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Overcoming Change Fatigue

by

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Structured Abstract

Purpose of this paper

This paper explores the practicalities of organizational change in complex settings where much change has already occurred. It therefore offers insights into tackling and overcoming change fatigue.

Design/methodology/approach

The paper uses a longitudinal study of change within a healthcare organization. The paper draws on interviews, focus groups and observations during a 2.5 year long action research project.

Findings

The paper reports findings on the speed at which change takes place, the importance of communication and the burden placed on senior officers during such communication and consultation processes, the use of appropriate external resources and expertise, the benefits of sharing best practice across sectors and the role of academic researchers in change processes.

What is original/value of paper

The paper offers valuable insights to those charged with effecting organizational change in change fatigued settings.

Key Words

Strategic Change; Change Fatigue; Healthcare; Assessment Centres; Management Consultancy; Co-production

Author Bios

Robert MacIntosh holds a chair in Strategic Management at the University of Glasgow and is a chartered engineer. He has researched strategic change in a variety of public, private and voluntary sector organizations for over 15 years. He also publishes on research methods and practitioner relevance.

Nic Beech is a Professor of Management at the University of St Andrews. His research is focused on the social dynamics of organizational life – the intertwining of people’s identities, relationships and practices. He has a particular interest in Creative Industries and the Health Sector. He has published five books on these topics.

Juli McQueen is Head of Organizational Development, Corporate Services with NHS Greater Glasgow and Clyde and has been with the organization for over 4 years. Prior to joining the NHS in 2003, Juli was Human Resources Development Manager for Compaq Computers, EMEA with a specific focus on Change Management and Cultural development during significant global business mergers.

Ian Reid is Director of Human Resources with NHS Greater Glasgow and Clyde, having worked in the NHS for over 20 years. Previously he was Chief Executive of the Greater Glasgow Primary Care Division, with particular experience of developing community care. Ian’s main interest is in the use of organizational development techniques to drive change.

Introduction

Senior managers often face the challenge of changing their organization with some trepidation. After all, the empirical evidence suggests that change is a difficult thing to achieve. We have spent the last two years studying an organization that faced a particularly difficult change challenge and the study reveals some interesting insights. NHS Greater Glasgow and Clyde faced a difficult task in that the organization had a large and change-fatigued group of employees, needed to effect the change very quickly and faced real public scrutiny over the both the change process and performance outcomes. This paper explores some of the lessons learnt from this longitudinal and in-depth study of complex, rapid and radical organizational change.

NHS Greater Glasgow and Clyde

The National Health Service (NHS) was introduced in the UK in 1948 with the objective of offering healthcare services which were free at the point of delivery; it has since grown to become the third largest employer in the world. Although the NHS is often talked about as a singular organization, it is in fact made up of many, many components. The advent of devolution meant that responsibility for policy decisions were devolved from the UK's central government to the Scotland parliament and the Welsh assembly on their formation in 1999.

NHS Greater Glasgow and Clyde (NHS GG&C) is the largest Scottish health board by some distance and employs around 44,000 staff to provide healthcare to a population of approximately 1.2 million. Partly because of its size, an earlier incarnation of the organization had been broken up into four autonomous trusts during an previous restructuring. In 2004, the Scottish Executive decided to re-integrate these four organizations into a single pan-Glasgow organization. Many of the staff involved had therefore lived through several rounds of reorganization to stitch together or pull apart similar, but distinct, organizational forms. Suffice to say, that staff were not overly enthusiastic about the prospect of another wave of reform.

Here, then, was a huge organization, facing a complex reorganization within a very tight time frame. The new organization had to be up and running within 16 months. Further complication was added several months into the change process when the Government Health Minister took the radical decision to dissolve a neighbouring health board (NHS Argyle and Clyde) which had been posting heavy financial losses for some time. NHS Greater Glasgow, as it was then known, was invited to take on a large geographic territory and the staffing which went with it to form the newly merged NHS Greater Glasgow and Clyde. When questioned about this, the chairman of NHS GG&C said that incorporating 9000 thousand new staff during an already complicated restructure was “modular.” The reality was a little more complex, not least because of the £30M deficit that was inherited and the demoralized staff group who had been stigmatized as working for a “failing organization.”

