Change Management in Action

Planning and implementing change in healthcare: a practical guide for managers and clinicians

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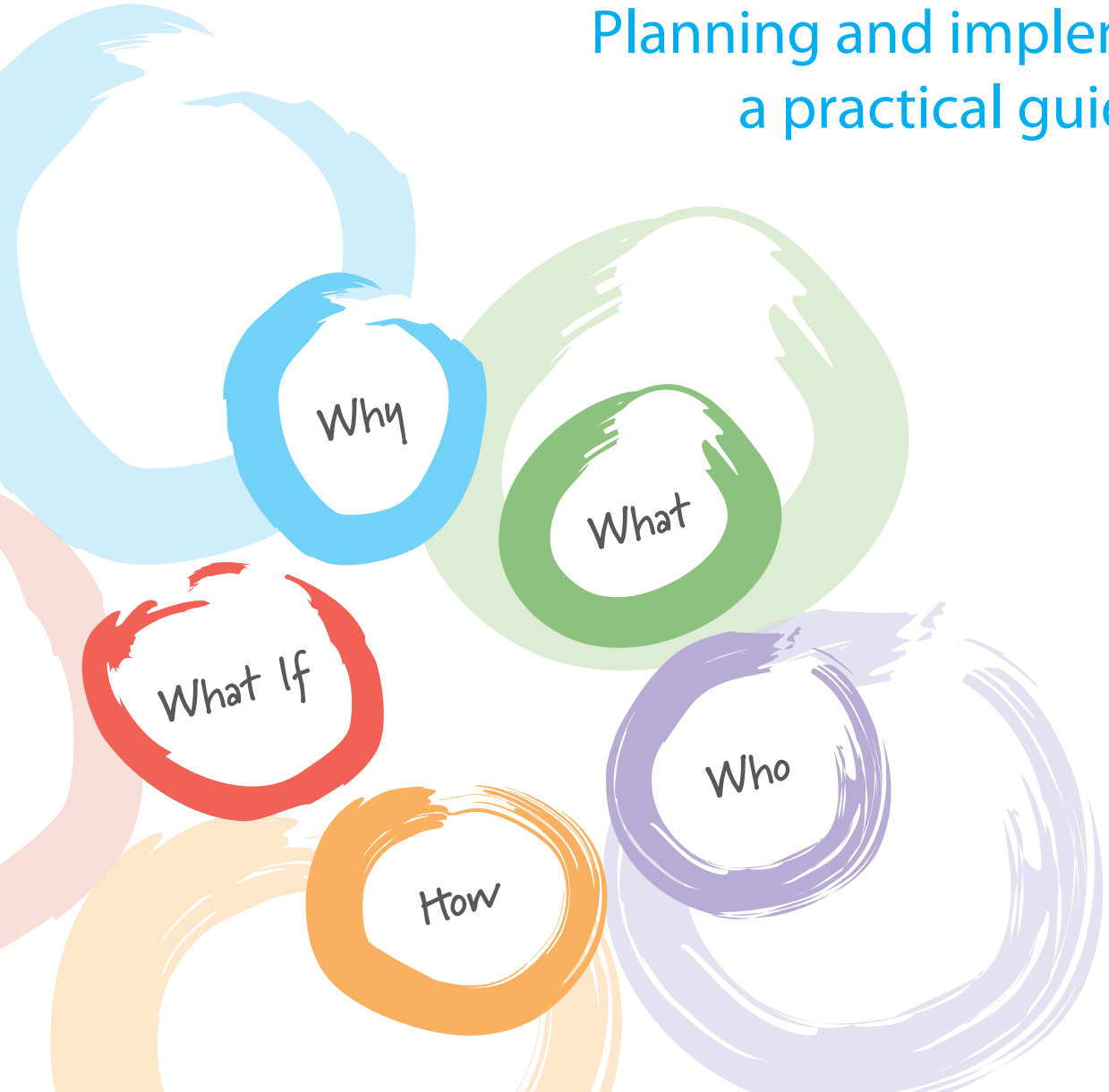

ABOUT THIS BOOKLET

This booklet is aimed at senior clinicians and healthcare managers who would like help in thinking through, planning and then implementing changes to their healthcare services locally. It provides practical assistance in a way that assumes no prior theoretical background to what is often called 'change management'.

The booklet is based on HLSP's experience in supporting individuals and organisations in several countries including Nigeria and Russia. Most recently, HLSP designed a successful change management programme conducted for over 400 Iraqi clinicians, administrators and policy makers during 2007-2009. The aim of this programme was to assist participants to become Agents of Change in re-establishing their healthcare system[1].

There is a wealth of tools and techniques to help with planning and achieving change. Based on HLSP's experience, the team refined the approach and focused on the tools that really help clinicians to formulate, sell and negotiate their vision of change, and then to plan for successful implementation. The tools presented in this booklet are the ones that clinicians and managers participating in change management programmes considered most helpful.

