Health Services Management Centre

UNIVERSITY OF BIRMINGHAM

Middlesex University London

An adult social care compendium of approaches and tools for organisational change

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Robin Miller

Tim Freeman

Deborah Davidson

& Jon Glasby

Acknowledgements

Disclaimer

Contents

Purpose of compendium

The purpose of this compendium is to support managers working in adult social care to be more knowledgeable about and confident in the application of different approaches and tools relevant to managing change in their organisations. In the compendium an 'approach to change' is used to denote an 'overarching framework that can guide a change process' and 'change management tools' as 'techniques or templates to understand or support a specific aspect of the change process'. Examples of the latter would be stakeholder mapping exercises, organisational diagnostic methodologies, engagement processes, and direct team based interventions. The compendium does not provide detailed guidance on how to apply each approach and tool, but presents an accessible overview of what each entails, the thinking that lies behind them, and (where available) a reflection on the empirical evidence of their application in practice. Having access to this information will help to demystify the often confusing and intimidating terminology that surrounds change approaches, and in doing so will enable managers to identify the approaches most relevant to a change they are leading and explore in more depth. Understanding the method being followed will also support individuals who access services and their families to engage on a more equal playing field within a change process. This includes people who access services and their families.

While potentially relevant to social care managers working at all levels of an organisation, the compendium is specifically designed for those responsible for a single service (e.g. home care team, residential care home) or team (e.g. care management team), and those who directly manage service and team managers.

Structure of compendium

The compendium has main two sections:

Section 1   Fictional case studies which illustrate how four key approaches to change could be deployed within adult social care. These case studies also illustrate how other change management tools could be incorporated within such a change process. Further details and supporting resources for each approach and tool are provided in Section 2.

Section 2   A directory of change approaches and change management tools based on a review of current literature including available empirical research and the views of people who have experienced and led change. A short commentary on the application of the social care change principles through these approaches is also provided.

Appendix 1   A full reference list.

Process of development

An initial high-level literature review of seminal texts in the field of organisational development known to the authors was completed to identify commonly deployed 'approaches to change' and 'change management tools' within the field of organisational development. An advisory group that included representatives of individuals who access services, wider partners, service providers and commissioners provided insight into change within adult social care and the principles that should underpin it. These insights were used to develop a short-list of approaches and tools for further review. Consultation was undertaken with experienced change practitioners and national social care leaders on the emerging principles and short-listed approaches and tools. This led to the selection of four overall approaches to change and a number of change management tools which were subject to further literature review. Finally, additional consultation with the advisory group and the change practitioners helped to identify change scenarios commonly encountered by adult social care managers which could be used to illustrate the practical application of the approaches and tools.

Principles of change in adult social care

Organisational change management involves assisting people moving from arrangements that are familiar and predictable to a future scenario that is often uncertain and unfamiliar. This may result in anxiety and stress being felt by individuals, their families, and staff who work in the services. As a consequence leading a change process can be difficult, particularly when there are a range of options and a lack of agreement about which is the best one to take. In such situations it can be helpful for those responsible for leading organisational change to have a set of principles to guide the process that they follow and the decisions that they make. Principles have the potential to act as a common binding vision of what is important, a compass to guide direction in complexity, and a standard by which those leading change can evaluate their practice. They help to clarify how underlying values (or 'what people commonly believe is worthy or valuable') can be applied, including situations which are contested and unclear (BASW 2012). Common principles held in adult social care include: the need to uphold the rights of all, to promote the welfare and inclusion of those who are disadvantaged, and to recognise and build on the assets of individuals and their communities (Waine et al 2005). These reflect those held by the field of organisational development, which arose out of a recognition that people who work in companies are more than resources to be deployed and that they have a right to be treated with respect by senior managers (see e.g. Jones & Brazzel 2006).

For this project, principles were required to enable the assessment of different change approaches and their relevance to adult social care. However, whilst those involved in such initiatives may have had an implicit personal understanding of what these principles will be, there was at the time of the compendium's development' no agreed national set of organisational change principles. Building on previous work published by Skills for Care (2009), SCIE (2007) and the perspectives of change experts and wider stakeholder groups, we

developed a set of principles regarding change management in social care (below). These were used to consider relevant change approaches highlighted in the literature and to develop guidance about how the selected approaches could be used in practice. They could also be adopted more generally to underpin organisational change initiatives.

Principles of change management in adult social care

■ **Be co-produced with users and carers and facilitate positive engagement with staff and other stakeholders**

All participants in the project emphasised that central to modern adult social care practice is active involvement of people who use services and their families in shaping and deciding on the overall purpose of a service and how it should be delivered. Frontline workers were also seen to play an important role in guiding organisational change due to their knowledge of the needs and aspirations of people who access services and their central contribution to a good quality of care.

■ **Be based on a clear purpose with defined timescales, outcomes and indicators**

A common weakness raised by study participants was that the expected outcomes of the change were not clearly specified. This meant that it was difficult to know if the project had made the required difference to the lives of people who accessed it, the organisation and the commissioner. There was also a danger that in such circumstances the need to save money could become the main priority and improvements in service quality were lost.

■ **Be well planned and coordinated with flexibility to adapt to other changes that emerge**

Most participants reported experience of change projects which had either been delayed or derailed during their development or implementation. This was seen to be often due to those leading the change project not sufficiently planning what would happen and when, and taking action when circumstances or requirements altered. External factors beyond the change team's control were sometimes to blame, although at times the potential for these could have been predicted and contingency plans put in place.

■ **Be sensitive to local governance and political processes to ensure initial agreement and long-term support**

A key influence on the success of a change project was the degree of support of senior management. Particular challenges were raised when there was a new political party in control of a local authority, but independent organisations also experienced changes in the views of their governing bodies or senior management team. Seeking positive engagement and endorsement throughout the life of a project were therefore seen as vital.

- Be an opportunity to promote learning and development, and develop trust and partnership between stakeholders

There were many accounts of the negative impacts that could result if the change process had not been managed constructively. These included a loss of trust between key stakeholders and the organisation or service, a disillusioned workforce, and people who access services and their families feeling powerless and excluded. These negative impacts could be experienced even if technically the change project had delivered the organisation's objectives. Equally, if a change process was committed to working with people, was led honestly and transparently, and was willing to listen and adapt it could help to set a strong foundation for future engagement and joint-working. This could be the case even if the project had not ended up achieving the initial objectives. It was also reported that in general adult social care organisations are poor at drawing out learning from the success or otherwise of change projects and sharing this within the organisation and the wider adult social care community.

The future

The University of Birmingham, the University of Middlesex and NIHR School for Social Care Research are working with the Social Care Institute of Excellence to produce an on-line interactive version of the compendium. We hope that this will be of interest to the management community in social care, and that managers will share their practice experience of these approaches and identify other approaches of relevance.
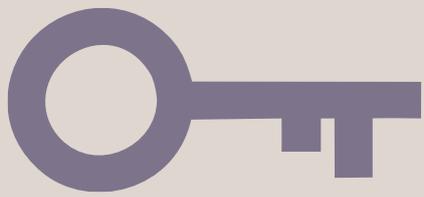
Section One

Four key approaches
to change

Introduction to Section 1

In this section four key approaches to managing organisational change are illustrated through the use of case studies. Whilst fictional, the case studies are based on common change scenarios that are faced by adult social care managers. They also draw upon organisational development work that has been previously undertaken by the authors and the change agents involved in the project. To select the key approaches we drew upon the practice experience of our participants, the evidence from research literature and the extent to which the approaches reflect the principles of social care change discussed above. They are not presented as the only or indeed the best way to approach change as this will depend on the context, the nature and scale of the change, the available resources and other issues of each situation. However they are recommended as change approaches worth exploring in more depth. Fuller details of the change approaches and change management tools are given in Section 2.

It was clear through our consultations that change in adult social care needs to a degree to be a pragmatic process. We therefore take a 'real' rather than 'ideal' world view to the implementation process whilst remaining true to the key principles within each approach. Our real world perspective also includes deploying other change management tools within and alongside the key approaches to change. The case studies and the approaches they illustrate are summarised below.

Case study	Approach to change	Scenario
A	Appreciative Inquiry	Personalising practice in a care home for older people
B	Lean	Improving care management process in an adults assessment & care management team
C	Action Research	Integrating social care services with health services and third sector organisations in a mental health recovery hub
D	Soft Systems Methodology	Replacing a care home for people with disabilities with supported living opportunities

NOTE: more details of the approaches and the tools are provided in Kection two.

Each case study is structured in five sections which reflect a social care friendly version of the planned cycle of change (see Diagram 1 below). Such cycles are used within organisational development to provide a framework to guide a change process. In the text of the case studies, change management tools highlighted in bold are included in the directory in Section 2.

Diagram 1: Planned Cycle of Social Care Change

UNDERSTAND
Identify potential data sources
Gather & analyse data
Develop multiple perspectives

DECIDE
Share findings and developing conclusions
Prioritise areas for improvement
Structure evaluation and feedback
Agree what will not be changed

START
Develop capacity & resilience
Establish authority & responsibility
Clarify the focus & set the outcomes
Map & engage stakeholders
Put people and their families at the centre

Social Care Change Cycle

IMPLEMENT
Sequence co-ordination the change process
Maintain involvement and participation
Build in learning & development

SUSTAIN
Embed into process, behaviours and practices
Review learn and improve

Case Study A:
Appreciative Inquiry in a care home for older people

Background

Acorns care home for older people was established 20 years ago by a local businessman. He and his wife ran it as a family business, and as they were not from a care background employed a home manager. The owners sold Acorns to a Housing Association which runs a number of care homes in the area. The home requires refurbishment and had been carrying a number of bed vacancies which meant that the previous owners were reluctant to spend additional money. All of the staff members in the home have been transferred over to the Housing Association, except the previous home manager who decided to retire. The staff group were caring but outdated in their approach – this reflected the approach of the previous home manager. There was a 'Friends of Acorns' group associated with the home that raised charitable money and was largely made of families of current and previous residents.

Case Study Manager A

Manager A was the home manager appointed by the Housing Association.

*The Organisational Brief to Manager A*

- To update care practices in the home.
- To provide a modern living environment that draws upon relevant technologies.
- To fill the current vacancies.

The overall approach to change

Staff members in the home were largely a well-meaning and caring set of individuals who had become out-dated in their care practices. In particular, they had a traditional 'care for' perspective in relation to the importance of people having control over their lives, people contributing to the day-to-day running of the home, engagement with the local community, and opportunity for people to take risks. Morale was low as the previous owners appeared to blame the staff group for the home not being able to fill their vacancies and many felt that their failings had led to them being 'sold' to the housing association. They further saw the change project as being instigated to respond to their poor practice. That said, they were still proud of their work, had a sense of responsibility for the people living in the home, and had stuck with the home despite its low wages and poor promotion opportunities. People living within the home seemed reasonably content but spent considerable time in their bedrooms or dozing in the lounge. Families felt that their relatives were safe and that this was the most important issue – many privately expressed frustration that the staff group were so criticised when they are 'doing a good job'.

To address the low morale amongst the staff, Manager A was keen to take an approach which emphasised the positives within the home rather than being seen to once again highlight the things they were not doing well. She therefore decided to use **Appreciative Inquiry** as an approach to underpin the change. Many traditional approaches to change focus on what is not working as a means to avoid similar problems in the future. **Appreciative Inquiry** instead seeks to understand the positives, and to use these as a platform for future improvement. It is based on the premise that organisations and individuals will move towards the positive images that others have of them. It follows a process which seeks to identify the best of what *could be*, discuss what *should be* and then taking action to create what *will be*. **Appreciative Inquiry** seeks to overcome individual and team resistance to change through generating a common and inspirational vision. It does not start with a set premise about what the end result will be but instead the future gradually unfolds through conversations, stories and discussions.

Diagram A1: Appreciative Inquiry
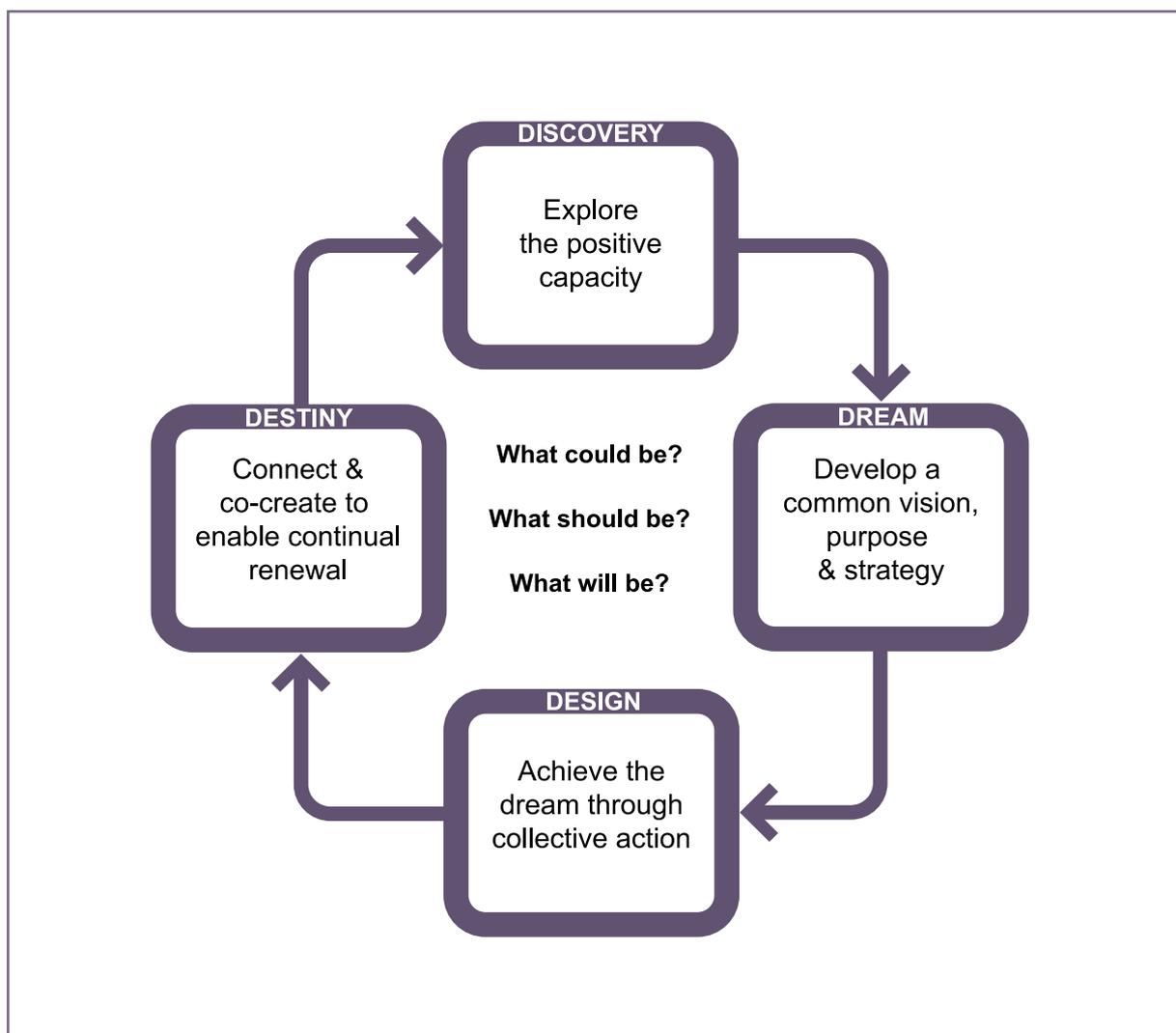
Starting the Change

To begin the change process Manager A met with key stakeholder groups to gain their initial perspectives about both the *content* (i.e. what the change should be) and the *process* (i.e. how the change will be achieved). This stakeholder engagement included:
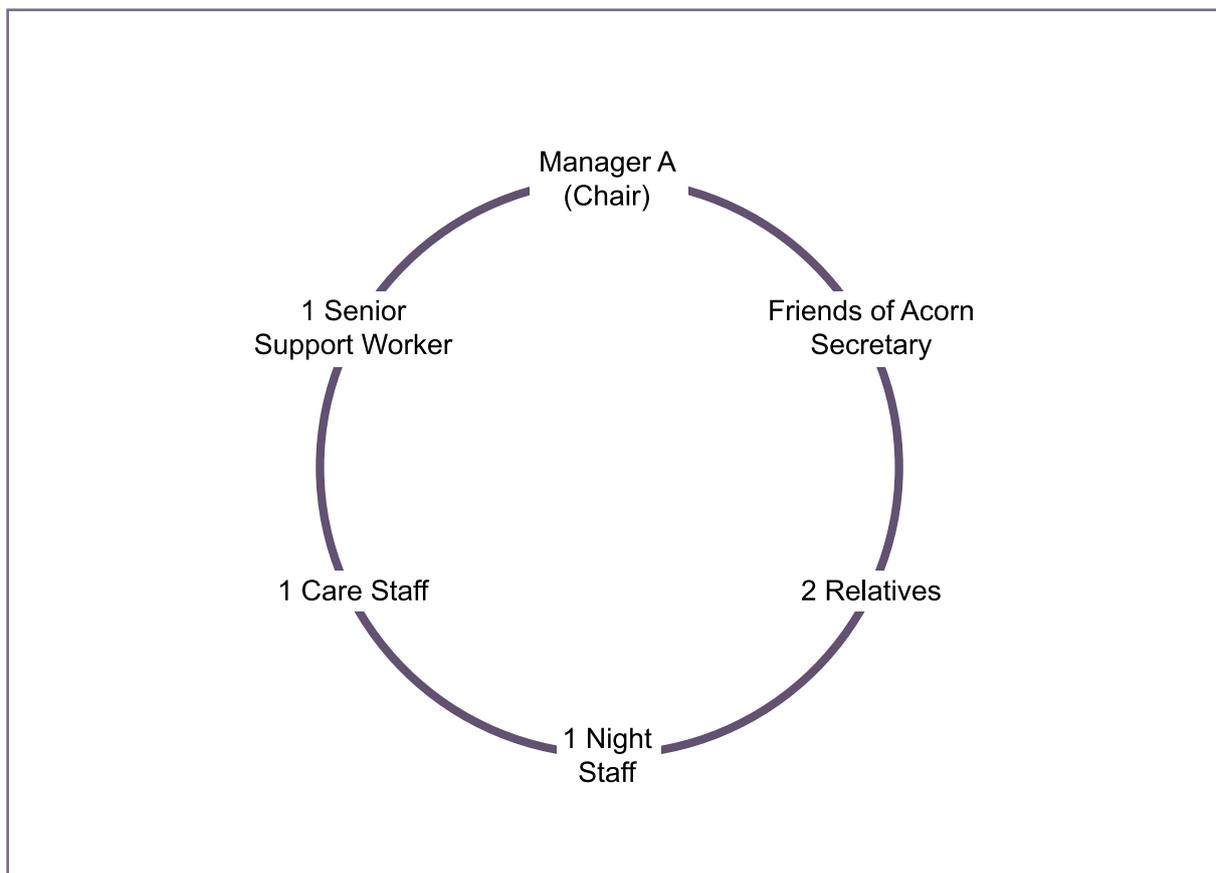
- Spending a day in the home talking to the residents and observing their interactions with staff

- Being present on a Sunday afternoon in the home (when many of the families visit) talking to the relatives and then staying on to talk with the night shift

- Attending a staff meeting

- Meeting with the chair of the Friends of Acorns

- Consulting with her line manager in the Housing Association

On the basis of these discussions and her previous knowledge Manager A developed a **Power Interest Grid** of these stakeholders (Diagram A2). The tool recommended that people with low power should be monitored or informed of the change but not necessarily engaged within it. Manager A however reflected that in social care it is often the people who will be most affected who have least influence and it is vital that they are given a voice within the process. This highlighted for her the importance of thinking through how to put people living in the home at the centre of the process. She therefore secured funding from the housing association to commission a local advocacy group for older people to help support their engagement and representation. She also reflected that night staff are often excluded from such discussions, and therefore ensured that a member of night staff was able to participate in the change team (Diagram A2).

Diagram A2: Power-Interest Grid applied to Acorns

High Power	Housing association	Care staff working in the day
	Care management team	Engaged families
Low Power	Less engaged families	Care staff working at night
		People living in the home
		Friends of Acorn Home
	Low Interest	High Interest

Diagram A3: Change Team in Acorns

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                        Manager A
                         (Chair)


    1 Senior                              Friends of Acorn
 Support Worker                               Secretary




  1 Care Staff                                2 Relatives




                         1 Night
                          Staff
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Understanding the Change

The first stage of **Appreciative Inquiry** is 'Discovery' in which stakeholders share what is positive about the service. Initially manager A thought that it would be helpful to bring together different stakeholders. However, when she discussed with the change team their view was that the stakeholders might be reluctant to share their views with others present, particularly as this was a new process for the home. They therefore agreed that the 'Discovery' phase would be undertaken within stakeholder groups and once their confidence was developed they would then be ready to come together within the next stage. It was also recognised that there was no one way to engage with all the different stakeholders, and therefore a variety of approaches were deployed –

- *People living in the home*: each afternoon for a week the staff on duty asked people if they wanted to explore their views which were recorded on sheets in the day room of the two homes. The advocacy group also held two creative workshops in which people living in the home were encouraged to express what they valued about the home through paints and other medium.

- *Family*: questionnaires were sent to all family contacts and the members of the Friends of Acorns and two drop in sessions offered for people to share their views directly

- *Staff team*: two focus group sessions were undertaken with all staff (including night staff) required to attend one of the focus groups

- *External stakeholders*: Manager A contacted the team manager of the social work team, the clinical lead within the dementia team and the older person's commissioning lead in the local authority.

Within all of these the same questions were asked:

- What is good about Acorns?

- What is not good about Acorns?

- What resources have we got to make things better in Acorns?

A pure **Appreciative Inquiry** approach would have only asked about the positives, however Manager A wanted to understand also what stakeholders saw as the priority for change and therefore questioned about what was not working so well. The responses to different questions were written on postcards, with different colours for each stakeholder group. The change team spent half a day going through the feedback and theming the different responses to each question so that they could gain an overall picture of what was seen as good and what could be used to make it better. The aims of the initial brief from the organisation regarding the environment and filling the vacancies had also been raised by most stakeholders. Feedback regarding the practice in the home had been mixed, with many people supporting the current approach and being wary of any change. There were quite a few concerns raised regarding the potential for the housing association to change the caring culture of the home.

Deciding how to change

The second stage of **Appreciative Inquiry** is 'Dream' in which stakeholders come together to develop a 'vision' of how the service can be better, a 'purpose' to create the vision and a 'strategy' of how to move to this vision. Key to the process is that the 'Dream' has to be shared – by the key stakeholders. If they do not share the vision then there is a danger that there will be resistance from stakeholders that will prevent the dream being achieved. Ideally, the change team wanted to hold an event to which all the residents, carers and staff would be invited. However, when they thought through the practicalities and cost of holding such an event they realised that it would not be possible. Most of the people living in the home would find a gathering with so many people a difficult experience. Furthermore from the 'Discovery' phase it looked as though there were few relatives who would actually want to participate.

The change team therefore decided to invite a sample of staff, relatives and the friends of Acorns to a workshop to develop a 'Dream' which would then be shared with the wider range

of stakeholders. The findings of the 'Discovery' stage were shared and those present asked to consider how they could build upon what was seen as being good, and respond to what was seen to be less good. The workshop identified a better environment, more selection of food and a better range of activities but did not come up with more visionary ideas. The workshop participants seemed to be unable to move beyond making what they a bit better. They could also not see how they could make any major changes without more funding for staffing and they knew this was not an option. At the end of the session everyone, including Manager A, felt deflated.

Manager A discussed with her line manager what had happened and the lack of momentum. He suggested contacting another home in the neighbouring area which was seen as a national example of best practice. Manager A arranged for the change team to visit the home. They were impressed by the way in which residents were involved in undertaking day-to-day tasks. Two hours per week of support had been separated out for each person in an Individual Service Fund in order to facilitate them undertaking an activity of their choice. This could be used each week or saved up for a longer activity. Underpinning the support were individual person-centred plans for each resident. A second workshop was held and the change team fed back what had been observed during the visit. At the end of this workshop there was a very different vision that was based on a set of principles regarding what people can expect from the care in the home and a set of outcome statements regarding what this would look like in practice if successfully implemented.

The vision was shared with people living in the home, staff team and families and comments received about how it could be improved. Suggestions were made for minor amendments and additions but there was a general agreement about what was being proposed.

