



## Office for Health Management

**Irish Health Service Reform Programme**

# **Dialogue on Implementing Reform**

**Communication and Consultation Programme**

**July – September 2003**

Laraine Joyce  
Tina Joyce  
Dearbhla Casey

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## Introduction

### 1.1 Context

The structure of the Irish health services has remained largely unchanged for over thirty years. In June of this year the government announced the Health Service Reform Programme, initiating an era of unprecedented change in the health system.

The Department of Health and Children (DoHC) was concerned that the purpose and content of the proposed reforms should be communicated clearly to all staff, that staff would have an opportunity to raise their concerns and that they would be consulted on how the reforms should be implemented. The DoHC also wanted to ensure that staff would begin to feel some ownership of, and commitment to, the reforms proposed.

The Office for Health Management (OHM) was therefore requested by the Department of Health and Children to carry out a communication and consultation programme in relation to the Health Service Reform Programme.

The precise purpose and objectives of the communication and consultation programme, as indicated by the DoHC were the following.

### 1.2 Purpose

**The purpose of the communication/consultation process is to ensure that everyone working in the health sector, within the DoHC and the wider system is**

- **fully informed about the content of the government decision in relation to organisation reform in the health system**
- **knows and understands the commitment to the consultation process**
- **avails of the opportunity to have an input, individually and collectively into developing the best way to implement the programme of reform.**

### 1.3 Objectives

**The objectives of the consultative process are to present to and discuss with a wide range of stakeholders the minister's vision for the future of the health system, as reflected in government reports and decisions aimed at implementing his vision, by**

- **developing the widest possible awareness**
- **explaining the rationale for the changes proposed**
- **securing the widest possible input on how the implementation of the reports can be delivered**
- **maintaining involvement in and support for the process**
- **making recommendations on priority ways forward for implementation of key elements of the reports.**

#### **1.4 The policy context**

The national health strategy, *Quality and Fairness*, identified the need for system changes to occur in order for the health system to achieve the goals and objectives it set out. In particular, organisational reform was identified as a key framework for change with the aim of providing a responsive, adaptable health system which meets the needs of the population effectively and at affordable cost. To this end, action 114 of the strategy specifically provided that an independent audit of the structures and functions of the Irish health system would be carried out. Prospectus Strategy Consultants were commissioned to carry such an audit in 2002.

In April 2002 the Commission on Financial Management and Control Systems in the Health Service was established under the auspices of the Department of Finance to examine, evaluate and make recommendations on the relevant financial systems, practices and procedures throughout the health services.

Two key reports on the Irish health system were the result of these endeavors, namely:

- The Audit of Structures and Functions in the Health System (The Prospectus Report)
- The Commission on Financial Management and Control Systems in the Health Service (The Brennan Report).

These reports concluded that the system was highly fragmented with overlap and uncertainty in terms of who was responsible for services delivered. It was argued that this fragmentation means the system is increasingly hard to manage as a national service. The reports also argued that governance, planning, financial management and controls, all needed strengthening to support the management of a health system as broad in its scope and as complex in terms of the services it delivers.

In June 2003, the Government announced a radical Reform Programme for the Irish health system. The Health Service Reform Programme was based on the

existing commitments in the health strategy and the conclusions of the Prospectus and Brennan reports.

The purpose of the Reform Programme is to further the implementation of *Quality and Fairness*. The Programme is aimed at equipping the health system to deliver high quality health services by implementing the Government decision in relation to structural, organisational, financial management and systems reform. It provides an integrated platform for the implementation of a range of system changes set out in the national health strategy.

The key elements of the Programme include:

- A major rationalisation of existing health service agencies to reduce fragmentation. This includes the abolition of the existing health board/authority structures and the mainstreaming or merger of a number of health agencies.
- The reorganisation of the Department of Health and Children, to ensure improved policy development and oversight.
- The establishment of a Health Services Executive which will be the first ever body charged with managing the health service as a single national entity. The Executive is to be organised on the basis of 3 core divisions:
  - National Hospitals Office
  - Primary, Community and Continuing Care Directorate.
  - National Shared Services Centre
- The establishment of a Health Information and Quality Authority to ensure that quality of care is promoted throughout the system.
- The modernisation of supporting processes (service planning; management reporting etc.) so that they will be in line with recognised international best practice.
- The strengthening of governance and accountability across the system

The Programme's priority focus is improved patient care, better value for taxpayers' money and improved healthcare management.

The Minister for Health and Children and the Government recognised the scale of the Reform Programme. To succeed, it was deemed necessary to clearly set out the Government's vision of reform to all within the existing health system, staff and staff representatives, consumers and the public. This engagement was the vital first step in the implementation process. This was the context within which this communication/consultation programme within the health service took place.

### **1.5 Office for Health Management role**

In the communication and consultation programme the role of the Office for Health Management was to design, manage and quality control the exercise,

liaising throughout with employers and the DoHC. Given the limited resources of the Office, most of the staff consultation was carried out within employing organisations, using health service staff, but supported centrally by Office for Health Management guidelines and advice.

## Methodology

### 2.1 Guiding principles

The guiding principles enunciated by the Office for Health Management for the communication and consultation process were the following.

- This reform can potentially bring about a better health service for patients, clients and users.
- Change is inevitable but it doesn't mean that past achievements or experiences are to be forgotten.
- This change has critical local and central elements – both need to play their part and to work in tandem.
- Everybody has some power in implementing change.
- Managing change requires talking, listening, decisions and action.
- It is important that people can have their say, and express their opinions openly and honestly.
- All feedback will be treated in a confidential manner – individual responses will not be identified.

### 2.2 Three elements

There were three elements to the communication and consultation exercise.

#### 2.2.1 Briefing on the proposed reforms

Briefing on the reforms was conducted using the materials provided by the Department of Health and Children. In the case of management workshops, DoHC staff gave a presentation on the reform programme and responded to questions at the start of the workshop. In the case of staff workshops carried out within employing organisations, briefings were usually given by a member of the organisation's management team.

#### 2.2.2 Dialogue on the proposed reforms

Following the initial briefing, staff were facilitated to think through the implications of the reforms for themselves and their organisation. Their hopes and concerns were documented. It was not the purpose of this dialogue to

defend the reforms but rather to let staff reflect on them and recognise their inevitability.

### **2.2.3 Discussion of the future implementation process**

The final element of the communication and consultation exercise was a facilitated discussion on how the implementation process could best move ahead, protecting the service to patients and with least discomfort to staff. Staff were asked to indicate what they believed needed to happen at both central and local levels within the next six to twelve months in order to progress the implementation of the reforms. They were also asked to indicate what key messages they wished to send to their line manager, their CEO and to the DoHC/minister.

## **2.3 Levels of consultation**

A distinction was drawn between two levels of consultation/communication, namely CEO/management-team level and staff below that level. The needs and issues vary at these different levels and hence the approach was different.

