of staff and patients was her first concern. 'Belt and braces' was a phrase she used often. 'You can't compromise with safety.' Stuart and his boss, Penny, the Principal Pharmacist for Patient services, were old friends of hers, and very supportive of her and her views. They had been slightly alarmed when Ashok was appointed. Anne, though (with her clinical services responsibilities), couldn't wait for the change. But Anne had been agitating for change ever since she arrived 12 months ago. She grumbled that the dispensary was like a magnet, drawing all the resources towards it; and that if the technicians were on the wards they should take on a 'proper job' and not just a supplies

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[3] Patient Own Dispensing scheme, in which patients 'self-administer' their drugs which are dispensed for them early in their stay and which they will take home with them when they are discharged. In this way they avoid waiting for TTAs and become familiar with their medication before they leave. It requires a dedicated locker at the side of each bed, and a ward technician to take their medication history on admission.

function. In so saying she had thoroughly alarmed most of the technicians who said they wouldn't know where to start with the patient medication histories Anne was advocating. But Karen noticed that two of the student techs had collaborated on a project exploring the idea and seemed very enthusiastic.

The dispensary had two full-time technicians, one of whom had recently become accredited for checking prescriptions, and the other was responsible for the education and training of all the techs in the department (see Figure 1.3, page 31). They were the backbone of the dispensary, Karen thought; in fact, the technicians were the backbone of all the pharmacy departments. It was all very well Anne advocating an enlarged role for them, talking of how much more interesting they would find it, but they were very happy where they were, part of a friendly, busy, safe team. Life could be much more frightening and isolated on the wards.

Friendly was what Jacqueline had striven for, Karen thought. She had had friends all round the hospital, greeting her warmly wherever she went, supporting her whenever she argued for the pharmacy centralising services (such as the I/V additives) which had previously been done on the wards, and agreeing with her when she argued against greater computerisation in the pharmacy on the grounds that this would take too much time and get in the way of the friendly relationships that were so much a feature of life in a district general hospital like Woodville. Friendly and safe.

Karen knew that Anne held different views about safety. Anne argued that Jacqueline's insistence on safety within the pharmacy was not sufficient anymore, that safety should be considered in relation to the whole 'career' of a medication, within the pharmacy but also, more importantly, outside, on the wards, in the patient's home. Jacqueline disagreed: 'What we need is everyone to take responsibility for doing their own job properly, I'll make sure we take responsibility for the pharmacy, other people must take responsibility for the rest, we can't control *everything*'. Instinctively Karen agreed with her, if everyone did as they should then medication errors wouldn't happen, and yet she knew the research showed concordance[4] to be a big problem. 'So if patients themselves, the people who have the most to gain, aren't taking their responsibility perhaps we can't rely on anyone doing so', thought Karen. 'Perhaps it's safest to assume that people won't.'

Tuesday evening – Anne's home

'Oh this is hopeless!', Anne fumed at her husband that evening. 'I'm supposed to be in charge of ward services but I don't have control of any of the people who actually go onto the wards. They're all scurrying round trying to get back to doing something else, either the dispensary (and don't ask me if the dispensary's getting any better, it's just a complete shambles) or to other duties – like the anticoagulant clinic. And as for Penny, she won't accept any kind of direction from me at all, she obviously thinks she's more

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[4] Concordance: the degree to which patients take the medication prescribed for them.

experienced than I am and that she knows it all. But she doesn't, she's hopeless at discussing things with the doctors, far too timid, no wonder Pharmacy is ignored – we've always been seen as people like Penny. Do you know, she told me the other day that she thought it was more important to persuade doctors than to "have a go at them". As if doctors ever listen if you don't stand up to them.

'I think Ashok will be good for us, just a bit worrying he's always at conferences'

'She suggested I go and talk with Sheila Elliott (the Medical Director) to get her "on side" about the formulary proposal. Honestly, I haven't got time to go buttering people up, she's bound to see it's a good idea, it deals with all the problems she's been having about the Woodville consultants resenting the formulary decisions being made by St Matthew's.[5] When I said that Sheila was bound to see that, Penny went all *touchy feely* and talked about the personal problems Sheila is having. Well that settles it, I'm definitely not going anywhere near her if I'm going to have to be sympathetic about her divorce. Why do people think you're going to be interested in their home lives? They're not friends; the only stuff I want to hear about is how we're going to get better prescribing and more efficient distribution.

'Still it must get better now that Jacqueline's out of the way. She's held us back for years. Do you know when the clinical governance team asked us last week for statistics on the use of statins we couldn't give it to them? Honestly, our computer system is as old as the ark. I spelled out our need for a new one in that strategy paper I wrote last year. Remember?

'I discussed the paper with Jacqueline and she was enthusiastic about it – said she would show it to the clinical director and that it might get us some more resources. The strategy described how we need to be able to respond more flexibly to what other HCPs [health care professionals] want from us, that we have to review how we are using our staff, and that we need to introduce new systems. When I last asked her about it she just said that Paul[6] hadn't agreed to fund it, so we would have to wait ... But we could do a lot of it without any extra funding, and once we were being more helpful to other departments they may help us lobby for the new computer. The PCT might even be able to help.

'Oh anyway, back to here and now', she went on. 'I must remember to book time to see Jayesh. He's in charge of the education and training for all the technicians and I must get him to build medication histories in to the programme. Last time I mentioned it he wanted a lot more detail about exactly what I wanted, he does do that, he's so cautious. But his work is excellent – when it finally comes! And at least he concentrates on the task in hand and doesn't waffle on about feelings or "hearts and minds".

'I think Ashok is going to be good for us', Anne mused. 'At least he has some experience of decent ward systems. Just a bit worrying that he's always talking at so many conferences. Karen knows people who work with

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[5] St Matthew's is a nearby teaching hospital and there are many links between clinicians at Woodville and St Matthews. For historical reasons Woodville uses the St Matthew's formulary, with only a few modifications.

[6] Paul is the Clinical Director for clinical support services, reporting to the Director of Operations, and is the line manager for the Chief Pharmacist.

him and apparently he's always got some bright new idea, starts to implement it and then goes and gets a paper published about it before anyone can really say whether it works or not. Bit of an egomaniac, they say. Still he does get on and do things, unlike Penny who seems to spend all her life gossiping. Do you know she's stopped Stuart relying on Nicki to do the checking? Nicki's accredited now and Stuart wanted to use her last week when Karen was away. But Penny thought Nicki might not feel ready to take it on just yet, said they must wait until she feels ready to take on the responsibility. Honestly, what was the training all about?! Sometimes I think she isn't at all interested in the work we're trying to get done, just everybody's feelings. Doesn't she realise patients have feelings too, that they hate being kept waiting? – the wait to have a prescription dispensed was over an hour when Karen wasn't here.

'Well, we've got the journal club coming up soon, that's good. That's one of the best times of the week. We nearly always hear about something we could think about introducing here. Of course not everyone seems to enjoy it – or perhaps it's that we all enjoy different aspects of it. Jayesh pulls all of the ideas to pieces – although I've noticed that on the rare occasions he is satisfied with the answers he becomes a firm advocate for it! Hina always knows someone who's already tried it (or something like it) and volunteers to get them to come to talk about it. Nicki's good at making sure we meet the deadlines for any submissions we decide to make, and Karen always makes sure we go away with a sensible action plan. Not always the actions I'd have chosen, and sometimes I get pretty cross when people won't see that what I'm suggesting is much better, but somehow it does seem to work. It's just Penny. She spends all her time checking that people "feel happy" with what we are doing! Oh well, she's away next week; we may be able to get some things done while she's away.'

Thursday mid-morning – Pharmacy Department

At the end of the journal club Azim hurried away. Another battle royal between Anne and him. Why was she always so belligerent? They were surely all on the same side, all trying to ensure that medication made the maximum contribution to people's welfare. But it never felt like that, it always felt like a competition to see whose idea or approach would win. It was never so bad when Charles attended the meetings (see Figure 1.4, page 32). Somehow he could enthuse about a project without ruffling feathers. Or at least that was what he had found, he knew Jayesh always found Charles difficult, not taking enough interest in the detail and always wanting to rush onto another project before the last was finished, but Azim didn't mind that.

Anyway, enough about the club, he had a problem of his own. The basic grade rota had been suspended for a while because of the C grade vacancy in his department (see Figure 1.5, page 32). One of the basic grade pharmacists had been asked to act up into that post and the others were staying in the department where they happened to be until the recruitment process was over. Frankly Azim hoped they would have some good candidates from outside, as it was so difficult to find basic grades at the

moment, what with the supermarkets offering so much more money. But the basic grades were now fed up and had asked to see him. Why him he wasn't sure, except that he knew they found Anne difficult, and Penny rather ineffectual. Well, he would hear what they had to say and see if it was anything he could deal with.

If it wasn't really his responsibility it was difficult to see that it was anybody else's either. Oh, Penny was responsible for overseeing their rota and doing their appraisals and so on, but in practice she didn't work with them day-to-day and the managers of the areas they worked in didn't give her feedback that was very useful. They filled in forms but talked only generally, about 'improving communication skills' or 'taking more care'. Without any specific examples it was almost impossible for Penny to discuss these. And anyway, the appraisals were only 6-monthly; some people didn't stay long enough to have one. Still, Penny was certainly no worse than Anne. Azim was relieved to think he wasn't due for his next appraisal for several months; last time Anne had been so brusque with him he had felt very demotivated for weeks. He appreciated the fact that she had told him where he was going wrong (he'd had bosses in the past who only gossiped about that to other people, and never criticised him to his face) but wasn't he doing anything right? He had thought he was, indeed the fact that the basic grades were coming to him when they wanted something sorted out was a testament to that, he thought.

Azim appreciated honest feedback but wasn't he doing anything right?

While he was smarting about his appraisal he had asked Karen what hers was like. 'Oh, a non-event', she'd replied. 'I wasn't sure whether it should be Stuart or Penny, in the end Penny did it and just told me how well I was doing. It was just after I'd had that incident on Suffolk ward and we never talked about it at all, I know I need to get better at standing up to consultants but she just told me not to worry. I don't think any of us find the appraisal helpful, I think it's only there for people in Personnel to justify their jobs.'

'Yes, that's what Jacqueline always said, wasn't it?' said Azim.

'Yes, it wasn't one of her enthusiasms', replied Karen. 'Perhaps because she didn't devise it herself. She was always enthusiastic about systems she introduced herself: all that emphasis on risk management, remember? But if she was asked to implement someone else's she resisted like mad. I think that's why we're so far behind other departments now.'

'No, I think that's because we haven't got the money we've asked for', said Azim. 'I know Anne was fuming that we couldn't get funding for the training for the ward technicians. Said it was all because we couldn't get hold of the data to put together a decent business case. By the way, were you there when she and Jacqueline discussed the robot? Talk about fireworks! Actually I think Jacqueline could have been persuaded if there was some kudos in it and if Anne hadn't tried to push it down her throat. Still, we may have a chance to revisit it now Ashok is here.'

'Talking of rows, did you hear about the formulary meeting? Apparently Anne was shouted down about her proposals to develop our own', said Azim.

'But why?' asked Karen, 'I thought all the consultants hated having to use the St Matthew's one.'

'They do', Azim replied. 'But I think they couldn't bring themselves to have to argue with Anne over everything they wanted to include. She can be so rude to them, I don't think she means to be, I think she believes she's just presenting the evidence, but somehow she does it in such a way that you feel as though you're being made to look a fool. I think we'll only get that proposal through if someone else represents Pharmacy on the committee.'

'Oh, that's interesting', Karen mused. 'The PCT prescribing advisor was asking me about it a few weeks ago. He is very keen that he or his boss (Elaine, the PCT's new Director of Pharmacy Services) are members of it. Now that the PCT holds the drug budget for the hospital they want to develop a joint formulary. He was pointing out how much more medication is prescribed in the community than in the hospital, and how important it is that it is informed by state-of-the-art thinking from our consultants.'

'Well he's just rehearsing the arguments he wants to use with the consultants', said Azim. 'The PCT want to get on it to drive down costs. You've seen how they behaved over the ACE inhibitors. They took that evidence (yes, good evidence, a convincing meta-analysis of a series of well conducted RCTs [randomised control trials]) which showed that drug X reduces mortality, and then applied the results to the whole of that class of drugs – and promoted the cheapest one. We would never have done that – we just don't know how transferable those results are.'

'Yes, I know there are problems, that's why we must get them on the committee – so they can hear these arguments', Karen retorted. 'But they are right about some things. For example, when some of these highly specialised (and very expensive) new drugs come out, it's ridiculous that GPs have carte blanche to prescribe them without any guidance from specialists in that field. If our consultants (or we ourselves for that matter) drew up protocols everyone would be better off – especially patients.'

'Well, they'll have to overcome some hostility from the consultant body', said Azim. 'There was a furore when the PCT refused funding for drug Z. Dr A. was ranting for days about "how can these primary care pharmacists make decisions about my specialty! They should stick to what they know about". Of course we know they had access to the same evidence as Dr A., and are excellent at evaluating it – but instead of discussing it they just issued a policy statement.'

'Letting them onto the committee might be the start of a slippery slope', Karen said, thoughtfully. 'We can't tell where it might end. Edgebury, St Luke's PCT, have been running warfarin clinics in the community rather than in hospital for over a year now. That would have quite an impact on roles and processes here. And in their last newsletter the PCT were talking about how intermediate care will require major redesign of existing services – including ours. They want us to work much more closely with community pharmacists.'

'Community pharmacists! They'll only do it if there's more money in it for them', said Azim, 'they're as bad as GPs.'

Karen laughed. 'You certainly got out of bed the wrong side today', she said. 'We seem to be the only goodies round here according to you, all the rest are baddies out to get us!'

'Yes', Azim laughed with her, 'the PCT, community pharmacists, consultants, patients … they all see their role as making life difficult for us!'

Thursday evening – Ashok going home

Ashok wondered briefly whether he had done the right thing in accepting the Woodville job. Perhaps he should have hung out for another teaching hospital role, or one of the new PCT opportunities. But when he thought about it more rationally he realised it would be an interesting challenge. He hadn't realised quite how far behind the times Woodville was, Jacqueline had always come over as quite impressive when he'd met her at meetings. Very chatty and purposeful, he'd felt they had quite a lot in common. And it wasn't as if the systems here didn't make sense, they did, but only if you thought that pharmacy was essentially about safe supply. If you saw pharmacy as being the coordinator of an effective medicines management network then there were a lot of changes to be made. He'd have to start with a POD system. Apart from anything else it would be such a money saver. And the dispensary needed a dose of the twenty-first century. A pharmacist at the front end of the process, screening the prescriptions and dealing straight away with anything problematic would yield huge time savings and get those waits down. He couldn't believe they'd got away with those for so long. He had called a staff meeting tomorrow to introduce some of these changes to them. He strongly believed that it was important to be open with your staff, so they didn't hear things from other people before hearing them from the top. Oh, and then he had his first meeting with Dr Elliott. 'What an interesting day ahead', he thought.

Friday, early morning – Trust Directorate

Sheila Elliott, Woodville's Medical Director, was slightly surprised to see she had an appointment that morning with the new Chief Pharmacist. She remembered her secretary asking if she could book him in and had thought vaguely that it would be a good idea. She expected he wanted to ask for more money for some pet project or other. That was the only reason Jacqueline had ever made a proper appointment to see her. Of course they had known each other so long that they often had a sociable chat over coffee.

Formally Jacqueline had been accountable to the Director of Clinical Support Services, Paul, but Sheila doubted if they ever met. She knew that Paul had plenty on his plate with other initiatives and that he had grown suspicious of what he described as 'empire building' on the part of many of

the services he managed. He would grumble regularly: 'Sheila, if only they would concentrate on what they're supposed to be doing and get that right the NHS wouldn't be in the mess it's in. Everyone seems to want to expand their role and make life more interesting for themselves, and of course they always claim it's in the best interests of the patient, but it means the basics just aren't done.' This view often led to fireworks with Sally, Director of Education and Training, who was a firm believer in personal, professional and service development. 'Paul, if you had your way', Sally had said at a meeting last week, 'everyone would still be using leeches!'

If she was honest Sheila was slightly irritated with the Woodville Pharmacy. At the clinical governance seminar she had attended last week, her colleagues seemed to have access to all sorts of valuable information about prescribing. Yet whenever she had asked Jacqueline for this kind of support for the clinical governance team Jacqueline had asked for funding for a locum to come in, to free up her staff to analyse the figures. Jacqueline's counterparts elsewhere seemed to be able to pull the answers off their computer system without any fuss.

That reminded Sheila: computer system. The Director of Finance and IT was nearly ready to go out to tender for the new computer system. Work on the specification had been going on for months. Perhaps the meeting with Ashok this morning would be an opportunity to find out whether Pharmacy had any special requirements they wanted built in. It might not be too late. All heads of department had been sent a request form, asking for these requirements, six months ago, but Sheila happened to know that no response had been forthcoming from Pharmacy. When reminded, Jacqueline had jokily pointed out that if someone would come and tell her which of Pharmacy's other activities she was supposed to forego then she would be happy to fill in all these forms. Sheila had had a laugh with her but had come away feeling defeated.

'I'm not quite sure what they do in Pharmacy nowadays'

Sheila realised she wasn't quite sure what they did in Pharmacy nowadays. Dispensing yes, although wasn't that done by machine now? A bit of manufacturing, she supposed; and the help-desk function was very useful for junior doctors unsure of their drugs. But were they up to supporting a new formulary? After the fracas at the Formulary Committee on Wednesday Sheila wondered whether she should commission a team of consultants to come in for the development phase. The local medical school had a very good pharmacology department with people who did that sort of thing. Or the PCT perhaps. She had an appointment to see Elaine, their new Director of Pharmacy Services, in a couple of weeks' time. There had been that palaver from Dr A. over drug Z, that was unfortunate. But she knew there was a lot of energy for modernisation in the PCT which could be very useful – as long as they didn't get too bossy about it. St Luke's, she knew, had freed up a huge amount of junior doctor time by putting warfarin clinics out in the community, and that had been prompted by Edgebury PCT. With the pressure for meeting targets, addressing the EU working time directive, developing new services (such as intermediate care), etcetera, Woodville simply couldn't go on doing things in the same old ways. They would have to learn to think differently. 'But I don't know where to begin', thought Sheila,

'there's just so much hitting my desk every week.'

In the meantime, the new formulary. Yes, subject to her liking what she saw when they met, Sheila would suggest the PCT Director of Pharmacy Services join the committee, with a view to taking a leading role. Anne would be furious, of course, and disappointed too. But she didn't seem to realise that influencing prescribing habits wasn't simply a matter of feeding clinicians the evidence – they needed to *want* to change those longstanding habits. Berating them when they didn't just antagonised them, it didn't achieve anything. Yes, she thought, the PCT might be useful for all sorts of things. They might even be able to put some pressure on Woodville's Pharmacy about the clinical governance data. They were so used to analysing the PACT data they would be surprised at how little formal review of prescribing took place in the hospital. They might be able to push harder than she could, she hoped so. Of course, she didn't know what Elaine's priorities would be. The new GP contract would undoubtedly have an impact: lots of redesign options that would presumably involve pharmacy. But she had sounded keen to meet and that was a good start.

In the meantime, it would be useful to see Ashok today, but perhaps the action was now moving to the PCT.

Friday mid-morning – Pharmacy Department

The coffee room was abuzz. The meeting with Ashok had just finished and he had gone to see the Medical Director.

'Well, what do you think of that?', Azim asked Anne. Across the room a number of people were asking the same.

'I think it's great', said Anne. 'It's what I've been wanting for ages, the sooner we start the better. This will move us into the twenty-first century and it'll get other people realising the contribution Pharmacy can make. We've been ignored and forgotten about for far too long'.

Overhearing her, Stuart turned to Karen: 'She's right of course, we are ignored. Look at how we can't get the money we need for any of our service developments. And we're desperately short of staff in the dispensary and no-one ever agrees to increase our establishment. But we always have been. Introducing these new systems isn't going to change that. It'll just mean we take on more work with the same number of people.'

'Yes', Karen replied, 'if only we could recruit to our vacant posts things mightn't feel so bad but we can't do anything until that happens – we're all far too busy.'

Nicki and Bola, two of the technicians, discussed it too. 'Well I can see it makes sense. I think it'll be good for the technicians *and* for the pharmacists. I'm just worried we'll all be landed with new responsibilities without proper training. I've heard that happened all the time when he was at St Luke's', said Nicki.

'Yes, I'm not sure what it means for those of us who are rotating', Bola thought aloud. 'We may end up having to learn a new set of skills every time we move departments. Still, it sounds exciting, I'd like to give it a go.'

'What I really want him to concentrate on', said Penny to Charles, 'is the D grade vacancy in technical services. While that post is vacant we're just rushed off our feet.'

Charles wasn't sure he agreed. Privately he had thought for some time that he could do that job, certainly at least as well as Mike, the chap who had left two months ago. When he'd mentioned this to Jacqueline she had refused to think about it though: 'You've got plenty on your plate at the moment, don't go looking for more', she had said. 'I need someone thoroughly reliable in your role, and we'll find another D grade soon. It would be a huge jump in terms of responsibility – a big worry for you, that you don't need. Especially with all the demands of a young family.'

Charles wasn't as sorry as Penny and Stuart to see Jacqueline go. He'd felt patronised and restricted. Ashok was a breath of fresh air. 'Now all we need is for the hospital management to listen to us', he thought, 'but I don't suppose that will ever happen.'

Figure 1.1: Pharmacy Department organisation chart

* Ashok is organisationally accountable to Paul, Director of Clinical Support Services. Paul accounts to the Director of Operations, and also has a dotted line relationship with Sheila, the Medical Director.

Figure 1.2: Dispensary services

- Dispensary Manager (Technician) — Stuart
  - Assistant Dispensary Manager (C grade Pharmacist) — Karen
  - Technicians
    2 F/T (Jayesh and Nicki)
    2 rotating
    2 students (rotating)
  - Basic grade Pharmacist (rotating)
  - Pharmacy Assistant/Reception

Figure 1.3: Technical services

- Technical Services Manager (D grade Pharmacist) (vacant for last 2 months)
  - Senior Technician — Hina
    - Basic grade Pharmacist (rotating)
    - Technician (rotating)
    - 2 F/T Technicians
    - Student Technician (rotating)
    - Pharmacy Assistant

Managing
Change
in the NHS

Figure 1.4: Procurement and Distribution services

Chief Technician (Procurement)
Charles

Buying Clerk

Distribution

Storekeeper

Technician
(rotating)
Bola

3 Pharmacy Assistants

Student Technician
(rotating)

Figure 1.5: Clinical services

Principal Pharmacist – Clinical Services
Anne

Medicines information

Ward services

Medicines Information Manager D grade Pharmacist
Azim

Basic grade Pharmacist
(rotating)

Principal Pharmacist (Patient Services)
Penny

C grade Pharmacist
(split post: wards/ anticoagulant clinic)

Basic grade Pharmacist
(rotating)

C grade Pharmacist
(split post: wards/ anticoagulant clinic)

Dispensary C grade
Karen

and Technical Services D grade
(vacant)

Managing
Change
in the NHS

■ Articulating a mission

Consider the challenges facing Ashok. He has joined the Woodville Pharmacy team with a broad view of the kind of service he would like staff to deliver and patients to receive. He's developed this view over time: through his experience of other departments, from things he's read about in journals, from his own training and his interaction with other health care professionals. This view is leading him to suggest some immediate changes within the department. If asked what his view or vision is he may be able to describe it, he may not; it may be explicit or implicit.

A **mission statement** is a means of making this view explicit. There are two benefits of its being explicit: one is that it is communicable and discussible; the other is that it can inform decision making, and form the basis of a rigorous analysis.

One definition of a mission statement is that it encapsulates the aims of an organisation and often its key values, offering a vision from within the organisation which is oriented to the outside. It's important to note, however, that mission statements can hinder as well as help, especially 'if the vision and values are merely proclaimed, but not lived convincingly' (Peters, 1987: 40). One authority in the field of discourse analysis argues – in an article entitled 'Mission impenetrable' – that many mission statements are recycled management jargon: verbose, concerned with being politically correct, and linguistically unmemorable; the challenging conclusion is that mission statements of UK public services are often vague, dull formulae that could mean anything to anybody (Cameron, 2001).

The mission statement we are talking about here must not look anything like that! It must convey succinctly and simply the *purpose* of the service, as perceived by opinion formers within it.

Key opinions formers and the mission

The title of this section is 'Articulating a mission', and this means putting into everyday, memorable words whatever it is that enthuses and drives the key opinion formers – people who play a critical role in supporting or challenging initiatives, people who are able to play an exemplary role in showing how the mission can be 'lived convincingly'.

First, then, you will want to identify who the key opinion formers are. This is an informal process of observing whose views are listened to and acted upon; how people are referred to in their absence over the coffee room table; and how people respond when opinions are voiced, both verbally and through their body language. Of course, those who contribute most frequently to conversations and meetings are not necessarily those whose views carry the most weight. Indeed, the most influential opinion formers may seldom be present at all. Having identified the opinion-formers, you will need to observe their enthusiasms: the words and phrases they tend to use; where they focus their

The mission statement must convey succinctly and simply the purpose of the service, as seen by opinion formers within it

■ Articulating a mission

time and energy; what they talk about with evident passion and what they don't. Gathering together on a large single sheet of paper these 'magpie snatches' of key people's thoughts, feelings and preferences will get you nearer to capturing something approaching the *essence*, the *underlying purpose*, of the department.

Isn't this suggestion undemocratic? Surely all stakeholders, including patients, should be given a chance to contribute equally and transparently to the mission of a department? Undemocratic yes, but real. In every department some people's views carry more weight than others on a day-to-day basis, and you need to reflect this in your understanding of the department.

In Ashok's mission there is a balance between working outside the pharmacy, with others, and inside

So, you may like to think about the following questions:
- Who have been the key opinion formers while Jacqueline has been the Chief Pharmacist? And what do they most care about?
- Will they still be the key opinion formers now that Ashok has arrived? If not, who will be? What are their concerns and enthusiasms?

As Chief Pharmacist Jacqueline was most concerned about the safety and accuracy of pharmaceuticals as they left the pharmacy. Where possible she centralised activity into the pharmacy (for example, the I/V additives service) so that she could control it and ensure accuracy and hence safety. When there was a tension between different uses of resources (for example, dispensary and manufacturing staff going onto the wards) she tended to support the pharmacy based functions at the expense of those outside it. Her language included phrases like 'belt and braces', and 'safety' and 'security' were words she often used. Penny and Stuart were her closest friends and allies and saw the world in a similar way. They were therefore the most influential people within the department. The mission statement in Jacqueline's time might be characterised as:

To ensure that all pharmaceuticals leaving this pharmacy are formulated accurately and safely as instructed, for the protection of patients and staff.

Ashok sees the world differently. He knows that there is a great deal that can happen to a pharmaceutical between it leaving the hospital pharmacy and being taken by the patient, whether on the ward or at home. He wants to ensure safety and accuracy not only on leaving the pharmacy but throughout the 'career' of each medication, until (and including when) it is taken by the patient. Anne shares this view of the world, but Penny and Stuart do not. Thus there is likely to be a shift in influence within the department. In Ashok's mission there is a *balance* between working *outside* the pharmacy with others, influencing and persuading but not controlling, and *inside* the pharmacy, where he can ensure a safe and timely service. The mission Ashok and Anne will seek to establish is:

Working with other health care professionals to ensure that people receive the pharmaceuticals they need in a safe and timely way, and use them appropriately.

■ Articulating a mission

Managing *Change* in the NHS

■ The Seven S Model

The Seven S Model is a means of thinking holistically about all the resources and competences available within a team or an organisation, and seeing whether they are supporting it in achieving its purpose. Devised originally by Waterman, Peters and Phillips (1980), the model proposes that any organisation can be considered under seven headings, all beginning with the letter S, each referring to an essential aspect of effective operation. Initially the Ss were: structure, strategy, systems, staff, skills, style, and super ordinate goal. They have been modified over time and most commonly now include: structure, strategy, systems, staff, skills, management style and shared beliefs (or culture). The seven aspects should support and be supported by each other. Headings do not depict discrete classes and one resource may fall into several of the Ss. The model is best thought of as a prompt rather than a checklist.

Applying the Seven S Model

To use the Seven S Model in the current Woodville example you would take each S in turn and test it against the mission for the Pharmacy Service as in Box 1.1.

Seven Ss:
staff, skills, structure,
systems, strategy,
(management) style,
shared beliefs

> **Box 1.1: Seven S Model**
>
> - What **staff** do we need if we are to achieve our mission? Do we have them? *Here it is best to think in terms of numbers, and grades, and things like attitude/motivation.*
> - What **skills** are the most important if we are to achieve our mission? Do we have them? *It can be helpful here to consider skills under four headings: clinical/technical; interpersonal; managerial (deployment of resources including time); research/reflection.*
> - What are the most important features of an organisational **structure** if we are to achieve the mission? How does this compare with the structure we have in place? Does the structure make the most of the staff and skills we have within the department? Does it fit with our systems, our management style and our shared beliefs?
> - Of all the **systems** that make any department function (and there are multiple candidates here: referral, assessment, discharge, recruitment, appraisal, training, and so on) are there any that are absolutely critical to achieving our mission? Do we have them in operation?
> - What **strategy** are we working towards over the next 6-12 months? In other words have we declared any priorities, have we discussed where we are going? Is this strategy going to help us achieve our mission?
> - What is the predominant **management style** within the department? Is it autocratic, laissez-faire or participative? Paternalistic or challenging? Empowering or controlling? What words come to mind as you think about it? Is this the management style we need if we are to achieve the mission?
> - What about the **beliefs** we share (and don't share) as a department? What beliefs will be helpful to achieving the mission? Is there a match or a gap? *Beliefs can include beliefs about: self, the value of the work, colleagues, patients, bosses, the organisation, the future ...*

■ The Seven S Model

When using the model, each S is tested against the other Ss. For example:

- Does the organisation *structure* make the most of the staff we have and the *skills* they bring?
- Is it supported by the information and appraisal *systems*?
- Is our *strategy* built into a cascade of team and individual objectives using this *structure*?
- How does it fit with the *management style*, how do people feel about it?

From these seven Ss a list of strengths and weaknesses is eventually drawn up to encompass everything you think is relevant about the department.

You will find it helpful to try applying the Seven S Model to the Woodville Pharmacy, putting yourself in Ashok's position and using the mission he wants to establish.

Staff

- What staff, with what behaviours and attitudes, are needed if Ashok's mission (see page 34) is to be achieved?
- What staff, with what behaviours and attitudes, are in post?

Skills

- What skills will be needed to achieve the mission?
- What skills are available? And which are not?

Add comments to the blank spaces in the following table.

Table 1.2: Types of skills

Type of skills	Skills needed for the new mission	Skills available
Technical/clinical		
Managerial/resource deployment		
Interpersonal		
Evaluative		

■ The Seven S Model

Structure
- What structures will allow and encourage achievement of the mission?
- What is the current structure?

Strategy
- What are the likely key priorities for the next year if the mission is to be achieved?
- Is there an agreed strategy for the department?
- What are the priorities people are working towards now?

Systems
- What systems will be essential if the mission is to be achieved?
- Are they in place?

Management style
- What is the most appropriate management style for achieving the mission?
- What is the prevailing style in use currently?

Shared beliefs
- What beliefs would it be helpful for staff to share, if the mission is to be achieved?
- What beliefs are currently held by members of staff?

Table 1.3: Types of beliefs

Beliefs about	Needed	Currently
Team members themselves	'Can do', I work hard and have the skills I need	Unsure I can cope
Colleagues – inside the pharmacy		
Colleagues outside the pharmacy (other health care professionals)		
Value of work	This is important and worthwhile	
Patients	Deserve a good service and have important things to do with their lives	
Pharmacy Department		

■ The Seven S Model

Table 1.3 *continued:*

Beliefs about	Needed	Currently
Resources		
Woodville Hospital Trust		
Future		
Bosses		I'm not quite sure who my boss is
Keeping up to date		I fit it in when I can, if there's anything important it's up to the Chief Pharmacist to make sure I hear about it

Illustration and analysis

This is our reasoning, and we offer it so that you can compare it with yours. Please note that ours is not necessarily 'right' and, if it differs, yours 'wrong' (or vice versa!). We have brought to ours our understanding of this fictional department and your picture of it may be very different. In a real situation there would be more possibility of testing out assumptions.

Staff

HIDE | SHOW

Working much more outside the pharmacy, with other health care professionals, and with patients and user groups, will require experienced people with a good knowledge of the hospital and its staff, supported by people in a wide range of grades and pharmacy disciplines. A large vacancy rate or high turnover would make this much more difficult.

When we look at the staff currently in post we see a good mix of grades, with no major shortages (there are always likely to be some vacancies in most departments, as here).

In the real world we might look harder at the people in post to see if we have a mix of personality types and preferred behaviours. Ashok will be able to do this

■ The Seven S Model

as he gets to know them. We also need to think about how they feel about the old and the new mission. Here we can see that some key staff members still believe the focus should be on 'safe supply'.

Skills

Table 1.4: Types of skills

HIDE | SHOW

Type of skills	Skills needed for the new mission	Skills available
Technical/clinical	Medicines information; production; dispensing	Strong: excellent technical skills
Managerial/resource deployment	Use of own time, system design	Weak: time and priorities management poor; systems are not working and are not being reviewed
Interpersonal	Ability to empathise, engage with, challenge and support others	Poor: some staff aggressive and domineering, some insufficiently assertive, few able to engage in robust relationships with other health care professionals, especially doctors
Evaluative	Ability to reflect on own and department's performance	Weak: lack of reflection and experimentation

Structure

HIDE | SHOW

The balance in the new mission requires a structure that balances strong supply functions with excellent liaison with other health care professionals outside the pharmacy. The current structure is a matrix, with a greater pull towards the 'home departments' than towards the wards and 'external' settings.

■ The Seven S Model

Strategy

(**HIDE** | **SHOW**)

We can see that there is a strategy document that includes many of the key components of the shift in mission: a Patient Own Dispensing (POD) Scheme; greater involvement in clinical governance across the Trust; and input into multi-professional education and continuing professional development (CPD). But none of this is built into team action plans and personal objectives. It is therefore sitting on a shelf, not influencing current priorities.

Systems

(**HIDE** | **SHOW**)

The systems need to reflect the balance of the mission. There will need to be ways of responding flexibly and knowledgeably to the needs of a diverse group (e.g. patients, health care professionals, clinical governance team) and this requires that the most experienced and senior staff are operating right at the frontline.

A high quality checking function will prevent mistakes within the pharmacy. Ashok knows that checking is most effectively carried out by experienced technicians and not by pharmacists.

Neither of these key systems is in place effectively.

Management style

(**HIDE** | **SHOW**)

If staff are to go out from the pharmacy and feel confident engaging with others then the management style needs to be empowering and supportive. To ensure safe and timely service within the pharmacy it also needs to support attention to detail.

Jacqueline was very protective of her staff, not exposing them to challenge, and ultimately disempowering them; Penny and Stuart, having followed Jacqueline's lead, still adopt this style. They are prepared to place an emphasis on detail, however. Anne is very demanding (challenging) but also inclined to be harshly judgemental. Ashok himself is supportive and challenging, but is not very interested in detail.

■ The Seven S Model

Shared beliefs

Table 1.5: Types of beliefs

(HIDE | SHOW)

Beliefs about	Needed	Currently
Team members themselves	'Can do', I have the skills I need	Unsure I can cope
Colleagues – inside the pharmacy	Have good skills, work hard, I can rely on them to do what they do well	Work hard, I like most of them, we all gossip
Colleagues outside the pharmacy (other health care professionals)	Have the interests of the patient at heart, will work effectively with pharmacy if I can persuade them	Are irresponsible with medication. Things go wrong if we leave it to them.
Value of work	This is important and worthwhile	This isn't quite what I imagined when I started but somebody has to do it
Patients	Deserve a good service and have important things to do with their lives	Have unreasonable expectations and can wait
Pharmacy Department	We are important to the organisation and are valued	Nobody notices us
Resources	We have a lot of resources and can be much more cost effective than we are	We don't have enough
Woodville Hospital Trust	This organisation is a good place to be	Don't know much about it
Future	The future will be different but still interesting, exciting, and safe	The future is worrying
Bosses	My boss wants me to do well and is fair	I'm not quite sure who my boss is
Keeping up-to-date	It is vital and I make it a priority	I fit it in when I can, if there's anything important it's up to the Chief Pharmacist to make sure I hear about it

■ PEST analysis

In thinking about Seven S we analysed factors affecting the *internal* environment of the Pharmacy Department. A PEST analysis offers a similar holistic approach, this time to analysing the *external* environment. The term PEST is an acronym, abbreviated from Political, Economic, Social and Technological, each heading referring to factors in the environment surrounding a service such as Woodville's.

- **Political** factors might include initiatives stemming from central government, from your local health community, and from the 'small p' politics within an organisation such as Woodville Hospital.
- **Economic** factors might include finances, and also the different markets the pharmacy operates in. For example, the department may be competing for staff in the local labour market. And so on.
- An increasing interest in work-life balance, the ageing of society and the impact on caring responsibilities for women, and multi-cultural aspects, are just some of the trends you might think relevant under the **sociological** heading.
- When it comes to **technologies** you need to think wider than new kinds of equipment and use the term in its original sense of 'an approach'. So you might think of clinical audit, plan-do-study-act (PDSA) cycles, and some of the other tools described in *Organisational Change* (Iles and Sutherland, 2001) – and of course all the new systems that Ashok is considering introducing.

Using these four headings, let us identify some factors likely to be affecting Woodville Pharmacy *at the present moment in time*. We have not included in the case much information about the external environment, so do not restrict your thinking to what is described in the case, draw on *your* knowledge of what is happening now in the wider health and social care environment.

Illustration and analysis

If you compare your notes with the following you may well have identified other factors – our lists at the time of writing (August 2004) have certainly been superseded as you read now. We have also added some speculative items *in italics* within the bullet point lists.

Political factors

(HIDE | SHOW)

National
- Government initiatives about modernisation and about involvement of frontline staff, including: the NHS Plan; Shifting the Balance of Power; Agenda for Change; Improving Working Lives; Choice; and Public and Patient Involvement, Payment by Results, Foundation Trusts

Local
- Development of local PCT: pharmacy team there is strong and getting stronger
- *Local health economy in deficit*

Organisational
- Medical Director has close links to Department of Pharmacology at nearby medical school and is aware of potential support from PCT pharmacists
- Pharmacy is in a Clinical Support directorate, and the Clinical Director has a limited view of the role of pharmacy
- HR Director knowledgeable and enthusiastic about developing 'new staff to deliver new services'

Economic factors

(HIDE | SHOW)

- Pharmacy operates in a number of markets:
  - *A new ring road is about to bring a nearby town much closer, offering alternative employment opportunities to pharmacy staff.*
  - *Hospital B is a 3-star Trust, keen to apply for Foundation status, and may be able to offer attractive career opportunities and perhaps more money.*
  - *Within the hospital, the clinical support directorate is being squeezed to concentrate resources on waiting time targets and cancer and CHD NSF targets.*

Sociological factors

(HIDE | SHOW)

- Changing expectations of consumers in relation to:
  - illness, well-being, prevention and treatment
  - the nature of service provision
  - professional care providers
  - changing views about the professions within the professions themselves.

Technological factors (approaches, ways of doing things)
- POD schemes
- The thinking behind the development of pharmacist-led services
- Approaches to management and to learning (the tools in this book for example)
- Quality improvement tools: patient journey mapping, statistical process control, etc.

■ PEST analysis

■ SWOT analysis

Both Seven S and PEST enable us to think clearly about aspects that are relevant to the service but they are even more useful when we draw on them to conduct a perceptive and rigorous SWOT analysis. SWOT is an acronym for Strengths, Weaknesses, Opportunities and Threats, in which strengths and weaknesses refer to your use of resources within your organisation, opportunities and threats to the external environment.

SWOT analysis was first described in the management literature by Igor Ansoff in the 1940s (see Ansoff, 1965). But Ansoff was merely articulating a principle used for centuries, especially by military strategists: that you make decisions about how to deploy your resources by trying to ensure there is a fit between your goals, the way you are organising your resources and the environment in which you are operating. All of the four SWOT categories relate back to your goals or mission, so a strength or an opportunity is something that helps you achieve your mission, a weakness or a threat is something that inhibits this. The SWOT analysis is conceptually very simple, but it is often conducted badly: with muddled thinking about strengths and weaknesses, and without any focus on the mission. This merely results in 'more or less relevant facts organised under four headings' (Iles, 1998). The process we suggest encourages the kind of clear thinking that will make the results more useful.

Strengths and weaknesses

The Seven S analysis looked at the way the resources are being organised, so this is where you look to find your strengths and weaknesses.

How can you best determine whether something is really a weakness or a strength? One way to do this is to answer the following questions in sequence:

Table 1.6: How to identify strengths and weaknesses

What features may be strengths?	How is this a strength?	What are the underlying factors that lead to this feature?
Here you look back to the Seven Ss and list one of the aspects that help the department to make progress towards its mission	Now you check that it does indeed enhance the department's ability to reach the mission by spelling out how. If you cannot see how it does then it is not a strength and can be ruled out.	What is it that *causes* the feature you have listed in the first column?

■ SWOT analysis

A hypothetical illustration follows.

Table 1.7: A hypothetical illustration

What features may be strengths?	How is this a strength?	What are the underlying factors?
Highly motivated and committed staff	The staff can act flexibly to make the most of every opportunity to achieve the mission	Possible factors: • the department has a good reputation for research and state of the art service delivery and attracts high calibre staff • there is an excellent training and development programme • one of the managers is particularly challenging and supportive

As you can see, it is the underlying factor which accounts for the staff motivation, and indeed could be considered the true strength. It is important to identify which of these factors it is, so that you can protect and nurture it, and in turn the motivation.

Opportunities and threats

Opportunities and threats arise in the external environment, so your thinking under the headings of the PEST model is the place to look for these.

In a similar way to the thinking about strengths and weaknesses, thinking about opportunities or threats can also be clarified by answering three questions, as follows:

Table 1.8: Thinking clearly about opportunities and threats

Which external factors may be opportunities?	How is this an opportunity?	What must we do about this?
Referring back to the PEST you can see that some factors will help achieve the mission (opportunities) and others will hinder progress towards it (threats)	Check that it does indeed enhance the department's ability to reach the mission by spelling out how. If you cannot see how it does then it is not an opportunity and can be ruled out.	In order to exploit this opportunity is there anything you need to do straight away?

■ SWOT analysis

Managing *Change* in the NHS

Another illustration follows.

Table 1.9: Another illustration

Which external factors may be opportunities?	How is this an opportunity?	What must we do about this?
Tools and approaches sponsored and supported by the Modernisation Agency	There is energy, expertise and perhaps additional resource that can help you identify service and cost improvements	Find out more about these, perhaps by visiting the relevant websites for more initial information

Identifying priorities

Once you have clearly identified strengths, weaknesses, opportunities and threats as suggested, you come to the most valuable part of this whole process: developing a change agenda by deciding which are the critical issues that you need to address. You do this by reminding yourself of the mission, and then scanning all the left and right hand boxes of the SWOT (particularly the right hand). You will find that there are a number of problems that occur in different ways in several of the boxes. You can cluster these together into a small number of key issues.

At this point you might want to carry out a SWOT analysis based on the Woodville Pharmacy, looking at the strengths, weaknesses, opportunities and threats, and referring to Ashok's new mission:

Working with other health care professionals to ensure that people receive the pharmaceuticals they need in a safe and timely way, and use them appropriately.

After you have tried your own you will probably want to compare it with ours.

■ SWOT analysis

Illustration and analysis

Mission: Working with other health care professionals to ensure that people receive the pharmaceuticals they need in a safe and timely way, and use them appropriately.

Table 1.10: Our analysis of the Pharmacy's strengths

(HIDE | SHOW)

Which features may be a strength?	How is this a strength?	What are the underlying factors?
Good skill mix, right numbers, right grades	Good potential to achieve new mission	Location? Good relationship with a school of pharmacy? Intransigence of previous Chief Pharmacist?[7] Others?
Good technical skills in right areas	There are skills to achieve mission	Historical emphasis on technical skills
Strategy focuses on just the right things	If implemented this would make significant progress towards mission	Vision of one principal pharmacist
Good mix of management styles	If people act as a team they will be able to offer challenge and empowerment and attention to detail – just what the mission needs	Happenstance

■ SWOT analysis

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[7] Note that a strength may be caused by something of which you disapprove. Here Ashok would use this knowledge to reflect that, as he behaves more cooperatively, he will need to ensure he can marshall effective arguments against reductions in establishment.

Managing
Change
in the NHS

Table 1.11: Our analysis of the weaknesses

HIDE | SHOW

Which features may be a weakness?	How is it a weakness?	What are the underlying factors?
Poor resource deployment skills	Staff not able to respond flexibly. Finding new ways of doing things will be needed if new mission is to be achieved.	Victim mentality. Stuck in 'we do it this way and this is the right way' mode. No experience of a different approach
Inappropriate interpersonal skills	Some staff cannot engage with other health care professionals	No feedback, no training, no supervision in this area
The matrix structure isn't working in practice	Over emphasis on safe supply and not enough on medicines management	Interpersonal skills of Clinical Services Principal Pharmacist (CSP) Pressures of patients waiting – because the systems are not working Matrix structures often don't work
The strategy is not being enacted	The priorities identified are now reduced in credibility and it will be even more difficult to put these into practice, and they are major milestones along the way to the new mission	No work has been undertaken to underpin the strategy with action plans, no building into personal objectives
Current systems use staff ineffectively	Pharmaceuticals dispensed in a way that is not safe nor timely	Victim mentality. Stuck in 'we do it this way and this is the right way' mode. No experience of a different approach

Table 1.11 *continued:*

Which features may be a weakness?	How is it a weakness?	What are the underlying factors?
Person with most important clinical skills has least supportive management style	Staff are actively antagonised against mission	No management attention given to this previously, no feedback, target setting, support
Helpful beliefs not shared widely within department	Staff are not thinking positively about what they can do differently in pursuit of the mission	Unhelpful beliefs have not been challenged, nor tested against evidence

Table 1.12: Our analysis of the opportunities

HIDE	SHOW

Which external factor may be an opportunity?	How is this an opportunity?	What must we do about this?
Modernisation Shifting the Balance of Power	New mission very much in line with these – so there is energy around to support them	Keep up to date with developments Explicitly frame arguments outside and inside the dept in this language
PCT establishment and development	Potential for change in priorities	Find out more, keep up to date, identify key decision makers, develop relationships
Knowledge and enthusiasm of HR Director	Important skills and knowledge available to help with new mission	Plan how to access these and use them wisely
Patient expectations	The new mission is needed, hence supportive energy	Frame arguments using this vocabulary

■ SWOT analysis

Table 1.12 *continued:*

Which external factor may be an opportunity?	How is this an opportunity?	What must we do about this?
Workforce expectations	Potential both for constraints on what can be done differently, and for enthusiasm about things being done differently	Keep in mind when developing new systems and structures
Professions changing	New mission is timely	Keep abreast of developments locally, feed into SHA/WDC and to key education decision makers
Lots of thinking available to help support shift to new mission, e.g. POD scheme	These are the means of delivering new mission	Keep up-to-date, find out more, be open to new ideas – set up mechanisms for doing this, e.g. journal club

Table 1.13: Our analysis of the threats

(HIDE | SHOW)

Which external factor may be a threat?	How is this a threat?	What must we do about this?
Medical Director looking for more support from Pharmacy in PCT	May lose part of 'business', and opportunities for credibility with other HCPs and this may jeopardise new mission which relies on this credibility	Find out more about MD's concerns and address them. Keep MD informed about progress towards new mission Find out more about PCT Pharmacy Department. Analyse distinctive competences and investigate benefits of working together.

■ SWOT analysis

Table 1.13 *continued:*

Which external factor may be a threat?	How is this a threat?	What must we do about this?
Limited vision of Clinical Director	Danger of negative energy impeding new mission	Find out more, about interests, drivers, preferred behaviours, attitudes to innovation, etc. Frame arguments accordingly.
Financial constraints locally: across health economy and within directorate	Any changes must be self-financing Danger that change will lead to undesirable financial scrutiny	Use all resources to maximum efficiency and proactively demonstrate you are doing this Identify key decision makers, and their key concerns. Keep them informed about how you are addressing those concerns.
New ring road, Foundation status of competitor	May lose staff and jeopardise ability to deliver	Find out more: about competitors, about staff and staff preferences. Work with HR director to devise new packages, etc.

Now that our information is organised in this way it is accessible for us to use, to identify a small number of key priorities. It is to identify these priorities that this analysis is undertaken so this is a crucial step. However, this step is easier to illustrate than to describe in the abstract, so in the following section we give four critical issues that we have teased from Tables 1.10-1.13 above. You may like to refer back to these tables as you read, to see which boxes from the tables we have drawn from. This is a subjective process and the priorities chosen will depend on the perspective of the analyst. The set of key priorities that we would draw out of the SWOT above if we were in **Ashok's** shoes would be as follows:

■ SWOT analysis

Critical issues

Issue 1

'We have the right number of people, the right skill mix, with the right technical skills to be able to offer an excellent service, but we are not doing so. This is because people are stuck in a "victim" mentality, observing that the current systems are not working but believing this is because of a shortage of resources and thus not challenging the systems themselves. They are "stuck" here because a number of unhelpful beliefs have not been challenged or exposed to evidence.'

Issue 2

'The emphasis in the past has been on "safe supply" from the pharmacy, very inwardly focused, with little engagement with other HCPs outside the pharmacy. People are daunted by the prospect of working more closely with others, particularly doctors, and do not have the interpersonal skills to do so. This is because they have had no training, no supervision, no feedback, in this area and it has not been part of their personal objectives.'

Issue 3

'Pharmacy is not up-to-date with what is going on around it. The modernisation agenda has resources attached to it, and there are skills and tools that can be helpful to us as we think about how to offer a better service. At the moment many of the staff are resisting this, but if we work with this agenda we can offer a better service and also much more satisfying careers.'

Issue 4

'The department is not up-to-date with pharmacy developments locally and nationally and, apart from one journal club, has no self-sustaining mechanisms for being so. This means that new ideas are passing us by and we are in danger of being seen as a second rate department.'

Different perspectives

Other analysts would reach different conclusions. For example **Jacqueline** may have done the analysis as follows, based on her suggested mission:

To ensure that all pharmaceuticals leaving this pharmacy are formulated accurately and safely as instructed, for the protection of patients and staff.

■ SWOT analysis

Table 1.14: Strengths of Pharmacy Department as seen by Jacqueline

Which features may be strengths?	How is this a strength?	What are the underlying factors?
Committed staff	Work hard in spite of pressures	Good support from me and from Penny
Excellent dispensary manager	Dispensary staff withstand pressures of difficult patients	As above
Good systems controlled by pharmacy, e.g. I/V additives	We control accuracy and safety	We have been proactive in identifying areas where we can support other staff in this way

Table 1.15: Weaknesses as seen by Jacqueline

Which features may be weaknesses?	How is this a weakness?	What are the underlying factors?
Shortage of staff	Cannot offer the service and services we would like to	Trust won't give us any more resources
Poor computer system	Cannot provide the information we are asked to	Trust won't listen to us and give us more resources
Anne's poor interpersonal skills	She causes friction wherever she goes, and that makes it more difficult for us to be seen to offer a good service	She's just like that

■ SWOT analysis

Table 1.16: Opportunities as seen by Jacqueline

Which external factor may be an opportunity?	How is this an opportunity?	What must we do about this?
New pharmaceutical team at the PCT	May be an opportunity to secure more resources	Lobby them

Table 1.17: Threats as seen by Jacqueline

Which external factor may be a threat?	How is this a threat?	What must we do about this?
Patients' expectations are increasing	They can be difficult about the waiting times	Educate them
Money is getting tighter and tighter	We cannot obtain the resources we need to offer a good service	Complain
Other professionals seem to want more and more from us	We cannot satisfy their expectations and that makes us look weak	Educate them about our role and get them to respect it

Critical issues 1-4, as identified by Jacqueline

1. 'We are trying hard but are short of staff and resources, we will have to ask for more. In the meantime, Penny and I must keep on supporting them and not allowing them to get burnt out.'

2. 'Other health care professionals have unrealistic expectations of us, we must keep telling them how busy we are.'

3. 'Patients' expectations have risen so much they think they can have a prescription filled in the time it would take to be served a burger. We must educate them so they know how long they can expect to wait, and make sure our frontline staff know they are supported and that they must still take their time and check everything carefully.'

4. 'The government/Trust/profession are setting more and more onerous targets without giving us the resources. I must protect my staff from this by resisting these pressures.'

■ SWOT analysis

Someone else in Ashok's position, even working with a similar mission may reason as follows:

Mission: 'Working with other health care professionals to ensure that people receive the pharmaceuticals they need in a safe and timely way, and use them appropriately.'

Table 1.18: Strengths of Pharmacy Department as seen by a different incoming Head

Possible strengths	How is this a strength?	What are the underlying factors?
Some good skills: medicines information, manufacturing	We will need these	Jacqueline clearly valued these and appointed people with good technical and clinical skills
Some good systems, e.g. I/V additives	We have a credibility that will help us with the new mission	Jacqueline's desire for safety and accuracy was valuable here

Table 1.19: Weaknesses as seen by a different incoming Head

Possible weaknesses	How is this a weakness?	What are the underlying factors?
Lots of the staff are not up-to-date	They are whinging about resources instead of reviewing their systems	They haven't been exposed to new thinking
Many systems are antiquated	We cannot offer a good service with these in place, we are not credible, and we are wasting resources we could use much better	They are designed to protect staff more than patients

Table 1.20: Opportunities as seen by a different incoming Head

Which external factor may be an opportunity?	How is this an opportunity?	What must we do about this?
The new computer system	This will allow us to integrate our information with the rest of the Trust and be much more effective	Write a specification as soon as possible, get onto the committee, make sure we respond to all requests for input
All the new pharmacy systems in operation elsewhere	These are just what we need to deliver the mission	Implement them as soon as possible
Audit Commission report on Pharmacy	Lots of authority behind our new mission	Look at what they suggest in the way of new systems and practices. Be able to quote from whenever needed.