Implementing the change

Having established the vision, Manager A met with the change team to undertake the 'Design' of the new care at Acorns (the third stage of **Appreciative Inquiry**). They looked again at the feedback about what was good and what needed to improve, and did a mapping of the vision and the degree to which they were currently meeting the aspirations of the vision. To facilitate this process and ensure that they thought creatively about the potential resources that could be drawn upon, Manager A suggested that they use **de bono's six thinking hats exercise** to help people to think differently. This also led to much laughter as Manager A went to the charity shops at the weekend and bought a range of unusual headgear.

They identified four main areas for improvement and potential strengths that can be built upon with Acorns (Table A1). Mini project groups were set up to take forward the different areas of improvement with representatives from the stakeholder groups, and one of the two deputy managers also present. A **Project Plan** was drawn up to ensure that the necessary activities were completed.

Table A1 Areas for improvement and current strengths in this area

Area for improvement	Strength that can be built upon
The environment within the home	Housing association had agreed to prioritise in next year's capital programme
	Friends of Acorns hadsome budget that they could contribute to new furniture
	One of the staff used to be a painter and decorator
	A number of the people living in the home were keen gardeners prior to admission
Making care planning processes more person centred	Staff members generally wanted to do the best for the people living in the home.
	Many people had family members who were in contact and could contribute to planning discussions
People living in the homes to be more involved in the day-to-day activities	There were some staff members who currently supported people to tidy their rooms rather than doing this for them.
	Two people living in the home were keen on baking and occasionally got to bake cakes with the cook.
	The care management team had a linked Occupational Therapist who would be able to provide training to staff
Promoting the home to local older people, their families and care management team	The Friends of Acorn held a jumble sale once per year which always generated considerable interest in the local community

One of the deputy managers agreed to lead on changing practice regarding the involvement of people living in the home within its day-to-day running. He organised a training session with the staff group to discuss how they might achieve this, but during the session a number of staff members started to raise concerns regarding the time that this would take and the potential risks to the residents. The deputy manager struggled to respond to this negativity and to avoid the conflict that was developing said that she would postpone the discussion and they should instead focus on how to promote the vacancies in the home. At the next supervision with

Manager A he was initially vague about what happened and then when pressed became upset. Manager A was empathetic but maintained that a further session would have to be organised. She suggested that the next week they discuss the **Thomas-Kilman framework** for understanding how people deal with conflict and that the deputy manager should consider what different approaches to use in the next training. At the following supervision session they considered how the deputy manager responded to conflict and identified that if possible he would choose to avoid it. They talked through how he could develop greater confidence and respond to different potential conflict scenarios in the next training session. He had decided to try and apply an Appreciative Inquiry approach within this and build on the few examples in which staff members did involve people who lived in the home.

Sustaining the change

Following the Appreciative Inquiry process there was enthusiasm for the agreed changes to happen and current strengths to be built upon. However, it was not clear how to implement these in practice and what had been tried previously would just be repeated. Manager A therefore decided to introduce the **Plan Do Study Act** cycle as a means to encourage the project groups and the staff team as a whole to pilot new ways of working and learn from what worked and what was less successful. Following a training session at the staff meetings, the deputy managers then explained the process to the project groups and took a lead in facilitating the **Plan Do Study Act** cycles that built on their ideas. One example was in trying to involve people more actively in their own reviews. It was recognised that each person would require a tailored approach for them (i.e. an individual **Plan Do Study Act** around each person's engagement) but that there was also general learning for how the staff as a group engaged (i.e. a group cycle that combined the learning and innovation from the individual **Plan Do Study Act**s).

One year after the implementation began Manager A repeated the 'Discovery' phase to review what was going well to date and to refresh the shared 'Dream'. Renewing the vision together enables the final stage of **Appreciative Inquiry**, 'Destiny', to be achieved and Manager A noted that those who participated seemed more comfortable with the approach than the first time they had been asked to contribute.

Case Study B:
Lean in a care management team

Background

The local authority brought together social workers and care managers from the older people, physical disability and learning disability teams into generic adult teams. Management posts were reduced, with team managers required to manage bigger teams and work outside their previous user group specialism. Alongside saving money by reduced management costs, the change aimed to deliver a more holistic service by removing the barriers that existed between the specialisms. It also hoped to improve assessment and care planning practice so that more people took up direct payments and were encouraged to rely on their own networks and resources rather than funding from the local authority. In general staff supported the principles of greater self-direction and use of community resources, but were cynical that the main interest of the local authority was to save money not improving quality of life of service users. The social workers often had a strong allegiance to their previous specialism and their ways of working– this was accompanied by a lack of interest or confidence in working with other user groups.

Case Study Manager B

Manager B was the new Team Manager. He previously managed an older people's care management team.

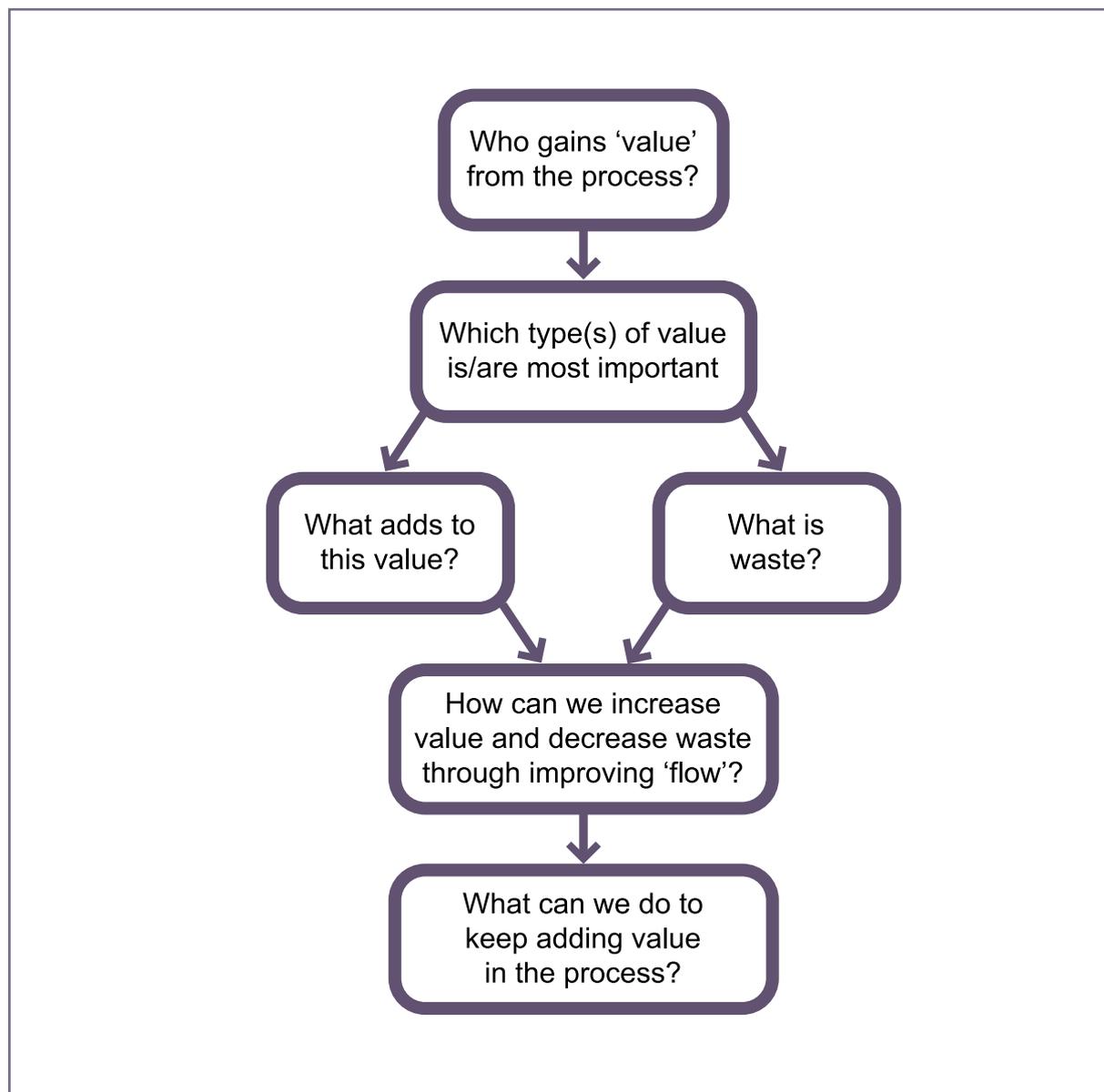*The Organisational Brief to Manager B*

To ensure that the team works together to ensure that all of the service users and their families are supported.

To oversee a change in practice which leads to service users and families relying more on their own resources and use direct payments to supplement these.

The overall approach to change

The previous specialist teams had different strengths but also weaknesses in relation to their care management processes. For example, the older people's team performed strongest in relation to meeting assessment timescales, the physical disability team had the highest proportion of people receiving direct payments, and the learning disability team were seen as being highly competent in relation to safeguarding. Manager B reflected therefore that he needed to ensure that the new team developed processes that combined the best of previous practice whilst phasing out of what had not worked well. The local authority had created a central team with expertise in improvement methodologies, and from discussions with them it was suggested that **Lean** could be a useful approach. The improvement team agreed to work with Manager B on implementing the approach.

Diagram B1: Lean Methodology

Who gains 'value' from the process?

Which type(s) of value is/are most important

What adds to this value?

What is waste?

How can we increase value and decrease waste through improving 'flow'?

What can we do to keep adding value in the process?

Developed initially within Japanese car manufacturing **Lean** methodology has been used within a variety of industries including health care. It begins by seeking to understand the value of a service or process, primarily from the perspective of people who access it, but also that of other stakeholders. Value adding activities are mapped out, along with those that are seen as wasteful through adding delay, duplication, and diversion from more beneficial activities. **Lean** is therefore particularly relevant for improving organisational processes, for example the referral, assessment and care planning pathways used by care management teams. As well as removing waste, the change centres around developing 'pull' rather than 'push' in the system.

This means that the next stage in a process is ready to undertake the necessary task rather than only doing so because it is under pressure from early stages.

Starting the Change

Manager B had set up a management team which comprised of the four senior practitioners from the previous teams and her admin manager. He decided that another project team was not required, but that at their monthly meeting they would dedicate at least an hour to the change process. Manager B was aware that culture has been shown to be a key issue in the merger of organisations and services. From discussions within the management team there had already been a few instances in comments had been heard such as 'that's not the way we do things in older people's services' and 'in the old days we used have a greater focus on the people accessing services'. The management team therefore brought together all the staff from the new team (including administration staff) into a full day workshop. Following a brief introduction the staff members were divided them into three groups which represented their previous specialism, and asked them to provide a pictorial representation of the previous culture in their teams using the **Cultural Web**. The groups then took turns presenting their **Cultural Webs** to the rest of the team, with opportunities for questions. This then led into lunch in which there was considerable discussion regarding the similarities and differences between the presentations. After lunch, participants were divided into three groups with mixed representation from the previous teams. They were asked to develop different aspects of what they would see as an ideal **Cultural Web** for the new team. When they had developed their initial ideas a 'carousel' exercise was used to share this with other team members and refine what the ideal culture would look like.

The day finished with a presentation by the improvement team on the **Lean** process that they would be following and an exercise in which the team identified the main stakeholder groups that they would deliver 'value' for. This was on the basis that the first step in using **Lean** is to 'specify value' from the customer perspective. Four main stakeholder groups were identified – the people who had their needs assessed and care managed by the team, their family carers, other services in the council including support services such as finance and performance, and external partners such as the NHS, housing associations, and third sector organisations.

Understanding the change

Working with his management team, Manager B identified different ways to gather data that would help to understand value from their stakeholders' perspectives (see table below). Whilst the questions were phrased differently, all stakeholders were asked about three key areas:

- What types of value do you need from this team?

- What types of waste have you experienced or observed from the team?

- What ideas do you have for improving the team's work?

Table B1: Data collection approached for care management team stakeholders

Stakeholder group	Methodology
People accessing the service	Details of complaints, comments and compliments that had been made over the past 12 months
Family carers	Working with the local Healthwatch group to seek feedback from people who access the service, their carers and local representative and advocacy groups

Writing to a sample of the people who are currently known to the team |
Internal stakeholders	Members of the management team met with a representative of the other services within the Council, including support functions and the other social work teams
External agencies	A short on-line survey was developed for partner agencies to record their perspectives
All	A twitter feed was created that was open to anyone who had an interest

As would be expected there were many issues raised in the feedback. The management team spent a morning feeding back the views that had been gained through the different data collection exercises. They brought together the main comments that had been made by each stakeholder group and summarised them under the three questions. They also developed a **Pareto Chart** based on the type of issues that people had identified.

The second stage of **Lean** is to 'identify the value stream for each process and identify 'wasteful' steps that do not add value'. The management team broke down the care management process into four key stages, and added a fifth element which reflected the requirement of the team to respond to urgent situations (Table B2).

Table B2: Key stages of the Assessment & Care Management Process

Stage	Details of process
Referral	Receiving contact, taking initial details, signposting to other services if appropriate, assessing if a full assessment is required
Assessment	Assessing need, identifying personal support networks, consider eligibility and calculating personal budget
Care planning	Developing support plan that builds on personal and community support networks
Reviewing	Reassessing eligibility, personal budget level and meeting of outcomes
Crisis	Assessing presenting need and risk, liaising with relevant services and arranging support package in short timescale

Manager B wanted to engage all the team members in an event to consider how the pathway could improved. The improvement team advised that this would mean too many people would be involved and the event difficult to manage. He therefore asked the senior practitioners to meet with the staff that they supervised and to explore with them their responses to the three questions above and to ask for volunteers to attend the improvement event. They also ideally wanted to involve people who accessed services in the event, but due to the variety of people that the team supports could not see how this could be done in practice. Instead he decided to begin with presentations of the feedback that had been gained from the stakeholder consultation, and summaries of were written on flipcharts around the room. Participants were allocated responsibility for raising the issues from different stakeholder groups at appropriate steps on the pathway.

The improvement event was timetabled to last three days and was facilitated by the mentor from the improvement team. This enabled Manager B to participate in the discussions. Following an overview of the process, it began with the presentations on the feedback from the stakeholders regarding the current service provided. A long roll of paper was then placed around the room and the sticky notes developed in the previous stage were used to illustrate different elements of the current process including the key areas of 'waste', 'potential value' and 'ways to improve'.

On the second day they began by discussing the key areas of 'waste' that had been identified and trying to understand what the issues were that led to these. To help them explore the underlying reasons behind the waste they used the **5 whys exercise** (Table B3).

Table B3: An example of the 5 whys exercise in relation to waste in the current processes

We do not always promptly informing the person concerned, their family & other professionals about the outcome of the referral		
Why	It is not clear who is responsible for providing this feedback	Duty workers are reluctant to liaise with professionals outside of their previous specialisms
Why	The previous teams had different processes regarding this and a process in the new team has not been developed as yet	Many workers had spent most of their career supporting people with same needs and had little understanding of services outside of their specialism
Why	Managers have had other priorities	This was encouraged to some extent by the previous structure and many workers were anxious about making a mistake and looking unprofessional to other services
Why	Confirming that referrers have been informed is not a requirement of the IT system and no one had raised the issue until now	Previous relationships with other agencies was often tense due to a number of high profile failures in partnership working
Why	The team has been inward facing following the restructuring	Social workers were not sufficiently exposed to other agencies and also lacked confidence in their profession

They also completed similar exercises in relation to the potential added value that could be delivered. For example, Table B3 portrays what was highlighted in relation to concerns from people accessing services and their carers that the social care support was not always integrated well with their informal networks. This linked to the issue from the other stakeholders that the team did not always make best use of the individual's own resources and those available in the community.
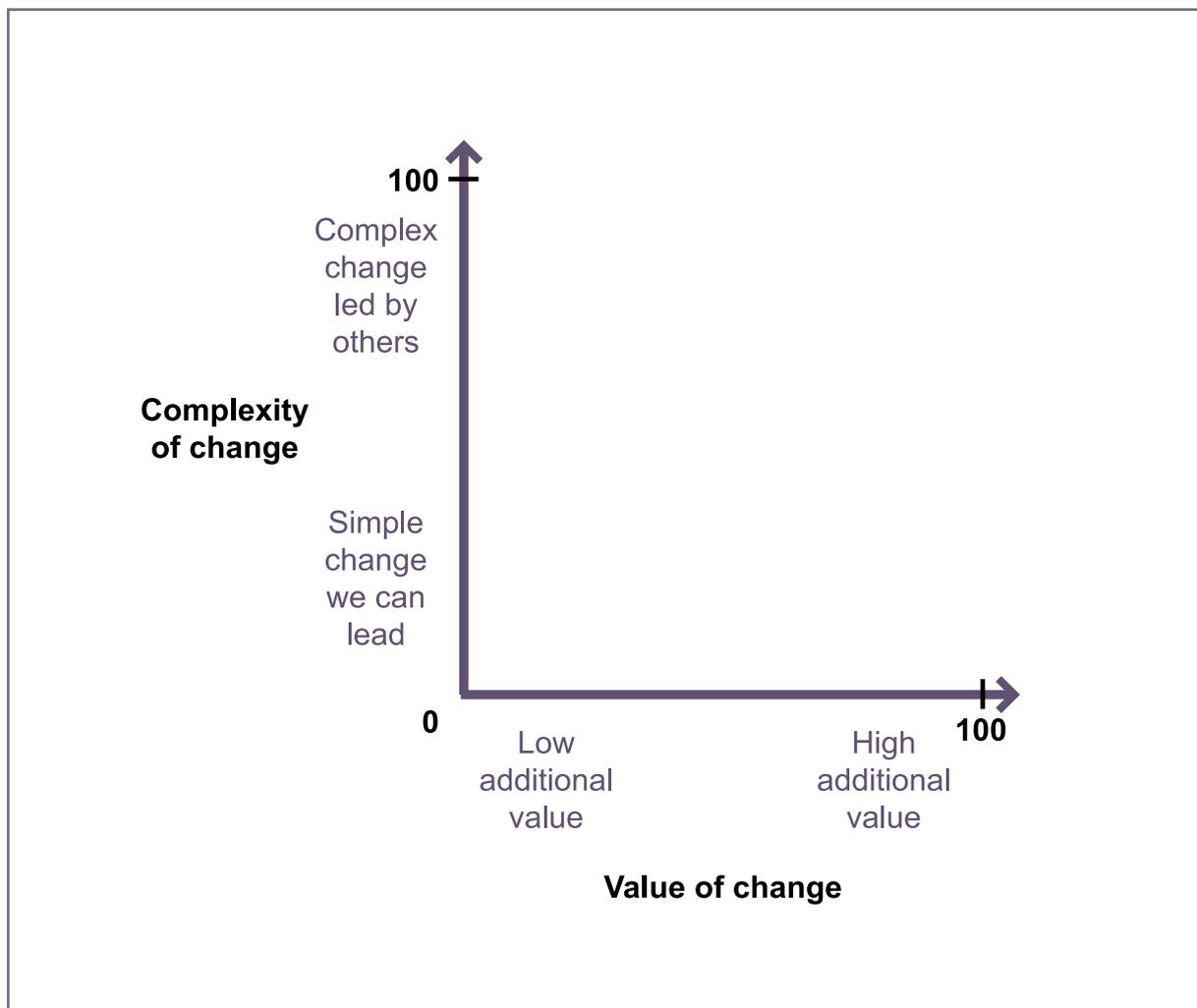
Table B4: An example of the 5 whys exercise in relation to missed opportunities to develop value in the current processes

We are not always building on the assets available to the person, their family and within the local community		
Why	Assessments tend to focus on what the local authority can do to help rather than what people can access themselves	
Why	Social workers want to advocate for people to get the support that they are eligible to receive	Social workers do not feel they have time to look at broader social circumstances.
Why	They are worried that people may not be able to cope without local authority funded support	They have targets regarding the number of assessments that must be undertaken each week
Why	They are concerned that community resources will not have sufficient capacity	Previously there were many people who were waiting for a service and social workers varied in how many they were completing
Why	There are reductions in funding and social workers not aware of what this means in practice	Social workers worked at different paces and some were not pulling their weight

Deciding how to change

At the end of Day 2 they had a good idea about the strengths and weaknesses of the current pathway and the underpinning causes behind aspects that were not working well. The first task of Day 3 was to prioritise which aspects of the pathway they would seek to improve first. They used a graph to map out the potential benefits of the changes against their ability to change these within the resources available to them. It was agreed that they would start with the changes that had high benefit and were under their control, and that manager B would raise the other issues with her manager for potential discussion at a more senior level (Diagram B2).

Diagram B2: Prioritisation Graph

```
        100 ─┤
            Complex
            change
            led by
            others

  Complexity
  of change

            Simple
            change
            we can
            lead
                                                        ┤├─►
          0 ┴──────────────────────────────────────────
              Low                          High      100
              additional                   additional
              value                        value

                        Value of change
```

The second task of the final day was to discuss how they would know if the changes had made a positive difference. They used the feedback from stakeholders to develop a series of 10 key standards to work towards, and identified potential data sources that could be used to measure if they were improving against these standards. To ensure that each team member understood how their work contributed to the meeting of these standards they were incorporated within each staff member's **Performance Appraisal Process**.

Implementing the change

Photographs were taken of the day and used to write a report of what had been discussed. This report was circulated to the rest of the team and discussed at team meetings. A two page accessible summary of the planned changes was sent to everyone who had provided feedback and a link circulated via twitter.

The final stage of **Lean** is 'managing towards perfection', with an emphasis on using live data to understand how a referral is 'flowing' through the system. Manager B set up a large white board in the middle of the office which provided an overview of the number of people in each stage of the process – this was updated every morning and afternoon so that the whole team could see what the current demand and response was. When new issues arose in the process, a short term action group would be set up to explore and respond to the problem through the use of **Plan Do Study Act** cycles.

One of the issues raised by external partners such as the learning disability healthcare service was that one of the main 'values' of the team members was their specialist expertise in working with people with different support needs. Team members had raised losing of this expertise as a potential danger of them being put together into a generic team. Manager B therefore raised with his fellow team managers the possibility of developing '**communities of practice**' around the support needs of different user groups. These would enable workers with a special interest to meet with colleagues and share experience, insights and resources.

Sustaining the change

The 'performance board' remained in use to provide a visual overview of how the process was working each day. Every 3 months the standards of 'value' that had been developed were reviewed, and 12 months post the improvement event the team reviewed the whole process again. This included repeating the data collection exercise to understand stakeholder perspectives.

Case Study C:
Action research in a mental health recovery hub

Background

Community mental health teams had been in operation in the locality for over 5 years. In these teams social workers were co-located with health professions with a shared referral and care coordination system. Previously social care staff remained employed by the local authority and were managed by social work team managers. These staff members have now been transferred into the Mental Health NHS Foundation Trust along with their team managers and one service manager. Community mental health teams have a single team manager that can come from a health or social work background. The social work staff team had mixed views about being transferred over to the Trust – some felt it would lead to a dilution of their professional independence whilst others believe that the Trust would have a greater understanding of working with people with mental health problems than the local authority and therefore provide opportunity for better services. One of these community teams was to form the core of a recovery hub for people with long term mental health problems. This would be based within an ex-local authority library building and include a third sector organisation that provides accommodation and employment advice services, and an advocacy group. The Trust wanted to increase its research profile and was encouraging staff to consider undertaking research directly and/or working with local universities.

Case Study Manager C

Manager C would be responsible for managing the recovery hub.

The Organisational Brief to Manager C

- To improve outcomes for people with long term mental illness.

- To increase the productivity of the service (i.e. to support more people with the same resources)

- For the hub to be a national good practice example in relation to recovery services.

The overall approach to change

From initial informal interviews Manager C discovered that most people were cautiously positive about the new arrangements and the potential to provide a more seamless and recovery orientated service. However, whilst aspirational, these ideas were also vague and there were conflicting views about could be achieved. For instance, the health staff thought that one benefit would be that social workers would be able to work with people who had previously seemed to be out with their eligibility criteria, the advice services thought that their role within care pathways would be formalised and this would secure their funding, and the social workers that community nurses would take on more care management (including people receiving direct

payments). A number of stakeholders, in particular from the health professions, raised the need for evidence to support and inform this change. The psychology lead suggested working with a university in an **Action Research** approach as this could both gather relevant data regarding the impact and contribute to the change process. **Action Research** arose within the field of organisational development to better enable people who would be affected by a change to participate in the enquiry and decision making process. It seeks to analyse an issue from a wider range of perspectives, generate a range of possible solutions, and to test the ability of the chosen solutions to respond to the original issue. It involves cycles of collecting and analysing data, joint consideration of what can be learnt and taking action on the basis of these discussions.