### **2.3.1 CEO/management-team level**

At this level, the Office for Health Management commissioned independent management consultants to conduct workshops with groups of CEOs (in some instances including management teams) from across the system. The following are the workshops that were convened in July and August:

- Department of Health and Children Management Advisory Committee (1 workshop)
- CEOs of health boards, HeBE and ERHA (3 workshops)
- CEOs and management-team members of health boards, HeBE and ERHA (2 workshops)
- Management-team members of health boards (1 workshop)
- CEOs and management teams of Dublin maternity and pediatric hospitals and management teams of Dublin academic teaching hospitals (1 workshop)
- CEOs of other voluntary hospitals (1 workshop)
- CEOs of specialist health agencies (2 workshops, one for those to be "subsumed")
- CEOs of voluntary agencies (1 workshop)
- Union representatives (1 workshop).

In all a total of 287 top and senior managers from across the service participated in these central workshops.

The CEOs of the Dublin academic teaching hospitals met independently with the DoHC. The CEOs of the health boards requested the additional workshops

which were provided for them alone and also in company with their management teams.

A report on the discussions at each workshop was drawn up by the Office for Health Management.

### **2.3.2 General staff level**

For other staff within the health service, employers themselves organised the consultation process using Office for Health Management guidelines and templates. Employers took responsibility for writing up the results of the exercise so as to provide the Office for Health Management with the data needed to feed into the Department of Health and Children in this final report.

To enable the Office for Health Management to guide the local consultation process, CEOs of all organisations were asked to nominate a person who would liaise with the Office and who would also assume responsibility for organising the local consultations. It was thought desirable that the local liaison person would have skills in organisation, change facilitation or change management. A total of eighty liaison people were nominated and worked with the Office for Health Management throughout this exercise. In addition, CEOs were asked to ensure that someone with excellent writing skills was appointed to compile the final results from each organisation and submit them to the Office.

The Office held four workshops to brief liaison persons, provide them with guidelines and resource materials and monitor progress. The final workshop, held in early September 2003, was designed to consider the findings from the consultation exercise and to work together to draw up conclusions and recommendations for this final, composite report.

Throughout the consultation period close contact was maintained via email with liaison persons by the Office for Health Management. Thus, once any new material was available from the Department, it was immediately circulated to all liaison persons. If new questions arose from staff, answers were sought from the Department and these were then circulated to all.

## **2.4 Mobilisation of change process facilitators**

The Office for Health Management invited to a meeting all of the graduates of the Office's leadership programmes (up to 120 in all), plus the participants in the Making Change Happen Change Facilitation Skills Programme (which included the Partnership Facilitators) (another 74), plus the members of the Organisation Development Network (approximately 25) to investigate their willingness to act as facilitators of communication/consultation within the system during the local consultations. Approximately 100 attended the meeting and of these, 98

indicated they were willing to come on board. Their names were then made available to local liaison persons as a resource that could be used in organising the consultation. They represent a resource additionally that could be used in the future during the implementation of the reforms.

## **2.5 Electronic consultation**

The Department's website was used to provide online information and briefing on the proposed changes. Health service staff were encouraged to visit the DoHC website in order to access briefing material.

The Office for Health Management website was also used as a means of providing briefing information and gathering feedback from the system. Staff were invited to make comments. In the event, few comments were received in this way from staff.

## **2.6 Submissions**

In addition, the Office for Health Management invited organisational submissions from CEOs and management teams. Staff members were also invited to make personal submissions directly to the OHM if they so wished. These were accepted by post from staff who perhaps might not have been able to participate in the consultation process and/or who did not have online access. In total 68 reports and submissions from organisations and 15 submissions from individuals were received.

## **2.7 Interim reporting**

Once the majority of the central management workshops had been completed in mid-August the reports on these were forwarded by email to all liaison persons for circulation to their CEOs. This procedure had been requested at an early stage by a number of the workshop participants and also met the Department's need for interim findings to inform decisions on the implementation process.

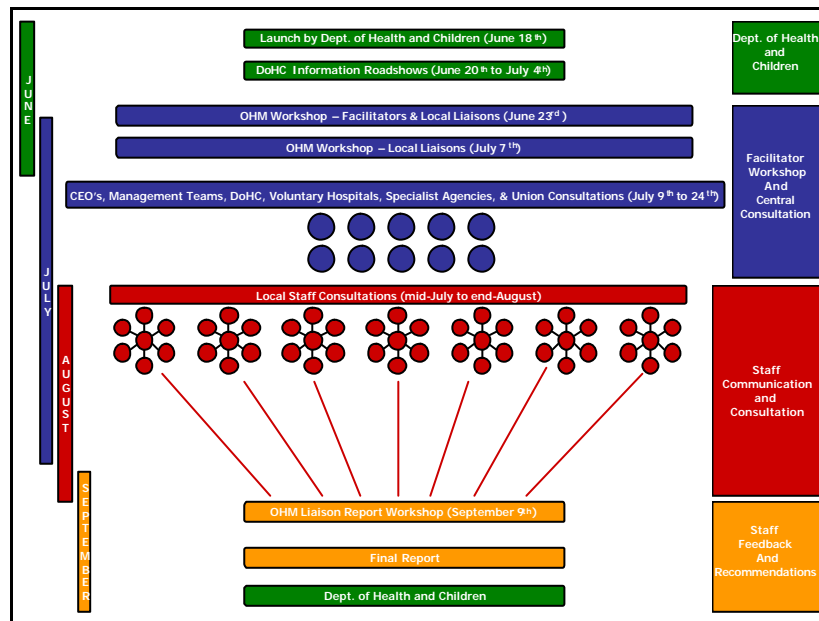
To reflect the desired partnership in implementation between the CEOs of the health boards and the DoHC, the CEOs recommended in the course of the communications and consultation exercise that in each instance Action Projects be jointly chaired by a member of the Department's Management Advisory Committee (MAC) and a CEO. They also recommended that a CEO should work in partnership with the Assistant Secretary of the Department of Health and Children overseeing the work of the Project Office and the implementation of the Reform Programme. Both of these recommendations were accepted by the Department in its recognition that the system had to work as a partnership in a highly communicative, engaging and transparent manner in implementing the Reform Programme.

The health board CEOs further suggested that, in order to ensure that the members of the Project Office and the Action Projects were seen to be appointed in a fair and transparent manner, a competency-based selection procedure should be followed. The procedure would be followed to select people to act as change leaders in regional locations as well as in the central working groups. It was agreed that this method of selection would be followed for health board staff.

## 2.8 Timescale

The timescale for the communication and consultation programme is indicated in the diagram below. Central workshops commenced in early June once the minister and the DoHC had finished the first round of briefings conducted around the country. Local consultations with staff commenced after CEO/management-team workshops had been held. Staff consultations concluded at the end of August when reports were submitted to the Office.

Figure 1: outline of communication/consultation process



## 2.9 Extent of communication and consultation

Different methods of communication were utilised. All organisations placed a heavy emphasis on communicating information on the details of the Reform Programme to all staff, or at least indicating where the information could be obtained through their intranet or on the DoHC website. In some organisations, staff received a briefing note with their pay slips. Other organisations used the staff newsletter and posters to inform staff.

The extent to which staff were consulted varied considerably across organisations. In the larger organisations, such as health boards, up to 20% of staff were engaged in face-to-face consultations. In smaller organisations, from 80% to 100% of staff were consulted. This figure was much lower in the voluntary hospitals (at around 10% in those hospitals that participated) because they felt that staff consultation should await the publication of the Hanly report.