We recommend that you read the Introduction since this summarises the key issues and approach taken. Thereafter you have a choice. Either follow the booklet from beginning to end, or go to the sections where you feel you will get the most benefit.

[1] For more information watch the film *Agents of change: rebuilding Iraq's medical system* on http://www.youtube.com/watch?v=_LHeLEvWdEo

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INTRODUCTION

WHY CHANGE MANAGEMENT MATTERS

Changes to services and organisations can often be difficult. Top down change can feel threatening and destabilising. Many colleagues find it difficult to see the potential benefits. The changes may impact on the role, position and the status of individuals and therefore may test levels of self-confidence and confidence in others.

Change may require new clinical responsibilities, time for training and development, and an openness to new ways of doing things. It also requires letting go of previous practice.

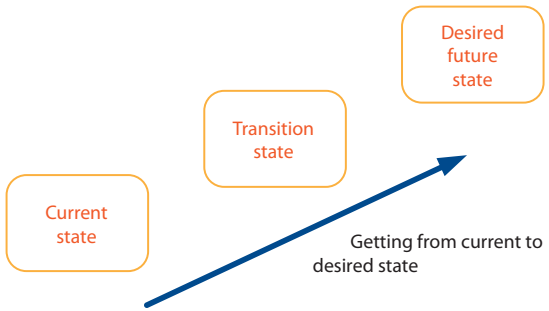
Change may require significant investment in people, systems, equipment and facilities, and is therefore likely to require financial backing. These challenges make the planning of the change process a prerequisite for success.

PLANNING FOR CHANGE

The work of Organisational Development practitioners has helped with ways of thinking about the process of change, and the complex reactions to it, at individual, organisational and system level.

Well known models of change often assume a linear progression from one state to another (fig.1).

Fig.1 Beckhard and Harris' model of change



This is a useful starting point but its simplicity masks a number of more intricate and subtle aspects associated with different phases of change. These aspects require clear thinking, communication and agreement on the reasons for change and the longer term vision. A clear assessment is required of who needs to be involved in planning and implementing change to make it successful.

Finally there needs to be a clear plan for change, which also anticipates the potential pitfalls and problems.

We brought these considerations together in an effective framework which we called the '**Five Wonders of Change**' (fig.2, overleaf).

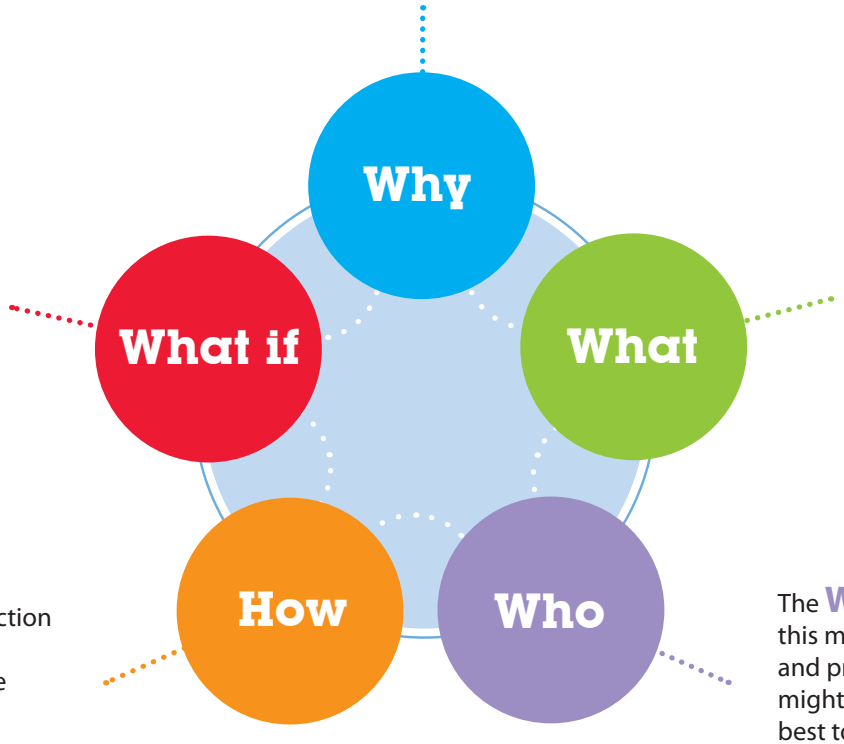
This simple framework enabled clinicians to study change made by other organisations, as well as to prepare their own proposals and plans.

THE FIVE WONDERS OF CHANGE

Fig.2 The Five Wonders of Change

The **Why** of change –
this means assessing carefully the problems inherent within the current set of services and organisation and why resolving these problems is so important and urgent.

The **What if** of change –
this means giving attention to potential problems early in the planning process to minimise the risk of late delivery and to prevent failure.



The **What** of change – this means having a clear and compelling vision of services and organisation with the benefits that will be realised.