Diagram C1: Action Research
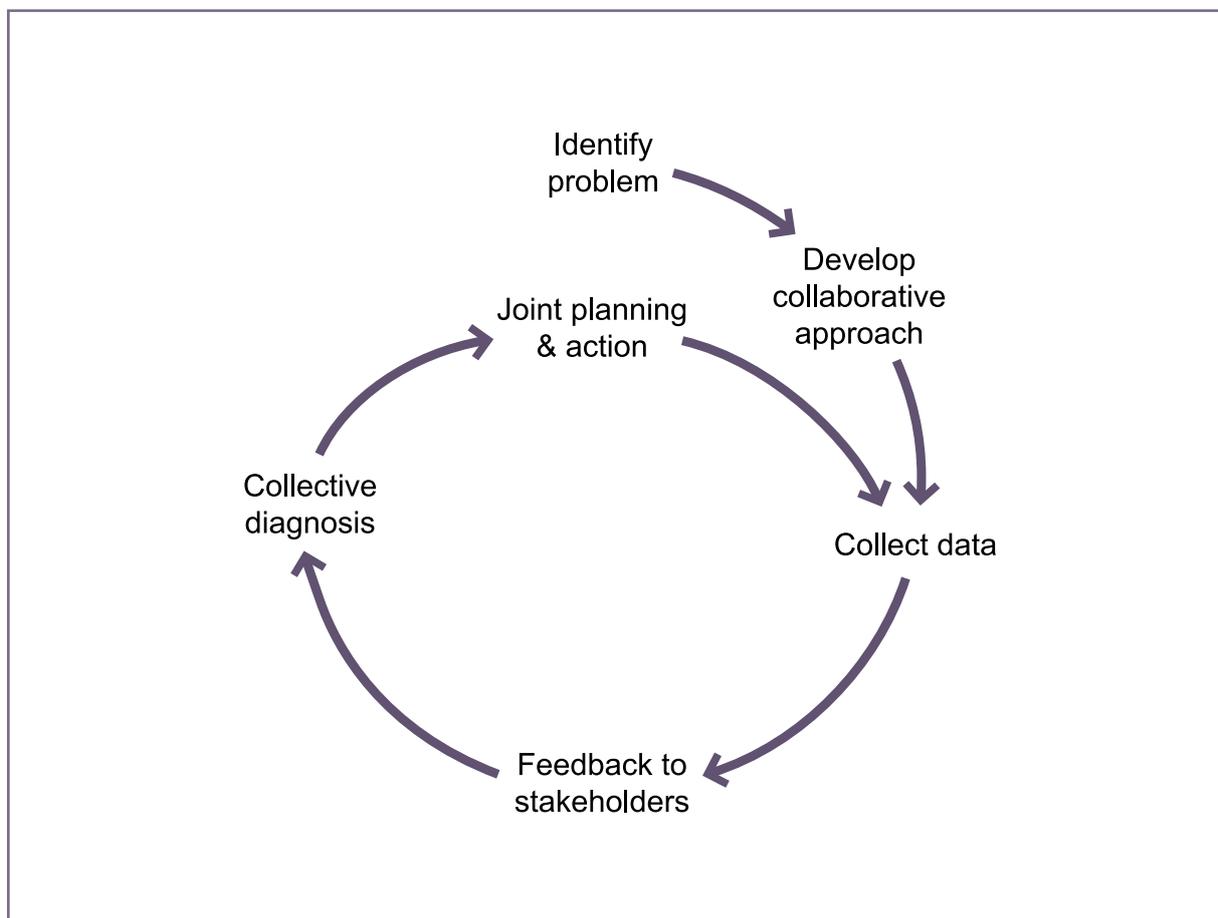
Starting the change

The first stage of **Action Research** is 'problem identification'. The recovery hub was itself a response to a perceived weakness in services for people with long term mental health problems, but Manager C wanted to understand how different stakeholders viewed the current services and what problems they would identify. As he previously managed the social work team Manager C already knew both the health and social care staff and the third sector organisations, and had a good relationship with most of the people with these different teams and services. He recognised though that they would have seen him in the context of a different role and this could be a barrier to others accepting that he had greater responsibility and a wider remit. For the health staff this would involve them seeing him as a manager rather than as a colleague, and for the third sector organisations as a contract manager. He also recognised that whilst he had some knowledge of the roles and professional backgrounds of his health colleagues this was limited.

Manager C therefore decided to meet individually with the team leaders or senior clinicians from all the health disciplines and the leads within the third sector organisations. This enabled him to re-introduce himself in his new role, find out more about their work, and understand their hopes and concerns for the new hub. Manager C also arranged to speak to the director within the Foundation Trust who would be his new line-manager. Manager C and the Psychology Team Leader contacted the health and social care management faculties within the local universities to enquire if any of them would be interested in working with the recovery hub. One responded with experience of organisational development and integrated working and seemed to be a good fit for the project. Together they drew up a proposal for a one year action research project and submitted this for funding by the Foundation Trust. It was approved, although at slightly less than was initially applied for. A senior researcher agreed to act as the main point of contact with the university with a more junior researcher providing fieldwork support. The university also suggested that they could engage co-researchers who had experience of mental health services.

Manager C's director had advised that the hub was seen as a 'flagship' by the Foundation Trust, the Local Authority and the Clinical Commissioning Group. There would therefore be merit in arranging a periodic meeting of the relevant representatives from these organisations. Manager C also wanted to create a local change infrastructure that was separate (but linked) to his management team and which emphasised that people with mental health problems needed to be at the centre of the developments (Diagram C2).

Diagram C2: Change infrastructure in the recovery hub
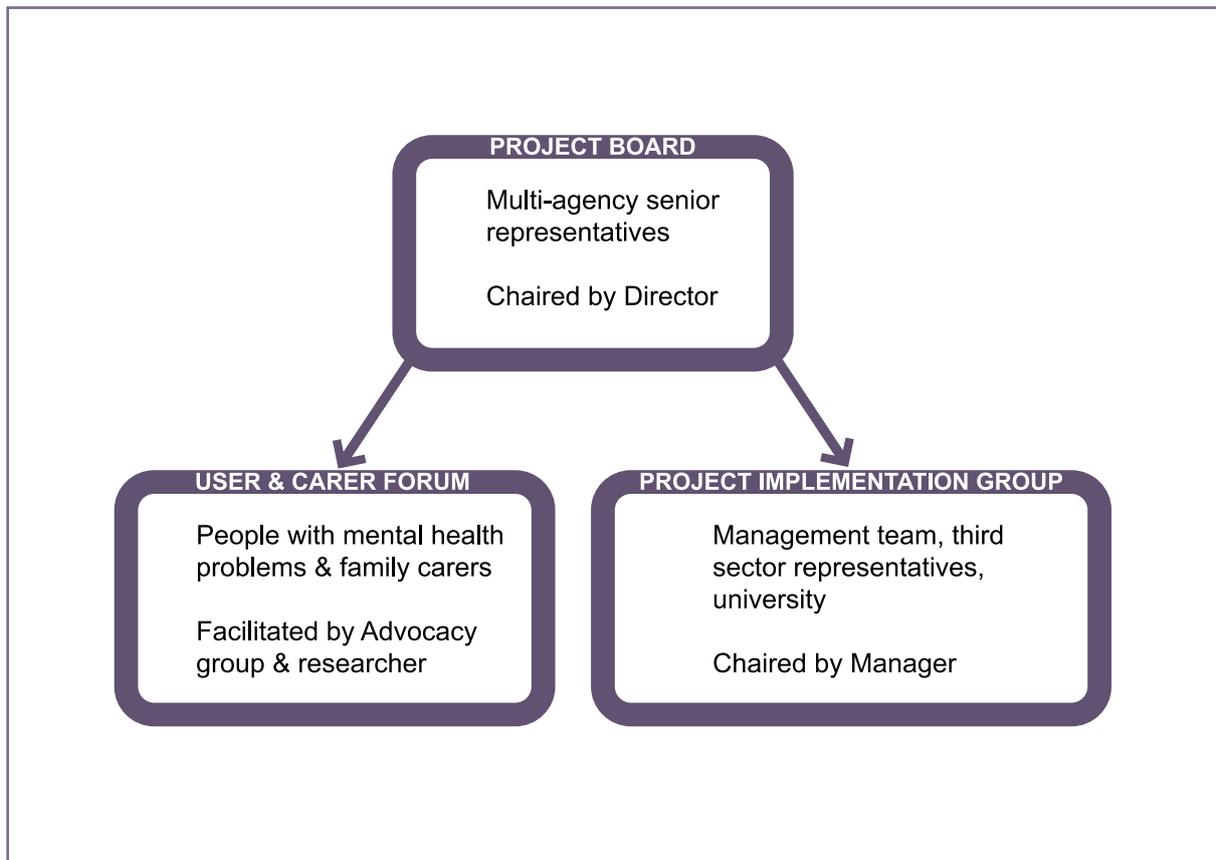
While he had considerable experience of managing social work services this project was a larger scale and higher profile that Manager C had been responsible for previously. He was also anxious about his ability to engage and demonstrate authority with the health staff in particular. With the transfer of the social work staff into the Foundation Trust there were a number of managers in similar positions. His manager therefore approached the human resource department to set up an **Action Learning Set** for these managers to support them in their new roles.

Understanding the change

The next stage of the **Action Research Approach** is 'data collection'. The university proposed using an organisational diagnostic model to frame the data gathering process. They suggested a number of potential models – **Weisbord 6-Box Model**, **Organisational Congruence Model** and **Tichy's Technical Political Cultural Framework**. Manager C and the team leader psychology asked the lead researcher to present the models to the Project Implementation Group so that they could be part of the selection process and would have an understanding of what the model could provide. The Project Implementation Group decided to use the

Organisational Congruence Model. This was on the basis that it is relatively simple in design (and so could be shared more easily with staff and other stakeholders, looks at the formal and informal aspects of an organisation and was developed to support change initiatives. Data would be gathered through an on-line survey sent to all staff who worked in the community mental health team and the third sector organisations. The research team also attended a user and carer forum to ask them what they saw as the key objectives for the recovery hub in relation to individual outcomes and people's experience of accessing a service. Talking to the forum provided helpful views on what these objectives could be as well as what was wrong with the current arrangements. This led to a number of key themes being identified which were used to develop a simple on-line questionnaire that could be circulated via the face-book page and the local carers centre contact list.

Deciding on the change

The research team undertook a number of analyses of the data including breakdowns by different professional groups. However they did not provide any overall conclusions. This is because under an **Action Research Process** it should be a 'collective' rather than 'expert' diagnosis of the issue in question. They fed back their findings to the Project Implementation Group in the first instance. This enabled the Group to discuss what the main issues were and agree how to then engage a wider group of people in the decision making. They identified that the issues could be grouped according to their focus –

- *Individual professional issues* (e.g. terms and conditions of social work team)

- *Joint working between the different health and social care professions* (e.g. referral and care coordination processes and pooling of staffing budgets)

- *Implementing the wider recovery hub* (e.g. overall vision and the role of the third sector organisations).

The Project Implementation Group decided that issues related to individual professions should be dealt with within their line management structure. Those regarding joint working processes should be dealt with by the community mental health team management group, however these should be informed by the overall vision for the recovery hub. The setting of this vision and its subsequent development should actively engage people with mental health problems, their family carers and the third sector organisations. Two wider stakeholder meetings would be held to set the vision, objectives and joint working principles. The first meeting would involve the university feeding back their findings and those present reflecting on these, and the second one would build on these through making decisions. A series of task and finish groups would then be setup with relevant representation to discuss how to apply these in practice.

The stakeholder events were held with facilitation by the university. Manager C welcomed everyone and emphasised the importance of the days but then took on the role of participant.

The university used the two days to develop a **Theory of Change** for the recovery hub. In Day 1 the findings from the data collection were used to agree the 'context' and 'key problems' that the hub would address and the 'resources' that were available to it. Initially the discussion on resources was limited to those funded by the local authority and the NHS. In response to this an informal presentation was given by the university on the evidence of what supports people in their recovery. This presentation this highlighted the importance of a people's social networks and generic community resources to their recovery. This led to a review of the 'resources' as event participants realised that resources were more than just those provided or funded by the local authority and NHS.

The objectives of the national mental health strategy were agreed as an overall vision for the recovery hub. Two of these objectives were seen as important but being addressed to a satisfactory level and could therefore be incrementally improved ('*positive experience*' and '*harm*') and two were seen as being a broader issues that would require coordination by a more strategic group than the recover hub which had representation from a wider range of community agencies ('*stigma*' and '*discrimination*'). It was therefore agreed that the priority change objectives for by the hub should be '*recovery*' and '*good physical health*'.

In the second event the broad objectives of '*recovery*' and '*good physical health*' were developed into local outcomes, i.e. what was hoped to be achieved by the changes. Participants were asked to write their suggestions for these outcomes onto sticky notes. Suggestions were collated by the university into themes, and participants asked to vote on which of these they wanted to prioritise. This led to three outcomes being developed for '*recovery*' and three outcomes for '*good physical health*'. Participants were then divided into groups to think about potential 'high level interventions' (i.e. what would be done differently) and what the corresponding 'outputs' and 'short term outcomes' would be. The groups then provided peer challenge to each other and this led to a refined **Theory of Change** for each outcome (Table C1).

Table C1: Example of theory of change developed for a recovery hub outcome

Context	Resources	Process	Outputs	Short-term outcomes	Long-term outcomes
People with mental health problems have shorter lifespans and poorer health than the general populations.	People with mental health problems and their families	Training to be provided to smoking cessation services on working with people with mh by specialist services	People with mental health problems attend smoking cessation	People report that they know what smoking cessation services are available	People with mental health problems report better health related quality of life
	User-led representative groups	Training to be provided for specialist services and user led groups	Discussion re smoking is recorded in care plans	People who want support to stop smoking report that services were accessible and responsive	People with mental health problems have reduced smoking related conditions and illnesses
More people with mental health problems smoke.	Mainstream smoking cessation services	specialist services on encouraging people to engage with smoking cessation	Health and well-being checks are undertaken	Less people with mental health problems smoke	
Smoke cessation services are not always confident in supporting people with mental health problems	General practices	General practice to promote health and well-being checks for people with mental health problems	Referrals to smoking cessation by general practice and specialist services	People who do smoke have less cigarettes per day	Life expectancy increased for people with mental health problems
	Specialist mental health services				

Implementing the change

The Project Implementation Group met following the second event and agreed to develop task and finish groups for each of the priority outcomes. These began by turning the **Theory of Change** that had been developed into more detailed project plans. The university worked with the task and finish groups to develop measures that could be used to monitor implementation of the projects. They then developed an evaluation framework to understand the impacts on the overall recovery hub. This data was to be largely gathered by the service advising on developing the necessary data gathering systems. They would also provide an objective validation of the recovery hub's findings. Three monthly reports were provided to the Project Implementation Group and these were used to review progress.

Manager C also continued to participate in the **Action Learning Set**, which he found a helpful forum to present uncertainties and dilemmas that were faced.

Sustaining the change

A year post implementation the research team reran the on-line surveys to staff and to people accessing the service gather an update on how the recovery team had progressed. They undertook focus groups to understand different perspectives on the process of change. Finally, the university ran an **Open Space** event to which all stakeholders, including people accessing the service and their family carers were invited. They set an overall question of '*how can people be better supported in their recovery journey?*' and those who attended highlighted the key issues that arose for them from his overall question. The university combined the views expressed at the event with the evaluation data to provide a report on the impact of the hub. They also undertook interviews with key participants in the process and incorporated a reflection on the change approach in report. This was made available via the internet and shared within the Foundation Trust via a series of briefings. The data was also used within applications for good practice awards.

Case Study D:
Soft systems methodology in the development of supported living

Background

Local Action for the Disabled (LAD) was set up in the 1970s by parents of children with a learning disability to provide respite services. It grew steadily over time and diversified its range of services to include three residential care homes, domiciliary care services, and schemes promoting access to leisure services. It also opened its services to support for people with any form of disability, including those with autism. Alongside these internal changes the local authority reviewed its learning disability provision some time ago and identified that it wanted to move to more supported living rather than residential care homes. Until recently though this had not significantly altered the services that were purchased. Financial pressures meant that the new commissioning manager advised that the Local Authority would not place anyone further in residential care and that existing homes should deregister if possible. LAD had already been considering closing the homes as there have been two vacancies that have not been filled for several months and a resident may need to move to nursing home care due to advanced dementia. A local housing association had a new residential development that they were willing to offer up to 12 tenancies for people with a disability.

Case Study Manager D

Case study manager managed the residential care homes in LAD.

The Organisational Brief to Manager D

- To ensure that the homes are closed and the current residents are supported in appropriate accommodation.

- To avoid negative publicity regarding the closure of the homes.

- To redeploy the suitable members of the current staff within a domiciliary care service that can support the people who move into the new tenancies.

The overall approach to change

From her knowledge of the stakeholders, Manager D could predict that they would have very different perspectives on what services LAD should provide to replace the homes. Furthermore from the previous attempts to move from a residential care model it would be unlikely that the Board of LAD would be able to 'impose' their views in practice. She therefore decided to use **Soft-Systems Methodology** as an overall change approach. This recognises that people have different 'world-views', and that it may not be able to reach a compromise that is agreed by all. Instead it aims to deploy a learning cycle to better understand these worldviews and respond to

them by finding 'accommodations' that they can live with, even if they do not still see eye-to-eye. The other aspect of **Soft-Systems Methodology** that Manager D connected with was its emphasis on 'purposeful activity'. This means that even if others did not think staff or indeed the people living in the service were using their time as productively or meaningfully as possible, for the individuals concerned they may have seen this activity as worthwhile. Finally, **Soft-Systems Methodology** encourages the use of diagrams to capture and communicate what is being learnt, and Manager D thought that this could help to facilitate engagement with people who are not able to read and write.

Alongside the use of **Soft-Systems Methodology** Manager D liaised with the local care management team to ensure that each of the current people living in the home had a new person centred plan and a reassessment of their need.

Starting the change

To explain to the Board of LAD the reasons that the homes would need to close the Chief Executive prepared a **PESTELI** analysis so that they could gain a better understanding of the current challenges and opportunities (Table D1).

The organisation had previously tried to replace the homes with supported living arrangements. Whilst there has been some people in the home, families and staff who were supportive, there were a number that were very concerned that it would lead to people being abandoned in the community. Those who had previously been against the change were able to successfully lobby the Board to not proceed with the plans. At the Board meeting the chief executive worked with the members to draw up a **Force Field Analysis** that set out the forces for and against the change. Several Board members initially proposed undertaking an exercise in which they would try to convince stakeholders that such a move was in everyone's interest (so reducing the 'resisting' forces). The Chief Executive though was concerned about this approach, as ultimately the homes did not appear to be financially sustainable and so the question was not if the homes should be closed but rather what they should be replaced with. It could therefore alienate the people in the homes, the staff and the carers if the Board were seen to be undertaking a consultation when actually the decision was made. He therefore convinced the Board that they should inform all stakeholders that the homes would be closed within 12 months but that there would be a period of consultation to discuss what accommodation and services should replace the homes and for the people currently living in them to be supported to identify alternative arrangements that best suit them (which may or may not be with LAD). In the terms of the **Force Field Analysis** the introduction of the decision to close the home was the equivalent of adding an irresistible force for change. To ensure that Manager D was able to focus on planning the future the Chief Executive offered to take the lead on informing people of the closures and asked the Board to support him with this.

Table D1: Examples of the issues highlighted in the PESTELI analysis

| Aspect of environment	Example of issues noted by LAD
Political	The two main local political parties are in agreement about the general move to supported living rather than residential care
Economic	There are a number of competitor care providers in the local area and national organisations will also bid for major tenders. Local authority budgets are stretched and in view of the increasing numbers of people who have complex needs such financial pressure is likely to grow
Sociological	There are increasing number of older people with a learning disability and young people with complex health needs and/or autism
Technological	Rather than people simply being looked after, care services are becoming more skilled at supporting people to become more independent over time Assistive technology provides opportunities for people to receive support without members of staff being present
Ecological	There are a number of new developments within the local area of the proposed accommodation in line with the local authority's vision for the locality. These include increased training schemes and healthy living services
Legislative	Human rights legislation is likely to continue, as will duty on local authorities to assess social care needs of people with a disability and to arrange services
Industry	Supported living enables people to have more choice and control over lives and resources and is therefore likely to fit in with the increasing wish for people to be self-directing A proportion of people with a disability will be likely to need some degree of support for the foreseeable future

Soft-Systems Methodology suggests that there are three key roles that are always present in a change process:

Role client   person or people who initiated the change being considered (in this case the Board of LAD and the Local Authority)

Role practitioner   person or people who are exploring the situation (in this case Manager D)

Issue owner(s)   person or people who would be affected by the situation and by changes within it (in this case people living in the home, their families and the staff)

People can have more than one role in the process. For examples, Manager D was leading the process (*role practitioner*) but her own job would also be affected by any changes (issue owner). The Board were instigators of the process (*role client*), but they would affected if people were not happy with the alternative provision and choose different providers *(issue owner)*.

Having worked in LAD for a number of years Manager D knew most of the residents, families, and staff within these services. She had met all of the Board members and was familiar with the local health and social care services including the commissioning team. She therefore thought that he had a reasonable knowledge of the priorities of these main stakeholders and their likely response to the plans would be. However, Manager D thought it was worth speaking to them as soon as possible to ensure that she had an up to date awareness of the general positions of these 'issue owners'. These meetings would also enable her to establish her role as project manager and the coordinator of the change process. From these discussions Manager D began to draw up a 'Rich Picture' of the homes and the perspectives of the stakeholders (Diagram D1).

Diagram D1: Rich picture diagram
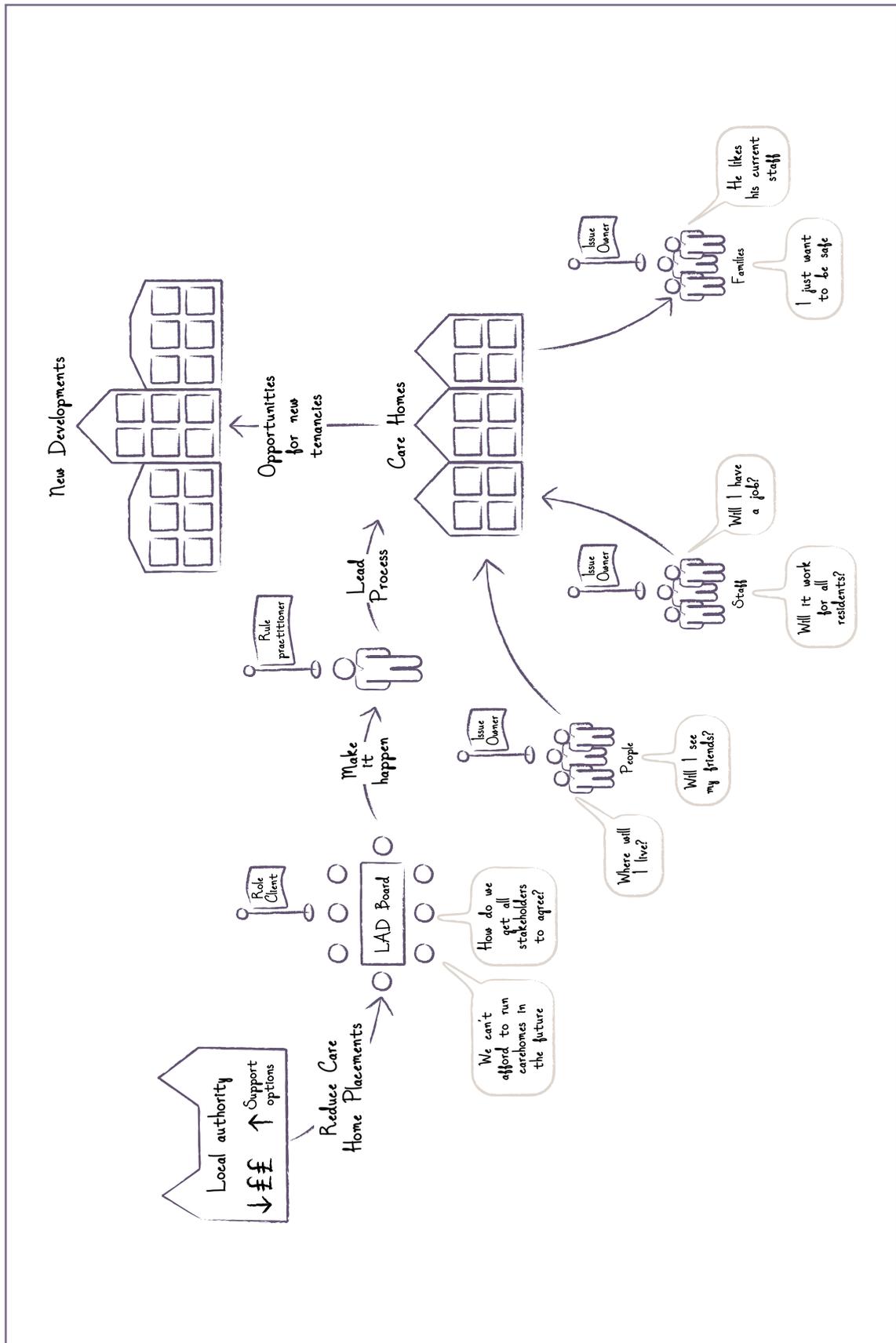
Understanding the change

Manager D had a good feel for the culture within LAD, which (in **Soft-Systems Methodology**) can be understood as resulting from a dynamic interaction of three elements – *roles* (both formal and informal), *norms* (the behaviours that are expected when someone is in a particular role) and *values* (the criteria by which behaviour gets judged). She began to depict these elements for the different stakeholders connected with the homes (Diagram D2). During the course of the project Manager D kept updating and amending these culture diagrams as he gathered more information.