Consultation took the form of workshops, focus groups and questionnaire surveys. In the case of some workshops, participation was open to all interested staff; in the case of others, selected staff were invited to attend. Some organisations relied on their managers to cascade the information down the line, consult with their staff and report back centrally.

### **2.10 Feedback on the process of communication and consultation**

Feedback on the impact and depth of the communication process was sought from the liaison persons at their final workshop in September. They indicated that staff generally were very satisfied with the process, that they found the sessions to be useful and timely. One staff member had this to say: "Thank you for the opportunity of consultation. It has been appreciated. Please listen to our feedback and act on it."

One health board made the following comment:

Facilitators reported that staff appreciated hearing even what little information was known and contributing to the discussion about the future of the health services. Recognising that staff contributed to this process as employees, as service users and as citizens, emphasised the importance of their engagement in the process.

Another board reported: "It was evident from the commitment of presenters, facilitators and participants that there are staff and structures in place that can rise to the implementation challenge. Partnership will also play a significant role in this regard." Yet another observed:

The majority of submissions received welcomed the reform programme and demonstrate a willingness to begin implementation of the changes envisaged. There is a strong message that staff at all levels and across all disciplines need to be kept informed, consulted and involved at all stages of the implementation process. It is clear that this two-way communication process will be critical to successful implementation.

Despite the generally positive response of staff, there remains a degree of suspicion among some of them, perhaps best expressed as follows by one

individual: "Staff feel this whole process is about perceived consultation and may now be used to say that staff were consulted with".

Factors identified as facilitating the process included

- project team to steer the process
- use of trained facilitators and reporters
- role of OHM in co-coordinating and steering the process
- briefing material provided by DoHC and OHM
- overall management buy-in to the process, following their participation in OHM management workshops
- where line managers were central to the process, and felt ownership of it, this was felt to be very helpful
- where a range of options on how to contribute or get information were made available to staff, this was found beneficial.

Factors hindering the process included

- the absence of the as yet unpublished Hanly report
- lack of detailed information on the reforms
- timing of consultations during holiday period
- perceptions that the Reform Programme was drawn up, unlike the national health strategy *Quality and Fairness*, without prior consultation
- staff availability to attend meetings
- line managers feeling intimidated because they did not have answers to all questions posed.

The process was constrained insofar as it had to take place immediately after the reforms were announced, during the peak holiday period of July-August. This was however unavoidable, given the need to consult with staff as soon as possible.

Nevertheless, as one health board indicated, "For those who were involved, movement has already occurred for them with regards to their readiness for change and local implementation".

## **2.11 Final report**

This final report contains a summary of the key findings of the communication and consultation exercise. It concentrates on the main object of the consultations – the views of staff on how the reform programme should be implemented. It does not include the detail of questions posed by staff concerning the reform programme because the answers to these will be worked out in the coming months and are being conveyed separately to the Department of Health and Children.

Together with this report the OHM is submitting to the DoHC copies of all the reports compiled by the organisations who consulted with their staff. All submissions received from organisations will also be given in full to the DoHC, with a recommendation that they be made available to the Project Office and the relevant Action Projects. Submissions from individuals will not be included, in line with our commitment to preserve individual confidentiality.

## Findings

### 3.1 Introduction

In this chapter the main findings from the communications and consultations with the staff throughout the service during July and August 2003 are indicated. Quotes from individuals or from summary reports are included to give a flavour of the views expressed. The views of staff across the service in response to the reforms are broadly similar and hence are reported without distinguishing between different sectors. There were however some differences across sectors of the health system and these are indicated at the end of the chapter.

The findings are presented under five main themes.

- Responses to the reforms and the consultation process
- Vision and values underlying the reforms
- Leadership of the reforms
- Funding the reforms
- Managing change in the reform process

### 3.2 Responses to the reforms and the consultation process

#### 3.2.1 General reactions

The reactions of staff, other than senior managers, to the reforms were broadly positive. They recognised that the system was in need of reform and while they had some uncertainty about why these particular reforms had been chosen, they clearly felt that the time was now right for change in the system and they wanted swift movement forward in implementation.

Managers tended to be more cautious. Initially, particularly among those who would be most affected by the reforms (health boards and specialist agencies), there was a degree of anger, suspicion and mistrust. This was exacerbated by the fact that the Hanly report (i.e. the report of the National Task Force on Medical Staffing) and the National Health Information Strategy had yet to be published. However, as the workshops progressed, managers began to recognise and accept the inevitability of the reform programme. As they discussed how they would like the implementation process to work, they began to take some ownership of the process and expressed strong views about how it should proceed.

"The message must be brought forward that staff are willing to play an active part in health service reform and organisational changes needed to bring this about but that the benefits of the change must be clearly visible in the quality of services provided to the people of Ireland."

"Staff are tired of the 'public misconception' that they are a large group of lazy, well-paid and pensionable individuals."

"Concern that they will tinker around the edges and not tackle core issues such as the ... consultants' common contract."

"Senior managers need to be fully committed to the Reform Programme – staff are very sensitive to their managers' views, and the level of cynicism and negativity currently being expressed by many managers could be fatal to the success of the Reform Programme."

### 3.2.2 Communication and consultation

Virtually all staff welcomed the communication and consultation process as a very positive first step. Many questions were posed concerning the details of the Reform Programme and there was disappointment that more information was not available. **The very strong view of all staff was that once further information became available, it should immediately be transmitted to all staff.** As a confidence building move, it was recommended that there should be a response from the DoHC to the views elicited during the consultation process.

There was a view that a communication plan needed to be developed and adequately resourced to facilitate ongoing two-way communication in relation to the Reform Programme. Some suggestions as to what such a plan might contain included

- a specific newsletter on the reforms
- regular feedback on progress at local and national level through a designated person
- regular briefing sessions for all members of staff to facilitate information flow and discussion of the progress of reform at national and local level
- use of structures and mechanisms already in place, for example communications officers, partnership structures
- continuing use of the Office for Health Management as designers and co-ordinators of the process
- continued consultative workshops with sector-specific management groups but also periodic joint consultations with integrated groups on specific issues.

Staff asked that management teams communicate with one voice; they perceived that they had been getting mixed, confusing messages from their senior managers that could have negative implications for the Reform Programme.

Mechanisms needed to be found to enable consultation with the service user and the citizen so that they too could have an input into decisions. This view was common to all sectors but was expressed particularly forcefully by the voluntary/disability sector.

"When push comes to shove – be clear and truthful about what is negotiable and non-negotiable."

"Continued support for the reform programme will depend on getting clear, unambiguous answers to the questions they have been given the opportunity to raise through this process and on evidence that their views have actually informed the programme." (Health board report)

"Staff were adamant that this should not be a once-off exercise." (Health board report)

"Staff are ready and willing to work on the transition and are asking for ongoing communication/consultation."

"It should ... be borne in mind that the consultation has generated certain expectations among staff. They expect to be fully consulted throughout the reform process and they expect to see action soon. A certain momentum will be lost if a timetable is not put in place and adhered to." (Department of Health and Children report)

"If we are to be closed down, don't let us read about it first in the newspaper."