The **How** of change –
this means knowing what action is required in the short and medium term to achieve the desired set of changes.

The **Who** of change –
this means knowing who may be key to championing and promoting change as well as understanding who might oppose or block it. Part of the thinking is on how best to involve and work with these key individuals.

The next five sections set out each of the '**Wonders of Change**' in more detail. The booklet ends with two case studies illustrating how the approach was used by participants during the programme for Iraqi health professionals.

THE WHY OF CHANGE

This is the first step on the road to change. If you and your colleagues are clear on the reasons why change is needed and you are convinced of the urgency, then the foundations are laid. If you are not clear, or the reasons are not shared by those who matter, then change may fail to take off or will stall and fall away.

Most often change is driven by necessity or in response to problems; there is something wrong with the service or organisation that requires fixing. The need for this can be seen in performance data for health outcomes (mortality or continuing morbidity), or in service efficiency (waiting times or costs per unit). Performance may have declined or just not be good enough in comparison with other similar units.

The need for change may be made more urgent because of changes occurring outside the organisation. For example there may be increased competition from other units, regulators may move to close unsafe services, healthcare purchasers may be looking for more effective or less expensive alternatives or it may be that there is a pressing shortage of skilled labour which will undermine services.

By contrast, progressive external developments can provide encouragement for change internally. One example is the emergence of new technologies offering benefits of better, safer and less expensive healthcare. Other examples include the availability of new funds and grants to support change.

Whether the trigger is positive or negative, there needs to be an internal desire for change with a sense of urgency. The leader of a change initiative can use the evidence gathered during the why of change process to build this collective desire.

A number of analytical tools and techniques can assist with gathering data and building a rational case for change.

- Using comparisons over time or with other units on significant outcomes and measures of performance (known as benchmarking)
- Surveying users and healthcare purchasers on the experience of service
- The systematic appraisal of the environment using for example the PESTELI model (fig.3) to understand the key trends in the factors influencing change
- The systematic appraisal of the organisation using for example McKinsey's 7-S (fig.4) to understand how the various elements relate and function together within the organisation's internal culture

Fig.3 PESTELI model for assessment of external environment

External Environment

POLITICAL FACTORS
National government policies, local policies, small 'P' politics

ECONOMIC FACTORS
Availability of funding, nature of competition

SOCIOLOGICAL TRENDS
Demographic trends (lifestyle, health issues, behaviour)

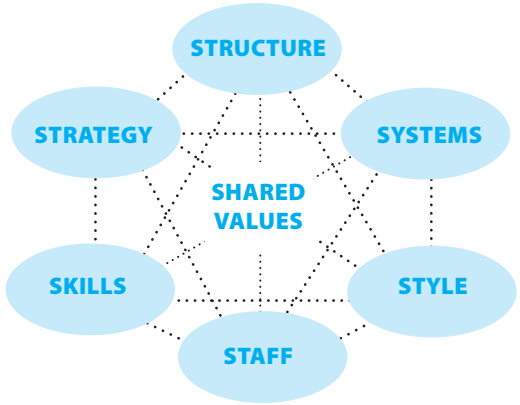
TECHNOLOGICAL INNOVATIONS
Medical technology, information

ECOLOGICAL FACTORS
Environment, public health and systems developments

LEGISLATIVE REQUIREMENTS
Health, safety, employment

INDUSTRY ANALYSIS
Demand and supply issues

Fig.4 McKinsey's 7-S model



- The integration of data and information on the external and internal environment (opportunities and threats) with conclusions on the fitness or otherwise of the organisation (strengths and weaknesses or limitations), known as the SWOT analysis.

Fig.5 The SWOT analysis

Strengths	Weaknesses
Opportunities	**Threats**

These tools and techniques will assist in developing a rational presentation of the case for change, focusing on a clear account of why the current situation can not continue and what would happen if no change was made.

Rational analysis will not in itself compel others to consider change. For this to happen we need to make connections with the underlying motivations and drives of those who are most affected. The case must have resonance with human nature and the desire to generate greater levels of certainty for the future and offer satisfaction.

We will come back to the issue of motivation later when we look at stakeholder engagement.

KEY POINTS

Ownership of problems comes before ownership of solutions. The acceptance of the need for change will be assisted by good rational analysis based on data with external validation. But the rational case must also fit with the drives and preoccupations of key colleagues.

THE WHAT OF CHANGE

Developing a vision of change is vital in clarifying the end result and in defining success. It is also critical for inspiring others, building confidence and winning support for the future.

But describing the vision can be difficult. Ask yourself the question "if I came back in 12 months or two years what do I hope to see in place and being achieved?" This will be your vision.

Visions can be described in terms of outcomes and benefits, services and organisational features.

For **outcomes**, the vision may be described in terms of the reduction of mortality and morbidity, of infection rates, of lengths of stay or increases in patient satisfaction. These are the mirror image of the problems set out in the 'why change' section but are set out now in positive 'benefit' terms.