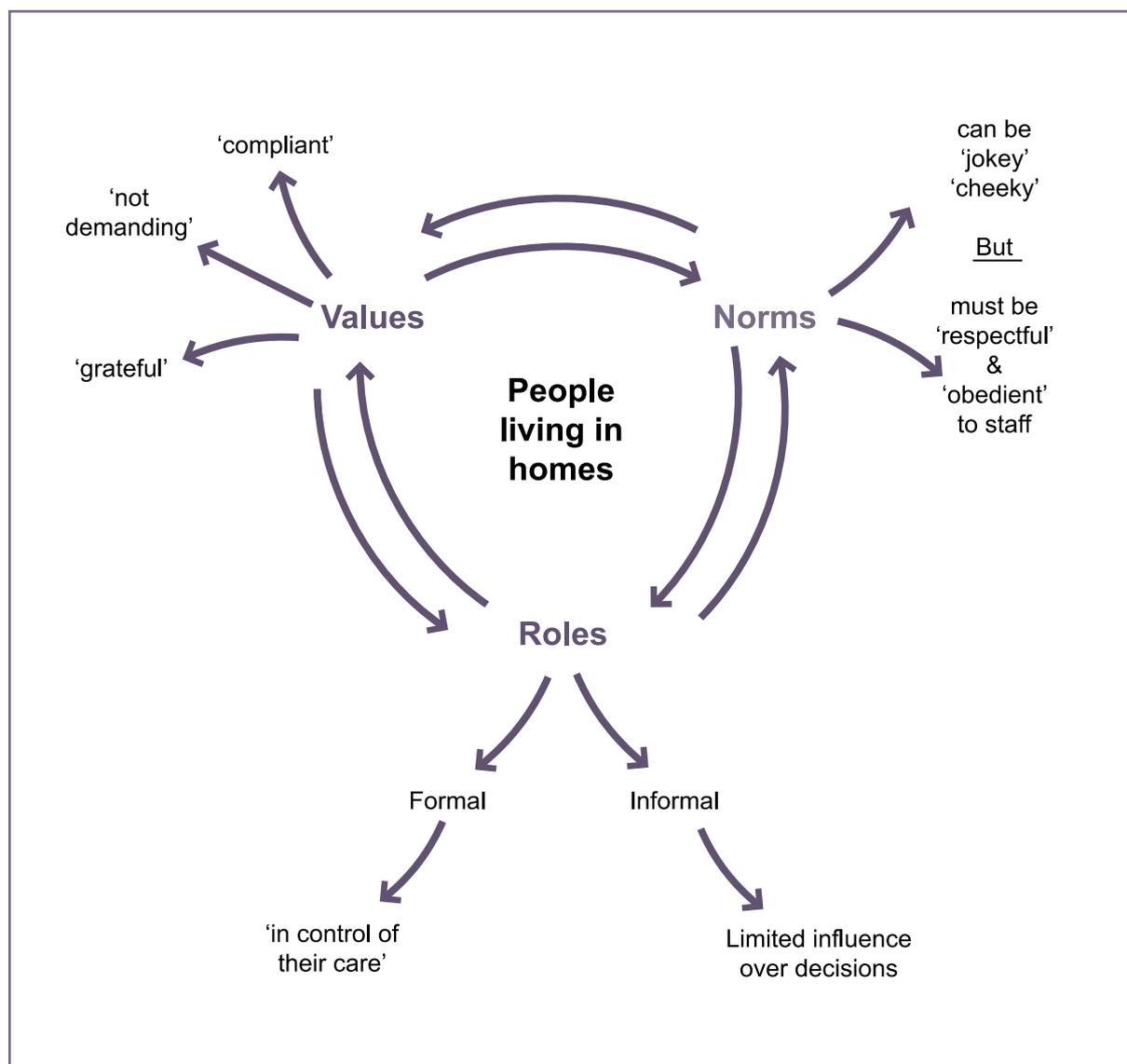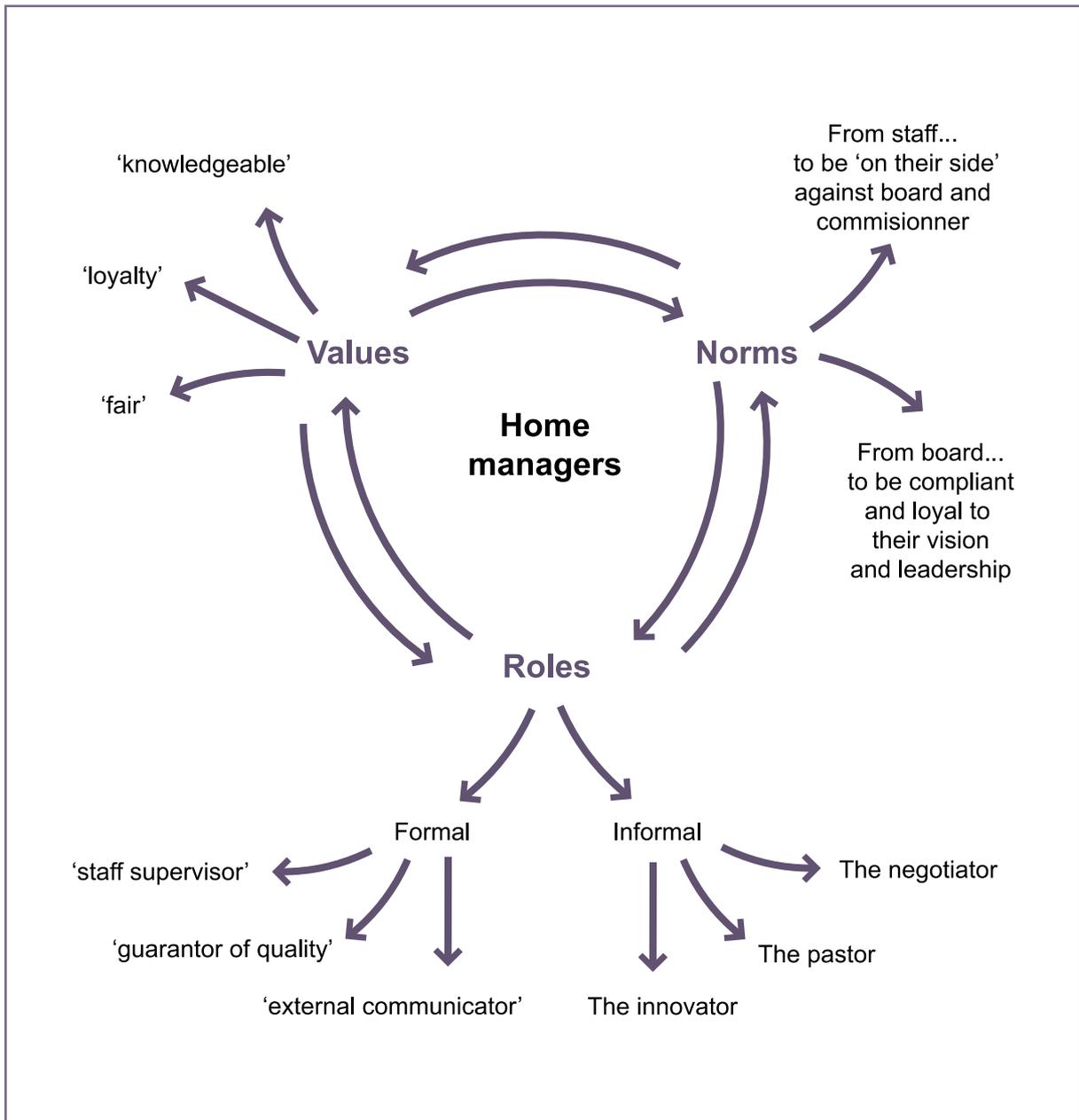Diagram D2: Culture in relation to people living in the homes

Diagram D3: Culture in relation to home managers

'knowledgeable'

'loyalty'

'fair'

Values

Norms

Home managers

From staff...
to be 'on their side'
against board and
commisionner

From board...
to be compliant
and loyal to
their vision
and leadership

Roles

Formal

Informal

'staff supervisor'

'guarantor of quality'

'external communicator'

The innovator

The pastor

The negotiator

Alongside culture Manager D was also interested in thinking through power in the organisation (Table D2).

Table D2: Example of power in Case Study D in relation to family carers

Type of power	How was it obtained?	How was it used?	How was it defended?	How was it passed on?	How was it given up?
Through being named family contact	Through being closest relation Through the person in the home seeing them as important By the staff giving them respect Through managing the person's money	To request that staff undertake tasks, relate to the person in certain ways To make decisions on behalf/with the person	By complaining the home manager if they did not think they were being listened to By encouraging their relative to act in a certain way	By telling the person that they had to listen to the staff By telling the resident in the presence of the staff that they should/ could do something	By not taking a close interest in the person's affairs Through illness or death

The next stage in **Soft-Systems Methodology** is to develop 'root definitions' of the 'purposeful activity' system. This involves drawing diagrams which depict different 'worldviews' on how the service achieves the expected outcomes. Rather than focus of what was currently happening in the homes, Manager D wanted to look at what stakeholders thought should happen in any new accommodation and support arrangements. She met with the different groups of stakeholders and mapped out their main 'root definitions' (Diagram D3) using the PQR formula – i.e.

P: what should the service do? **Q**: how will it do this? **R**: why will it do this?

Table D3: Example of root definitions

Stakeholder group	P (what does the service do?)	Q (how will it do this?)	R (why will it do this?)
People living in the accommodation	It will give us somewhere we can be safe and keep all our belongings	By having a strong front door and staff who can look after us	Because we pay for the service and because the staff care
People living in the accommodation	It will help us to have fun and to see our friends and family	By having phones so we can contact people; let us choose who live with; be close to public transport	Because it is what is most important to us
Staff	It will keep people safe from others and from hurting themselves through accidents etc	By having risk assessments and management plans; training for the people; panic alarms and enough staff	It is our duty to make sure people are protected from harm and we could get in trouble if we do not do this properly.
Staff	It will be able to demonstrate how it is working to help people to become more independent	By encouraging people to do more for themselves, having support of occupational therapists and making sure that skills development are in care plans	The care managers expect us to help people to be less dependent and also ask at reviews what we have done to promote this
Staff	It will give us a job that we enjoy and a wage that we can live from	By us being paid a decent hourly rate and having some security about the future	LAD say they are a good employer and if we are happy in our work then people will have a better life

Deciding on the change

Having developed the alternative PQR formulae Manager D met with a selection of frontline staff, senior care assistants, residents and families to consider the different viewpoints and build an overall model that incorporated all of the elements that had been developed to date, with connections between the relevant aspects (Diagram D4). The model was based on the mnemonic CATWOE:

Customers affected: People living in accommodation

Owners who could stop it: Family
Care management team

Environmental constraints: Person's personal income
Funding for care package
Accessibility of local community

Purposeful **activity**:   Encouraging people to have more control over their lives and greater confidence in achieving their goals

Transformational process: Values driven care

Worldview: Disabled people have right & assets

Diagram D4: CATWOE
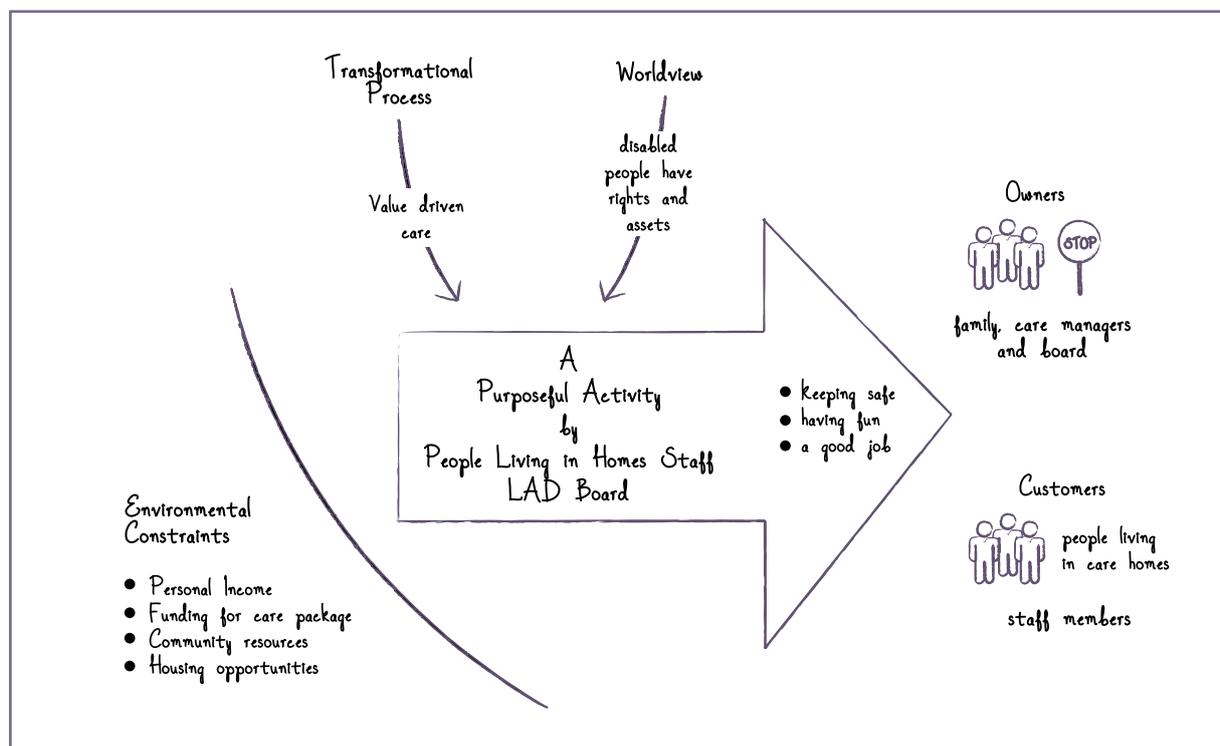
Building the model required them to keep returning to the various diagrams to ensure that they had captured all of the viewpoints. One striking element of the model was that being in a care home did not seem to be required as such – rather it was about the location, the facilities and the support that was available within the accommodation.

Having designed the model Manager D then facilitated workshops for the three different homes which included all the people living in a house, those of their families who wanted to attend, and the staff members (including the night shift). The meetings were held in a church hall so that there was plenty of room. On the walls of the room were the different PQR diagrams which Manager D introduced, and the draft model. She explained this in depth, and used it to generate discussions regarding what was important about the new arrangements and who could contribute. She also introduced the need to monitor what impacts the service was having, and used the following outcomes-

- Is the service providing what people want and need day to day (efficacy)?

- Has the funding (local authority, benefits and individuals' own) been used efficiently?

- Are the longer term outcomes (such as being happy and health) being met effectively?

At the end of each meeting manager D would redraw the model to incorporate the discussions that had taken part into the model, and then present the new model to the next meeting. At the end of this sequence of meetings she did not have consensus regards all aspects, but did have a number of areas of agreement. There were also a few issues that were of less concern to most people but for a number of key stakeholders were of crucial importance. Most importantly there had been a good discussion amongst those who had taken part about what was important in any future arrangements and there was a better sense of shared purpose and respect for other people's viewpoints.

Implementing the change

The care management team had completed the person centred plans for each of the people living in the home and also calculated their personal budgets. Out of the 10 people currently living in the home, two people were going to move into nursing home care and another one person was going to leave the area to move closer to his brother. This left 7 people who were interested in moving into the new tenancies. Using the model developed in the 'deciding' phase and the person centred plans for the individual people Manager D started to work with the staff team to consider what their responsibilities would be in the new service and what skills and team processes they would need to respond to these. One of the 'world views' from the staff was that they were stifled in developing new practices due to the Board wanting to agree to any new ideas. Manager D therefore proposed that they try a self-managed team approach, in which the staff would have greater autonomy and responsibility on creating how the new support would operate. Having talked to the Chief Executive a paper was presented to the

Board proposing that the service be given greater freedom to develop new working practices, and that Manager D was given authority to use the budget creatively so long as the services remained within the available funding. This would in turn enable Manager D to give the staff team more flexibility in how the resources were used.

Another issue that had been raised through the **Soft-Systems Methodology** was that people living in the homes did not always feel able to make decisions over their lives. This was often mentioned in connection with being able to arrange support from a staff member that they liked in order to pursue an activity or interest. Following the care management reviews each of the people had been informed of their personal budget, but none of them or their family members were able or interested to hold this directly. Manager D therefore suggested that the funding be held in the form of Individual Service Funds. These would be managed by LAD but with greater transparency over how they were deployed and therefore greater opportunity for them to be used more creatively and flexibly that previously. She secured agreement from the Chief Executive that this could include them buying in hours (or indeed the whole care package) from another agency if this was in the person's interest.

As part of the implementation process Manager D kept a focus on the monitoring processes that had begun to be sketched out in the decision phase. She was very keen that these would be sufficiently understood before the move happened so that the various sources of information could be gathered from the first day.

Sustaining the change

Throughout the process of implementing the move Manager D continued to amend the various diagrams that had been developed during the **Soft-Systems Methodology**. Once everyone had settled in to their new flats she met with the tenants and reviewed with them their initial PDRs, the original model and a new one that included the additional or amended elements that he had been picked up over the past few months. Following their comments she amended this again. She then called a meeting in the community centre located in the housing scheme and invited the tenants, their families, staff and the board to attend for as long or short a time as they choose following an open space event approach. He put up the posters that had been previously been used to capture the PQRs previously and the two models. People were encouraged to have a conversation regarding the model and to write on (or ask someone else to write on) their views, with the only rule being that people had to put their name next to a comment. This led to considerable discussions and following the day Manager D redrew another model. This process was continued every year.

Section Two

Directory of change approaches & change management tools

Introduction to Section 2

In this section we present a directory of 'change approaches' and 'change management tools' based on a review of literature in the fields of organisational development and change. These include tools, frameworks, models and direct interventions which can be applied at different stages within a planned cycle of social care change. For each approach and tool a summary is provided which incorporates the following:

- A description of its purpose and the principles that lie behind the approach

- An overview of how it can be applied in practice

- A comment on the strengths and weaknesses highlighted in research and from practice.

- A commentary on its potential to implement the principles of social care change.

The approaches are presented in alphabetical order with an index overleaf.

Index of Approaches

ACTION LEARNING SET (ALS)

Description

Action Learning Sets (ALSs) are used to stimulate critical reflection on real-life, work-based problems the answers to which are unclear (Revans 1980, 1982, 1998). Rooted in experience based learning theory, this widely-adopted, group approach to problem-solving emerged in response to the assumption 'only that which can be observed and measured counts as knowledge' (Whitehead & McNiff, 2013). It takes the challenges of professional practice in a context of organisational change and uses these as an opportunity for reflection and development.

The approach is formulated as: L = P + Q + R (with P relating to the formal knowledge and skills that people have been trained in through external and in-house training). Where:

L = Learning

P = Programmed knowledge

Q = Questioning

R = Reflection

Use

A common Action Learning Set process

- each member reports briefly on recent work events

- members choose who will speak about a situation they are currently facing at work

- the presenter describes the situation, problem or challenge

- set members ask open questions to help the presenter gain insight and be open to new solutions – set members do not give advice, pass judgement or talk about their own situation; rather they help the presenter review options and decide on action

- set members reflect on the group process and share their own individual learning

- the presenter initiates changes in the workplace

- at the next set meeting the presenter reports on the action they have taken, and any further issues

(Adapted from Revans, 1980)

Strengths and limitations

It has huge potential in continuing professional development terms by offering group members a way of developing skills in active listening, inquiry and advocacy with the aim of gently challenging peers about the nature and possible causes of the problem they are seeking to understand. However, some are critical of the subjective nature of such reflection.

In relation to social care change, Action Learning provides a means through which key change leaders can reflect on how they can respond to issues and improve their future practice. In doing so they can help to achieve the principles of social change in practice and create both personal and organisational resilience. Clear and agreed values within the set help to keep the focus on achieving positive change with others, and guide the interactions between set members.

Further reading

1. Megginson D and Whitaker V (2007) *Continuing Professional Development* (2nd edition), London: CIPD.

2. Revans R (1980) *Action Learning: New Techniques for Management*, London: Blond & Briggs.

3. Revans RW (1982) *The Origin and Growth of Action Learning*, Brickley: Chartwell-Bratt,

4. Revans RW (1998) *ABC of Action Learning*, London: Lemos and Crane.

5. Reynolds M (1998) Reflection and Critical reflection in Management Learning, *Management Learning* 29, 2, 183–200.

6. Reynolds M and Vince R (eds) (2004) *Organizing Reflection*, Aldershot: Ashgate Publishing Company.

7. Skills for Care (2014) *Critically Reflective Action Learning: Improving Social Work Practice Through Critically Reflective Action Learning*, Leeds: Skills for Care. Available at: www.skillsforcare.org.uk/Document-library/Social-work/Action-Learning/Critical-reflective-action-learning.pdf

ACTION RESEARCH

Description

Action Research provides the methodological basis for many planned models of organisational change and is widely used. The process is designed to enable participants to gain new insights into their situation as a spur to action and change. It seeks to:

- analyse a known problem from a wide range of perspectives;

- identify a range of possible solutions; and

- test the ability of the chosen solution(s) to solve the original problem.

Use

Ideally suited to exploring and addressing complex 'known' problems with no obvious solutions, the approach is often undertaken by practitioners with the help of external consultants to facilitate the learning process. It involves cycles of planning to inform interventions, action in the light of planning, and an assessment of impact used to inform future planning cycles.

Stages in the Action Research Cycle

1. *Problem identification*: by a person with influence within the organisation

2. *Consultation with expert facilitator(s)*: facilitators and organisational representatives share and explore their values to foster open collaboration

3. *Data collection and preliminary analysis*: typically undertaken jointly by facilitators and organisational members to explore the underlying causes of manifest problems, drawing on multiple sources of data (observation, interview, questionnaire, and performance data)

4. *Feedback to client/group*: basic data and initial analysis presented for validation

5. *Joint diagnosis of problem*: facilitator explores the main themes of the problems with the group

6. *Joint action planning*: agreement on action required drawing on the culture of the organisation, nature of problems identified, and available resources

7. *Action*: implementation of interventions to an agreed timescale

8. *Data gathering and action*: measurement of the effects of the intervention(s), leading to re-diagnosis and further action (cycle back to step 4 above, as required)

(Adapted from Cummings & Worley, 2009$pp. 25–6)

Participants' learning is thus informed by a combination of theory, action and observed effects rather than by theory alone. In this way the approach directly addresses the relationship between theory and practice.

Strengths and limitations

Much of the appeal of Action Research lies in its potential to actively engage and involve diverse groups of stakeholders in change, and therefore skilled and collaborative facilitation is vital. It is increasingly used in complex multi-agency settings to explicitly address power imbalances across multiple stakeholder groups. This often includes the training and development of stakeholders in change management techniques to promote the sharing of responsibilities and encourage continuous change.

On this model, external consultants work with organisational members as co-investigators; each bringing their expert knowledge of change techniques or local context to bear – and each gaining insights into the nature of complex change as a result. While there is much agreement on the need for collaboration for the approach to work, accounts within the literature are largely written from the perspectives of facilitators rather than wider team members. Concern may also be expressed over the extent to which inhibitors to change will be identified by collaboration alone; the impact of changes ('solutions') are thoroughly investigated; and the model is implemented in the light of the collaborative principles which underpin it, as opposed to being used to build support for a 'preferred solution' by powerful individuals.

In relation to social care change, Action Research can support the gathering of evidence to inform the purpose and detail of a change process. Participatory models can facilitate the engagement of people who access services, carers and staff within the research and decision making process. If the findings are written up then they can be shared for wider organisational learning.