"Communication will be the key. It has done quite well so far with the consultation process. But consultants, senior managers and politicians must buy into this reform. None of this will work if consultants do not buy into it and if senior managers are thinking of getting out." (Union workshop)

### **3.2.3 Personal concerns**

Personal concerns were foremost in the minds of most staff. They were critical of the lack of information about possible changes to their jobs or working conditions. These concerns centered on the future of their jobs, contracts of employment, security within their jobs and what their future roles and responsibilities were going to be. They sought early clarification of the exact position with regard to redundancies, exit packages, etc.

Sensitivity was needed in dealing with a change of this magnitude, it was suggested. If individuals were going to be moving to other agencies and

different locations, their concerns and fears should be acknowledged and dealt with.

Unions said that what was needed was a protocol to resolve industrial relations issues, and warned that the service could lose experienced staff if the process was not well managed. They reiterated that human resources were the key to the health services.

“Convince us that we don’t need to be afraid as fear is everywhere among your 95,000-odd staff throughout the country.”

“How will this impact on my life in terms of travelling, etc? Will I be forced to move house? Will I even have a role, given there are too many people at my level?”

“Buy in must occur from the word go. Clarity must be brought to staff as to where they will fit in the new system. The longer uncertainty remains as to where people will fit in, the greater the anxiety and the more prone to resist change.”

### **3.3 Vision and values underlying the reforms**

#### **3.3.1 Rationale for reforms**

Many, particularly senior managers, questioned the rationale and the motives for the Reform Programme. Most, however, admitted the need for reform but felt that the rationale needed to be clearly spelt out. The national health strategy *Quality and Fairness*, it was felt, had been constructed following a major consultation process throughout the health service. Staff were committed to it and its implementation and would be committed to the Reform Programme if it could be clearly shown to be based on the principles and values underlying *Quality and Fairness* and an integral part of its implementation. Health boards, in particular, were critical that population health goals did not feature at all in the Reform Programme and that it did not take a sufficiently holistic view of health and its determinants. In addition, there was disappointment that issues of equity and the two-tier system were not addressed.

“It is critical to recognise that the challenges that lie ahead are multi-dimensional including cultural as well as structural changes. The reforms are as much about ‘how we work’ as the structures and boundaries that surround us ... The challenge is therefore not to lose sight of the challenges of *Quality and Fairness* and the development of truly people-centered services.” (Health board report)

“Rationale for reforms should be documented and communicated as it would assist in people understanding the necessity of proposals and being prepared to

accept them rather than adopt defensive attitudes to proposals ... A baseline position of where we are today that can be compared to new proposals would also facilitate the debate and the 'selling' of new proposals."

"Convince us that these changes are for the good of the population's health and that they are not just about saving money."

"We need to be convinced, because if we're not convinced, how are we to convince our staff?"

"The vision in *Quality and Fairness* must remain the focus – people-centered at all times."

### **3.3.2 Values and principles**

Many staff placed an emphasis on the need for a clear enunciation of the values underpinning the Reform Programme and a recognition of the current commitment of staff which must be protected during the transition. The CEOs of the health boards also endorsed the need for a clear set of values and guiding principles to steer the Reform Programme.

"Ensure initiative is driven by the values of all stakeholders involved – staff, clients. Don't forget the importance of the staff, whose co-operation and commitment is necessary to make this work. Develop a partnership approach with greater involvement and transparency."

"Emphasis to be on the delivery of an efficient, equitable, accessible, responsive health service which is patient/service-user focused rather than politically driven. However, staff must be valued throughout this reform process."

"Reaffirm values in the health system. Most people going to work in health do so with a sense of belief. Affirm this and be clear about values around client. This requires linking the logic for change with the client."

"Ensure that the process is driven by values and appreciate that the staff working in the health services are driven by these values – values such as a desire to contribute to the improvement of clients' health and to make a difference in their lives. Employees derive job satisfaction from this and cannot contribute to their best potential to a system they do not believe in."

"The dedication and commitment of staff needs to be recognised. This commitment is essential to the implementation of the programme of reform. There is a positive attitude among staff at present and this should be maintained and maximised."

### **3.4 Leadership of the reforms**

It was recognised that leadership was needed to implement the reforms and that leadership skills needed to be developed in order to achieve success. The Department's Management Advisory Committee recognised that the issue of managerial capacity within the system needed to be addressed both in the short and the long term. It recognised that a key tension rested in the requirement that highly capable people had to be used to work both on the transition and on managing the existing system. In addition, people had to be developed personally for the future system. Many of these people required somewhat different skills and abilities to those they currently possessed. Leaders of change had to be identified and developed and a supportive human resource strategy was needed to enable this to happen.

Staff indicated the need for good leadership and effective management at all levels to support them in maintaining services in the current health service context, i.e. "business as usual during alterations".

Questions were raised regarding the political will to pursue the reforms fully. Would they be implemented if there were a change in government or minister? Would local politicians relinquish their positions on health boards?

"Strong visionary leadership at all levels."

"Real leadership needed to get the management team to work as a team on this rather than as competing interests."

"The sentiments expressed by senior managers during the consultation process would suggest that the level of leadership required may not be present among existing health service senior managers."

### **3.5 Funding the reforms**

Concerns expressed about funding ranged from the need for additional funding to support the proposed changes to concerns over losing funding, to the need for multi-annual budgets. Some were anxious that the funding of projects that had already been approved would be maintained, others feared that future funding allocation decisions might be made without some local input. A financial plan was needed, it was felt, that would provide the seed capital to get the Reform Programme off the ground. Very clear views were expressed that the Reform Programme could not proceed without some funds being allocated to get it off the ground in the short term.

“There will be costs – time and money, etc – this is not a resource-neutral process. Investment in ICT and HR will be needed, particularly skills development and succession planning.”

### **3.6 Managing change in the reform process**

#### **3.6.1 Change management – strategy and process**

There were strong assertions that the way in which the implementation of the Reform Programme was managed was vital. It was felt that there needed to be a change management strategy at both national and local levels and that staff needed to be supported through the change. Also, the success or failure of the proposed changes needed to be audited/evaluated, with agreed performance indicators.

Adequate organisation, planning, preparation and thought had to be invested in all changes before they were introduced. Many managers wanted to see a clear project plan for the implementation of the Reform Programme with timescales, milestones and performance evaluation. All changes should be piloted before large-scale implementation. Adequate and realistic time frames should be indicated. Shadow structures should be put in place now to facilitate a seamless implementation of the new structures. Implementation plans should be carefully monitored and corrective action taken as necessary.

The involvement of all staff could be facilitated through the partnership model and the use of partnership structures.

Staff expressed conflicting views concerning the pace of reform. Most wanted reform to move quickly, so that people were not left wondering when things would change – if that happened it was feared staff morale would drop and good people would leave. At the same time it was felt, particularly among senior managers, that the initial decisions were crucial and should not be rushed. Such decisions included the setting up of the Project Office and Action Projects and the methods used to select staff for these.

There was agreement across all parts of the system that a detailed and realistic timeframe was needed for implementation and that this needed to be drawn up and communicated as soon as possible.