Table 1.21: Threats as seen by a different incoming Head

Which external factor may be a threat?	How is this a threat?	What must we do about this?
PCT pharmacy team	May take the most interesting bits of our business and leave us the rest	Make sure we are credible by implementing new systems and being seen to deliver a good service
Paul, our Director of Clinical Support Services	He doesn't see pharmacy as a priority and won't support any bids for new resources	Implement the new systems and then show him how effective we can be

■ SWOT analysis

Critical issues 1-4, as identified by **a different incoming head of department**:

1. 'These staff are behind the times, so I must provide them with lots of opportunities to catch up – suggesting they go to look at my last department for example.'

2. 'We need to implement lots of new systems and quickly, so I must draw up a plan for doing so very soon, and let my staff know as soon as possible so they know what is going on.'

3. 'Once we have set our own house in order we will be in a good position to argue for more resources, so the sooner we get started on these new systems and the new training, the sooner we will be able to make credible bids.'

4. 'We have to act quickly to be able to compete with the pharmacy department who are more exciting and state of the art than us, otherwise we will lose our ability to recruit good staff.'

What are the differences between these second and third SWOT analyses, and between these and the first one?
- Jacqueline is behaving in a reactive manner, seeing herself and her department as victims of other people.
- The different incoming head of department is behaving more proactively by taking responsibility for moving the department forward, but is concentrating almost entirely on changes within the department, and not on relationships outside.
- In our analysis, on Ashok's behalf, we suggest that although these internal changes are vital, they must accompany efforts to focus the department outwards and working together with the wider organisation.

Planning the change

Returning to the critical issues we teased out earlier (page 52) we are now able to set some goals for each one and this is now your agenda for change. For example we may set the following goals:

Issue 1
'We have the right number of people, the right skill mix, with the right technical skills to be able to offer an excellent service, but we are not doing so. This is because people are stuck in a "victim" mentality, observing that the current systems are not working but believing this is because of a shortage of resources and thus not challenging the systems themselves. They are "stuck" here because a number of unhelpful beliefs have not been challenged or exposed to evidence.'

Goal 1
'Pharmacy staff review the effectiveness of their own ways of working on a regular basis, constructively challenge each other, and are aware of assumptions they make, and expose these assumptions to evidence.'

■ SWOT analysis

Issue 2

'The emphasis in the past has been on 'safe supply' from the pharmacy, very inwardly focused, with little engagement with other health care professionals outside the pharmacy. People are daunted by the prospect of working more closely with others, particularly doctors, and do not have the interpersonal skills to do so. This is because they have had no training, no supervision, no feedback, in this area and it has not been part of their personal objectives.'

Goal 2

'Pharmacy staff communicate effectively with other health care professionals: they have their views sought by others, and are prepared to challenge others when it is constructive to do so, and in a manner which allows their challenge to be heard and acted upon.'

Issue 3

'The Pharmacy Department is not up-to-date with what is going on around it. The modernisation agenda, for instance, has resources attached to it, and there are skills and tools that can be helpful to us as we think about how to offer a better service. At the moment we are fighting this, but if we work with it we can offer a better service and also much more satisfying careers.'

Goal 3

'We start to think "how can pharmacy help the Trust meet its objectives and targets?" rather than the other way round. Pharmacy staff talk this way, are demonstrably helpful, show how we are using pharmacy resources efficiently to achieve Trust objectives. We frame arguments differently for particular audiences so that our arguments are relevant to the recipient.'

Issue 4

'The department is not up to date with pharmacy developments locally and nationally and, apart from one journal club, has no self-sustaining mechanisms for being so. This means that new ideas are passing us by and we are in danger of being seen as a second-rate department.'

Goal 4

'We are open to new ideas, proactively look out for them, seek out opportunities for hearing about them, and have a regular forum for sharing and reflecting on them. As a result we begin to experiment with new ways of doing things, developing our confidence in our ability to do so.'

Under each of these goal headings you would then list a number of actions that would make progress towards that goal. When you look at all the actions you have listed for all of the goals you will probably find that several are duplicated, so you can rationalise the list. At this point you are ready to build an action plan, thinking carefully about each of the actions, deciding who needs to be involved, which actions depend on others being completed first, whether there are critical deadlines for some of them, and generally how best you can deploy people and resources to put this into practice. One way of representing your action plan is in the form of a Gantt chart.

■ SWOT analysis

Table 1.22: Gantt chart

Action	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6		Week n

■ Readiness and capability

If Ashok is going to be successful in implementing these changes he will need support from other people. Not all of the people involved may be currently willing to support him, and of those who are, not all of them will have the skills or the arguments to be able to do so. Analysing the kind of support he needs will allow him to focus his attention and energy where it is most needed.

Imagine yourself again in Ashok's shoes. A number of people have a stake or interest in the changes you are proposing for your organisation. They can ensure the success of the change programme or they can wreck it. You need to know which, so that you can take action accordingly.

You will find it helpful to list all the key stakeholders, and then decide whether they:
- are *key opinion formers*, or have sufficient *power* to block your ideas if they do not like them, or must *actively champion* the change for the change to be successful
- must at least *support* the changes but do not need to be vociferous in their support
- *do not need to support* the change because they have little influence.

An organisation chart will be a helpful prompt in identifying these stakeholders. However personalities, relationships and politics ensure that the influence of an individual cannot be gauged entirely from their position or status.

■ SWOT analysis

■ Readiness and capability

One way of doing so is to enter individuals' names on Table 1.23 below according to where you think they sit in relation to three main stakeholder categories.

Table 1.23: Identifying whose support is needed

Stakeholders	Must actively champion	Must acquiesce	Have little influence

Stakeholders can then be categorised again according to whether they *are* strongly in support of the changes, strongly opposed to them, or are currently going along with a majority view. Completing Table 1.24 below, and comparing it with the table above, will enable you to identify those individuals whom you will need to invest the time and energy needed to convince them of the benefits of the changes you are proposing.

Table 1.24: Readiness of stakeholders

Stakeholders	Are ready to champion	Are adamantly opposed	Going along with the majority

■ Readiness and capability

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Some of the people you have listed already have the skills and arguments to be able to support you in this change, others do not. Enter stakeholders' names and decide which of the blue columns each can be assigned to by adding a tick.

Table 1.25: Capability of stakeholders

Stakeholders	Have the skills and arguments to be able to champion	Are not yet in a position to champion

When you have done this it will be possible to see clearly where you need to spend time, and what it is you should try to achieve in that time – convincing *that individual* of the argument, or giving them *arguments* they can *pass on* to others.

In order to do this well you would need to know a fair amount about the people involved, and as a newcomer Ashok will not have this knowledge. He will therefore need to look out for clues about the kinds of things that enthuse them, the way they like to behave, how they respond to the behaviours of others, their attitudes to change, and so on.

You may like to practise using this approach, using the empty tables above, drawing on the information provided in the case. Naturally it is limited and you are making guesses. In a real situation you would make efforts to find out a lot more.

■ Readiness and capability

Analysis

You probably identified Sally and Sheila as people whose support Ashok needs to secure: Sally because she has skills that he will need; and Sheila because she is in a position to limit or increase the level of influence pharmacy can have on the consultant body.

You may have listed individual consultants (or the consultants as a group) and suggested that they must at least support the changes; similarly the nursing staff.

What about Paul? Will he need to champion the changes? Probably not, but life will be difficult for Ashok if Paul actively opposes them. He belongs in the 'Must acquiesce' box.

When it comes to how ready and how capable these people are of offering the support that is needed, you may have suggested the following.

Sally has the skills but may need orientating to the particular agenda of pharmacy, and Sheila has the skills and positional power to influence but is not yet convinced of the arguments she would need to be able to give to others.

The consultants are currently hostile and need persuasive arguments (delivered with persuasive behaviours) for them to reach a position of being prepared to go along with the changes.

And the nursing staff? If Maria is representative they appear well disposed towards pharmacy but clearly have their own priorities. If pharmacy can help them address these then they may be prepared to support.

■ Commitment, enrolment and compliance

When considering people within his department Ashok may find another tool helpful: an analysis of the commitment, enrolment or compliance he needs if he is going to introduce change successfully. For an example of this model see Table 1.26.

■ **Readiness and capability**

■ **Commitment, enrolment and compliance**

Table 1.26: Commitment, enrolment and compliance

DISPOSITION	PLAYERS' RESPONSE TO THE CHANGE
Commitment	Want change to happen and will work to make it happen Willing to create whatever structures, systems and frameworks are necessary for it to work
Enrolment	Want change to happen and will devote time and energy to making it happen within given frameworks Act within the spirit of the frameworks
Genuine compliance	See the virtue in what is proposed, do what is asked of them and think proactively about what is needed Act within the letter of the frameworks
Formal compliance	Can describe the benefits of what is proposed and are not hostile to them. They do what they are asked but no more. Stick to the letter of the framework
Grudging compliance	Do not accept that there are benefits to what is proposed and do not go along with it. They do enough of what is asked of them not to jeopardise position. They voice opposition and hopes for failure. Interpret the letter of the framework
Non-compliance	Do not accept that there are benefits and have nothing to lose by opposing the proposition Will not do what is asked of them Work outside framework
Apathy	Neither in support of nor in opposition to the proposal, just serving time Don't care about framework

Source: Iles and Sutherland, 2001

Again, as a newcomer, Ashok probably does not have enough information to be definitive about the levels of commitment, enrolment and compliance that individuals are likely to display when he introduces the idea of change to them. But he could estimate the numbers of people he needs at which level of commitment, and perhaps what level he should aim for on the part of some of the named individuals we have come across (Penny, Stuart, Charles, Anne, Azim, Karen). He could think too about whether he can afford to have anyone at the level of non-compliance, or apathy. You might like to think about these questions too, we will discuss them further on page 68.

What happened in practice?

As we know, 'the best laid plans of mice and men gang oft awry', so let's look at what might have happened.

■ Commitment, enrolment and compliance

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Managing *Change* in the NHS

Episode 1.2:
The best laid plans ...

'In conclusion, I am disappointed that you did not give credit where it was due, to the skills and support (both financial and organisational) of the PCT, and instead presented the results as entirely your own work.'

Ashok read the letter again, surprise on the first reading becoming anger on the second. Perhaps a hint of guilt in the anger too. Elaine had heard of his talk at the intermediate care conference. She had probably read a summary, it had been well reported in the pharmacy press. She was right, of course: without her support he wouldn't have been able to form the network of community pharmacists nor appoint Azim to the liaison role that made this medicines management model work. But support was one thing, and banging heads together, taking the flak, making the changes, that's another – he thought.

When Ashok thought back over the last fifteen months the overall feeling was of hard work and uphill battles. Successes certainly: the POD scheme was in operation and working well, and Sheila Elliott had thanked him recently for the information that now fed routinely into the clinical governance reports. Ashok remembered how difficult he had found her initially, how all his attempts to enthuse her about his innovations had fallen on deaf ears. He had tried so hard to think about what would encourage her, he had subtly pointed out the conference opportunities, offered to add her name to the papers he would submit, all things that would have encouraged him, but not her. In the end it had turned out to be information that enthused her: the provision of information, that would enable her to be sure that prescribing was being effectively audited. Ashok noticed too that this was especially important in the run up to the regular clinical governance meeting across the strategic health authority.

But there were disappointments too; the I/V additives service had had to be re-centralised after Suffolk ward staff had protested they didn't have time to take it on – especially irritating since it was their complaints that instigated the decentralisation. And the plans for the technicians to take full medication histories as part of the admission process was back in place, but only due to a huge dose of luck.

People in the department had surprised him, he thought, some being more helpful than he had predicted and others less so.

Anne had been an enthusiastic supporter of all his proposals. She had worked tirelessly, overcoming all the objections others foresaw. For example, when Stuart quoted dispensary procedures as reasons for not increasing the time available for staff on the wards, Anne got hold of the relevant procedures from three other pharmacy departments to show how things could be done differently. Ashok winced as her recalled the meeting when these were discussed! Strong opinions on both sides, heatedly expressed, but there was no doubt it had been a turning point. Perhaps the precise turning moment was when he, Ashok, had said, 'Stuart, Penny, I know that these procedures Anne has gathered for us may not work here, we must design our own, but I personally am telling you that the procedures we have in operation at the moment will not do. I will not try and justify to anyone a two-hour wait for an outpatient prescription or a five-hour wait for a TTA. I

don't believe you want that either, you wouldn't want any of your friends or your neighbours to have to wait that long. And before you tell me again that we need more staff let's look at the staffing levels at St Luke's – very similar to ours and yet their waits are 20 minutes and an hour. We can do it differently and we must do it differently. I'm not going to tell you how to do it, we must work that out together, but we *must* do it.'

He remembered being slightly shocked at his own vehemence, and the others had looked surprised too. But somehow it had set the ball rolling, things felt different. As though one set of options was now out of bounds, and people could mourn their passing but know they were going, not torn between conflicting loyalties.

Somehow it had set the ball rolling. Things felt different and were being done differently.

Sending Stuart to look at St Luke's and several other departments had been a breakthrough. Seeing different systems in action, being able to check out how other departments ensured safety and accuracy, building a relationship with his counterparts so he could discuss issues with them, had made a big difference.

Observing this, Ashok had asked Anne to organise visits for all the staff to see how St Luke's ward services worked, and their community anti-coagulant clinics too. On their return Ashok had led a discussion about 'How will pharmacy look in 2020?' Some people had launched themselves into this thinking, enjoying themselves, and coming up with funny, outlandish, creative pictures of the future. Others had raised their eyebrows, and Roy had suddenly remembered an appointment at his daughter's school and had to leave. A pity, Roy had so much to gain from the changes, he had been stuck in a boring role for years, complaining to everyone and anyone about anything and everything. Ashok had spent hours trying to persuade him of the need for change but found Roy unresponsive. Not quite rude, not quite sullen (at least not when Ashok was around – there were reports of how much he would vent his spleen when Ashok wasn't in the room), Roy made his opposition known through his body language rather than his words.

The steering group had been a success. Originally with a remit for introducing the new ward services, Anne, Azim, Karen and Bola had been obvious participants. Charles was more of a surprise, but he had pointed out how any change would have an impact on his services and had become a very useful member. Penny and Stuart were invited but did not often come.

The group had listened to Ashok's views of the systems they needed to implement but only Anne was immediately convinced all the changes could be made without extra resources. The visits to St Luke's had helped. As did the information gathering exercises Anne organised – where every member of the steering group sought feedback and suggestions about the way pharmacy could support other health care professions. In many cases the health care professionals they asked knew so little about pharmacy that they couldn't come up with suggestions, but the discussions gave the pharmacy team lots of ideas to follow up. That was an exciting time – trying to pull the ideas together while observing organisational, political and resource constraints. Sally had been helpful there. She was much more tuned in to the

politics of the organisation than was Ashok. She had gently challenged proposals that he focus his energy on introducing new systems within the pharmacy, encouraging him to interact with other heads of department, clinicians, senior managers. In so doing he had learned how pharmacy was perceived, spotted gaps where pharmacy could offer a valuable service, and kept people informed of his plans and his progress. Although even that hadn't helped prevent the storm over the technicians' history taking, he thought ...

'I couldn't have made this happen. I can see how it did, but I couldn't have predicted it.'

Anne had proposed that full medication histories be taken by specially trained technicians for all patients admitted on to the wards. She had devised an excellent training programme for them (using the best of programmes elsewhere), involved Sally in having it piloted, evaluated and then accredited, and most of the technicians had embraced it with enthusiasm. And then, a few days after the system had been introduced a storm had blown up. Dr B. had been on Essex ward when Hina had tried to insert the history into the medical notes. Dr B. said he had not known of this and he hit the roof. 'Look, we're trying to reduce the number of steps in the patient journey', he had said, 'you can't just go adding them without any discussion.'

Of course Anne should have discussed it more widely, Ashok thought, although everyone involved had had an opportunity to comment on the suggested scheme. But the argument was a silly one. It was not adding a step so much as improving an existing one. But Dr B. had called into the pharmacy, discussed it with Penny because Anne was not there, and she had agreed to halt the scheme until it was formally approved by the drugs and therapeutics committee. Anne had been incandescent, especially when Roy had almost gloated at this turn of events when it was reported at the next departmental meeting. Less predictably, the technicians were also incensed. They searched the literature for evidence to support their case and, when they couldn't find any, decided to generate their own. Guided by Azim, they designed a research protocol comparing the prescribing on wards where medication histories were taken by trained pharmacy technicians and those where they were taken by junior doctors as part of a general history. Dr C., Director of Research, saw the proposal when it came to the research and ethics committee and had taken a personal interest. When the results had demonstrated lower costs, fewer side effects and greater patient satisfaction, he encouraged the technicians to write it up for the Trust's research bulletin. More than that, he was now referring other staff groups to the technician team for advice about getting started on their own research, and he had mentioned it to the Trust's Modernisation Team as an example of a PDSA cycle. Anne was now thrilled. 'Look what an opportunity it gives us to get people to use pharmacy wisely; we can often alert them to things we can do, information we can provide, things they just didn't know about.'

It was certainly encouraging just the kind of relationships with other professions that Ashok had hoped to promote – and it had happened without any deliberate action on his part. 'I couldn't have made this happen', he thought. 'I can see how it did, but I couldn't have predicted it.'

How had he done as far as predictions and plans went?

The steering group had looked at the original action plan, the Gantt chart they had drawn up, only last week. Much of it had been completed, albeit not always to time! Some actions were still relevant and work was underway to tackle them. But some had been overtaken by events: 'We just crossed them off the list', he thought. Lots more had happened beside the actions on the plan. The relationship with the PCT had blossomed and there had been an opportunity to work closely with the Professional Executive Committee (PEC) over medicines management. That had allowed the steering group to spot the possibility of running a local development programme for community pharmacists. The PCT had paid for it, it had been good experience for Azim and Karen to run it, they had established constructive relationships with a group of pharmacists they had not had much to do with previously. All in all it was a real 'win-win'. Ashok smiled when he thought back to the way he had described this to Paul at his appraisal interview last month. Naturally he had presented the programme and all these outcomes as pre-planned objectives rather than the opportunistic serendipity they were!

If only the training for the I/V additives scheme had gone as well. Looking back, Ashok suspected that Anne had selected the wrong people. She didn't know the wards nearly as well as Penny. So, although she had devised a selection process, the people who volunteered were a mixed group and Penny had suggested swapping some out and others in. Penny's knowledge of the organisation was deep and Anne should have listened, he thought. More than that, she should proactively go and seek it out; because it is so deep, Penny uses her knowledge intuitively and can't always explain why she is so sure of something.

'That was something Jacqueline had', Ashok thought, 'and I don't. Longevity, an intuitive understanding of the place and its dynamics. Of course I think Jacqueline misinterpreted it by the end, and felt defeated by it. It's important I don't get drawn into and down by it, but I do need to have access to that kind of understanding of the place. Sheila has it, Sally doesn't. That's one of the reasons why sometimes they complement each other well, and other times they talk past each other. I'm so glad I had that chat with Sheila after the clinical governance meeting back in June. The message that the consultants' committee believed that all these changes were for my personal aggrandisement, and not for the benefit of the Trust was so valuable – painful but essential. We would never have been able to persuade the Drugs and Therapeutics Committee to let us keep the work on the formulary with that kind of feeling in the background. But this letter. What am I going to do about my relationship with Elaine? Silly, I know she likes to be given credit, in fact I've managed to persuade her to support us during the last year by convincing her of the kudos the PCT will gain from this work, and now ...'

Analysis

Commitment

In the last section we wondered what level of commitment Ashok needed from people within the department if his changes were to be successful. We can see here that Anne has been fully **committed** right from the beginning. Unfortunately her poor interpersonal skills prevented her from being very effective until she had participated in some relevant training, and those skills were being discussed in regular supervision sessions. The evidence that she is committed is not only in her expressions of support but also in her preparedness to challenge existing structures and procedures in order to move the change forward. Ashok needed a few people to be **enrolled**, but in a department of this size probably only two or three. Anne, Azim and Karen would be plenty. Penny and Stuart have been the most influential members of the department for a long time, and there will be a lot of informal alliances in their support, so Ashok could not afford to have them less than **formally compliant**, and it would be useful if they were **genuinely compliant**. However it may not be possible to move them up that extra level and it is certainly not worth him expending lots of energy there that could be more usefully spent elsewhere. In any department at a time of change there is likely to be someone or some people (perhaps a small number) who are **non-compliant** and it can be tempting to spend a lot of time trying to convince them. However, the chances of success are often small and it may be better to identify the individuals who may be contaminated by those reactions and spend time keeping *them* at formal compliance or above. Here Ashok has miscalculated this and wasted too much time on Roy.

Persuasion

How can we influence and persuade? The most important thing to remember is that people are different, and here we move into the province of organisational psychology. Many of the psychometric frameworks can be helpful: the more comprehensive ones such as Myers-Briggs Personality Type Inventory (MBTI)® or Sixteen Personality Factor Questionnaire (16 PF)®, or the simpler frameworks such as Belbin's 'Team Roles' (Belbin, 1981). Consideration of motivational drivers can be valuable, and awareness of status differences between professions, too.

What we are trying to do with these tools and frameworks is to predict how people will respond to particular arguments, so that we can frame those arguments accordingly. Ashok himself is motivated by recognition, among other things, and (as it happens) so is Elaine. So when Ashok persuades Elaine to back his ideas he uses arguments that would appeal to him (kudos, doing something that is different and leading edge). Because he has not considered clearly enough Elaine's motivational drivers he finds himself offending her when he fails to give her enough praise when he has an opportunity to do so. He tries the same approach with Sheila, again relying on arguments that he himself would find appealing, and finds her unresponsive. If he were to seek to find out more about her work-related motivations he might discover that her motivation profile is quite different. She may be more enthusiastic about, for

The most important thing to remember is that people are different.

■ Readiness and capability

■ Commitment, enrolment and compliance

example, the power to influence events. If so, then information that can help her assure quality is more relevant than the opportunity to contribute to conferences. Her reference group is likely to be other clinicians, and not a managerial cadre, so again conferences will be less relevant for her than meetings with her peer group.

There is sufficient material in the case study, particularly on pages 23-25, for you to have fun thinking about how best to approach the people within it. There is not enough for us to be more definitive. In real life you would be able to build up much more representative pictures of the people involved, varying them as you had more and more interactions with them.

Project management

As we saw in *Organisational Change* (Iles and Sutherland, 2001) there are a number of project management tools that can be useful in implementing changes, and in this case Ashok has used a Gantt chart. We see that this was especially useful in kick-starting the change and the cascade of team and individual action plans that will be necessary. But, even with updating, it became less and less relevant over time. Let's think about some of the reasons for this.

■ Schools of thinking about change

The kind of analysis we have illustrated so far presupposes that when interventions are made predictable results can be achieved. And yet there are other views about how change is guided by managers. Henry Mintzberg (1989) compares a manager with a potter, crafting a strategy for his or her organisation in the way that a potter works with the clay on the potter's wheel: setting out with an intention but making minor adjustments in response to the way the clay is handling, and sometimes even major changes as an opportunity arises that hasn't been visible before. He terms this kind of strategy 'emergent' and contrasts it with 'deliberate' strategies. Ashok's project plan is a *deliberate* strategy. Mintzberg would predict that the changes that do in fact take place will reflect in part that deliberate strategy but will also emerge as the situation changes and as opportunities are taken that could not have been foreseen. So the work with the PEC, leading to the programme for community pharmacists, would be examples of *emergent* strategy.

The new sciences, too, suggest that we cannot predict the outcome of any particular intervention. The sensitivity to initial conditions can be too great. Complex results can arise from even simple rules if they are applied recursively. New behaviours and properties will emerge *spontaneously* from interactions of as yet unforeseen behaviours, and self-regulating sets of behaviours can co-evolve. All this means that a straightforward link between an intervention and a predictable result is unlikely. An example of this is the unforeseen result of the response of the technicians to the behaviour of Dr B. This sparked off a set of actions that led to a very positive cluster of outcomes. Looking back, it is possible to trace a link between them (to explain) but looking forward it would not have been possible to predict.

Mintzberg talks of the importance of authenticity and intuition, born of longevity in an organisation, in crafting a strategy. He compares this with the skills of an analyst coming in from outside and applying an analytical framework (such as the one we have illustrated here). He describes the importance of tacit knowledge, knowledge held by people as a result of their interactions with an organisation over many years, knowledge that is not always available to be put into words, at least not in a prescriptive way, knowledge that gives an intuitive sense of whether a proposed action is right or not. In our case, Penny and Sheila are holders of this tacit knowledge. Sally, Anne and Ashok have not had time to develop it.

Mintzberg, Weick (2001), Bate (1994) and others also draw attention to the process by which actions and events (whether planned or not) will be woven into stories by participants and observers, and many of these stories will assume that there was a conscious intent followed by a course of action. Actions which emerged as a reaction to other actions, opportunities that were taken on the spur of the moment, may all be woven together into a story that starts with someone making a decision (or set of decisions) A that ended in result B. Sometimes these stories will reflect reality, more often they will not but, more importantly, sometimes these stories will be helpful and at other times they will not. Ashok found that the actions resulting from the work with the PCT and with the research director were interpreted as a bid for self-aggrandisement rather than a means of offering greater support to other healthcare professionals and to patients. Here the story woven was unhelpful. However, he himself was able to take credit with his line manager for what he presented as a plan of action, about the work with the Professional Executive Committee and the community pharmacists, that had not been planned but emerged as the year went on.

Each of these three different schools of thought – deliberate, spontaneous, emergent – contribute in important ways to thinking about change management. When considered alongside one another, however, they may initially appear to lead to mutually exclusive courses of action. How are change managers to choose which approach or approaches might be more appropriate, depending on circumstances and need? And, importantly, how might key lessons from these approaches be brought together in a coherent way? One way to do this is to highlight the different types of contribution each school of thought can make at three different points in time of a change management effort.

The lessons from these three schools of thought can be brought together into the following matrix (Table 1.30), in which the three schools form the columns and the rows are three time periods in relation to a change intervention: prospective, real time and retrospective.

Change practitioners find there are a few times and occasions when a single column will offer the most valuable approach. However, on most occasions *all* of the three columns (schools) in the matrix are important to bear in mind. At each stage of the change process (the rows) there is one activity that naturally tends to dominate, and these are boxes: 1, 5, and 9. But outcomes are likely to be more successful if concepts from the other two boxes in the row are also utilised.

■ **Schools of thinking about change**

Table 1.30: Matrix to show the kinds of activities to be undertaken when managing change, drawing on the insights of three different schools of thinking.

TIME	STRATEGIC APPROACH		
	Deliberate *(analysis followed by plan and implementation)*	**Spontaneous** *(events, actions and behaviours emerge spontaneously from interactions)*	**Emergent** *(foster, craft, discover things, detect patterns)*
Prospective	**1** Undertake a strategic analysis, of the kind we have performed for Ashok above, that leads to a list of critical issues that need to be addressed, and some form of implementation programme.	**2** Encourage everyone who will be involved in the implementation to engage with the analysis, so that this understanding will later influence their behaviours.	**3** Identify the people with 'tacit knowledge', an authentic and intuitive understanding of the organisation, and involve them in the analysis. When you design the implementation programme, build in some review and reflection processes.
Real time	**4** Project manage the implementation programme.	**5** Along with everyone else, respond to events, cause unanticipated consequences, change plans (in ways which emerge in response to other unpredicted events), behave off plan, but with knowledge of the plan. Help others to behave in the spirit of the plan. (Note that the more association people have had with the plan – in Box 2 – the more their emergent behaviours will be within the spirit of the plan.) Be careful that the behaviours that emerge do not perpetuate existing inappropriate power structures.	**6** Make all your usual everyday decisions that appear to have little connection with the implementation plan. Take opportunities as they arise, but test them against the plan or the critical issues to see that they fit, and/or check with people with tacit knowledge to see their reaction. (The more authentic and intuitive the leaders are able to be the more the choices will be crafted to make best use of opportunities as they arise.) Reflect on what is happening, spot patterns as they emerge, and adjust the 'story' you are telling about the plan accordingly.
Retrospective	**7** Compare the actual events and outcomes with those of the plan, and with the analysis that led to the plan. This will help you to analyse and plan better in the future.	**8** Try and understand what actually happened and how, by considering the events and processes that emerged as time went on. This will give you a better understanding of the dynamics of the system and enable you to design development programmes that will influence the way people respond in the future.	**9** Tell stories: help people make sense of what has happened, by selecting some events and decisions and not others. (Note that the stories woven here are not accurate pictures of reality but simplified, coherent versions of reality, that can be told to multiple stakeholders.) This will enable you to impart a sense of meaning and of belonging to a longer narrative.

Source: Iles, 2003

Applying the matrix to the case

At Woodville we see that there has been a lot of activity in Box 1 (Seven S, PEST, SWOT). The steering group was brought into the analysis and design early on (Box 2), and Ashok found that people were able to envisage change more easily when encouraged into a creative state by imagining the future. However, people with greater longevity in the department whose tacit knowledge could have been valuable (Box 3) were not actively included.

The project plan (Box 4) was useful especially in the early stages, but what has carried the day over the longer term has been the flexibility with which the steering group could work in the spirit of the plan (Box 5) as new factors emerged, rather than being bound by the plan itself. Penny's tacit knowledge is not exploited, so on occasion things go unnecessarily awry (as would be predicted by Box 6). We could also predict from thinking about Box 6 that opportunities will be taken as they arise, regardless of whether they were foreseen in the plan; and that people will make sense of events by weaving them into a story. We saw both of these happening at Woodville.

The steering group have reviewed progress against the project plan (Box 7) although not as fully as might be helpful when designing a project plan in the future. Ashok has engaged in a bit of Box 9 when he wove a narrative for Paul that suggested greater prescience and intention than had in fact been exhibited. But, as is often the case, there is scope for much more reflection in Boxes 7, 8 and 9.

You may like to think about how Ashok could have used more of the boxes more effectively.

Concluding thoughts

The tools we have illustrated here form a sensible analytical pathway for anyone running a team, department or service. To be useful they need to be applied rigorously, perceptively and creatively, and when they are, they can yield valuable insights and a coherent agenda for action. The agenda developed in this way often allows a service leader to take account of external pressures and resource constraints without feeling overwhelmed by them. The same tools can be applied superficially and yield none of these benefits.

However, even where they are used well, there is a limit to the usefulness of any plans drawn up based on this kind of analysis, as we have seen. This kind of analysis and planning is necessary but not in itself sufficient. Concepts that are illustrated in some of the other case studies will also be needed by someone in Ashok's position.

■ Schools of thinking about change

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Managing *Change* in the NHS

Case Study 2:

Changing a team, from inside it

Community mental health trust (substance misuse service)

Overview

In this four-episode case a new member of staff without managerial responsibilities tries to find ways of initiating change. Episode 2.1 leads into a discussion and illustration of the *Five Whys* model, to arrive at ways of exploring change in the medium to long term. Episode 2.2 provides additional material for exploring models such as *force field analysis* and *stakeholder analysis* (also considered in Case 1 as *Commitment, enrolment and compliance* and *Readiness and capability*), to assess how change can be facilitated in the immediate and short terms. A look at what has happened in the service six months later in Episode 2.3 allows you to consider the value of a tool, *ladder of inference*, associated with individual and organisational learning. Episode 2.4 shows us what has happened a further six months on.

Approaching this case

The case is designed to be read in the following sequence. We suggest some places for taking breaks in the material, with indicative times.

Episode 2.1 Welcome aboard, but don't rock the boat – one week's events as seen through the eyes of a new member of staff	15 mins
Five Whys – an outline and illustration of the tool	40 mins
Experimenting with Five Whys – an opportunity to apply the tool to the case	15 mins
Illustration and analyses – a chance to compare your findings with ours	10 mins
	Total 80mins
Force field analysis – an overview and illustration of the theory and model	40 mins
Nina's diary notes – events over one month as seen and summarised by the new member of staff	10 mins
Force field analysis (cont.) – an opportunity to experiment with the tool, applying this to Episodes 1 and 2 of the case	20 mins
Illustration and analysis – a chance to compare your findings with ours	20 mins
	Total 90 mins
Stakeholder analysis – for an overview of the models to be used refer to Case 1, pages 59-63	25 mins
Experimenting with stakeholder analysis – an opportunity to apply the analysis to the case	20 mins
Illustration and analysis – another chance to compare your findings with ours	25 mins
	Total 65 mins
Episode 2.3 Six months later – a view of events as discussed by the mental health liaison worker with her action learning set colleagues	10 mins
Ladder of inference – an introduction to the tool, with an illustration	10 mins
Experimenting with the ladder of inference – another opportunity to apply a tool to the case	10 mins
Illustration and analysis – again, a chance to compare your findings with ours	10 mins
Episode 2.4 One year on – subsequent events as seen through the eyes of another member of staff	5 mins
	Total 45 mins

You may find it helpful to have access to *Organisational Change* (2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Note

The (HIDE | SHOW) icon refers to those parts of the electronic PDF version of the document where readers have the option to hide or show the text, depending on whether they want to stop and think before comparing their own ideas with ours.

If you prefer to display all the hidden text for the case, click on the 'Show all' button; similarly, if you wish to hide all the text for the case, click on 'Hide all'.

(SHOW ALL | HIDE ALL)

Main characters

Nina Cooraswamy – Mental Health Liaison Worker
Ed McIntosh – Service Manager
Chris Marshall – Team Leader
Suzi Henshall – Director of Mental Health Services
Paul Flowers – Drug Action Team (DAT) Commissioning Officer

Other characters

Shirley Fallon – CDAS Receptionist
Dave, Mark, Martin, Anthea – CDAS Team Members
Marina Klugkist – DAT Coordinator
Krish Singh – Pathways Project Director

Setting

A Community Drug and Alcohol Service (CDAS). The CDAS offers a range of prevention and treatment services for people with drug and alcohol problems, including out-patient detoxification, drug- and alcohol-free counselling, a mobile needle exchange, and various partnership projects with community agencies and the Criminal Justice system. Treatment targets and waiting-list times are set nationally.

Services are commissioned by the local Drug Action Team (DAT) and managed by a Community Mental Health Trust. The team consists of 12 staff, including a full-time Service Manager, a Team Leader, 7 Team Members, a part-time Social Worker and a Receptionist. A part-time Consultant Psychiatrist post has been vacant for a year; currently a local GP provides a prescribing service and limited medical cover.

A new full-time post of Mental Health Liaison Worker has recently been funded by the DAT with a remit of working with clients who have a dual diagnosis, of drug and alcohol misuse problems combined with mental health problems.[8]

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[8] 'The term "dual diagnosis" covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently'. Department of Health 2001. *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, Section 1.2.1.

Perspective

The case aims to illustrate how change can be achieved by an individual without managerial responsibilities working within a team.

Events in the case are seen mainly through the eyes of this one individual. Episode 2.1 limits itself to an account of events over a one-week period. Episode 2.2 contains notes and impressions from the same individual over the following month. Episode 2.3 contains an account of events six months on: again, by the same person discussing the issues in a group. Episode 2.4 looks at what has happened one year on, through the eyes of one of the other team members.

Please note that we do not discuss the impact of factors such as awareness of gender and race on the main character's choices and actions. However, we have written the case in such a way that an exploration of these issues could be fruitful, for example in relation to the support needs of individual change agents and the influence of institutional racism and processes of marginalisation on a change initiative. An example of such an exploration might be to consider how people in the case appear to make conscious and unconscious alliances with others on the basis of race and/or gender.

Tools chosen

- Five Whys
- Force field analysis
- Stakeholder analysis
- Ladder of inference

Episode 2.1:
Welcome aboard, but don't rock the boat

Community Drug and Alcohol Service

Nina Cooraswamy was really looking forward to starting her new job as Mental Health Liaison Worker at the local Community Drug and Alcohol Service (CDAS). After ten years of working in mental health services she was ready for a new challenge. She knew from experience that many clients with dual diagnosis issues did not respond to more traditional substance misuse treatments so she was excited about this opportunity to combine new skills with old, to develop and support flexible, client-centred models of care.

She recalled how quickly it had all happened: she'd seen the advert in the *Guardian* ten weeks ago, applied, and then been interviewed and offered the job the same day. The interview panel had consisted of the Service Manager, the Team Leader and a representative from Human Resources. They had explained that this was a new development, funded by the Drug Action Team (DAT)[9] to fit in with the National Treatment Agency's (NTA)[10] framework for commissioning treatment, known as Models of Care.[11] Although they were very upbeat about everything, she hadn't felt they had answered all her questions about what she would actually be doing, or how she would work with the teams in mental health and substance misuse. They had used a lot of terms she only vaguely understood and she hadn't wanted to show her ignorance lest it impact on her chances of getting the job. 'Oh well', she thought, 'I'll have a chance to check all that out with my manager during my induction.'

Monday morning

Nina set off early; although she had been asked to arrive at 9.30 a.m., she wanted to be in good time. At 9.10 a.m., Nina arrived at the CDAS to find it completely closed, despite a notice saying services open 9-to-5. She waited for 25 minutes before someone arrived. A harassed administrator called Shirley quickly introduced herself, and then proceeded to let them into a building that seemed on a par with Fort Knox. Nina asked Shirley why all this security was needed. She was met with an abrupt reply: 'Bunch of nutters round here, got to protect ourselves these days'. Nina was slightly shocked at this attitude but said nothing, thinking that she'd save her comments for her meeting with her new manager.

During the next half-hour a stream of workers arrived, some looking very tired: 'Out on the tiles again!', laughed Shirley. However, most managed a smile, and seemed pleased when Nina introduced herself. Several of them, however, made cheerful reference to the 'cavalry arriving'. 'Cavalry?', Nina wondered, 'Is that me?'. Another question for the induction meeting, she thought. Eventually, Service Manager Ed McIntosh arrived, flustered and apologetic, asking if Nina had received his message. Shirley yelled from Reception that

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[9] Drug Action Teams (DATs) bring together senior representatives of all the local agencies (including police, prison, probation service, primary care trusts, social services, education, housing and community safety from the local authority) responsible for tackling drugs misuse on a borough basis. Each DAT is supported by a co-ordinator and is accountable to the Home Secretary.

[10] A special health authority created in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

[11] A national framework for the commissioning of treatment for adult drug misusers.

she hadn't played the answer phone messages yet. It was 10.15 a.m.

Ed ushered Nina into his office, explaining that he had been called to an urgent meeting by Suzi Henshall, the Director of Mental Health, to discuss Nina's post. Openly, he told Nina how angry Suzi had been because she had not been kept in the picture about the post, and had even argued whether placing this post within the CDAS was the right way forward.[12] Ed scoffed that this was typical: 'Any whiff of new resources then senior management become interested all of a sudden. Ask for help any other time, they don't want to know.'

He reeled off a list of examples of what he clearly thought was unhelpful behaviour by Trust senior managers, and might well have continued in this vein had he not been cut short by a knock at the door. Team Leader Chris Marshall put his head round and asked if he could have a quick word. Ed left the room and Nina overheard a lively discussion about why Ed had forgotten Chris's supervision session for the second time in a row.

Ed returned red-faced and introduced the subject of Nina's induction process. He handed Nina a 4-week timetable which detailed meetings with Human Resources and a few other departments, and a couple of Trust statutory training days. When Nina asked what she was expected to do the rest of the time, he replied that it was up to her to make arrangements with fellow team members and other key services. Nina asked if she could go through the job description with him to clarify her role and responsibilities and how she would work with the rest of the team, but at that moment Ed's pager went off, and he quickly excused himself from the room to answer it.

When Ed returned he had Chris and Shirley in tow. He said he was going to hand over Nina's induction to them for a couple of hours and would see Nina later. Nina was shown around and introduced to a number of staff, and made appointments to see them in the week. At the end of the tour, she asked about the service's policies and procedures, and when she could go through them. 'Ah yes, the famous manual', Chris replied. 'I'm revising it at the moment, so you might spot a few gaps. I'll ask Shirley to dig it out.'

For the remainder of the day Nina read through sections of the policies and procedures manual, but found many of them too broad or unclear to be helpful to her. Many were also out of date. Nina suspected that Chris had yet to start proper work on them, and wondered how new staff usually found out what the service's current operating policies and procedures were. Perhaps they were covered in regular meetings or training days. Several team members came to introduce themselves during the afternoon and stayed for a chat. 'Friendly', thought Nina, 'just a pity that everyone seems to have a strong opinion about what I'm going to be doing in this job, and that they are all different, and certainly don't coincide with mine!'

When Ed returned at 4.30 p.m., he brought with him a copy of a service

'Friendly', thought Nina, 'just a pity that everyone seems to have a strong opinion about what I'm going to be doing in this job, and that they are all different, and certainly don't coincide with mine!'

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[12] Suzi may have cited the argument that integrated treatment can be delivered by existing mental health services following training and with close liaison and support from substance misuse services. Ed may have pointed out that some specialist dual diagnosis teams are based in substance misuse and include liaison workers.

specification for Mental Health Liaison Services, from the DAT. Implementing this would form the core of Nina's role. Nina read through it with mounting concern. She was sure it would take at least two people to deliver this specification, and she suggested as much to Ed. She had also assumed she would be working closely with the wider mental health services, but there was little specific mention of this. The 'spec.' also required ready access to medical back-up and Nina wondered how this would work out, as the CDAS had yet to replace the consultant psychiatrist who had left six months ago. Ed chuckled: 'Welcome to the world of drugs and alcohol, Nina. It's bound to seem chaotic at first. Rest assured, I'm on the case about the consultant. And of course you'll be in close contact with the mental health team. ... Now, I've just arranged for you to meet tomorrow with Paul Flowers, the DAT Commissioner, to discuss monitoring arrangements and performance indicators. I wanted you two to meet up a.s.a.p.'

Ed went on to explain that the DAT wanted to develop a set of performance indicators including such things as the percentage of clients accessing services, numbers engaging in treatment, how many are drug or alcohol free, and other areas of their life where positive changes have been made. Nina said she was familiar with the use of indicators but not in this field and would like somebody else be at the meeting with her. For instance, what counted as 'treatment', exactly? 'We could be here all day on that one!', Ed chortled, adding that he or Chris would be at the meeting. 'I think that's important', said Nina, privately unconvinced she would have that support.

Tuesday

It was obvious to her that the expectations of the Commissioner were far too high, given that her post was as yet the only specialist dual diagnosis resource for the whole of the Borough

Nina felt more positive when Chris took time to describe the service in more detail, clarified the CDAS's thinking about how to respond to Models of Care, and described how the service operated and linked with other providers. She also met up with Mark, the Outreach Worker, and he had some interest in using Nina's experience of assertive outreach to develop services for people not in touch with treatment services. Things started to make more sense and she went to sign for her set of keys, already feeling part of the team. After lunch, however, things took a different turn. Nina found the meeting with the DAT Commissioner quite overwhelming (in spite of the fact that Ed had arrived only slightly late). It was obvious to her that the expectations of the Commissioner were far too high, given that her post was as yet the only specialist dual diagnosis resource for the whole of the Borough. She was also increasingly worried that Ed had unwittingly agreed to provide this service too cheaply by not costing it realistically.

Nina drew on her experience of working with complex needs to try and raise her concerns about the mismatch of resource and DAT expectations. Once she had established that no further resources would be available she suggested that it might be necessary to review the performance indicators. Neither Ed nor Paul took up this suggestion and Nina wasn't sure whether this was because they hadn't heard her, hadn't understood her, thought the suggestion was naive, or didn't want to rethink. She felt ignored. In that state of mind she did not react happily when Ed presented her with a state-of-the-art notepad computer at the end of the meeting, for her to start collecting the data that would be needed to monitor performance against these indicators.

Wednesday

Nina approached Chris about the notepad, explaining she wasn't familiar with the software, and asked if she could she have some training on how to use it. Chris said he would try and arrange it, but his agreement seemed to fuel some resentment from two team members, Anthea and Colin, standing nearby. One of them said loudly: 'It's alright for some, special post, special privileges'. Chris took her to one side and apologised, explaining that there was currently some staff discontent about how posts were graded, resourced and supported.

Before Nina could respond to this, shouting could be heard from outside the main front door. A number of staff went out to see what was happening and Nina, Chris and Shirley followed. They found a client and a team member Dave engaged in a loud and angry slanging match, followed by pushing and shoving.

'Told you', replied Shirley, 'nutters'. She then returned quickly inside to answer the phone.

Meanwhile, the client at the centre of the commotion had run off. Chris had taken Dave to one side while remaining team members argued heatedly about what to do next: whether to call the police, whether to ban the client. Overall, there was a lot of sympathy for Dave, and anger at the client's behaviour: 'He's a head banger, I've seen him hanging about the day centre' (Anthea) ... 'Ban him and be done with it!' (Colin) ...

Nina tried to calm things down by asking whether there was a relevant operating procedure and, if so, what it said. Most looked at her if she'd come from another planet. Shirley quipped that the procedure was 'on the waiting list for treatment'. Then someone said sarcastically, 'I knew this would happen as soon as we had a dedicated Mental Health Worker, we'll have weirdoes like this turning up at the door every five minutes'. Someone else then brought up an incident from last summer when a mentally disturbed client had fired a starting pistol into the ceiling during a counselling session, 'as a joke'; no real action had been taken on that occasion either, apart from Ed reassuring everyone it was a one-off. Even so, Shirley had lost no time in having a reinforced glass security screen installed in Reception.

The fracas was the main topic of conversation for the rest of the afternoon; indeed it seemed to usurp any other activity. Everyone had his or her say, but no decision on further action was reached. Nina was surprised that Ed did not put in an appearance, and worried that Chris did not seem to be coping very well. She even wondered angrily whether Chris, rather than she, should have read the policy and procedures manual; he seemed not to be at all clear about what to do next.

She sought out Dave to find him still feeling badly shaken. He had been in post four months and this was his first experience of dealing with someone exhibiting bizarre behaviour and paranoid thoughts. Nina listened, sharing with Dave her own experiences of being in similar situations and how she and colleagues had dealt with them. As she did so she realised that Dave had had

Nina listened, sharing with Dave her own experiences of being in similar situations and how she and colleagues had dealt with them. As she did so she realised that Dave had had little training or supervision in working with dual diagnosis clients and certainly none in dealing with bizarre, aggressive or challenging behaviour.

little training or supervision in working with dual diagnosis clients and certainly none in dealing with bizarre, aggressive or challenging behaviour.

Thursday

By now many of those involved in yesterday's incident had calmed down. Ed and Chris met together and then called everyone into the meeting room. As the meeting got underway Nina became concerned that the possible causes of the client's behaviour were not being considered or fairly represented and said so. There was a mixed reaction with some, including Dave, nodding in agreement, while others continued to press for the client to be banned from the CDAS. There was even some hostility, with one member of the team asking whose side Nina was on, suggesting it would be different once she had a full case load of dual diagnosis clients to work with: 'Bet it will be a different story then.'

Nina firmly pointed out that this would not be the way she was working. She would not be taking over all the dual diagnosis clients, rather she would use her experience of working with people with mental health problems to support the team in working positively with their clients who presented with mental health symptoms. There was a stony silence in the room; some team members looked at Nina, then at Ed and Chris: 'That's not what you told us', they said. 'Let's talk about that later', said Ed, thanking them for their views and saying that he would let them know later in the day what he had decided about this particular incident.

Friday

After yesterday's meeting Nina started to ask herself some serious questions.

Was this normal or just bad timing? She couldn't understand how a service that was fairly well resourced overall, managed by an NHS Trust of some repute, could be in so much disarray. She had worked in the NHS for 10 years, and although things hadn't always been perfect, she'd never come across a service quite like this before. She briefly started to doubt herself, recalling Ed's comments that the substance misuse field only appeared chaotic to outsiders, wondering if it was her inexperience of this field that was making her feel despondent and frustrated. Then she quickly recalled the lack of clarity at the interview; the lack of a prepared induction; the misunderstandings about her role and responsibilities among the team; the attitudes of staff towards clients with mental health needs; the conflict between CDAS and Trust Management; and the unrealistic expectations placed on her new post by the DAT Commissioner.

Based on her experience so far, then, Nina felt that there were two main options open to her. She could leave quickly, and if the job wasn't 'doable' then she should do so. Or she could stay and try to make it work.

Based on her experience so far, then, Nina felt that there were two main options open to her. She could leave quickly, and if the job wasn't 'doable' then she should do so. Or she could stay and try to make it work, in the way she thought it could do. If she were to do the latter how could she approach it? As a new member of the team, what lay within her power to change in the situation? And who else might help her, and how?

■ Five Whys

'Why is this happening? And what can I do about it?'

If Nina decides to stay, how might she identify what lies within (and also outside) her power to influence and change for the better?

The case study illustrates a number of negative dynamics inimical to effective change: for instance, people avoiding dealing with issues, strong differences of views between staff members, envy and stereotyping. But these are likely to be symptoms of a problem rather than the underlying causes of it. If Nina is going to be effective in achieving change she needs to understand the underlying causes of the problems facing the CDAS. To do so she could try using a diagnostic tool called **Five Whys**.

Five Whys is a simple tool which is especially useful for single-problem events and for situations where the analyst is not sufficiently aware of the wider picture that would allow them to conduct a fuller analysis (of the sort described in the Case 1).

If a problem occurs, a first Why? is asked, namely: 'Why has this happened?'. A number of answers may be found. For each of these a further set of four Why? questions is asked: 'Why is that?'. The process is repeated until five sets of Whys have been asked and answered in each case.

The aim of Five Whys is to enable people 'to recognise the difference between an event-oriented explanation, and a systemic explanation' (Ross, 1994: 110). We explain this distinction further below.

An illustrative example of Five Whys is given in *Organisational Change* (Iles and Sutherland, 2001: 31). Another illustration is given in Table 2.1 below. In this, question 1 generates two answers which are then pursued through four further questions (2-5).

■ Five Whys

Illustration

Table 2.1: Five Whys

	Problem situation: a Community Psychiatric Nurse (CPN) complains that a pharmacist has been unhelpful and would not check the medication record for a patient in the CPN's care			
1	*Why did the pharmacist not check the record?*		The pharmacist was a locum who believed she was following the pharmacy department's procedure for dealing with requests of this kind. In fact she was interpreting the procedure too strictly.	
2	*Why was there such a procedure?*	A large number of requests had been received from CPNs and this was disrupting core pharmacy work	*Why did the locum misinterpret the procedure?*	The procedure had not been fully explained
3	*Why were there so many requests from CPNs?*	Psychiatric consultants are making amendments to the medication and failing to record this in the proper place	*Why had the procedure not been fully explained?*	The induction training for locums had fallen into disuse
4	*Why are the consultants failing to record their amendments in the proper place?*	They are unaware of the consequences of their not doing so	*Why had the induction training for locums fallen into disuse?*	Shortage of staff meant there were so many locums that senior staff had become disheartened at repeating the training so often
5	*Why are the consultants unaware of the consequences of their not amending the medication records?*	The CPNs find it easier to ask pharmacy than to ask the consultants – so the latter never experience the difficulties their actions cause	*Why had senior staff allowed the training to become less routine?*	It was a shared responsibility and no-one was held to account for it

■ Five Whys

To identify the changes to be made, answers to all the levels of the Whys are considered.

Here, you can see that if you were to make changes to address this complaint, the changes you would make might include:

- Ensuring the consultants are aware of the difficulties caused when medical staff do not enter medication changes in the records correctly
- Encouraging the CPNs to request any missing information first from the clinician who has failed to provide it
- Setting up a report system, so that consultants are informed of all incomplete medication records
- Allocating responsibility for the training of locum staff to a single named individual, perhaps rotated every six months.

These will be far more effective than chastising the pharmacist against whom the complaint has been made.

Experimenting with Five Whys

There is sufficient information in the case study to allow practice in using the Five Whys tool.

For example, take the following two presenting problems, each of which can then be treated to the Five Whys:

1. A member of staff, Dave, shouts back at a client exhibiting challenging behaviour and this leads to a fracas.
2. As a result of the fracas many staff members are keen to ban the 'nutter'.

Below we offer two illustrations of Five Whys based on these presenting problems. Before reading on, you might want to have another look at what happened on Wednesday and Thursday in the case study and **try out a Five Whys analysis of your own on these problem situations, identifying at which level or levels (2–5) in the analysis Nina might consider trying to intervene and effect changes.**

You will then probably want to compare your analyses and observations with ours.

■ **Five Whys**

Illustrations and analyses

One answer to the first Why? question 'Why did Dave shout back?' might be: 'Dave does not know any other way of handling this "bad" behaviour'. There may be several others.

Here we restrict ourselves to only one answer at Level 2. If you wish to pursue more than one the method is exactly the same for each.

Table 2.2: Five Whys

(HIDE | SHOW)

Problem situation: a member of staff, Dave, shouts back at a client exhibiting challenging behaviour and this leads to a fracas		
1	*Why did Dave shout back?*	**Dave does not know any other way of handling this 'bad' behaviour**
2	*Why does he not know how to respond appropriately?*	**He has not received any training, despite such training being required by the policy on handling challenging behaviour**
3	*Why is the policy not being followed?*	**It is new, introduced in response to an incident a year ago, and has not yet been built into the operational practice of the unit**
4	*Why has the policy not been operationalised?*	**Responsibility for doing so was given to Chris and he has not tackled it**
5	*Why has Chris not implemented this?*	**Chris is receiving irregular supervision and thus limited support in managing time and priorities** **There is a culture reinforced by senior staff (Ed and Chris) of not referring to policies in their decision-making and handling of incidents**

Now that she has a better understanding of the causes Nina needs to ask: 'At what level or levels (2-5) could I make any changes?'.

Nina cannot directly influence Level 5, the lack of supervision Chris receives from Ed, since this is the responsibility of someone else, a more senior manager. However, she can try and make supervision a priority by presenting convincing arguments for its benefits and by expecting it herself. She can intervene directly at Level 4, by taking responsibility for designing the training and building it into the service's training schedule. She has already intervened at Level 2 with Dave himself by offering informal supervision based on her own knowledge and experience of ways to manage critical incidents of this kind. She can continue to do this on an ad hoc basis.