Further reading

1. Dickens L and Watkins K (2006) Action research: rethinking Lewin. In: Gallos JV (ed) *Organization Development*, San Francisco: Jossey-Bass, pp. 185–222.

2. Greenwood D, Whyte W and Harkavy I (1993) Participatory action research as process and as goal, *Human Relations*, 46, 2, 175–92.

3. Lewin K (1946) Action research and minority problems. In: Lewin K and Allport GW (eds) (1948) *Resolving Social Conflict*, London: Harper & Row.

4. Lewin K (1947) Group decisions and social change. In: Gold M (ed) *The Complete Social Scientist: A Kurt Lewin Reader*, Washington, DC: American Psychological Association.

5. Peters M and Robinson V (1984) The origins and status of action research, *Journal of Applied Behavioral Science*, 20, 2, 113–24.

6. Weisbord M (1987) *Productive Workplaces*, San Francisco: Jossey-Bass.

Other resources

Collaborative Action Research Network: an international network which aims to encourage and support action research projects in educational, health, social care, commercial, and public services settings: www.esri.mmu.ac.uk/carnnew/index.php

APPRECIATIVE INQUIRY (AI)

Description

Many approaches to change begin with identifying the 'problem' to be solved and working back to understand what are the causes of the problem and therefore how can it be addressed. In contrast, AI frames change as a mystery to be embraced and starts from identifying the best of what could be, discussing what should be, and innovating what will be. It is sustained by the belief that social systems evolve in the direction of the positive images that individuals hold about them – looking forwards and extending 'that which is going right'.

Use

The approach applies positive questions with the aim of surfacing, and then extending, those 'positive core' ideas across the networks of individuals which make up organisations. By making positive human spirit publicly available, self-organising networks begin to construct a more positive organisational future, leading to revolutionary transformation.

Stages in Appreciative Inquiry

1. *Discovery*: Exploring the positive capacity present in the organisation through engagement by and with large numbers of organisational members in order to discover and share awareness of positive potential.

2. *Dream*: Coming together to share findings, positive feedback leads to the development of a vision (of a better world), purpose (to create the vision), and strategy (towards this end)

3. *Design*: Once a dream has been agreed, redesign is undertaken in order to realise it. Sources of resistance are reduced to the extent that the dream is widely shared by participants

4. *Destiny*: The transformative effect of changes in the way that people think and talk about the world results in realisation of the vision. The organisation is created anew through organisational members connecting and co-creating and so mobilising the potential for change. (Adapted from Cooperrider and Sekerka, 2006, pp. 225–26)

(Magruder-Watkins et al. (2011) offer detailed guidance on each, and add a preparatory stage ('Define') to incorporate initial discussions between those facilitating the process and those who instigated it)

Strengths and limitations

It is suited to changes which require the development of networks of relationships between participants across multiple organisational boundaries. Additionally, the exploration of positive experiences, capabilities and visions for a better future may act as a powerful mobilising force, focussing participants' energies on action toward shared goals. It is designed to tap into participants' feelings and connect their developing awareness of the interconnections between individuals to an emergent change agenda. There are possible tensions between the focus on overarching change and the engagement of individuals, which may reduce the ability of AI to adhere to its humanistic value base.

In relation to social care change, Appreciative Inquiry fits well into the principles of encouraging shared learning and partnerships and seeking positive engagement from people accessing services, carers and other stakeholders. Its ability to engage senior management and other political interests in the process will be vital, and there is a potential that the perceived strengths and assets may not match the objectives set by internal or external requirements.

Further reading

1. Cooperrider DL (1999) Positive image, positive action: The affirmative basis of organizing. In: Srivastva S and Cooperrider DL (eds) *Appreciative Management and Leadership: The Power of Positive Thought and Action in Organization* (revised edition), Cleveland: Lakeshore Communications, pp. 91–125.

2. Cooperrider DL and Sekerka LE (2006) Toward a theory of positive organizational change. In: Gallos JV (ed) *Organization Development*, San Francisco: Jossey-Bass, pp. 223–38.

3. Magruder-Watkins J, Mohr B and Kelly R (2011) *Appreciative Inquiry: Change at the Speed of Imagination*, San Francisco: Wiley.

4. Quinn RE (2000) *Change the World: How Ordinary People can Achieve Extraordinary Results*, San Francisco: Jossey-Bass.

Other resources

Appreciative Inquiry Commons: a worldwide portal devoted to the fullest sharing of academic resources and practical tools on Appreciative Inquiry: http://appreciativeinquiry.case.edu

BUSINESS PROCESS REENGINEERING (BPR)

Description

BPR has been developed to support rapid and large-scale transformation of organisational processes led by senior managers. While less well documented than many other approaches, the key underlying principles may be summarised as:

- BPR requires radical rethinking of how a process works that will often be very different to what happened previously;

- The direction of change is set by senior (top) managers;

- Organisations should be redesigned around key processes rather than previous functions and structures; and

- Specialist roles should be replaced with generalist roles, organised within self-managing teams

Use

At the heart of BPR is discontinuous thinking, requiring a holistic perspective on organisational change as opposed to more linear, sequential approaches. Rather than defining a problem and then seeking to develop solutions with stakeholders from a range of options, BPR is given as the solution; executives are encouraged to "…seek the problems it might solve, problems the company doesn't even know that it has" (Hammer, 1990, p. 85).

Strengths and limitations

Results have proved disappointing, BPR typically achieving much less than expected. Indeed, reported failure rates are as high as 70%. Successful reengineering cases have been shown to be characterised by a clear future vision, specific change goals, use of IT to support change, commitment from executive management, clear measurement of milestones and the training of participants in process analysis and teamwork.

Evaluations of BPR projects within the NHS suggest that a pure imposed BPR model is unsuited to professional organisations which require bottom-up commitment from professional staff, as well as top-down commitment from senior managers, in order to succeed. The NHS evaluations reported that BPR projects were implemented in an evolutionary way, and struggled to be able to identify generic processes demanded by the model.

In relation to social care change, Business Process Reengineering would seem to clash with the principle of engaging people who access services, carers, staff and other stakeholders in the change process. Its emphasis on senior management forcing through changes may lead to mistrust and poor engagement in future.

Implementation steps in BPR

1. Prepare the organisation: through clarifying the opportunities and challenges facing the organisation; clear stating the objectives and strategy; and communicating these throughout the organisation;

2. Fundamentally rethink work processes: through identification of current core processes ('process mapping'); specification of new performance objectives; and design of new processes consistent with objectives. These key tasks are typically well resourced and performed by a cross-functional team to encourage new ways of working. Existing processes are redesigned in accordance with the following rules:
   - Processes start and finish with expressed customer needs;
   - Simplify old processes through combination and elimination of steps;
   - Attend to social as well as technical aspects of processes;
   - Do not be constrained by past practice;
   - Identify crucial information required at each step;
   - Perform activities in their natural order;
   - Assume that work is done correctly first time;
   - Listen to people who do the work

3. Restructure the organisation: around the new processes identified; and

4. Implement new measurement systems: to reinforce the changes

(Adapted from Iles and Sutherland, 2001, pp. 50–1)

Further reading

1. Bowns I and McNulty T (2000) *Reengineering Leicester Royal Infirmary: An Independent Evaluation of Implementation and Impact*, Sheffield: School of Health and Related Research, University of Sheffield.

2. Buchanan DA (1997) The limitations and opportunities of business process reengineering in a politicized organisational climate, *Human Relations*, 50, 1, 51–72.

3. Dixon J (1994) Business process reengineering: improving in new strategic directions, *California Management Review*, 36, 93–108.

4. Hammer M and Champney J (1993) *Reengineering the Corporation: A Manifesto for Business Revolution*, London: Nicholas Brealy.

5. Lessem R (1998) *Management Development Through Cultural Diversity.* London: Routledge.

6. Packwood T, Pollitt C and Roberts S (1998) Good medicine? A case study of business process re-engineering in a hospital, *Policy and Politics*, 26, 4, 401–15.

7. Wastell DG, White P and Kalawek P (1994) A methodology for business process redesign: experience and issues, *Journal of Strategic Information Systems*, 31, 1, 23–40.

COACHING AND MENTORING

Description

Mentoring'is intended to improve an employee's performance in a variety of ways, e.g. their ability to plan and meet goals, to lead organisational change, handle conflict or improve their interpersonal skills. This is achieved through development of a relationship with a more experienced colleague or organisational member, who is charged with transferring specific knowledge/skills as part of a career development process. Coaching refers to a developmental relationship between an external Organisational Development (OD) practitioner and a senior manager/executive, and tends to be less directive and more open-ended. Informed by techniques such as active listening, reframing and guided inquiry, overlaid with experience and good judgement, individuals are encouraged to identify new possibilities and redirect their efforts toward those things that matter most to them, yielding performance improvements.

Use

The two approaches are broadly similar. The main difference concern the extent to which the assessment element (stages two and three in box below) is presumed in mentoring, and the process thus moves directly from stage one (establish principles) to stage four (planning interventions)

Strengths and limitations

While common in many organisations, the evidence base for these interventions remains largely anecdotal and based on single case studies. However, it is reasonable to assume that effective mentoring requires mentors to have detailed knowledge of the work of the organisation and be willing to share their experience and knowledge with the mentee – both dimensions are important and need to be carefully considered in the selection process. Mentor relationships may also be particularly important within diverse organisations in order to develop and effectively promote staff from minority social groups.

In relation to social care change, Mentoring can be an important means to share experience and expertise within the organisation. It can promote reflection and learning, and help to strengthen the resilience of individuals to lead change.

Further reading

1. Thomas D (2001) The truth about mentoring minorities: Race matters, *Harvard Business Review*, 79, 198–107.

2. Fagensen E and Baugh G (2000) Career paths, networking and mentoring. In: D Smith (ed) *Women at Work*, Saddle River, NJ: Prentice-Hall.

Stages in coaching and mentoring interventions

1. *Establish principles*: this initial phase involves establishing the goals of the intervention; the resources available (frequency, duration, compensation); and ethical considerations including confidentiality.

2. *Conduct assessment*: this may be either personal or systemic. In the former, the client is guided through an assessment framework that may consist of a range of assessment measures, such as the Myers-Briggs Type Inventory (MBTI) and FIRO-B. Systemic assessments engage the client's peers, managers and team in the process, typically through 360-degree feedback processes.

3. *Debrief the results*: client and facilitator discuss the results and consider the implications for action for intervention goals (which may be revised in the light of the data) and consequent actions.

4. *Develop an action plan*: the specific actions of both client and coach (mentor) are identified and agreed. These may include actions designed to achieve specific goals, new learning opportunities to develop skills, and projects to demonstrate competency.

5. *Implement the action plan*: the coaching and mentoring process consists of one-to-one meetings between coach and client in which the coach facilitates learning through challenge and support.

6. *Evaluate results*: progress is reviewed by coach (mentor) and client at appropriate intervals, with goals and/or action plans reviewed as appropriate, or the process terminated.

(Adapted from Cummings and Worley, 2008, pp. 452–53)

COMMUNITIES OF PRACTICE (CoPs)

Description

A community of practice (CoP) is a group of people who share a profession or craft. They can either develop informally through a mutual interest or be created specifically to gain knowledge considered to be relevant to the field of enquiry. They are considered a good means by which to capture and disseminate tacit professional knowledge within informal settings through members meeting to share their expertise and experiences. In doing so they can contribute to the professional development of the individual members of the community and the community as a whole.

Use

Stages

1. *Support the natural evolution of the community*: CoPs are by nature dynamic and they need to be able to develop and change interests, goals and membership over time

2. *Create opportunities for discussions and reflection*: within the CoP and with outside perspectives to encourage different ways of achieving the COP's goals

3. *Welcome different levels of participation*: for example a core group with leadership roles, an active group who participate regularly, and a peripheral group who learn from their level of involvement. This latter is usually the largest group.

4. *Develop public and private spaces*: CoP members should be able to develop relationships within the group as a whole and between individuals according to specific needs

5. *Focus on the value of the community*: in which participants discuss the value of their participation

6. *Combine familiarity and excitement*: to energize members through sharing their insights into practice

7. *Nurture a regular rhythm for the community*: coordinating cycles of activity which allow members to regularly meet, reflect, and evolve

(Adapted from Wenger, McDermott and Snyder, 2002)

Strengths and weaknesses

In supporting the transfer of professional knowledge, CoPs may potentially increase organisational performance through decreasing the 'learning curve' facing new employees, generate new ideas for addressing customer/client needs and be a source of support for the individuals involved. In doing so they may also increase motivation and collaboration between colleagues.

In relation to social care change, CoPs can enable collaboration between people in different roles and can include people who access services too. They are an excellent opportunity for learning and development and to develop trust between members. The danger is that those who are not members may seem them as exclusive and feel less valued.

Further reading

1. Lesser LE and Storck J (2001) Communities of practice and organizational performance, *IBM Systems Journal*, 40, 4.

2. Wenger E (1998) *Communities of Practice: Learning, Meaning and Identity*, Cambridge: Cambridge University Press.

3. Wenger E, McDermott R and Snyder WM (2002) *Cultivating Communities of Practice*, Harvard Business Press.

CULTURAL WEB

Description

It can be difficult to bring to the surface the assumptions that underlie how people view an organization and what is acceptable in terms of behaviour and values. The Cultural Web is a tool that can be used to reveal the way that people understand their organization and help them to share their underlying cultural assumptions.

stories

rituals and routines

symbols

The paradigm

control systems

power structures

organisation structures

Aspect of culture	Description of aspect	Key question
Organisational structures	Formal and informal relationships that constitute the power structure	How formal or informal are these structures?
Control systems	Administrative systems which illustrate what is valued	What is monitored/controlled and why?
Rituals and routines	The protocol for 'doing things' – what is important	What core management beliefs do these reflect?
Stories	The way in which culture is reproduced and shared with new members	What stories are told and what do these reveal?
Symbols	Signifiers of meaning	What symbols limit, deny or control behavior?
Power structures	People and processes which control the behavior and expression of members	What are the core beliefs of top management?
Paradigms	Shared frameworks regarding how the organization works	What are the dominant cultural assumptions?

Use

The Cultural Web is used to guide staff and managers to consider current expectations about the organisation and in so doing promotes reflection on the expectations required to support new ways of working.

Stages

1. Analyse the culture as it is now. Consider each element in turn and pose the question associated with it to stimulate discussion;

2. Repeat the process, this time considering the culture that is wanted/needed;

3. Map the two together to identify:
   a.   Current strengths
   b.   Misalignments between elements
   c.   Factors that need to be reinforced
   d.   Factors which need to be changed
   e.   Behaviours/beliefs which need to be fostered

4. Prioritise required changes and develop an implementation plan

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Strengths and limitations

Widely used in consultancy, the model provides an accessible approach that enables participants to share their understandings of organisational life. Critics raise concerns over the extent to which organisational cultures may be considered to be singular or as amenable to change as implied in the model; while helpful in surfacing the insights of organisational members, such critics question the extent to which cultures may be changed mechanistically to align with expectations without incurring unintended consequences.

In relation to social care change, the Cultural Web can help to bring to the open the underlying beliefs and behaviours of staff, These beliefs and behaviours may help or hinder achieving positive change and the greater engagement of people accessing services and their families. It can also help to illustrate the thinking of different functions and professional groups.

Further reading

1. Johnson G and Scholes K (1999) *Exploring Corporate Strategy* (5th edition). Prentice Hall.

2. Johnson G, Scholes K and Whittington R (2008) *Exploring Corporate Strategy* (8th edition), Prentice Hall.

DE BONO CREATIVE THINKING ('SIX THINKING HATS')

Description

The 'Creative Thinking' approach is a tool for stimulating focused group discussion and individual thinking. It builds on the assumption that the human brain may respond to challenges in six distinctive ways:

- *Information (White)* – the facts at hand

- *Emotions (Red)* – intuitive reactions of emotional feeling

- *Discernment (Black)* – logic of caution

- *Optimism (Yellow)* – logic of possible benefits

- *Creativity (Green)* – investigation of possibilities

- *Meta thinking (Blue)* – a combination of the other types

Each of these responses may be harnessed to encourage reflection on a specific problem/challenge/question. By organising participants to consider the problem specifically from each of the six perspectives, the group will be more creative in their response to the problem. The metaphor of 'six thinking hats' is adopted to describe the ordered use of the six approaches in an agreed sequence.

Use

The Creative Thinking process

- Successful use of the approach requires the adoption of the right 'hat' as required in sequence, to review the nature of the presenting problem; develop a set of solutions; and finally select the course of action

- The meeting opens form a 'blue' hat (meta-thinking) perspective, to agree the conduct of the meeting and the goals;

- The group then considers their response to the issue from a 'red' hat (emotion) perspective, to collect reactions to the problem, and any constraints on possible solutions;

- Discussion moves to yellow (optimism) and then green (creativity) thinking explore options and possible solutions

- Discussion then follows from white (information) and black (discernment) perspectives, to explore the development of ideas and problems in the solution set

(Adapted from De Bono, 1985)

Strengths and limitations

The principal strength of the approach is its structuring of thought process is in group situations. In usual practice Creative Thinking proposals will be considered from each of the perspectives identified each at the same time; so that while participant X considers the potential of a situation (yellow), participant Y considers the potential problems (black). This can prove to be destructive, especially where there are status distinctions between participants and/or ego clashes. This is largely avoided under the 'hats' method, in which everyone present considers the issue from the same perspective at the same time, and remain focused on the task. However, conflict may result if the process is poorly facilitated – participants may feel 'railroaded' if there is not time to consider the problem from all of the perspectives during the course of the meeting.

In relation to social care change, the 6 Hats exercise can help to free up stakeholders from their usual perspectives and enable them to jointly develop more innovative responses.

Further reading

1. De Bono E (1985) *Six Thinking Hats*, London: Little Brown and Company.

FIVE WHYS

Description

A simple yet powerful approach, it enables the factors that lead to a situation arising through asking a series of questions related to the event or issue.

Use

This approach is useful to guide the investigation of single problems or issues rather than explore an organisation holistically. Once a problem has occurred, the first 'why' question is 'why did this happen?' It is likely that a number of answers will be found, and for each the next 'why?' is asked: 'Why is that?' The sequence continues until the question has been asked and answered five times.

Manifest problem: a care home resident complains that a request for water was ignored		
1. Why?	Care assistant A did not bring it when asked	
2. Why?	She was sent by senior staff member B to help with another resident with a more serious need	A failed to inform B of the request to fetch a drink of water
3. Why?	The team were handing over to the next shift with fewer staff available to undertake tasks	B did not ask A to hand back outstanding tasks
4. Why?	Staff handover practice requires attention	B would benefit from communication training
5. Why?	The handover system has not been looked at for some time and not all requirements are being observed in practice	Appraisal processes are not well developed and require attention
(Adapted from Iles and Sutherland, 2001, p. 31)		

Strengths and limitations

A very simple tool, it enables potentially complex events and influences which underlie a problem or negative event to be explored. It encourages the search for solutions to underlying problems rather than to simply deal with presenting symptoms. It may also be used with client groups, as part of a participatory approach, to encourage reflection on their experiences and identify root causes to be addressed.

In relation to social care change, the 5 Whys' simple language makes it potentially accessible to staff and people accessing services. The exercise does though need to be facilitated well to enable those taking part to challenge what may be long held assumptions and beliefs. It can be used throughout a change process to understand and therefore respond to the existing practice in an organisation and also why a change programme has encountered barriers to its implementation.

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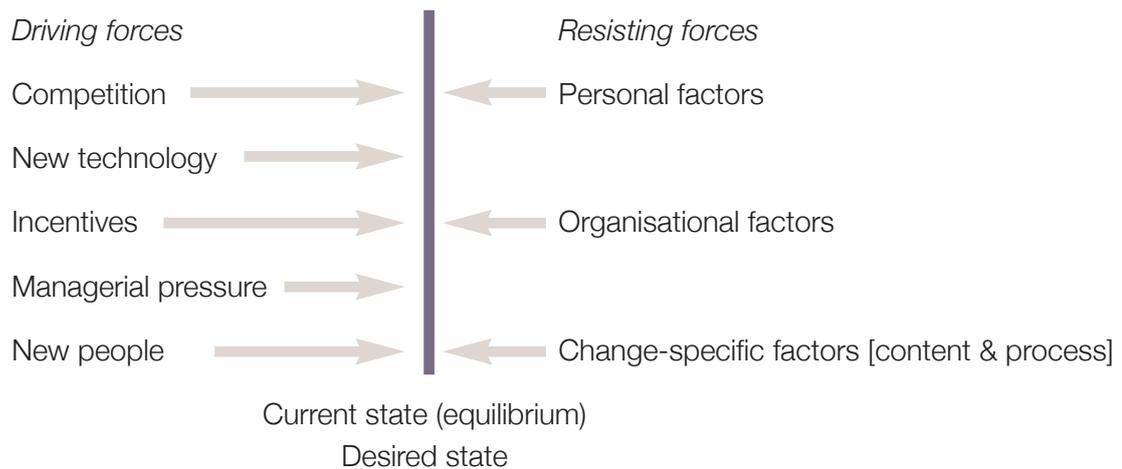
FORCE FIELD ANALYSIS

Description

This diagnostic approach is designed to assess the likelihood of organisational change occurring within a given context. The forces in the title refer to the perceptions of staff about a specific factor and its influence;

- *Driving forces* are those which seek to move change in a particular direction

- *Restraining forces* act to reduce driving forces

Equilibrium refers to the point at which the sum of driving forces is equal to the sum of restraining forces.

Force Field Model

Driving forces		Resisting forces
Competition	→ ←	Personal factors
New technology	→	
Incentives	→ ←	Organisational factors
Managerial pressure	→	
New people	→ ←	Change-specific factors [content & process]

Current state (equilibrium)
Desired state

The diagram incorporates three types of 'resistance factors' (Self and Schraeder, 2008):

- *Personal factors*: aversion to change; impact of change on personal life; external concerns

- *Organisational factors*: history of change interventions; credibility of change agent(s)

- *Change-specific factors*: planned change perceived as erroneous; flawed planning; concern over interpersonal impact of proposed change

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Lewin's three 'rules' in relation to force fields and change are:

1. Any increase in a 'driving' force results in an equal increase in 'resisting' forces; the equilibrium point is maintained, but under increased pressure/tension. Rephrased, for every action there is an equal and opposite reaction;

2. Consequently, effort should be made to reduce resisting forces, enabling movement toward the desired goal without increasing tension; and

3. Group norms ('culture') are an important force in influencing organisational change, as perceptions constitute reality i.e. what is thought to be the case will inform action

Use

The approach is used once priorities for change have been identified and agreed, using methods such as SWOT, PESTELI, 7S or the Six-box model. Its value arises from its focus on the actions required to support successful implementation of the change programme though identification of, and response to, the specific 'resisting' forces at play.

Strengths and limitations

The approach is particularly suited to complex 'political' environments and offers an analysis of the increased tension and opposition that can arise through attempts to 'force through' change. For the approach to work in practice requires thorough and perceptive identification of resisting forces (diagnosis), and creative ways of addressing/reducing them (action).

In relation to social care change, Force Field Analysis provides a simple framework that most people can follow. It can help to bring clarity to barriers to and supports for change, including political influences and likely responses from staff and other stakeholders.

Further reading

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JOB ENRICHMENT

Description

Job Enrichment seeks to make work more meaningful and satisfying through increasing autonomy and responsibility of staff by providing a variety of significant tasks. Its main focus is on the attributes of the work itself ('core job dimensions'), mediated through individual member differences ('critical psychological states'), and it is suited to contexts which do not require high levels of coordination and where employees have a high need for personal growth (Hackman and Oldham, 1980).

Use

Stages in Job Enrichment implementation

1. *Diagnosis*: current jobs are profiled using the Job Diagnostic Survey (JDS) for their motivational score. This is a combination of their meaningfulness, autonomy and feedback. The JDS also records employee readiness for change, and this information is combined to identify whether additional interventions are required to reduce staff dissatisfaction prior to job redesign.

2. *Formation of natural work units*: by grouping tasks together to increase 'ownership' of the tasks. Grouping increases both task identity and significance, which together improve meaningfulness.

3. *Combination of tasks*: jobs are typically enlarged and tasks combined to increase task identity, autonomy and skills development.

4. *Establishing client relationships*: this requires that the client(s) be identified, contact directly established, and client judgements of quality be made directly. Improved feedback increases staff motivation to perform.

5. *Vertical loading*: i.e. handing responsibility and control from manager to worker. The increased autonomy leads to accountability and feelings of responsibility for outcomes, improving performance.