All staff needed training in moving forward and the Action Plan for People Management had to continue to be implemented. Managers and professionals needed to develop their management capability and their change management skills so that they could manage the change in the short and long term. Training in budget management needed to be provided for those staff likely to become budget holders under the Brennan proposals.

Many stressed the need to learn from previous Irish experiences of change, for example the establishment and operation of the ERHA and the amalgamation of the Adelaide, Meath and National Children's Hospitals in Tallaght. Others suggested that insights should be gleaned from the experiences in structural change in Northern Ireland and the rest of the UK.

It was felt that much could be gained by undertaking pilot studies on a small scale and evaluating them, so that the potential impact could be assessed before large-scale change was introduced.

There was also in evidence a certain fear that knowledge and expertise embedded in different parts of the system might be lost in the midst of the re-structuring, as had happened during change in the Eastern region.

"Flexibility is needed when implementing this change. If something is not working, then flexibility is needed to be able to step back and re-adjust the plan so as to make it more effective."

"Provide answers and direction quickly. Prolonged uncertainty creates instability which affects service delivery."

"Our sense is that for those engaged in the consultation process there is now a desire to get on with implementing the change process with a minimum of disruption to service delivery. **A prolonged period of transition would not be in the interest of service users or staff.**" (Health board report)

"Most importantly, I feel that nothing should be set in stone for the first three years. The process of the ERHA has shown that you do not have a clear idea of the scope of organisational responsibilities, the external environment, the relationship between all key players and your modus operandi until at least two years into the operation. Legislation or rules written too early can potentially constrain the development of roles and responsibilities. Therefore, I think to manage these changes a huge amount of piloting and learning from lessons needs to be done."

### **3.6.2 Participation and collaborative working**

There was a strong demand, particularly from senior levels, for working in partnership with the centre in implementing the reforms. This was very evident at the final liaison persons' workshop where the liaison staff advocated partnership between the centre and the delivery system in implementation. Recognising that there were limits to partnership and consultation, they felt that the parameters needed to be clearly stated. There was a need to identify situations in which collaborative working would be beneficial and practical.

A clear view of what collaborative working would entail needed to be developed and conveyed. Such working would need to be facilitated and supported and would require honesty, transparency and integrity in working together.

As well as demands for collaborative working between the centre and the delivery system, attention was also drawn to the need for alliances and joint working across the system, for example across health boards, across specialist agencies and across sectors, as staff pondered the kinds of lateral linkages they needed to make.

Unions feared that they might buy into new structures where they had no power. They sought to be involved in project teams and shadow bodies and queried how the union-management partnership process would be affected.

“We need to recognise the need for change, engage in the change process and make a positive input.”

“The trade union movement wants safeguards to bring the reforms forward and top of the list for us is representation in top-level decision making and assurances about jobs.” (Union workshop)

### **3.6.3 Change management structures: Project Office and Action Projects**

As it became clear to senior managers that the details of the Reform Programme were yet to be worked out, there was much discussion on how they themselves could begin to influence that process and the Project Office and the Action Projects became a major focus of attention. There was a perception that staff assigned to that work would have an added advantage over staff who continued to manage the day-to-day work of service delivery.

Both the Department’s Management Advisory Committee (MAC) and the health board CEOs recognised the need to build up the resources and expertise within the Project Office to ensure that it could address its complex task of analysis and integration effectively and to ensure that Action Projects were driven with the appropriate expertise. Their concerns in this regard led to changes being made in the establishment of these structures, as indicated in 2.7 above.

Health board management team members also pointed to the need for shared leadership between policy makers and managers in the service delivery system in leading the reforms. They also expressed a wish that the selection process for people to work at the centre on the reforms should be open and transparent and that all interests should be represented.

Many of those consulted stated that front-line staff would have an important contribution to make to the work of many of the Action Projects and thus a mixed methodology for staff selection was recommended, some selection by competition, some, where specific expertise or experience was required, by co-option. Staff in one health board recommended that, where possible, planning groups should contain senior managers, line managers, front-line staff and consumers. Others recommended clinical involvement in all relevant Action Projects. It was also suggested that local working groups should feed into each Action Project.

The health board CEOs suggested that the Project Office would need to have at its disposal the necessary wide range of competencies to deliver in the following ways in support of the Action Projects:

1. provide a vision of the future and make the linkages to *Quality and Fairness* and the value system that should underpin the Reform Process
2. engage in whole-systems thinking
3. be skilled in critical and soft systems analysis
4. communicate clearly
5. make sense of the work of the different groups
6. co-ordinate the work of the different Action Projects
7. give life to the process and create a sense of urgency.

The issue of the representativeness of central project staff was a recurring theme in many workshops. Liaison persons, for instance, advocated the proofing of project groups to ensure that they reflected geography, gender and skills. Staff located outside the Eastern region were keen that project groups might be located around the country or work "virtually", using electronic means of communication, to ensure they were not disadvantaged.

"Giving front-line staff opportunities to be involved in the action groups so that they have a sense of responsibility and ownership attached to the process."

"... staff who had the opportunity to engage in...the consultation process have a greater sense of being able to impact on the design of a health service that will more effectively meet the needs of service users. Involving front-line staff in design of future services prior to the implementation of change could enhance the success of the reform programme." (Health board report)

"The key leadership roles in implementation of the reforms need to be filled through the most rigorous selection process, open to those within and outside of the health services. Using only DoHC or health board staff to lead the reforms may prove fatal to successful implementation."

"It was suggested to use the expertise of someone who has experienced change of this magnitude. This person may be from within the civil service or an outside consultant, but it is felt that this level of expertise is needed to ensure success."

#### **3.6.4 Local change management structures**

It was recognised that a structure needed to be put in place to facilitate change locally, such as a local team to manage the change. Some suggested that a key contact person be allocated within all services to be responsible for managing the changes within that service and to support staff in that area through the implementation process. Such contact persons would however require education and support themselves to acquire the skills to deal with resistance.

At a local level, the tasks required needed to be clearly laid out. All staff should be assigned specific areas of responsibility in order to "complete the picture" of overall change relevant to each department. Each staff member needed to be clear that her/his contribution was essential to the overall success of the Reform Programme.

Some senior managers suggested that they might begin to design a working model of the change from the bottom up which could then be matched with any plans coming from the centre, for instance a model which ensured that community care areas were coterminous with hospital networks, etc.

One hospital proposed that named and identifiable individuals should take responsibility for different aspects of the changeover in the transition period. Accountability for the reform should therefore start immediately. It was also proposed that each hospital should set in place an evaluation and review process to examine the current status of the Clinicians in Management initiative, ICT and governance structures and plan for whatever change was needed.

Managers mentioned that they needed to examine their services in the light of the planned establishment of a national shared services centre. Those services that might move to the centre had to be identified and the potential impact examined. It was felt that the shared services model should be informed by the experience in the Eastern region.

Change management responsibilities and tasks should, it was felt, be clearly and explicitly built into service plans for 2004.

Organisations such as health boards could review their own philosophy, policies, procedures and standards for the future merging. They could also mirror locally the immediate actions/plans. Each service needed to appraise its positive points, to be maintained and developed in future structures.