Table 2.3: Five Whys

(HIDE | SHOW)

Problem situation: as a result of the fracas many staff members are keen to ban the 'nutter'		
1	*Why?*	They blame the client and have not considered the possible contribution of staff behaviour to the incident
2	*Why do they blame the client?*	They have limited understanding of dual diagnosis clients
3	*Why do they lack this understanding?*	They have had no training, and no challenge to the views they regularly express, so these views are reinforced
4	*Why has there been no challenge to their views?*	There has been no clinical leadership in this area because the consultant post has been vacant for 6 months
5	*Why has there been a leadership vacuum?*	Everyone has been waiting for a resource they are unlikely to find, and not taking any responsibility themselves in the meantime. We could characterise this as a culture of being reactive rather than proactive.

Here again Nina must decide where she can usefully intervene. She can do so directly at Level 3, by designing relevant training and gently but firmly challenging unhelpful views. She can also intervene at Level 4, by taking on a leadership role, spearheading action, influencing the way team members think about these clients. She may be inhibited by not having the formal leadership responsibilities but we know that leadership can be exhibited without formal titles. The cultural issue at Level 5 is something Nina can influence only slowly, by behaving proactively herself and challenging reactive comments.

In Tables 2.2 and 2.3 we can see that by the time the fifth Why? is answered the causes of the immediate problem have shifted from an *individual* (Dave) to *activities* (supervision in the Table 2.2, commissioning in Table 2.3). Five Whys allows us to home in on a recurring problem within the system. Hence, the tool works best when the problem is recurrent rather than one-off. In the case study all the signs are that Dave's experience is not an isolated incident, e.g. the previous incident and concerns expressed about physical safety.

The aim of the technique is to empower its users to be able to identify solutions that lie within their reach. If it is to have this empowering effect it is important to avoid both event- and blame-related answers. To avoid these hazards, especially if you are working with groups of people directly concerned, you may find it useful to ask: 'OK. Is that the only reason?'. This allows people to probe beneath stock explanations.

Taking the incident we have already worked on, let's look at two examples of how Five Whys could have been applied in an incomplete way and to lesser effect by sticking too closely to events and blaming individuals, respectively. The initial Why? is our first problem situation: Dave believes that shouting back at clients is an effective response.

Event-related analysis

Why? Because Dave regularly dealt with challenging behaviour in this way
Why? Because neither Ed nor Chris told him to behave differently
Why? Because the number of critical incidents has been under-reported
Why? Because neither of them have asked about these recently

Blame-related analysis

Why? Because Ed avoids the staff's development needs
Why? Because Ed is not managing staff supervision well and is unaware of these needs
Why? Because Ed spends too much time outside the service
Why? Because Ed is distracted by the organisational politics

In Tables 2.2 and 2.3 we gave a single set of answers at Level 2. In using the technique in real life with a group a number of answers might be put forward. If this happens you can ask participants to select the most plausible answer, perhaps by a show of hands or other voting method. Or you can pursue all the

answers in turn and then look to see if there are causes in common that occur across sets.

The majority of those contributing to a Five Whys ought to be familiar with the system in which they are operating. A group of mainly new staff or outsiders might identify a presenting problem but be stumped when it comes to potential causes. In our case example, Nina would need to do some subsequent reality-checking if she were to carry out a Five Whys by herself.

■ Force field analysis

Choosing goals and changes that have a good chance of success

Nina's appointment is evidence of the fact that considerable change is already underway within the CDAS: new resources, new staff, new models of care, new monitoring arrangements. There is a danger, however, that while the changes are addressing some problems, e.g. the need to meet national targets, they are leaving others, e.g. unhelpful staff attitudes and skills deficits, untouched. How then can Nina assess her chances of being able to influence and effect the kind of changes she wants to see? Another technique that can offer help in this situation, one which has been empirically tested over many years, is **force field analysis** (Lewin, 1951). Following is a résumé of its main principles and findings, based on Iles and Sutherland (2001: 43) and the Program Management Group (2004).

Force field analysis is a diagnostic technique which has been applied to ways of looking at the variables involved in determining whether organisational change will occur. It is based on the concept of 'forces', a term which refers to the perceptions of people in the organisation about a particular factor and its influence.
- *Driving forces* are those forces affecting a situation which are attempting to push it in a particular direction. These forces tend to initiate change or keep it going.
- *Restraining forces* are those acting to restrain or decrease the driving forces.

A state of equilibrium is reached when the sum of the driving (+) forces equals the sum of the restraining (-) forces.

Lewin formulated three fundamental assertions about force fields and change, which have been demonstrated empirically:
1. Increasing the driving forces results in an increase in the restraining forces; the current equilibrium does not change but is maintained under increased tension.

2. When attempting to effect change it is preferable to reduce the restraining forces because it allows movement towards the desired state, without increasing tension.

3. Group norms are an important force in resisting and shaping organisational change.

■ Five Whys

■ Force field analysis

A comprehensive force field analysis characteristically consists of the following stages:
- Define the nature of the change required, the 'desired state'
- Identify the forces driving (+) the change from the current to the desired state, and those restraining (-) it
- Determine the relative magnitude of these forces
- Identify 'polarising' forces where a change in one (+) may influence a change in the other (-) or vice versa. In other words, identify the points of maximum tension.
- Sort (+) and (-) forces in order of importance based on, e.g.:
  - their ability to affect more than one opposing force
  - the size of the projected impact (large, medium, small)
  - ease of implementation
  - likely response time for effect of impact
- Develop a plan of action to change the balance of forces that specifies how you will strengthen the relevant (+) forces and/or minimise (-) forces, with the greater emphasis on the latter.

Although the term 'force field analysis' sounds objective and quantifiable, the technique is concerned with the *perceptions* of people involved in the process and these are both hard to quantify and difficult to identify objectively, especially by people close to the situation. Often, too, those carrying out an analysis may have a limited awareness of what is going on outside the organisation (or their part of it) and may overlook the existence of important external drivers. To reduce the effects of bias and partiality, Lewin (1951: 235) and later proponents of the technique advocate the use of methods designed to include the perceptions of more than one individual and quantify these, for example by using rating scales or voting methods. However, the very subjectivity of force field analysis allows it to be valuable in the hands of perceptive individuals who can use it to structure their thinking and target their energies.

Some additional points about the method:
- Driving forces are not necessarily 'positive' in nature and restraining forces and not necessarily 'negative'.
- Force field analysis depends on careful *listening*.
- The means identified for dealing with the restraining forces need to be creative.

■ **Force field analysis**

Illustration

Below is a figure showing how to represent forces.

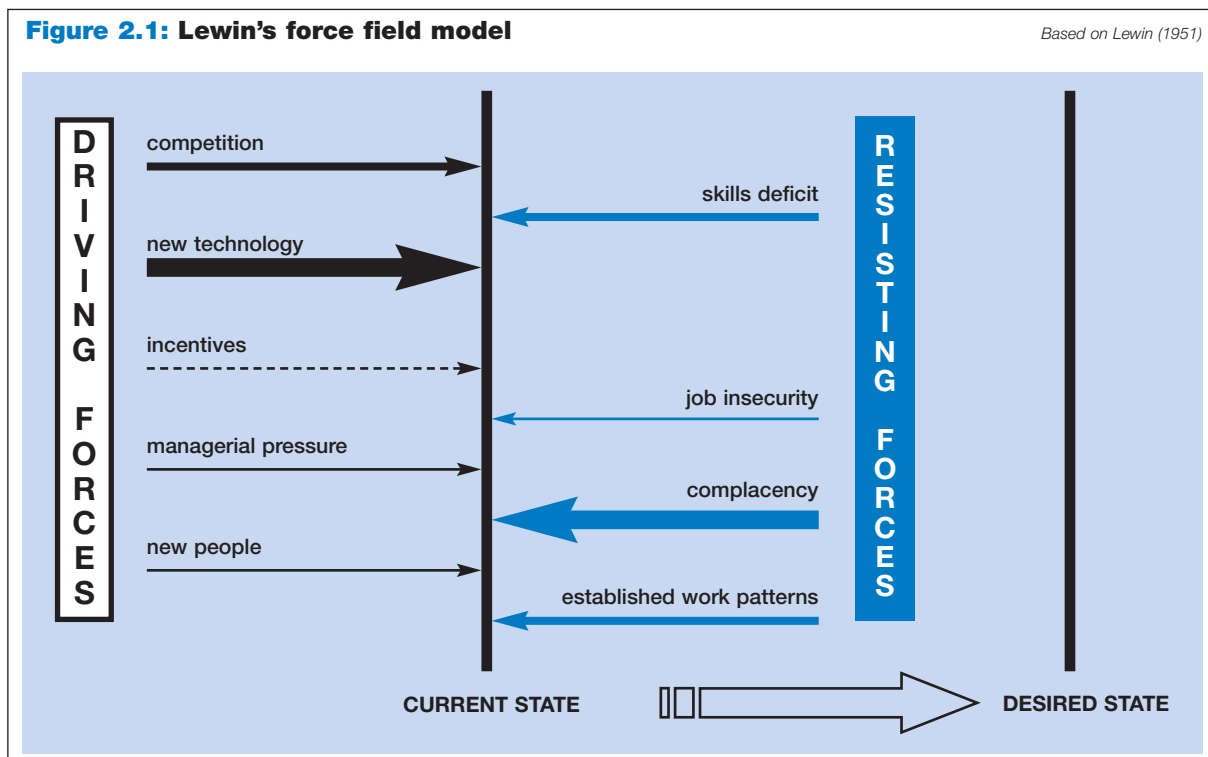**Figure 2.1: Lewin's force field model** — *Based on Lewin (1951)*

Figure 2.1 shows a state of equilibrium where the sum of the driving forces equals the sum of the restraining forces and change towards the desired outcome is not taking place. Looking at the restraining forces allows us to think about how to reduce them. In this case, for example, by skills training, by meaningful assurances about job security, by giving information that challenges complacency. We can see here, as Lewin suggested, that unless these restraining forces are tackled increasing the driving forces will simply lead to greater tension and not to change.

Force field analysis at the CDAS

Nina may find it very useful to identify the forces (the relevant factors and the perceptions held about them) that are active in her situation. However, before she can do so she will need to understand much more about the setting, recent past events and the wider forces affecting the service. Let us assume that by meeting with people within the Trust and outside, chatting with team members, asking pertinent questions of Ed and Chris, and generally keeping her eyes and ears open during her induction period, she finds out some useful information. In order to reflect on this information and put together an action plan, Nina decides to keep some running notes and observations in her private diary.

As you read through the following section, you may want to look out for the types, sources and relative strengths of forces that Nina is beginning to identify.

■ Force field analysis

Episode 2.2:
Nina's diary notes

End of Week 1

Talk about in at the deep end! I give myself four weeks max. to come up with the basis for a concrete, realistic action plan. It seems to boil down to managing the managers.

Issues to clarify in that time:
- Misunderstandings about my role, the service spec.
- Negative attitudes towards the clients – why? what can I do?
- **Ed's** relationship to the Trust and the DAT

Potential allies in **Chris, Dave** and **Mark**. I don't need to see myself as a knight in shining armour – or a damsel in distress.

End of Week 2

Meeting with **Marina Klugkist**, DAT Coordinator. Much more amenable than **Paul**. But under the same sort of stress, implementing Models of Care, attacking waiting lists, and the other priorities identified by the NTA they have to deliver on.

Seems the **NTA Regional Manager** set the ball rolling on my job. She called Paul a few months back to see what was happening with the mental health agenda. The DAT had received some feedback on this following the submission of their treatment plan.[13]

*Note: have a look at the treatment plan for 20--. It's online: http://www.—

Paul was snowed under, sorting out service specifications and contracts. He came into post less than a year ago, from Trust commissioning. DATs had been crying out for people with commissioning experience, it seems. Paul has no background in the drugs and alcohol field, or in mental health. That all figures.

Reading between the lines, Paul was planning to involve the SHA and local PCTs over my post but didn't have time.

Downloaded DAT Treatment Plan. Also had a look at the NTA's national analysis of previous year's plans. Under our DAT's 'Planning Grid and Investment Portfolio':
Implementation by all mental health and substance misuse teams of an agreed Integrated Care Pathway (ICP) for dual diagnosis.

What ICP? Must ask **Ed**.

Trust training day went really well. On mental health and employment: impact of new legislation and policy, models of occupational interventions.

To reflect on this information Nina decides to keep some running notes and observations in her private diary

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[13] Treatment plans outline how DATs plan to expand and develop treatment services in their areas. They are submitted annually to the NTA.

Very useful stuff. Varied crowd, good to meet people in the local mental health services face-to-face, including **Roland** in community who I'll be seeing a lot of. He says that they have had major problems with alcohol and cannabis use among some of their clients. They haven't handled incidents well. Haven't really given substance misuse education much thought. Staff 'don't have the time, don't see it as life-threatening'.

I was the only CDAS staff member present at the training.

Excellent speaker in the morning: **Krish Singh**, Coordinator of Pathways into Employment Project. Sharing findings of their innovative IPS[14] scheme. Went up and introduced myself and arranged a visit.

Afternoon. **Suzi Henshall** the Director made a brief appearance at the training. She asked how I was getting on. I had to tread carefully. She suggested I contact her PA to arrange a slot with her. I should mention this to Ed.

Visit to Pathways Project. **Krish** says proper dual diagnosis service is long overdue. He would like me to get involved in the IPS scheme. He's hot on user involvement. He says my post appeared under 'A.O.B.' at a DAT meeting. Krish had asked whether there had been any consultation with other providers or service users and **Paul** had given an evasive reply. **Ed** had added something about the user representative group being 'in limbo'. Someone from Probation questioned levels of resourcing and said it looked like a token gesture to keep the NTA quiet. Unhappy faces all round. Next Krish had heard about it was when he discovered the job advert in the *Guardian*.

If Nina is to identify the forces that are active in her situation she will need to understand much more about the setting, recent past events and wider forces affecting the service

Dropped into CDAS on way home. Good chat with **Chris**. He seems well liked and respected by staff. He acknowledges that the team does do some things well and are struggling to make changes in some areas of their work. There has been investment in additional staff but very little in improvement in CDAS accommodation and working environment. This seems to promote negativity within the team. He isn't convinced I can change **Ed** or **Paul's** way of going about things. Odd thing is, clinical governance, Models of Care, national standards, they are all there, so why are they not being felt at grass roots?

Trust Complaints Manager was in earlier in response to a call from Ed about last week's incident. Wish I could have been present. No client ban likely but recommendation that CDAS institutes some in-house training on management of challenging behaviour. Ed happy to hear that client has not made a formal complaint. I could put myself forward to help.

Chatting to **clients** in the waiting area. Overheard one making very rude comments about her GP. **Martin** (assessment team) was joining in, agreeing that this GP is 'a right berk'. I asked Martin later whether it's helpful to join in attacking other service providers in front of clients. He says I shouldn't take it so seriously, the client was under the influence of drugs. Clients can insult

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[14] Individual Placement and Support. Aims to get clients into competitive employment through rapid job search and time-unlimited support. Requires employment specialists who are part of the community mental health team.

him to his face as much as they like, anyway, he isn't going to burst into tears or throw a wobbly like Dave did.

Ed chatting to Chris and others in the kitchen area. Says Suzi circulated a memo about the Trust's vacant chair of the Equality and Diversity Working Group. She thinks Ed should be putting himself forward. Excellent development opportunity ... Cross-fertilisation ... I don't imagine Ed as the ideal chair, but I don't think that's why he is dismissing the suggestion.

Asked **Ed** in a quiet moment about the Integrated Care Pathway for dual diagnosis clients. He says it's been discussed 'vaguely'. Sees me as taking a lead. He remembers a group of service leaders doing one as an exercise at an NTA-sponsored briefing session. His went on to two sheets of flip chart paper! That's what convinced him that a liaison worker would be a good idea. Pity he seems not to have translated this insight into more realistic resources. This was before **Paul** broached the idea.

'Front-line staff feel more solidarity with the clients than they do with co-workers'

Spent afternoon with **Mark** (outreach worker), in the mobile needle exchange. Mark tells me he is an ex-user in recovery. Fascinating perspective on how he has made the leap from being helped to being a helper. No time for those members of the team who want to be 'chums' with clients (I think he means Martin). Chris aside, he seems to be the only one who recognises (or voices) the need for support and supervision for staff. He gets most of his from his recovery network.

He agrees with **Ed** that senior managers have little idea about what goes on in the service. One such came on a flying visit and said, sarcastically: 'Why do we need to give out free condoms as well as clean needles, can't people buy their own?' With attitudes like that, it's not hard to see why some front-line staff in the CDAS feel more solidarity with the clients than they do with co-workers in the Trust.

Spoke with a **parent/carer** of a client. She's at her wits end trying to cope with her son's paranoid behaviour and alcohol use. Says mental health and the CDAS are much too secretive about care plans and treatment: 'I only want to know what's going on, after all he is living under my roof'. Little involvement of families in CDAS, from what I can see.

Shirley says there are plans to relocate the CDAS to a purpose built site shared with acute services but they have ground to a halt. A local residents' association has been mounting a strong campaign against having 'junkies and pushers on our doorsteps'. Shirley says relocating would knock 30 mins off most people's journey times. She's all for it but the staff have got so used to being 'in the back of beyond' they quite like it.

End of Week 3

Bumped into **Paul** from the DAT by chance at the Probation Service. He says the NTA Manager was in the other day, and 'especially pleased' to hear I had started. He asked how I was getting on, and whether I had got my head round data collection. He then had to dash off before I could open my mouth. Again, I felt I was being brushed off.

Visited the **Community Mental Health team** again. Learned this time that they were the ones who had first complained to Suzi Henshall about not being included in the development of the post. I need to smooth some ruffled feathers here.

Overheard Chris telling Shirley that **Ed** is in trouble with Suzi again. The Trust has a Training and Development Strategy aiming to have all Service Managers complete the Diploma in Management Studies (DMS) by 20--. Ed presented Suzi with an alternative he had been mulling over and she authorised Ed to go ahead with this. Only, Ed missed the application date. Now Ed is the only service manager in the Trust not doing any management training at all.

Chris tells me 1-2-1 that Ed and Paul have had a bit of a falling out. Paul has refused to side with Ed against Suzi over my post. Paul says it was all Ed's idea to begin with!

Short meeting with **Ed** to touch base. More history.
- No money for my post had been allocated for developing services in the DAT treatment plan (I knew this already)
- Paul found some under-spend (where from, Ed didn't ask)
- Main reason for my post: it would look good for the DAT

Also, it would help Ed to start constructing the kind of mental health agenda he wants the new consultant – whoever that is – to slot into. Suggested to him that we need to include practitioners in the mental health services in our thinking before rather than after the event.

My view of Ed is changing. He can be so *disorganised*. But when he slows down, and sticks to specifics rather than going off at tangents he does make sense. He sees my job as a great opportunity to start tackling some of the unmet mental health needs of existing clients: depression, anxiety states, poor self-image. I think he's already begun to accept that I'm not 'another pair of hands'.

End of Week 4

Ed chatting about Suzi Henshall. His previous line manager went off sick and then left 2 years ago without being replaced. This explains why Ed reports directly to Suzi. Ed is disillusioned with top management. Rapid turnover of staff. Ed says Suzi is more enlightened in her attitudes, gets interested for a while and then moves on to other priorities.

I raised the critical incidents training issue. Offered to help. Ed keen, suggests I get together with Chris. Discussion about training needs generally. Ed is suspicious of new-fangled training ideas. He says he came a cropper with process mapping. He was introduced to it at an NTA briefing session and later tried it out with the team. It went down like a lead balloon. I suggested it might be because people in the service aren't quite ready yet to think they can introduce change. He seemed to take this on. I feel I am offering Ed supervision and support rather than vice versa.

Meeting with **Suzi**. Shorter than planned, she had another meeting to go on to. Lots of questions about the team I came from and then about the CDAS and the DAT.

'Reviewing what I noted down in Week 1 – what have I found out?'

'If only people didn't have such a "go-it-alone" attitude' (Suzi). My main points:
- I see myself as being based in both the CDAS and mental health, although technically I am in the CDAS
- I want the post to 'add value' to services overall – already have ideas for doing this
- The service spec. is 'probably' too ambitious (had to choose words carefully)
- I'm trying to work with Ed and Paul on this issue.

She agrees with all the above. But I get the impression she is not convinced that the CDAS itself (rather than me personally) can deliver.

Reviewing what I noted down in Week 1
- *Misunderstandings about my role, the service spec*
  Lots of confusion still, mainly inside the service and DAT, some outside. This really is the thing to sort out. Do I have a clear aim to present as an alternative goal? Who can help me achieve it?
- *People's attitudes towards clients*
  Some of these are worrying, negative, stereotyped, lack of boundaries. Chris and Mark seem to be the exception. Work for the long term here, though keep challenging as and when.
- *What's going in with Ed and the Trust?*
  Lack of consistent support, supervision, leadership. Again, not a lot I can do to influence this short term, but I need to keep my eyes peeled.

■ Force field analysis *continued*

Experimenting with force field analysis

Having gained some important background and contextual information, Nina is now ready to carry out a more informed force field analysis. We presume that conducting even a limited analysis based on information available to her could be empowering. She will need to:

- identify the main driving and restraining forces
- sort these in order of importance, focusing on those she thinks she can influence
- develop an action plan designed to maximise and/or minimise the forces she sees as the most important, in order to reach her goal.

Using Figure 2.1 as a prompt we can see that if Nina were to undertake this analysis she would first need to identify an appropriate 'desired state' which her change efforts will aim to achieve.

In Case Study 1 (page 33) we look in more detail at the importance of having an underlying mission or goal for a department or service. In Nina's case this goal or mission might be an expanded version of what she explained to staff in the Thursday meeting with staff during Week 1:

To enable the staff working in mental health and substance misuse services to work positively with their clients who present with both substance misuse and severe mental health problems.

This could be rewritten as a 'desired state'.

Staff working in mental health and substance misuse services have the skills and support they need to feel able to work positively with their clients who present with both substance misuse and mental health problems.

Reflecting as dispassionately as possible on the current state Nina might articulate it as:
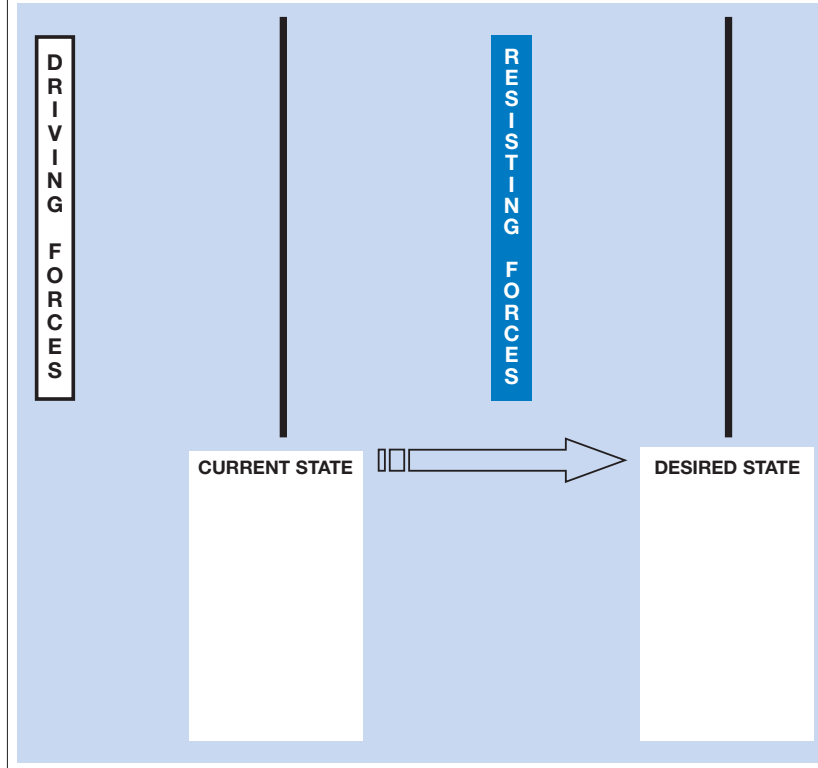
Staff working in the CDAS team have no understanding of clients with mental health problems and do not know how to support them. As a result they have negative attitudes towards them and frustrate both themselves and their clients.

You may now like to attempt a force field analysis, from Nina's perspective, in the empty figure provided, and then compare it with the one following.

Experimenting with force field analysis

Figure 2.2: Nina's blank force field analysis *Based on Lewin (1951)*

You may like to use the forces given in Figure 2.1 as a starting point:
- crossing out any of the driving and restraining forces that do not apply
- adding any other driving or restraining forces that might apply.

Or you may prefer to start afresh. Either way, once you have listed all the forces you will need to:
- **gauge the relative strength of the forces** and represent this by the thickness of the arrows
- **assess** whether the sum of the driving forces or the sum of the restraining forces is stronger, or whether the sums are roughly balanced, and thus what kind of change if any is likely to occur without any intervention from Nina
- **identify possible action Nina can take** that will change the balance so that progress can be made towards the desired state.

■ Force field analysis

Illustrations and analysis

Which forces apply?

Let's show these as forces on an expanded and slightly modified version of Figure 2.1, filling in the desired and current states, and describing these forces and those below, and indicating their strength with the thickness of the arrow.

[HIDE | SHOW]

Figure 2.3: Nina's completed force field analysis

Based on Lewin (1951)

DRIVING FORCES

- pressure from centre
- parallel models
- opportunities for development
- Interest of Trust management
- tools and frameworks
- research evidence
- commitment to change
- pressures from clients and carers
- clinical audit tools

RESISTING FORCES

- workload
- ignorance
- complacency
- unnattractive career opportunities
- unrealistic expectations
- autonomy and isolation

CURRENT STATE
Staff working in the CDAS team have no understanding of clients with mental health problems and do not know how to support them. As a result they have negative attitudes towards them and frustrate both themselves and their clients.

DESIRED STATE
Staff working in mental health and substance misuse services have the skills and support they need to feel able to work positively with their clients who present with both substance misuse and severe mental health problems.

■ Force field analysis

Driving forces

(HIDE | SHOW)

- *Pressure from the centre* to further the mental health agenda; to meet performance targets – manifest in DAT, NTA, Models of Care
- *Interest of Trust management* in performance for these clients
- *Pressures from clients and carers* to offer a more responsive service
- *Research evidence* demonstrating good outcomes for dual diagnosis clients when both diagnoses treated appropriately
- *Clinical audit tools* which would demonstrate poor services for dual diagnosis clients
- *Parallel models*: ways of working used in other dual diagnosis groups
- *Tools and frameworks* for thinking about deploying resources effectively and efficiently
- *Tools and frameworks* for thinking about learning organisations
- *Commitment* of staff to clients with substance misuse problems
- *Opportunities for developing* new skills and career advancement.

Restraining forces

(HIDE | SHOW)

- *Workload:* team members feel overloaded with single diagnosis clients and do not want to have the additional burden of dealing with clients with mental health problems
- *Established work patterns:* procedures have been developed for clients with a single diagnosis, dual diagnosis will require new ways of working, and working with another team, with all the implications for challenge, accountability and loss of autonomy
- *Ignorance, unchallenged negative attitudes and assumptions* towards clients with mental health problems; skills deficits; poor handling of challenging behaviour
- *Autonomy and isolation:* CDAS works independently and sees itself as uniquely on the side of clients
- *Complacency, self righteousness and blame:* a belief that CDAS is doing a good job, that the problems are all the fault of funders or managers. Lewin himself observed that 'One of the causes of resistance to change lies in the relation between the individual and the value of group standards' (Lewin, 1951: 234); and 'As long as group values are unchanged the individual will resist changes more strongly the further he is to depart from group standards' (228). Thus changing the culture is often an important aspect of change.
- *Unattractive career opportunities* at consultant level; absence of medical leadership and advocacy.

■ **Force field analysis**

Most powerful forces?

You will see we have suggested the most powerful forces are, in order:

Driving forces

(HIDE | SHOW)

- External drivers at national and strategic level, leading to managerial pressure at DAT and service levels. This seems to be the strongest driver.
- The Trust Directorate may be an important driver (Nina needs to gain further information about this)
- Commitment of staff to clients will also help drive change
- Existence of successful models for dual diagnosis clients in other related fields will also assist, as will research evidence
- Staff have inured themselves to pressure from clients and carers so this is less significant as a driver but does add to the pressure
- Tools for knowing (audit), learning and reorganising are all valuable means of achieving change and their very existence and use elsewhere is a driver.

Restraining forces
The first three of the following restrainers are very significant but may be thought of as different symptoms of the same underlying problem. The unrealistic expectations are particularly important for Nina who is, after all, conducting this analysis.

(HIDE | SHOW)

- Workload: real or perceived
- Ignorance, negative stereotyping of mental health clients, and skills deficits in interacting with them
- Complacency, self-righteousness and blaming of others, because of isolation
- Unrealistic expectations of the new post
- Lack of leadership
- Established work patterns.

Balance of forces?

At present there is a state of equilibrium or stasis. Why is this? And what inferences should Nina make?

(HIDE | SHOW)

Very little is changing. This is interesting because there has been a significant increase in the driving forces especially from the centre and the trust; so the restraining forces must also have increased. As a result, tensions have increased. Staff are feeling even more overloaded, more victimised, more isolated, more resentful and more ready to shift the responsibility onto a new post holder than they may have been before these pressures. Nina is not in a position to increase any managerial pressure but, even if she were, this would not be the way to

■ Force field analysis

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approach it. She needs to look at ways of reducing the restraining forces. She could also look at the driving forces that are potential means of achieving change, to see if these could be valuable. So the tools for auditing, experimenting, learning (including process mapping), reorganising (many of the tools from the Modernisation Agency, for example) could come in useful. She must heed the learning from the unsuccessful process mapping incident though: unless she addresses the restraining forces she will not find a receptive context for the use of these tools.

Actions Nina can take

Now Nina needs to identify actions she can take to tackle the restrainers. She might for example think of the following.

Table 2.4: Nina's action plan

HIDE | SHOW

Restraining force	Actions I can take to deal with this
Workload: real or perceived	Be proactive, go in and help with clients as soon as I think they have a mental health problem, don't wait to be asked
	Take a lead with the in-house training, for example, but avoid appearing to preach at people
	Be effective: by using skills well keep the client calm and enable interaction to be shorter and with a better outcome
Ignorance, negative stereotyping of mental health clients, and skills deficits in interacting with them	Demonstrate good use of skills, respond to requests for training/shadowing, challenge any negative stereotypes (humourously, gently) immediately, help team achieve good outcomes with mental health clients
	Challenge Martin more effectively
	Find a non-patronising way of dealing with Shirley's negative one-liners, they really set a bad tone

Table 2.4: *continued*

Restraining force	Actions I can take to deal with this
Complacency, self-righteousness and blaming of others, because of isolation	Stay positive, don't gossip, use newness to be able to take every statement at face value and question or challenge it Introduce mental health team workers to the team, find reasons for joint working. Stay in touch with Suzi.
Unrealistic expectations of the new post	Develop convincing arguments for doing things my way Demonstrate (without blaming) that doing it their way doesn't work – look for examples of what other Trusts and DATs are doing Keep Suzi on side, she sees things the same way – don't undermine Ed and Chris though or that will make things worse Keep calm, and firmly but gracefully resist pressure to take on tasks that are inappropriate
Lack of clinical leadership	Fill the gap: by guiding perceptions, improving skills, increasing integration with other services – we may make the service attractive enough for a consultant to want to come and join it!
Established work patterns	Develop really workable protocols, discuss them with everyone to test them out, offer them as an option rather than trying to impose them

Without trying to frighten Nina off, we should encourage her to take care. You will see that the actions we have suggested she might take are ones that can only be helpful. If her analysis had indicated that she tackle something much riskier, then we would caution that she may not have been in post long enough to understand all the drivers and restrainers and that she should not take such a career risk until she has.

Different people will identify different drivers and restrainers, and the value of the analysis will depend on how well they understand the situation, and how

■ **Force field analysis**

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perceptive they can remain, when they are in the midst of a situation themselves. In Case 1 we demonstrated how different people could use the same tool (SWOT analysis) but derive very different results. You may like to experiment with a force field analysis from Ed's perspective, for instance.

The fact that people will have different assumptions and world-views means surfacing and considering these is important. Conducting this type of exercise in pairs or a group provides an opportunity to allow this to happen, to facilitate development of consensus and reduce the impact of individual bias on results, e.g. by using rating scales or voting.

■ Stakeholder analysis

In the course of her four-week induction period Nina has met many of the people who have a stake in the effective delivery of her role. These will have included: users/clients; carers; DAT Commissioner and Coordinators; mental health staff and services Director; local Primary Care Trusts; social services; clinicians (including GPs) and clinician's groups; police, prisons and probation; and support services for vulnerable people. She can begin, now, to analyse how to interact with them individually in order to achieve the changes she sees as necessary.

The analysis Nina undertakes is similar to that of Ashok more fully described in Case 1 in the sections on Readiness and capability and Commitment, enrolment and compliance (pages 59-63). You may wish to read or re-read this first and then revisit Episodes 2.1 and 2.2 of the current case study, identifying implications that arise when looking at the same material with a different framework.

Experimenting with stakeholder analysis

Before Nina starts the analysis she must be clear about the change that she is trying to achieve. Let's look again at what Nina decided in 'Force field analysis', page 100.

Nina wants to work towards a situation in which:

Staff working in mental health and substance misuse services have the skills and support they need to feel able to work positively with their clients who present with both substance misuse and mental health problems.

■ Force field analysis

■ Stakeholder analysis

Experimenting with stakeholder analysis

The current state is one where:

> *Staff working in the CDAS team have no understanding of clients with mental health problems and do not know how to support them. As a result they have negative attitudes towards them and frustrate both themselves and their clients*

Thus the stakeholder analysis serves to identify which people and agencies are likely to support or impede the movement from the current state to the new one.

You might like to look again at the description of the stakeholder analysis on pages 59-62 and conduct one from Nina's perspective in the empty tables that follow.

Table 2.5: Identifying whose support is needed

Stakeholders	Must actively champion	Must acquiesce	Have little influence

Managing
Change
in the NHS

Experimenting with stakeholder analysis

Table 2.6: Readiness of stakeholders

Stakeholders	Are ready to champion	Are adamantly opposed	Going along with the majority

Table 2.7: Capability of stakeholders

Stakeholders	Have the skills and arguments to be able to champion	Are not yet in a position to champion

■ Stakeholder analysis

Illustrations and analysis

We have reasoned as follows.

Table 2.8: Identifying whose support is needed

(HIDE | SHOW)

Stakeholders	Must actively champion	Must acquiesce	Have little influence
Ed	Ed is so disorganised that the team do not rate him highly so he is not influential within the team. However, he has links with very many other people and organisations and must be able to persuade them to play their part.		
Chris	Chris is a major opinion former with the team, so his active support for the change will help Nina significantly		
Suzi	Suzi has a remit which means she can open doors for Nina and especially encourage joint working with the mental health teams		

■ Stakeholder analysis

Table 2.8: *continued*

Stakeholders	Must actively champion	Must acquiesce	Have little influence
Paul		Paul must not oppose the change, and must be able to describe the benefits of the change to his organisation when asked, but is too busy and not sufficiently close to the CDAS to have a major influence on the outcome	
CDAS team members, including Dave	There are bound to some team members in each of the columns	Over the next few weeks and months Nina will need to find out who is in which	She may find it helpful to think in terms of commitment, enrolment and compliance (see pages 59-62)
Mental health team members	Ditto	Ditto	Ditto
Service users and families/carers			Feel they have little voice at present

As we see in Case 1 (pages 59-62), in any team there are likely to be people who will never be enthusiastic about the changes being proposed, and Nina will find it useful to identify the levels of enrolment, commitment or compliance she can realistically expect different team members to adopt.

■ **Stakeholder analysis**

Managing
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Table 2.9: Readiness of stakeholders

(HIDE | SHOW)

Stakeholders	Are ready to champion	Are adamantly opposed	Going along with the majority
Ed			Ed has not really thought this through and is being driven by the wishes of those around him
Chris			Chris has not been exposed in depth to the idea of working in the way Nina wants to see
Suzi		Suzi is antagonistic to the CDAS team because of their isolationist tendencies. However, she is in favour of the model Nina is proposing. She will need persuading that CDAS can deliver but could then be evangelical about it.	
Paul		Paul has a problem (meeting the NTA targets) and thinks he has solved it by paying for an extra pair of hands. If Nina moves into a training and consultancy role he fears she will be less useful.	

■ Stakeholder analysis

Table 2.9: *continued*

Stakeholders	Are ready to champion	Are adamantly opposed	Going along with the majority
CDAS team members, including Dave		Team members feel overloaded, undervalued, and resentful. They do not want to think about doing things differently, they want Nina to come in and take some of their problem clients away from them.	
Mental health team members			Mental health team members have clients with substance misuse problems and know they do not handle them effectively. They can see the benefits of working with CDAS but do not want to increase their own workload to do so. They haven't thought about it enough to actively support or oppose.
Service users and families/carers			Not included or consulted at present in decisions

■ Stakeholder analysis

Table 2.10: Capability of stakeholders

(HIDE | SHOW)

Stakeholders	Have the skills to be able to champion	Do not have the skills to champion
Ed		Ed will need persuasive arguments to use with Paul and with Suzi. Currently he has not thought about their perspectives nor paid enough attention to the issue to have formed a view. Nina will need to help him understand Suzi and Paul's concerns and objectives and give him the arguments he can use with them.
Chris	Chris is well liked by the team and has the skills to enthuse them. However, he is not yet convinced of the benefits of Nina's suggestions.	Nina will need to show him how her suggestions will benefit team members as well as their clients
Suzi	Suzi has the skills to sell this idea to the Board and to other relevant parties, but is not yet convinced CDAS will be able to deliver	Nina will need to assess for herself CDAS capability (because she herself doesn't want to work with a team that can't deliver) and help Ed and Chris to reassure Suzi
Paul		Paul needs to be convinced that the new arrangements will help him meet NTA targets
CDAS team members, including Dave		Team members need to be convinced that there is a problem with their current approach to dual diagnosis clients, and have confidence that the changes will make life easier/better for them as well as for their clients. It must not lead to more onerous bureaucratic arrangements.

■ Stakeholder analysis

Table 2.10: *continued*

Stakeholders	Have the skills to be able to champion	Do not have the skills to champion
Mental health team members		Mental health teams are not convinced CDAS are interested in their clients or concerns. They will need to be convinced that liaison will yield benefits and not just a lot of meetings.
Service users and families/ carers		Might be empowered with Nina's arrival to have more of a say in how services are run for their benefit

Nina now knows who she needs to target, and what she needs to achieve with each of them. In order to persuade these stakeholders Nina will need to pick up clues about the kind of things that motivate them, so she can use arguments that appeal to them, just as Ashok needed to in Case 1. Like him, she will also benefit from noticing the behaviours they adopt themselves, and adjusting hers to complement theirs, so that they find it easier to hear what she has to say because they are not unwittingly antagonised by the way she speaks or the attitudes she displays.

Let's now see what happened to Nina sixth months later.

■ Stakeholder analysis

Episode 2.3:
Six months later

Nina's action learning set

Nina sat with her six other action learning set[15] members and the set facilitator at their fourth meeting together. Today was Nina's first 'airspace', her opportunity to present a problem about work. Joining the set had been Suzi Henshall's idea originally, and after Nina had presented a good case to Ed he had agreed. It had taken Nina a while to adapt to the specific discipline imposed by the set: allowing time for space and silences; not judging or giving advice; asking open questions that encouraged the problem presenter to think differently about their problem and about approaches and resources, and not offering solutions. But everyone had found this difficult; indeed, according to the facilitator every new set took time to develop the skills and discipline that allowed it to be really valuable, and it had come easier to Nina than to some other members, partly due to her previous experience of facilitating therapeutic groups.

Everyone in the set was an experienced practitioner in health or social care: mental health nursing, physiotherapy, pharmacy, speech and language therapy, the voluntary sector, and social services. The facilitator, Janice, was highly experienced in this model of action learning, and Nina knew that Janice was also a member of a learning set herself, and considered it important to be so.

In spite of their different roles Nina had learned a lot from the exploration of other people's problems. So many of them had parallels in her own situation: team members who were difficult to get on with, managers or commissioners who were unsupportive, colleagues from other teams or agencies who wouldn't cooperate. Until now Nina had been happy to let others with more pressing needs bid for the time available, but today she wanted to work on a problem of her own. And the problem was … the DAT Commissioner Paul. She started her presentation:

'My post was created to get the DAT commissioner off the hook. The DAT had just had feedback on their treatment plan from the NTA, and been told they had to do something about substance misuse clients who also had mental health problems. So they found some money and appointed me, to sort it all out for them. Actually no, not to sort it out, but to see all the clients and collect all the statistics and, well everything. Of course, it was a job that simply couldn't be done – and a job that shouldn't be done. This is not the best way to deal with these clients.

'Well I nearly left straight away, but instead I did some thinking and worked out what was needed. I also thought about who I needed to persuade of the virtues of my approach and I've been working very hard on doing just that. And I've succeeded with almost everyone. Of course, there are some people who don't like what I'm doing but there always will be, and I'm not worried

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[15] A group of usually 4-8 people who meet on a regular basis to discuss issues of personal or mutual importance. Sets are designed to deal with specific needs of members and require agreed action by the end of each meeting. Proceedings are confidential to the set. For further information see Gaunt (1991) and Pedler (1991).

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about them, except for Paul. He is causing such problems. Only interested in things that aren't important: data mostly. Whenever I hear his voice on the phone I know what's coming next: "Nina, have you got the returns for last month?". He never shows the slightest interest in clients, or in how the overall service is going, only in numbers.

'I don't care about what he thinks, very much, but now he's beginning to cause trouble. He's told Suzi Henshall that I should go back to the original job description, and says that if I don't he is not going to approve continued funding for the post, he will spend it somewhere else. Honestly, everything else is going so well, the CDAS team members are really tuning into the needs of these clients and are coming up with all sorts of ideas about how to improve the service they receive. They call me in as soon as they feel they can't handle a client, and I notice they are calling me less and less. The mental health teams are referring much more appropriately and are maintaining an involvement instead of washing their hands of them as quickly as they can. I really feel that's down to the work I've been doing. And it's all threatened because of this one individual who just isn't interested in the quality of the service, only money and figures.'

They drew on their own experience to frame questions that they thought would prompt Nina to think differently, to see the problem in a new light and to think creatively about how to approach it

The others listened carefully, trying to understand the problem as Nina saw it, and felt in it. They needed to ask some questions to clarify the situation, just to make sure they understood where Suzi fitted into the picture, what the organisational connection was between Nina and Paul, the size of the client group Nina was concerned with and so on. Then they moved into a different kind of questioning mode. By carefully refraining from anything that might sound like 'If I were in your shoes', they drew on their own experience to frame questions that they thought would prompt Nina to think differently, to see the problem in a new light and to think creatively about how to approach it.

Among other things they asked Nina to describe her early meetings with Paul, how she had felt at those meetings, how she thought Paul had felt, what Ed's attitude to Paul was, whether she could think of anything really positive Paul had done, how Paul's performance was monitored, what pressures he was under. They also asked her about how she had been so persuasive with others, Suzi for example. Perhaps the most difficult moment was when one member asked:

'What does Paul really care about? How does he describe his job when he's asked about it by friends?'

'Oh he only cares about money and numbers', Nina retorted, 'I've told you that.'

No one spoke and the facilitator smiled at her. 'You did tell us that, do you really mean it?', she asked.

In the silence that followed Nina felt foolish, that she had given the 'wrong' answer. She wanted to get back to being respected by the rest of the group,

but she also didn't want to waste her own time by not being honest. In the end she said, 'No, he does care about clients, he wants as many as possible to be treated well, and he knows that if he can't show he's meeting the targets we'll all lose resources.'

With the help of further questioning she developed a different perception of Paul, a different view of her ability to persuade him, a realisation that she must challenge Ed's view of him too. Eventually when Janice asked her to outline the steps she would take before the next set she was able to list four concrete actions she would take. What was more she knew she would do them, because she would report back on them at the next set, and if they had not been as successful as she hoped, be able to explore with the others what she had learned from trying, and what else she could do.

When the members reflected on the process of today's set Nina was reassured that everyone had found it valuable and that they would use some of the lessons she had learnt in their own settings.

'This is so helpful for someone like me', she thought. 'Without some kind of support, I think I might have burned out by now.'

She developed a different perception of Paul, a different view of her ability to persuade him, a realisation that she must challenge Ed's view of him too

■ Ladder of inference

Nina has only recently begun to identify a long-standing problem which she ignores at her peril: her negative perceptions of Paul. She may or may not be interpreting Paul's latest intentions towards her post correctly, but one thing is sure: her perceptions are based on certain invisible assumptions about how Paul thinks and feels. Nina therefore now realises that there is a risk of misunderstanding Paul, of jumping to the wrong conclusion, and of sinking into victim/blaming mode. This threatens to undermine many of her hard-won achievements as well as her continuation in post. To avoid this type of defensive reasoning, and to begin to formulate a different type of response, she needs to explore how she interprets Paul's actions. She can do this by bringing to light the assumptions she makes when rationalising Paul's behaviour and challenging these where necessary.

In the context of the learning organisation, Senge *et al*. (1995) have set out to demonstrate the importance of **mental models**.[16] Challenging our mental models – one of the functions of action learning sets, for example – requires us to refine our skills in reflection and inquiry, to increase awareness of reasoning as we move from observable data to a choice of action. Often we jump from observable data to contemplated action – c.f. 'Paul is threatening my job, all Paul cares about is saving his own skin, I'd be letting my clients down if I were to give in to Paul' – when we could usefully take time to think through the assumptions and inferences that lead to the way we respond.

One tool designed to help practise the discipline of mental models is the **ladder of inference**. This is a tool first developed by Argyris (1990) and elaborated by Senge *et al*. (1995). Nina might well have been introduced to the theory and practice of individual and organisational learning (including the work of these authors) as part of her action learning set.

The ladder of inference breaks down the jump from observable data to choice of action into a number of 'rungs' on a conceptual ladder. Argyris (1990: 88–89) states that: 'The ladder of inference shows ... that evaluations or judgements people make automatically are not concrete or obvious. They are abstract and highly inferential. ... The ladder of inference helps us to explain ... defensive reasoning'.[17]

Theorists and practitioners differ over the exact number of rungs we run up in the process of thinking on autopilot but these usually include the following:
1. Observe data
2. Focus on the data you wish to use, ignoring the rest
3. Construct a meaning for the chosen data, based on your personal and cultural beliefs to construct meaning for the data
4. Make one or more assumptions, using the added meaning
5. Draw conclusions from your assumptions and selected data
6. Use the conclusion(s) to adopt personal beliefs to use now and/or in the future
7. Select a course of action which is based on your beliefs.

■ Ladder of inference

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[16] For more about mental models and learning theory see 'The Learning Organisation', pages 162-172.
[17] For more about defensive reasoning see pages 131-132.

See Table 2.11 for a simple illustration of the ladder of inference, showing two alternative ways of perceiving the significance of the same event: a Trust manager arriving late for an important group meeting which you are chairing. (*Note*: you need to read the ladder from the bottom upwards.)

Table 2.11: Ladder of inference

Take action based on personal beliefs	Avoid scheduling important business at the start; summarise the discussion for John; have a quiet word with him after	Start and finish meetings on time; stick to the agenda; remind everyone of starting times verbally and in writing
Adopt personal beliefs to be used in the future	It's vital to include John in decisions, even if this means over-running or keeping the others waiting	I don't want to waste everyone's time or look ineffectual by making allowances for just one person, however important
Draw conclusions	John can't be expected to arrive on time	John will continue to arrive late if I let him
Make assumptions using the added meaning	John must have had an emergency to deal with	John knew when the meeting started and was deliberately late
Use personal and cultural beliefs to add meaning	Trust managers lead very busy lives	John does not sufficiently value the importance of the meeting or respect my status in running it
Select the data	No one seems to mind John being late	John is 30 minutes late and has not explained why
Observable data	John the Trust manager enters the meeting half an hour late, for the third meeting in a row	John the Trust manager enters the meeting half an hour late, for the third meeting in a row

In each case, the ladder of inference helps to make explicit the chain of reasoning leading to the choice of action/interaction. However, we can see that very different conclusions may be reached according to the inferences chosen.

By itself the ladder of inference does not provide solutions to dealing with difficult incidents and awkward behaviour. As Argyris suggests, it offers a way to identify and explore generic patterns of misunderstanding that can become embedded in the way we interpret verbal and non-verbal clues and it encourages us to avoid falling into automatic and stereotypical responses.

Experimenting with the ladder of inference

Nina has come to realise that she has been using defensive reasoning in her perception of Paul. By assuming that Paul's fallback position is 'money and numbers' Nina is likely to overlook some ideas and arguments she might use to persuade Paul to reconsider his point of view about the future of the post. One of the tasks Nina has set herself in the action learning set meeting is to explore how she makes the leap from observing what Paul does or says to how she decides to act in response, identifying stages where she might challenge and alter her own chain of reasoning before she attempts to alter his.

Table 2.12 provides an example of a ladder which Nina has begun to complete in two contrasting versions. The data Nina has selected is from one year ago, an incident that occurred during the first meeting she had with Paul and Ed. The left hand column represents how Nina has been thinking up to the point she raised this issue with her action leaning set colleagues today. The right hand will demonstrate how she might perceive this same incident differently in relation to Paul, bearing in mind today's discussion with her set.

■ Ladder of inference

Experimenting with the ladder of inference

Table 2.12: Ladder of inference

Take action based on personal beliefs		
Adopt personal beliefs to be used in the future		
Draw conclusions		
Make assumptions using the added meaning		
Use personal and cultural beliefs to add meaning		
Select the data		
Observable data	Paul did not respond verbally to my suggestions about looking at the performance indicators	Paul did not respond verbally to my suggestions about looking at the performance indicators

You may want to try completing both ladders for yourself before looking at the completed example.

■ Ladder of inference

Illustrations and analysis

Here is our example.

Table 2.13: Ladder of inference

HIDE | SHOW

Take action based on personal beliefs	Don't waste time trying to persuade Paul of anything	Persuade Paul that my goals will support his goals
Adopt personal beliefs to be used in the future	You can't expect Paul to listen to rational arguments	Paul wants to see innovation but has to justify this within current targets and resources
Draw conclusions	Paul has already made his mind up about how the post will help him meet the targets	Paul is embarrassed that he did not think of the arguments I am raising, he could look a fool
Make assumptions using the added meaning	Paul just wants me to meet the targets	Paul was not expecting to hear my kinds of arguments and is alarmed by them
Use personal and cultural beliefs to add meaning	People in commissioning are driven by targets, not by clients	As a Commissioner Paul must have taken a risk in creating this post
Select the data	Paul and Ed ignore me, as if nothing has been said	Paul is silent and is looking to Ed; Ed is silent too
Observable data	Paul did not respond verbally to my suggestions about looking at the performance indicators	Paul did not respond verbally to my suggestions about looking at the performance indicators

■ Ladder of inference

Managing
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The left hand ladder illustrates the assumptions and reasoning that have shaped Nina's perceptions of Paul so far. Her initial interactions with Paul left her feeling disappointed, frustrated and angry. She supplies Paul with the information he needs on time (with reminders from him) but otherwise keeps out of his way, inferring that he has little interest in clients or workers. Other colleagues are unlikely to challenge her negative view of Paul and she has had few incentives to modify it.

In the right hand ladder we see an alternative set of inferences about Paul's behaviour. Nina still assumes that Paul will find it hard to listen or change his mind. But her conclusions have changed. What was a problem beyond her ability to influence or control is reframed as a challenge which helps set an agenda for action.

Let's see what has happened a further six months on.

■ Ladder of inference

Episode 2.4:
One year on

CDAS, Chris Marshall's office

Team Leader Chris Marshall was at his desk after a morning carrying out home visits, monitoring clients on the home detoxification programme. He unwrapped a sandwich and began making entries in the clients' case notes. A pile of non-clinical paperwork sat on his desk, at the top of which was a folder labelled 'Policies'.

After the Trust's Complaints Manager had paid them a visit nearly a year ago, Ed had agreed that Chris needed ring-fenced time and proper regular supervision to overhaul the procedures and policies. (Ed had begun to support a lot of changes now that he was pursuing his management training at long last, including carrying out a review of staff gradings.) As a consequence Chris had been spending half a day a week on overhauling the policies over several months. It had given him the time he needed to prioritise policies, convene a working group, pay visits to other services, and have some extended conversations with staff at national agencies such as Alcohol Concern and DrugScope. Nina's mental health experience and contacts had also proved valuable in providing useful leads and back-up. Chris and Nina had already run some joint in-house training on managing critical incidents which had been well evaluated.

Chris realised that Nina had been right to say that the best way to introduce new ideas or alternative ways of working was to chip away at unhelpful attitudes, exploit every opportunity to explain your case, model good practice. That seemed to have worked with Paul, he was certainly listening more to what services, and to what service users, were saying these days, even if it hadn't translated into a further mental health liaison worker post, as Nina had argued for. Indeed, Nina had eventually and reluctantly agreed with Ed and Paul to drop some of the plans she had for the job, in exchange for them downscaling their expectations in the service specification. One casualty had been the 'quit smoking' programme for dual diagnosis clients, based in the CDAS. A pity really, even if it did technically fall outside the remit of the DAT treatment plan as well as Models of Care, it had been a real opportunity to bring mental health, substance misuse and health promotion together.[18] As Nina said, it didn't seem fair that she had to abandon a really good idea in that way. Still, health promotion were keen to progress the idea themselves.

At least they now had a date for moving to the new building. Local residents' objections had to some extent been met by Mark working closely with tenants groups locally and agreeing to join the management committee of a local youth club. Meanwhile, the number of critical incidents involving clients had dropped considerably. A sessional advocacy worker was on loan from the Trust for the CDAS weekly drop-in sessions but had found few attenders expressing any but minor and easily resolvable dissatisfactions with services.