6. *Opening feedback channels*: direct, immediate feedback of performance as it occurs typically has a motivational effect

(Adapted from Walters, 1975, pp. 57–71)

Relationships between job dimensions, psychological states and work outcomes

Core job dimensions	Critical psychological states	Personal/work outcomes
• Skill variety • Task independence • Task significance	Experienced 'meaningfulness' of work	• High internal motivation • High performance • High work satisfaction • Low absenteeism and turnover
Autonomy	Experienced responsibility for work outcomes	
Feedback (performance)	Knowledge of results of work undertaken	
Mediated by individual differences:	• Knowledge and skills • Need for growth/development • Context satisfaction	

(Adapted from Hackman and Oldham, 1980)

Strengths and limitations

While the approach has much potential to motivate staff, it requires a supportive organisational context for the potential benefits to be realised. In particular, this context will include:

• *Technical systems*: standardised systems such as rigid practice guidelines limit employee discretion (autonomy);

• *Human resources system*: formal job descriptions may limit job flexibility and thus enrichment potential. Change may require significant negotiation with professional bodies and/or unions

• *The control system*: budgets and accounting practices may limit the variety (and thus the challenge) of jobs, and quality control systems may effectively curtail employee discretion, reducing motivation

• *Supervisory systems*: line managers effectively determine employee autonomy and feedback, and a controlling management approach makes enrichment very difficult.

In relation to social care change, Job Enrichment has the potential to provide an organisational environment in which staff are able to take more responsibility for the work of the service and to develop new approaches. This could be seen to clash with the need for senior management to be assured that regulation and good practice standards are being met across an organisation but this is not necessarily the case.

Further reading

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LEAN

Description

LEAN is a systems-based approach to change. The term refers to an organisation's ability to do more with less and has two key pillars of the approach: Just-In-Time ('continuous flow'), and Jidoka ('intelligent systematisation').

1. *Just-In-Time* ('continuous flow'): seeks to minimise costs from end-to-end of the entire process through developing which meets the demands upon it in a continuous flow with minimum spare capacity.

2. *Jidoka ('intelligent systematisation')*: also known as 'automation with a human touch', Jidoka is considered applicable to any situation in which human decisions are replaced with processes. It requires standardisation without removing employees' ability to actively intervene as required, in order to absorb variety and attend to quality issues in real-time. Standardisation should thus only ever be used as a method for workers to improve processes (a means to an end), never a way for managers to impose rigid controls which drive out flexible responses to expressed customer need (an end in itself). It is the exact opposite of a call centre approach where workers follow a 'script' and have no authority to address variation, which is considered 'dumbed-down' systematisation.

Since its primary application in automotive production techniques, LEAN has subsequently been applied in a range of service industries and those provided or funded by public sector.

Use

Steps in LEAN

1. *Specify value from a customer (client) perspective*: this is a crucial first step in order to ensure that the organisation is designed to provide the correct service(s). Where services have a range of potential values and different perspectives in what value is most important it is recommended to design value streams around service users at each step of a process rather than around functional silos such as 'day care'.

2. *Identify the value stream for each process and identify 'wasteful' steps that do not add value*: this requires mapping of all processes involved in providing a service. For example, all stages involved in provision of adaptations to assist home living to identify value-giving and wasteful steps in the pathway. Start and end points are agreed, for example diagnosis of a physical disability to provision of an aid. The mapping activity is undertaken by those who come in contact with the client throughout the process, initially looking at current practice on their own part of the pathway and subsequently coming together to identify wasteful steps.

3. *Make the product/service flow continuously and standardise the process to 'best practice'*: this requires redesign of the process and elimination of the identified wasteful steps, such as waits for assessments to be undertaken.

4. *Introduce 'pull' between all steps where continuous flow is impossible*: where it is not possible to eliminate a wasteful step immediately bring in practices and capacity which 'pull' the client/customer to the next step in the process. For example, a reablement service which is aware of and able to respond to demand for people being discharged from hospital.

5. *Manage toward perfection*: systematically reducing waste within processes should become part of the organisational culture, so that non-value adding activity is constantly removed.

Implementation could be simplified as: focus on clients; design care around them; identify value from a client perspective and get rid of everything else (waste); minimise time waiting for care and throughout its course.

(Adapted from Burgess and Radnor, 2013, p. 222)

Strengths and limitations

Most implementations of LEAN within health and social care sectors have used lean principles and adapted these to suit the service and context. Key steps include a review of processes and/or assessment of capacity and demand, and linking the intended improvement activity to strategy. There are potential issues through the difference in workforce-manager relationships from that found in private manufacturing.

In relation to social care change, the terminology within LEAN may seem unfamiliar to people accessing services, carers and other stakeholders. However through its focus on value for the customer, engagement of staff, and aspiration of ongoing learning and improvement it does have a good fit with the principles of social care change. This will though require a flexible and accessible approach to implementing LEAN.

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Other resources

Lean Healthcare Academy: A UK-based collaboration which helps NHS and social care organisations generate time and cost savings and improve the patient experience through implementation of Lean principles: www.leanhealthcareacademy.co.uk/

OPEN-SPACE METHOD

Description

The approach brings together groups of people to identify and address issues connected with a shared matter of interest. Its basis is that shared understandings built through participation will yield coordinated action. The purpose of the event is to surface differences in understanding, work through them, and build a new response. Successful events require a compelling theme; attendance of all those with a stake in change; and relevant tasks to complete within subgroups during the event. The approach seeks to addresses four dilemmas facing facilitators:

• *Voice*: need for participation tempered by possibility of being overwhelmed

• *Structure*: needing structure to complete task, but freedom to explore nuances

• *Egocentricity*: participants holding tightly to their personal view will foreclose options

• *Emotional contagion*: participants feed off the frustrations/excitement of others ('groupthink') resulting in solutions people cannot accept in reality

Open-space responds by imposing a minimal formal structure, allowing participants to self-organise around topics associated with the overarching conference theme

Use

Stages in an Open-Space event

1. *Set conditions for self-organising*: The stage is set by announcing the conference theme. Participants are instructed that there will be small group discussions run by participants themselves, addressing any topic they believe critical to the theme. Two sets of norms are established:

   a. '*law of two feet*' – moving between groups is encouraged, participants stay only if they are interested, learning or contributing; and

   b. '*four principles*' – the people who attend are the right people (the contribution counts, not who said it); whatever happens is the only thing that could have (responsibility for what happens); whenever it starts is the right time (creativity); and when it's over, it's over (freedom to move on)

2. *Create an agenda*: participants suggest topics related to the conference theme. This process continues until all topics have been identified. All topics are collected and displayed along with locations – times to meet and discuss. Participants sign up to as many topics as they wish. The person announcing the topic convenes as agreed

3. *Coordinate activity*: as events happen, convenors summarise discussions/recommendations/actions proposed and make these available in a central 'newsroom' to encourage further reflection

Strengths and limitations

The approach is designed to focus the attention and energy of participants who make up a whole system to developing shared changes in vision, strategy and culture. It is well suited to large scale system-wide change, or in addressing a major change in the operating environment. Practical difficulties include the need to suspend service delivery for the time required to stage the event, especially where services are provided to vulnerable clients.

In relation to social care change, Open-Space events can be a good way to bring together people accessing services, carers, staff and other stakeholders and generating constructive discussions. If facilitated well they can lead to better understanding of other's positions and be an opportunity to strengthen collaboration and trust.

Further reading

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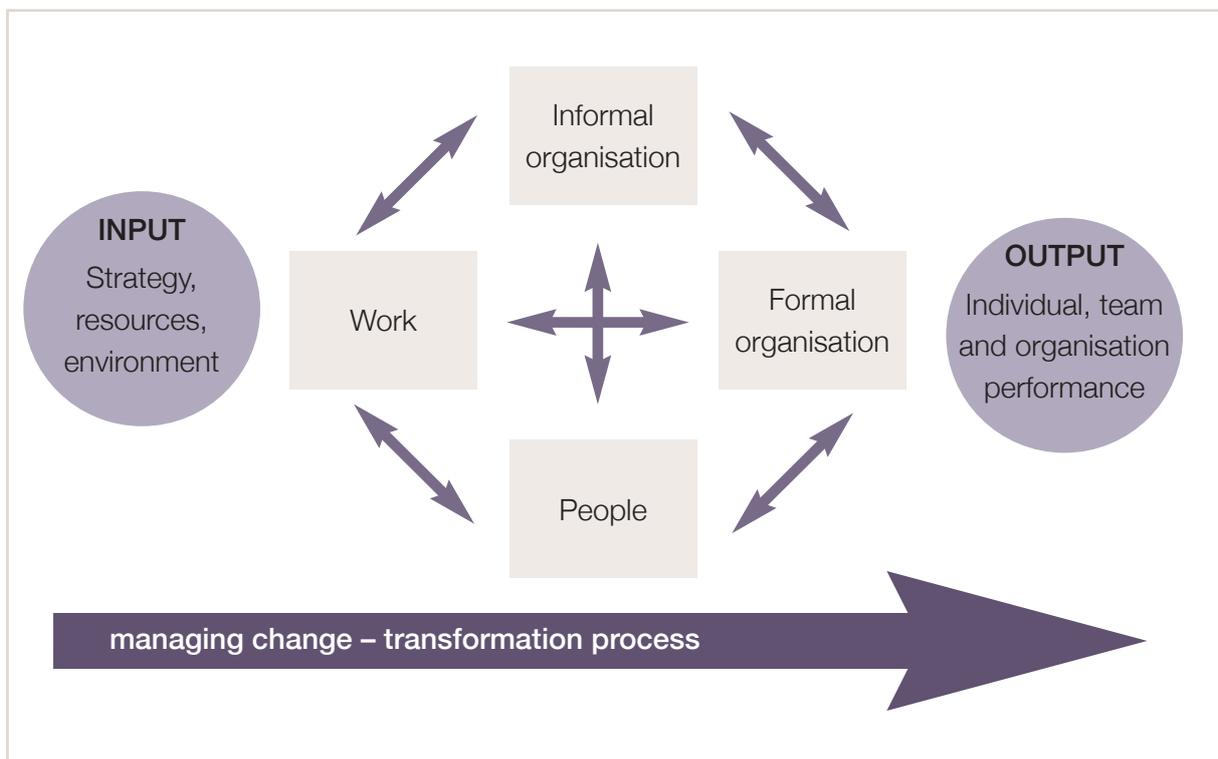
ORGANISATIONAL CONGRUENCE MODEL (NADLER & TUSHMAN)

Description

The Organisational Congruence Model is designed to capture the dynamics of change management. Organisations are characterised as sets of interacting sub-systems which scan changes in the external environment. The political dimensions of organisational life are incorporated within the model in the 'informal organisation' dimension. The organisation is viewed organically as a system that takes inputs from strategy, resources and the external environment, transforming them into outputs (activities, behaviours and performance) at individual, team and organisational levels.

The Nadler & Tushman Congruence Model

(After Nadler & Tushman, 1977)

Use

Designed as a tool to aid analysis of the change process, the model does not provide set answers about what to do, but what might be required in a specific organisational context. It is based on the idea that the social, managerial and technical aspects of organisations are interdependent, and that these different elements need to be aligned (i.e. congruent) in order to optimise performance.

The four interdependent organisation components in the model are:

* *Work*: the daily activities of individuals, and the processes, pressures and rewards available to them

* *People*: the skills and expectations of the workforce

* *The formal organisation*: the policies, systems and structures which organise the work; and

* *The informal organisation*: the unwritten practices which emerge over time, including influence and norms

The model assumes the interdependence of each of these components, and the underlying expectation of *congruence* means that an organisational change in any of the subsystems requires complementary change within the others. Thus a change in the nature of the work undertaken may require realignment with the skills of employees (the people), the way work is organised (the formal organisation) and the alliances between employees (the informal organisation). Failure to undertake alignment work results in problems of resistance, control and power – from a fear of the unknown, flux in formal systems and the threat of removal of power from currently powerful interests. These may be reduced by engagement activities in change, transition management structures and building powerful coalitions for change.

Strengths and limitations

A flexible tool designed to encourage exploration of organisational dynamics in context, rather than specify detailed configurations regardless of time and place. Its concern social, in addition to technical, components is also helpful in considering the warp and weft of organisational life. However, the very flexibility and absence of a 'template' of proven solutions to common problems may limit its appeal.

In relation to social care change, the Congruence Model can be criticised through its focus on internal stakeholders. However, the contribution of people accessing services and other external stakeholders can be integrated within the transformation process. Its emphasis on the interconnection of different components of a change process will support the planning and coordination of activities, and through exploring the formal and informal dimensions it encourages discussion of different experiences and influences.

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ORGANISATIONAL LEARNING

Description

Organisational Learning approaches emphasise the organisational structures and social processes which enable individual employees and teams to learn and to share their knowledge. Learning is organisational to the extent that it:

- Aims to achieve organisational goals;

- Is distributed among organisational members; and

- Outcomes are embedded in systems, structures and culture(s)

Much of the Organisational Learning literature offers concrete advice on how organisations should be designed and managed to promote organisational learning. Most agree on five key characteristics:

1. *Structure*: flat hierarchies with few organisational layers, good relationships between different services and functions, and networking across internal and external organisational boundaries. These features promote information sharing, system thinking and involvement in decision-making

2. *Information systems*: these are required to provide an infrastructure for the collection, processing and rapid sharing of complex information

3. *Human resources practices*: appraisal, training and rewards are designed to encourage the acquisition and dissemination of skills and knowledge

4. *Organisational culture*: the values of the organisation promote creativity and openness, nurture innovation, encourage staff to risk failure, seek to learn from mistakes and to share information

5. *Leadership*: leaders are required to model the openness and risk taking required of employees and so provide the required empathy and support

Organisational Learning is seen as a transformational process, and the characteristics above enable members to carry out organisational learning processes related to discovery, invention, production and generalisation.

Use

The intervention process is designed to help shift organisational members' thinking from *Mode I* to *Mode II* learning. *Mode I* is concerned with defending self and others from hurtful information, and results in defensive behaviours such as withholding evidence, rivalry and blaming others. It is strongly related to *single-loop* learning, in which existing understandings are uncritically

reinforced. In contrast *Mode II* learning is based on continuous assessment, resulting in low defensiveness, personal mastery and collaboration with others, and the public testing of understandings. It is related to *double-loop*, or '*generative*', learning in which theories in use are changed openly, and '*deuterolearning*', in which learning processes are themselves challenged and improved routinely.

Stages in Organisational Learning interventions

1. *Discover theories in use and their consequences*: this initial phase involves establishing the mental models ('theories in use') of organisational members, and the consequences which follow from their application. As such models are usually not clearly articulated or understood, members need to infer them by generating and analysing data in open dialogue, inquiring into their own beliefs and those of colleagues and reflecting on the assumptions on which they are based. This enables faulty assumptions which lead to ineffective behaviours being uncovered. Alternatively, theories in use may be explored by constructing an 'action map' out of interviews with members concerning recurrent problems, actions taken to resolve them, and the results of such actions. These are fed back to members for them to identify functional and dysfunctional learning within the organisation.

2. *Invent more effective theories in use*: drawing on the results above, members produce alternative theories in use associates with *model II* learning, involving double-loop learning to create and enact new theories ('learning by doing'). Practitioners support this though facilitation of open disclosure about the effects of habitual approaches on development of more efficient processes, and exposure to insights from *systems thinking* (inter-relatedness, holistic processes; processes of change), with the result of supporting efforts to change.

3. *Continually monitor and improve learning processes*: this is the '*deuterolearning*' element – learning how to learn. This involves periodic assessment of the structures and processes which support single- and double-loop learning, and is reliant upon members' skills in *Model II* learning.

(Adapted from Cummings and Worley, 2008, pp. 444–47)

Strengths and limitations

While increasingly popular as a means of fostering innovation, full implementation of Model II systems remains elusive and difficult, if not impossible, to achieve in practice

In relation to social care change, Organisational Learning presents a framework through which individual and organisational learning can be encouraged in a supportive and collaborative culture.

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PARETO CHARTS

Description

A type of chart that helps to identify the key issues that cause negative or positive impacts on a service. The number and/or percentage of different factors are mapped on a graph and put in order of frequency with the most common on the left. Those that contribute to the first 80% of an impact are seen as the most important ('the vital few') with those which contribute to the remaining 20% seen as relatively unimportant ('the trivial many').

Figure: An example of a Pareto chart
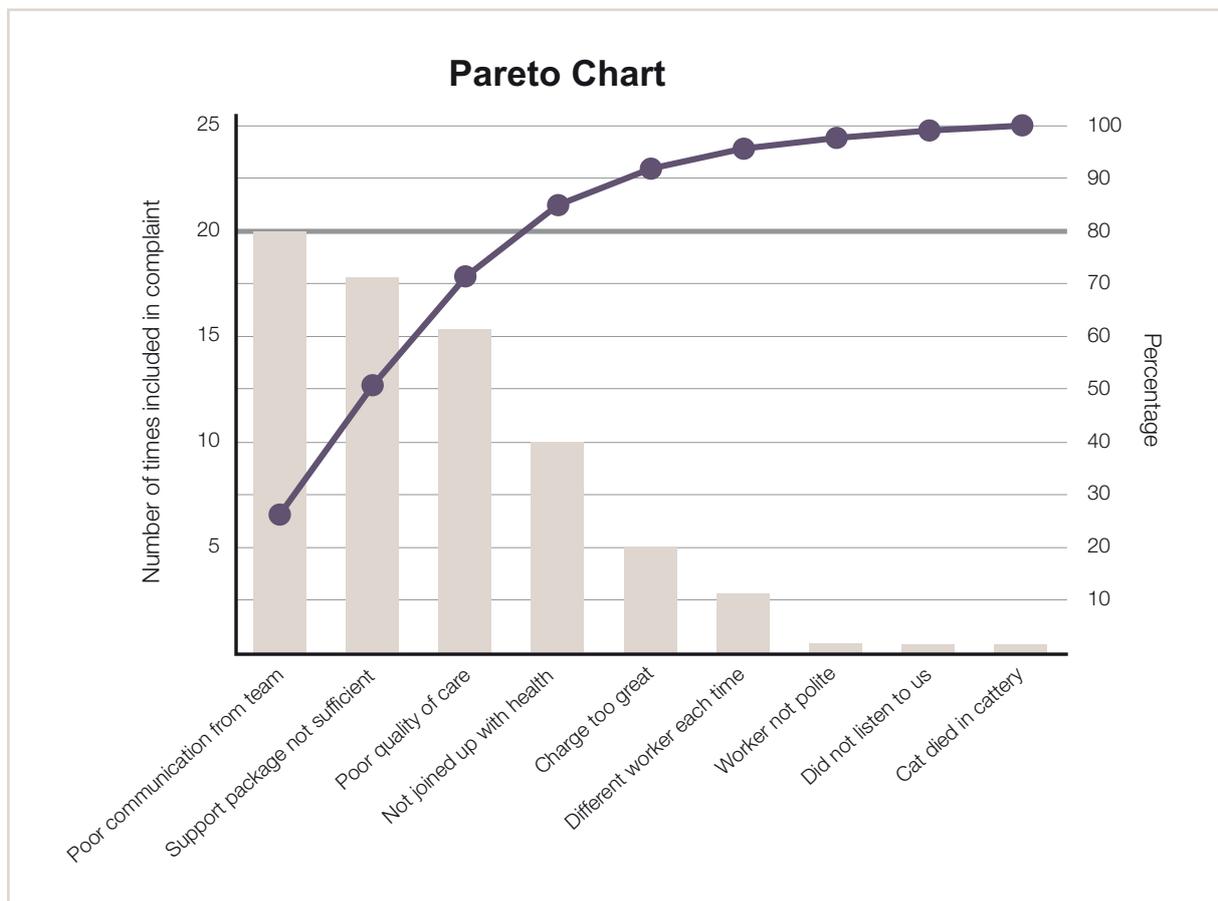
The purpose of the chart is to show the relative importance of each of a list of categories/factors in relation to the specified unit of measure. In the context of improving quality, it is used to highlight the most common errors, the most frequent types of customer complaints, or the most complained about product or service etc. Effort is concentrated on solving the problems with the most frequent occurrence (towards the left hand of the distribution).

Strengths and limitations

Focusing on the most frequently occurring problems promotes organisational efficiency, and the social process involved in data collection and analysis may promote organisational cohesion and the 'acceptability' of a proposed change. However, the analysis does not indicate the root cause of problems – only their relative frequency – and therefore cannot be used in isolation to identify a specific course of action in response to the identified problem. Further, while they show which problem is the most frequent, they do not indicate the severity of each problem, and thus relatively infrequent problems with catastrophic impact would not be prioritised.

In relation to social care change, Pareto charts can be a helpful means to focus on the issues of most importance and so define how best to channel the available energy and resources. However there is a danger that issues that are not that common may be of great individual importance to the people concerned. As some types of information are more easily analysed in this format, if used in isolation the Pareto chart could lead to other valuable information sources not being considered.

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PERFORMANCE APPRAISAL

Description

Performance Appraisal systems involve the direct evaluation of performance (individual or group) by others (manager or peer). Their main use is to link organisational goal-setting processes with systems of reward in terms of pay and career progression. While this may act as a powerful incentive for improving individual and team performance, traditional appraisal systems often show poor effects. As a result, newer forms of appraisal, which seek to enhance employee involvement and better balance employee and organisational need, are gaining ground.

Table: Comparison of traditional and high involvement appraisals

Performance appraisal		
Elements	Traditional appraisal	High-involvement appraisal
Purpose	Organisational, legal, fragmented	Developmental, integrative
Appraiser	Supervisor, manager	Appraise, co-workers, others
Role of appraise	Passive recipient	Active participant
Measurement	Subjective, concerns over validity	Objective and subjective
Timing	Periodic, fixed, administratively driven	Dynamic, timely, employee-driven

Use

Appraisals are conducted for a variety of purposes including skills development and decisions over pay and promotion. Given multiple purposes, appraisal systems are best tailored to balance multiple organisational and employee needs, through direct involvement of appraise, co-workers and managers in assessing the purposes of any appraisal, and adjusting process to fit the purpose, whether pay, development or promotion.

Implementing Performance Appraisal systems

1. Select the right people: include human resources staff, legal representatives, trade union representatives, senior management and system users in the design process to ensure organisational and staff needs are fully recognised.

2. Diagnosis: obtain a clear overview of current appraisal processes, work design and goal-setting and reward systems – to consider current strengths and weaknesses.

3. Establish purposes and objectives: these could include career planning, performance improvement, disbursement of rewards, providing employee feedback

4. Design the appraisal system: informed by the purposes identified above. This includes consideration of who is to perform the appraisals, how performance will be determined (and who by), and the frequency of feedback. Information needs to be timely, accurate, acceptable to appraises, focused on important strategic requirements, and feasible.

5. Experiment with implementation: Pilot implementation is recommended to identify and address flaws, given the complexity and potential for problems of such systems.

6. Evaluate and monitor: ongoing evaluation is important. User satisfaction should be monitored and changes made accordingly.

(Adapted from Mohrman et al, 1994, pp. 16–19)

Strengths and limitations

While appraisal systems linked to rewards may act as a powerful incentive for increased performance in relation to organisational goals, employee engagement in the process is required for the benefits to be derived. Such involvement in gathering performance data and identifying training needs is likely to increase employee acceptance of the feedback process. Similarly, participation in goal setting and how these will be measured is likely to result in greater validity and acceptance of results.

In relation to social care change, Appraisal Systems will be familiar in most organisations within the sector. To fulfil the principles of social care change these should be implemented in line with the 'high involvement' approach outlined above.

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PESTELI

Description

This is a checklist tool to support reflection on the environment in which an organisation, or specific sub-unit of it, operates. It is an acronym of seven factors:

- *Political*: the internal and external influences which may affect organisational performance and the options available to it

- *Economic*: the extent and nature of the competition faced by the organisation, or the services provided by it, and the economic resources available to it

- *Sociological*: changes in demography or broader culture which may affect the demands for services provided by the organisation

- *Technological*: innovations in ways of doing things and/or tackling new or old problems. Not necessarily limited to technical equipment, such innovations may include ways of thinking or organising

- *Ecological*: definition of the wider system of which the organisation is a part, and how it interacts with the people and organisations within this system

- *Legislative*: the legal context within which the organisation operates

- *Industry*: a consideration of the attractiveness of the industry in which the organisation currently operates.

Use

PESTELI may be used to assess factors which may favour the organisation and those which may prevent it growing and achieving its mission. Its potential value resides in using the information derived from the assessment to inform strategic change interventions.

Strengths and limitations

The strength of the approach lies in its potential to stimulate reflection on a range of potentially important factors in organisational performance. The danger common to all such checklist approaches is that once an entry is made under each heading this may be considered to be the end of the process of reflection, bringing discussion to a premature close before the full complexity of the factor has been considered. Similarly, a common mistake is to make entries under the headings without reference to the underlying objectives of the organisation, and without informing any change programme. While the tool may be used to promote reflection in the light of major developments with the potential to radically alter the operating environment of

the organisation, these insights will be of little consequence unless the tool is used to inform a wider organisational change process.