Some of these outcomes may take a long time to achieve but they are the key drivers for your change initiative and will form the basis of an evaluation of success.

A vision focused on **services and organisation** helps to present the desired changes with a shorter term perspective before the benefits and final outcomes are achieved.

For services the vision may set out a completely different approach to serving patients. For example the application of non-invasive surgery offers new day case care without the need of in-patient services.

The provision of diagnostics in the community offers a new locally accessible service close to home. Integrating HIV services into mother and child health care, or tailoring services to meet the needs of young people, will affect both users and providers in many ways.

In **organisational** terms, changes in staffing, buildings and equipment are key enablers for service delivery and for the achievement of outcomes. Organisation changes will need to be in place well in advance of the desired outcomes.

A vision of service and organisation will help funders understand both the benefits being sought (the outcomes) and the required investments.

The vision for service is most important for those who pay for healthcare and those who use it. They will want to understand how service changes might affect them.

Staff in an organisation will want to understand their future role and contribution and how change might affect their working and personal lives. The vision of change in organisational terms is most significant for this group.

Sometimes the vision of change is unclear. You know about all the problems but the solutions have yet to be identified and appraised.

In this situation the vision of change will have to be described in terms of the journey and first steps to make the vision clear. This is hard for colleagues as anxiety is raised during the discussion on the need for change, and remains high given that no obvious solution exists or has not yet been considered in detail.

KEY POINTS

A clear vision provides a positive view of the future to counter the anxiety raised by the acknowledgement of current problems and issues. It will address desired outcomes and describe both service and organisational features. These aspects are vital to address the different interests of key stakeholders. In the early stages the vision of change may be clearer about the desired outcomes than about the specific solutions in service and organisational terms. In this case the vision will need to include something on the first steps of change.

THE WHO OF CHANGE

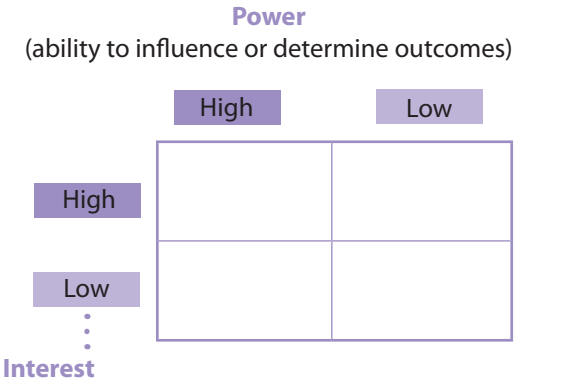
Success in making difficult changes often depends on effective involvement of key individuals or groups. But there are important judgements to be made on who needs to be involved and how.

It is easy to generate lengthy lists of individuals and organisations potentially affected by the change. This exercise can rapidly become unmanageable. So there is a need to focus effort and energy on those who really can make or break the change effort.

Fig.6 Stakeholder map

This is where we use assessments of power and influence and make judgements about whether individuals and organisations are likely to advocate and champion change, or block it (fig.6 and 7).

Fig.7 Assessing stakeholders' power and interest



The next step is to plan how to manage the key stakeholder groups to optimise levels of active support and to minimise resistance (fig.8).

Fig.8 Planning stakeholder management

Stakeholder (individual or group)	Key interests and issues	Desired support or project role	Actions and communi-cations

In order to make an accurate assessment it is important to understand what motivates the key stakeholders as well as considering their personalities, temperaments, and their needs. This will help you to take a view on:

- How they might initially regard the change (positive and negative);
- What might provide some motivation to back the proposals or how proposals might need to change;
- What role they may wish to play;
- How they might be involved.

There are many theories that can be employed for an initial appraisal (fig.9 and 10)[2].

Needs based theories of motivation can assist in understanding the fears of loss that some may associate with change, or what might be potentially attractive.

Fig.9 Motivation theories

Herzberg	Maslow	McClelland
Achievement Work itself Responsibility Advancement and growth	Self-actualisation	Need for achievement
Recognition	Esteem needs	Need for power
Supervision and relationships	Belongingness	Need for affiliation
Job security	Safety needs	
Pay and working conditions	Physiological needs	

[2] For more information see Moorhead & Griffin, 1995.

Fig.10 Application of the Myers-Briggs Type Indicator (MBTI)

Energy	**Extraversion (E)** Prefers to draw energy from the outside world of people, activities and things	**Introversion (I)** Prefers to draw energy from the internal world of ideas, emotions and impressions
Information gathering	**Sensing (S)** Preference for taking in information through the senses, and focusing on the here and now	**Intuition (N)** Preference for taking in information through insight, and noticing possibilities
Decision making	**Thinking (T)** Preference for deciding according to general truths, logic and objectivity	**Feeling (F)** Preference for deciding according to person-centred values and harmony
External world	**Judging (J)** Preference for closure, and a planned and organised life	**Perceiving (P)** Preference for spontaneity, open-endedness and flexibility