Chris realised that these changes were not due to any one individual, or a single event; they had been a real team effort. However, he wasn't the first to admit that many of the changes had started only after Nina had arrived on the scene.

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[18] Dealing with nicotine dependence would be outside the remit of the DAT treatment plan as well as the CDAS, and falls outside the Models of Care framework, upon which Nina's post is based. National guidance has identified nicotine dependence as a major health issue for many dual diagnosis clients.

Concluding thoughts

In this case we see that an individual without a formal leadership position is able to effect change but that to do so when immersed in a situation requires a preparedness to look for underlying causes and not to dwell on particular events or the actions of individuals. Using the energy available in a situation is one way of not becoming burned out, and while it may be tempting to increase driving forces for change it is important to remember that it is usually more effective to reduce the restraining forces. For an individual to stay effective, an awareness of their own assumptions and responses will also be critical.

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Managing *Change* in the NHS

Case Study 3:

Challenging a health economy to change

Overview

Primary Care Trusts (PCTs) are younger organisations than most others in the NHS. In a relatively short time they have had to discover the potential and limits of their role, establish their ways of operating and develop working relationships with other organisations. All this has been at a time when tiers above them in the NHS hierarchy have been preoccupied with coming into existence themselves. In many ways, therefore, PCTs have had an opportunity to learn, rather than be told, how to function effectively. Accordingly, we have chosen to explore in relation to this case the concepts of *organisational learning* and the *Learning Organisation*.

Episode 3.1 of the case introduces a series of perspectives within the PCT that allow you to diagnose the dynamics using the concepts that have been introduced. In Episode 3.2 a series of perspectives outside the PCT allows you to diagnose the dynamics at work there. Episode 3.3 looks at one character's subsequent perspective which leads to an exploration of the question 'How can I engender a culture of organisational learning?'.

Approaching this case

The case is designed to be read in the following sequence. We suggest some places for taking breaks in the material, with indicative times.

You will note that the theoretical components are introduced before the case material. This is to enable you to bear in mind the various concepts as you read through the case itself.

Organisational learning: 1 – an outline of the theory	30 mins
Episode 3.1 Challenging a health economy to change – a series of perspectives within the PCT	20 mins
Diagnosing a situation – an opportunity to diagnose the dynamics within the PCT using the concepts introduced	20 mins
Illustration and analysis – an opportunity to compare your analysis with ours	10 mins
	Total 80 mins
Diagnosing a situation within and between organisations – an invitation to read the following Episode 3.2, diagnosing the dynamics within the PCT using the concepts introduced	20 mins
Episode 3.2 Partner? What partners? – a series of perspectives outside the PCT that allows you to diagnose the dynamics using the concepts introduced	20 mins
Illustration and analysis – an opportunity to compare your analysis with ours	10 mins
	Total 50 mins
The Learning Organisation	30 mins
Experimenting with the Fifth Discipline: 1 – an opportunity to apply the theory to Episodes 3.1 and 3.2 of the case	20 mins

Illustration and analysis – an opportunity to compare your analysis with ours	10 mins
	Total 60 mins
Episode 3.3 On being a Chair ... – a look at one character's subsequent perspective which leads to the question 'How can I engender a culture of organisational learning?'	20 mins
Organisational learning: 2	5 mins
Experimenting with the Fifth Discipline: 2 – a further chance to apply the theory to the case	10 mins
Illustration and analysis – again, you can compare your thoughts with ours	15 mins
	Total 50 mins

You may find it helpful to have access to *Organisational Change* (2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Note
The (HIDE | SHOW) icon refers to those parts of the electronic PDF version of the document where readers have the option to hide or show the text, depending on whether they want to stop and think before comparing their own ideas with ours.

If you prefer to display all the hidden text for the case, click on the 'Show all' button; similarly, if you wish to hide all the text for the case, click on 'Hide all'.

(**SHOW ALL** | **HIDE ALL**)

Perspective

Each episode includes one or more different perspectives on the same situation. In Episode 3.1 we hear from a number of players within the PCT. In Episode 3.2 we hear from a number of partners or potential partners outside the PCT. Finally, in Episode 3.3 we hear again from one key player within the PCT. Information about the PCT and the various characters is provided as your read through it.

Tools chosen

- Organisational learning
- The Learning Organisation

■ Organisational learning: 1

Organisational learning (OL) is a term first introduced in the 1970s by Chris Argyris and Donald Schön. It draws on the work of, among others, Dewey, e.g. *Experience and Education* (1938), one of the most influential texts on adult education, and Lewin's (1946) development of action research.

OL is a field of study that explores how agents of organisations interact with each other, and develop and use knowledge, to the ongoing benefit of the organisation. It involves behaviours that are radically different from those present in most organisations and so can be thought of as a transformatory process.

The term organisational learning may be confused with the Learning Organisation (LO); though related, the terms have distinct origins, meanings and applications. OL forms part of the discipline of organisational psychology, with all that this implies in terms of generation and testing of theory and amassing and judgement of empirical evidence. The Learning Organisation (LO), which is considered further on (pages 162-172), is a term that derives in part from OL but also encompasses a wide variety of approaches and prescriptions for action advocated by researchers, change managers and consultants working in the areas of: sociotechnical systems; organisational strategy; production; economic development; systems dynamics; human resources; and organisational culture. LO is a field where there is little hard evidence so far of the effect of theory on practice (Iles and Sutherland, 2001: 65). Accordingly, approaches and advice offered by advocates of LO need to be interpreted with care and applied and tested critically (*ibid.*:13)

OL is a field of study that explores how agents of organisations interact with each other, and develop and use knowledge, to the ongoing benefit of the organisation

We look first at three central concepts of OL:
- Theory of action and theory-in-use
- Model I and Model II
- Single loop and double loop learning.

Theory of action and theory-in-use

Argyris and Schön (1996) observed that within an organisational context individuals tend to promote one set of behaviours, and use another set. In explaining this disparity, Argyris and Schön defined two kinds of theory of action: **espoused theories** and **theories-in-use**.

A theory of action has the following generic format: *In situation S, if you want to achieve outcome O do activity A*. A theory of action includes the values we attribute to O that make us see it as desirable, as well as causal assumptions we bring that lead us to believe that A will lead to O.

Argyris and Schön suggest that we use espoused theories to explain or justify our actions. In practice, however, and especially when there is any risk of embarrassment or threat, we use a theory-in-use which is at variance with the espoused one.

Model I and Model II

Almost everyone participating in Argyris and Schön's original research, when at risk of embarrassment or threat, could be seen to adopt a theory-in-use that Argyris and Schön term Model I. This is a set of behaviours learnt early on in life and which is supported by a set of virtues widely held within society and within organisations. These virtues include:

- *caring, help and support:* give people approval and praise, tell people what you think will make them feel good about themselves, reduce their feelings of hurt – by saying how much you care, and if possible agreeing with them that other people have behaved improperly
- *respect for others:* defer to others when they are talking and do not confront their reasoning
- *honesty:* tell no lies, and/or tell others all you think and feel
- *strength:* advocate your own position and hold it in the face of attack from others. Feeling vulnerable is a sign of weakness.
- *integrity:* stick to your principles, values and beliefs.

Behaviours associated with Model I are shown in Table 3.1.

Table 3.1: Behaviours associated with Model I

Aims	Actions	Consequences
Define goals and try to achieve them	*Design and manage the environment unilaterally* – e.g. be persuasive, appeal to larger goals	Actor seen as defensive, inconsistent, controlling, fearful of being vulnerable, overly concerned about self and others, or under-concerned about others
Maximise wining and minimise losing	*Own and control the task* – claim ownership of the task, be guardian of the definition and execution of the task	Defensive interpersonal and group relationship – depending on actor, little help to others
Minimise generating or expressing negative feelings	*Unilaterally protect yourself* – speak in inferred categories, accompanied by little or no directly observable data, be blind to the impact on others and to incongruity, use defensive actions such as blaming, stereotyping, suppressing feelings, intellectualising	Defensive norms, mistrust, lack of risk taking, conformity, external commitment, emphasis on diplomacy, power-centred competition and rivalry

Table 3.1: *continued*

Aims	Actions	Consequences
Be rational	*Unilaterally protect others from being hurt* – withhold information, create rules to censor information and behaviour, hold private meetings	Mistrust, defensive relationships, further withholding of information

Adapted from Argyris and Schön (1996)

We apply Model I automatically because we become skilled at it from an early age. Because we are skilled at it, and the better at it we become the more averse to learning we are, Argyris and Schön call this *skilled incompetence*. If we are operating in Model I and are asked why we behaved in such-and-such a way, we tend to justify our actions by referring to our good intentions: the desire not to hurt other people's feelings, the wish to advocate a position in accord with our values, and so on. If probed more deeply we will blame the situation we are in on other people, attributing to them negative attributes and motives, for example, their inability to handle the truth or readiness to play political games.

Although hidden from us, the disparity between our theories-in-use and our theories of action tend to be apparent to those we interact with. Do they draw our attention to this? Generally speaking, no. This is because they too have adopted a Model I theory-in-use: they too wish to avoid hurting our feelings and want us to save face. They also attribute to us an inability to handle honest feedback or a lack of willingness to work cooperatively with them.

In this situation both participants engage in what Argyris and Schön call **bypass and cover up**. Moreover, they make the bypass undiscussible, and they make that undiscussibility itself undiscussible. This set of activities is known as an **organisational defensive routine** (ODR). Because ODRs are pervasive, individuals tend either not to notice them or to feel powerless to change them. They can see that they inhibit organisational effectiveness, yet challenging them requires the courage to risk making the situation more uncomfortable. Unchallenged ODRs lead to further **fancy footwork**, as Argyris and Schön call it, as people get to know the 'way we do things round here' and find ways around this. This in turn leads to what they call a state of **organisational malaise** whose general symptoms include hopelessness, cynicism, distancing and blaming others. Specific symptoms are:

- seeking and finding fault with the organisation, without accepting responsibility for correcting it
- accentuating the negative and de-emphasising the positive
- espousing values that everyone knows are not implementable but acting as if they are. One example might be 'respect for others', something we all espouse but are rarely able to observe.

■ Organisational learning: 1

The following overall sequence:

skilled incompetence > ODRs of bypass and cover up > fancy footwork > organisational malaise > mediocre performance

To engage in productive reasoning we need to adopt a new theory-in-use

is called an **organisational defensive pattern** (ODP), and the reasoning at its heart is known as **defensive reasoning**. Argyris and Schön contrast this with **productive reasoning**, a way of thinking and talking which enables us to test the validity of our own and others' theories. To engage in productive reasoning we need to adopt a new theory-in-use, called **Model II** (see Table 3.2).

Model II is not the converse of Model I, since we still need to be able to draw on the behaviours and virtues of Model I. We simply need to choose more judiciously and awarely when to use or be guided by them. As with Model I, there is a set of corresponding virtues that support Model II behaviours:

- *help and support:* increase others' capacity to confront their own ideas, to face their unsurfaced assumptions, biases and fears, by acting in this way towards them
- *respect for others:* attribute to other people a high capacity for self-reflection and self-examination – without becoming so upset they lose their effectiveness and sense of self-respect and choice
- *strength:* combine advocacy with inquiry and self-reflection. Feeling vulnerable during inquiry is a sign of strength.
- *honesty:* encourage self and others to say what they know (having tested assumptions and attributions) and yet fear to say
- *integrity:* advocate principles, values and beliefs in a way that invites inquiry into them and encourages others to do the same.

Table 3.2: **Behaviours associated with Model II**

Aims	Actions	Consequences
Get all valid information out into the open	Design situations where all participants can be the originators of ideas and can feel that they are in control of their actions	Actor experienced as minimally defensive
Allow everyone a free and informed choice		Minimally defensive interpersonal relations and group dynamics
Seek genuine commitment to the choice and to monitoring its implementation	Control tasks jointly	Learning is the norm
	Recognise the importance of everyone protecting themselves and make this a joint enterprise, orientated towards growth	High freedom of choice, internal commitment and risk taking

Adapted from Argyris and Schön (1996)

To be able to implement Model II we usually need to slow down our reasoning and increase our capacity for analysis and reflection, otherwise we unwittingly revert to Model I. One way of doing this is to use the approach introduced by Argyris and Schön, known as the **left hand column**. This is as follows:

1. Think of a work situation you are concerned about.

2. Think of a conversation you either have had, or would like to have, with a colleague or someone else involved in that situation – someone you perceive as contributing to the problem.

3. Divide a piece of paper into two columns. In the *right* hand column write down what you actually said or did (or would like to say and do).

4. In the *left* hand column write all the things you would be thinking in response to what the other person was (or would be) saying.

5. Put the paper away and come back to it at a later date. (Optional)

6. Review the *left* hand column entries to see how often you fell into Model I thinking. For example, consider asking yourself the following questions:

– How often did I attribute negative motives or evaluations to the other person's performance and yet not want to tell them?

– How confident am I that I attributed those negative motives etc correctly? If I use the **ladder of inference** (see page 117) can I see that I have used data very selectively and added other beliefs that are not necessarily appropriate?

– Did I advocate my own position firmly to the exclusion of the other person's?

– Did I tell the other person that I care about his or her views while not truly being open to these?

– Did I find a third party to blame for the overall situation, e.g. budget, the Government, and so on?

Model II leads us to be able to reason productively rather than defensively and to:

• strive to make premises and inferences explicit and clear

• develop conclusions that are publicly testable

• test them in ways that are independent of the logic used by the actor involved

• while taking action, reflect and be aware of our own thoughts and feelings

• be clear about the position we are advocating and about any evaluations or attributions we make of others

• check constantly for unrecognised gaps or inconsistencies and encourage others to do the same

• combine taking the initiative with being open to any constructive confrontation of our own views, evaluations and attributions.

Let us now consider two approaches to learning that Argyris and Schön argue are needed in organisations if they are to promote productive reasoning and Model II behaviours.

Single loop and double loop learning

Sometimes the kind of learning that is needed in an organisation, as discovered through an organisational inquiry, is simple. If we want to achieve outcome O and we know that action A leads to O but that A is not being done properly, then we know we have to increase training in A and supervision of it. If we discover that A does not lead to O_1 (desirable) but O_2 (irrelevant or undesirable)

■ **Organisational learning: 1**

then we change the operating practice from A_1 to A_2. This process is called **single loop learning**.[19]

For example, within the discussion of Five Whys on page 84 (Case 2), in the right hand column of Table 2.1 we see that a locum pharmacist has misunderstood a procedure and is interpreting it too strictly. Ensuring that the locum understands the procedure and how to interpret it is an example of single loop learning. There are occasions, however, when upon inquiry we realise that the set of assumptions that lead us to believe that O_1 is a desirable outcome, or that it can be achieved in anything like the way envisaged, needs to be challenged. Here, instead of implementing a simple change we may need to introduce a change to a whole system. This is called **double loop learning**.

In the answers to subsequent 'Why?'s in Table 2.1 we find a number of systems that need to be changed if this situation is not to happen again in the future. Making changes to those systems is an example of double loop learning.

Inevitably, when systemic changes are needed certain doubts and questions arise:
- How did the people involved not spot sooner that these changes needed to be made?
- What can we do to increase from now on people's ability to identify these changes, to develop their capacity for double loop learning?

When such questions are asked and answers sought, whereby people reflect on their capacity to learn about learning, the resulting process is called **deutero learning**.[20]

In the Five Whys example we have been considering, as senior people in the department reflect on why they had not felt willing or able to challenge the norm which had grown up, of not inducting locums properly, they become aware that they have chosen not to do so and this awareness will enable them to do so in future. This is deutero learning at work.

A Model I theory-in-use is often appropriate where single loop learning will suffice. But for double loop learning Model II is necessary.

■ **Organisational learning: 1**

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[19] A term borrowed by Argyris from electrical engineering and cybernetics.
[20] A term first introduced by Bateson (1973).

Experimenting with organisational learning: diagnosing a situation within an organisation

In Episode 3.1 of the case that follows we see a number of able individuals in a PCT, all striving to offer good services, analysing the situation they are in, and devising courses of action that address the problems as they see them. All these courses of action require the cooperation of others, however, and this cooperation is proving hard to find.

As you read the case see whether you think there is any indication of organisational malaise.

If so, what instances are there of the following symptoms within the PCT:
(a) hopelessness?
(b) cynicism?
(c) distancing and blaming others?
(We will be looking at these symptoms of malaise between the PCT and other organisations in Episode 3.2.)

According to Argyris and Schön, we can expect a situation of organisational malaise to be preceded by pattern of organisational defensiveness:
Model I behaviour > bypass and cover up > bypass and cover up are undiscussible > organisational malaise.

You will recall that features of Model I behaviour include the following:
- attributing negative motives to others
- making negative assessments of their performance
- selecting data and leaping up the ladder of inference to do this
- not testing these assumptions, largely because they are untestable
- advocating your own position, opposing the position they advocate, advocating harder in the face of opposition
- saving the other's face by finding excuses or by blaming others.

As you read you might like to identify and make note of instances of Model I behaviour, of bypass and cover up, and of this process being undiscussible. On a more positive note, you could look for evidence of behaviour more associated with Model II.

■ Organisational learning: 1

Episode 3.1:
Challenging a health economy to change

Characters

Board members of North City Primary Care NHS Trust (PCT)

Sarah Trent – Chair. Sarah is Operations Director for an IT software company, and also Chair of the Board of Trustees of a local charity.

Anne Howard – Chief Executive

Jake Manning – Non-executive Director

Yvonne Smith – Director of Commissioning

Karen Lyons – Director of Modernisation and Services

Helen Young – PEC Chair

Leaders of other organisations in the local health economy

Colin Everett – Chief Executive of St Edward's Hospital NHS Trust, a two-star District General Hospital

Setting

North City PCT has a budget of £150million with which to provide services for 130,000 people. Together with South City PCT it covers the whole of the area served by the City Council, a unitary authority. It purchases acute services from two hospital trusts: St Edward's, a local hospital offering a broad range of secondary services to people living within the city; and the County Hospital, a teaching hospital also offering many secondary services and a specialist provider of tertiary services across a much wider area (to some 90 PCTs in all). North City is a two-star PCT, as is South City. Both PCTs were established 2 years ago.

North City PCT offices

Anne Howard, the Chief Executive of North City PCT, is meeting with **Colin Everett**, Chief Executive of St Edward's Hospital NHS Trust. Anne has just taken a deep breath …

'I was hoping to be able to recommend a course of action to my Board, but unless we can agree on this I really don't think I'll be able to', said **Anne** firmly. 'We really must believe that you are taking genuine steps to address this budget deficit.'

'But the solution lies as much in your hands as in ours', **Colin** repeated. 'It is your GPs who are referring the patients and unless they reduce those referrals, and between 30 and 50 per cent of them are inappropriate, we

can't reduce our costs. It isn't St Edward's deficit, it's a problem across the whole health economy.'

Here we go again, thought Anne. Why did Colin always sound like a stuck record? And why was he so unbothered about the problems *his* clinicians were causing everyone else? Anne was losing patience but decided to remain outwardly calm.

'We *are* taking steps to reduce the inappropriate referrals', Anne responded, 'but your clinicians are admitting too readily and keeping patients in too long, your length of stay has to come down. I know it isn't easy to persuade the clinicians of that, and I know you've had your hands full with the Trust merger, but increasing your efficiency just has to be your top priority. We simply cannot go on funding these inefficiencies.'

Colin frowned: 'Look, your GPs are referring to us a level of activity that we are providing, if you cannot pay for it then you need to tackle them and not us. If you are refusing to pay us money for activity we have undertaken for you, then we will have to ask for arbitration from the Strategic Health Authority.'

Anne was losing patience but decided to stay outwardly calm

'That's not what I said, and involving the SHA doesn't *worry* me', she said. 'But I think we would do both our reputations a favour if we could sort it out ourselves, if we need to involve the SHA, well so be it.'

'Ouch!' thought Anne as Colin departed shortly afterwards. 'Arbitration? We could do without that.'

The PCT Board had been keeping an eye on the results of other arbitration cases and formed the view that the SHA was 'Region Mark 2', doing the same as the old Regional Health Authorities and always supporting the acute trusts at the expense of the new PCTs. Indeed, there was a view, particularly among the non-executive directors, that the SHA was trying to usurp the Board's role in relation to commissioning from the acute trusts, telling the executive directors what to do, without allowing local discussion. A recent example had been the 1% inflation increase the SHA had agreed with the PCT, and their subsequent support for a 2% rise for both St Edward's and the County – to come out of the funds they themselves had uplifted by only 1%. So this was redistribution towards the acute sector at a time when there was much local pressure for the opposite.

'Sometimes it does feel as though the Board is pulling in one direction and the SHA in another, and the person bearing the brunt of this is always the Chief Executive', Anne reflected. 'After all, the PCT is performance managed by the SHA, and chief execs' careers are made or broken according to how they are perceived by the SHA executive team, and yet they or "we" are personally appraised by the Chair of the PCT.

'If only St Edward's were the only problem relationship. I would love to forget about the County but that's a major problem too. Perhaps even worse, because at least St Ed's worry about their relationship with us, since we

fund nearly 50% of their activity. The County have over 90 contracts with different PCTs all over the country and, although we and South City are their two biggest clients, together we only account for 25% of their income. They don't even bother to pay lip service to keeping us happy.

'And while I'm thinking about unproductive relationships: we're not collaborating nearly as well as I'd like with South City. We could increase our commissioning leverage hugely if we could only work together. And we're still getting complaints that patients near the boundary are being bounced from one service to another if their GP refers them to the "wrong" one, so clearly things aren't working seamlessly at operational level either. Shared services are a problem too – yes that's a relationship that definitely needs some attention.

'Of course they all complained about us behaving unilaterally when we issued the service strategy last year without consulting them – but we really had no choice, we would have missed the LIFT[21] deadlines if we delayed.

'But St Ed's is infuriating. They are their own worst enemy. They say they can't possibly meet the A&E wait targets because they don't have enough bed capacity to admit, yet when we offer to free up some capacity by training our District Nurses in I/V therapy (estimated 100 bed nights a week saved) their consultants won't give written endorsement. We have had to ask every GP to sign up to it instead, overcoming LMC[22] resistance in the process. The consultants at the County gave approval without any trouble – in fact they may have suggested it in the first place. Honestly, St Ed's managers can't deliver their clinicians at all, they are all bluster and no substance – they threaten but then back down, and of course the clinicians end up with no respect for them.'

High Street Health Centre

For the third time that week **Helen Young** thought about relinquishing the post of PEC Chair. Not just the chair, of coming off the PEC[23] altogether. The first time was during a heated argument with a fellow GP over 'advanced access'.[24] Her colleague was so angry and personally abusive: 'Can't you see the problem is that we're all overworked, fiddling around with fancy new names won't change anything, all it means is that patients can't book ahead and have to phone on the morning when they want to see us, and then the phone lines are blocked. The PCT is hopeless, they don't understand GPs at all.'

The second time was when she saw the PEC agenda and realised that, yet again, it was reflecting management priorities rather than clinical. She didn't know which was worse: being forgotten and left out of key meetings and decisions so that the PEC voice was inaudible, or being remembered and

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[21] Local Investment Finance Trust.
[21] Local Medical Committee.
[23] Professional Executive Committee.
[24] A system in which capacity is matched to demand and the two are in equilibrium.

invited to every meeting the rest of the 'three at the centre' were attending. She couldn't carry all this and a fair load at the practice.

She knew all the PCT managers were stretched. There were so few of them and so many roles and responsibilities to be taken on. And in some ways she was lucky that she could retreat from the PCT to her clinical work. But she doubted they had to cope with the emotional load that she did. Facing hostility from other GPs, when ever since she qualified she'd been encouraged to work collegially with other doctors, was very difficult. She knew she must support a decision made by the PEC, and she did in fact believe advanced access could work well, but faced with self-righteous anger and the kind of behaviour that almost blatantly accused her of betrayal, well it was very wearing. Managers could walk away, writing a particular GP off as uncooperative, but she couldn't. This was her core role – engaging local clinicians in making and implementing decisions.

Finding her feet in this new role had been hard. The realisation that she was now part of the management of this organisation ...

Finding her feet in this new role had been hard. The realisation that she was now part of the management of this organisation – the decision making, the governance – had taken a while (and she knew other PEC chairs who still saw themselves as union shop stewards rather than having corporate responsibilities). Distinguishing the role of the PEC from that of the Board hadn't been easy, either. A couple of her own PEC members had found this difficult too – the transition from a PCG where they made the decisions, to a PCT with a separate Board. Helen had been flummoxed by their behaviour: tantrums, sulks, attempts to blackmail the PCT into a particular decision by threatening to change to more expensive prescribing habits. Dealing with that hadn't been easy. The 'three at the centre' meetings had been helpful there, the Chief Exec and Chair had years of experience of dealing with that sort of thing. The other PEC members had been helpful too, they had stayed calmly constructive – not sure what they were all supposed to be doing, but prepared to work it out and learn as they went along.

Yes, the PEC had come together, was working well, able to decide its own priorities. So it was disappointing to see the agenda hijacked again. Of course, the LDP[25] was important, but time to reflect on the diabetes pathway discussion (while it was still fresh in people's minds) was more so.

The diabetes discussion day had been a disaster. Unfocused, unstructured, no clear questions, no solutions to the very evident (but undiscussed) problems. A waste of time. Helen would have great difficulty persuading colleagues to attend anything similar in future. A pity really that so many had turned up for this one.

So, apart from GPs, managers, PEC members, oh and the odd consultant who didn't want to discuss their service with people outside the speciality – things were fine. Oh and except for the Luddite old LMC.[26] But the last thing she needed was another set of meetings. Were Anne and Sarah serious about calling a meeting on partnership? She hoped not.

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[25] Local Delivery Plan.
[26] Local Medical Committee.

North City PCT, Directorate of Modernisation and Services

'I'm very sorry you feel like that, and I'll get back to you when I've investigated further. Thank you for letting me know'.

Karen Lyons, Director of Modernisation and Services, put down the phone. Another call from the practice manager at Upper Street surgery, and about the same thing: Jane, the Practice Development Manager, not delivering on something she had committed to. It didn't matter what the precise instance was, Upper Street would have found something to complain of anyway, they were on the phone every week. It looked as though there was a personality clash. She'd ask Jane for her version of events when they met later in the day.

Development was what Karen's job was all about. The personal and professional development that would result in better services for all. And, boy, had North City needed that. When the PCT was set up it inherited some of the most sadly managed community services you could imagine. Services like podiatry, community dentistry, physio, and speech and language therapy, had all been raided over the years to fund deficits at the County and St Ed's. So they were starved of money, demoralised, had no decent managers, and the staff were just 'going through the motions'. Miserable. It had taken a while to realise this – at the beginning their constant whinging had annoyed her, they had seemed unable to respond positively even to terrific opportunities. Now she realised they had just had no experience of managers with enthusiasm for their own services. They had been amazed to hear the Chair say that the Allied Health Professionals made a crucial difference to people's lives. They had almost forgotten that themselves. The PCT had offered some people early retirement (their choice being thought through with care and concern for the people involved, as well as the service) and appointed several new managers. They had also prompted service development plans that reflected the need in the city for these services. The teams had become so inwardly focused they had needed a lot of support and information to make a start on these. And in response to the plans the PCT had offered some real investment in staff, premises, and equipment.

This had all been so exciting, as though she had been able to turn on a light switch in their heads. They saw the world differently now, positively, proactively, not victims any more but in charge of their own destinies. They had elected some excellent members of the PEC and were bringing their experiences to the Trust's decision making in a helpful way.

If only it were the same with the nursing teams. Some good people, but their managers were resisting like mad any attempts to move even into the 1990s! And whatever Karen said to them, or offered them, she always felt she had again used a switch, but this time a dimmer. They seemed to become less and less innovative, the more she interacted with them.

She knew some of her counterparts in other PCTs found the GPs like that, but Karen hadn't. They had protested initially about being exhorted to

'We should be able to come up with a plan that takes us where we want to go and meets all the targets along the way. I don't know whether they don't trust us to do that, or don't believe it can be done.'

change their prescribing habits, to curb the steadily rising prescribing costs. But they had responded very well to the information they had been given about their own and other people's prescribing, to the work on the joint formulary with St Ed's and the County. Karen's choice of prescribing advisor had helped: authoritative but friendly, she had been able to convey information in a way the GPs found helpful and not threatening. Karen had told her on arrival: 'Look, I want you to see the GPs as trying their best to be as effective as possible, and your role as helping them to be as effective in their prescribing as they want to be. No disparaging of them, no doubting their motives. Yes they are independent contractors and need to make money, but we're not going to assume all their decisions are motivated by that.'

These aspects of the job Karen enjoyed enormously. Even the nurses – she'd get there in the end. There were other parts of it that frustrated her. Chief among these was the way the Chair and Chief Executive would have knee jerk reactions to things instead of thinking them through carefully and holistically. So the access targets, for example, were being met the easiest and quickest way (opening a surgery in each patch for open access sessions every lunch time, and putting a GP in the A&E department at St Ed's). What a wasted opportunity to build towards their longer term aim of City-wide walk-in centres! And how were they going to re-educate people not to go to A&E for minor injuries if you were encouraging them to do just that by putting a GP in there?

'Leading health services isn't about opportunism, it's about building consistently for the future', thought Karen. 'I reckon those two are so driven by the need to be seen to deliver the targets they've forgotten what it's all about. It's not as if the two are mutually exclusive either, we just need to do some real planning. We can guess what the imposed priorities are going to be, and we know what our own local needs are and local priorities, so we should be able to come up with a plan that takes us where we want to go and meets all the targets along the way. I don't know whether they don't trust us to do that, or don't believe it can be done. Instead we all have different action plans to address different initiatives, and no-one ever looks at any of them until the time comes to report on progress.

'And their open forums are driving me crazy!' Karen grumbled. 'They want to be seen as open and accessible, so they have meetings every quarter where anyone can attend. Quite popular with staff, especially those who want to moan. And they promise to address the complaints and feed back. And then don't have any systematic way of making that happen. So several weeks later I get told in a meeting about something else entirely: "Oh will you check out X, I promised the OTs I'd look into it."

'The Chair is taking this public engagement role very seriously, too seriously, she's getting buffeted by any interest group that comes to see her. Last week it was the appointments system for podiatry, this week it's the elderly care wards. Yes they're both important, but no they are not top of my priority list – but now I've got to make them so. Doesn't she realise just how busy I am, how busy we all are?

'Both of those are something I'd like the PEC to think about first. They are clinical issues where they need to do the thinking and give it to me to implement. But I've already had one argument with Helen over the PEC agenda and I don't want to alienate her completely.

'And that's another thing! The PEC isn't working brilliantly either, but neither is the Board. They're not thinking for themselves what they need to know, it's very much up to us as a senior management team to guide them. Yet they're furious when they believe their autonomy has been threatened. I can't really work the NEDs out. The Chair is very impressive, fantastic experience in industry and the voluntary sector, and wonderful at dealing with people. And the other NEDs are all great, as people, but I don't know how to involve them effectively and I don't see my colleagues doing so either. We always have to waste so much time bringing them up to speed, and then they are so naïve. Their greatest contribution is to bring a lay view, but we could find other ways of doing that. The private sector is being told to clear up its act in the light of all these corporate scandals, but I don't think our NEDs would be able to spot anything that might lead to a governance scandal here.

'With all that in the background I could do without this vendetta against Jane. Upper Street have been gunning for her for months now, and I see some of the other practices are joining in, always the same complaint, so I'm sure it's cooked up: making commitments and not delivering. They just don't realise how busy we all are.'

North City PCT: Commissioning Directorate

Yvonne Smith, Director of Commissioning, allowed herself to be optimistic. They had finally agreed a particularly troublesome SLA[27] with St Ed's. The SLA itself was always the end of a long process of gradually building the confidence of the provider Trust that they were happy to be held to account for what was written down. And not the end really, they were part of an ongoing relationship around commissioning that was dynamic so the SLA had to reflect that. It was no good anyone holding people to a written agreement if circumstances changed so significantly that needs or capability were radically different. On the other hand, it was time the acute providers were challenged to be consistent in their service provision. Yvonne recalled the way St Ed's Elderly Care team had regularly cancelled at least half of their sessions at the North Street Health Centre, and without any notice usually. The latest SLA still hadn't addressed that properly, but Yvonne observed that now that she reported on them monthly to Colin the cancellations were very few and far between.

Yvonne had also managed to ensure that GPs received much better information from the acute trusts about their patients. It had been a

The SLA itself was always the end of a long process of gradually building the confidence of the provider trust that they were happy to be held to account for what was written down

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[27] Service Level Agreement.

complaint for as long as Yvonne could remember, and it still wasn't perfect, but much, much better. That had been through sensible requests within a set of relationships she had worked hard at, and backed up with as much hard data as she could find. 'There's no magic about this job', she thought, 'it's just keeping your eye on the ball and plugging away at it, making sure you get hold of as much relevant information as you can.

'Information is the key to it. And it's still so limited. Unless we understand the way activity works we can't credibly begin to challenge and change it. And to understand it we need data, without sensible data we're floundering. Where we can we are building in efficiency indicators, that will show us where staff aren't being used as productively as they could. For example, the County have a 1:11 follow-up ratio in some specialties and feel they can justify that! We've tried to have conversations about how to bring that down, how to get those patients back out into primary care much earlier (and more cheaply) but the meetings have been difficult. Involving the clinicians seemed a good idea but in practice the consultant was rude about GPs (exempting, of course, from his comments the PEC members who were present). When asked what would make him feel confident, what level of expertise the GPs would need to demonstrate, he was completely unrealistic.'

'Information is the key to it'

It had been one of the early clinician-to-clinician meetings and the PEC members involved had needed a lot of support afterwards. And it had worked: these GPs were holding their own now in discussions with consultants. Yvonne knew she couldn't afford to have them lose heart. The PCT had worked hard to engage with the key GP opinion formers, and they were good members of the PEC, but beyond that there was not a lot of interest among the other GPs. They tended still to regard the PCT as another interfering government layer of bureaucracy. They would have to 'grow' some new GP advocates though, and soon, the agenda was huge and the current group would burn out otherwise.

'I think **Colin** [Chief Executive of St Edward's] is suspicious that we want to run his hospital', thought Yvonne, 'but we just want to understand it. Of course, if he understood it himself he could explain it to us, but the truth is he doesn't either. The management team are just so close to it they don't realise what they don't know. One of those unknown unknowns! Fortunately, there's some good stuff out now about efficiency and I've been able to challenge them to think about that.'

A good capacity utilisations study would be immensely informative, perhaps she would be able to persuade them to cooperate with an outside team in a way they found difficult with the PCT. Would the SHA help persuade them perhaps? Difficult to gauge that, thought Yvonne. Although the SHA talked about the commissioning and modernising agenda needing to be agreed between acute trusts and PCTs, in practice they tended to have a very close relationship with acute trusts themselves and that could easily undermine the credibility of the PCT team.

Information was the key to everything: to understanding, to designing change, to monitoring performance that mattered (Yvonne was tired of performance being judged on things that didn't matter). But the information skills across the whole health economy were rudimentary. Not just computer skills, she meant skills and attitudes about *information*. At the moment people still saw information gathering as 'feeding the beast'. Even where the information could be seriously revealing to them they were just filling in forms and passing them on. This itself was indicative of people not asking the right questions, of not appreciating that their role was to challenge the system, to think in new ways about how to manage work and work flows. Part of Yvonne's role, she was finding, was to feed back to people the information they had already given her, but having done some analysis on it, and with the questions that jumped out at her attached. Perhaps if she did this often enough they would learn to start analysing it themselves.

If the PCT didn't succeed in shifting money from later in the pathway to earlier, they would never address those health inequalities, people with higher incomes would still receive better care and live lives ten years longer than those on less. It was literally this important, real people would live longer.

This wasn't about empire building, about asserting inappropriate authority as the new kid on the block. If the PCT didn't succeed in shifting money from later in the pathway to earlier, they would never address those health inequalities, people with higher incomes would still receive better care and live lives ten years longer than those on less. It was literally this important, real people would live longer, and yet the PCT had to negotiate with those whose whole focus was ensuring that their organisation drew in as much resource as possible. She didn't want to negotiate organisation-to-organisation any more, all the discussions should be around patients and programmes of care for them. It was actually in the interests of the acute trusts as well. For example, the County was still having problems reaching its A&E targets.

'If they would think across the whole pathway we could invest in the ambulance service and treat people at home using emergency care practitioners. Better care, better results, and happy ministers! A real win-win. But will they?!'

The clinical networks were beginning to come up with interesting ideas in a number of areas, but against a lot of muttering from general and business managers, under the seemingly innocent question about accountability. These hid concerns about loss of control, the fear that this would present them in a bad light, that it would negatively impact on their careers. So instead the PCT were approaching it the other way round, any requests from organisations for resources for, for example CHD,[28] must now be supported

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[28] Coronary heart disease.

by a recommendation from the CHD clinical network. It would work, but take longer.

Overall there was a need to build up an intermediate level of care, a level of expertise that would give the consultants confidence about referring people back to the community, or allowing them to stay there in the first place. 'We're only in the beginning stages of that', Yvonne thought, 'and we'll have to work out how to do it as we go. We'll share our experiences with other PCTs, but we're all so new that no-one has the answers yet.'

North City PCT, Chair's office

'The more I think about it, the more I think the fact that our GPs are independent is an advantage', reflected **Sarah Trent**, Chair of North City PCT.

'When the PCT was new, when I was new, it didn't feel like that at all, they seemed so non-corporate, so impossible to work with. But because we didn't manage them, we've had to persuade them, to really find out about them and work with them, and now we are doing it so much better than our acute sector colleagues. At least that's how it seems, from my discussions with the chair of St Ed's. Their clinicians are split into two warring factions, neither of which is remotely interested in the welfare of St Ed's, only in "their" patients (interpreted very narrowly) and in scoring points. We can talk with St Ed's managers until we're blue in the face, but even if we can reach agreement with them there's no way they can deliver their clinicians. How are we ever going to modernise these services against that background? With no pump priming money we can't invest in primary care services unless we can pull it out of secondary, and although they argue like mad that they can't release money until there is better primary care, we know they are hugely inefficient. They're like a black hole, when we respond positively to a request for funding for additional posts or services and hand over the money it just disappears. We can't get information about how it was spent, what the impact on performance was, nothing. They seem to think we are just a never-ending source of money. This is crazy, in my world we couldn't survive without demonstrating to our customers how we were meeting their needs. None of that here.

'Still there are a lot of things that are going well, that's why I'm still enjoying it. We've attracted a good management team, and they are working well together. The staff are fantastic, so committed and enterprising (on the whole) and they are saying how much more they enjoy the PCT than their old Trust. Recruitment of GPs is still a big problem, but it is everywhere, and we are attracting some very good people in the AHPs.[29] Relations between the Board and PEC are more harmonious now, we've agreed our respective roles now, and I think we're keeping to them. I know **Helen** feels the PEC agenda is being imposed by managers, but I think she just has to wake up

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[29] Allied health professionals.

to the real world: there are things we want to make a priority locally and there are those that are imposed from above, and we can't simply ignore the latter to concentrate on the former. It's only by making progress on the national agenda we give ourselves the space to focus on the local. Now I choose to devote time and energy only to issues where I can have an impact, I don't waste my time fighting battles we can't win.

'I can be much more value to **Anne** that way. After all, it's her career, it's only an interest for me. And she has to make sure she is seen in a good light by the SHA team. I don't think Anne is seen as a star performer, and she will have to get better at managing perceptions, about distinguishing between what the SHA see as really important and what they don't. I could help her there, in making those kind of judgements, because it's about judgement and not about detailed knowledge of the NHS, but I'm not sure she believes that. I think she sees me as trying to be helpful but not yet "up to speed" on the NHS. Certainly that was the focus of the last Board Away Day – giving the non-exec team the information we need to be able to understand the proposals put to us at Board meetings. I agreed the format at the time, I felt we weren't informed enough, but I know Jake and some of the others were disappointed. They felt patronised, thought they were being treated like rather poor managers rather than good non-execs, and reckoned the execs had as much to learn from them as the other way round.

'Tensions are rising, and it's largely to do with the fact we are so short of capable managers. We're a tiny organisation with so many demands upon us that everyone is wearing at least five hats. People are working 60-70 hour weeks, this just can't go on. So many demands for action plans to address this issue or that, and people produce them. **Jake** (a non-executive director) is sure they don't use them, they don't look at them again until it's time for a review. They don't build them into a coherent management agenda and team and personal objectives. He sees this as ludicrous, fragmented, impossible to manage, and a waste of both the time put into to devising the plan, and the fact that much of the information gathered for them could be so useful if only it was used instead of sitting in files.

'It is certainly different from my day job. There I know exactly how every product, every team is doing. OK, it isn't as complex or as big, but I still need to know how people are performing in other countries with different local conditions, and I do. Here I'm not at all sure *how* I can know how the PCT is doing. How do I *really* know? I can ask questions, but that just gives me answers, how do I know what is truly going on?

'How do I know if we are living up to the values we all agreed six months ago? We discussed them in response to complaints that we had issued a service strategy without any consultation with users, the acute trusts, the voluntary sector. We would have lost our chance of LIFT funding if we hadn't, but still we really shot ourselves in the foot! People are still quoting that to us as evidence of our high-handedness.

'I could help Anne there, in making those kind of judgements, because it's about judgement and not about detailed knowledge of the NHS, but I'm not sure she believes that. I think she sees me as trying to be helpful but not yet "up to speed" on the NHS.'

'It's a pity it has got in the way of our discussions with partners, and partnership *has* to be the way forward. We *have* to be working on pathways of care, not have little episodes along it completely oblivious to the rest. Some days I think we are getting there, that people are beginning to use a common vocabulary, and then I hear of St Ed's and the County putting fences up around their services, refusing to let us look over them, swearing that everything on their side of it is working fine (efficiently, effectively), but never giving us any convincing evidence of it; and I wonder whether things will ever change.'

The White Lion Pub

'How's the non-exec role going? Enjoying it? Having an impact?', **Jake Manning's** friend John was asking him.

'No and no', replied Jake, 'it's a complete waste of time. Interesting yes, but probably the most frustrating thing I've ever done. I don't know whether the execs think we don't notice, but they don't value our contribution at all. They are ever so courteous, I've never had so many nods of agreement when I make a suggestion, but then they ignore it completely. And as for asking questions – you'd think that was the job of a non-exec, wouldn't you? to ask the questions that allow the whole Board to be sure that everything is hunky dory. But questions are seen as criticisms, they hate them. They hate the whole thought that they could possibly do things any better. They would see that as failure. And they may be right when it comes to Board meetings in public, any "noise" and the SHA is furious. But even in private, in seminar meetings without any public, they just can't entertain the idea that they could learn from being constructively challenged. Agendas are so full it's all reporting and no debating, congratulating rather than arguing. Anyhow, they hardly ever answer them, my questions. They just give a whole load of detailed information about "how things are done" in the NHS. Honestly that assumes the NHS is a huge success story! They've got so much they could learn from the experiences of the NEDs around their Board table, but they just want us as a rubber stamp. And Board seminars and away days are all about "bringing us up to speed". Honestly we could do with bringing them up to speed – with the real world, with the way they are perceived locally, with the way other organisations succeed (we've got so many years of good experience around that table), we could add so much value, but no, it's all one way – the other way.

'The Board can't entertain the idea that they could learn from being constructively challenged'

'No, I joined because I care about the NHS and I wanted to try and use my experience to help improve things, to push for local decisions that meet local needs, but this lot just wait to be told by the Centre what to do, and then are completely consumed with showing how brilliantly they are doing it. They aren't a Board, they're a conduit. Sorry, bad day to ask me, I'm not always so negative!'

Box 3.3: Summary of perspectives and concerns

- **Anne Howard, Chief Executive**
'If only St Edward's were the only problem relationship'

St Edward's Hospital Trust is overspent again, is unlikely to meet its targets and its Chief Executive is threatening to enlist the SHA on his side. Anne reflects on the lack of leverage the PCT has with both of the acute trusts and the SHA. Nor has the PCT improved its image by having failed to consult with key stakeholders over the Local Service Agreement. The health economy seems to be stymied by unproductive relationships between organisations. Everyone is fighting their own corner; few seem really committed to the goal of shared services.

- **Helen Young, PEC Chair**
'The PCT is hopeless, they don't understand GPs at all'

Helen is having doubts about whether to continue her commitment to the local PEC. Being Chair takes up a lot of her time and energy, dealing with interpersonal conflicts is draining, and the role is creating an unanticipated conflict of interests for her. Now she sees the clinical agenda of the PEC being sidelined once again by management's priorities. The PEC could be a real force for change if only it if weren't for all the red tape and political agendas. Is it worth the all hassle and the back-biting?

- **Karen Lyons, Director of Modernisation and Services**
'Leading health services isn't about opportunism, it's about building consistently for the future'

Karen sees a mixed but ultimately hopeful picture in the way different professional groups are responding to the modernisation agenda. She is more frustrated by what she sees as the problems in reaching the access targets and the idealistic but ineffective methods of public consultation and involvement by the PCT executive team. She also detects wider problems, with the PEC and the NEDs. A local difficulty meanwhile has arisen with one of the practices. A personality clash, apparently.

- **Yvonne Smith, Director of Commissioning**
'Information is the key to it'

Yvonne is convinced that better information management, and more positive attitudes towards this, will eventually help her to crack many of the 'wicked' organisational problems she faces. In her view, it will enable care to shift from being provider-led to become truly centred on the patient experience. This shift is not happening without a struggle and she is having to nurture fledgling relationships and networks in an atmosphere of some scepticism and mistrust about the PCT's role and motives, particularly from GPs.

Box 3.3: *continued*

- **Sarah Trent, Chair**

  'We're a tiny organisation with so many demands upon us'

  Despite heartening progress and an improvement in morale among staff working across the PCT, Sarah sees a continuing shortfall between demands and expectations being placed on the PCT and its managerial capacity to meet them. She identifies a problematic relationship with St Edward's, of clinicians split into warring factions, and a management team there unable to intervene. People in both Trusts are beginning to grasp the need to modernise, however, and starting to work in partnership, but at the first sign of pressure they retreat behind the old barriers.

- **Jake Manning, Non-executive Director**

  'They don't value our contribution at all'

  Jake has joined the PCT Board because he wants to see better, more locally accountable health services. He feels kept in the dark about the real issues and problems and is frustrated by what he sees as a waste of his and the other NEDs' skills, experience and good will. He thinks Board meetings are little more than window-dressing.

Diagnosing the situation

Now decide whether you can detect any of following symptoms within the PCT:
(a) hopelessness
(b) cynicism
(c) distancing and blaming others

– and also whether you can identify instances of Model I and Model II behaviours.

You may want to stop here and review some of the preceding material again before continuing.

Illustration and analysis

Now that you have made your own list of symptoms you may like to compare that with ours. We do not include every single incident, but give examples.

Specific symptoms of organisational malaise

The symptoms of malaise include hopelessness, cynicism, distancing and blaming others. Specific symptoms are:
- seeking and finding fault with the organisation, without accepting responsibility for correcting it
- accentuating the negative and de-emphasising the positive
- espousing values that everyone knows are not implementable but acting as if they are.

(a) Hopelessness
Examples within the PCT include:

(HIDE | SHOW)

- **Anne** and **Sarah** feeling that St Ed's and the County are a 'black hole'
- **Anne's** and the Board's view that the SHA is 'Region Mark 2'
- The GP who verbally abused Helen about the advanced access system
- **Helen's** feeling that pressures are inclining her to think of resigning
- **Karen's** sense that her priorities are skewed by the PCT Chair
- **Karen's** despair about the means of meeting the access targets
- The nursing team's lack of enthusiasm for change
- **Jake's** negative assessment about the executive directors' attitude towards the non-executives

(b) Cynicism
Within the various parts of the PCT:

(HIDE | SHOW)

- **Karen** is so used to 'whingers' that she initially downplays the complaints of the AHPs she is managing.
- **Jake** describes the executive team as just waiting 'to be told by the Centre what to do', and then being 'completely consumed with showing how brilliantly they are doing it'.
- **Yvonne** sees general managers' concerns with their own careers impeding the work of the clinical networks; she also does not want to talk 'organisation to organisation' because she sees managers caring more about their organisations than about patients.

■ Organisational learning: 1

(c) Distancing and blaming others

It might be asked: Are the feelings of many of the individuals referred to above not largely justified? Is this not cynicism at work but simply hard-nosed realism? According to Argyris and Schön, if people are being guided by productive reasoning they will be able to use their assessments productively. Defensive reasoning, on the other hand, will lead to them distance themselves from the problem and blaming others. Are there examples of distancing and blaming here?

People in the case are quite clear about the part others have to play in generating the problems they themselves are experiencing. They are less forthcoming about their own contribution.

Anne, Jake, Karen, Yvonne – all are blaming others. They are seeking and finding fault without accepting responsibility for correcting the situation. To do so they accentuate the negative and de-emphasise the positive. They also espouse the values of 'partnership' while knowing that it is highly unlikely it will live up to its theoretical promise.

We would conclude that these are all the features of an organisational malaise that is affecting many in the system – it is certainly impacting on the local health economy if this is considered as a 'virtual organisation'. We will look further at this issue in Episode 3.2 below.

Evidence of Model I behaviours

Negative motives and negative assessments of performance

(HIDE | SHOW)

- The PCT board perceive the SHA as being 'Region Mark 2', suggesting negative attributions to both the SHA and the old Region. They are similarly disparaging about the old HA.
- **Anne** feels the County is 'not even paying lip service' to the relationship with the PCT. She also believes St Ed's managers cannot 'deliver' their consultants.
- The GP who berates Helen is very negative about the PCT.
- **Helen** accuses Karen of manipulating the agenda.
- **Karen** assumes the complaints of Upper Street and other surgeries are due to a personality clash and does not take them seriously.
- **Anne** does not see Sarah as able to help her in her relationship with the SHA.

All of these assessments involve observing particular incidents, adding a set of prior beliefs and assumptions and inferring a generalisable set of behaviours and motives that have not been directly observed. In all these cases the assumptions have not been tested, largely because they are untestable. For example, how might Anne test out her conclusions about St Ed's not 'delivering' their consultants?

We also see examples of people *advocating their own position*, doing so even

■ **Organisational learning: 1**

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more strongly in the face of opposition, and not inquiring into the reasoning behind their antagonist's position. Anne and Colin are one example. Yvonne and the general managers from the acute trusts would be another. All of the individuals described in the case have valid arguments and are rehearsing them for just such a conversation. One interesting example of strong advocacy is the GPs on the PEC in its early days, where they advocate so strongly that they threaten and try to blackmail, and have a sense of grievance both with the PCT and the Government. As they are not familiar with large organisations they have not applied the art of Model I behaviours as skilfully as those who are familiar with them. They have the mindset, but not yet the skills. We also see Anne presenting herself as unconcerned about a threat to bring in the SHA when she is rightly worried about it. Clearly she feels expressing this concern is not an option; it would make her appear weak and weaken her negotiating position.

We also see that none of the individuals here appear likely to surface their assumptions or their thinking about their antagonists, except in private, off-the-record moments. And they are wise not to do so while they are still in the mindset of Model I as this would only inflame the situation further. So instead, we see faces being saved: Anne suggests that Colin is not able to focus on inefficiencies because of the merger he is dealing with.

We also see that while Model I behaviour is hidden from those adopting it, it is quite apparent to others. For example, Anne can see that St Ed's' managers are not using the theories they espouse when the are 'all bluster and no backbone' with their consultants.

Bypass and cover up

HIDE | SHOW

When Yvonne believes that business managers in the acute trusts are impeding the work of the clinical networks she does not raise this with them. She may talk about it within the PCT, but not with them. Instead she devises a bypass: no requests from them will be considered unless they have been approved by the clinical network first.

Sources of embarrassment and threat

HIDE | SHOW

Many people in the case observe that careers are made and broken according to the perceptions of those in higher tiers in the NHS. So there is a real threat to livelihood if performance is not judged well. Anne, for example, must satisfy the SHA about her performance and that of her PCT. All the organisations are concerned about their star ratings and the results of a number of inspections. So any unmanaged anxiety about these concerns will not encourage Model II behaviours. Neither will the presence of the public at board meetings: no one will want to risk looking foolish in front of others, especially if this includes the Press. Even in private seminars people do not enter into dialogue, into an exploration of the issues in a way that draws on the expertise of all those present. They still operate in Model I, which means they are still thinking from

None of the individuals here appear likely to surface their assumptions or their thinking about their antagonists, except in private, off-the-record moments. And they are wise not to do so while they are still in the mindset of Model I as this would only inflame the situation further.

■ Organisational learning: 1

within Model I. There is an opportunity here, which they do not take, for them to move into Model II.

In bypassing and covering up, many of the people we have met in the case so far make the reasons behind their actions undiscussable.

Evidence of appropriate Model II behaviours

Is it all bad news? Are there no examples so far of learning behaviour appropriate to Model II? Following are some instances.

HIDE	SHOW

- PEC members, once Helen has steered the well intentioned but unskilled GPs in a more constructive direction, work well together, learning as they go what being a PEC is all about. It may be easier for them to behave in ways that accord with the values they espouse because they are all new, they have little management experience, and expectations of them are not as great as they may be for other parts of the organisation. Thus they are perhaps at less risk of embarrassment or threat and we know that it is this risk that increases the tendency to Model I behaviours.
- **Karen** explicitly warns the new prescribing advisor against making false inferences about the GPs, giving her instead a positive set of assumptions to use.
- **Anne** and **Sarah** are able to help Helen model the behaviours she wants to see in other PEC members, and to talk with them about the way they are responding. Is this an example of appropriate learning? It may be, or it may be the way skilled incompetence is engendered so effectively as people rise in organisations.

In Episode 3.1 of the case study we looked at what was going on within and between certain parts of the PCT. Now let's look at what's going on outside the PCT among some of the organisations that the PCT needs to collaborate with or at least learn to co-exist with. We rejoin the story at the point a few days later when a letter of invitation from North City has landed on people's desks.

Diagnosing a situation within and between organisations

As you read this second episode see whether you think there is any indication of organisational malaise, using the same headings as in Episode 3.1.