In relation to social care change, PESTELI will help to define the purpose of a service or organisation and the political pressures that a change process will have to respond to. Its broad headings mean that it can be adapted for use in a social care context.

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PLAN-DO-STUDY-ACT (PDSA) CYCLE

Description

The PDSA cycle is a four-stage process improvement model used to rapidly trial planned changes to practice, incorporate the lessons learned from the trial into the change process, and integrate continuous improvement into the new service.
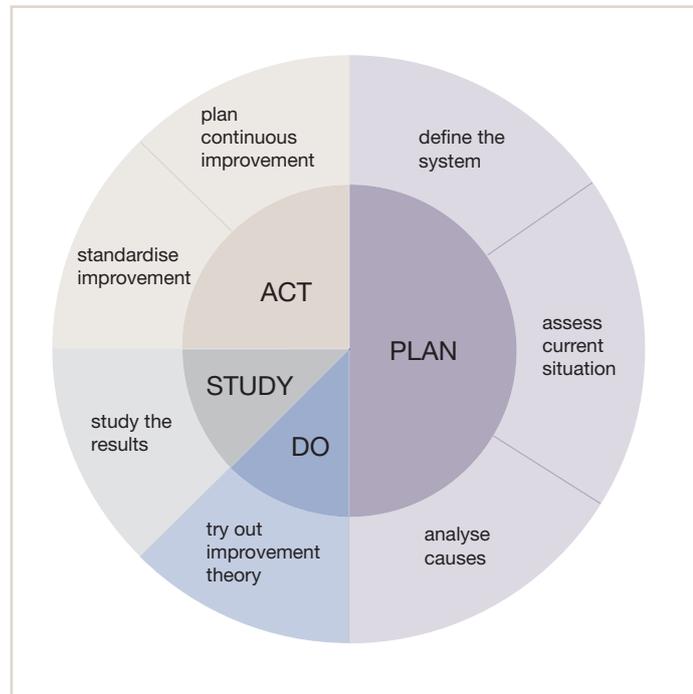
Use

Stages in the PDSA Cycle

1. *Planning*: this initial stage requires a thorough diagnostic evaluation of the problems/issues that need to be addressed by the change – firstly to identify their probable causes and secondly to design possible solutions;

2. *Doing*: a small-scale (pilot) project is undertaken as a limited implementation of the proposed change(s). Data is collected and observations made to identify the impact of the change and any unintended consequences;

3. *Studying*: results of the pilot are compared with expectations to identify unintended consequences and shortfalls in improvements;

4. *Acting*: improvements to the proposed intervention are made, incorporating lessons learned from the pilot phase. The changes may be tested again in another pilot, or the decision taken to proceed to full implementation. Ongoing quality improvement activity (continuous cycles) may also be adopted

Strengths and limitations

The main strengths of PDSA cycles are derived from the rapid testing of proposed changes on a small scale. This allows changes to be achieved relatively quickly and cheaply, with good early indication of the strengths and weaknesses of the proposed changes. Data from the pilot intervention enables the early identification of potential problems, and the involvement of staff in the implementation and improvement process means that they are less likely to resist the changes – they are part of the solution and their input is central to the process.

In relation to social care change, PDSA provides a means to test out improvements in service delivery that have been suggested by people accessing services, their carers, staff or other stakeholders and to learn what works and what does not. It will require senior management to allow frontline staff to test out new ideas and share this learning across the organisation.

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POWER-INTEREST GRID

Description

Stakeholder mapping techniques are used to assess the attitudes of a range of stakeholders to the proposed course of action, and to select the most appropriate course of action with regard to each. The most widely used technique is the Mendelow Power-Interest Grid, which presents the two dimensions of interest in a grid, and indicates the course of action required for such a stakeholder.

Figure: Power/Interest Grid

(Mendelow, 1991)
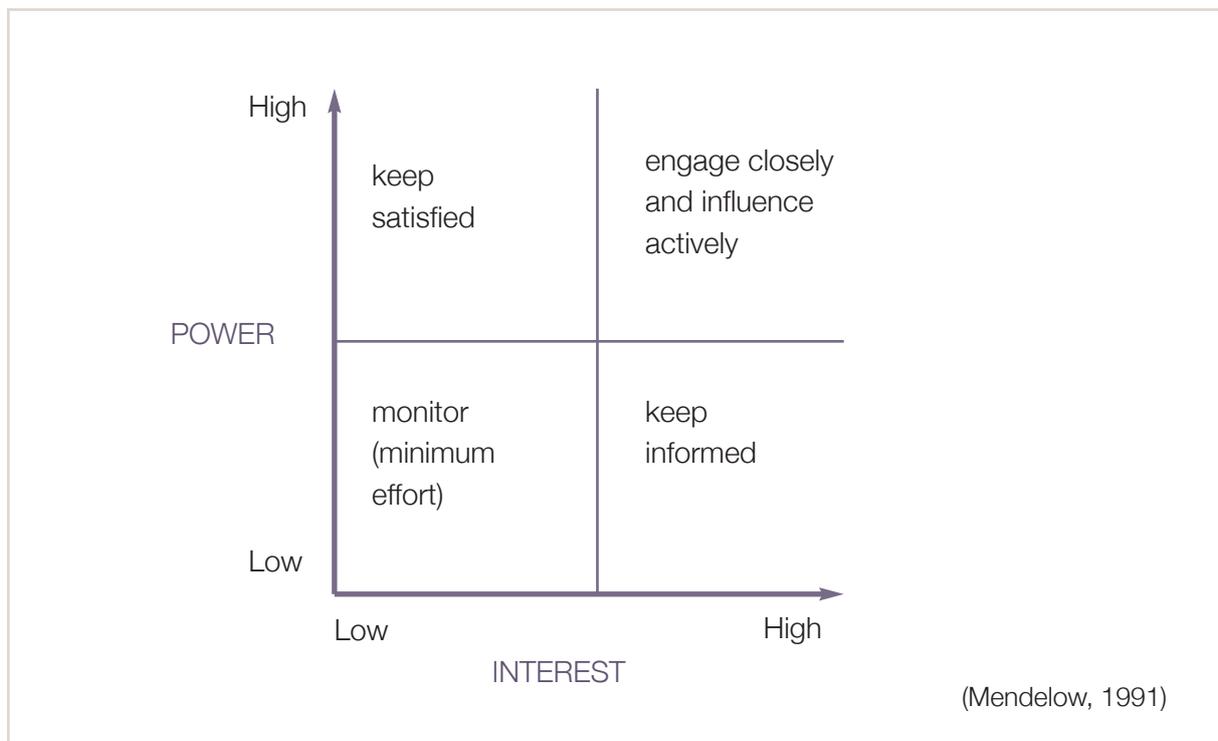
Use

Stakeholders are defined as those who have an interest in the actions of the organisation, either directly or indirectly. Used to clarify the potential consequences of proposed changes for a range of affected parties, stakeholder analysis helps planners of change to prioritise the stakeholder groups to engage with, and the manner in which they should be engaged. They may be undertaken at the start of the change project, or periodically throughout the change process.

Strengths and limitations

The simple diagnostic tool may help to identify the key people needing to be informed about the project during implementation, including potential risks and the possible effect of 'negative' stakeholders.

In relation to social care change, the Power-Interest Grid helps to identify the governance and political processes that will be important to navigate and stakeholders who could be a barrier to what is proposed. However, it suggests that most energy should be spent on stakeholders with most power which means that those who could be principally affected by the change could be neglected.

Further reading

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PROCESS MODELLING: PROCESS FLOW

Description

Process modelling may be used to clarify the range of different views on, and expectations of, current processes. It seeks to visually represent the dynamic interaction between different elements of a system and may be used to engage those involved in discussions about potentially beneficial changes. Process modelling tools are adaptable, can be used in different settings, and may be used as stand-alone diagnostic tools as well as supporting a wide range of interventions such SSM and organisational development. Two principle methodologies are *Process Flow* (described here) and *Theory of Constraints* (see next Tool).

Process Flow diagrams capture all of the individual stages in a process in an accessible manner. They may be developed to show what should happen, what actually happens, or what a team would like to happen in the future; often, all three are developed so that teams develop their 'ideal' process in the light of their detailed understanding of the shortfalls in current practice against expected processes.

Use

Stages

1. Facilitator brings together the staff responsible for each stage of service delivery to map out the process. Staff members are asked to consider the process as it should currently operate, and write out each step on a 'post-it' note and assemble the process by posting the notes on a flip-chart in sequence. They are encouraged to discuss this as they work and capture all of the steps to provide as accurate a picture as possible.

2. Discussion continues until everyone is happy that the process has been accurately captured.

3. The facilitator leads discussion on differences between the process as it should happen, and what actually happens in practice. Staff members capture the differences with additional 'post-it' notes to detail problems with the current process.

4. The facilitator then leads a final discussion in which staff members are encouraged to suggest alternatives that make the pathway more efficient, through removal of redundant stages or duplications.

Strengths and limitations

The approach is a good way of exploring the current reality of processes from a range of perspectives. It is often used as a starting point from which to plan an 'ideal' process which improves on current practice.

In relation to social care change, Process Flow can engage people accessing service, their families and other stakeholders either directly or indirectly in mapping out how processes can and should work. If being applied in an service it is important that there is support from senior management and they are willing to allow flexibility. If not, then staff members may not be able to make the changes due to standard organisational processes and standards.

Further reading

IISO (1985) *Information processing – Documentation Symbols and Conventions for Data, Program and System Flowcharts, Program Network Charts and System Resources Charts,* International Organization for Standardization.

PROCESS MODELLING: THEORY OF CONSTRAINTS

Description

Process modelling may be used to clarify the range of different views on, and expectations of, current processes. It seeks to visually represent the dynamic interaction between different elements of a system and may be used to engage those involved in discussions about potentially beneficial changes. Process modelling tools are adaptable, can be used in different settings, and may be used as stand-alone diagnostic tools as well as supporting a wide range of interventions such SSM and organisational development. Two principle methodologies are *Theory of Constraints* (described here) and *Process Flow* (see previous Tool).

The Theory of Constraints (TOC) seeks to improve interdependent organisational processes. As the overall speed of the process is limited by the slowest step, TOC concentrates on the process as a whole to identify the constraints ('bottlenecks') that limit the speed of the process, and then restructures the organisation around these constraints. Changes are made in the light of five focusing steps (below), designed to facilitate a process of ongoing improvement. Constraints may be internal or external to the organisation; the former consisting of problems with equipment, people or policies, and the latter referring to insufficient demand for the product or service.

Use

Stages: The five focusing steps

1. Identify the system constraint(s) preventing the organisation from obtaining more of the goal in a given unit of time;

2. Decide how to address the system's constraint(s)in order to get the most out of the constraint(s);

3. Align the whole system or organisation to support the decision made above;

4. Make the other major changes needed to increase the constraint's capacity; and

5. If in the previous steps a constraint has been removed then, go back to step 1.

(Adapted from Goldratt, 1999)

Strengths and limitations

Developed in a manufacturing context, the technique has latterly gained ground in marketing, sales and public services, particularly health care in the context of waiting list reduction. Any evidence on its strengths/weaknesses?

In relation to social care change, Theory of Constraints can engage people accessing service, their families and other stakeholders either directly or indirectly in mapping out what prevents a process being implemented successfully. If being applied in a service it is important that there is support from senior management – if not then the service may not be able to make the changes due to standard organisational processes and standards. The language connected with this approach may be off putting for many stakeholders and therefore other phrases such as 'blocks and barriers' may be more helpful.

Further reading

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PROJECT PLANNING

Description

The approach consists of a range of tools designed to bring structure and coherence to a time-bounded change process. It shares generic functions with the wider range of change management approaches:

- The assumptions underpinning plans and analyses are made explicit

- Iterations are required between planning, analysis and action

- Comparison of actual achievements with anticipated results is used to make changes in implementation and assess success

Such projects have four defining features:

1. Defined objectives (performance, time, cost)

2. A temporary life-span

3. Limited resources, not all of which may be under the direct control of the project manager

4. A wider organisational context with multiple other purposes

Large-scale projects are typically grouped into a programme of linked projects, each constituent part considered as a discrete entity.

Use

Stages in Project Planning

1. *Defining project goals which are measurable and attainable*: this requires generating a shared understanding of why a change is necessary; what the change hopes to achieve; its scope and constraints

2. *Planning the work programme to meet the specified objective(s)*: this requires mapping the interdependencies of component parts required to meet intermediate goals, activities and resources required

3. *Implementation*

4. *Monitoring progress*: assessment of progress against the plan and undertaking corrective actions as required to ensure delivery

5. *Completion* ('embedding' within mainstream activity)

(Adapted from Iles and Sutherland, 2001, p. 68)

Tools

Given the complex nature of projects, a wide range of tools is available to support their management. The most common are briefly introduced, additional information available as indicated in 'further reading' below.

* *Work Breakdown Structures* (WBS): the first step in detailed project planning, WBSs define project scope, specifying the work required and acting as a project boundary. General objectives are progressively broken down into increasingly defined areas of work, identifying the specific, detailed tasks required of individual team members.

* *Milestone plan*: this specifies the sequence of achievements required to build towards attainment of the final project objectives, detailing the various stages of the project.

* *Responsibility chart*: this details the lines of communication and responsibilities held by staff involved in the various project phases. It differentiates decision-makers, those that undertake tasks, those providing expert advice and those needing to be kept informed.

* *Gantt chart:* effectively combining the milestone plan and responsibility chart. Tasks are indicated according to duration, showing for each task the prior tasks required to be completed and the subsequent tasks dependent on its completion.

* *Network diagram*: this involves the explicit mapping of the interdependencies between tasks, to identify the critical path of activities required for the deadline to be reached.

* *Risk matrix*: this identifies potential adverse events which may impede project progress, plotting the likelihood of occurrence (low to high) with the potential impact to the project if the event occurs (low to high). It is designed to facilitate risk management to reduce the likelihood of occurrence or the potential impact, especially for those risks considered both likely and of high potential impact.

* *Stakeholder analysis*: considered earlier, this requires an assessment of the power and interest of various stakeholder groups, in order to develop management strategies as appropriate.

Strengths and limitations

Strengths of the approach include clarity of direction, transparent accountability of participants and the anticipation of problems/difficulties before they arise. These significantly improve the experience of participants throughout the life of the project. However, their utility depends upon the degree to which adequate time is spent in their preparation (which is itself a limited resource) and also their use; a plan which is not referred to during implementation is simply a waste of time.

In relation to social care change, Project Planning can support with the organisation and coordination of change. There is a danger that a too rigid approach could lead to the process becoming more important than the outcome. Flexibility, accessibility of terminology and regular review of the overall purpose are vital.

Further reading

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READINESS AND CAPABILITY

Description

Change interventions require the active support of the specific individuals and groups deemed central to their success. Once the appropriate individuals and groups have been identified, their readiness (attitudes; willingness, aims) and capability (ability, influence, authority) to successfully undertake the activities required of them may be assessed. The 'Readiness – Capability Assessment Chart' is a simple diagnostic tool to support the process of identification of individuals and groups and their ranking (high, medium or low) with regard to both readiness and capability on the dimensions above.

Use

Relatively straightforward in use, such assessments lend themselves to planning further interventions to increase readiness and capability as required – the phrase 'as required' is however important. In relation to securing compliance, Senge (1990) advises that an assessment be made of the level of support required from the individuals and groups identified, and concentrating energy to achieve the required level (active commitment, genuine compliance, formal compliance) in each case.

Strengths and limitations

Two major limitations common to the change readiness literature are a failure to directly address the role of emotion ('affect') as well as knowledge ('cognition') in individual readiness to change; and the need to address readiness at multiple levels organisational levels (individual; work group; wider organisation) simultaneously. It is helpful to the extent that it draws attention to the role of emotion in mobilising staff support/resistance to change, and the hierarchical nature of many complex organisational structures.

In relation to social care change, the Readiness and Capability Chart provides a simple framework to consider the potential support or resistance to the proposed change and so help to plan how to appropriately engage people in shaping the process.

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SELF-MANAGED TEAMS (SMTs)

Description

SMTs consist of a group of individuals who undertake interrelated tasks. Typically charged with delivering a complete product or service, they are collectively responsible for making decisions on work tasks (processes) and working methods (practices). They are usually responsible for setting their own goals, act as generalists rather than specialists within their area of responsibility, and are rewarded on the basis of team (as opposed to individual) performance. Team performance and member satisfaction are underpinned by three sets of inputs: task design; process interventions; and organisational support systems.

1. *Team Task Design*: tasks are derived from stated team goals which must be aligned with organisational strategy and objectives. Tightly-defined tasks provide a clear team boundary and area of responsibility. Large enough to accomplish the required set of interrelated tasks yet small enough to allow coordination and face-to-face decision-making, SMTs are typically responsible for specific work processes. Team members need to be trained to perform tasks without reliance on other teams. Similarly, SMTs require the authority to manage resources, information to monitor performance and freedom to make adjustments as necessary.

2. *Team process interventions*: over time, teams may not function effectively due to poor communication between members, unclear roles and responsibilities, and an inability to resolve conflicts. If such problems emerge then reflection and possibly external support will be required.

3. *Organisational support systems*: in order to function well, there needs to be a good 'fit' between SMTs and wider organisational processes. Despite their greater autonomy, external leadership remains important and it requires an understanding by senior managers of group dynamics, the wider external environment and the team's skills.

Use

Stages in SMT implementation

1. *Agreeing the approach*: this involves suspension of existing work rules, provision of time and external facilitation to diagnose current practices and devise new ones. Typically, job and wage security is provided to ensure workers engage fully;

2. *Diagnosis of the work system*: an assessment of the extent to which current practice meets external demands (e.g. customer expectations of quality)

3. *Generating appropriate designs*: if diagnosis identifies interdependent tasks then redesign is undertaken to specify team mission/goals, an ideal workflow, skills required of members, training plans for induction, and the decisions over which the team has autonomy. This is undertaken following two guiding principles:

   a.   *Compatibility*: design processes are consistent with the values underlying the approach i.e. joint communication and boundary management requires a highly participative process involving all stakeholders in order to jointly derive acceptable solutions;

   b.   *Minimal critical specification*: designers should only specify the features critical to implementation; all others left free to vary according to circumstance (e.g. work methods; task allocation; job assignments)

4. *Specifying support systems*: wider organisational systems (pay, measurement) also need to be redesigned to support and incentivise team practice

5. *Implementation*: this generally requires extensive training to enable team members to undertake many tasks, together with opportunities to build the team and its skills in relation to self-management. Evaluation of the work design is also required, together with ongoing adjustment and monitoring in the light of identified difficulties.

6. *Continual improvement*: continuous redesign of processes as required to optimise operation

(Adapted from Cummings and Worley, 2008, pp. 391–92)

Strengths and limitations

Most published evaluations show sustained positive results; increased productivity, efficiency and quality is a common finding, as are marked improvements in staff job satisfaction. It is important to note that for the benefits to be derived interventions need to honour the core principles – no meaningful information or decision-making autonomy, no improvements.

In relation to social care change, Self Managed Teams will potentially facilitate trust and learning within and between teams. In turn this could enable staff to have greater autonomy of how they work in practice. There is a danger that teams could become inward looking and therefore it will be important to ensure that the focus remains on the needs and aspirations of the people who access services and their carers.

Further reading

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2. Elloy DF (2011) Superleader behaviours and self-managed work teams: perceptions of supervisory behaviours, satisfaction with growth, and team functions, *Journal of Business & Economics Research, 4, 12, 97–102.*

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4. Cohen SG and Bailey DE (1997) What makes teams work: group effectiveness from the shop floor to the executive suite, *Journal of Management,* 23, 3, 239–60.

7S MODEL

Description

This model identifies organisational components required to harmonise; if each supports the others the organisation is considered to be 'organised'. The seven components, all of which are identified with words starting with the letter s, are:

- *Strategy*: the plan of action which informs resource allocation to meet identified goals;

- *Structure*: features of the organisational chart (such as the degree of centralisation/decentralisation, degree of hierarchy, presence or absence of an internal market) and their interconnections within the organisation

- *Systems*: organisational processes and procedures, including the flow of information

- *Staff*: job titles and responsibilities/duties within the organisation

- *Style*: Senior managers behaviour intended to achieve organisational goals

- *Shared values*: the values held in common by organisational members, and the extent to which they are consistent with organisational goals

- *Skills*: the capabilities of staff

Use

The model is intended to be used in two ways:

1. Organisational strengths and weaknesses may be considered by assessing the links between each of the Ss: as the model is primarily concerned with alignment, no S is a strength or weakness in itself; this may only be considered relationally. Harmonies between Ss are considered strengths, dissonances weaknesses.

2. The model suggests that changes in any one S will have a reciprocal impact on the others. Thus any planned change should consider the necessary complementary changes required in other Ss to ensure harmony, and thus strength.

Strengths and limitations

The approach has been praised for its combination of 'soft' organisational components (staff, style, shared values and skills) as well as 'hard' factors (strategy, structure and systems), and its emphasis on the importance of organisational culture in enabling people to agree on what behaviour is acceptable. However, its' usefulness has been challenged by others who argue that different viewpoints are important and if managed properly conflict and disagreement can lead to an organisation being stronger.

In relation to social care change, the 7S model will be primarily be of help in discussions with internal stakeholders in an organisation. It could be adapted to have a broader view which incorporates the perspectives of external stakeholders include people accessing services.

Further reading

1. Hughes D (1996) NHS managers as rhetoricians: a case of culture management? *Sociology of Health and Illness*, 18, 3, 291–314.

2. Martin J (1992) *Cultures in Organisations: Three Perspectives*, New York: Oxford University Press.

3. Waterman RH, Peters TJ and Phillips JR (1980) Structure is not organisation, *Business Horizons*, June, Foundation for the School of Business, Indiana University.

SOFT SYSTEMS METHODOLOGY (SSM)

Description

SSM assumes that most change processes which involve people will be complex as there will different views about what is important and how the processes can be improved. To address such complexity, SSM uses action learning methods in diagnosis of problems and the crafting of solutions. Stakeholder views are explored iteratively, with the intention of identifying feasible changes which can accommodate the range of views (or even to reach consensus).

The approach places participants at the centre of the process, tailoring the SSM approach to a specific situation – deriving a unique approach in order to ensure learning and change within the specific context. It developed in response to the disappointing real-world application of 'hard' approaches to systems design. In contrast to 'hard' systems analysis, which treats systems as objective phenomena, SSM explicitly incorporates the social dimension into the analysis of systems, taking account of the existence of multiple worldviews in relation to the operation of systems and the dynamism at the heart of human systems. Most importantly, it seeks to take account of the *generative* nature of social action; the way in which the social world is continuously (re)created by people thinking, talking and acting. Systems are present in the very process of inquiry in the world, rather than simply in the world awaiting discovery.

Use

Stages in SSM

1. Exploring a problem, and its causes, from a wide range of stakeholder perspectives. Investigation proceeds with an open mind without giving priority to a particular point of view

2. Developing statements ('root definitions') which accurately describe the main purpose(s) of the organisation from the perspectives of different stakeholders, as well as its inputs, outputs and dynamics

3. Debating the manifest 'problem' with stakeholders, drawing on;

    a.   Activities required to achieve 'root definitions' through diagrammatic depictions of 'root definitions' using flow charts

    b.   Comparing idealised service models with current reality through discussion and observation

    c.   Considering possible changes in structure(s), process(es), practice(s)

4. Undertaking a programme of change implementation in the light of agreements

 (Adapted from Iles and Sutherland, 2001, p. 34)

Strengths and limitations

SSM has been criticised for its use in practice to appease stakeholder groups rather than undertake radical system changes. In contrast, Seddon (2005) identifies SSM as a means of forging a single unifying organisational purpose, so that stakeholders' thinking is influenced during the analysis and discussion of problems in order that they might be addressed. Concerns have also been raised by the time and cost implications of the approach.

In relation to social care change, SSM's emphasis on valuing different perspective, seeking to shape change through discussion, and organisational learning is in line with the change principles. The facilitators will need to ensure that extended discussions do not lead to the implementation of change being delayed.

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SWOT ANALYSIS

Description

SWOT is a tool for identifying priorities for action. The term is an acronym for organisational or service Strengths, Weaknesses, Opportunities and Threats, and is intended to promote reflection on the extent to which an organisation or service can meet the needs and expectations made of it through encouraging reflection from a wide range of perspectives.