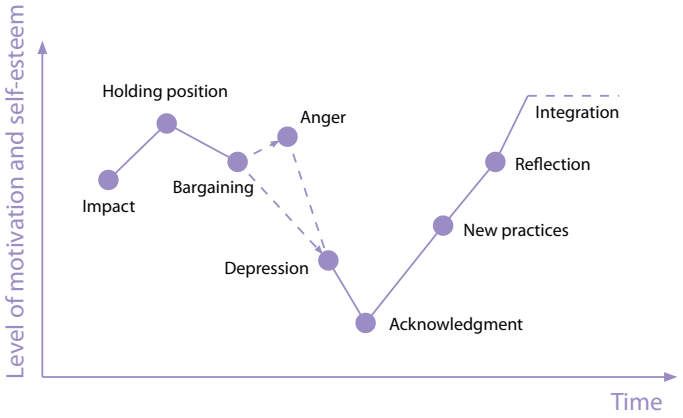
Theories of personality can assist in understanding how best to communicate and work with individuals. Some people will work best with data and detail, others may be better at concepts and ideas. Some will be more comfortable in large groups, while others will need the opportunity for individual reflection and small groups.

Above all we need to recognise the various phases of psychological change that organisations and individuals might experience, in order to ensure that the right level of communication and support is offered at the right time.

For organisations or groups there may be discernable and distinct phases of change; moving from early steps to prepare the ground to providing a platform for the next phases of movement and then consolidation.

Both individuals and organisations experience the turbulence of transitions from old to new. On a personal basis the feeling of loss may come before the exhilaration of gain. This is shown in the Change Curve (fig.11).

Fig.11 The Change Curve



KEY POINTS

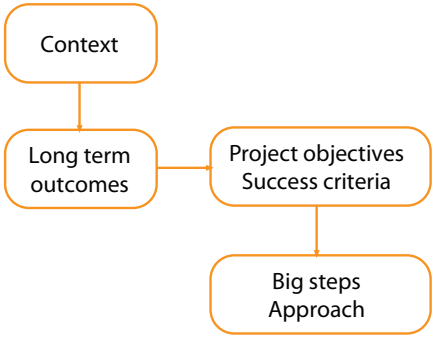
Contentious and difficult change requires sensitivity to those affected. Change management begins to resemble a political campaign starting with calculations about who is affected and who needs to be involved, and then moving to a plan of engagement working at the rational and emotional levels.

THE HOW OF CHANGE

Being clear about the journey is important not only to reach the destination but also to provide reassurance to those who are making the trip.

As mentioned in the previous section, significant change programmes have a predictable set of phases, requiring planning at both the conceptual and more detailed level. This can help to design the change process as a project, with specific objectives and activities.

Fig.12 The big steps



The **big steps** provide an overview of a change programme which might last for weeks, months or years.

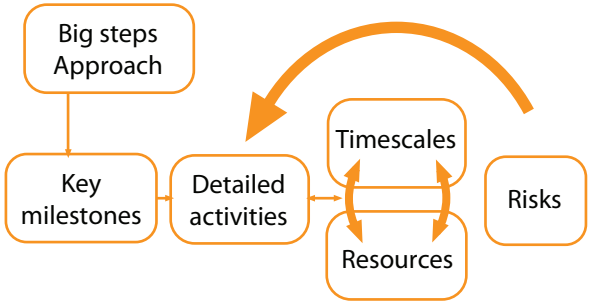
The first phase in the change process is often the building of the case for change and the development of clearer visions for services and organisation.

The second phase ushers in a set of investments around people, systems, processes and capital assets, sometimes moving through intricate pilots before permanent solutions are put in place.

The third phase may be the commissioning of new services, with evaluation and consolidation occurring in the final stages.

Within the phases, we need much more **detailed plans** to address what needs to be done daily or weekly.

Fig.13 The detailed plan

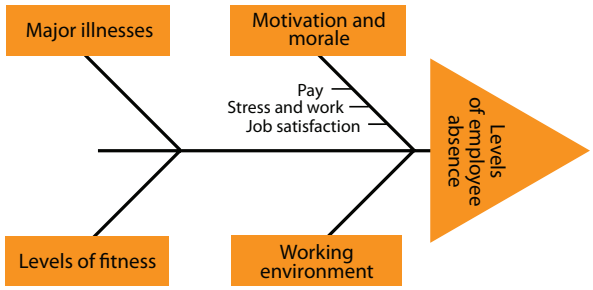


Journey planning requires good **process thinking**. By process we include all the rational steps in moving from A to B as well as the steps required to address the psychology of change.

If the process is effective, you will end up with solutions that are grounded in reality and command the support of key stakeholders.

Successful group work will require some more process planning in terms of the tools and techniques to be used in sessions to make progress from problems to solutions. A wide range of tools and techniques can be deployed. Some of them support creative and divergent thinking (brainstorming, and a range of lateral thinking techniques), others facilitate convergent thinking to explore in depth and specific aspects of a task or problem in hand (Fishbone analysis, problem analysis, decision analysis)[3].