Specifically, what further instances are there here of:
(a) hopelessness?
(b) cynicism – within organisations and organisation-to-organisation?
(c) distancing and blaming others?

As with Episode 3.1 you may also want to identify instances of Model I behaviour, including bypass and cover up, and of this process being undiscussable. You can also look for evidence of behaviours associated with Model II.

■ Organisational learning: 1

Episode 3.2: Partners? What partners?

Characters

Leaders of other organisations in the local health economy

Colin Everett – Chief Executive of St Edward's Hospital NHS Trust, a two-star District General Hospital

David Asprey – Deputy Chief Executive of the County Hospital NHS Trust, a three-star teaching hospital acute services trust

Ian Jones – Chief Executive of South City PCT

Councillor Bob Williams – Cabinet Member for Health in the City Council, a unitary local authority whose boundaries are co-terminous with the two PCTs

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North City Primary Care **NHS**
NHS Trust

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Telephone: ---------
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October 4th 200-

Dear Colleague

We would like to invite you to a meeting on ------- at 1.00 p.m. the North City Centre (directions enclosed) with the aim of forming an overview of all the partnership activities our organisations are involved in across the City.

We believe there is some duplication and several gaps, and would welcome the opportunity to see whether you observe this also. We think it would also be useful for us all to share information about new initiatives that may be interesting for the rest of the City organisations, for example on our side the Patients Forum. In this way we can explore ways of interacting in the most productive way.

Please confirm your attendance with Femi Anikeno on the above number. A buffet lunch will be provided.

If you have any questions about the meeting, please contact Femi or either of us. We look forward to seeing you.

Yours sincerely

Anne Howard
(Chief Executive)

Sara Trent
(Chair)

Enc. directions
cc. --------

St Edward's, October 5th

'"Partnership". Yet another word for "cuts"', thought **Colin Everett**, as he looked again at the joint letter from Sara and Anne. 'They come in to these new jobs in new organisations thinking they've got some magic solution that the rest of us have never thought of, when actually they just don't understand the problem. Right now it's "public engagement" and "thinking across the whole system", bandied about with great sincerity but in a meaningless way and usually followed by an insistence on more investment in the community paid for by cuts in our budget.

'Their perspective on the "whole system" is just as blinkered as ours may be! You can't tell me the public have been agitating for cuts in hospital budgets. Sure, if we can afford both they want good primary care too, but if they have to choose they want excellent hospitals for when they really need them. The Government understands that, that's why most of the targets relate to acute services.

'Targets. Not popular with the clinicians, of course, but a huge help in focusing attention. Partly because of the new money drawn in, partly because the management team have made sure they understand the dynamics that lead to delays, and partly the clinicians themselves. It would be nice to think it was mostly the clinicians, that would give me confidence about our ability to perform well in the Healthcare Commission inspection, but they are still locked in battle between the two halves of the merger. Bringing two Trusts together into one may have looked neat on paper – in practice it's two cultures, two sets of working practices, one long argument! We may have a single Board and Senior Management Team but forming one organisation will take years – and what are the chances of being left alone to do that, without being reorganised again?

'They come in to these new jobs in new organisations thinking they've got some magic solution that the rest of us have never thought of, when actually they just don't understand the problem'

'It's all very well for the PCT to issue diktats about activity levels and length of stay, I know our whole management team are very firm in their messages to clinicians about these. But, faced with incompetent GPs, most of our clinicians will put the patient first and keep them here, where they are going to get the best treatment. I don't blame them, if the patient were my mother or child that's exactly what I would want.

'Now the PCT are saying they don't want to talk "organisation-to-organisation", but about patients and programmes of care. Fine, but I have an *organisation* to run and that means I have to be able to take opportunities as they arise – wherever they arise. I can't predict where they'll be, so someone leaving "here" means I can fund someone else "there", but I can't guarantee it. Already, if an idea is good, and most of the requests from clinicians are sensible, I commit myself to finding the money before I can see where on earth it will come from. That's what running a big, busy organisation like this is about; all the best chief execs I know are "fixers". The old Health Authority understood that, this new lot at the PCT don't. Very hoity-toity they are about the HA too. Saying *they* are here to represent the public, to make sure local needs are met, whereas the HA saw its role as

supporting the acute sector. They just mean they are going to impose a different set of prejudices, they aren't any better at really finding out what the public thinks. They may have a bunch of community activists on the Board but that doesn't mean they are more in touch with local concerns.

'And at least the old HA wasn't a direct competitor, they didn't hang onto money to spend themselves. The PCT spends as much as it can on its own services at the expense of ours; take that new money for Children for example. They funded how many new posts in the PCT? No discussion then with our paediatric teams. Partnership? How about when they issued that North City service strategy last year? No discussion with us, nor with anyone else. I know why they did it, they'd have missed the LIFT deadline and all the funding associated with that, if they hadn't acted quickly. I'd have done the same. But don't come whinging that we aren't acting as good partners though.

'No, if they want partnership they've got to convince me, and my clinicians, that they really understand us and want to help us to offer excellent services. Otherwise we'll just wait until they're reorganised out of existence!'

The County Hospital

'Not another partnership meeting', sighed **David Asprey**, Deputy Chief Executive of the County Hospital NHS Trust, as his PA passed on to him North City's letter. 'It'll be another boring set of platitudes about increasing health gain and reducing health inequalities, all motherhood and apple pie. Pass the request on to Corporate Development please, and see if anyone can spare the time.'

'I know that's not in the spirit of that letter from the SHA exhorting us all to collaborate', thought David, 'but we do collaborate. We have contracts with 90 different PCTs, that's *real* collaboration.

'I don't have anything against them as people, in fact I think their Board is a more interesting bunch than the old HA (new faces, more enthusiastic about local concerns), nor against them as effective managers, nor as an organisation. It's just that our paths don't often cross. Our focus is on tertiary care, services too specialist for them to have any relevant expertise. They are good at primary and community care, and they seem to be getting better at commissioning secondary services. Commissioning from us is problematic though. They want to discuss "clinician-to-clinician" and ours can be persuaded to meet them if they think it's a good use of their time. In practice that means they go to a meeting once. They just can't spare the time to "negotiate" with GPs over specialist services that only other specialists are able to discuss sensibly.

'It's a pity. Some of our consultants do need more challenge, some of their behaviours are distinctly prima donna-like. But this isn't the way. Interestingly, the thing that seems to have had the greatest effect is the

service meetings facilitated by the Modernisation Agency where everyone describes the world as they see it. Users, cleaners, consultants from St Ed's, our own staff. So simple, but choosing people who have a genuine and legitimate interest in a clearly defined group of patients seems to prompt a discussion that is revealing and thought-provoking. I've seen people really changed by it – only when it's well facilitated though.

'Now if the PCT wanted to fund that kind of partnership work – fine. But what they want is waffly conversations between senior people, which they fondly think will lead to changes in behaviour on the ground. Well it won't. And what are the changes they want? For us to increase our "efficiency". They've discovered a new-to-follow-up ratio somewhere of 1:11 and think that's inefficiency. I'll have a chat with the clinicians involved but I know what they'll say, that they can't trust the GPs to monitor this condition appropriately (there was that case that went badly wrong a couple of years ago) so they hang onto the patients themselves. And the patients aren't complaining. Of course if the PCT can improve GP services that will be great, then we'll be able to reduce those ratios,[30] but they can't pull money out of our services to fund that – it would be a triple whammy – we'll be paying for the 1:11 service, and for the GP training, and it will probably be our consultants they use to do the training anyway.

'They seem oblivious of the fact that it is the wider system, the pathway as a whole, that is inefficient, not just our bit of it'

'They keep telling us to think "outside the box", to think of patients not organisations, services not buildings. And then they come up with the same old tired solutions themselves. More money into primary care, more services into primary care sites. Honestly, if we are really thinking out of the box let's think wider and further. Shopping habits have changed, entertainment too. People travel to fewer, bigger facilities. Why should health care be any different? We could at least be thinking about out-of-town health malls! Where primary care practitioners travel to secondary and tertiary centres, following the patients. Why is it always patients or consultants who are required to move?!

'Now they are saying they want to build efficiency indicators in to all the SLAs. They seem oblivious of the fact that it is the wider system, the pathway as a whole, that is inefficient, not just our bit of it. Another example of them using terms always to their advantage – they prattle on about thinking "whole system" but usually just as a stick to beat us over the head with, they don't think that way themselves. I'm happy to work with them on identifying how to improve efficiency, but not if we are always going to be seen as the "bad guys", with the solution always being to move money from us to them.'

South City PCT Offices

'So Anne is agitating for partnership commissioning now', thought **Ian Jones**, Chief Executive of South City PCT. 'But the founding principle of PCTs was to identify and meet local needs. Partnership cuts right across

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[30] Ratio of the number of appointments in out patients that taken by new referrals to the number taken by those being 'followed up' by the County team.

that. Sure: collaborative relations, especially with Trusts we're commissioning from, but we don't want to disappear inside a large commissioning partnership where the influence of our Board and our priorities is too remote. Leverage yes, joint decision making no. All sorts of accountability issues would need to be thought through.

'After all we can't make shared services[31] work properly – no-one is happy with the level of HR or IT support they are getting. As for payroll I am still writing a monthly cheque for the Sengebury Team Leader, and he's been in post for over six months! It's not surprising: people joined those departments to be part of the NHS, to be part of caring for patients. After all, they could have done HR, finance or IT anywhere and in all sorts of interesting settings. And now we've taken away their links with the organisations who are really doing that, and told them to relate to a contract instead. "Sorry. You aren't part of our organisational decision making any more, you just do what we negotiate with you in our SLA." It means you get a different kind of person managing those services. The leaders who enjoyed organisational challenges have gone. In their place we've tried to find people who enjoy focusing on efficient service provision. Unfortunately, of course, we aren't very good at working in this contract way either. We didn't get the SLA right because the only people who knew what should go in it were the people we were contracting with.

'Our Board is incandescent about the level of service. Actually that's partly because the shared services can't keep the Chair sweet in the same way as they used to! The way to manage chairs is to do whatever they ask immediately, it keeps them happy and stops them interfering in too many other things. Same with NEDs[32] generally: be nice to them, listen politely, and ignore what they say. They notice eventually, of course, but if you are successful overall they don't worry too much about it. I'm more worried about keeping the SHA happy. It's their perception of my performance that matters, mine and the PCT's.

'So, if North can come up with a tight proposal about something for us to work on together, with clear arrangements for accountability and convincing cost estimates, that's fine. If not, I'll go on meeting them and being pleasant, talking generalities, a bit like dealing with my NEDs, but I'm not going to risk my reputation and that of South City PCT in some ill-thought-out partnership structure.'

City Council

Bob Williams, Cabinet Member for Health in the City Council, also sighed at the invitation to a partnership discussion. Yes, in theory the statutory agencies working together as partners had to be a good idea, and yes, the new PCTs were much more genuinely prepared to seek the Council's views

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[31] Services that are employed ('hosted') by one organisation in the local health economy and provide services to several. Often include human resources, information technology, payroll.
[32] Non-executive directors.

than the old HA had been. So why his reluctance? Because, for all their good intentions, for all their belief that they just wanted to be partners, Bob was forming the view that the North City Board were after control. They didn't see it as that of course, they saw it as collaboration, as a means of solving intractable problems. But if the collaborators didn't come up with an answer that North City had decided on beforehand then somehow they got in the way of it being agreed or implemented.

So wouldn't this partnership meeting be a step forward?

No. The Council didn't need partnerships, what it needed was solutions to problems. If the meeting identified some of those problems, and the kinds of constraints the different organisations were working within (like the whole business of getting re-elected, for example) then that would be worth doing. But this talking shop wouldn't. North City, perhaps with some input from South, will talk about health improvement, the public health agenda and health inequalities. Great, but the benefits of that won't happen before the next election. In fact, it was likely to be worse than that. The PCT's solutions always seemed to involve taking money away from the hospitals. Probably right, the doctors were still largely unmanaged there, unchallenged, doing things the way they thought best without consulting with others. But closing hospitals or cutting services was a real vote loser. If the PCTs wanted the Council to be partners in that kind of decision, well they'd have to start all over again with a new flavour of council after the next local election.

The Council didn't need partnerships, what it needed was solutions to problems

Lots of talk about public involvement, Bob noticed. Of course, they were innocents at that game. The Council had been doing it for years, even experimenting with a Citizens' Panel now. Bob had met the PCT Chair and had offered to come and think through with the Board how they might constructively use the Panel for issues of joint importance. He hadn't heard any more, except for this invitation to a partnership meeting – he noted though that 'Collaborative use of the Citizens' Panel' was listed on the agenda. That was turning out to be pretty typical of North City. They talked about being partners, but somehow didn't trust others and wanted to control everything themselves.

The Overview and Scrutiny Committee had been interesting. The PCT had obviously decided to work closely with them, offered all sorts of training (called briefing) and actively asked for input to things like consultation processes ahead of time. But it was all a bit too helpful, they did not want to hear bad news, to be challenged, they wanted to do all their learning in advance, not take any risks. The same was about to happen with the Patients' Forum. Much concern that they would not be allowed to get too friendly with these. Not from any malice, but from some kind of implicit belief that because their intentions were good and their decision making sound they shouldn't be challenged. It would, he supposed, affect their careers. Careers seemed to be made or broken at the whim of the next tier in the hierarchy. It was all a much more political system than local government! He noticed the Director of Social Services had been invited too, he'd send his apologies and ask for a debrief from her.

Illustration and analysis

Again you may like to compare with ours your own observations about symptoms of organisational malaise and Model I and II behaviours. As before, we have not included every single instance of symptoms or behaviours.

Specific symptoms of organisational malaise

(a) Hopelessness
Examples outside the PCT

(HIDE | SHOW)

- **Bob** is disappointed at the inability of the NHS organisations to operate in a way that meets the needs of locally elected councillors.
- **David** is tired of the County being seen as 'the bad guy'.
- **Colin** believes there will be another reorganisation before he has sorted the problems bequeathed to him by the merger.

(b) Cynicism
Within organisations

(HIDE | SHOW)

- **Ian** describes a certain way of 'handling' non-executives..

'Organisation-to-organisation'

(HIDE | SHOW)

- **Colin** thinks of waiting until the PCT is 'reorganised out of existence', and views the PCT managers as coming 'in to these new jobs in new organisations thinking they've got some magic solution that the rest of us have never thought of, when actually they just don't understand the problem'.
- **Colin** also sees the PCT as a competitor.
- **Bob** welcomes the thought of working with others, but not a 'talking shop'; he also ascribes North City's agenda item about Citizens' Panels to ambition.

(c) Distancing and blaming others

(HIDE | SHOW)

Colin, Ian, Bob and David – these too are all blaming others, just as those within North City PCT are. They are seeking and finding fault without accepting responsibility for correcting the situation.

■ **Organisational learning: 1**

Evidence of Model I behaviours

Negative motives and negative assessments of performance

HIDE	SHOW

- Colin assumes 'partnership' mean 'cuts'. He is disparaging about the new PCT team's grasp of the problems. He also sees the PCT as a competitor.
- The County consultants see GPs as 'not specialist enough' to discuss the commissioning of specialist services.
- David assumes the PCT wants 'waffly conversations'.
- Ian assumes a particular (unfavourable) model of partnership commissioning when North City suggest it. He assesses very negatively the value of his NEDs.

As with Episode 3.1, people's assumptions have not been tested, largely because they are untestable. For example, how might Ian test out his conclusions about partnership always meaning cuts? We also see that while Model I behaviour is hidden from those adopting it, it is quite apparent to others. For example:

HIDE	SHOW

- **Bob** sees North City's attempts to control the relationship with the Patients' Forum and the Overview and Scrutiny Committee.
- All of the other partners observe that North City advocated partnership but did not consult them when they had pressing reasons for not doing so.
- St Ed's in particular feels aggrieved that there was no discussion with their paediatric teams about the pattern of expenditure of new money coming in for children's services.

Bypass and cover up
Do Bob, Colin or David raise their cynical interpretations of North City's action with Anne or Sarah?

HIDE	SHOW

No, instead they refuse invitations, or attend but talk platitudes. This is a bypass. None of those invited to the partnership meeting and who decide not to go will give their real reasons for not going, they will plead shortage of time, pressure on the diary, and so on. The fact that they have chosen not to attend, or do so with little hope of success, is kept hidden ('clash with another appointment'; 'it's very good to be here') so this is a 'cover up'. Of course, both the bypass and cover up are 'undiscussible'.

■ **Organisational learning: 1**

Sources of embarrassment and threat

(HIDE | SHOW)

In many meetings between partners there is bound to be some tension, some risk of embarrassment as unfamiliar jargon and terms are used, as other people are perceived to be hostile and judgemental or as more powerful and controlling. There is also a very real perceived threat in this situation: losing resources to another organisation. Moving into Model II here is not at all straightforward.

Evidence of appropriate Model II behaviours

(HIDE | SHOW)

Bob's genuine offer to help North City think through consultation processes, based on his experiences with the Citizens' Panel, was rooted in a desire to help rather than a wish to impose his views, so we could see this as Model II behaviour. Otherwise there is little being demonstrated here as the potential partners contemplate each other.

What about the way North City are interacting with the Patients' Forum and the Overview and Scrutiny committee? Surely that is positive, and we can applaud them for being mature enough to open themselves to this kind of relationship and learning?

(HIDE | SHOW)

Yes, if they are genuinely open to learning in real time, as they work with these scrutineers to understand how they see the world differently and challenge their own ways of thinking as a result. This would be genuine double loop and deutero learning, e.g. 'What systems do we need to completely rethink? How come we didn't notice they needed rethinking before this?'. If however, as Bob suggests, they are keen to 'do all their learning in advance and not take any risks' then there is a real danger of the only learning done being single loop, e.g. 'What particular activities do we need to do differently?'.

Let's now bring together the two main parts of the picture (perspectives from within and outside North City PCT) with the aid of the second main model in this case study, the Learning Organisation. What other ideas and approaches can be applied to this situation?

■ Organisational learning: 1

■ The Learning Organisation

The Learning Organisation (LO) is a term often used to encompass a variety of approaches. These include the Learning Company (Pedler *et al*., 1991), 'learning systems' (Nevis *et al*., 1995) and 'learning organisations' (plural) (Davies and Nutley, 2000). One aim these approaches have in common is to show how organisations should be designed and managed to promote effective learning. Several approaches build upon the work of Argyris and Schön discussed above as well as other, related concepts such as 'defensive' and 'offensive' adjustment (Hedberg, 1981).

Like Argyris and Schön, proponents of LOs seek to demonstrate that groups of people can collectively learn patterns of behaviour. They also accept Argyris and Schön's premise that the term 'organisational learning' is merely a metaphor, a shorthand way of saying that members of the organisation act as learning agents for the organisation.

Unlike Argyris and Schön, advocates of LOs tend to be prescriptive about the design of aspects of organisations, for example, systems and structures based on the experiences and/or commissioned research of the authors as part of their consultancy work. While there is relatively little independent evidence to support these prescriptions, they do offer a more immediately implementable source of advice to practitioners, and can provide a valuable adjunct to theory and empirical research of organisational learning. One much-cited example is the Learning Company by Pedlar *et al*. (1991). The authors of this approach have developed an 11-section 'blueprint' for assessing an organisation against their ideal Learning Company profile. This can provide a useful tool and checklist to remind us that an organisation must be considered holistically.

Equally, learning as part of organisational change is not the sole preserve of those models that have the word 'learning' in their title. Other tools and approaches, for example the Seven S Model (page 35) and the Content, Context and Process Model (page 186), also look at organisations in holistic terms and highlight the importance of learning and adaptation, and can be just as useful in this context.

For more about the literature and background of the Learning Organisation, see *Organisational Change* (2001), page 64.

Rather than discuss a number of these approaches here we have chosen what is probably the most widely read of these texts, that of Peter Senge (1990).

■ The Fifth Discipline

Senge, in *The Fifth Discipline* (1990), draws on the work of Argyris and Schön (reprinted, 1996), as well as on the work of a wide range of systems and other thinkers. In it he describes an LO as one

> *where people continually expand their capacities to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together.* (3)

Senge suggests that learning is a journey which has no final destination; learning is never-ending and it is the journey of discovery itself which counts. Moreover, the more we learn, the more we become aware of our ignorance. He also quotes Arie de Geus when he suggests that 'the ability to learn faster than competitors may be the only sustainable competitive advantage' (4). However, he does not explain why this would be any more sustainable than other competitive advantages that involve new disciplines or technologies, and the overall tone of his work is inspirational and optimistic, in contrast to the more measured and sceptical tone of Argyris and Schön. For instance, Argyris and Schön point out that Model II theory-in-use is an ideal and have conceded that they are unaware of any organisation that has fully implemented a double loop learning system (see Iles and Sutherland, 2001: 65). Claims about LOs need to be subject to a similar caveat. For practising managers, therefore, Senge's messages are likely to prove valuable when combined with a thorough understanding of the work of Argyris and Schön.

Senge lists **five disciplines** which he suggests will lead to the kind of LO defined above. These are:

1. *Systems thinking* – seeing processes rather than events, wholes rather than parts, dynamic rather than detail complexity
2. *Personal mastery* – the discipline of personal growth and learning, continually striving to clarify what is important, to be clear about the vision we are aiming for, and at the same time being ruthlessly clear about the current reality
3. *Mental models* – the tacit models we use to interpret and interact with the world. This directly refers to Argyris and Schön's Model I theory-in-use, skilled incompetence and ODRs.
4. *Shared vision* – the vision that encompasses the personal visions of all those working within the organisation
5. *Team learning* – the process of aligning the personal visions and developing the capacity of the team to work together to achieve the results they are after. Here Senge promotes the virtues of Model II.
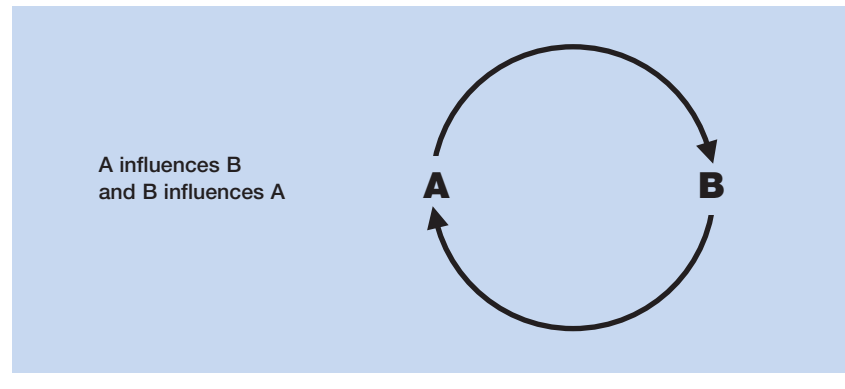
Following are some key messages arising out of the five disciplines.

Systems thinking

(For further background information on systems thinking see 'What is systems thinking?' in Iles and Sutherland (2001), pages 89–91.)
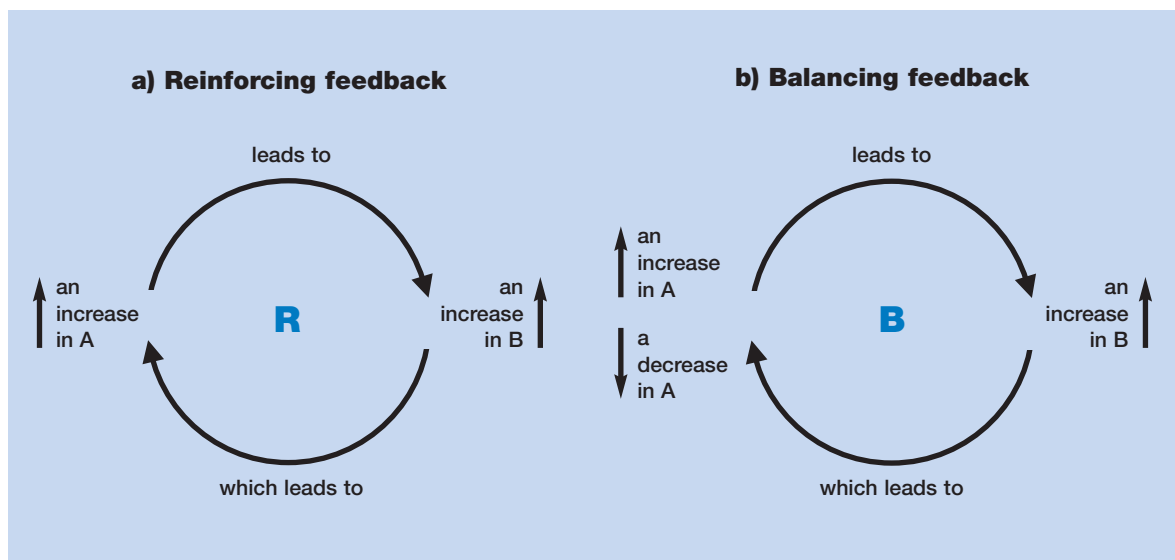
The essence of systems thinking, suggests Senge, lies in seeing inter-relationships rather than linear cause-effect chains and seeing processes of change rather than snapshots. It starts with an understanding of the principle of feedback and builds to learning to recognise types of recurrent structures. Feedback is a reciprocal flow of influence. (See Figure 3.4.)

■ The Fifth Discipline

Figure 3.4: A feedback loop

A influences B
and B influences A

A   B

There are two kinds of feedback: reinforcing and balancing. In reinforcing feedback an increase in A leads to an increase in B. An increase in B leads to an increase in A. (See Figure 3.5a.) Similarly a decrease in A leads to a decrease in B, a decrease in B leads to a decrease in A. So an initial increase or decrease in one escalates in effect. In balancing feedback an increase in A leads to an increase in B, but this increase in B then produces a decrease in A. This decrease in A leads to a decrease in B which produces an increase in A. Thus there is no escalation, but a balance. (See Figure 3.5b.)
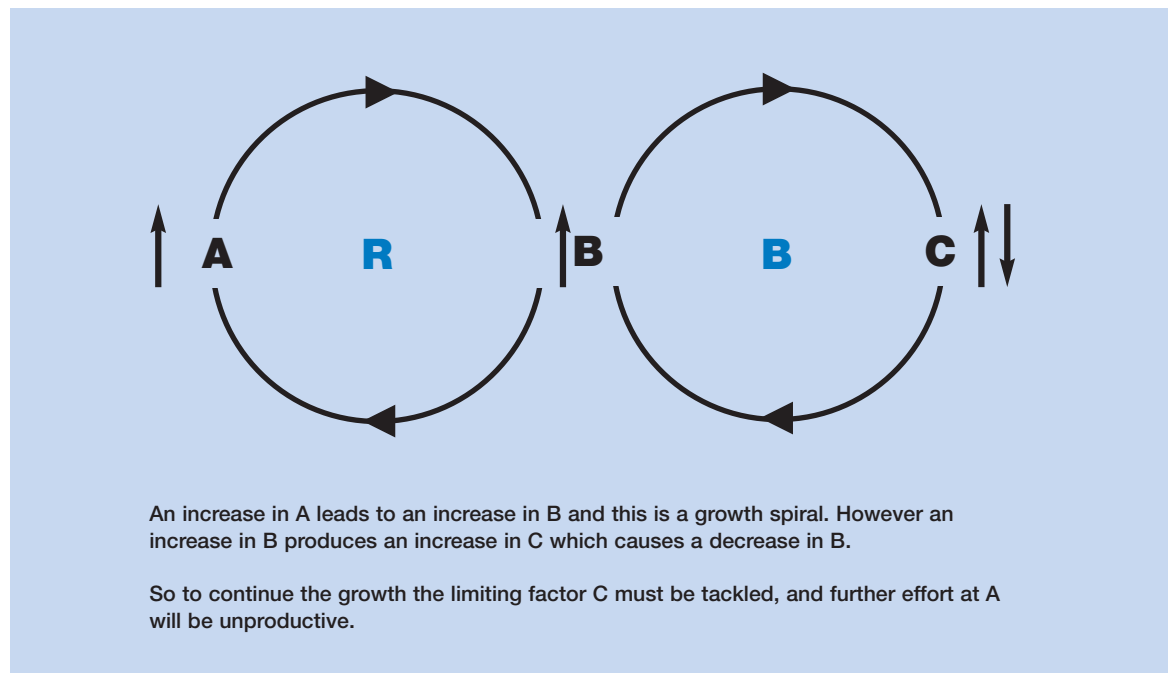
Figure 3.5: Types of feedback

a) Reinforcing feedback

leads to

an increase in A   R   an increase in B

which leads to

b) Balancing feedback

leads to

an increase in A

a decrease in A

B   an increase in B

which leads to

In many feedback loops there are delays so that an increase in A now leads to an increase or decrease in B but only after an intervening period.

From these simple elements we can build descriptions of much more complex systems and while systems vary, there are what Senge calls templates which

can be found occurring in many places. The two he describes as the most common are **limits to growth** and **shifting the burden**.
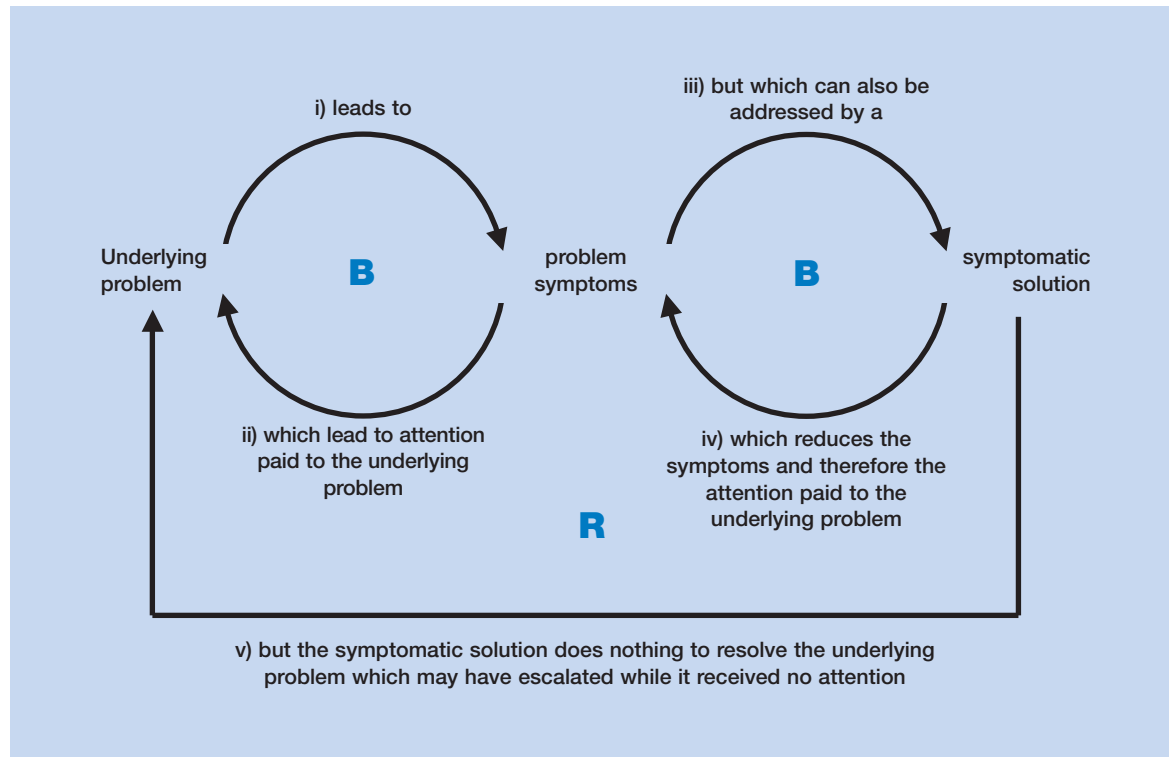
In the Limits to growth template a reinforcing circle is set in motion, leading to a desired result, but it also creates an inadvertent secondary process which is a balancing feedback loop and eventually slows down the rate of growth. (See Figure 3.6.) Senge suggests that if we wish to encourage the growth characterised by the reinforcing loop we will do so most effectively by minimising the secondary inhibiting loop.

Figure 3.6: Limits to growth

An increase in A leads to an increase in B and this is a growth spiral. However an increase in B produces an increase in C which causes a decrease in B.

So to continue the growth the limiting factor C must be tackled, and further effort at A will be unproductive.

Shifting the burden refers to a situation where an underlying problem generates symptoms that demand attention. Because the underlying problem is difficult to address people 'shift the burden' of their problem to solutions that address the symptoms. The symptoms respond in the short term but as the underlying problem is not addressed they eventually return, possibly worse than before as the problem may have increased while unattended. Senge (1990) quotes Meadows: 'any long term solution must strengthen the ability of the system to shoulder its own burdens' (62). (See Figure 3.7.)

■ The Fifth Discipline

Figure 3.7: Shifting the burden

i) leads to

iii) but which can also be addressed by a

Underlying problem

B

problem symptoms

B

symptomatic solution

ii) which lead to attention paid to the underlying problem

iv) which reduces the symptoms and therefore the attention paid to the underlying problem

R

v) but the symptomatic solution does nothing to resolve the underlying problem which may have escalated while it received no attention

Personal mastery

People with a high sense of personal mastery, says Senge, have a clear purpose, see current reality as an ally, feel connected to others and never arrive on their learning-in-progress journey. They see failure as an opportunity for learning, for example, learning about inaccurate pictures of reality, about strategies which did not yield the results expected, and about clarity of vision. They do not see failure as a sign of unworthiness or powerlessness. Above all, people with high personal mastery have a commitment to truth, to reality, to really understanding situations, including their own behaviour.

Mental models

To challenge mental models Senge draws on Argyris and Schön to recommend the use of the **left hand column** exercise referred to above (page 132) and the **ladder of inference** (discussed on pages 117-122), to recognise leaps of abstraction which often lead us to jump from initial data to the wrong conclusions. He similarly describes using reflection and inquiry skills to identify ODRs.

■ The Fifth Discipline

Shared vision

Senge indicates that without a shared vision it is not possible to have a learning organisation (see also the discussion of missions statements on pages 33-34). This claim is probably aspirational. Visions of the people at the top of organisations are, he says, usually just that, they may not be shared except at the top. Senge argues that to foster a learning climate in which individuals are encouraged to have personal visions means not imposing one top down. He also suggests that there must be a shared appreciation of the current reality, and of the gap between the vision and the reality, and the work needed to reduce the gap.

Team learning

Team learning is a process of aligning the individual within the team and developing the capacity of the team to achieve the results it is seeking. To facilitate team learning Senge advocates distinguishing between dialogue and discussion, and moving awarely from one to the other to explore different topics. His description of dialogue coincides with Argyris and Schön's Model II. He also describes it (1990) as being a 'free, creative exploration of complex and subtle issues which involves deep listening, suspending one's own views, being aware of one's own thinking processes and of others'. He defines discussion as the presenting of views and defending them in a search for the best argument. This, he suggests, will usually be appropriate for more straightforward issues. Unless the decision to use one rather than the other is explicit, Senge suggests, the result will be an ineffective amalgam. Dialogue, he observes, will probably always need the involvement of a facilitator of some sort.

> ### Experimenting with the Fifth Discipline: 1
>
> **To what extent can North City PCT and the other organisations represented in the case study be considered as Learning Organisations? A lot? In part? Not at all?** As Senge tells us, there are no simple recipes for creating an LO, no single pattern to which all LOs will conform, and hence there is no checklist that we can be expected to apply. However **we can look out for indications of the five disciplines he describes, and apply questions to the various organisations described.**
>
> *Systems thinking*
> - Are there examples of the templates Senge calls 'limits to growth' and 'shifting the burden' that North City has left unaddressed?
>
> *Personal mastery*
> - Is it the case that members of North City have a clear purpose, see current reality as an ally, feel connected to others and 'never arrive but are always learning'?
> - Do they see failure as an opportunity for learning?

■ The Fifth Discipline

Experimenting with the Fifth Discipline: 1

- Are they committed to reality, to really understanding situations, including the impact of their own behaviour?

Mental models
- You will already have considered this in your thinking about organisational learning, but you may also like to observe whether members of North City slow down their thinking to avoid leaps of abstraction, so that their mental models are as sound as possible.

Shared vision
- Are members of the PCT encouraged to have personal visions, visions that senior members are interested in and try to build into a shared vision?
- Do they have a shared appreciation of the current reality, and of the gap between the vision and the reality and the work needed to reduce the gap?

Team learning
- Are there examples of where people are distinguishing between dialogue and discussion, and moving awarely from one to the other to explore different topics?

Illustration and analysis

Examples of the five disciplines
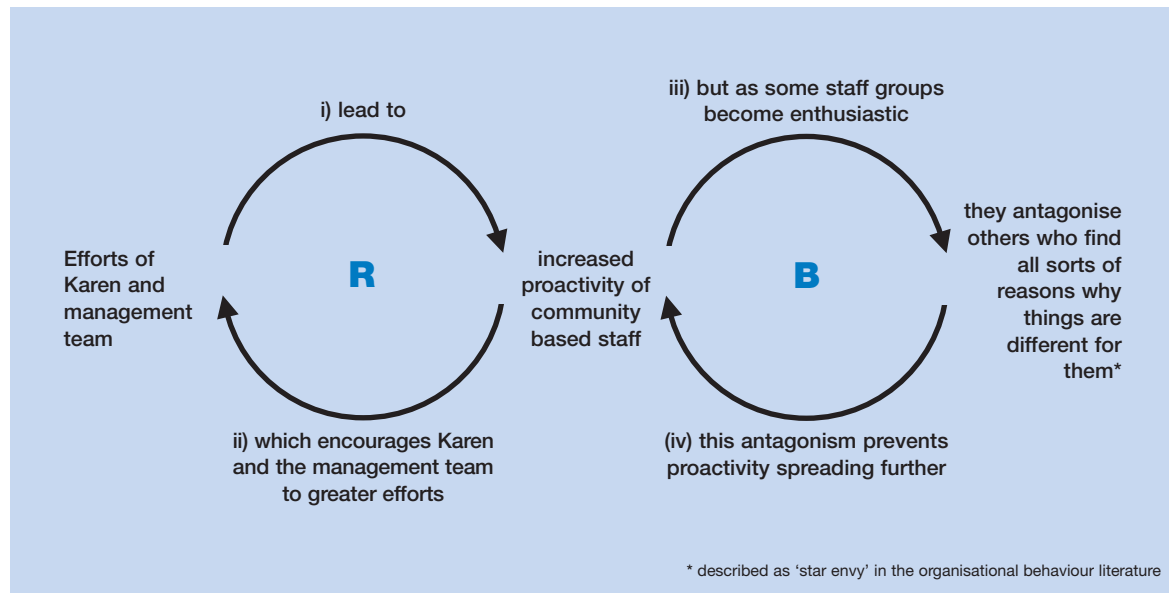
1. Systems thinking

Limits to growth. The level of proactivity among community based staff has been increasing as a result of all the efforts made by Karen and the rest of the management team. However, it has not spread beyond the AHPs. Could this be an example of a 'limits to growth' system? If it is, what could be the limiting loop? You may want to stop and sketch the loop here.

HIDE | SHOW
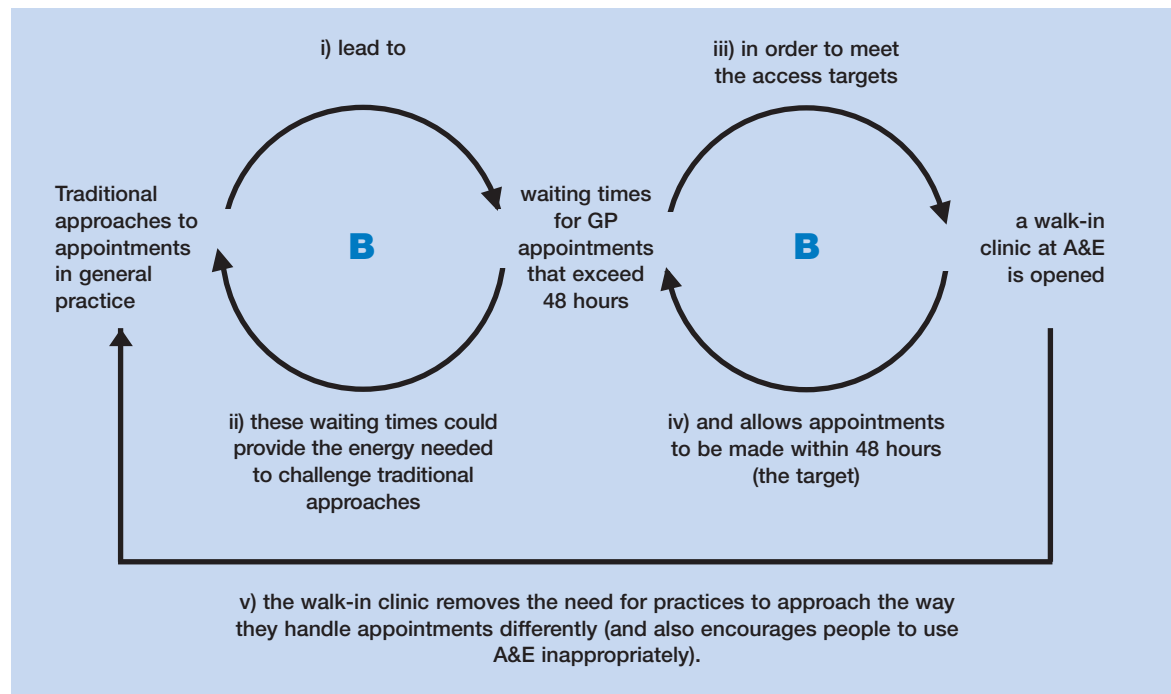
Figure 3.8: Limits to growth – limiting loop

i) lead to

iii) but as some staff groups become enthusiastic

Efforts of Karen and management team

R

increased proactivity of community based staff

B

they antagonise others who find all sorts of reasons why things are different for them*

ii) which encourages Karen and the management team to greater efforts

(iv) this antagonism prevents proactivity spreading further

* described as 'star envy' in the organisational behaviour literature

So if Karen wants to encourage the wider spread of proactive behaviours she will be wise to focus first on reducing the feelings of envy and only then resume her enthusiastic efforts at development.

Shifting the burden. Karen is irritated that the method chosen to achieve the access targets will work only in the short term, and indeed that in the longer term it will cause problems that will need to be overcome if access is genuinely and sustainably to improve. We can recognise this as following the 'shifting the burden' template. Again, you might like to sketch your illustration of the template before looking at the one below.

HIDE | SHOW

Figure 3.9: Shifting the burden – an illustration

2. Personal mastery

HIDE | SHOW

(a) In our view, **Sarah** is probably the character most able to see current reality as an ally. She sees now, although she did not see so at the time, that the fact the PCT does not manage GPs is not a problem but an opportunity to develop skills that are sorely needed throughout the NHS. She also does not waste energy fighting national directives but decides to treat them as a baseline from which North City will then meet its local priorities.

(b) **Colin** is an example of someone who regards current reality as the reverse of an ally. He sees a prospect of reorganisation and interprets this as a problem because he and his team won't have had time to integrate the clinicians, who are still in two factions as a result of the merger of two previous trusts. He may be correct about the chance of reorganisation, but he does not need to see it as a problem, merely a reality with which he has to deal.

(c) When it comes to management capacity everyone agrees there is not enough – and the solution is for everyone to work very long hours. Perhaps there is another way of looking at this that depends on current reality being seen as an ally. What might this mean in practice, for example, if we were to say that managers in the PCT must not exceed their hours?

■ The Fifth Discipline

HIDE | SHOW

The functions of the PCT would have to be approached differently. The PCT is advocating redesign for clinical services, for acute trusts. Perhaps it would benefit from using those principles of focusing on outcomes and thinking creatively about the resources available and how they are deployed, to redesign their management pathways. In the process they may need to think 'whole system' and the redesigned management and commissioning pathways may lead to genuine partnership working.

3. Mental models

There are many examples where people's mental models are inhibiting their effectiveness. We give just one here.

HIDE | SHOW

Colin could set about the integration agenda in such a way that it can succeed whether or not there is another reorganisation. He would probably concentrate on different things as a result of thinking about the issue differently.

4. Shared vision

HIDE | SHOW

A shared vision is one that draws on the personal visions of those involved and we see in the case that **Sarah** has helped the AHPs to reconnect with their personal visions. These teams have also been supported by Karen in the development of a shared vision, and in making progress towards it.

The **Board** however appears not to share a vision. It is possible that North City itself does not. When we look wider it appears that potential partners too do not share a vision – except perhaps one that laments the difficulty of the economy-wide situation.

5. Team learning

There are several examples of lack of dialogue, and of the lack of awareness of he need for both discussion and dialogue:

HIDE | SHOW

- **Colin's** scepticism that the outcomes of partnership discussions are decided in advance and that the PCT issues diktats
- **David's** view that the PCT is 'an interesting bunch' but, given the chance, will label the County as 'the bad guys' and manoeuvre them into a tight corner
- **Jake's** frustration that any questions he asks of executive board members are only met with answers

■ The Fifth Discipline

However there are examples too of dialogue:

HIDE | **SHOW**

- Helen's awareness that the PCT Chief Executive and Chair were skilled in being able to convert the PEC discussion (heated) into a dialogue (constructive)
- Karen's recognition from her interactions with nursing teams that it is not the volume of talk that matters but its quality and ability to 'switch' people on
- Yvonne's discovery that for discussion to become meaningful dialogue it needs to have a solid grounding in information and that she has an important role in interpreting this information to others.

Now let us go back to North City and see how they might address the situation outlined here.

■ The Fifth Discipline

Episode 3.3:
On being a Chair ...

'I know **Jake** has thought about resigning before, but this time I think he may do it', thought **Sarah**, Chair of the PCT Board.

It would be a pity, Jake a non-executive director, had a huge web of local contacts, people he had cultivated over the years, all interested in good local services for local people, people he had met fighting one closure or another – a local hospital, a social services office, libraries. If anyone qualified for the title 'community activist', it was Jake, and Sarah had been delighted to appoint him to the new PCT Board. He was chafing though at the lack of ability to make a difference, at the slow pace of change, at the way he couldn't get the execs to listen to what he had to say. Jake had returned from a national conference recently spitting feathers. He had overhead one manager talk to another about their 'Muppets', and realised they were referring to their non-execs. Sarah didn't think for one moment that Anne and her team would be so disrespectful, but equally she knew they were under pressure from the SHA to 'deliver' their Board, and that they felt aggrieved that PCT NEDs were so often so much more outspoken than their acute sector counterparts.

There was such an ambivalence toward the role of non-execs: locally there was constant pressure for them to attend this meeting or that, as an informed but lay, local voice. Nationally every new initiative required a non-executive 'champion'. And yet there was a real resistance to hearing the views of those non-execs, to using the different kinds of perspective they brought with them as a result of their other experiences. And not just ambivalence, there was some real ambiguity about the role – Anne had been furious with Sarah after the public consultation meeting about the most recent service reconfiguration. Anne had felt let down, that Sarah was not supporting her and the exec. team. Sarah was very clear that her role was to chair the meeting, to allow every sensible point to be made and to be addressed, to ensure that the consultation was just that. But Anne had wanted a firmer line, a stronger support for the option they were proposing.

'But it was a Board decision', Anne had said, 'not mine, not the execs' but the Board, you left us to carry the can for a decision you were party to.'

While feelings about that particular incident still rankled, on the whole she and Anne had developed a shared understanding of where one role ended and the other began. Sarah knew this was slightly different to those of other CE/Chair pairs, indeed she didn't know any two who were interpreting the boundaries exactly alike.

The cause of Jake's exasperation was information – the, as he saw it, complete lack of it. 'How can we make a decision on this?', he would say, 'it won't be a decision but a guess'. For a long time he had been very supportive of **Yvonne**, in the belief that she felt the same and was determined to try and remedy it. Now, though, he was furious, he had invited Yvonne to a management meeting in his own company so he could show her the kind of information they were using and how, but she had cancelled at the last minute because of an urgent meeting locally about orthopaedic

targets, and had made no effort to rearrange it. It was, he fumed to Sarah, another instance of the NHS thinking their way of doing things is the only way, and that they don't need to learn from anywhere else.

Learning ... Funny, that wasn't a word you'd use to describe the PCT any more, perhaps it had been at the beginning. Now there was a great emphasis on finding things out, but not really on learning – finding out facts, measuring indicators, carrying out studies, but always with a view to dealing with an immediate problem. They didn't seem as a Board to be gaining a sense of the shape of things, trends (ones that mattered), patterns. She wondered how she could influence that. One area where she knew she legitimately had a role was in establishing the culture of the organisation, another was the behaviour of the Board. How could she foster a spirit of learning within the Board and the wider organisation?

■ Organisational learning: 2

In Sarah's further reflections we see more evidence of Model I behaviours. We also see her determination to do something about them.

- How specifically can Sarah tackle Model I behaviours?
- How can she reduce the defensive reasoning and see it replaced with its productive alternative?

Argyris and Schön put forward a multi-pronged intervention in such situations, to 'get to there from here'. First of all we need to understand where 'here' is, to discuss with people the theories-in-use they adopt. As people's theories-in-use are tacit, hidden from the person using them, they have to be detected through observation.

The aim of the discussion is that everyone agrees that these ODRs exist, and that they want to tackle them

Thus, the first step is observation by a skilled outsider, able to draw up a map of these theories-in-use, the values that seem to be governing them, the action strategies that people are adopting, and the consequences of these. Often there are first-, second- and third-order consequences (the first set lead to the second and so on). This map is then fed back to the participants who discuss all the elements and the feedback and feed-through processes within it, with the observer and each other. The aim of the discussion is that everyone agrees that these ODRs exist, and that they want to tackle them.

According to Argyris and Schön people most usually do recognise ODRs, and are keen to address something they have felt powerless to change.

Sarah may well want the Board to engage in this kind of mapping process. However, with the current tensions between executive and non-executive directors she might choose instead to start with the 'three at the centre'.

The learning process to address the ODRs occurs in four main phases, as follows.

1. At a first meeting the concepts of **Model I** and **Model II** are introduced. Often participants are fired with enthusiasm and believe they can change their behaviours instantly as a result of the 'Aha!' of discovery they have just experienced. Argyris and Schön have observed that instant change is not possible, because of the skill with which people use Model I and the way it is embedded into our habitual ways of responding.

2. Participants are then asked to undertake the **left hand column** exercise described above (page 132), thinking about an issue of particular concern to them and imagining a conversation they would like to have with the person they perceive to be causing the greatest problem. They bring their imaginary scripts and the associated thoughts and feelings with them to a meeting at which they discuss their scripts and the left hand columns with the others. This process allows them to slow their thinking down sufficiently to be able to use **Model II concepts**. (Here the **ladder of inference** (see page 117) may

be used and the theory and practice of **learning conversations** (Brown and Isaacs, 1996)[33] could also be usefully introduced.)

Argyris and Schön suggest these discussions are taped and that the tape is given to the person whose issue is being discussed. They find that people often use Model I thinking during the discussion to attribute words or phrases to others which are not in evidence when the tape is played back.

3. It is useful then for participants to be able to have further **one-to-one work** with the facilitator in which they work on real issues, often involving unproductive relationships with each other. It can be useful to gather the learning experiences together in a further **reflective seminar**.

4. The work can then be **expanded to the rest of the organisation** in a similar way. If an organisation is serious about doing so, Argyris and Schön report some success with the development of a cadre of internal change agents and educators who foster a particular expertise in working with Model II thinking, in addition to their day jobs.

In the absence of more quotable experience Sarah may want to enter into such a programme in the spirit of learning from trying it out, rather than overselling it

Is there evidence that this multi-pronged intervention works? As explained earlier, Argyris and Schön themselves report that they do not know of any organisation that can call itself a learning organisation, but companies they have worked with have benefited from this intervention. We do not know of health organisations who have attempted such a comprehensive approach, but we have worked with individuals on moving from Model I to Model II theories-in-use, and find that we can recognise Argyris and Schön's observation that it takes as long to acquire these new thinking processes as it does to learn to play a 'middling game of tennis'.

In Sarah's position we suggest she may want to work on her own use of Model II before doing anything else. Once she becomes more effective as a result, this will be noticed and she will be able to raise the topic either with the other two 'at the centre', or with the Board. In the absence of more quotable experience she may want to enter into such a programme in the spirit of learning from trying it out, rather than overselling it. Indeed, she may want to define it formally as action research (see Iles and Sutherland, 2001: 66).

In any event, once she has decided to work on this formally she will need to identify a good facilitator, one who can demonstrate in his or her own approach the good use of Model II behaviours.

■ **Organisational learning: 2**

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[33] Informal conversations at work that become a medium through which ideas that are created at all levels within and on the periphery of the organisation make it into the mainstream. See the online article by Brown and Isaacs (1996) listed in References, page 178.

Experimenting with the Fifth Discipline: 2

If Sarah were to use the prescriptions advocated by Senge (1990) in *The Fifth Discipline*, what strategies might she consider implementing in terms of:
1. Systems thinking?
2. Personal mastery?
3. Mental models?
4. Shared vision?
5. Team learning?

You may want to re-visit the discussion of Senge and consider some strategies under these headings before comparing your ideas with ours.

Illustration and analysis

Here are some examples of strategies Sarah might consider.

1. Systems thinking

(HIDE | SHOW)

- Notice feedback loops, simple systems structures
- Identify any 'limits to growth' and 'shifting the burden' patterns
- Use these observations to intervene more appropriately, especially by helping others to see their own role in exacerbating a situation.

2. Personal mastery

(HIDE | SHOW)

- Be clear about her own personal vision
- Encourage others to be clear about theirs, by helping people get back in touch with the reasons they came into health and social care in the first place
- See current reality as an ally, e.g. in some of the ways described earlier
- Encourage others to do so as well
- See failure as an opportunity to learn (while avoiding naïvety).

3. Mental models

(HIDE | SHOW)

- Work on her own Model I responses
- Aim for Model II responses
- Reduce the degree of embarrassment or threat others can perceive in situations so that they are more able to enact the theories they espouse.