Use

The technique is used in many settings and sectors, with analysis typically following the steps below:

Stages in SWOT analysis

1. The team writes down its organisational purpose ('mission');

2. Using this frame of reference, they then apply tool(s) to assess internal organisational *strengths* and *weaknesses* (e.g. 7S, or Weisbord's six-box model);

3. A similar analysis of environmental opportunities and threats is then undertaken, again using an appropriate tool such as PESTELI;

4. Further questions are then asked of each of the factors listed under the four SWOT headings:

a. Factors related to strengths or weaknesses (internal)

   i.   What are the consequences of this?

   ii. Does it help or hinder our mission?

   iii. What are the causes of this strength/weakness?

b. Factors related to opportunities or threats (external environment)

   i.   What impact is it likely to have on us?

   ii. Will it help or hinder us to achieve our mission?

   iii. What must we do to respond to this threat?

5. Reflection follows on the mission and the four components; specifically the causes of strengths and weaknesses, and response required to the identified opportunities and threats. These are then linked and prioritised, for action by the team.

(Adapted from Iles and Sutherland, 2001, pp. 40–41)

Strengths and limitations

Its key potential strength is the simultaneous analysis of both external *environmental* context [opportunities and threats] and internal *organisational* elements [strengths and weaknesses]. The benefit derived from any specific SWOT analysis depends partly upon the extent to which the factors identified are valid, prioritised, and addressed directly via specific change interventions. SWOT has been criticised on the grounds that it often results in an over-long list of factors without prioritising between them, little in the way of verification or supporting evidence, and its results often unused. The typically subjective, unsystematic and non-quantifiable nature of many SWOT analyses means that in practice they may have little predictive power. However, they may still have some practical benefit to the extent that they provide some opportunity for engaging staff in change programmes. The approach has been praised for its combination of 'soft' organisational components (staff, style, shared values and skills) as well as 'hard' factors (strategy, structure and systems), and its emphasis on the importance of organisational culture in enabling people to agree on what behaviour is acceptable. However, its usefulness has been challenged by others who argue that different viewpoints are important and if managed properly conflict and disagreement can lead to an organisation being stronger.

In relation to social care change, SWOT analysis provides a simple framework that most people can follow and if well facilitated can add to any stage of the change cycle.

Further reading

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THEORIES OF CHANGE (TsoC)

Description

Initially developed as an evaluative methodology, the approach is increasingly used to support the development of social change interventions as well as evaluate their implementation. In developmental applications, the focus in on facilitating stakeholders to identify long-term programme objectives and then working back through the sequence of events ('causal pathway') required to reach the goals, planning changes accordingly. These sequences are mapped diagrammatically to show the logical relationships between each step. The distinctive elements of the approach lie in the requirement of participants to explicitly model the desired outcomes of an intervention, and enabling explicit comparisons between planned effects and those actually achieved following implementation.

Use

The technique is used in many settings and sectors, with analysis typically following the steps below:

Stages in the TsoC approach

1. Identify long-term goals (and the assumptions behind them)

2. Map backwards from these goals, identifying the preconditions required for the goals to be realised

3. Explain the rationale linking the preconditions to outcomes

4. Consider and identify the optimal interventions required to bring about the required changes

5. Identify performance indicators to measure required outcomes (and so assess the initiative's performance)

6. Write a narrative which summarises the logic of the initiative

Strengths and limitations

The approach is very flexible and may be used at any point of programme implementation. From the outset, it may be used to inform the development of interventions consistent with planned outcomes. Alternatively, it may be used following implementation to assess the extent to which changes were implemented as planned and the degree to which anticipated benefits were realised. Implementation and evaluation are kept transparent to stakeholders, so that

participants are always aware of what is happening and why. There is some concern that the linear logic of 'cause and effect' may be too simple to capture the recursive nature of causation within complex social systems; however, this may be offset to an extent by feedback cycles to inform ongoing changes to implementation (as in action research).

In relation to social care, the explicitly participatory planning phase of Theories of Change is helpful in involving a wide range of partners in reaching agreement over anticipated outcomes, discussing what changes will lead to these outcomes, and planning the stages required to implement these changes.

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THOMAS-KILMANN CONFLICT MODE INSTRUMENT (TKI)

Description

The TKI is designed to explore preferences for behaviour in conflict situations. It uses two axes, assertiveness on the vertical and cooperation on the horizontal, to differentiate five different conflict modes: competing, avoiding, collaborating, accommodating and compromising. The tool consists of thirty pairs of statements and respondents select the extent to which each statement accords with their preferred style of dealing with conflict.

Figure: TKI conflict modes
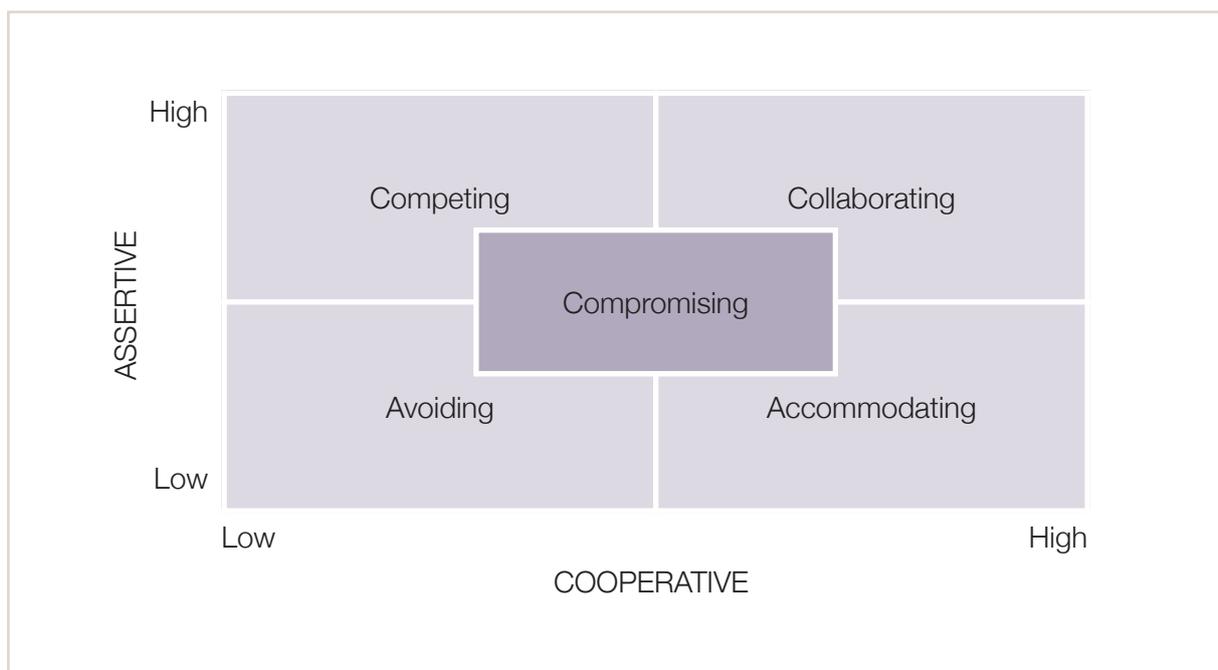
Use

Available to purchase as a self completion questionnaire, the TKI is useful for exploring preferences for behaviour in situations of conflict. It is commercially available form Kilmann Diagnostics by following the web link in 'further reading' below.

Strengths and limitations

Widely used, quick to administer and available in English, French and Spanish versions, the tool affords respondents insights into their conflict preferences for further discussion within coaching /mentoring situations. Concerns have been expressed over cultural bias in its use in non-western contexts.

In relation to social care change, Thomas-Kilmann can support those engaged in the process to more positively respond to conflict. It can be an opportunity for those involved to learn about the styles and preferences of other stakeholders.

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TICHY'S TECHNICAL POLITICAL CULTURAL (TPC) FRAMEWORK

Description

Tichy offers an open system model of organisational change management, consisting of inputs (environment, history and resources), throughputs or change leavers (mission/strategy, tasks, people, processes and networks), and outputs (performance). The focal point is the output variable, performance, which is dependent on the effects of the input and throughput variables. These are considered to be interdependent, but some are considered to have stronger effects than others.

Figure: Tichy's TPC Framework
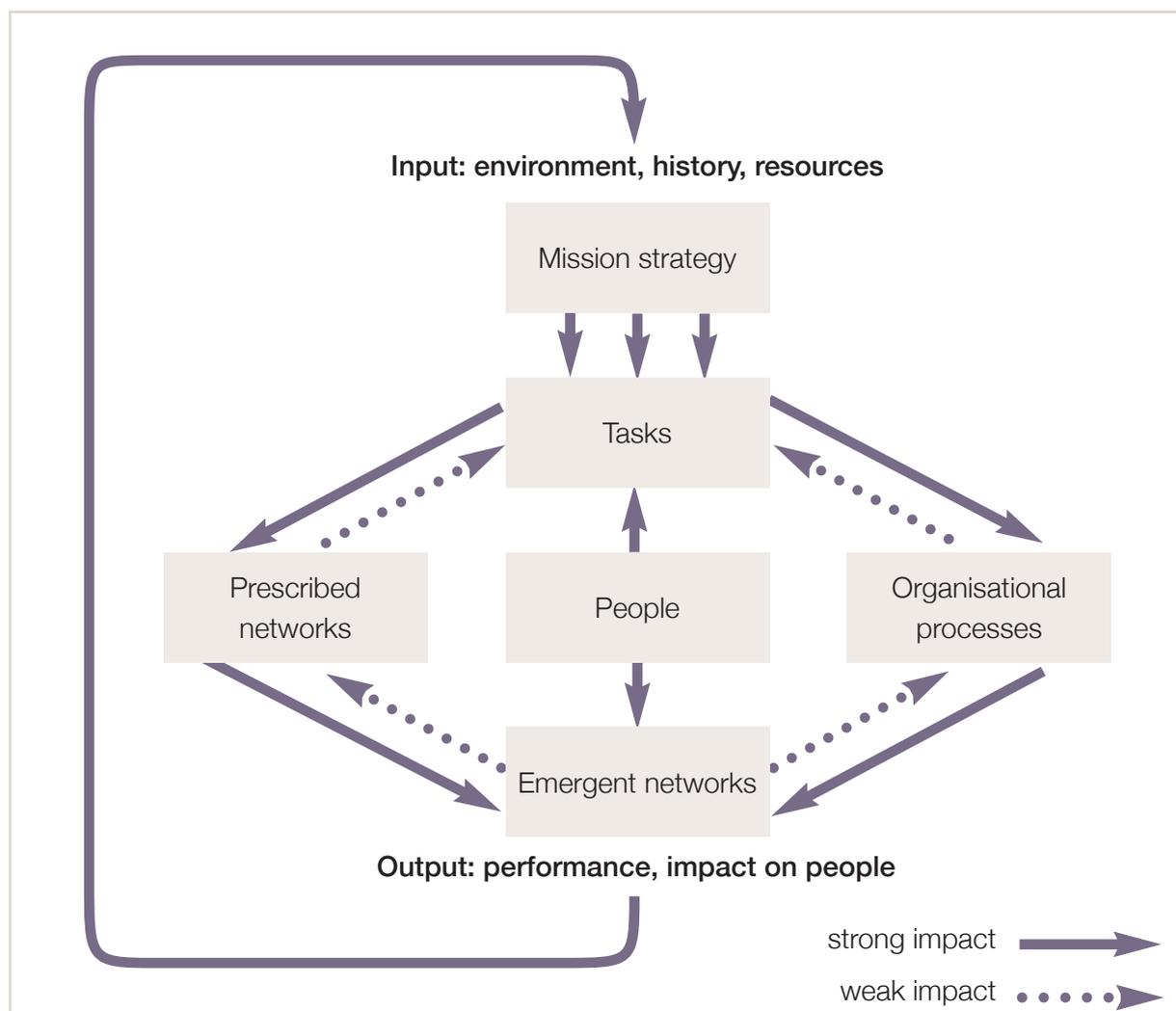
(Adapted from Tichy, 1983)

In the model above, *mission* is understood as the approach adopted to meeting organisational goals; tasks as the means by which work is accomplished; *prescribed networks* the 'formal' organisational structure of departments and governance relationships; *people* the characteristics of organisational members; *processes* the mechanisms by which formal organisational structures are discharged including rewards and sanctions; and *informal processes* those emergent relationships between members. Crucially, Tichy overlays the technical, political and cultural (TPC) dynamics operating within each of the variables to generate four diagnostic questions:

1. How well are the parts of the organization aligned with each other for solving the organization's *technical* problems?

2. How well are the parts of the organization aligned with each other for solving the organization's *political* problems?

Tichy's rope metaphor

3. How well are the parts of the organization aligned with each other for solving the organization's *cultural* problems?

4. How well aligned are the three subsystems of the organization, the technical, political, and cultural?

The model posits that each of these three systems (TPC) must be aligned with each other in order for change to be effective. This is often explained through the metaphor of a 'rope' in which each strand needs to be interwoven.

Use
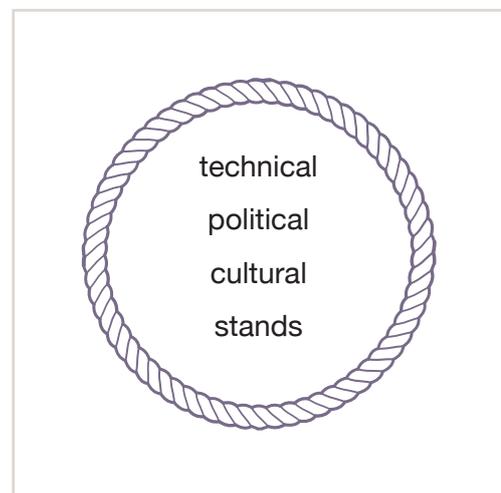
The model is intended to be used to facilitate discussion and to diagnose areas requiring improvement from a predetermined set of factors including coordination of tasks, staff relationships and organisational processes. It was initially envisioned that it would be used by an external organisational development consultant. They would collect data relevant to the four questions for each variable in the model, through document analysis, interviews and/or questionnaires. Summary data is be displayed in a matrix and analysed for alignment to inform action planning.

Strengths and limitations

The approach has been praised for its combination of 'soft' organisational components (staff, style, shared values and skills) as well as 'hard' factors (strategy, structure and systems), and its

emphasis on the importance of organisational culture in enabling people to agree on what behaviour is acceptable. However, its usefulness has been challenged by others who argue that different viewpoints are important and if managed properly conflict and disagreement can lead to an organisation being stronger.

In relation to social care change, TPC will primarily be of help in discussions with internal stakeholders in an organisation. It could be adapted to have a broader view which incorporates the perspectives of external stakeholders include people accessing services.

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TOTAL QUALITY MANAGEMENT (TQM)

Description

Also known as Continuous Quality improvement (CQI), TQM aims for wide-ranging employee involvement in continuous change process designed to exceed customer expectations of services. The focus is explicitly on processes, and management support is directed at providing employees with the necessary training and coaching required for them to undertake this work. Employees' knowledge of change processes is increased, autonomy and decision-making responsibility given to front-line staff, and process improvements incentivised by linking rewards to performance improvements.

Originally implemented to boost the quality of post-war Japanese industry, the approach became popular in the west in the early 1990s during a period of economic downturn. Iles and Sutherland (2001) distil four underlying principles from the authors most closely associated with the approach:

- Success requires organisations to continuously meet the needs of internal and external customers;

- Quality results from the implantation of the connected tasks, processes and interaction – these may be understood and modified to yield higher quality;

- Most employees aspire to do a good job and this motivation may be supported , enhanced and harnessed to further improve processes; and

- Insights into the causes of variation in quality within processes may be made with the application of simple statistical methods if the data is reflective

Table: Quality guidelines

The Fourteen Points	The Seven Deadly Sins
1 Create a common purpose	1 Changing your purpose on a regular basis
2 Have a clear vision and values	2 Emphasizing short term profits
3 Do not go always go for lowest cost	3 Evaluation of performance or annual review
4 Ensure there is good leadership	4 High turnover of senior management
5 Stop using empty statements that people do not believe	5 Only focussing on meeting financial targets
6 Do not give people a set number of tasks	6 Excessive medical costs
7 Train people on the job	7 Excessive costs to ensure that standards of performance are met
8 Have a culture of trust	
9 Enable different teams and services to work together	
10 Plan and take the actions required to achieve the change	
11 Keep improving how the service or organisation works in practice	
12 Do not only use a standard way of measuring quality	
13 Encourage people to have pride in their work	
14 Keep providing training updates	

(Adapted from Deming, 1986)

Use

TQM is typically implemented in five stages:

TQM implementation steps

1. *Gain long-term senior management commitment*: their role is to give direction and support through long-term implementation over multiple years, especially in enabling the workforce to make changes to support systems (e.g. human resources, finance, customer services) and in the allocation of significant resources to training.

2. *Train the workforce in TQM methods*: extensive training is required in Statistical Process Control (SPC) techniques, brainstorming, histograms, flowcharts, scatter diagrams, Pareto charts and control charts. These techniques are used to understand variations in processes, identify avoidable costs, select and prioritise improvement projects, and monitor the impact of changes made. Many TQM projects require considerable facilitation and support, and consequently many companies develop internal consultants with knowledge and experience of TQM to guide teams through specific improvement programs.

3. *Start improvement projects*: work groups apply the methods to identify projects with the largest potential quality gains. TQM is concerned with variations in process as well as output. Quality improvement projects apply statistical analysis to identify the causes of variation and then run pilot programmes to assess which changes to processes cause variations to fall and quality to rise. These are then adopted throughout the organisation.

4. *Measure progress*: this concerns measurement of organisational processes against quality standards; identifying world-class performance by competitors and setting targets (benchmarks) for organisational achievement that surpass them.

5. *Reward achievement*: reward systems are linked to process-oriented improvements, such as increased customer satisfaction, on-time delivery and meeting of outcome standards, not outputs (number of units produced). This reinforces the importance of continuous improvement within TQM.

(Adapted from Cummings and Whorley, 2009, pp. 361–63)

Strengths and limitations

Applications of TQM approaches in care settings (health) have typically been disappointing, with little evidence of a relationship between TQM implementation and quality indicators such as length of stay, or clinical impact, or of staff empowerment. This is considered to be primarily due to the piecemeal implementation of the limited number of interventions and lack of focus on core organisational processes as required in the model. However care professionals appear to be reluctant to commit to the approach as its philosophy is perceived to be alien to their cultural expectations of work.

In relation to social care change, the language connected with TQM may be unfamiliar to stakeholders. The gathering and analysis of quantitative data may require new systems and training. The principles behind TQM are though a good fit with the principles of social care change.
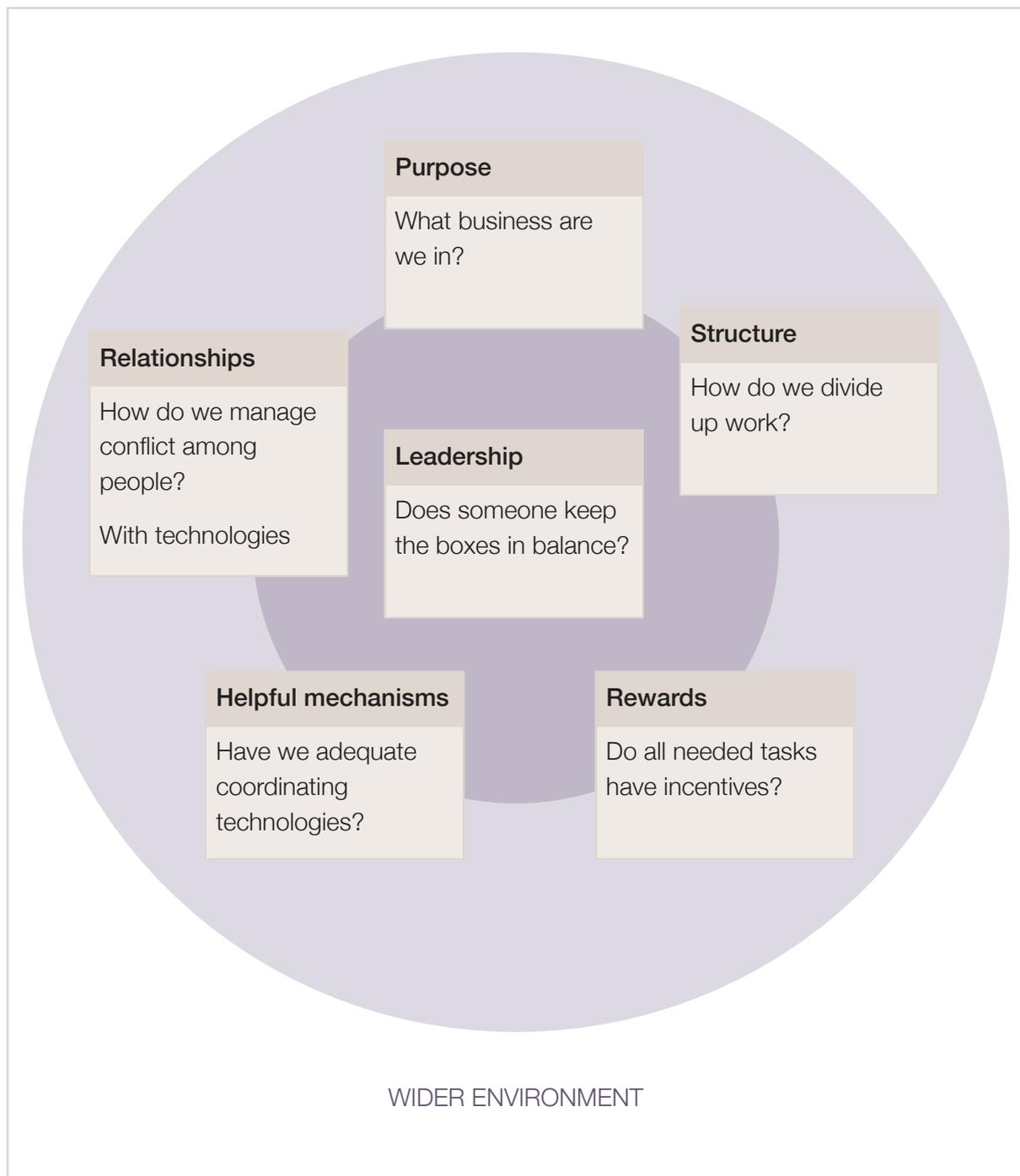
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WEISBORD'S SIX-BOX ORGANISATIONAL MODEL

Description

Weisbord's model indicates six key factors required for organisational success:

Purpose

What business are we in?

Structure

How do we divide up work?

Relationships

How do we manage conflict among people?

With technologies

Leadership

Does someone keep the boxes in balance?

Helpful mechanisms

Have we adequate coordinating technologies?

Rewards

Do all needed tasks have incentives?

WIDER ENVIRONMENT

Use

In common with similar approaches such as PESTELI and SWOT, the model is intended to be used as a means to facilitate discussion between stakeholders and diagnose aspects of the organisation that require improvement. It highlights the factors that it sees important within an organisation and is primarily concerned with coordination of tasks and staff relationships.

Strengths and limitations

As with all such 'checklist' approaches, its strength lies in its potential to stimulate reflection on a range of factors potentially important to organisational performance. The danger common to such approaches is that once an entry is made under each heading this may be considered to be the end of the process of reflection, bringing discussion to a premature close before the full complexity of a factor has been considered. Similarly, a common mistake is to make entries under the headings without reference to the underlying objectives of the organisation, and without informing any change programme. While the tool may be used to promote reflection, these insights will be of little consequence unless they inform wider organisational change processes.

In relation to social care change, Wiesbord's model will be primarily be of help in discussions with internal stakeholders in an organisation. It could be adapted to have a broader view which incorporates the perspectives of external stakeholders include people accessing services.

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Organisational change is now an integral part of the life of an adult social care manager. Whatever their context, scale, pace and objectives, change projects encounter common challenges. These include securing necessary support from key stakeholders, being clear about outcomes, resolving different interests, coordinating multiple activities to timescales, and sustaining improvements in the long term. While the process of organisational change appears difficult in most sectors, social care has particular complexities due to the vulnerability of many of the people which it supports, its interconnection with other professions and agencies, and public scrutiny of perceived failings in its work. There is little empirical evidence though to guide how change can be successfully achieved in social care organisations. This compendium seeks to address this gap in knowledge combining generic evidence on organisational change with the experiences of those who have led and participated in change initiatives in adult social care.

The compendium has main two sections:

Section 1: Fictional case studies which illustrate how four key approaches to change could be deployed within adult social care. These case studies also illustrate how other tools and interventions could be incorporated within such a change process. Further details and supporting resources for each approach and tool are provided in Section 2.

Section 2: A directory of change approaches and change management tools based on a review of current literature including available empirical research and the views of people who have experienced and led change. A short commentary on the application of the social care change principles through these approaches is also provided.

Health Services Management Centre
University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham
B15 2RT
United Kingdom