Health boards argued the need to ensure that best practice was reflected in the new structures. Each board, it was felt, had services or practices which were ahead of the rest of the system in certain aspects. The new Health Service Executive (HSE) should adopt these as the standards of excellence to which all regions should aspire. Work needed to be done to identify these examples of excellence across the health board system. In addition work was needed to collect and analyse baseline data on the existing situation to use in monitoring and evaluating the Reform Programme.

One health board suggested that a local project team, representative of all areas in the board, be set up to lead out the reform process at a local level.

Health boards also identified a need for a system-wide network of health leaders to meet on a regular basis to ensure collaborative working and system-wide thinking on issues.

### **3.6.5 Managing the transition**

Managers raised the issue of the need for clarity as to where accountability would lie during the transition, especially once interim structures were in place.

One health board summarised the key messages from its staff to local managers as follows:

1. lead us through this change process
2. represent us when decisions are being made with regard to services in (our region)
3. communicate with us and let us know what is happening
4. maintain and mind our good practice
5. change is difficult for all of us – respect and value the staff.

Within the DoHC itself there was recognition of the need to start immediately planning for the devolution of certain functions and tasks from the Department to the new HSE. These functions had to be identified quickly so that individual sections could plan ahead.

Concerns were expressed that there will be tension during the transition phase as senior managers line themselves up for the new posts and consequently do not collaborate with each other in their existing roles; there was a view that some evidence of that was emerging already.

Many, particularly at senior management level, expressed anxiety as to how services could be maintained and developed during the transition. In the DoHC, the Management Advisory Committee saw it as vital that the system be managed tightly in terms of finance and staffing levels in 2004 to ensure that the new HSE

did not start with a major financial deficit in 2005. This was particularly the case in view of the fact that 2004 already promised to be a challenging year. It was therefore important that incentives to operate within budget limits be developed for organisations which were due to transfer into the HSE.

It was acknowledged that during the transition period some staff may be juggling two sets of responsibilities (day-to-day work and Reform Programme work). There was a recognition that this would require effective management. Priorities needed to be set out for staff so as to avoid confusion and stress.

Health board CEOs agreed that they themselves would have to examine how they structured their time and they would have to delegate significantly greater amounts of work. The work and procedures of the CEO Group were reviewed in the light of the additional workload the Reform Programme implied. A distinction was drawn between the role of the Chair of the CEO Group and that of the CEO overseeing the Project Office, the former leading the management of the present state and the latter leading the change management process arising out of the Reform Programme.

"There must be clear ownership and responsibilities for the change process both locally and nationally. Change to be the responsibility of everyone and all levels of staff will be provided with the knowledge to change".

"Just as much attention and resources focused on 'keeping the show on the road' especially in the current financial climate – not everyone can be involved in the change."

### **3.7 Specific sector concerns**

#### **3.7.1 Health boards**

Health boards outside the Eastern region expressed significant concerns that the reforms might result in a Dublin-dominated, centralist service where the needs and issues of the peripheral regions might be overlooked. They were particularly fearful that they would not have sufficient flexibility to continue to respond to the needs of their local populations.

There was a strongly expressed desire for an early decision on where the headquarters of the four regional offices would be located.

"One would have a genuine fear that within the new Health Service Executive, 'he who shouts loudest will be heard', for example east-coast hospitals."

“Will the people in (this region) get lost in a centralised system? Can our ability to be innovative and creative in service delivery, in the best interests of consumers, be maintained?”

### **3.7.2 Voluntary hospitals**

All voluntary hospitals that participated in the exercise welcomed the Reform Programme but generally felt that the consultation was premature until the Hanly report was published. All expressed a desire for further consultation once that report became available. The low participation by medical staff in the communication/consultation process was commented upon and also attributed to the absence of the Hanly report. It should be noted that some of the large hospitals did not participate in the exercise, feeling it was pointless until the Hanly report was published.

Voluntary hospitals suggested that joint working groups should be set up across health boards and voluntary hospitals to facilitate unification of standards and resources. They feared that, as things stood, all of the change would be led and determined by the health boards. There was, senior managers felt, a need to focus on services and client groups, rather than on hospitals.

Concerns were expressed about the continuing independence of the voluntary hospitals. Would their autonomy, philosophy, identity and freedom of action be negatively affected once they came under the National Hospitals Office? Where would single specialty hospitals fit in? What impact would all of this have on patient care?

Voluntary hospitals were fearful that the linkage to community services would be hampered under the new structures. They also had some misgivings about the impact which shared services might have on them.

### **3.7.3 Specialist agencies**

Specialist agencies in general were concerned about issues such as governance and their loss of their board, and the dangers of a dilution of their expertise

They made a number of suggestions.

- The rationale for the decisions about the location/mainstreaming of different agencies should be spelt out clearly.
- Agencies with similar interests in relation to the Reform Programme should form alliances.
- There should be ongoing bilateral discussions held with the specialist agencies.
- There should be a named person in the DoHC to whom each agency could relate.

Agencies that were to be mainstreamed sought representation on the mainstreaming project group. They asked how their independent policy advisory functions were to be protected if they were to be subsumed into, for example, the HSE. Making policy and advising on policy are two separate functions, they suggested. They regretted their loss of identity as separate organisations and the possible implications this might have on staff morale and performance.

In specialist agencies which were to be mainstreamed, staff were anxious to know the specific timetable for implementation so that they could plan accordingly.

Many of the specialist agencies made individual submissions to the OHM as part of the consultation process. They raised concerns specific to themselves. It is recommended that these submissions be made available to the Project Office and the Action Projects on mainstreaming, Health Information and Quality Authority (HIQA) and the HSE (as appropriate) so that each agency's views and concerns feed directly into the planning process.

Submissions were received from the following agencies and have been transmitted in full to the DoHC as an appendix to this report.

- An Bord Altranais
- BreastCheck
- Comhairle na nOspidéal
- Crisis Pregnancy Agency
- Health Research Board
- Health Service Employers Agency
- Institute of Public Health
- National Cancer Registry
- National Council on Ageing and Older People
- National Council for the Professional Development of Nursing and Midwifery
- National Disease Surveillance Centre
- National Federation of Voluntary Bodies
- Pre-Hospital Emergency Care Council

(Submissions were also received from the Association of Chief Ambulance Officers, and the Technical Services Officers and Directors of Capital Projects in the health boards. In addition, a number of staff within organisations made group submissions.)

#### **3.7.4 Voluntary/disability sector**

As with other groups, organisations in the disability sector sought increased clarification of the details of the Reform Programme, continued communication in

relation to it and ongoing consultation. In addition this sector made the following sector-specific points.

- This consultation process should be extended to include consultation with service users.
- There is no clear vision as to where personal social services, and therefore the disability sector, fit into the Reform Programme.
- A vision needs to be defined for the personal social services and the disability sector in consultation with all stakeholders and from that could emerge a national disability strategy.
- Consideration needs to be given as to whether the funding and support of personal social services and thus also organisations serving persons with a disability should be shifted to another government department.
- Will national agencies have to form working relationships with all thirty-two community care areas?