■ Organisational learning: 2

4. Shared vision

(HIDE | SHOW)

- Meet people from all over the organisation and outside it
- Encourage their personal visions to be encompassed within the corporate vision.

5. Team learning

(HIDE | SHOW)

- Distinguish between issues that can be dealt with in discussion, and those that need exploring in dialogue
- Encourage opportunities for both and for learning conversations
- Be conscious of the need for a facilitator role for dialogue discussions, if appropriate
- Adopt this role herself on occasions
- Encourage reflections on the process of group discussions, by the trio at the top, and by the board (in private, not public forums)
- Encourage Anne, the Chief Executive, to reflect in this way in one-to-one work.

Concluding thoughts

As we have seen, encouraging people to learn on behalf of their organisation is all-important in contexts that are new, changing, uncertain. However, organisational learning is equally important in institutions of long standing if they are to improve services, make the very most of their resources, and be challenging, fulfilling places to work. The principles of organisational learning are just as relevant therefore in acute hospitals and mental health services as in primary care trusts. And it goes without saying that it is relevant to all levels in the NHS. Indeed, it is possible to argue that without due attention to these learning behaviours any investment or reform will yield less than optimal results.

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Managing *Change* in the NHS

Case Study 4:

Supporting change as an SHA

Managing
Change
in the NHS

Overview

In this case a team from an SHA use the eight factors identified by Pettigrew, Ferlie and McKee (1992) as differentiating higher from lower performing organisations when it comes to introducing change in the NHS, in order to decide what approach to take to a hospital trust that is deemed to be failing.

After meeting the team and the decisions they are trying to make in Episode 4.1, you are introduced to a model – often known as the Context, Content and Process model – and the eight-factor framework derived from this. As the team attempt to apply this framework in Episode 4.2 you have an opportunity to reflect on whether you would use it in this way, and then compare your reflections with those of the team. Episode 4.3 shows the decisions that are arrived at and the immediate consequences of these.

Approaching this case

The case is designed to be read in the following sequence. We suggest some places for taking breaks in the material, with indicative times.

Episode 4.1 'And such a silly mistake' – and introduction to the SHA team and the problem they are faced with	5 mins
Content, Context and Process Model – an overview of the theory	20 mins
	Total 25 mins
Episode 4.2 A receptive context? – the SHA team discuss and analyse the situation under review, guided by the model's eight-factor framework	30 mins
Experimenting with the eight factors framework – an opportunity to analyse the material the SHA team has generated, using the same framework	30 mins
Illustration and analysis: 1 – a chance to compare your findings with ours	15 mins
	Total 75 mins
Illustration and analysis: 2 – a further opportunity to analyse the material using a matrix format	40 mins
Comparing our analysis – a further chance to compare your findings with ours	20 mins
	Total 60 mins
Episode 4.3 Some decisions – shows the the decisions that are taken, together with the SHA's subsequent reflection and analysis	30 mins
	Total 30 mins

You may find it helpful to have access to *Organisational Change* (2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Note

The (HIDE | SHOW) icon refers to those parts of the electronic PDF version of the document where readers have the option to hide or show the text, depending on whether they want to stop and think before comparing their own ideas with ours.

If you prefer to display all the hidden text for the case, click on the 'Show all' button; similarly, if you wish to hide all the text for the case, click on 'Hide all'.

SHOW ALL | HIDE ALL

Perspective

Events are seen through the eyes – or more accurately, the spoken words – of an SHA Executive team and a Trust Chief Executive. Events unfold through scripted dialogue and we are not privy to people's thoughts other than those which they share in discussion.

Tool chosen

- Content, Context and Process Model

Characters

Strategic Health Authority

Robin Forster – Chief Executive
Penny Harris – Director of Organisational Development
Ian Pentland – Director of Finance
Kathy Jones – Director of Performance
Blanche Hillier – Director of Nursing
Thom Walsh – Medical Director/Director of Public Health

St Perrin's Hospital NHS Trust

Gill Rose – Chief Executive
Yvette – Director of Nursing
Martin – Medical Director
Mark – Finance Director

Primary Care Trust

Serhat – Chief Executive

Background

The Strategic Health Authority has just learned that a mistake in data collection at St Perrin's Hospital NHS Trust means that it has missed one of the key access targets, having previously reported achieving it. This will almost certainly lead to the Trust losing its only star. The Trust's Chief Executive, Gill Rose, was appointed only twelve months previously with a remit to turn this 'failing' trust around. Such is the perceived gravity of the situation that the Chief Executive of the SHA has convened a meeting of his team to consider what their approach to this news should be.

Episode 4.1:
'And such a silly mistake'

Strategic Health Authority, Executive Offices Monday 1 February 200-

'What I want us to think about, very carefully, is whether we go on supporting Gill Rose and giving her the help we think she needs, or whether it's time to find her another role and for us to put someone else in as Chief Exec.'

The speaker is Robin Forster, Chief Executive of East Benning Strategic Health Authority (SHA), and he is referring to St Perrin's Hospital NHS Trust, a trust offering acute services – what some might refer to unflatteringly as a 'bog standard District General Hospital'. The present conversation is between Robin and his Executive team:
- *Penny Harris* (Director of Organisational Development)
- *Blanche Hillier* (Director of Nursing)
- *Kathy Jones* (Director of Performance)
- *Ian Pentland* (Finance Director)
- *Thom Walsh* (Medical Director/Director of Public Health)

Robin: As you know, instead of making progress from one star to two, as we were hoping, St Perrin's are in danger of losing that one. Seems like we have a crisis brewing.

Kathy: Yes, and for such a silly reason, a basic mistake in their data collection. It really makes me question whether Gill has her eye on the ball. And then for us to be given the news by the Information Manager rather than Gill herself, it makes me wonder whether Gill has a measure of just how serious this is. Perhaps she has, and she's like a rabbit caught in the headlights. But whatever it is, we can't let this go on any longer.

Penny: But Gill didn't create the mess, we put her in there to sort it out. Rather than blame her, I think we really must look at the bigger picture. Otherwise we'll just have this situation repeated with the next person we put in – unless there are any paragons of leadership virtue out there!

Ian: Well, I wouldn't expect a paragon, but I do want someone who will stick to financial agreements. Gill promised she'd achieve an overspend no greater than £2.5million and now she's projecting £4.5million. That says to me that the Trust is out of control, and we can't have that. We need to do something and perhaps replacing Gill would be a good start – and a signal too, to the rest of our trusts. They'll be watching how we deal with this and they'll be jumping on us hard if we insist on St Perrin's being bailed out financially yet again.

Thom: Yes, but they'll be even more vociferous if, this time next year, we're having the same conversation – about another chief exec at St Perrin's. I'd like us to review everything we know about St Perrin's before we decide what to do about Gill. Perhaps we should include her in that discussion too.

Kathy: No, I agree that thinking about the wider picture would be helpful, but I'd like

to keep Gill out of it for the moment.

Robin: Right, this is what I think we'll do. Now, Ian and Kathy, I know that Finance and Performance are under pressure with the Departmental 'returns', and we all need to get to grips with the new performance targets, and of course all the work on the balanced scorecard is taking a lot of everyone's time. But I think this is important so let's take some time to gather our information about the organisation and meet again on Thursday. And let's use the model of receptive contexts, the one we used before, to try to get a really comprehensive feel for what is going wrong. Kathy, I think you're right, we'll do this without Gill as we're looking at the context Gill is operating in. I've booked a meeting with her to hear about it from her perspective on Friday. Blanche, I don't think we've used the context model since you've been with us.

Blanche: That's the one that deals with change programmes, isn't it? I haven't looked at that in a while.

Robin: There's an interesting article on it in *Health Management Digest*, about it being used in PCTs. Kathy, you did a good PowerPoint summary of it at the away day in June, could you email it to Blanche? Thanks.

■ Content, Context and Process Model

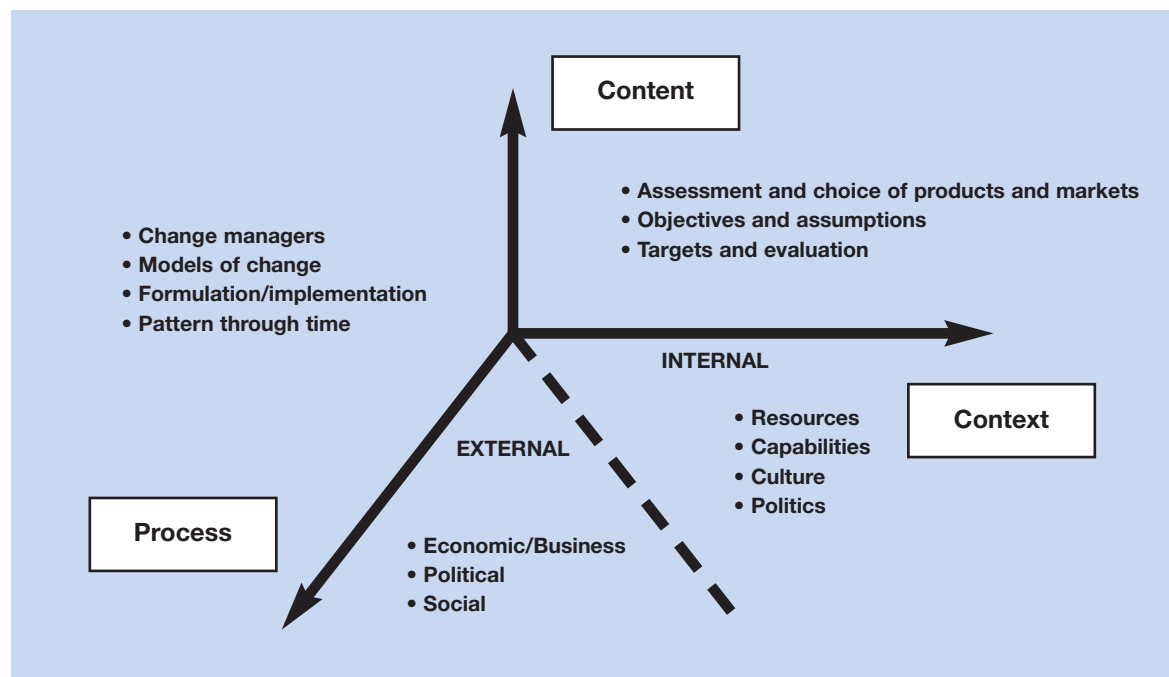## Understanding change holistically

The Context, Content and Process Model was developed during the 1980s by Andrew Pettigrew and Richard Whipp and published in *Managing Change for Competitive Success* (1991).[34] The model arose out of their empirical research into why some companies in the UK performed more competitively than others and were better able to embrace and manage strategic change. The model, and a modified framework derived from it, were subsequently applied to the context of the NHS in England through a major cross-case analysis of different types of change in several localities (Pettigrew, Ferlie and McKee, 1992).

According to the model there are three essential dimensions of strategic change. These are designated as Content, Context and Process (Figure 4.1). These dimensions roughly translate as:
- the content or *what* of change (objectives, purposes, goals)
- the organisational context of change (internal and external environments)
- the process or *how* of change (implementation).

Figure 4.1: Understanding strategic change: three essential dimensions

Source: Pettigrew and Whipp (1991)

- **Content**
  - Assessment and choice of products and markets
  - Objectives and assumptions
  - Targets and evaluation

- **Change managers**
- **Models of change**
- **Formulation/implementation**
- **Pattern through time**

INTERNAL

EXTERNAL

- **Context**
  - Resources
  - Capabilities
  - Culture
  - Politics

- **Process**
  - Economic/Business
  - Political
  - Social

■ Content, Context and
   Process Model

[34] A checklist for the model, devised primarily for researchers, had appeared two years earlier (Pettigrew, Whipp and Rosenthal, 1989).

Strategic analysis typically begins by looking at the dimension of **content**. This covers the components of the organisation's strategy: e.g. financial, technological, marketing, human resources and governance. It includes key objectives, built-in assumptions and expectations, targets, sources of drivers of strategic change and methods and rules of evaluation.

Analysis then moves on to the dimension of **context**. This refers to ways in which the organisation is configured. The context can be divided into two categories:

- *Internal context* includes the organisation's structure, culture, distribution of power, micro-politics and internal capabilities.
- *External context* includes wider elements of the organisation's environment, including the economic, political, legal and social contexts in which the organisation operates. If the external context changes, the internal context must respond concurrently.

After analysis and discussion of content and context, comes the dimension of **process**, the practicality of how individuals, groups and organisations embrace (or resist) change over time. Process issues, it is argued, acquire particular significance in the NHS where 'energy and capabilities which underpin [service change] cannot be conjured up over a short period of time through the pulling of a single lever' (Pettigrew, Ferlie and McKee, 1992: 275). Moreover, in this particular setting history often has a prominent role in people's thinking: 'The past weighs a heavy hand in determining local perceptions, and layers of competence emerge only slowly to enable and protect champions of change' (275).

The astute manager is constantly scanning all three dimensions, and will see to it that a management team is created that ensures that all dimensions play their due part in strategic decision making and that no single dimension dominates thinking

The astute manager is constantly scanning all three dimensions, and will see to it that a management team is created that ensures that all dimensions play their due part in strategic decision making and that no single dimension dominates thinking.

Like other models which adopt a holistic perspective, the Content, Context and Process Model requires as much attention to the inter-relation of its constituent parts and their relation to the whole as to the individual components themselves. Again, like some other holistic models, such as Seven S (page 35) or the Learning Organisation (page 162), the Content, Context and Process Model is best considered as an 'umbrella' approach to leading, managing or influencing change rather than a prescriptive template. The model can also complement and incorporate other, qualitative and quantitative change management tools and methods. At a basic level it can serve as a diagnostic checklist; more comprehensively, it can be used to design, monitor and assess a change management intervention or programme or to help inform quasi-experimental before-and-after studies. In this instance we will be looking at its value as a diagnostic tool to inform decision making.

■ Content, Context and
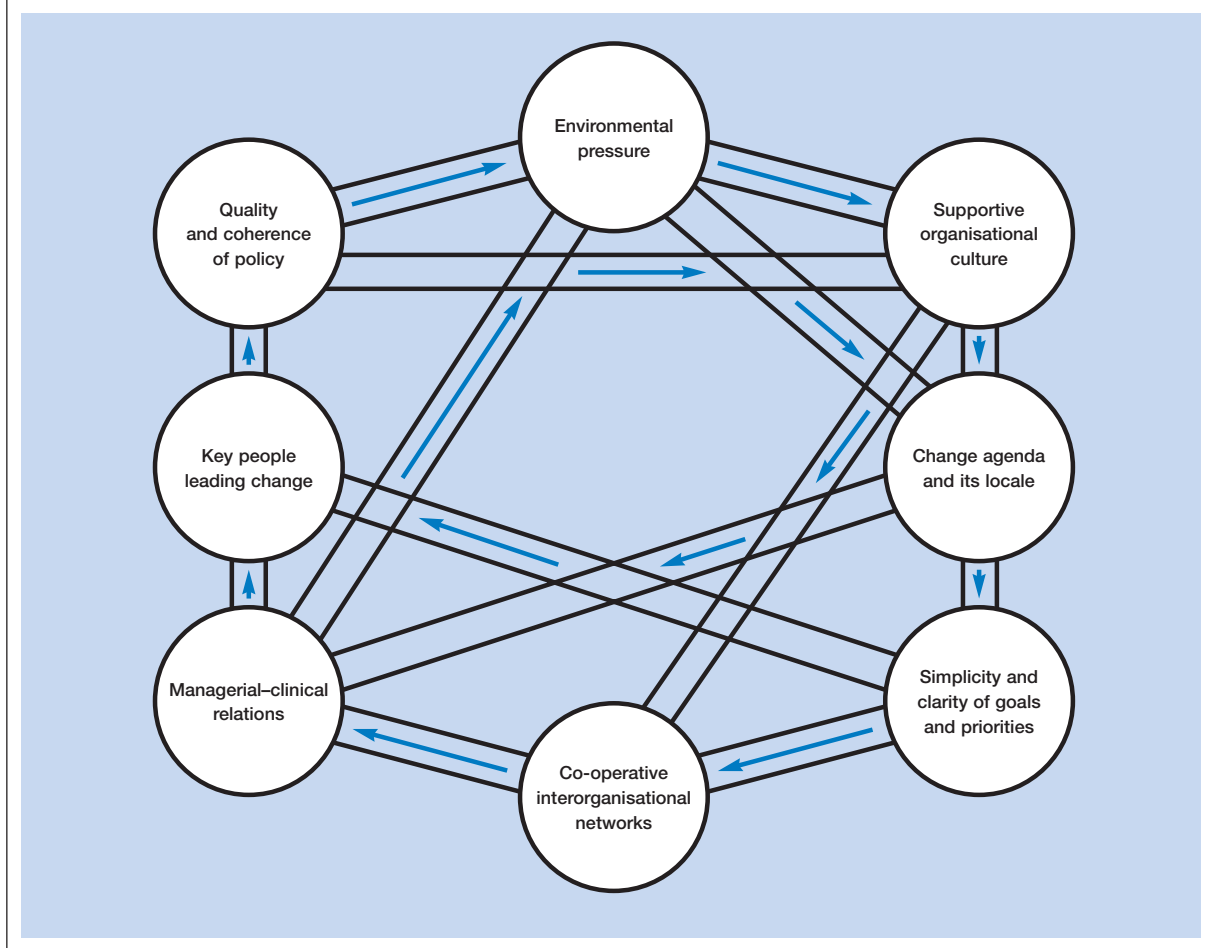   Process Model

Receptive contexts for change

The modified framework (1992) considered factors of particular relevance to the NHS and identified eight interacting factors likely to support, block or divert change. (See Figure 4.2. The arrows are illustrative only of the many possible connections between factors and we discuss this further below.)

Figure 4.2: Receptive contexts for change: the eight factors *Pettigrew* et al. *(1992)*

Individual factors are as follows, in numbered sequence (1992). We note immediately that while there is an approximate reflection here of the logical sequence Content-Context-Process – in that the first factor highlights 'content' issues such as strategy, objectives, targets, and many of the remaining focus on 'context' – process issues are integrated throughout the factors.

1. *Quality and coherence of local policy.* The quality of 'policy' at local level is as important as policy from the centre. If policy is not allied to shared world views at the operational end, inertia is likely to result. Hence, the ability to analyse and communicate convincingly policy data and decisions, to both

■ **Content, Context and Process Model**

specialist and non-specialist audiences, is an important change management skill. Policy needs to be actionable, e.g. by being broken down into manageable pieces, and matched to a realistic and achievable financial framework (wobbling capital budgets, for instance, can destabilise strategic change exercises). Long-term issues (such as psychiatry and care for the elderly) need to be kept on policy agendas, 'which could be difficult in the NHS where there is a tendency for every issue to be famous for 15 minutes' (Pettigrew, Ferlie and McKee, 1992: 278).

2. *Key people leading change* need to be identified, especially in the multi-disciplinary team settings of the NHS. Leaders and change agents need not be 'macho managers'; rather, leadership is likely to be exercised in more subtle and pluralist fashion or diffused across purposeful teams.

3. *Long-term environmental pressure*. There has been a tendency for the NHS to be inward looking and hence to be less geared up to what the world outside needs and wants. Environmental pressure can produce movement, especially if skilfully orchestrated. However, excessive pressure can deflect the energy for change. Inadequate buffering against environmental pressure can be a key factor in sapping energy out of major change processes.

4. *Supportive organisational culture*. The NHS is not one culture but a collection of different subcultures: managerial, clinical, professional, and so on. Cultures which support change are likely to be characterised by the following: purpose-designed structures rather than formal hierarchies; a focus on skill rather than rank and status; an open, risk-taking approach; openness to research and evaluation; a strong value base that helps to give focus to an otherwise loose network; and individuals, teams and organisations with strong positive self-images and a sense of achievement.

5. *Effective managerial-clinical relations*. This is a critical component in stimulating strategic change. Manager-clinician relations are easier where negative stereotypes are broken down, perhaps as a result of the emergence of mixed roles. Managers tend to be best who are semi-immersed in the world of clinicians. Likewise, clinical directors are an important group in thinking managerially and strategically. That said, relations between the two groups can often quickly sour and be slow to rebuild.

6. *Co-operative interorganisational networks.* The most effective networks are both informal and purposeful, rather than self-absorbed and narcissistic. However, they are often vulnerable to staff turnover.

7. *Simplicity and clarity of goals and priorities*. Managers need to be able to narrow down the change agenda into a set of key priorities and to insulate this core from the constantly shifting short-term pressures apparent in the NHS. One way to simplify and clarify is to shrink the problem or break it down into more manageable pieces. (See also 'Quality and coherence of policy'.)

8. *Fit between change agenda and locale*. In the NHS the nature of the locale has an impact on how easy it is to effect change. Influencing factors include:

The eight factors are considered as 'a linked set of conditions which provide high energy around change'

■ **Content, Context and Process Model**

coterminosity, or lack of, with social services departments; proximity to large centres of population; presence of teaching hospitals; strength and nature of local political culture; and the nature of the local NHS workforce.

The eight factors are considered as 'a linked set of conditions which provide high energy around change' (Pettigrew, Ferlie and McKee, 1992: 275). The authors caution against treating the factors as a 'shopping list'; they suggest positively, however, that they can serve as a handy checklist of 'signs and symptoms' likely to be associated with energy for change (Bennett and Ferlie, 1994). They can also form the basis of more detailed investigations aiming to understand and support the strength, direction and continuity of the energy for change (Newton *et al.*, 2003). As in the earlier framework, they can be used to differentiate higher from lower performers.

Receptive and non-receptive contexts

The eight-factor framework introduces the over-arching metaphor of **receptivity** – i.e. the degree to which a given context is likely to be more or less sensitive and sympathetic to a particular change.

The notion of receptivity is dynamic, not static. A receptive context can quickly become non-receptive by the removal of key individuals or precipitate, ill-considered action.

The metaphor of receptivity or non-receptivity seeks to reflect the varying rate and pace of change in different parts of the NHS and to acknowledge the importance of process issues in this area. It also highlights important aspects of the change process itself: emergence, possibility, precariousness and iteration (see *Organisational Learning* (2001); see also page 69 in Case Study 1).

The notion of receptivity also takes into account the highly professionalised nature of the organisation and the importance in it of 'micro-politics'. Professionalised settings within the NHS which display a long history, a given set of power relations and established patterns of belief (often based on legacies from the past) might be seen as being less receptive contexts for change (Bennett and Ferlie, 1994: 159). For example, some clinicians may spend their entire working lives in one locality and interpersonal disputes which might otherwise be solved by one party moving to another locality may simply rumble on for years. Conversely, professional settings with less historical 'baggage' may be seen as more receptive contexts.

The notion of receptivity is dynamic, not static. A receptive context can quickly become non-receptive by the removal of key individuals or precipitate, ill-considered action. This negative process may be reversed, but probably much more slowly, by changes in policy at higher tiers, changes in the environment and by managerial and professional action at local level.

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Episode 4.2:
A receptive context?

SHA, Executive Offices

Two days later

Robin: Right. Time for us to share our knowledge of St Perrin's. You'll see I've already put up eight sheets of flip-chart on the wall over there. ... Ian and Kathy, would you be willing to make sure we capture this information as we go along, under each of the eight headings? ... Whichever heading you think an item goes under. And don't let the writing stop you joining in. We'll swap writers at half-way stage. I want us all to have a good and frank conversation ...

Kathy *and* **Ian** *make their way to the flip-charts.*

Robin: ... Now, since I've been in this area the longest, shall I kick off by reminding us all of some of the background history? When I first came here 15 years ago I remember being told as part of my induction that services offered by St Perrin's and what was then the Singleton Trust would be rationalised, that A&E and 'hot' surgery would move to Singleton and St Perrin's would have a minor injuries and elective surgery. You know the kind of idea, you'll have come across it all over the place. Here it was presented by the management teams of the time as a 'done deal'. What they hadn't taken into account was that both Singleton and St Perrin's are in marginal seats – they still are – and that neither MP was going to agree to this. So, after a lot of hard work, a lot of persuading the clinicians that this was the best way forward, and so on, the decision was blown completely out of the water. Of course, key people in the management teams moved on and out fairly quickly, leaving behind a legacy of lack of confidence in management, management decisions, managerial judgement.

Kathy *starts writing on the 'Managerial-clinician relations' sheet and* **Ian** *does the same on 'Locale'.*

Blanche: Sorry to sound dense. Why include that event under those two headings and not 'Environmental pressure' or even 'Organisational culture'?

Kathy: I've put it under 'Managerial-clinician relations' because although that event has influenced the culture of the organisation as a whole, the major impact has been on relations between clinicians and managers. Correct me if I'm wrong, Robin, but clinicians still fling this piece of ancient history at managers whenever any new type of change is mooted. They say 'We've seen all this before, nothing will come of it'.

Robin: That's right. And managers will tell you they feel helpless in the face of it, even when they know the situation now is completely different.

Ian: I've put it under the 'Locale' heading, because the political dynamics are specific to that location.

Blanche: Now I'm with you.

Thom: Since then, several chief execs have come and gone. How many, Kathy? In the five years before we put Gill in?

Kathy: Four. I didn't know them, so I don't know what they were like.

Robin: Oh, they were mostly good, solid career managers, none of the appointments was inappropriate.

Blanche: *(Tentatively.)* So this is a career graveyard? Did we spell that out to Gill when we appointed her?

Penny: No more of a graveyard than Kings Hale Trust. That went through five chief execs and three chairs in five years, but the current team there have been in post now for over two years and we all know just how much of a transformation they've achieved.

Robin: Yes, that's a useful comparison. Let's keep Kings Hale in mind.

Penny: Well, they've both received adverse coverage in the press, and they were both seen as basket cases within the NHS. But now, if you forgive the mixed metaphors, they're like chalk and cheese.

Blanche: From a nursing point of view things are certainly very different. In Kings Hale their previous Nursing Director used to have other equally important responsibilities, as Director of HR, and was based on another site. So there was no real or visible leadership. Now the hospital is a stand-alone acute trust with its own management team and the Nursing Director is a star. She's credible and enthusiastic, and she's managed to galvanise change, shift attitudes and behaviours. Early on she discovered that some of their basic nursing skills just weren't up to scratch. I remember having lunch with her at the time, when I was at the neighbouring Trust, and she was shocked at what she'd found.

Ian: Is that so?

Blanche: Yes, but by passing that shock on, the nurses could see for themselves the problem. And by making good use of new resources, she's had a major impact. St Perrin's is different though ...

Ian: In what way?

Blanche: It's hard to say precisely. Their Director of Nursing has always been on-site, and focused on nursing. But the relationships throughout the hospital between doctors and nurses have somehow meant that nursing has never developed in the way it has elsewhere – and that's been replicated at Board level. The nursing directors there have been expected to be (and usually have been) so supportive and helpful as to be slightly subservient. At Kings Hale the complete absence of leadership led to lots of terrible practice with a few pockets of innovation and excellence. Whereas at St P.'s the pattern is that practice everywhere is *just* about OK. Much more difficult to tackle in a way ...

Blanche *hesitates*.

Blanche: Gill appointed a new Nursing Director, Yvette, an internal candidate. She's got a number of strengths, but I'm worried that she's been part of the St P. way of doing things for so long that she isn't challenging as much as she needs to.

Robin: While we're thinking about clinical leadership, how about the docs?

Thom: Well, it's interesting that neither St Perrin's nor Kings Hale had effective medical directors, but for completely different reasons. St Perrin's' Director was known nationally for his work on informatics. He came from psychiatry originally and he didn't carry a clinical case load for the last five to six years. End result? He lost all credibility locally. It was difficult to see how he was benefiting the Trust, although undoubtedly his informatics work has been useful at the Department. Kings Hale had a big 'shop steward' of a medical director. Only ever complained about how hard life was for the consultants – never put forward any solutions, only problems.

Pause.

Thom: Of course, they've both been replaced, and both by in-house candidates. But Kings Hale managed to attract someone who was very credible locally, prepared to say what she thinks, to challenge her colleagues, someone who truly believes things need to be done differently. At St Perrin's, Martin is much more accessible than his predecessor and he's been on good training programmes, he talks the right language, people like him, but ... I don't think he cares enough about things changing. In fact, the whole consultant body there doesn't have a huge interest in change. There's a private hospital nearby and they do very nicely out of that.

Penny: That's true. They see little benefit to themselves personally from the changes and they tend to see managers as agents of the government, just imposing more and more unnecessary pressure. If I were a cynic – which of course I'm not! – I'd say that if the Trust *did* succeed in hitting many of the targets there would be less reason for patients to go privately, and so they'd see their income much reduced.

Kathy: *(Turning to face the group directly.)* Yes, but it isn't only income, it's autonomy they're fighting for. Protocols and guidelines have been fiercely resisted, and they don't hesitate to call in the relevant Royal College if they want to counter any suggestions they don't like from the management team.

(Sighs.)

You can't blame them for behaving in counterproductive ways, of course, if they are rewarded for it. They've learned that if you have a long waiting list you get extra money to sort it out, and that if you overspend one year, your budget is increased the next. For years they've revelled in not meeting targets, they keep getting more resources to sort it out.

Ian: That's certainly a major gripe the PCT had against the old health authority. Mind you, they are blaming us for doing the same – said we undermined them initially when we supported St Perrin's in their dispute over inflation increases.

Penny: Are we doing that again, now? Discussing this without involving them?

Robin: *(Slightly indignant.)* Oh, but we have and will involve them. We've kept abreast of their thinking and will discuss this with them before we do anything. We're just getting our own thinking straight first.

Ian: Back to St P's: How do the clinicians see the Board then? How do they respond to questions and challenges from them?

Kathy: Oh, mostly they are seen as benign but irrelevant, I think, and without decent information it is very difficult for the Board to ask questions that are penetrating or challenging.

Robin: Thinking about the St P. doctors ... It all feels rather old-fashioned, there's a real lack of team work with other professionals.

Thom: Yes, it's very much a matter of individual personalities as far as the doctors at St Perrin's go. They aren't united in anything except resistance to change. In fact, they could do with uniting *more* ...

Robin: Uniting more? in what way, Thom?

Thom: They don't so much unite, around a positive agenda, as coagulate in huddles. The organisation's structure keeps them very separate and each specialty has its own business manager. That means most of them are fairly junior, and if they were to amalgamate they could afford much more experienced, effective managers looking after several specialties. None of this is rocket science, it's all been done in other places.

Ian: *(Dryly.)* Including Kings Hale, no doubt. We're in danger of casting them as the blue-eyed boys and St Perrin's as the rascals. But I know for a fact that not all the clinicians at Kings Hale are on board yet, several of them have had their noses put out of joint. It's not that one management team is wholly successful and another is completely failing, it's just a matter of degree —

Blanche: *(Butting in.)* We were talking about the Board a few minutes ago, and I happen to know (because one of them is a friend of mine) that some of St Perrin's' NEDs are irritated by the lack of action prompted by their Serious Incident reports. They feel that Gill just reassures them that action already underway will address them. Whereas I know at Kings Hale they have used them extensively to examine basic system faults and have found them very useful. The other thing the NEDs are worried about is the plethora of plans. They say that at every Board meeting there's another action plan to address another set of 'must dos'. They don't see how they fit together, they don't think they are looked at from one monitoring period to the next, and they don't see how service managers can be expected to operate to so many goals at the same time.

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Ian: *(Speaking over his shoulder as he writes.)* Huh! Isn't that the same everywhere?

Penny: No, I don't think it is. Sure, everyone is under pressure, and all management teams are having to show how they're going to deliver the NHS Plan. And all the sets of guidance from the Department increase the feeling of overload. But the better teams, especially in DGHs, can see they have a lot to gain and are pulling their thinking together into a coherent local agenda. It's the weaker ones who develop new action plans for every new target or initiative. It makes it easier for them to demonstrate to us how they are intending to deliver it, but harder for their own staff to actually do so.

Several minutes pass in which the team discusses the situation at national level and some of the environmental pressures affecting all trusts, including St Perrin's.

Thom *and* **Penny** *then take over the writing up.*

Ian: But I still haven't got a feel for what Gill has done in this last year. With all the extra resources around, especially for trusts like hers, has she made the most of them? What about the Modernisation Agency? How have they responded to offers of help from them?

Penny: Gill has welcomed them in, and the fact that the feedback from the clinicians wasn't as enthusiastic as at Kings Hale – Stop rolling your eyes Ian! – may be due to the fact they were run by different people. I don't think the team coming into St Perrin's was nearly as experienced.

Blanche: To answer your question, Ian, in a slightly different way. Gill has finally sorted out a problem in Radiology that had been going on for absolutely years. Did you know about this, Penny? The two consultants there have been at loggerheads for — ever! So the whole department is stuck in the Dark Ages because if ever one of them suggests an improvement the other one vetoes it on principle. They've missed out on all the new money, IT, support for modernisation, and they haven't collaborated with work on protocols. And so they've been left – all these years – because as soon as a manager spots the source of the problem and is ready to address it, that manager moves on. Everyone else in the organisation has found ways of working round it (tortuous and expensive, but they worked) so it has just dragged on and on. Now Gill and Martin have done something about it.

Thom: Not just Radiology, I hear. The two of them are working with all the new consultants they've appointed, to widen their horizons and give them support when they need it. And I know Gill sits on as many appointments panels as she can. She takes a personal interest in complaints, goes onto the wards, talks with patient groups and keeps the NEDS well in the picture. I don't think we can say she hasn't performed, only that in that setting no-one could do it any better or faster.

Penny: We've concentrated on the medical and nursing professions, but what about the AHPs? I've noticed so often that where the AHPs are flourishing, so is the organisation as a whole.

Robin: *(Raises his eyebrows.)* Oh really? Are you suggesting cause-and-effect?

Penny: No, only a correlation. Where you find one, you find the other. Well, perhaps a bit stronger than that – rather like these eight factors. We're not saying that any of them alone causes a problem, are we? Or even that a particular combination will predict success or failure. Only that changes are more likely to be made and maintained where the eight factors are positive.

Robin: Yes, that's right. And we do seem to be short on positive factors on some of the lists. Blanche, what do you know about the AHPs?

Blanche: *(Suddenly remembers.)* Ah! They have some good services, and some strong service leaders, perhaps because of the unassertive nursing and self-interested medical cultures ... But they aren't being encouraged to think corporately. No clear voice at Board level, for instance. Altogether, I'd say the Trust doesn't have a strong middle management – they're junior, as we've discussed. But also they're a mix of new and naïve, the 'old' (as in people who've been there a long time) and the bogged down. They aren't able to pull together a feasible local agenda for their own services, so they're more of a post-box, a conduit passing 'must dos' down and complaints about lack of time and money up.

Ian: So why is there such resistance to merging departments and putting in good management support? And why hasn't Gill overcome this and done something about it?

Penny: Because she herself hasn't got strong support. *(Blanche nods in agreement.)* At Kings Hale the Chief Exec recruited a new Nursing Director and found a credible Medical Director. Gill has appointed to both of those posts, but in-house candidates who aren't as strong as she needs.

Robin: Has she brought in *any* new blood? ... Oh yes, she took her Director of Finance with her, Mark Edwards, and I can see why: sound, reliable, open (with Gill anyway). If I remember rightly, his predecessor was a domineering sort who'd been in place for years. Made the books balance each year, but not in a transparent way that anyone understood.

Ian: Yes, Mark inherited a mess, and that's not all he inherited. The Finance Directorate included information services and the Information Manager had been close to the previous chap. Lots of game playing to start with, withholding information, that sort of thing. Seems to be sorted now.

Robin: Well, I don't know. It's an information issue that is prompting this discussion.

Penny: Well, in the face of that kind of opposition I can see Gill would only push through changes to organisation structures with strong support from her key players, without that it would just sap too much of her energy. Somehow I

can't see the support from Martin and Yvette ever being strong enough. That's her real problem, no strength where she needs it most. She's got a good FD in Mark, but he won't be able to challenge the thinking of the clinicians in the way a good medical and nursing director can. No matter how good Gill is herself she has to able to appoint a strong team, I think that has been her major failing here. How the Chair hasn't spotted it, I don't know.

Robin: Well, I'm not sure how Gill relates to the Chair. I know she keeps him informed but I don't know how useful their exchanges are.

Thom: I don't know that we've helped there. (*To* Robin.) I hear you told the chief execs recently that they had to 'deliver' their boards. With respect, that hasn't exactly encouraged them to draw on their chairs' experience!

Robin: Maybe, but it's not their career, they don't know the NHS, and anyway it's not the chairs we're considering here, it's one Chief Exec – so please let's stay focused.

Kathy: (*Looking at the charts.*) I'm getting a picture of a very isolated position. Gill can't draw confidence and strength from her relationship with her Chair, Martin and Yvette need cranking up (and perhaps more), and she hasn't got a strong middle tier. Who does she confide in, brainstorm with, chat it over with? Mark, I suppose. Is that enough? He's new too, after all. Neither of them will know what really makes the place tick, and Mark can't help her with the face-to-face operational discussions that are so crucial.

A long pause.

Kathy: What about outside the organisation? I know there's friction with Serhat at the PCT. But what about the Council? the Chief Exec? Leader? Director of Social Services? Are those relationships sound?

Penny: Yes, I think they're fine, and the relationship between St Perrin's and social services is particularly strong – there's some good work going on delayed discharges, and those will soon have an impact on access targets.

Robin: How soon? We need results now.

Blanche: And what are the problems with Serhat? The usual? Or something more than that?

Robin: (*Laughs.*) If by 'the usual' you mean the PCT complaining at the lack of information from their acute trusts, and the acute trusts being indignant at being asked for any, then yes, it is more than that. ... Gill is finding it hard to keep the PCT off her back, because Serhat has appointed a team with a lot of acute sector experience and they know what to look for and what questions to ask.

Thom: Of course, Gill could use that to her advantage – use them as a resource. Their strategic partnerships really are beginning to pay dividends, and they've put public health top of the agenda. They've even attracted all that regeneration money. Of course, Serhat isn't always the easiest of people to work with ...

Kathy: Yes, he was appointed for his ability to challenge and confront and he doesn't always know when he's pushing too hard. And that style has spread throughout the PCT now. Where the provider trusts have strong management teams the relationships are forthright and generally fairly productive. I think St Perrin's just sees them as hostile though.

Another long pause.

Ian: This is all sounding rather bleak. Remind me why we appointed Gill!

Robin: Oh, she unquestionably has ability. Her track record is impressive, she's led major change initiatives at two tricky teaching hospitals, and she has a good grasp of the issues. I don't think she's weak, just that she may not be right for this post. What do the rest of you think? ...

Experimenting with the eight factors framework

Let's leave the meeting at this point. There is enough information already in the discussion and the viewpoints expressed for us to start experimenting with the framework.

Let's assume that the team, with some fine-tuning and clarification, compile an agreed set of eight lists. These now provide a basis for assessing the context in which Gill is trying to introduce change and deliver the NHS Plan.

Below again are the headings of the eight factors:

1. Quality and coherence of local policy	5. Effective managerial-clinical relations
2. Key people leading change	6. Co-operative inter-organisational networks
3. Long-term environmental pressure	7. Simplicity and clarity of goals and purpose
4. Supportive organisational culture	8. Fit between change agenda and locale

1. What items, notes, or questions, would we expect to see on the eight lists in relation to St Perrin's?

2. How receptive a context is St Perrin's to the changes Gill needs to introduce to deliver the NHS plan?

With regard to the first question we may find that items included in the eight lists differ in terms of the evidence to support them. And of course we have not heard directly the viewpoints of those outside the SHA, including Gill herself. At this stage of the proceedings we need not rule anything out as long as we realise that some items can be considered as 'facts', some can be seen as surmise, and some provisional.

You may want to note items down under the eight factors headings before comparing your notes with ours.

You might also want to include some additional items under Factor 3, 'Long term environmental pressure', based on your up-to-date knowledge of environmental pressures affecting all Trusts, if you are thinking about using this tool in your own setting.

■ **Content, Context and Process Model**

Illustration and analysis: 1

What items, notes, or questions, would we expect to see on the eight lists in relation to St Perrin's?
While we have attempted to cover all the eight factors we have not included every single incident or viewpoint, and some of the more uncertain items we have turned into questions.

1. *Quality of the processes for developing local policy, and the coherence of the policy produced*

(HIDE | SHOW)

- Gill lacks solid information management to inform her analysis and her options
- Perceived lack of management credibility in developing policies that can be delivered
- Clinicians not actively involved in informing or developing policy, perhaps because no obvious hybrids[35] at strategic or middle levels
- Structure of autonomous clinical departments favours fragmented policies
- No evidence of rigorous analysis to inform the development of St Perrin's own management agenda. The focus instead is on priorities imposed form outside.
- Looking at this the other way round: central policies/directives seem to be being passed on 'raw', rather than being converted into a feasible management agenda
- Some long-term, deep-seated problems are being addressed (e.g. Radiology) but others left untouched (e.g. 'good enough' nursing practice).

Conclusion: This factor seems to be a problem area.

2. *Key people leading change*

(HIDE | SHOW)

- High turnover at executive level, lack of continuity and 'tacit' knowledge
- Nursing/medical leaders have this knowledge and have the support of their colleagues, but may be unlikely to challenge the status quo – compared with Kings Hale
- Strong Financial Director, but he is being sabotaged by resentful staff who understand the organisation better than he does
- Gill has a good track record, a core team in place, but has she hit on the right drivers to lead on change?
- No leadership cadre: lack of a strong middle management tier because departments won't combine to allow big enough posts to attract excellent candidates

■ **Content, Context and Process Model**

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[35] Hybrid roles: clinicians who take on managerial responsibilities. Some strategists argue that hybrid roles help to span the managerial-clinician divide in the NHS.

- Little multi-disciplinary input at strategic level – e.g. absence of AHPs
- The Board isn't seen as leading, e.g. Gill appears not to turn to her Chair for support, and the experience of NEDs is not being used
- Modernisation Agency (MA) team failed to kick-start change – why? lack of local sponsorship? inexperience of team used here? lack of receptivity of context?
- Has too much energy been spent on lead clinicians who *need* to change but resist doing so (the laggards), too little on those who *want* to change (the innovators, early adopters)?

Conclusion: Not much good news here.

3. *Long-term environmental pressure*

HIDE | SHOW

- Lots of it!
- External pressures seen by 'old' staff as threats, not opportunities
- A history of badly managed external pressures has left clinicians feeling cynical, demotivated, preferring to concentrate on their own areas of interest
- Top-down pressures, including performance management, national targets, have not yet been orchestrated to improve performance
- Pressure from SHA on Trust CEs to 'deliver' their Boards indicates a tension between national and local accountability that may leave staff feeling pulled in two directions
- Lots of other long-term changes in delivery of health and social care – some good progress which will help reach access targets
- PCT is exerting strong pressure but needs 'buffering' if this is be positive
- Negative publicity in local media – likely to impact on staff morale and recruitment
- Royal Colleges' attitudes relevant (and not always perceived as helpful)
- Attitudes and experiences of staff in other trusts will have an influence through clinical networks.

Conclusion: A lot going on in the environment, difficult to see the overall balance of drivers and restrainers.

4. *Supportive organisational culture*

HIDE | SHOW

- Isolated subcultures: mutually exclusive, not communicating across boundaries
- Executive is developing high visibility on the ground
- Good induction programme for new consultants, will pay off in long term
- Has Gill's team got a handle on the 'micro-politics'? Could they have anticipated scale of resistance of existing staff?
- Is culture apathetic? How is it challenging staff?
- Some openness to experimentation
- Clinical networks are not bound by strong, positive inclusive value bases:

■ **Content, Context and Process Model**

nursing is unassertive, medical is self-absorbed, AHP is strong at service level but not thinking corporately

• Professional tribalism, hierarchical thinking – e.g. AHPs' 'post-box' behaviours, general resistance to merging departments.

Impression: Culture is individual, independent, autonomous, not corporate.

5. *Effective managerial-clinical relations*

(HIDE | SHOW)

• Entrenched lack of trust, among 'old' clinicians, in management
• Regaining this trust is a slow process, perhaps too slow, managers are listening to clinicians' 'broken record' and not confronting them with current reality
• Are managers too quick to dismiss what the clinicians really value?
• Hard to engage clinicians in strategic thinking
• Nursing and Medical directors more popular than predecessors but not providing dynamic role models.

Conclusion: A major problem, developed over years and with many structural causes, that demands serious attention.

6. *Co-operative inter-organisational networks*

(HIDE | SHOW)

• Good relationships forged between Trust and social services, might provide lessons for how to share processes of effective involvement
• Trust at risk of starting out on the wrong foot with PCT, worried about having its power challenged
• Some departments missing out on funding mechanisms that are based on collaboration.

Assessment: These are good, but how important are they?

7. *Simplicity and clarity of goals and priorities*

(HIDE | SHOW)

• Situation inherited was, is, complex, messy – but then so was/is Kings Hale's
• Where is the vision?
• Trust is issuing too many action plans
• Operational energy is sapped by multiple, fragmented goals.

Assessment: This is a result of the lack of performance on Factor 1.

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8. *Fit between change agenda and locale*

(HIDE | SHOW)

- St Perrin's is a District General Hospital, hence there are opportunities to benefit from new money coming in to deliver NHS Plan
- Coterminous with LA, allowing good relationships
- Marginal seats, so any decisions affecting services will receive much attention from press and public
- Possible for disgruntled staff to use local press, so policies must all be thoroughly defensible, and public engagement at an early stage will be critical
- Private hospital nearby is a disincentive to medical changes
- Lack of teaching hospital 'ethos' that might support a climate of innovation; alternatively, clinicians are not overly distracted by teaching/research responsibilities

Assessment: Executive and Board need to be media-wise and attuned to local political sensitivities. Not many signs that they are being proactive here.

How receptive a context is St Perrin's to the changes Gill needs to introduce to deliver the NHS plan?
This is the point at which we need to bring the eight factors together. This model requires us to give due attention to the inter-relation of its constituent parts and their relation to the whole, i.e. the balance of content, context and process. If we were to opt for a 'shopping list' approach, selecting only one or two items that demand immediate attention and proceeding to outline options and courses of action, we would miss the all-important work of cross-analysis between factors.

However, while the 'atomic' model (Figure 4.2) suggests the importance of seeing things holistically, it does not direct us as to *how*. For this we need an additional device or method to help structure our assessment of the factors against each other, and in particular in order to identify 'interchanges between agents and contexts which occur over time and are cumulative' (Jeremy, 2002: 452).

Here we use a matrix. This allows the testing of one factor against all the others, highlighting interactions that provide energy for change, and those which exacerbate resistance to it. Of course, the factors should also be compared in *clusters* against each other factor, but in practice this can be done more usefully once the two-way linkages have been assessed.

■ **Content, Context and Process Model**

Table 4.3: Matrix of the Eight Factors

	1 Quality and coherence of local policy	2 Key people leading change	3 Long-term environmental pressure	4 Supportive organisational culture	5 Effective managerial-clinical relations	6 Co-operative interorganisational networks	7 Simplicity and clarity of goals and priorities	8 Fit between change agenda and locale
1 Quality and coherence of local policy	▓							
2 Key people leading change		▓						
3 Long-term environmental pressure			▓					
4 Supportive organisational culture				▓				
5 Effective managerial-clinical relations					▓			
6 Co-operative interorganisational networks						▓		
7 Simplicity and clarity of goals and priorities							▓	
8 Fit between change agenda and locale								▓

As a result of the thinking so far, each of the eight factors now has a list of bullet points associated with it. If we try to reduce those to a summary to include on the matrix diagram itself we will impoverish the testing process, so we suggest the following approach.

1. Use the format of the matrix to mentally review the interaction between the bullet lists, and then capture only the essence of that interaction on the matrix itself.
2. Reflect on which boxes suggest sources of energy for change, and those that indicate resistance to it.
3. Think about the relative strength of energy for change or resistance to it.

For example, reflection on the bullet points for Factors 2 and 5 (see Box 4.1) may suggest the essence of the interaction as set out in Table 4.4.

■ **Content, Context and Process Model**

Box 4.1 Juxtaposing factors: the team's flip chart

Factor 2: Key people leading change

- High turnover at executive level, lack of continuity and 'tacit' knowledge
- Nursing/medical leaders have this knowledge and have the support of their colleagues, but may be unlikely to challenge the status quo – compare with Kings Hale
- Strong Financial Director, but he is being sabotaged by resentful staff who understand the organisation better than he does
- Gill has a good track record, a core team in place, but has she hit on the right drivers to lead on change?
- No leadership cadre: lack of a strong middle management tier because departments won't combine to allow big enough posts to attract excellent candidates
- Little multi-disciplinary input at strategic level – e.g. absence of AHPs
- The Board isn't seen as leading, e.g. Gill appears not to turn to her Chair for support, and the experience of NEDs is not being used
- Modernisation Agency (MA) team failed to kick-start change – why? lack of local sponsorship? inexperience of MA team used here? lack of receptivity of context?
- Has too much energy been spent on lead clinicians who *need* to change but resist doing so (the laggards), too little on those who *want* to change (the innovators, early adopters)?

Conclusion: Not much good news here.

Factor 5: Effective managerial-clinical relations

- Entrenched lack of trust, among 'old' clinicians, in management
- Regaining this trust is a slow process, perhaps too slow, managers are listening to clinicians' 'broken record' and not confronting them with current reality
- Are managers too quick to dismiss what the clinicians really value?
- Hard to engage clinicians in strategic thinking
- Nursing and Medical directors more popular than predecessors but not providing dynamic role models.

Conclusion: A major problem, developed over years and with many structural causes, that demands serious attention.

■ **Content, Context and Process Model**

Table 4.4: **Essence of the interaction of factors**

	5 Effective managerial-clinical relations	
2 Key people leading change	The lack of these good relations means good leadership is essential, it isn't available here	

This is a box that suggests resistance to change and we suggest that this resistance will be strong.

When you have experimented with the above you may want to compare your matrix with ours.

Illustration and analysis: 2

We suggest that if the SHA team were to use this approach they would develop the matrix that follows.

■ **Content, Context and Process Model**

Managing *Change* in the NHS

Table 4.5: Completed matrix

HIDE **SHOW**

	8 Fit between change agenda and locale	7 Simplicity and clarity of goals and priorities	6 Co-operative interorganisational networks	5 Effective managerial-clinical relations
1 Quality and coherence of local policy	Rigour of analysis and coherence of policy essential, must take into account local politics. DGHs are a focus for resources, so it will be possible to develop an agenda that pleases all.	Plethora of priorities: national 'must dos' being handed on 'raw'. Needs development of local management agenda.	Local policy can take account of the strategies of local organisations, to greater long term sustainability of change	Lack of this is impeding the development of the local agenda
2 Key people leading change	Will need a sensitive understanding of macro politics, as well as micro	It is through this clarity that the leadership will be manifested. Completely lacking at present.	Not helpful enough in the short term to warrant the time currently given to them. Could usefully develop links with other acute trusts.	The lack of these good relations means good leadership is essential, it isn't available here
3 Long-term environmental pressure	DGHs can do well out of resources for NHS Plan, local politics will mean they have to modernise without 'noise'	The abundance of directives is a resource for a set of clear goals, but may make it difficult	Potential for long term assistance to address targets of plan	Clinical networks (formal and informal) will influence attitudes to change, probably towards being more responsive. Targets will focus attention, and resources will help.

Blaming and cynical attitudes will impede |
4 Supportive organisational culture	Fragmentation is supported by existence of local private hospital	The clarity of goals is needed to overcome the fragmentation	Currently supporting the fragmentation but this may change as other clinicians establish good working relationships locally	These are closely related and are strongly supporting each other against change
5 Effective managerial-clinical relations	History of the locale has contributed to poor relations, managers must take politics into account to ensure it doesn't do so again	Simple, clear goals will help develop better relations, but the lack of these relations means the development of this agenda is difficult	Currently the networks mimic the separation of these roles within the Trust	
6 Co-operative interorganisational networks	The networks are not robust enough to help St P's with any politically sensitive decisions	External relationships not relevant to internal goals		
7 Simplicity and clarity of goals and priorities	Goals and priorities must not rock any political boats			
8 Fit between change agenda and locale				

Table 4.5: *continued*

4 Supportive organisational culture	3 Long-term environmental pressure	2 Key people leading change	1 Quality and coherence of local policy
Fragmented, tribal, suspicious, with no strong middle management tier, makes development of local agenda difficult	Many of these pressures will provide energy and means for change, others will impede it. The volume of it is inhibiting the development of a local management agenda, but must not be allowed to do so.	The lack of strong leadership is actively preventing the development of this local agenda	
Lack of supportive culture makes credible leadership essential. Examples of this happening (Radiology) but not widely enough.	Pressures not being used constructively, leaders need to be cheer leaders for ambitions of NHS plan		
These pressures will have an impact on the culture, but at the moment the culture is resisting the pressures			

**Looking across the matrix, do you think the SHA team will conclude
that constructive change at St Perrin's is more or less likely?**

The SHA team started by wondering whether to replace St Perrin's Chief
Executive, and decided to think more holistically about the receptivity of the
Trust to change. Having done so they conclude it unlikely that beneficial change
will be achieved if the situation is left as it is. Their concern centres on the
interaction between key people leading change, quality and coherence of local
policy, clinical-managerial relations and organisational culture (Boxes 1/2, 2/5,
2/4, 1/5, 1/4 and 4/5). They are more than ever worried that Gill has not
gathered around her a stronger management team who can work with clinicians
to develop an attractive local agenda for action.

The one source of energy for change (Factor 3 'Long term environmental
pressure') in the current situation cannot be directed into a clear set of goals
locally without an effective and credible management cadre.

So let's return now to the SHA and see what happens when Robin raises his
concerns with Gill.

■ **Content, Context and
Process Model**

Episode 4.3:
Some decisions

SHA, Chief Executive's office

Next day
Robin Forster *and* Gill Rose *are meeting to discuss the problem.*
After they have exchanged a few pleasantries, Robin *gets to the point.*

Robin: Gill I think we need to have a hard think about the future of St Perrin's. As you know, breaching that target is going to cause a number of problems, and I need to be sure this won't happen again. I know St Perrin's isn't the easiest of Trusts, that's why we appointed you to the post, and I'd like to look at whether your management team and management structure are strong enough to be able to handle it.