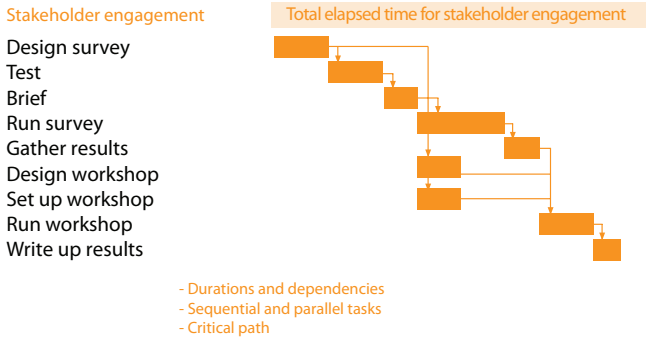
Fig.14 The Fishbone



All these elements will come together in the form of a consolidated plan making clear the mid-points of success as well as the actions and the relationship between the actions.

The first steps are critical and many of these may be focused on getting the key stakeholders together to work on the case for change and the vision (fig.15).

Fig.15 The consolidated plan



KEY POINTS

The successful delivery of change needs to be planned for each phase. Good process thinking will move from big to small steps integrating action to make progress on the task, as well as influencing individual and group psychology. You need to have a clear methodology with a good choice of analytical tools and techniques.

But this needs to be combined with the most effective processes of engagement of key stakeholders to ensure acceptance, support and commitment to solutions.

[3] For more information on these techniques see the references on page 25 on 'Process thinking skills'.

THE WHAT IF OF CHANGE

The path of service and organisation change can be beset with problems and pitfalls. Some will be political, others will be technical.

Many of the problems can be anticipated: equipment and systems that don't work or are delivered late; poorly trained staff who find it difficult to function in the new environment; time and cost overruns due to late procurement; rejections of proposals by key stakeholders.

Anticipating problems and analysing likely causes is an essential part of managing risk during change. The thinking around risk requires challenging the original plan with a critical eye. This is intended to test the robustness of thinking.

So we ask the question "What can go wrong?" and we give priority to problems that are more likely to occur and to those that have the most significant impact on our change plan.

Risks can be avoided or minimised by preventing problems occurring in the first place, or by establishing contingency plans to deal with them when they do arise.

Fig.16
The risk assessment and plan

Potential problem	Consequences	Possible causes	Preventive actions	Contingency plan

KEY POINTS

The 'What If' of change is deliberate 'negative thinking' about what might go wrong. This is essential to develop a sound approach to change which takes potential risks into account. A collective assessment of problems and their causes can open up positive thinking to prevent or minimise the risks.

CASE STUDIES

Two case studies illustrate the application of the **Five Wonders of Change**. Case Study 1 is based on a change process developed by a group of participants in the programme for Iraqi health professionals and then implemented on their return to Iraq. Case Study 2 is drawn from a review of UK-based change processes conducted by Iraqi doctors.

1. THE INTRODUCTION OF TRAINING PROGRAMMES FOR IMPROVED SELF-MANAGEMENT BY DIABETES PATIENTS

The Why of Change

Participants began their assessment of the current situation with an analysis of the incidence of diabetes within the general population in Iraq, and the consequences of poor management of the condition for individuals and their families (Box 1).

The groups then used a strengths and weaknesses (SWOT) analysis to comment on the current approach to education for patients on improved self-management.

Box 1 - Why change is needed on diabetes care in Iraq

Public health issues

- Increasing prevalence of Diabetes Mellitus (DM)
- Understanding the disease, its treatment and complications is highly important for patients to live normally
- Poor disease management leads to complications, resulting in increased vascular disease and the associated risks of limb amputation and blindness
- Poor control and complications of type 1 DM are due to poor educational standards

Assessment of current approach

- Diabetes management including education is undertaken by doctors in outpatient clinic time
- Doctors have limited time; as a result patients have limited understanding of the disease and what they can do to self-manage
- There is no specific educational program for health care centres and general hospitals
- Some specialised diabetic centres provide basic education programmes, but do not follow modern evidence based approaches

The What of Change

The project made clear the desired health and quality of life benefits for individuals and communities, as well as the desired economic impact, as costs of hospital care are reduced.

Then participants went on to set out their vision of the training programme and the team that would be required to support patients and their families (Box 2).

At this stage it is a broad vision, with much of the detail to be worked out in the early phase of the project (for example how many trainers there should be and where the training should take place).