Finally, the disability sector asked that it be allowed to contribute to all Action Projects arising out of the Reform Programme and that it be represented on any emerging or interim bodies.

## Discussion and Recommendations

### 4.1 Introduction

This chapter contains a discussion of the findings and recommendations structured under the five main themes of the last chapter.

- Responses to the reforms and the consultation process
- Vision and values underlying the reforms
- Leadership of the reforms
- Funding the reforms
- Managing change in the reform process

### 4.2 Responses to the reforms and the consultation process

The responses of staff to the announced Health Service Reform Programme are broadly favourable. This must be heartening for those charged with leading implementation.

This optimism must be tempered however by acknowledging the more cautious and even negative responses of managerial groups. Such responses to change are common in the early stages of all major change initiatives. It is recognised that in the midst of major change rumours, suspicion and mistrust grow. The only solution to this is constant and ongoing communication – communicate, communicate, communicate!

It was noticeable that the attitudes of all staff towards the Reform Programme became progressively more positive as they felt they were being communicated with and consulted, had a chance to discuss the proposed changes and to think through the implications for themselves. It is important to note however that expectations were raised as a result of the communications and consultations and have led to a strong and widespread demand that these will continue in some shape or form throughout the implementation process. This is the one key message that must be drawn from this exercise.

There is a need for “early wins” to convince people that the change programme is making a positive difference. Initiating a structure and process for regular ongoing communication and consultation would be an early win in the eyes of staff within the health system.

**It is recommended that the Action Project on Communications, in its role of overseeing the entire communications strategy for the Reform Programme, encourages ongoing communication and consultation with the health service and service users to ensure openness and transparency.**

**It is further recommended that, locally, CEOs should respond to their staff on the local issues raised in this consultation process. Centrally, it is recommended that the Department of Health and Children should respond to the clarifications sought and the concerns raised during this consultation process.**

Ongoing and frequent communication will however count for little if the concerns of staff about job security and location are not addressed speedily. It is recognised that there are difficulties in communicating at present because many of the details of the reforms are genuinely not known. Many people still suspect that there is some hidden plan. The fact that much of the detail will be developed only as the Reform Programme proceeds means that staff suspicions have to be addressed and dealt with.

**It is recommended that priority attention is given to seeking clarity for staff on the personal implications for them of the Reform Programme and that an IR protocol be put in place to negotiate with the unions as required.**

#### **4.3 Vision and values underlying the reforms**

People own what they help create. It was evident from the consultations that staff working in the health services, particularly at senior levels, felt ownership of the national health strategy, *Quality and Fairness*, and felt it charted a correct and inspiring vision of the direction in which the health service needed to move. Staff perceive no such inspiring vision as yet underlying the Reform Programme. There is a need for an inspiring vision to guide major organisational change. People need to see what will be gained by going down the road of change. The creation of a shared and inspiring vision, together with a statement of core values and guiding principles, must be one of the first tasks of the Project Office and the Action Projects, working together.

**It is recommended that the vision underlying the Reform Programme be articulated in such a way that it is linked back to the goals and objectives of *Quality and Fairness* and contains a statement of the values and guiding principles underpinning the implementation of the Reform Programme.**

#### **4.4 Leadership of the reforms**

The health service is essentially a people business. As the Action Plan for People Management puts it, it is about people serving people. A human resource strategy must be an integral part of the Reform Programme to ensure that the minds and hearts of staff are addressed, as well as the structures within which they work. Such a strategy would indicate how the health service is to get the right people, with the right skills, in the right place, doing the right things.

Change of this magnitude requires good leaders, and staff during the consultation process called for strong, effective leadership. Given the predominance of professionals within the health service, old autocratic styles of management cannot work. "Command and control" styles of management or leadership have negative impacts on a highly educated, committed workforce. Leadership which influences and inspires staff to give of their best in the service of others and of the health service as a whole is what is needed.

The leadership agenda includes enunciating for staff the clear and credible vision underlying the reforms, and generating pride and enthusiasm. The agenda includes energising people to come on board and work on implementation. Leaders must also be enablers, removing blockages, allocating resources and using rewards to reinforce the desired new behaviours under the reforms. Finally, leaders must be able to identify and prioritise the "must-dos" so that staff have a sense of direction and clarity in terms of their accountability during the change process.

Leadership skills can be developed and they are needed, not just among the managerial population, but also among clinicians. It is important also that the existing and emerging new leaders within the system receive developmental support through coaching and mentoring. It is vital that this strategic development of the leadership capacity within the system continue, but at a more intensive pace, with increased investment. Leadership and management development must however be carried out within the framework of a clear HR strategy.

It is noted that the Action Project on Human Resources/Industrial Relations includes in its terms of reference the outlining of "the principal elements of the HR agenda to inform the development of a HR strategy in phase II".

**It is recommended that a human resource strategy be developed in support of the Health Service Reform Programme, paying explicit attention to the development of leadership capacity within the system and the support of existing leaders.**

With a new, integrated service planned, it is also important that leaders involved in individual parts of the system are brought together to enable thinking and planning in a more cohesive manner than heretofore. A network of health leaders was one suggestion made. There is a need to ensure that those involved are enabled to respond to the pressures for change but at the same time remain open to the experience and learning of others. There is a need, for example, for once-off consultative meetings on change issues in which key decision makers come together to discuss such issues in a safe confidential setting, away from the distractions of day-to-day engagement.

**It is recommended that initiatives (such as seminars, workshops, conferences and consultative meetings) to foster and facilitate “whole-systems thinking” form an integral part of the planning for the Reform Programme.**

#### **4.5 Funding the reforms**

Managing major structural change cannot be budget-neutral; additional investment is needed upfront to fuel the change if the longer-term efficiencies are to be achieved.

This was the perception of many of the staff involved in the consultation process. It has also been borne out by the experience in the UK of major structural change in the NHS.

**It is recommended that additional funding be made available to facilitate implementation of the Reform Programme.**

#### **4.6 Managing change in the reform process**

##### **4.6.1 Planning and evaluation**

In terms of planning the implementation of the reforms, staff wanted an enunciated purpose and clear, realistic timeframes with identifiable milestones along the way to provide evidence of early wins. Work is already in progress on this within the Project Office and communication of an initial project plan would be welcomed. The extent to which major change of this nature can be mapped out in detail in advance is unclear however.

**It is recommended that, once the “road map” for the Reform Programme is drawn up, with milestones indicated, it should be communicated to all staff; regular updates on progress in implementation should also be provided, by newsletter and website.**

Staff also sought ongoing evaluation and review of the Reform Programme.

The implementation must be based on best practice in change management. It is recognised that a National Steering Committee is to be established to oversee the Reform Programme. It is necessary however that a feedback loop be set up so that there can be ongoing learning and reflection on the impact of the changes as they proceed and that the introduction of change can be managed and facilitated at all levels in the system. There is also a need to learn from the past, particularly from recent experiences with setting up the ERHA and Tallaght Hospital.