Gill: Any reason to focus on that particularly?

Robin: Yes, we've been discussing it as a team, and highlighted a couple of areas that we are worried about.

Gill: OK. ... I've made two excellent appointments as my medical and nursing leads, so we're on the way. I do think we're not well resourced at middle management level, but until we can persuade the consultants to collaborate with other departments and allow us to appoint more senior managers I can't move forward on that. That's coming on though, I expect to be able to appoint the first of the new breed in the next six months.

Robin: But Gill, what about now? We've got to have these targets delivered now, not in six or eight months' time.

Gill: I know and we're working on it, but it's surely more important to make gains that are sustainable than to implement a number of quick fixes that will only exacerbate the problem later on. That is certainly the view of my Chair and the Board.

Robin: Gill we've got to have both. Earned autonomy means making the quick wins to buy the time to bring in the sustainable changes. This may not be how it's done in the sector your Chair comes from, but we're in the goldfish bowl of politics, it isn't one or the other, it's one in order to do the other. I want to see some impact on clinical behaviours, and soon, and I think that means appointing people with a bit more leadership potential than the two you have there. And it means getting that middle management tier in post fast. We know it can be done – look at Kings Hale.

Gill: But Kings Hale was in a completely different position. They don't have anything comparable to our local political interference, no local private hospital either. They could go in and revitalise a demoralised workforce – a peach of a job. This is different, there is no benefit to anyone from making any changes to their practice, so I have to persuade and cajole, not inspire and threaten.

Robin: Well that's not what Kings Hale have done either.

Gill: Perhaps that's a bit strong. But you can't compare the two, and anyway they haven't won the battle over there either, they're just a bit further down the track that's all.

Over the next thirty minutes the two discuss means of harnessing the energy of the NHS Plan and how to turn it into a meaningful local agenda.

Again they disagree, with Gill *relaying the support of her Board for her decision to take time and make sure the clinicians, especially the consultants, are not alienated. Indeed, she reports that she has established a measure of credibility in doing so, with the consultants themselves.*

Robin: Gill, I have to ask you whether you've considered your own position in light of the target breach.

Gill: *(Smiles.)* As a matter of fact I have. I thought I'd wait and see how this conversation went before I made my decision. I'd like to hand in my notice, to be able to take up a post as Chief Executive of the Sentry for Care charity. They are keen for me to start as soon as I can, so can we discuss arrangements for me to do so?

SHA, Executive Offices

Following Tuesday

Kathy: ... I think that's a pity. This isn't going to help St Perrin's and I'm not sure it's the right move for Gill, I'd like to hear more about how the conversation could have resulted in such an outcome.

Robin: Well, I think it was inevitable, given the very different view of the situation that became evident during the discussion. Gill's take was very different from ours. In fact, if I had to sum up our conversation in terms of the eight factors matrix it would look like this. The light blue boxes are where Gill thinks she has acted appropriately given the circumstances, and the blue are the areas she thinks the context is still hostile.

Robin *circulates some handouts (see Table 4.6).*

Table 4.6: Completed matrix – Gill's perspective

	1 Quality and coherence of local policy	2 Key people leading change	3 Long-term environmental pressure	4 Supportive organisational culture	5 Effective managerial-clinical relations	6 Co-operative interorganisational networks	7 Simplicity and clarity of goals and priorities	8 Fit between change agenda and locale
1 Quality and coherence of local policy		I've appointed people who will work quietly and purposefully, rather than loudly and charismatically	This is huge, and will be helpful once I've encouraged the culture and relations with clinicians to be more positive	I'm tackling the culture by creating new myths and legends, e.g. our resolution of the Radiology problem	Such is the bad blood here that I'm engaging them gently, not heroically	This is the way to sustainable modernisation, yes it takes longer but it is worth investing in	Given the suspicion of management locally I have to make it clear that the targets and 'must dos' are centrally and not locally devised	Local politics are a minefield, gently and slowly is only the way
2 Key people leading change			The agenda is huge, and we have only a certain number of hours in the day	We're making progress	The people I've appointed will help this by being supportive rather than aggressive	Good investment of their time	We're after long term, sustainable change, so we are still working on these	In this context we need people who can grasp the complexities, and I've found and appointed them
3 Long-term environmental pressure				This has grown up over a number of years, we'll get there, but it will take time	Before long this pressure will be helpful, right now it is generating cynicism and resistance	This is the way forward, thinking across the whole community	As above	This is going to be very difficult to pull off
4 Supportive organisational culture					These are critical and so we've put a lot of effort in: sitting on appointments panels, good induction programmes for consultants, dealing with Radiology	The community-wide work will have a major impact on the culture in the longer term	it's essential to get these right, or we'll exacerbate the cynicism – so we'll take our time to ensure they are	The culture arises because of the locale, that's why it will be difficult to change it
5 Effective managerial-clinical relations						As above	As above	These are also a result of the locale and therefore difficult to influence
6 Co-operative interorganisational networks							We need our goals to mesh with those of our partners, this work on networks will help assure this	These are the way forward in this locale, if we are all in agreement it will be difficult for politicians or press to object
7 Simplicity and clarity of goals and priorities								The priorities need to be sensitive to the locale, that is why we must take our time and get them right
8 Fit between change agenda and locale								

KEY:
■ we are taking appropriate action in this context   ■ this is still problematic given the context

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Robin: As you can see, very different from our view of the situation of what needs to be done.

Thom: Yes, but her decisions about key appointments and so on now make much more sense. And if the local Board see the situation in the same way as Gill, then whoever is the Chief Exec., we will need to handle things rather differently.

Penny: Perhaps if we'd had more time we'd have been able to come to different conclusions. I know we're under huge pressure but I strongly suggest we never do this kind of analysis again without actively involving all the stakeholders.

Blanche: Yes, but just as importantly, we need to use the eight factors to think about how we can support St Perrin's. How we can help the new Chief Exec. find a more receptive context than Gill has found.

Ian: Interesting. I think all of us, and Gill too, have left one vital component out of our thinking. Under 'Co-operative inter-organisational networks', we appear to have forgotten one of the most significant relationships: with us.

Concluding thoughts

The three components of strategy – content, context and process – indicate areas where attention needs to be given rather than determining a plan for action. The model also cautions us that change is likely to be 'measured in years rather than months. ... There are no grand blueprints for long-term success or quick fixes for immediate salvation' (Pettigrew, Ferlie and McKee, 1992: 273). As with other cases in this resource, we can see that a framework will yield different insights according to the assumptions, beliefs and power of the people using it. Perceptiveness, an inclusive approach to information gathering, and discipline in organising the information, are all needed here. And creativity too, both when drawing conclusions and when devising interventions that will increase receptivity. It is also worth emphasising that change management is an immensely complex human and organisational process 'in which differential perception, quests for efficiency and power, visionary leadership skills, the vagaries of chance, and subtle processes of additively building up a momentum of support for change and then vigorously implementing change, all play their part' (Pettigrew, Whipp and Rosenfeld, 1989: 111).

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Managing *Change* in the NHS

Case Study 5:
Prompting change across an organisation

Acute trust

In Episode 5.1 of the case you see an acute trust through the eyes of people managing services on a day-to-day basis, and then from the perspective of an executive director. You are able to explore the concept of adding value and consider how the Trust's managers are able to add value to the services in their remit, and avoid diminishing it.

You are then invited to explore how the principles of Total Quality Management (TQM) could be used by an individual senior manager to influence quality across an organisation, and by a team to improve quality within a particular service: Maternity Services.

Episodes 5.2 and 5.3 enable you to explore the theory of Business Process Reengineering (BPR) and follow the course of a pilot reengineering project within the Trust, with the opportunity to reflect on the key learning points and consider whether this approach should be rolled out organisation-wide.

We do not discuss tools in as great a depth in this case as we have done in the others. This is because there is plentiful 'improvement' literature available, including a wealth of texts from the 'quality gurus', and from organisations such as the Modernisation Agency. In order to make their texts (many of which are either technical or piece meal) more useful we aim here to provide an overview and a sample of some of the main tools and concepts.

Approaching this case

The case is designed to be read in the following sequence. We suggest some places for taking breaks in the material, with indicative times.

You will note that some of the theoretical components are introduced before the case material. This is to enable you to bear in mind the various concepts as you read through the case itself.

Adding value – an outline of key concepts	20 mins
Episode 5.1 The joys of middle management – two sets of perspectives on the issues and problems facing managers in an acute trust	30 mins
Experimenting with adding value – an opportunity to apply concepts to the case	30 mins
Illustration and analysis – an opportunity to compare your findings with ours	20 mins
	Total 100 mins
Organisation-wide initiatives	20 mins
Total Quality Management (TQM) – an outline of the main principles	15 mins
Using the principles of TQM – an opportunity to apply these to Maternity Services within the Trust	40 mins
Illustration and analysis – a chance to compare your findings with ours, and to learn more about specific tools and techniques in TQM	40 mins
	Total 95 mins

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Business Process Reengineering (BPR) – an outline of the principles	15 mins
Implementing a reengineering project – an opportunity to consider the lessons that could be learned by the Trust	10 mins
Illustration and discussion – an opportunity to compare your observations with ours	5 mins
	Total 30 mins
Episode 5.2 Reengineering the admissions process – a chronological summary of events over a 1-year period	5 mins
Extending reengineering? – an opportunity to consider the implications of rolling out BPR organisation-wide within the Trust	15 mins
Episode 5.3 Dianne's memo to Jane – one character's assessment of the lessons learned	10 mins
	Total 40 mins

You may find it helpful to have access to *Organisational Change* (2001) either in hard copy, CD-ROM version or online via the SDO website: www.sdo.lshtm.ac.uk/publications.htm

Note
The (HIDE | SHOW) icon refers to those parts of the electronic PDF version of the document where readers have the option to hide or show the text, depending on whether they want to stop and think before comparing their own ideas with ours.

If you prefer to display all the hidden text for the case, click on the 'Show all' button; similarly, if you wish to hide all the text for the case, click on 'Hide all'.

(SHOW ALL | HIDE ALL)

Perspective

The story is told from the viewpoint of the leaders of maternity and of obstetrics and gynaecology services, both of whom are caught up in the day-to-day management of their respective services, and from that of Dianne, the Director of Operations, a member of the Board, one of the most influential members of the management team.

Tools chosen

In this case we look at how management tiers can add value to the sub-units they are managing. We also consider initiatives that are designed to be introduced across a whole organisation:
• Adding value
• Total Quality Management (TQM)
• Business Process Reengineering (BPR)

Main characters

Usha – Head of Midwifery
Barbara – Clinical Director for Obstetrics and Gynaecology
Dianne – Director of Operations and Deputy Chief Executive

Others

Jane – Chief Executive
Jim, Massimo, Denise, Michaela, Hattie, Andrew – members of the
Reengineering Team

Location

This case is set in an acute trust, a teaching hospital with over 3000 staff. The
Chief Executive and her Deputy, also Director of Operations, have been in post
for eighteen months.

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■ Adding value

In this case we look at the roles of managers at different levels within an organisation, and to help us to reflect on those roles we would like to introduce the concepts of **adding value** and **value added parenting**.

Adding value is an approach to strategic analysis which has its roots in financial theory. Its main focus is how to maximise the wealth of stakeholders (Rappaport, 1986; Goold, Campbell and Alexander, 1994). Research at the Ashridge Strategic Management Centre[36] over a number of years has identified situations in which 'corporate parents' can add value, and also means by which they can diminish it.

For a simplified example of what's meant by **corporate parenting** and adding value see Box 5.1.

> ### Box 5.1: **Medium plc**
>
> Medium plc is made up of 10 business units that began life as individual firms and which still trade on their own. They have been acquired by, and are now managed by, the Board of Medium who act as 'corporate parent'. Previously shareholders could invest in each of the 10 units separately, and workers could go and work in any of the firms' individual units, customers could buy directly from any one of them, and managers of individual units could develop strategy autonomously.
>
> If all these stakeholders are to benefit from the fact that Medium now owns these units, then Medium must in some way add value to them. If it doesn't add value then none of the stakeholders is better off and there is no justification for the change of ownership to take place.
>
> Indeed because there are always costs associated with managing smaller units within a larger company, belonging to a bigger company like Medium could result in stakeholders being worse off than they were before.

Goold *et al.* (1994) suggest that the purpose of any corporate parent is to add value to the businesses within its portfolio, net of any costs that are associated with belonging to the portfolio. In other words, the businesses should perform better in aggregate than they would as independent companies, and, ideally the parent should add so much value that the businesses perform better than they would in any alternative parent's ownership.

There are four ways in which corporate parents attempt to add value, as follows.
1. *Stand alone influence* – they seek to directly influence the decisions made by the management of the operating unit.

2. *Linkage influence* – by encouraging or requiring links to be formed between the operating units.

■ Adding value

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[36] A research centre headed by Goold and Campbell.

3. *Central functions* – by providing services and resources that would be too expensive for operating units to fund individually.

4. *Corporate development* – they can work on the composition of the units they are parenting, e.g. acquiring, divesting, restructuring.

Skilful parenting

However, adding value as a corporate parent is not straightforward and some parents can diminish or even destroy value. Why is this? One basic reason is that simply by existing the central organisation tends to take responsibility away from those running the businesses. Those who should be excited by the opportunity to be in charge of a unit feel and act instead like administrators rather than managers.

Goold *et al.* (1994) suggest other, more specific reasons which relate to the four main ways of adding value listed above.

1. If the management of the operating unit is competent, then there is no reason to suppose that a corporate parent will know better how to assess the local situation, deploy resources or make better decisions.

2. If units need to make links, or will benefit from making links, they will often have already done so, out of self-interest. If they have not, the links may be of little value.

3. It can be cheaper and easier for operating units to buy in specialist help from other sources than to do so from the central resource provided by the parent.

4. Studies suggest that although much energy is expended on organisational restructuring, there is little evidence of 'value' being added as a result.

So if corporate parents are indeed to add or create value, and not destroy or diminish it, they can only do so in certain conditions:

- The operating unit presents a parenting opportunity.
- The parent possesses the relevant characteristics, capabilities or resources to exploit this opportunity.

A **parenting opportunity** arises where the unit can improve its performance by doing something that can be achieved more readily if the parent is involved; or where it cannot do so on its own – it needs to involve other operating units.

Where there is a parenting opportunity there may be several companies that could provide the parenting role, and for maximum value to be added the parent who takes on that role should be the one which is best able to do so. Goold *et al.* (1994) talk of this company having a **parenting advantage** (one form of competitive advantage).

We must remember too that corporate parents also have governance and compliance roles – they must ensure on behalf of stakeholders that proper processes are in place and are being used. Goold *et al.* (1994) remind us that this is not the reason why the corporate parents exist, it is rather a result of the fact that they exist. These are clearly necessary, but because they do not add or create value they need to be discharged in such a way that they minimise value destruction.

■ **Adding value**

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Appropriate governance and compliance questions will usually include the following:
- Are sensible plans in place and being implemented?
- Are undue risks being avoided?
- Are required procedures being followed?
- Do we have confidence in the management team?
- How should we respond to crises?

Destroying value

Examples of value destroying activities include:
- unnecessary requests for information and redundant review levels
- unjustified interference and bureaucratic policies
- aimless or superficial challenge
- arbitrary capital restraints
- process-driven strategic planning
- unresponsive staff who add no real value
- uniform treatment for all businesses regardless of their needs and opportunities
- slowing down decisions.

So a useful question for corporate parents to ask is: 'What are we doing that we could usefully stop doing?'.

Intermediate parenting

Many companies consist of more than one tier of management and this gives rise to **intermediate parenting** (see Box 5.2).

Box 5.2: Medium Ltd and Bigger, Inc.

Medium is subsequently acquired by Bigger, Inc. Bigger is now the corporate parent and Medium an intermediate parent. Bigger has two choices about how to use the people and resources at the level of the managing company Medium.

Choice 1
Bigger reasons that there are very many operating units in Medium and all the other companies they own. They cannot possibly deal directly with them all, and so they need people to help them do so. This is the role (called a 'span breaker role') they could give to the Medium management team. As the policies and objectives will be being set by Bigger, then the role for Medium's management is much smaller than it was.

Action: Medium's team slims down to a small team passing on information and monitoring performance.

Choice 2
Bigger reckons that Medium's management team has a distinct role to play, a value they can add, that is different from what Bigger itself could offer.

Action: Medium's team remains much as it is.

■ Adding value

Goold *et al.* (1994) observe that there is a particular danger of value destruction when intermediate parents generate repetitive or mutually contradictory views or monitoring procedures. It is necessary for the additional tiers to act in a complementary way for value to continue to be added.

Complex organisations with interdependent sub-units

Not all organisations are as simple as the one described above and in complex organisations, where the sub-units are interdependent, the role of the corporate parent is more multi-faceted; adding value is but one of the issues it will be concerned with. However, the principle of adding value is still relevant, and the danger of destroying value still present.

How might this apply to the NHS?

Let's apply these concepts to the current (2004) organisational structure of the NHS. The NHS is a large organisation, made up of different 'generations' of corporate parents. For example, the corporate parent for Strategic Health Authorities (SHAs) is the Department of Health. SHAs in their turn act as corporate parents to the many NHS Trusts within their remit (the relationship with Foundation Trusts may, however, be different). Trusts in their turn are corporate parents for individual services under their wing. Managers working within any local health economy are, or should be, trying to achieve a lean network of well-parented services – services that have the parents best able to add value.

Of course there are differences, too. The 'customers' of the NHS do not have as much scope for finding competitors to turn to as do customers in other sectors, and the governance role may be more important, and complex, in health than in the private sector. But it is still worth remembering that mechanisms of accountability and scrutiny being introduced into health – for example, methods of reporting to government and the electorate – whatever other benefits these changes may bring, they do not by themselves 'add value', in Goold *et al.*'s (1994) sense of the term. Indeed, one of the main tasks of corporate strategy is to ensure that these mechanisms, responsibilities and layers of management and accountability do not unwittingly diminish or destroy value in some of the ways touched on earlier.

In the case we will now look at, we will begin to identify a number of ways in which the acute trust can or does add value to its Maternity (and other) services, and also some ways in which it could be seen as diminishing or destroying value.

■ **Adding value**

Episode 5.1:
The joys of middle management

Maternity Services

'Oh not another call from the Births at Home Group!' thought Usha, the Head of Midwifery, as she prepared herself to take the in-coming call. 'This telephone campaign they're coordinating is taking so much of my time it's beginning to damage the service. It's reached six calls a day now, asking for information they think will embarrass us, or haranguing me for decisions they tell me I've made (that I haven't). They don't seem to realise that the pressure they put on just makes it more difficult to concentrate on offering a really good service, it doesn't achieve anything.'

But she spoke courteously into the mouthpiece.

Barbara, Clinical Director for Obstetrics and Gynaecology, stuck her head round the door just as the call ended: 'Coffee? ... Oh, you look as though you need something stronger!'

'Just a shot gun.'

'Births at Home again?'

'Yes', said Usha. 'but they're not the main problem. What's making me tear my hair out is the midwives themselves – well, some of them.

'They don't like the new system?', asked Barbara. 'I don't understand that – it's been in place for months now and it just works so much better for them, and for the mothers.'

'But that's *rational*', Usha replied. 'Don't think rational, think emotional. Think of how the Surgical Admissions people reacted when they first heard about the reengineering pilot.'

'That's true', Barbara mused as she brought the coffees, 'that project has taught us some lessons.'

Usha scratched her head: 'Now the midwives are reacting against any form of accountability, any protocols, any suggestion of time management, in fact anything that doesn't allow them complete autonomy – on our pay roll.'

'That sounds like some of the gynae mob too!'

'Just as well we can laugh about it together.'

'True', said Barbara, 'your predecessor was so busy hating all doctors that she never found out we were on the same side. It's made a big difference having you here. Having offices next door to each other helps, of course, we didn't have that before.'

Barbara caught sight of some charts on Usha's desk: 'How are the changes progressing?'

'Oh pretty well I think', said Usha. 'The staff nurses are prepping for Caesareans, nursery nurses are working with mothers on the ward (now that we've got the extra training for them in newborns) and the housekeepers are working out ever so well. So, because we're so desperately short of midwives we're using those we have to the very best effect and the service is definitely improving. And because these new roles are on lower grades

we've freed up some cash to be able to appoint a couple of G grade midwives – so at last we have a career structure here. But what a battle! I know midwives *can* do all these things but it's a false economy to ask them to—'

Barbara stopped her there: 'But I thought they hated the old system, they were always complaining before.'

'Oh, our case loads were ridiculous – frightening', said Usha, 'and they were right to complain. Their main complaint though was that no-one listened. Now I have, and they're still complaining! Actually some of those who are the most difficult are the very best midwives. They are so passionate about the kind of service they want to offer, that they resist any proposals that are anything less than the best. And of course we can't offer a Rolls Royce service – no-one can, they're being unrealistic. To the point where they stop being as useful for mothers as they could be.'

Usha's tone changed from animated to defeated: 'And there's been no support at all from the top, whenever I've asked the Director of Nursing how to approach things or "them" or the three bolshie ringleaders especially … she's always brushed me off, saying midwives are always awkward, that they're such a small group but they make such a large fuss!'

Barbara commiserated: 'As you know, I've found the same with the Medical Director. You and I have done jolly well considering we've done it on our own! Well, with some help from the people in our own teams.'

'Yes, Michaela[37] has been ace with our new booking system.'

'You know, it's made such a difference having you here, Usha. At last I feel we can work to each other's strengths, obstetricians and midwives. That's been the key to the new triage system,[38] which is also evaluating very well. But it is a pity we can't get more support from the top – with the birth rate rising, women having babies when they're older, when they're sicker, we're going to have to get a lot smarter in the way we offer the service if we're not going to account for even more of the insurance bill! Oh if only we had some targets! Two would be enough: two weeks from GP referral to midwife appointment, and one midwife per delivery.'

'But come on!', Usha said with a smile. 'You never get the targets you want! They're like buses: not there when you need them and then loads when you don't. I know what you mean though – all the management attention is going on services with targets. Anyway, I'm not sure I want management attention – they're only ever concerned with avoiding failures, not with us being excellent. What I need help with is dealing with people – difficult people. How can I stop those three midwives stirring up Births At Home? Perhaps the Royal College of Midwives can help – I really think they are perilously close to a professional boundary.'

'Oh, if only we had some targets!'

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[37] Administrator, Maternity Unit.
[38] Mothers are triaged and those considered at low risk are allocated to a midwife and those at high risk to a named consultant for shared care.

'No doubt they'll see it as whistle blowing', Barbara commented. 'Perhaps someone in Human Resources could help?'

'Who?', Usha asked pointedly. 'Who has been any help to you about your battles with the gynaecologists? You really wanted the Medical Director to back you up when you tried to tackle the bullying of juniors, and she just told you to tread more softly, don't you remember? No, when it comes to the difficult part of management – dealing with people – we're on our own. Even when it's in the interests of the Trust as a whole. Basically we're squeezed between the frontline and management. I get really tired of that.'

Barbara paused before saying, thoughtfully: 'It's partly because they don't know who to believe. They've only been here five minutes and they've got rid of most of the managers with any organisational memory – so they don't know who they can trust and who is just shroud-waving. I think they're competent though – you do too! They just don't know us.'

Usha retorted: 'And they won't get to know us if they promise to come on our away days and then fail to turn up!'

'Yes, that was bad. Rude. Damaging', said Barbara. This incident was still annoying her. 'I looked silly, and Dianne looked uninterested.[39] Actually, what I think is even more damaging – I haven't told you this yet, Usha – is that from now on you can't come with me to the management meetings – apparently the room's too small! "Too many people going to too many meetings", I was told. And I have to learn to take personal accountability.'

'I thought everyone was talking about *more* team work! Just you? None of the rest of the team?'

'Yup. So I'll have to come back and discuss it with you afterwards, and then find I've agreed to something I shouldn't have.'

'Never mind', said Usha, 'that's the way doctors always negotiate! Agree with everyone in the meeting, then send an email around giving excuses about why you regret you have to disagree ...'

'You *are* in an anti-doctor mood this morning!', laughed Barbara, even though she too was familiar with this kind of behaviour.

'Well, you're welcome to all those "strategy" meetings coming up', Usha smiled. 'There are so many of them – and so airy-fairy – all that discussion about what will be happening in ten years' time. Honestly, we need to concentrate on what's happening next week! All those demographic statistics, I know they're important but it's more important they recognise the increasing birth rate *now*. And the idea of presenting our plans to all the other directorates is simply horrible! It will be so confrontational – at least if it's anything like the business planning meetings a few months ago. We all hate the conflict with each other, so I'll be glad to be out of it. Oh I know it's inevitable – quarts and pint pots and all that – but I can't believe it has to be so confrontational. Even the new money isn't helping.'

'When it comes to the difficult part of management – dealing with people – we're on our own'

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[39] Dianne, Director of Operations, promised to attend the Maternity Services away day, but for reasons to do with diary management had not done so. Her remorse was accepted as sincere, however her absence affected the nature of the discussion during the event.

'No, it's good to see it coming in, estates are benefiting, thank goodness – salaries too, and pensions. Just not *our* services …'

Usha suddenly remembered: 'Talking of estates, have you heard about Queens Mead?'

Barbara covered her ears: 'I don't want to hear any more about their fabulous new women's unit, "planned to be flexible and meet the needs of women over the next thirty years"'. Her accent had taken on the twang of the Project Manager, Tanya.

'Oh but, you do!' said Usha. 'In fact it's so flexible it's become an orthopaedic ward! Yes, I mean it. Queens Mead weren't meeting their orthopaedic targets so they've taken over half of the space of the new women's unit. Tanya is furious!'

Barbara almost spluttered her coffee: 'I should think so! They've been working on that project for five years. And as you say, Tanya wants it to be a resource for the next thirty. You have to admit the design is fantastic – so efficient, really good for keeping people in touch with each other … Talking of the future, Usha, have you thought anymore about making a case for a midwife consultant post? Perhaps that would help resolve some of these people issues – some clinical leadership.'

'No, I haven't', said Usha firmly.

'A touchy subject', thought Barbara, as she took her coffee and went back to her own office.

Privately Usha thought there was great danger that a consultant would cream off all the interesting parts of her role and leave her with the mundane, the difficult and the unpleasant: 'I'd be tempted to apply for one myself ... But I can't see how to make one work here.'

Executive offices

Following morning, 7 a.m.
Dianne enjoyed this part of her working day. The next hour and a half would be quiet, time for reading, for thinking, for writing. Later it would be fraught. She had stopped on her way in for a quick chat with Usha on the labour ward. She knew Usha would be there while her system changes were shaking down, and Dianne had wanted to show her own support. Now she had a few minutes at least to mull over next week's appraisal meeting with Jane, and jot down some notes as she went. She wasn't worried about it, the last twelve months had been productive. But she also knew that Jane was as perceptive as she was fair-minded. Dianne wouldn't get away with a cosy chat.

Dianne had a few minutes to mull over next week's appraisal meeting

It was good to see so much happening in Maternity, and Dianne could take some pride in the fact that she had recruited Usha – ('That might be the most important contribution I make this year', she noted) – and had arranged for a shuffle of offices so she and Barbara could be near each other. 'I don't suppose they know I had anything to so with that', Dianne

reflected, 'some of the best things I do are invisible! But I'm hoping some of Usha's ideas will rub off on Barbara, and vice versa.'

The resignation of Usha's predecessor had been a great opportunity to move things on in Maternity Services, and she had jumped at it. Opportunism was becoming a habit, she thought. That was how she managed to keep all the balls in the air. People would ask to see her, would make a sensible case for some service improvement or development, and although she didn't know exactly how she would manage it, she would agree: giving a commitment in return for a change in practice, or staffing, or location. Sometimes taking an opportunity meant putting people's noses out of joint, especially when decisions had to be taken quickly, so she had grown an extra layer of skin over the years.

'Thank goodness I have', she thought, 'that makes it easier to tolerate the constant cynicism about managers, the view of a lot of the clinicians here that the managers are only interested in balancing the books to further their own careers.'

'The one future we can be sure won't happen is the one we've calculated'

The trouble was that so many of the ways of getting the organisation to be more effective – to be better able to meet the needs of its clients – inevitably involved challenging comfortable but unproductive mindsets. Take the work of the Strategy Review group, for example: thinking ahead about what the demands would be in 10-20 years time, in order to ensure that decisions made today wouldn't get in the way. They had done some exciting thinking; commissioned some scenario thinking from different expert centres; used publicly available information from a wide range of sources to analyse trends; looked at plans developed by other local organisations (council, PCTs, other acute trusts, voluntary organisations); and developed a good sense of the role the hospital would play in 10 years' time. The Review group had then worked with a hundred or so leaders throughout the organisation to share this picture with them, and get them to use it when planning their own service developments. More than that, any new proposals that didn't indicate how they fitted with this future were being rejected. Not always popular …

In general, some of these leaders had found it exciting and stimulating and others had hated it – talking of 'fairytales' and believing it was a waste of time and money. 'They're right of course', thought Dianne, 'the one future we can be sure won't happen is the one we've calculated'. But the trends still needed to be addressed and this thinking process was one way of encouraging that to happen. Already some of the clinicians were taking more interest in the events and news from outside the organisation than they were before – and, perhaps just as important, in trends within the hospital but outside their specialty. Take what had happened with reengineering the admissions process, for instance.[40] With luck it would all make the business planning process less confrontational than it seemed to be here.

The whole idea of thinking strategically instead of incrementally was new to them. Thinking rigorously about the environment, thinking ahead,

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[40] Discussed in Episodes 5.2 and 5.3 below.

considering afresh how they were deploying their resources. 'I suppose resources is management jargon for people', one person had said pointedly. Dianne thought ruefully that she must be careful about language. They just hadn't done that kind of thinking before, so all that brain power had been massively under-utilised.

This was all part of a history of service leaders not thinking proactively for themselves, and not being required to do so. 'They don't really want us to *help* them to do something', Dianne thought, 'they want us to go in and sort it out *for* them. That means we go in and take the flak for them, but taking flak is part of the management task, I've had to do it, they have to learn how to do it …'

Some of her other initiatives were just as important but even less popular than the strategy work. Unsurprisingly, service leaders wanted help with things that were bothering them now. And lots of important necessary initiatives had a much longer pay back period. Working with schools and colleges to encourage more people from the local community into the NHS, for instance. Lots of grumbling when departments were asked to provide placements. They saw it as an additional burden (and it was) and complained about things being 'landed' on them, about not being consulted. 'But if I try to involve them they don't want to know, they've got more urgent things to think about, and rightly. If I didn't "land" it on them nothing would ever happen. My action now means they'll have staff in five years' time.

'People have to be encouraged to think beyond their department boundaries. I know some of them resist the process modelling workshops we've been running, for example, but for many it's been a revelation – they just hadn't realised how much activity took place beyond their involvement, and how their systems were causing problems further up or down the line. Again, they would never have prompted this themselves, it needed a manager with an organisation-wide perspective to sponsor it. Now we can foster our own internal team of facilitators, so it can be an ongoing project with real benefits for patients.

'Thinking of skills that are needed: the service leaders are going to need some specific project management skills. I don't want them trying, failing and getting disillusioned, so I can provide some resource of that kind from the corporate development department.'

Dianne began mentally rehearsing some of the issues she knew would come up in her meeting with Jane.

'The biggest skill *I* need right now is being able to challenge more effectively some of the childish behaviour being flung at me in meetings. Temper tantrums, irrational arguments, thinly-veiled threats … I find myself getting frustrated, not least with myself, I wish I could help some of the more stubborn people to stop digging their heels in, to engage in more constructive dialogue. I know that when people become emotional it's often only after years of trying hard and not getting anywhere, and sometimes their arguments are justified even when their behaviour definitely isn't! It's something I'm trying to work on. Jane is certainly better at grace under pressure. She ignores the emotion and takes the words at face value, then she calmly deals with those. Last month the haematologists complained

they were having to cut outpatient appointments by 20% because of the night cover arrangements to meet the EWTD.[41] Jane took the figures seriously, and set out an entirely rational programme of investigating working practices with the aim of reducing it. The study is already demonstrating that haematology are using their team very inefficiently, and that they can cover all their original outpatient appointments if they re-organise. We'd never have found that out if we'd responded by caving in, or behaving defensively.

'Of course, a lot of what I do is passing on requirements from the centre. If a new set of guidance comes out from the Department[42] then all I can do is make sure all the right people receive it. And if the SHA need some information to be able to provide answers for a Minister's PQ[43] then I have to chase people to find it out. That's why I sometimes seem and feel like a post-box.

'I've noticed that people respond very differently to requests for information. Some are fine, others are completely unreasonable and seem to think we have no right to ask for it. Even Usha grumbles about having to pass on information about the number of Births at Homes calls she gets. But all organisations have to collect data, and feed that through to the relevant regulatory bodies. We're not in business to provide work for prima donnas – we're here (including the prima donnas) to offer care that is needed (not what they fancy offering) and we have a duty to justify how we spend the resources we're given to do that with.

'Still, it does feel as though we're turning the corner: that people – well, more people than when I started – are beginning to behave more appropriately, that we've got a cadre of good people in place.

'And by working together we can see some of the patterns people can't see on their own – drivers of activity is one example. It was the PCT who pushed us into thinking about that but it's been valuable for all of us, and needed energy from me to get it going. One of my roles is being a finder – spotting good resources or ideas and bringing them into the organisation. Some of them from my own experience elsewhere. I remember how surprised I was to find that not all the wards here operated a good materials management scheme (bar codes in the stock cupboards, stock automatically re-ordered, that sort of thing, very 1980s but just not brought in here). Some of the ideas come from agencies within the Department, or the PCT. Others from all over the place, by keeping up to date with journals.

'That's another part of my role: developing relationships with the PCT, Social Services, Education, and other trusts. These will take a while to bear fruit, but must eventually be the way forward. Even now it's been possible to challenge some of their assumptions – to everyone's benefit. The plan for X-ray facilities in all of the proposed one-stop shops in the community would have been impossible to staff – we can't recruit enough radiographers for a centralised service, so setting up a service that relies on recruiting even

'I sometimes seem and feel like a post-box'

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[41] European Working Time Directive. This Trust has introduced a team arrangement for covering patients at night, that allows better patient care with reduced doctor hours.

[42] of Health.

[43] Parliamentary question.

more would mean it was bound to fail.'

The subject of X-rays brought Barbara back full circle to the thought she'd had earlier, about the best things she did being invisible, at least as far as the people she managed was concerned: 'As long as I know that I'm making a real difference to the care patients receive, and I do, that makes it all worthwhile. Now all I have to do is put that in a form that will convince Jane ...'

Experimenting with adding value

Before reading any further you might like to consider answers to the following questions.

Dianne

1. Is Dianne part of a corporate parent or an intermediate parent? If the latter, what kind of intermediate parent?
2. How is Dianne adding value to the services in her Acute Trust? Are there other ways in which she could do so?
3. What other roles is Dianne fulfilling?
4. Is there any way in which Dianne is destroying value?

Usha and Barbara

5. What would Usha and Barbara like Dianne to do, to add value to their services?
6. How can they encourage her to do so? Why might Dianne resist doing so?

Illustration and analysis

The case contains many details that could be brought into a discussion of these questions. We include only some of them, so your reflections will almost inevitably look rather different from ours.

1. *Is Dianne part of a corporate parent or an intermediate parent; and if the latter, what kind of intermediate parent?*

 HIDE | **SHOW**

Dianne herself refers to being a post-box. This is an indication of a role in which she is acting as an agent or administrator for a more senior parent who has such a wide span of control that they cannot deal with everyone and need a 'span breaker'. Thus she is an intermediate parent, with a span breaker role. However Dianne is much more than this. The work she leads on the Strategy Review group, for example, indicates that the Trust has a role in relation to the frontline services that is distinct from the role played by the SHA or the Department of Health. So she is also an intermediate parent adding value in her own right.

2. *How is Dianne adding value to the services of the Trust?*
    She is doing so in a number of ways as outlined in Table 5.1.

■ Adding value

Table 5.1: Ways to add value

HIDE   SHOW

Ways to add value	Examples
1. Encouraging good management of services	
• Appointing good people	Usha
• Making arrangements that will oil the wheels	Moving the offices so that Usha and Barbara are next to each other
2. Challenging mindsets of service leaders and within services	
• Encouraging service leaders to think strategically rather than incrementally	Giving relevant information to service leaders, helping them to use it to build into to their own thinking about strategy, requiring them to develop a strategy, ensuring the strategies are critiqued to increase their robustness
• Challenging practice	Introducing bar coding for materials management
• Encouraging fair play between services who are competing for resources	Facing down 'prima donnas'
• Feeding in information from other organisations appropriately	Looking at plans developed by other local organisations
3. Developing capability	
• Offering learning opportunities	Process modelling workshops
4. Offering central resources and being a resource	
• Spotting a need for a set of skills she has available	Project management skills
• Incorporating good ideas from elsewhere	Introducing good materials management from her past experience and ideas from other sources such as the Modernisation Agency
• Seizing opportunities generated by the PCT and working on them to the point where they can be useful to services	Drivers of activity, efficiency indicators
• Addressing long term issues not prioritised by service leaders who are focusing on the day-to-day	The work with schools and colleges
5. Influencing the environment	
• Challenging other organisations where their plans conflict	Urging realism about the number of radiographers available

■ **Adding value**

How do these ways to add value relate to the four headings of Goold *et al*. (1994), i.e.:

a stand alone influence
b linkage influence
c central resources
d corporate development.

We suggest that using the numbers in the table above:

1 is a
2 and **3** include actions that fit under a, b and d
4 is c
5 is d.

Although it is not part of Diane's remit let us consider the damage done to Queens Mead's women's services, as senior managers decide part of its new centre will be taken to ease bed pressures elsewhere? Surely this is not adding value?

In the short term this is probably true. However, the sacrifice made by women's services does protect other services, and staff affected may reflect that if at some later date they too need that protection it may be available to them as well. Of course, if women's services are regularly disadvantaged to support other services it may be that they could find a parent elsewhere who would add more value (or destroy less).

Let us reflect for a moment on the way in which strategy is being developed in this Trust. The Strategy Review group can prompt service leaders to develop their own service strategy, by requiring them to do so, by giving them information about the environment (now and in the future) that they can build in to their analysis, and by teaching them how to undertake such an analysis (perhaps using the approach described in Case 1, page 44). It can also host events at which service leaders present their strategies to each other, so that they are able to build the intentions of other departments into their own thinking. In all these ways it is ensuring that the strategies developed by services are more robust than if developed in isolation.

At the same time the Strategy Review group can prompt the Trust management team (and Board) to review its own strategy. It is important that this is not merely an amalgamation of service strategies, and certainly not a set of decisions in relation to those services that do not take into account those strategies. The strategy for the top of the organisation needs to be about how to undertake its own role. It needs to use the principles of strategic analysis (in a way similar to how services have done) to reflect on what it needs to do to improve its own performance in running the organisation. To do so it needs first to clarify its role: value added parenting, ensuring it is the most appropriate parent for a particular service (and if not, helping the service decide who is), compliance and governance. It will then look at the resources it has available to achieve that, and the environment in which it is doing so.

■ **Adding value**

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Thus the strategy of the Trust as a whole is made up of a set of strategies all interacting with each other, and all created through a process of interaction. This is dynamic and ongoing and not at all static and fixed. At times it will need to be captured in a document, and perhaps in other imaginative ways, but that will reflect only the thinking of that time and will need to be modified as events occur, unforeseen opportunities are taken and reactions emerge. At every level in the organisation the matrix of change approaches (described on page 69) will be being enacted.

3. *What other roles is Dianne fulfilling?*

| HIDE | SHOW |

She is fulfilling governance and compliance roles by insisting on information being provided by the services.

4. *Is there any way in which Dianne is destroying value?*

| HIDE | SHOW |

A simple mistake has left Barbara, Usha and Maternity Services hostile and suspicious – she failed to honour a commitment to attend their away day. More routinely, she is imposing on the time available to the service by requiring a regular update of the calls from the Births at Home group, and is requiring all the calls to be dealt with by the service instead of offering the assistance of the Press Officer. Over-zealous monitoring and collection of data are a common source of value destruction.

Usha and Barbara have formed a team approach to managing their service that is entirely appropriate in health care, and yet Barbara is being prevented from bringing other members of her management team to decision-making meetings. This will incur additional time, or result in impoverished or unworkable decisions. There is a danger that this will destroy value.

5. *What would Usha and Barbara like her to do, to add value to their services?*

| HIDE | SHOW |

If Dianne is adding so much value, how is it that Usha and Barbara are not feeling the benefits of it? They talk of feeling alone against the world. They would like her to help them with the things they find most difficult – e.g. dealing with difficult people within their services. In practice, they haven't asked Dianne for help, they have asked for it from others at Dianne's level and it has not been forthcoming. Indeed, the opposite is the case, they feel they have been deterred from acting in the way they know is needed. They are also experiencing many of Dianne's initiatives and the work of the Strategy Review group as an additional burden.

■ Adding value

In practice the value that is added is not always perceived by those benefiting, certainly not at the time and sometimes never. The Strategy Review group is undoubtedly helping Usha and Barbara think more clearly and be more effective in the longer term, but at the moment they notice more work, more meetings, more data to collect, more information to have to deal with. Because they are basically forward-thinking, proactive people they probably will see this positively in time.

6. *How can they encourage her to do so?*

| HIDE | SHOW |

An angry demand for support is unlikely to be successful, and a whinge to each other is a waste of time, but they could ask for a discussion about roles and responsibilities and the support they need if they are to fulfil those.

7. *Why might Dianne resist doing so?*

| HIDE | SHOW |

Dianne suspects that service managers are so driven by immediate pressures that they are not interested in developing skills in sorting things out longer term, they just want them sorted now. She may decide that the service will benefit more in the long run from Usha and Barbara developing their own skills than from her stepping in to help. Here again the value that is added may not be apparent immediately. Thus corporate parents cannot expect to be fully appreciated, although it is important they do not undervalue resistance to their ideas and automatically sweep aside objections.

■ Organisation-wide initiatives

One of the other roles of top management in organisations is to introduce initiatives that are organisation-wide; after all, they are the only people who have the authority and resources to do this. We will look here at two such approaches that have been described in the last twenty years: Total Quality Management (TQM) and Business Process Reengineering (BPR).

■ Total Quality Management (TQM)

■ Adding value

■ Organisation-wide initiatives

■ Total Quality Management (TQM)

TQM grew out of the work of Walter Shewhart, who in the United States in the 1920s introduced industrialists to the notion that the quality of their products was a function of the process by which they were manufactured and that by monitoring simple statistics they could gauge whether that process was stable and producing goods within acceptable quality limits, or whether it was not. They could also tell, when quality fell below standard, whether the process as a whole was failing, or whether there were specific one-off reasons that could be identified and dealt with.

This insight was developed and expanded by the 'quality gurus' including W. E. Deming, J. Juran, K. Ishikawa and others, working mostly in Japan through the 50s to the 80s.[44] Also in the 1950s A. V. Feigenbaum drew on the experiences of these and other figures to write what became an influential book, *Total Quality Control* (third edition, 1991), outlining an organisation-wide approach to quality. Many businesses attempted to introduce total quality management programmes, assisted by the large management consultancies who developed proprietary approaches to support them. The introduction of TQM to health care was spearheaded by the National Demonstration Project (NDP) on Quality Improvement in the United States, in 1987-8, under the auspices of Donald Berwick and A. Blanton Godfrey. Berwick's ideas have since gone on to influence the modernisation work being carried out within the NHS.

In this section we introduce the general principles of TQM and then illustrate the use of some of them, but we do not detail the various specific TQM approaches as there are many easily accessible guides to these.

Principles of TQM

Berwick, Godfrey and Roessner (1990) in their reflections on the NDP suggest that TQM is built on ten core principles, and the following section draws heavily on their work:

1. *Productive work is achieved through processes.*
   As individuals working in health care we are all parts of a process, and we all fulfil three roles (the 'triple role'): those of customer (of the person before us in the process), processor, and supplier to the person who is the next link in the process chain. To ensure quality overall we need to understand and define carefully our own needs as customers (and let our suppliers know), and similarly we must ascertain and define carefully the needs of our customers. When we talk of processes, these can be flows of patients, flows of information or flows of materials.

2. *Sound customer-supplier relationships are absolutely necessary*, and these can be improved by investment in interaction, in measurement and in clarification of roles.

3. The *main source of quality defects is problems in the process*, not in individuals.

4. Poor quality is costly, and *preventing defects is much cheaper than detecting them* later on.

5. *Understanding the variability of processes is key to increasing quality.*
   All processes are subject to variability, so it is impossible to say that a service or product will be exactly the same each time it is created. Rather, any process will produce services that fall between upper and lower limits, and it is these that we need to be sure are satisfactory if we are concerned

■ **Total Quality Management (TQM)**

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[44] For a critical introduction to the main management gurus and the different schools they have given rise to see Crainer and Dearlove (2003).

about quality. Collecting data will allow us to see whether actual performance is breaching those limits, and we will be able to tell whether the whole process is drifting to a level of performance that is not acceptable (in which case we must look at the whole process) or whether there are some special, one-off causes that are having this result. We need to understand variability because if we seek consistent regularity there is a danger of 'tampering' and interfering with a process that is working well within its limits.

6. *Quality control should focus on the most vital processes (the 'vital few' rather than the 'useful many').*

7. *Measurement is essential*, and this must encompass:
    - what the customer needs
    - inputs
    - characteristics of the process – is it stable? is it operating in the way it was designed?
    - results – what did the customer experience? how did the process perform?

    The purpose of this measurement is to understand the processes, to predict their performance and improve them. More radically the purpose (according to George Box of the University of Wisconsin) is to enable everyone to control and improve processes, not so that 'some people can control other people'.

8. Total *employee involvement is critical* – as everyone has a triple role, it is not possible to involve some and not others.

9. *New organisational structures can help.*
    Berwick *et al.* (1990) list a steering committee or Quality Council, made up of the senior managers who make other key decisions within an organisation, and Quality Improvement teams. The latter are 'special, short-life project teams assembled for the purpose of a specific improvement assignment, under the authority of the Quality Council'. They are almost invariably cross-functional.

    The Quality Council 'plans the training of managers and teams, plans the technical infrastructure for improvement, creates and maintains procedures for the nomination and selection of processes to be worked on, creates and maintains form of recognition and celebration of the quality improvement teams, and evaluates and improves the quality improvement effort itself'.

10. *Quality Management employs three basic, closely inter-related activities: quality planning, quality control and quality improvement.*
    - Planning includes developing a definition of quality as it applies to customers, developing measures of quality, designing services to meet those needs, designing processes capable of providing these, and transferring these to the routine operations of the organisation.

■ **Total Quality Management (TQM)**

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- Control is the development and maintenance of operational methods for assuring that processes work as designed, and that target levels of performance are being reached.
- Improvement is the effort to improve the level of performance of a key process.

Quality improvement consists of five basic steps:
  – Select a problem to work on.
  – Organise a team to carry out the improvement project.
  – Diagnose the problem, i.e. understand the process of which this is a part, gather information on the process, and search for the root causes of the problem, test hypotheses.
  – Plan, test, and implement a remedy guided by the process knowledge you have now gained.
  – Check and continuously monitor performance at the new level, taking further action as needed to modify the remedy.

Using the principles of TQM

Imagine you are Dianne, interested in the principles of TQM and wondering how to use them in the Trust, perhaps to improve quality in Maternity Services. What could you do?

If you are already familiar with the quality improvement processes of the Modernisation Agency or other organisations you will be able to answer this question in more detail than if you are relying on the information provided above.

We will introduce some other key terms in our answer, so please do not feel cheated if these are new to you!

Illustration and analysis

Dianne's role in introducing TQM principles in Maternity Services
Using the ten principles outlined above Dianne could do the following:

1. *Encouraging people to think in terms of processes.* How?

[HIDE | SHOW]

- Talk in these terms herself.
- Focus not on isolated events or individual actions, but look always for the process in which these are embedded. One way of doing so would be to use the Five Whys (see page 84).

■ **Total Quality Management (TQM)**

2. *Identify customer-supplier relationships.* How? And how could this be applied to the triage system (page 226)?

(HIDE | SHOW)

- Encourage others to do the same.
- Encourage customers to be exacting and suppliers obliging, and both of them to define what the customer needs. For example, on page 226 Usha refers to the triage system she has recently introduced. If we suppose that the system takes a referral from a GP to the triage midwife who then allocates the mother-to-be to a midwife or to shared care with a consultant, then we could conceive of this process as a series of customer-supplier links, of which the following is a part.

Table 5.2: Customer-supplier chain

GP ➔	Triage midwife ➔	Named midwife
Supplier of referral to triage midwife	Triple role: • customer of GP • 'processor': assessing the needs of the mother-to-be • supplier of referral to named midwife (or midwife and consultant)	Customer of triage midwife

- Dianne can also encourage everyone concerned to remember the end customer: the patient/client. She can do this by: always asking, when decisions are being made, what the impact on patients will be; including a patient/client perspective in all discussions about services; and taking an active interest herself in complaints and the responses to them.

3. *Avoid blaming individuals and always look for failures in the process.* What else?

(HIDE | SHOW)

- Recognise that processes are the responsibility of senior members of the organisation, not juniors.

4. *Encourage a culture of prevention rather than detection.* How?

(HIDE | SHOW)

- Ask people to think about processes and what could go wrong in them, how to improve them.

■ **Total Quality Management (TQM)**

5. *Understand variability herself and discourage tampering by others.*

6. *Develop her own skills in articulating operational definitions, thinking clearly about measurement, and how to interpret the resulting data. Encourage others to develop these skills.*

7. *Increase her own understanding of measurement, in the areas listed.*

8. *Increase understanding of the 'triple role' of customer, processor and supplier. Use the concept when discussing issues with clinicians and with service leaders.*

9. *Exploit the energy from modernisation initiatives to support suggestions for Trust-wide efforts.*

10. *Encourage all three 'Q' activities: quality planning, quality control and quality improvement.* For example?

(**HIDE** | **SHOW**)

• Be clear in her own mind about the distinctive roles of the three.
• Suggest the setting up of a senior team to do the planning.
• Work with multi-professional teams on quality improvement initiatives.
• Ensure quality control is given to the department directly responsible for the performance being monitored.

Let us now look at how Dianne, working with Usha and Barbara might use the principles of quality improvement in Maternity Services. The five main stages of the quality improvement process are:
1. *Select a problem* that needs to be worked on, then
2. *set up a quality improvement team* that can
3. *undertake a diagnosis* and
4. move on to *implement successful remedies*, then
5. *sustain and extend* the benefits of the changes.

Dianne will be able to see clearly that there is a quality problem in Maternity Services – since quality is defined as meeting the needs of customers, and many customers are expressing their unhappiness through the Births at Home group.

Stage 1
The first task to do is to **select a problem that needs to be worked on**.
Dianne would discuss with Usha and Barbara the areas where they believe quality is lower than they would like it to be. They in turn would discuss with this their staff and with customers – the mothers and mothers-to-be.
Customers themselves typically identify different concerns from those suggested on their behalf by service providers, so asking the mothers will be critical. A short patient satisfaction questionnaire would be one means of doing so.

■ **Total Quality Management
(TQM)**

As a result of this activity Barbara might suggest that the problem to be worked on is:

Mothers-to-be are unhappy with the birthing choices available to them.

This is a problem that is too wide to be addressed, and it needs to be further clarified, so the next step would be to collect more data from the mothers, using all the aspects over which they expressed dissatisfaction in the initial survey.
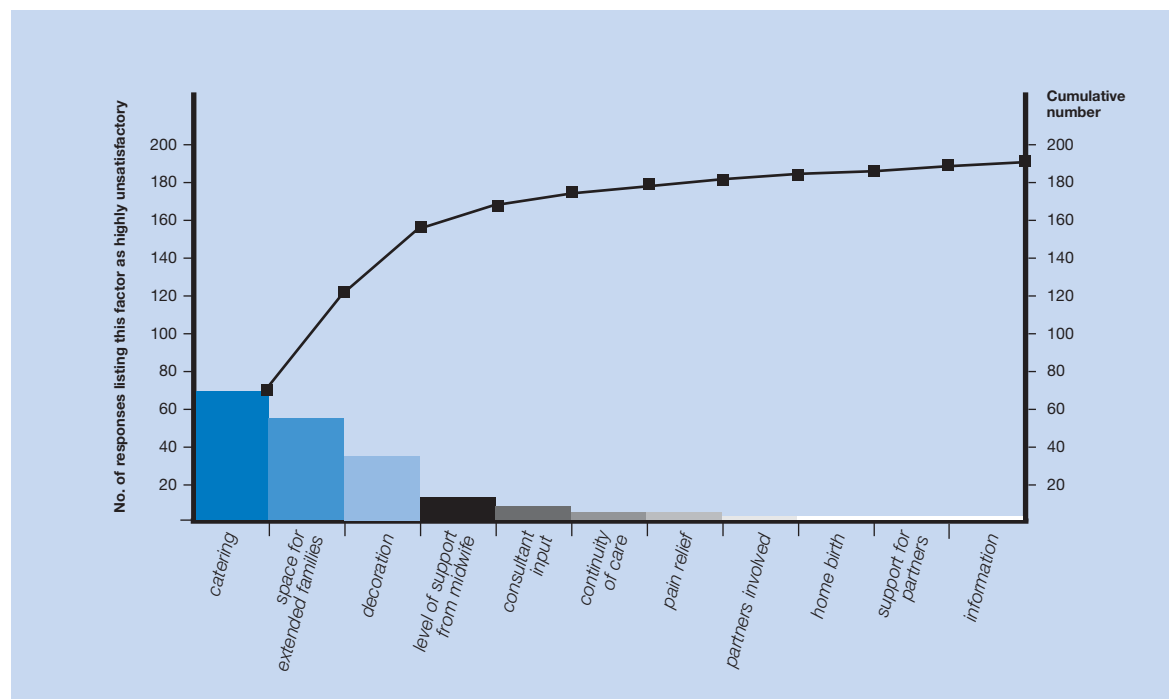
For example, let us suppose that the service decides to give the following questionnaire to a random sample of mothers-to-be and recent mothers:

Have we been able to support you in your preferences for:

home birth?   pain relief?   consultant input?   continuity of care?
level of support from your midwife?   partner involvement?   support for partners?
space for extended families?   catering?   decoration of facilities?   information?