Box 2 - The vision of change

The vision of outcomes and benefits

- Preventing disease complications
- Reduction of the economic burden on the patient, health care facilities and community
- Reduction in hospitalisation rates
- Easing the burden on doctors
- Giving patients the choice to eat a normal diet

The vision of service

- Translation and accommodation of international DAFNE[4] approach in Iraq
- Establishing effective education and training programme at the level of primary health care centres, and in more advanced health care facilities (e.g. general hospitals)

The vision of organisation

- Improve the educational standards of medical staff and patients
- Initiation of a team capable of handling all aspects – helping patients in Primary Health Centres (PHCs) and assisting in the establishment of similar programmes in other PHCs and other major general hospitals
- Making the treatment of this disease a team effort, rather than just a doctor-patient effort

[4] Dose Adjustment For Normal Eating (DAFNE) is a way of managing Type 1 diabetes.

The Who of Change

A long list of stakeholders had to be considered to move forward the project. These ranged from patients and their families to healthcare professionals and policy makers.

The assessment of power and interest placed emphasis on the executive senior manager of the hospital and senior doctors. However it was clear from later analysis that some of the less powerful but supportive stakeholders could be enabled to have more leverage on discussions. General Practitioners (GPs) were seen as a key group with influence, but little interest at this stage. They then became the focus for analysis, and specific actions were identified to engage them.

Box 3 - Stakeholder analysis

High interest, high power	High interest, low power
1. Ministry of Health 2. Senior doctors 3. Executive senior manager	1. Patients 2. Some of the doctors (especially senior doctors) 3. Junior health workers and some of the junior doctors
High power, low interest	**Low power, low interest**
1. Senior doctors 2. Senior administrative managers 3. Other health workers, senior managers 4. Non-governmental organisations	1. Patients 2. Health care workers 3. Junior medical staff 4. Nurses

How to gain the interest of GPs toward the project?

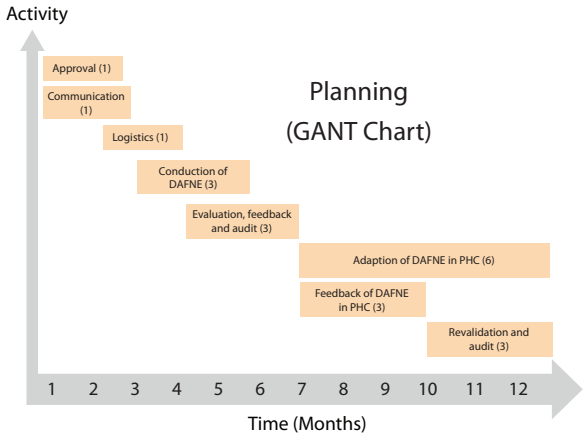
- Meet groups of GPs
- Inform them about the benefits of the project
- Ask them for help and support
- Involve them in the project
- Give them opportunity for training
- Listen to their feedback
- Rewards (gifts, certification, financial support)

The How of Change

Participants identified the key steps in moving forward with the introduction of the training programme. The example (Box 4) shows that there is a phased approach to implementation, with a trial programme in the first phase prior to wider roll out.

Box 4 - The plan of change

1. Identification of the managing team
2. Development of curriculum
3. Attracting funds
4. Identification of executive teams
5. Choosing the training medical centre
6. Starting the trial programme
7. Follow up
8. Launching a wider programme
9. Monthly training courses for more than 20 paramedical staff
10. Periodical training courses for doctors in PHCs and general hospitals



The What if of Change

In reviewing the plan participants identified a number of potential problems (Box 5). Poor trainee performance was seen as particularly problematic. Incentives would need to be put in place at the outset, and retraining offered as a contingency in case of poor performance.

Box 5 - Risk assessment

Key risk areas	Likely causes	Preventive action	Contingent action
• Poor trainee performance (high probability, high consequences)	• Poor calibre • Lack of motivation	• Rigorous selection • Work on reward and recognition programme	• Re-training of staff

2. THE DEVELOPMENT OF A NEW URGENT CARE CENTRE WITHIN COMMUNITY BASED WALK-IN CENTRES

The Why of Change

Participants began their assessment of the current state with an analysis of the current local system for urgent unscheduled care. They used a strengths and weaknesses analysis to draw conclusions on the need for change locally.

Box 1 - Why change is needed in urgent care

Current system

- Local Accident and Emergency (A&E) department within specialist teaching hospital
- 2 local walk-in centres (1 located by A&E)
- 50 local General Practices and Out of Hours services
- 35 pharmacies
- Specialist clinics for sexual and mental health
- The Ambulance services
- NHS Direct

Strengths and weaknesses

- Extensive range of options for local residents and visitors
- Ease of transport links to the local hospital
- Increased use of A&E leading to long waits and higher costs per case
- Up to 40% of A&E attendances for primary care conditions
- High numbers of discharge without follow up
- Higher admission rate
- Difficulties in gaining access to GPs during hours for urgent consultations
- Confusion by members of the public on which service to use when
- Cost burden of unnecessary hospital care
- Unaffordability of system given population growth