**It is recommended that the Reform Programme be subject to ongoing monitoring and evaluation and that data on current service levels be captured locally. In addition, it is recommended that pilot projects, simulations and examinations of past experience of change should be an inherent part of the Reform Programme.**

#### **4.6.2 Collaborative working**

It can be argued that the Reform Programme, at least initially, will have most impact on the senior managers within the system. They are the current leaders within the system and they must be supported and all efforts made to bring them on board as active supporters of the programme. Some may wish to leave the health service and should be supported and enabled to do so, sooner rather than later. Those who wish to stay must be recognised for the experience and wisdom they bring to the process and treated as equal partners in the implementation process. This change cannot be delivered by the centre alone – it requires active engagement and support from the delivery system. That active engagement and support will be forthcoming if all approach the table with mutual respect and a willingness to work together as partners, recognising their respective rights, responsibilities and concerns.

There is a danger, given the need to move quickly on this reform programme and to set up new institutions very rapidly (at an unprecedented pace in the Irish health service), that all the attention will focus on the task, rather than on the process. Doing things in a way which respects people and seeks their views can be time consuming and at times frustrating but it pays dividends because of reduced resistance to change and more effective implementation. There are times in major change however, when it is important to take the hard decisions quickly and live with the consequences – and staff are asking for speedy implementation. The lesson is that, at all times, account must be taken of the process and the costs and benefits of different approaches must be weighed up. The “slash and burn” approach may suit some phases of change and the “softly, softly” approach others.

The concept of collaborative working in implementation is one that can reap real benefits. Collaborative working is not however, deeply embedded in the culture

of the health service and it will need to be worked at. The desire of staff to contribute to the work of shaping the details of the reforms is noteworthy and this degree of interest and enthusiasm must be harnessed in some positive generic way because all cannot participate in the initial planning work.

Many staff and senior managers in particular have expressed a strong desire to contribute actively to the implementation of the Reform Programme. All cannot be involved in working at the centre. This means that the centre must reach out and consult those working in the field. Collaborative working between the centre and the delivery system must be based on parity of esteem.

**It is recommended that collaborative working be adopted as a basic principle underlying the implementation of the Reform Programme.**

#### **4.6.3 Local change management**

The need for central leadership and direction must be balanced with the need to encourage local ownership and innovation. There was clearly enthusiasm among those consulted for getting on with the task of planning for and implementing change locally.

The OHM recently published a collection of eleven case studies of change management in the Irish health services. The collection identified five key factors that were present in all successful change initiatives. These were

- a clear and common vision about how things could be better
- communication and consultation in advance of the change
- securing top management support
- communication and consultation throughout the change.
- empowering others to act on the vision/effect the change.

If we apply these to the experience so far with the Reform Programme, the need for a clear and common vision has already been discussed. There has been communication and consultation with the system and top management support has been secured. A clear view has been expressed by those consulted that communication and consultation should continue.

In relation to the fifth factor, namely, empowering others to act on the vision and effect change, it is important that people down the line are encouraged to start to think through what needs to happen in their own area. Managers and staff at local level need to be facilitated and enabled to try out new approaches, to develop new ideas and to provide leadership. The only constraint is that the actions fit within the broad parameters of the overall vision of *Quality and Fairness* and the Reform Programme. If this is not allowed to happen now, initiative and creativity will be stifled down the line for the next two or three years.

There is a need to manage the dynamics of this local change, using change facilitation as required. The OHM has been working with the system to identify and develop people with change facilitation and leadership skills within the system. There is now a cadre of such people and they were used during this consultation exercise. It is important that they and others with similar skills be recognised as a resource within the system, one that is constantly being developed, enlarged and utilised.

**It is recommended that the development and use of people with skills in change facilitation be actively encouraged.**

Many comments were made on the need for the central structures which are designed to manage the change to be filled with the right, appropriately skilled people and that those people should represent the interests of all stakeholders. This may need to be balanced by an alternative view that it is the skill and knowledge of the people working at the centre that is important, rather than their representativeness.

**It is therefore recommended that people working on central change projects be selected for their skill, knowledge and competencies and that they consult with relevant stakeholders rather than necessarily having all stakeholders represented on each project. It is further recommended that mechanisms be put in place to further such consultation.**

It is noted, for instance, that the National Consultative Forum meets annually to review progress on *Quality and Fairness*. Other fora should be constituted as reference groups to which project groups could go to discuss proposals.

#### **4.6.4 Managing the transition**

Staff were concerned about managing the service during the transition, about where accountability would lie and how to maintain quality and continuity of service.

When large private companies engage in major change projects they tend to have well thought out, extensive change plans. These describe the desired end state of the company and the major changes in policy and practice necessary to reach it. However, the implementation plan of these companies is rarely as well thought out and this very often gives rise to major problems. The change tends to be managed through the normal organisational hierarchy rather than through a dedicated change management resource. In addition, very few of these companies adopt a learning mode in implementing the change. If they had a

good implementation plan they would have thought through a structure and process for managing the transition.

This suggests that there needs to be an implementation plan for the Reform Programme that establishes change management structures and processes, both locally and centrally, for managing the service through the transition.

**It is recommended that change management responsibilities should be identified locally and reflected in service plans for 2004. These local change management structures should mirror central structures and liaise with them as necessary.**

Realistically, it will take time to achieve major organisational transformation of the kind envisaged in the Reform Programme. That message will have to be got across to the political system and the media.

Staff were concerned that the many positive developments in services might be lost in the midst of the reforms. It is important not to knock the past but to build upon it, otherwise there is a risk of alienating those upon whom the system depends to implement the change. Examples of excellence must be identified, celebrated, protected and expanded during the Reform Programme.

In moving towards a more integrated system of healthcare delivery, with improved governance and accountability, care must be taken to ensure that local initiative and creativity is not stifled. System-wide regulatory frameworks must allow for local variation to respond to local circumstances and to develop creative solutions to problems.

As we move forward in reform, the key elements of good practice in one part of the system must be recognised and taken up by others. There is a danger however in imposing approaches that suit one setting and may not work in another.

**It is recommended that a process be put in place to identify examples of best practice and feed these back into the system to influence the implementation process.**

#### **4.7 The Hanly Report**

It was noticeable that the clinical involvement, particularly the medical involvement, in the consultation process was limited. The Reform Programme will shortly be followed, we believe, by the publication of the Hanly report on medical staffing which will have implications for the acute sector and clinical practice in Ireland in the years to come. Some voluntary hospitals felt that the

communication and consultation with staff was premature without the Hanly report.

The patient/service user experience of a quality service depends crucially on the face to face interaction with a clinician, whose work is supported by that of other staff within the service. The quality of that interaction cannot be legislated for. It depends on the commitment, skill and engagement of the clinician. Clinical staff of all backgrounds and interests must be fully engaged with the purpose and processes of change. Strenuous efforts will be needed to involve clinical leaders in active engagement with the Reform Programme and the Hanly report, once it is published.

**It is recommended that the plan for implementation of the Reform Programme include a specific strategy for engaging with clinicians around the reform agenda and that there be further dialogue with affected staff once the Hanly report is published.**

#### **4.8 A final note**

The following quote from one workshop probably best summarises the views of all.

Staff welcome change if it is well thought out, if they are involved, if it is adequately funded, if services are de-politicised and objectively evaluated, leading to better outcomes for service users.

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