The answers could then be presented in the form of a **Pareto chart**[45] to distinguish between the 'vital few' (the small number that between them generate the majority of concerns) and the rest.

Figure 5.1: Pareto chart – causes of dissatisfaction with service in the delivery suite

■ **Total Quality Management (TQM)**

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[45] A chart that summarises and displays the relative importance of differences between groups of data.

In Figure 5.1 we can see that the 'vital few' are catering, space for extended families and decoration. Several of the others also caused concern, but not as much as these. Any improvements here will therefore yield a benefit which is disproportionate (in that costs will be much smaller than those necessary for investing in other areas to achieve the same level of benefit).

The questionnaire would also collect demographic data, and it is quite possible that instead of one nice neat Pareto chart as illustrated in Figure 5.1 there would be two: perhaps the one above would be relevant for women of South Asian origin, and another would be pertinent to women who are members of the National Childbirth Trust who may have identified additional specific concerns. For our purposes now we will pursue the simplified example.

It may also be the case that where mothers have expressed unhappiness with the level of support from their midwife there is a higher rate of dissatisfaction with other factors – in other words that this is more critical than a straight numerical count would suggest. These charts therefore have to be interpreted with care. In our example it is clear, however, that the preference for a home birth, although highly important to some (as evidenced by the daily calls from the Births at Home group), is not at the top of the list. So the chart can help keep energy focused where it is most needed, and prevent it being diverted to areas where the lobby is loudest.

At this point Dianne should ensure that a sound problem statement is articulated, one that:
• reflects shared values and a shared purpose (shared and understood by all those involved in the service provision)
• does not mention causes or remedies (especially not more money, more space, more staff …)
• defines problems and processes of a manageable size (if necessary, by narrowing down the customer group, the time interval, the diagnosis, the key quality characteristic)
• mentions measurable characteristics.

She will also want to see this problem statement refined as work progresses and there is greater understanding of the process that is causing the problem.

The problem statement arrived at here could look like this:

Mothers cannot find, in the menu, an attractive or acceptable choice that is available when they want or need it.

You may like to compare this to the requirements listed immediately above.

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Stage 2

At this point Dianne will feel well enough informed to set up a **quality improvement team** of people from a number of different disciplines (possibly here: midwifery, reception, catering, portering, dietetics, medical records). She may decide to include a recent service user. She may need to ensure the leader of the team receives some training in techniques like brainstorming, and idea generation, as well as developing skills in facilitating dialogue and disclosure. She may also want to link them to people with quality improvement expertise (either in the Trust, in the Modernisation Agency, the SHA, or elsewhere) who could be available to help if needed.

Stage 3

The team will then be able to undertake their **diagnosis**, i.e. defining and understanding the existing process and analysing where the opportunities for improvement lie. The most common tool used here is the **process flow diagram** in which the team maps out every step in the journey taken by a patient, by the information relating to a patient and/or by any equipment or materials that are used. There is a set of conventions about how to present these and examples are given in *Organisational Change* (2001: 37).
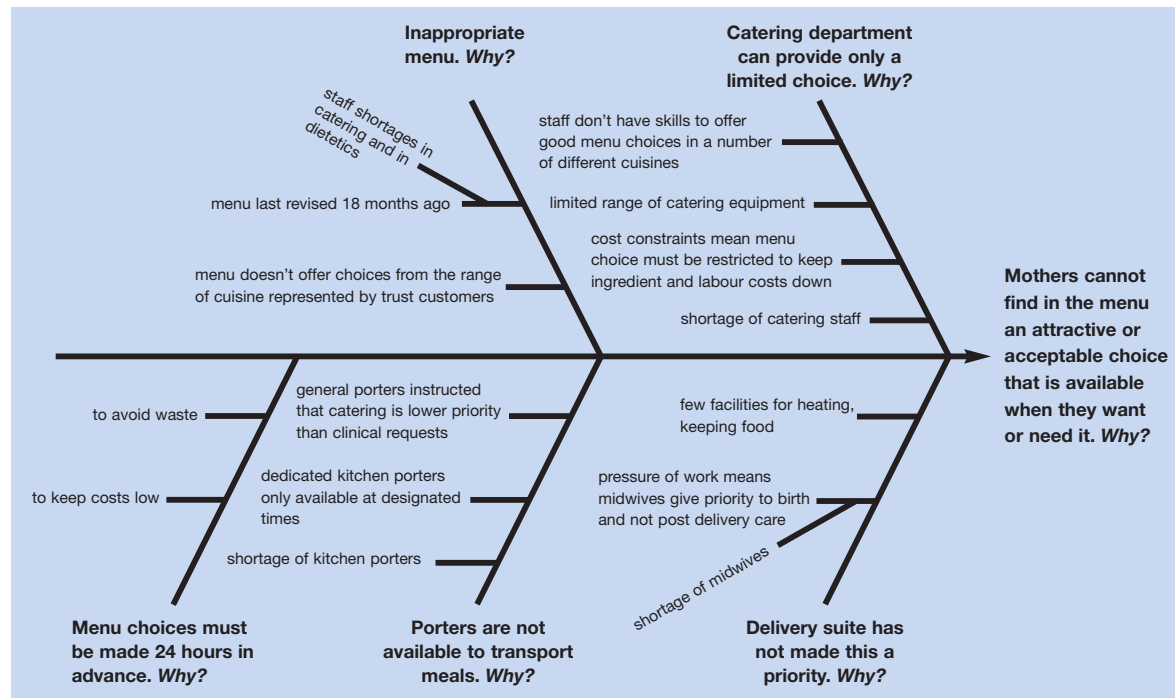
Here the team would probably map the existing process for designing menus, for patients to exercise menu choice on the labour ward, and for delivering food to the ward.

When the normal process has been mapped out it is important to map also the process as it operates when under a stress of whatever kind – so that it indicates what really *does* or *can* happen and not just what *ought* to happen.

Everyone listed on this process flow will be a customer and/or a supplier, and once these links have been identified there is an opportunity for customers to define exactly what it is they need from their suppliers. It is then possible to generate a list of hypotheses about the factors that prevent the customer (the external customer, the mother-to-be in this case) from receiving the choice of food they want. These hypotheses can be organised using a **fishbone diagram**. This is a cause-and-effect diagram devised by quality control 'guru' Kauro Ishikawa (1982) that looks much like the skeleton of a fish. The 'problem' is the 'head of the fish'. Reasons for the problem are the 'bones', and these are identified by asking the question 'why?' in relation to the problem. It can be useful to check the answers given against one of the following sets of four: the 4 Ms (Methods, Machines, Materials, Manpower); the 4 Ps (Place, Procedure, People, Policies); or the 4 Ss (Surroundings, Suppliers, Systems, Skills). (See Figure 5.2.)

■ **Total Quality Management (TQM)**

Figure 5.2: Fishbone diagram – possible causes of the problem

These hypotheses can then be tested, again by collecting relevant data and presenting them using a Pareto chart (Figure 5.1). Again, the 'vital few' can be subjected to a further level of consideration if that is necessary, so that these pressure areas can be fully understood.

Depending on the problem you are investigating, it may be helpful here to develop some **control charts**,[46] from which it is possible to see when the process (or a small part of it) is falling outside the limits of acceptable variation, and whether these are a result of the process degenerating, or of some particular cause (e.g. someone being called away to a meeting) that is unrelated to the normal process. These will indicate where attention has to be paid if quality is to be improved. (See page 248 for an example.)

Dianne's role here will be to keep an overall eye, to assist the leader if problems arise, and to make sure s/he has access to specialist help if needed. Where transformation is in the air, she and her colleagues (medical and nursing directors) may further encourage this by offering suitable opportunities and/ or learning resources.

Stage 4
Once the team has identified the problems they move on to **implementing successful remedies**. First they will develop the remedy by considering a variety of alternatives and choosing among them: reflecting on the cost of doing

■ **Total Quality Management (TQM)**

[46] A tool used in Statistical Process Control (SPC); an example is given on page 248.

so, the time it will take, and on the means of evaluating the effectiveness of each option. Once they have done so, and redesigned the process flow, they make recommendations to the relevant departments, and test out their proposals on a small scale to see that they do not introduce new problems in the process. Undoubtedly, too, they will need to deal with resistance to the changes from people who are affected by them, remembering to treat everyone with dignity – it is the process that is being fixed, no-one is being criticised or blamed.

Dianne's role here will be to take an interest, and ensure that feelings are being taken into consideration – appropriately.

Stage 5
Once the new process flow has been implemented it will be important to **sustain and extend the benefits** of the changes, and this requires that the performance of the new process is checked (to see that it really does address the original problem), and also that the performance of the new process is monitored to ensure that it remains at the new level of performance for a sustained period. This latter task – the monitoring of the data collection that will highlight early signs of slipping performance – is best undertaken by the department most closely involved, and not the quality improvement team which will now disband. In our example the redesigned flow may now include access to the take away menus of a small number of local restaurants, and the department monitoring performance probably needs to be midwifery, rather than catering.

Control charts could now be developed, to monitor key aspects of the process. For example it would be possible to monitor the length of time between the mother placing an order and the meal being presented to her. This would allow the service to take action if the process starts to drift away from acceptable limits, and to avoid intervening when the variation experienced is within those limits.
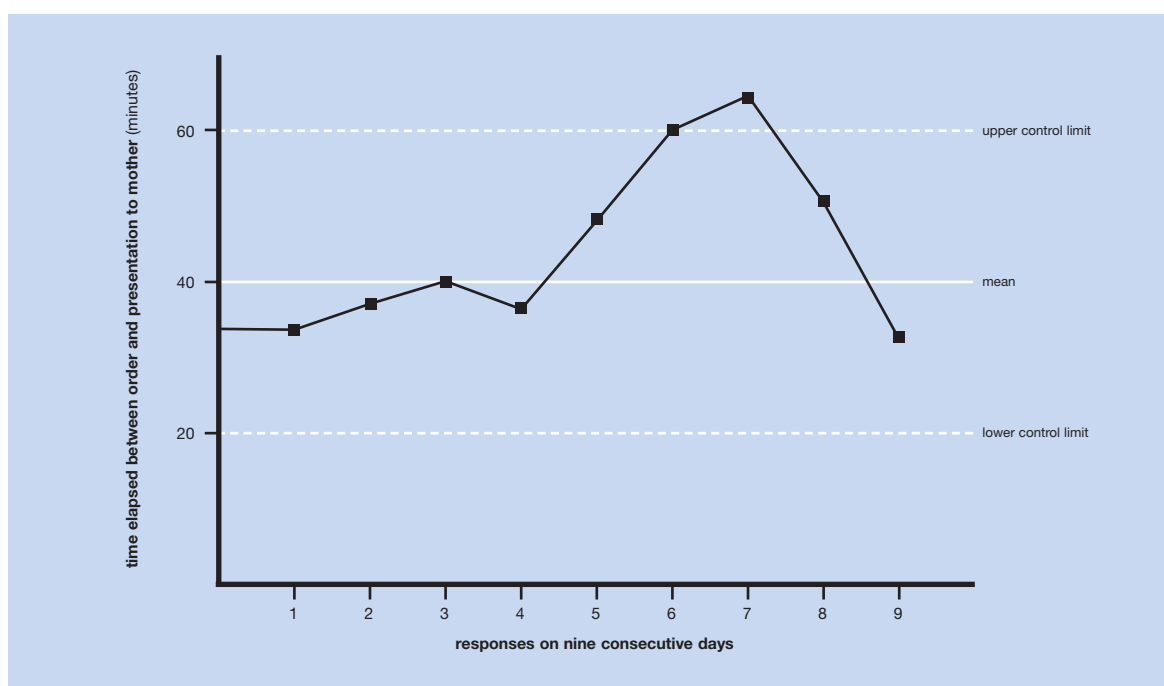
■ **Total Quality Management (TQM)**

Figure 5.3: Establishing a control chart: identifying upper and lower control limits

A control chart is established by taking a series of twenty data points and plotting them, as illustrated in Figure 5.3. The scatter will indicate the mean and the upper and lower control limits. These can then be used to monitor the performance of the new system as shown in Figure 5.4.

Figure 5.4: Control chart – does time taken to deliver a meal fall within acceptable limits?

In this example the times are all within the limits, except for Day 7. The person with responsibility for monitoring and taking action about this will now need to find out if this is a result of a one-off event (perhaps a birthday party being held in the restaurant where the order was placed; or a receptionist being called away to deal with an extremely rare event) or whether this is an indication of the system as a whole beginning to drift towards a longer delivery time. Armed with the charts he or she is able to have the conversations which will reveal this. What is Dianne's role here? She will want to see that the handover from improvement team to the maternity services happens. She will also want to promote any ways of using the same recommendations to deal with similar problems elsewhere in the organisation, and also to make sure that other good ideas dreamt up by the team are exploited.

Although perhaps less important in our example, Dianne also has another key role – that of ensuring appropriate contribution from doctors. Because it can be difficult to engage doctors in these processes, she will need to ensure that some are persuaded or chivvied into doing so. It may be easier for her to do this than for Usha and Barbara who are interacting with their colleagues on a daily basis.

Dianne could prompt this work on a limited basis, in Maternity Services only, but the real payoff for the organisation and its customers will be when these techniques and the attitudes they encourage are widely spread throughout. Thus it is likely Dianne will want to prompt this as an organisation-wide initiative. This could involve a detailed plan of engagement for every department, or it could be a more opportunistic approach, making use of what ever resources are available, any targets that focus attention and energy, and any interest shown by clinicians or teams. Once there are a few demanding internal customers and solicitous internal suppliers the ethos should spread.

■ Business Process Reengineering (BPR)

BPR is a technique for corporate transformation that came to prominence in the early 1990s and has been defined as:

> *the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical, contemporary measures of performance such as cost, quality, service and speed.*
>
> Hammer and Champy (1993: 35)

A fundamental thesis of BPR is that organisations need first to identify their key processes and then make these as lean and efficient as possible. Peripheral processes (and this includes peripheral people) need to be discarded. Value creation for the customer is what matters most in any process of reengineering; having good information technology is seen as key to value creation.

Hammer and Champy regard BPR as a bold, all-embracing revolution in management thinking and practice. They advocate that companies which accept the need for transformational change should start out with a blank sheet of paper, map out their key processes, and then decide how best to translate the paper theory into practice. For this exercise to work the past is dismissed

■ Total Quality Management (TQM)

■ Business Process Reengineering (BPR)

as 'history', existing processes are considered 'irrelevant' and the future is seen as something to be moulded into optimal shape.

At the time of its first appearance BPR was widely (if perhaps unfairly) seen as being synonymous with redundancy and 'downsizing', and many companies in the US rushed to apply BPR (or what they thought was BPR), to justify cost-cutting under the guise of fashionable theory (Crainer and Dearlove, 2004). Despite a lack of compelling evidence of either wholesale transformation or greater competitive success for many of the companies who applied BPR – for a review of the research evidence for BPR, including in health, see Iles and Sutherland (2001: 52) – Hammer and Champy insist that it can be a tool for transformational change. However, they now recommend that greater emphasis be placed on processes and managerial roles, styles and systems and less on the radicalism that was for many a source of controversy, unrealistic expectations and dashed hopes (Hammer and Champy, 2003).

Within health care there has been increasing interest in the idea of **redesign**, that is, blending BPR with TQM and other approaches and identifying those situations which can capitalise on BPR's characteristic aims and methods, namely:
- focus on the patient and the quality of their experience
- an emphasis on patient process or pathway rather than departments/tasks
- challenging the value and efficiency of current approaches and redesigning them
- the aim of dramatic improvements in quality.
(Locock, 2001)

Principles of BPR

(Based on Iles and Sutherland, 2001.)
The **main concepts** that underpin the BPR approach include the following.
- Organisations should be organised around key processes rather than specialist functions.
- Narrow specialists should be replaced by multi-skilled workers, often working in self-managed teams.
- In contrast with incremental techniques such as TQM, BPR involves total disassociation from current practices and radical rethinking. It also requires more intensive hands-on involvement from management.
- The direction for the requisite radical rethinking comes unequivocally from top management.

Steps involved in implementing BPR as follows.
1. Prepare the organisation: clarify and assess the organisation's strategic context; specify the organisation's strategy and objectives; communicate throughout the organisation the reasons for and purpose of reengineering.

2. Fundamentally rethink the way that work gets done: identify and analyse core business processes; define key performance objectives; design new processes. These tasks are the essence of reengineering and are typically performed by a cross-functional team that is given considerable time and resources to accomplish them (see **roles**). New processes are designed according to the following guidelines (Hammer and Champy, 1993):

■ **Business Process Reengineering (BPR)**

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- begin and end the process with the needs and wants of the customer
- recognise that work is performed best where it makes most sense
- simplify the current process by combining or eliminating steps
- reduce checks and controls that do not add value
- attend to both technical and social aspects of the process
- do not be constrained by past practice
- identify the critical information required at each step
- perform activities in their most natural order
- listen to the people who do the work
- make decision taking part of their work.

An important activity in successful reengineering efforts involves early wins to generate and sustain momentum.

3. Restructure the organisation around the new business process.

4. Implement new information and measurement systems to reinforce change. The following **roles**, according to Hammer and Champy (1993), are likely to emerge in the implementation of reengineering:
- *Leader*: a senior executive who authorises the initiative and motivates the effort. This is someone with enough clout to kick-start the process, create the right environment for radical change, and persuade people to accept it. The leader acts as a visionary and motivator.
- *Process owner*: a manager with responsibility for overseeing the process and the reengineering effort. Usually a senior-level manager with credibility who is involved in managing one of the functions that will undergo reengineering. He or she obtains the resources the team (see below) will require and acts as the interface with the organisation's bureaucracy and other systems.
- *Reengineering team:* a group of individuals dedicated to facilitating the reengineering, who diagnose the existing process and oversee redesign and implementation. These are the people who do 'the heavy lifting', i.e. produce ideas and plans and turn them into reality. Teams are usually small (5-10 people) and include insiders (those who currently work within the process) and outsiders (who do not work inside the process and who can bring different, more objective perspectives to bear). Ratio of insiders to outsiders is usually 2:1.
- *Steering group*: comprised of senior managers who develop the organisation's overall reengineering strategy and monitor progress. The leader usually chairs this group.
- *Reengineering 'czar':* responsible for developing engineering tools within the organisation and achieving synergy and added value across separate reengineering projects. Usually directly accountable to the *leader* and a source of ongoing advice and support to the *process owner*. Support should be enabling not over-controlling.

Methods and tools include: project management tools, problem solving, analysis of customer requirements and satisfaction surveys, benchmarking, process modelling tools, simulation exercises, root cause analysis,[47] audit, brainstorming and a variety of other methods to encourage creative thinking.

■ **Business Process Reengineering (BPR)**

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[47] A technique for finding the real cause of the problem and dealing with this rather than dealing with the symptoms. See also Five Whys on page 84.

Factors involved in planned change

An analysis of a major BPR initiative within the NHS has identified a range of positive and negative factors impacting on the pace, progress and impact of planned change. (See Table 5.3.)

Table 5.3: **Approach to planned change: positive and negative factors**

Factors with a positive impact on the pace, progress, and impact of change	Factors with a negative impact on the pace, progress, and impact of change
Internal leadership of change	Externally led change
Clinical ownership and support for change	Narrow base of change leadership including reliance on a single product champion
Weak clinical resistance to change	No clinical-managerial partnerships
External support for change both politically and materially	Unsophisticated preparation of the process, content, and context[48] of the intervention due to imposition of intervention objectives
Partnerships of clinicians and managers leading change	Culturally alien language
Objectives of change that incorporate professional development, service development, or service problem-solving	Disruptive and intrusive change methods
Formal and informal communications processes	Poor consultation with stakeholders within the process
	Approach to change that is unnecessarily confrontational

Source: McNulty and Ferlie (2002)

Implementing a reengineering project

In Episode 5.1 we heard how the Trust has already used redesign in its Maternity Services and Surgical Admissions. The Strategy Review group is about to consider the possible benefits of carrying out a more ambitious reengineering of services and reviewing the evidence.

We are going to ask you to think about the lessons that could be learned for the Trust as a whole from having used reengineering techniques for its admissions process. To do so you need some further information relating to one year ago:

- One year ago the elective admissions process for Surgical Services is

■ **Business Process Reengineering (BPR)**

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[48] For an explanation of these terms, see Content, Context and Process Model, page 186.

Implementing a reengineering project

identified by Barbara and colleagues as a source of dissatisfaction for patients and for staff. Patients with certain conditions face delays in admission and the rate of cancelled operations, particularly in gynaecology and orthopedics, is high.

- Barbara is impressed by the way in which aspects of redesign are being introduced into Maternity Services along with the arrival of Usha as Head of Midwifery. She is also encouraged by one of the consultant gynaecologists, Massimo, whose previous hospital introduced redesign to its outpatients to good effect.
- At the centre of the admissions process is the Admissions Team, a group of 10 staff all on A&C Grades 3 and 4, all female, and many in post for more than 10 years. The Team are deferential to medical staff, lack self-esteem and regard themselves as 'the bottom of the pile'. The one exception is Hattie, a recently-appointed Team Manager, who is more assertive but relatively inexperienced at this level.
- The General Manager for Orthopaedic Services is Jim, who has been in post 6 months and, like Barbara, has identified a need to improve processes in admissions.
- The Admissions Team is due to move to new offices which it will share with the Pre-Admissions Team (a rota of nursing and medical staff coordinated by two administrators Denise and Sally, both on A&C grades 4), with the intention of improving communications and pre-clerking and developing an integrated notes system. The Admissions Team has been told that three new posts will be created, a couple will be lost and some people's job descriptions changed. People are generally excited by the prospect of better working conditions and an extra pair of hands. However, the excitement at this stage is centred on the new computers and better desks, not on fundamental changes to working practices.

The following individuals are identified to take on the different roles in the planning, implementation and review of the reengineering process.
- *Leader:* Jane (Chief Executive)
- *Process owner:* Jim (General Manager for Orthopedics)
- *Reengineering team:* Jim, Hattie (Admissions Manager), Denise or Sally (Pre-Admissions), Massimo (Consultant, Gynaecology), Michaela (Administrator, Maternity Unit) and Andrew (patient representative)
- *Steering group:* a sub-group of the Strategy Review group, which includes members willing to champion redesign in different services
- *Reengineering 'czar':* Dianne

In real life the roles of these individuals and groups might have different titles.

If you were Dianne reflecting on the roles of those in the process:
- **What advantages does Jane bring to the role of leader over (say) Dianne herself?**
- **Why Jim and not Barbara as process owner?**
- **Why might Massimo have been co-opted?**

■ **Business Process Reengineering (BPR)**

> **Implementing a reengineering project**
>
> - **Why include Denise or Sally when they are not involved directly in admissions?**
> - **What kind of people within the Trust might Jane or Dianne approach to join the Steering Group?**
> - **What value might Jane, Dianne, Michaela and Andrew (the patient representative) add to the process?**
>
> You may want to make some notes before going to read our analysis of the reasoning behind the allocation.

Illustration and analysis

Allocation of roles might be based on the following reasoning. Please note we are not suggesting that people in these positions take on these roles in other settings – every situation is different.

Table 5.4: **The BPR team**

(HIDE | SHOW)

Role	Rationale and considerations
Leader (Jane)	Internal leadership for the initiative needs to be seen as coming from the very top. Jane will fit this role more appropriately than either Dianne or Barbara. She is also (by Dianne's admission one year down the line) more skilled at dealing with resistance to change from clinicians.
	It is common for BPR to be somewhat shrouded in mystery. Sponsorship from the top can help to effect a powerful paradigm shift so that people will take ownership of the project and want to initiate change that is important to them (McNulty and Ferlie, 2002: 192). This means not only championing the initiative with senior management and powerful professionals but also taking time to meet with those on the 'shop floor' whose ideas and enthusiasm are what will really make the difference.
Process owner (Jim)	Jim shares Barbara's strategic commitment to tackle a wider problem. However, as a General Manager he is likely to be rather closer to day-to-day operational details than someone at Barbara's level. He will be able to listen more regularly to front-line staff and monitor closely how the reengineered process is working.

Table 5.4: *continued*

Role	Rationale and considerations
(Jim)	Dianne will need to ensure that whoever takes on this role will need to: – have access to key resources and skills that the Reengineering Team (and the Admissions Team) will need to achieve its goals – be able to sign up to and apply reengineering methods, or be able to acquire the relevant knowledge and skills – be willing to devote time and energy to the project, and be given that time – be able to gain the trust and cooperation of the Admissions Team and work with them productively. This may be a group which feels relatively safe to try out new ideas but there are a large number of stakeholders who will be affected by, and potentially unhappy with, any changes that they perceive to impact negatively on their services or jobs.
Reengineering team	The team has four internal change agents and two outsiders, Michaela and Andrew. Michaela works within the same Trust, and is still initiating a change process, but she is sufficiently distant from Admissions to be able to act as a resource on the practicalities of reengineering and be a more objective observer. Denise or Sally's involvement at this stage will help to ensure that the proposed integration of the two teams goes more smoothly. User involvement is not a bolt-on extra. It is integral to BPR as to many other types of service improvement. In this instance, Andrew is being asked to contribute to decisions about a complicated system. In order to participate fully and add value to the process he may need extra time, information and support, and this will need to be factored in to the scheduling and costings. Massimo's inclusion is important for clinical ownership of the initiative. His speciality also has more to gain from an improved process so his motivation may be higher. Anyone below consultant level is unlikely to carry sufficient weight with clinical colleagues, including those with power to block changes. If Massimo lacks sufficient time or commitment another consultant should be sought, preferably someone with enthusiasm and willing to work closely and respectfully with staff from other disciplines.

■ **Business Process Reengineering (BPR)**

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Table 5.4: *continued*

Role	Rationale and considerations
Steering group	This sub-group of the Strategy Review group might wish to co-opt key opinion formers within the consultant body, for example, orthopaedic and gynaecological consultants who have most to gain from the reengineering of the admissions process. If the pilot project goes well these individuals could be influential in persuading other clinicians to 'buy in' to the changes and adopting new processes. They may also be able to identify other parts of the system (discharge, liaison with GPs) that could benefit from reengineered processes.
Reengineering 'czar' (Dianne)	This could be Dianne or possibly someone in the Trust's modernisation team or equivalent, i.e. someone with expertise in the methods used and with an organisation-wide remit to ensure that reengineering 'adds value'. (Some trusts may have a designated Reengineering team and/or overseer.)

Let's go back in time one year and see what happened after the decision was taken to undertake a further pilot, to reengineer the admissions process. What follows is a brief chronology of events over the last twelve months.

■ **Business Process Reengineering (BPR)**

Episode 5.2:
Reengineering
the admissions
process

Chronology of events

Month	Event/action/issue
1	Following informal discussions with Barbara and Jim, Dianne identifies Admissions as a good opportunity to pilot further reengineering and generates interest in this idea among Strategy Review group (SRG) colleagues
2	Draft proposal for pilot is discussed and put to SRG who give the go ahead

Reengineering roles are discussed, clarified and agreed by an SRG sub-group and most roles are quickly filled. There are some delays in finding suitable candidates for the patient representative.

Reengineering team meets for a team-building half-day. In the second part of the day it reviews positive and negative factors for change and identifies performance objectives, milestones and methods. Circulates these to SRG for comment. Less ambitious objectives and some scaling down of the training programme are agreed after feedback.

Massimo and Jim visit two other hospitals to look at how they reengineered outpatients and surgical services

Michaela arranges sessions for members of the Reengineering Team at the Maternity Services to see how their new booking system operates

Two consultant surgeons write a joint memo to Jane (copied to their Royal College), expressing anger at 'yet another invasive procedure from management at a time of considerable staff unhappiness about highly dubious methods being used to reach targets'. They also call into question the expertise and status of the Reengineering Team. Jane agrees to meet with them, with Massimo present, and explains that the pilot will be closely monitored through regular reports to the clinical directorates as well as the SRG.

3   Jim attends a day's training on process redesign. Hattie attends a 2-day course on group facilitation skills.

Admissions Team decline the offer of a planned away day, arguing this will take them away from their duties and create a back log. Hattie negotiates on-site sessions when the team is not dealing with patient enquiries, i.e. Friday afternoons. Far from the training ideal ...

Jim and Hattie co-facilitate first session using process mapping. Groups are initially frosty but soon respond enthusiastically. They produce a patient pathway that is not very different from the one the Reengineering Team would have predicted, but come up with several ideas they did not foresee, e.g. giving patients cards with an email address through which they can contact the Team any time of day. Reengineering Team confidently predicts

Month

*3
(continued)*

that the ideas for change will have ownership.

Changes which the Admissions Team can begin to deliver immediately are highlighted and given the go ahead

Jim thinks Hattie is pushing the Admissions Team faster than it can go. Second session has left everyone exhausted. Jim realises he should have built in plans for those running the sessions, and possibly for the Reengineering Team too, to receive professional supervision. He approaches Dianne who negotiates for Barbara to offer group supervision. After this, Hattie agrees to adopt a more facilitative, less confrontational style.

Jane visits the Admissions Team and is told: 'All of a sudden the whole organisation is recognising us and it is a good feeling'.

4-5

Third session with Admissions Team is postponed because it clashes with a consultant's retirement party. This would have been the first session to include doctors. Andrew drops out of involvement because of family commitments and ill health. Patient and staff satisfaction surveys, using a questionnaire, start to be administered.

Move to the new offices is delayed by at least 2 months. This stalls the implementation of some new practices. Admissions Team are becoming increasingly impatient.

Jim is struggling to fit in existing commitments with reengineering, including analysing and presenting data for the SRG and the clinical directorates about the 'reengineering deliverables'. Massimo is also surprised by the level of engagement with senior management that the initiative requires.

6-7

The team identify several more 'non-value adding tasks' in the Admissions and Pre-clerking processes and begin to be eliminate them

Middle managers who had previously ignored the reengineering complain that increased responsibilities have been 'dropped' onto them. Dianne sets aside time to speak to them individually.

SRG sub-group considers status report from Jim and recommends that if relocation to new premises is further delayed the reengineering process should be abandoned

8-9

Dianne puts pressure on contractors and Admissions move into new offices. Pilot continues. New Admissions staff member takes up post.

Massimo leaves the Trust to take up a post elsewhere, leaving a gap in the Reengineering Team at a crucial stage

Month

10   Further changes in admissions procedures are implemented

Surgical Directorate is subjected to additional pressures. The maximum time for elective surgery in some specialties is reduced by several months. This places additional pressures on the Admissions process. However, the Team is confident that it can cope now with the new processes are beginning to settle in.

Jim's analysis of data shows that not all the objectives for the reengineering will be met on schedule. Some changes to the admissions process are sustained, and procedures streamlined, while others have been resisted.

11-12   Admissions Team, in Hattie's words, is 'beginning to flex its muscles, not least with me!'. Team is keen to exercise greater control over the whole process but this creates frictions with Pre-admissions. Dianne arbitrates between the teams because Jim is seen by both sides as 'too involved'.

Results of patient and staff surveys continue to indicate an increase in levels of satisfaction for new admissions procedures

Reengineering Team meet with Dianne to debrief and to discuss provisional findings

Strategy Review sub-group's assessment on the pilot: 'a qualified success, but we need further evidence that reengineering was the critical factor'

Reengineering Team disbands. Admission Team continues to collect data.

Extending reengineering?

If you were Dianne, reflecting to Jane on the reengineering work described above:
1. What would you include as the key learning points?
2. How would you suggest the Trust use reengineering principles in its modernisation efforts?

You may find it helpful to remember the major stages in BPR are as follows:

1. Preparing the organisation and services to be redesigned
2. Fundamentally rethinking the way that work gets done
3. Restructuring services around the new business process
4. Implementing new information and measurement systems to reinforce change

The two lists of positive and negative factors for change in Table 5.3 (page 252) may also provide you with some useful prompts.

You may want to make some notes before going to read our suggestions contained in Dianne's memo.

Episode 5.3:
Dianne's memo to Jane

Reengineering Admissions

Jane

You asked for some reflections on the reengineering work in Admissions: what we have learned from it, and whether we should think about rolling it out organisation-wide.

What have we learned?
1. Preparing the service to be redesigned
We could have done more here to sell the idea, especially to the doctors. We underestimated the challenge of developing cross-functional teams for some of the senior clinicians. Reliance seems to have been placed on one enthusiastic surgeon (Massimo). Unfair confusion of roles for him, especially at the start. Another time we need to signal support from the top of the organisation (you, me, medical and nursing directors) much earlier.

Capacity turned out to be a big issue. If we do any larger projects we will need to appoint a dedicated reengineering team and manager – this was a small project and still consumed huge amounts of Jim's and Massimo's time. I asked Jim to keep a weekly work log (see attached) and this gives some useful indication of which activities in the process consumed the most time.

Skill levels were just about OK, and only then once we had introduced some emergency supervision sessions. Another time we must do more to offer more (and better) training and team-building in advance, supervision throughout, and access to people with specific reengineering expertise.

2. Fundamentally rethinking the way that work gets done
Surgeons should have been included earlier in the process mapping, even it that meant some re-scheduling. And direct involvement of the patient representative in this would have made for a richer and more challenging discussion. As it is, Andrew made a significant contribution in the early stages to the Reengineering Team. The Team have since kept him and the patient representative group in the picture about the improvements being made and this has been very much appreciated. The Admissions Team were not ready to express their views assertively in a multi-disciplinary setting, so as a first step this arrangement worked pretty well. We'll need to assess the dynamics of any team taking this on, rather than insisting on a 'one size fits all' set of principles about it.

In practice, the changes weren't radical, but were sound and have yielded great improvements in satisfaction from both patients and ward/theatre staff.

I think some of the tools we used in Maternity Services (e.g. Pareto charts, fishbone diagrams) could have been useful here – they would have helped us identify *priorities* for change.

3. Restructuring services around the new business process
In this project we've looked mainly at restructuring *within* a service, and

even here it hasn't been straightforward. Partly because we've lost key staff along the way. Massimo's departure was a blow since he was able to champion the process with the other consultants, as well as demystify it. (Some of them quite liked the word 'reengineering', though, it appealed to their technical side. Jim always used 'redesign' with the Admissions Team.) Reengineering across services will need a huge amount of preparation, and we'll need to help people see how this fits in with their own priorities, our existing strategies. Even on this small scale people tended to see a conflict between their reengineering goals and their 'day-to-day' ones.

4. Implementing new information and measurement systems to reinforce change
Surveys on a regular basis all indicate increased satisfaction with the new system. Again, we need to draw on the tools from the quality improvement work and develop some simple control charts.

There were some other problems that arose in the life of the project, and some that have continued afterwards. At some points the Admissions staff weren't sure who they were working for – was it the Reengineering Team or their own managers? Jim and Hattie soon sorted this out, but I can imagine it would be a problem if we tried it on a larger scale.

Now that the Admissions Team have experienced how much impact they can have (and this is real empowerment) they are being more challenging about other processes, and of other people's processes, not only their own. This is not always winning them friends! I can imagine this would be particularly problematic where there was interprofessional rivalry, so we would need to think carefully about the dynamics in any setting where we introduced this, especially where unions were involved. Jim tells me they have been challenging Hattie's own role as their manager – and Hattie has responded well, but not everyone would.

All in all, I do believe that the Reengineering Team is what has made a difference to the admissions process. I know the SRG have been sceptical, and think that perhaps the move would have prompted this increase in performance anyway – but I don't agree. Indeed, comparing Admissions with Maternity, I think the opposite is the case: the reengineering work without the move would have worked just as well. The move was useful as a focus for the effort, but it was the thinking, and especially making the patient experience the centre of the process, that made the difference.

Should we use BPR in our modernisation efforts?
The SRG are looking at the evidence about BPR, but from what I've read there are very few organisations who can say it has been as successful as they had hoped. I think we'd be wiser to think about drawing on some of the techniques, without going for a 'big bang' organisation–wide effort. We can still have ambitions for organisation-wide change, and develop plans to achieve this – I'm not suggesting we act only opportunistically as we have here (although we do need to be able to do so!).

I suggest we look at the tools from both TQM and BPR, at the resources the modernisation agency have developed which support some of these, and think through:
- where the biggest problems lie
- where we have the people who will work well with these approaches (innovators and early adopters)
- how we can engender an *ethos* of improvement across the organisation
- how we can exploit the success of the work we've done to date, and use it to encourage others.

I'm attaching an executive summary of a recent paper on 'redesign' in the NHS which you may find interesting, plus a draft of Jim's final report to the SRG with my additional comments in green.

Dianne

Concluding thoughts

The principle of adding value is not so much a change management tool as a set of ideas to bear in mind when operating in a management position. We can see in this case that individuals in managerial roles, and those they are managing, may place different weights on the value that is added, even where managers are performing well. So the ability of the manager and the managed to perceive how they each value the structures, services or support provided by the other will yield useful insights for both.

TQM and BPR are organisation-wide approaches, often promoted by people with a commercial interest in their adoption, which were developed from simple principles like those outlined earlier. NHS change managers will probably find it more beneficial to familiarise themselves first with these underpinning principles (and to gain a facility in applying them) and then critically select and combine a range of tools and techniques, rather than seek to apply a proprietary approach in its entirety. The examples given in this case can be encompassed within the term 'redesign' which conveys this sense of drawing on the principles and tools in a pragmatic manner, tailoring these to the needs of a particular context.

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3

Reflections on the cases

In this section we briefly discuss ways of applying the models to different cases, consider issues of evaluating models in practice and briefly discuss the need for rigour and creativity.

Applying the models

Each of the five case studies describes how a model or a particular cluster of models or approaches is used in a specific situation. The models selected have a wide range of applications, and their use is by no means limited to the setting in which we have chosen to illustrate them. One way of thinking about this is to see the models as raw ingredients; it's how you choose and combine ingredients, lending your own style and cooking methods, that counts.

For example, some of the models considered in Case 2 focus on change at an individual level. These models could be applied in various ways to aspects of the remaining four cases, whenever we are dealing with people, behaviour and change. Let's take a specific tool, the ladder of inference (page 117).

In Case 2 we show how one character Nina might use the ladder of inference to explore and perhaps change her negative assumptions about a senior manager whom she considers to be interested more in cost-cutting than meeting the needs of service users. Nina is first made aware of these assumptions during her action learning set where she comes to realise that they merit some urgent attention. Using the conceptual framework of the ladder, she looks (or rather we look on her behalf) at ways to use a less defensive and more empowering line of reasoning, to influence the manager and the change agenda in what would hopefully be a more positive direction.

In Case 5 a similar situation arises in which the characters Usha and Barbara hold negative assumptions about senior managers. Although in this case Usha and Barbara are not shown benefiting from being prompted into using the ladder of inference, it would be a valuable tool for them to use.

Similarly, some of the concepts drawn from the theory of organisational learning set out in Case 3, such as bypass and cover up, could be applied to the characters' situation in Case 5, to explore why the question of managerial support can become difficult for those directly affected to discuss.

Following are some further examples of ways in which models and tools in each case can be applied to other cases.

- **Case 1:** Explore ways in which concepts of organisational learning and the Learning Organisation can be applied to the challenges Ashok the Chief Pharmacist faces in introducing new ways of organising and delivering services.
- **Case 2:** Use the concept of adding value to explore whether a service like the Community Drug and Alcohol service has the right corporate parent(s) and whether these are adding value to the service.
- **Case 3:** Use force field analysis to assess the driving and restraining forces and to identify actions that would enhance successful implementation of change in the PCT.

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- **Case 4:** Apply the Seven S Model instead of the Content, Context and Process Model as an alternative way of understanding change holistically and managing change strategically. Alternatively, apply PEST analysis to identify factors in the environment which are helpful to the 'failing' trust, and those which may impede progress towards its organisational goals.
- **Case 5:** Explore how articulating a mission can be used to complement the TQM strategies in the Maternity Services, or how stakeholder analysis can be used to strengthen reengineering processes.

Table 3.1 outlines a suggested schema for applying the models across the cases. The models are listed alphabetically. Shaded boxes indicate which case the model appears in. A tick ✔ indicates alternative cases this model might be applied to.

Many of these models could be used to good effect in the settings described. However, we have not provided enough detail to enable you to do so in all cases. Following is a table indicating where we have provided enough detail to apply models to scenarios.

Table 3.1: Applying models to cases

Model	Case study				
	1	2	3	4	5
Adding value	✔	✔	✔	✔	
Articulating a mission		✔			✔
Business Process Reengineering (BPR)					
Commitment, enrolment and compliance		✔			
Content, Context and Process Model	✔		✔		✔
Five Whys	✔		✔		✔
Force field analysis	✔		✔	✔	✔
Ladder of inference	✔		✔	✔	✔
Organisational learning and the Learning Organisation	✔	✔			✔
PEST			✔	✔	✔
Readiness and capability			✔		
Seven S Model			✔	✔	✔
Stakeholder analysis			✔		
SWOT analysis			✔	✔	✔
Total Quality Management (TQM)					

Evaluating change processes

What kinds of evidence?

Throughout the resource you are encouraged to engage with the problems and concerns of the characters, to reason on their behalf, and to try out some of the change management models – all in the relative safety of an imaginary setting. As you contemplate the complexities of real-life practice the following question is likely to be at the forefront of your mind: 'Will such-and-such a model work, in quite this way, in my own organisation?'.

This question 'Will it work?' is explicitly addressed in *Organisational Change* (2001), in relation to empirical evidence. And, as you will see in that volume, the evidence is largely equivocal. If you consider how you might evaluate the change initiatives undertaken by the fictive characters in this volume you can see why. You might like to reflect on how change agents such as Ashok, Nina, Sarah, Robin and Dianne would approach an evaluation of the models and frameworks they have used. What would they be trying to evaluate? A particular model? A cluster of models? The way they had implemented it/them? The impact of the surrounding context? Whether other models would have worked any differently? How they would take into account any strokes of good fortune, or happenstance incidents that turn out to have a major impact?

Choosing a model in practice will depend, therefore, not only on the evidence available but also on utility – does it look as though it is appropriate in these circumstances? The evidence to answer this question is rather different from that for 'Will it work?', and will include tacit, uncodified knowledge and experience as well as the more formal types of evidence.

Developing evidence for local action

It is important for those using change management tools and frameworks to contribute to a greater understanding of their use in some way. Nelson *et al*. (1998) argue that intelligent change is likely to be guided by sound theory, research, or other empirical evidence, and to be tested first on a small scale by using a balanced set of process, outcome and cost measures. These measures should be built into the daily work routine, and displayed in ways that tell a story. What kinds of stories and evaluations do we see emerging in the case studies? And what are some of the issues that these raise? Consider the following examples.

- *Ashok* (Case 1) writes up his findings of the change initiative one year on and presents these in a conference paper. His enthusiasm will inspire others and this enthusiasm will be valuable. However, we note that his story initially finds a more receptive audience outside the locality than inside it, as he learns that he has miscalculated the likely response to the paper by an important opinion former.

- *Nina's action learning set* (Case 2) provides a safe but critical forum in which individuals are able to devise and evaluate change interventions and develop strategies for increasing personal effectiveness. The set is bound by the

commitment to maintain confidentiality, so members will need to think carefully about how they will appropriately share with outsiders the ideas and learning that are generated in the set.

- If, as suggested, *Sarah* (Case 3) were to undertake a small-scale action research (or work based learning) project, as a basis for initiating and evaluating change, starting with herself as change agent, she may want to draw on some specialist action learning expertise.

- *Robin's team* (Case 4) has a written record of its diagnostic exercise and this might form the basis of an evaluative case study, for example. However, the team would be wise to consider the limitations as well as strengths of first-person accounts. Arguably, more robust evidence would be generated if the account formed part of a comparative study and incorporated perspectives of other stakeholders. In this case we are made aware that time for discussion about change management models is limited. Managing the wealth of additional data generated by a case study might call for the involvement of one or more persons with specific research skills, e.g. interviewing skills and coding of qualitative data. The team would therefore need to consider whether this kind of evaluative method fitted within time limitations and cost constraints.

- *Dianne* (Case 5) compares results of the pilot projects in the trust with findings of published research. She recognises that her evaluation of the reengineering project is possibly at odds with that of her executive colleagues, so she may need to marshal her arguments and evidence in a different way to those presented in her memo to Jane if she is to tell a story that will convince the sceptics that BPR was a decisive factor in effecting change.

For further reflections on evidence and a discussion of the responsibilities of generating evidence and developing theory, see *Organisational Change* (2001), pages 74-81.

Making theory more available

As suggested above, intelligent change is likely to be guided by sound theory. This raises the question of how practitioners and managers can gain access to theory and how they can make sound use of it. *Organisational Change* (2001) identifies some of the specific difficulties that exist in making the literature more accessible to managers and practitioners, most notably the wide variety of disciplines, methodologies and tools involved.

In our experience there are additional factors that need to be taken into account in making theory more available as well as accessible, as set out below. You may be able to identify others. Using the following prompts, you may also like to consider how you might build an awareness of these factors into your own local evaluation strategies.

- **Lack of exposure to theory** – all too few opportunities exist for managers and practitioners to learn about relevant concepts and literature bases.
    - How might you exploit or create opportunities to make the literature more available and accessible?
    - Have you considered talking to specialists and learning networks (including researcher-practitioners') inside or outside your organisation?
    - How might you keep up-to-date with developments in theory as well as practice? By reading? talking? listening? (See Section 4, 'Sources and resources', page 273.)

- **Conflicts between schools of theory** – dispute between academics is a means of advancing knowledge, but this process can be misunderstood by managers and practitioners as standing in the way of practical action.
    - How might you use the Matrix on page 69, or alternative tools you are familiar with, to draw together different strands of thinking into usable frameworks?

- **Trivialisation of complex arguments** – in recognition of the time pressures on senior managers, sophisticated arguments and multi-structured approaches are 'dumbed down' into easy-to-remember sound bites, losing much of their value in the process.
    - How might you avoid adding to this problem? How can you ensure that in any rapid appraisal the messages and key lessons are kept simple but not over-simplified?
    - What support and guidance are available to assess the 'added value' of complex models and approaches? Through OD and training departments? Libraries and databases? Academics and practitioners?

- **Theories which are abstract and limited** – it is often difficult to imagine their use in the practical, messy, real-life situations that managers and practitioners face, for which more than one theory or approach may be needed.
    - How might you demonstrate the use of clusters of concepts to address different aspects of complex situations?
    - What initiatives are you aware of that are already doing this?

- **Over-optimistic promotion of particular approaches** – by authors and management consultancies who have much to gain from managers and practitioners grappling with their adoption.
    - How might you consider the uses, the limitations, and also the alternatives to many of these tools?
    - What sources of independent advice are available to you?

- **Lack of encouragement to think autonomously** – in centralised organisations with political masters local decisions about approaches may not be seen as important.
    - How can you demonstrate that people at all levels of the organisation can be encouraged to contribute their ideas for change? Who else is doing this, and how? What can you learn from them?

- **Imposition of change priorities** – by central departments who see the role of local organisations as merely implementation.
  - How can you demonstrate that the use of change management frameworks will enable the inclusion of local change priorities along with the central? Again, who else is doing this? And what can you learn from them?

Some final thoughts

We would like to introduce two final characters: the 'engineer' and the 'bricoleur' – terms that have been used to describe antithetical positions for acquiring and using knowledge (Lévi-Strauss, 1962).

The engineer (a term that is here not restricted to applied science) is a person who thinks systematically, draws up plans with a sense of the whole, and only then goes to work on the specific tasks of construction. The engineer's tools are always acquired for the purpose of the project in hand. In management terms, the engineer could be said to gravitate towards the paradigm of planned or deliberate change, where rules, procedures and resources are known in advance. The person who sits down and says 'I have a particular change I want to introduce, Model X will fit this, and I will work out just how to apply it' is a type of engineer.

By contrast the bricoleur (the French word 'bricoler' means 'to do odd jobs', so the nearest equivalent in English is DIY person) is open and pragmatic and the rules of the game are to use 'whatever is at hand'. Unlike the engineer, the bricoleur depends on a limited repertoire of tools and materials, which often bear no relation to the task in hand, and has to rely on improvisation, imagination and resourcefulness. Those familiar with DIY enthusiasts will recognise how they accumulate odds and ends, make inventive use of disparate materials and are reluctant to throw away anything left over that might come in useful at a later date. In management terms, therefore, the bricoleur could be said to tend towards the paradigms of spontaneous and emergent change. (For more about deliberate, spontaneous and emergent forms of change see the discussion on pages 69-71.)

We might speculate, accordingly, that many change managers will need to be, to varying degrees and depending on the context, both engineers and bricoleurs. We suggest that change managers will keep the models we illustrate here at hand, and use them pragmatically, but that they will use them in a disciplined, rigorous way, applying a considerable degree of perceptiveness of the situation and people involved. Discipline, rigour and perceptiveness are essential; however, they are not sufficient: the ability (or preparedness) to think freely and creatively when devising alternatives or solutions will also be needed.

Often forgotten, perhaps one of the most important factors of all will be the self-awareness of the change manager. Awareness of a tendency towards one kind of approach rather than another that may better fit the circumstances. Awareness of emotional responses that inhibit clear thinking. Awareness of helpful and unhelpful responses to particular kinds of pressure, to different people.

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We hope these studies will develop readers' abilities to encourage and sustain change within health care and other organisations. We also hope that some of you will want to enter into dialogue with us about learning in this area, and how best to further it.

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Sources and resources

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A selective list of links to online resources which you may find useful.

Databases for exploring further research evidence on organisational change

Health Management Information Services database (HMIC) – contains information on the literature relating to health systems management published in the UK and internationally – including journals, books, reports, official publications, and 'grey' literature (unpublished documents). Access via Ovid.
Web: www.ovid.com

National Library of Medicine (USA) – the world's largest medical library. The Library collects materials and provides information and research services in all areas of biomedicine and health care.
Web: www.nlm.nih.gov

HealthSTAR – is a bibliographic database from the National Library of Medicine and the American Hospital Association containing records of literature relating to health care delivery.
Web: visit www.nlm.nih.gov/nichsr/db.html and scroll down to Accessing HSR Literature at NLM

Bath Information and Data Services (BIDS) – provides UK academic institutions with a bibliographic service and offers links to 2,700 full-text electronic journals.
Web: www.bids.ac.uk/info/fs_aboutbids.htm

Reviews of evidence relating to health care delivery and organisation

The Cochrane Effective Practice and Organisation of Care Group (EPOC) – is a Collaborative Review Group of the Cochrane Collaboration which aims to inform health care practice through the production of systematic reviews, including reviews of organisational interventions.
Web: www.epoc.uottawa.ca

The NHS Centre for Reviews and Dissemination (CRD) – provides the NHS with information on the effectiveness of the delivery and organisation of health care.
Web: www.york.ac.uk/inst/crd/index.htm

The Campbell Collaboration – is an emerging international effort to help people make informed decisions. Prepares and promotes access to systematic reviews of studies on the effects of social and educational policies and practices.
Web: www.campbellcollaboration.org

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Other useful web sites and contacts

NHS Service Delivery and Organisation (SDO) R&D Programme – is a national research programme that has been established to consolidate and develop the evidence base on the organisation, management and delivery of health care services. Commissions research and development in change management in the NHS: www.sdo.lshtm.ac.uk/changemanagement.htm

NHS main web site – provides links to strategic health authorities, primary care trusts and hospital trusts: www.nhs.uk

NHS Clinical Governance Support Team: www.cgsupport.org

NHS HR Directors' Bulletin: www.publications.doh.gov.uk/hrbulletin/index.htm
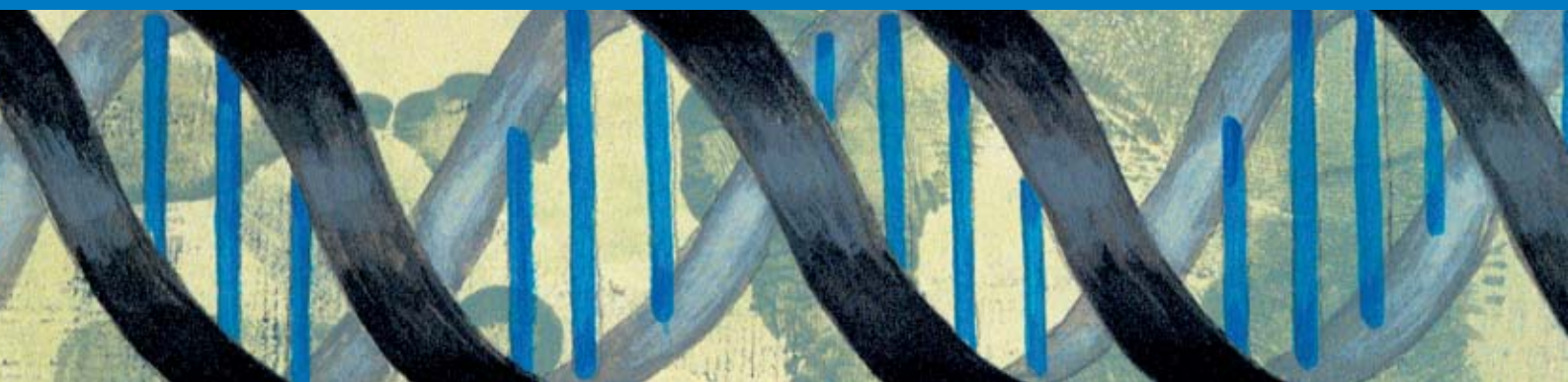
NHS Modernisation Agency: www.modernnhs.nhs.uk

NHS National Electronic Library for Health: www.nelh.nhs.uk Link to Health Management homepage at: rms.nelh.nhs.uk/healthmanagement

NHS National Primary Care Development Team: www.npdt.org

NHS Service Improvement Team: www.modern.nhs.uk/scripts/default.asp?site_id=17&id=2083

We have also found a wealth of useful information on a number of websites of private-sector organisations. We hesitate to recommend some over others but entering the names of the models illustrated here on a search engine can yield interesting results.