The What of Change

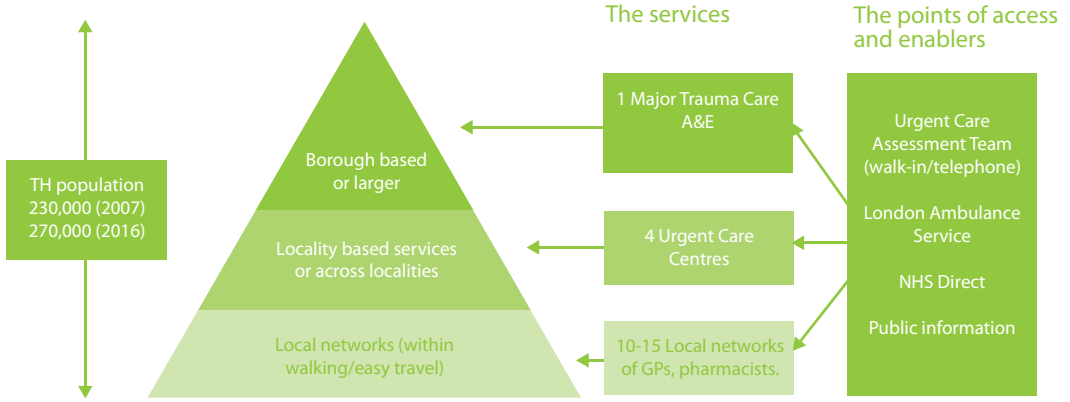
The vision for service covered outcomes and desired benefits for the community in terms of access to the service as well as value for money for taxpayers (Box 2). The vision for service was a new model showing support for urgent and non life threatening conditions from enhanced local primary care networks and four local urgent care services. Access would be assisted by one call centre. Emergency and trauma services would continue to be provided by the local hospital.

Box 2 - The vision of change

The vision of outcomes and benefits

- Easily accessible and understandable system for local people
- Improved locally accessible services
- Reduced waiting times
- Better use of hospital system and improved value for money
- Enhanced information and service for self-management

The vision of service



Drawn from: Tower Hamlets Urgent Care Strategy, 2008-2014

The Who of Change

A long list of stakeholders had to be considered to move the project forward. These ranged from patients and their families to community and hospital based healthcare professionals, the Ambulance service and NHS Direct. Analysis of current service use showed that considering the particular needs of different local groups was key to understanding current preferences and designing the new local centres.

Box 3 - Stakeholder analysis

Key stakeholders

- Local communities and user representatives
- GPs
- Hospital based A&E consultants and senior nurses
- Primary Care purchaser
- Key clinical representative groups
- Local Authority

Segmentation of community groups

- By locality
- By age group
- By ethnicity

The How of Change

The change programme was built around a number of developmental phases. In this way investment in people, systems and facilities could be carefully planned and then implemented to ensure smooth assimilation of new services with re-shaping of existing services.

Box 4 - Plan of change

- **Phase 1** Formal establishment of new processes at the front end of the A&E department with incorporation of an assessment team. Start up of first set of new community facilities. Establishment of new telephone service and enhanced access to local GP services.
- **Phase 2** Opening new purpose built emergency and trauma services at the new hospital. New clinical assessment and management pathways in place and utilised in the Urgent Care Centre based at the front end of A&E.
- **Phase 3** Opening of three other new Urgent Care Centres in the localities. Roll out of clinical guidelines and pathways developed for the hospital based Urgent Care Centre.

The What if of Change

This was an extensive five-year change programme and given the length and complexity of the programme, there were a number of risks to be assessed. These included macro risks arising from the general economic climate to more localised risks involving continued reliance on the hospital despite the investment in new facilities.

Table 2 Risk assessment for urgent care development

Key risk areas	Likely causes	Preventive action	Contingent action
1. Less money available for investments in local system	• General economic situation	• Development of more flexible plans within each of the phases based on two financial scenarios	• Revision of phases of change at the end of phase one
2. Local people continue to look to hospital for care	• Lack of awareness of alternatives and ease of access • Continuing difficulties in accessing local GP • Continued belief that best care is to be found in the hospital	• Planned local marketing campaigns using local media and key information points • Clear focus on improving access to GP services	• Revision of incentives to ensure that local commissioners take prompt action to influence local behaviour
3. Workforce shortages undermine new services in the community	• Insufficient numbers in training for new nursing positions • Inability to recruit locally	• Urgent attention given to workforce plan • Work with local partners to promote opportunities for local people	• Plans for re-deployment of nursing skills to cover critical shortages

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> My whole way of thinking changed, and this has helped me with the various projects that I have been carrying out in my hospital.

An Iraqi programme participant

Change management has found recognition as a discipline mainly across the private and public sectors of developed countries, but has been used less frequently in the context of developing and middle income countries.

At HLSP we have applied change management tools and techniques within projects in those countries. We have drawn from our experience to produce this practical, jargon-free guide to change management. The booklet sets out the five key steps for the successful planning and implementation of change. The approach is illustrated with project examples from HLSP's recent programme supporting doctors from Iraq to bring change to their healthcare services.

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