Our interest in studying this particular reorganization was heightened in early discussions when we realized that there were several other unusual dynamics in play. First, amongst the 44,000 members of staff involved there are huge disparities in pay from those on the national minimum wage to a limited number of senior clinicians earning substantial sums. Second, the organization spans over 80 professional groupings and the NHS as a whole is characterized by a number of intra and inter professional rivalries. Within the clinical staff we met senior consultants who claimed “I’m in more regular contact with research colleagues around the world than I am with people from [hospital name] two miles down the road, and we work for the same organization.”

More problematic still is somewhat uncomfortable relationship between the clinical staff and the managers. One board member commented that “many of our staff would see ‘management’ as an entirely negative construct,” and other research in the health service highlights the negative views that clinicians hold of managers who are described as having “started out as office boys” (Lewellyn, 2001:605). A third dynamic is the highly politicized nature of the organization’s work. Both as a large employer and as a provider of vital public services, NHS GG&C is under public scrutiny at all times. This is the first organization we have met where board meetings take place in public with journalists in attendance. This becomes particularly relevant when you consider the range of national targets for reducing patient waiting times, decreasing health inequalities and so on. Any boardroom discussion has the capacity to become national news and this adds a degree of pressure that is unusual.

Finally, the organization relies on a large number of partnerships and external contractor arrangements for the delivery of its services in ways which are not necessarily visible to users of those services. A local General Practitioner surgery is in effect an independent trader who is contracted by the health board to provide services, but for the patient it all feels like part of “the NHS.” Similarly, the introduction of a new way of working in primary and community-oriented health: Community Health Partnerships, which entailed partnerships between health and other services such as social work, meant that new organizational forms were being developed to deliver joint services with several distinct local authorities in NHS GG&C’s territory. Figuring out an effective system of both organizational and clinical governance arrangements was a labyrinthine task.

To their credit, those on the management team recognized the scale of the challenge facing them. They saw an opportunity to “reform the NHS in Greater Glasgow and Clyde” and were keen that the change process delivered more than just a reorganization of reporting lines on an organogram. A set of transformational themes were developed to help ensure that the change process went to the heart of the way NHS GG&C worked (see table 1). These themes cover issues such as performance and accountability but also leadership and integration with other agencies and services.

The Research Process

For over two years, we have had privileged access to the organization’s inner workings. We have been able to attend over 40 regular meetings that senior managers convene (e.g. board meetings, organizational development meetings, etc.), we have conducted a series

of 46 one-to-one interviews with executive and non-executive directors throughout the process to check the evolution of their thinking, we have held 9 focus groups, sent questionnaires to over 500 employees and been given the remit to follow up on lines of inquiry that we saw as relevant. What follows are our analysis and observations about the process of change to date, with the recognition that it is, of course, still taking place.

The Need for Speed

Faced with such an enormous change, you face two choices. Option A is opt for a careful analysis of change, to develop carefully thought out proposals and to take your time over the difficult decisions. Option B is to get down to business as quickly as possible. Tom Peters once observed that significant organizational change takes place over a weekend or not at all. NHS GG&C did not quite manage the change process over a weekend, though there were a number of crunch weekend sessions to progress key items of business, but 14 months from inception to going live was impressive given the complexities set out in the introduction.

The change journey started with consultations over the right structural approach. The need for open consultation seemed obvious and there were several big set-piece meetings attended by the top few hundred managers, as well as several smaller and more focused gatherings. During the consultation process, one audience member noted that he had “never seen this done before because every organizational building block is losing its stability at the same time.” At the same meeting, another commented that “this will be my sixth major restructuring in 14 years.” Consultation is a time consuming business and can seem unrewarding. When the Chief Executive was asked in a public forum “how much of these proposed new structures can we discuss with colleagues?” he answered emphatically “all of it.” Nevertheless, subsequent one to one interviews showed that some professional groups, notably the clinicians, felt that they were not being consulted.

As views of the appropriate structure firmed up, the next obvious challenge was developing a robust process for appointing people to roles within the new organization. Bearing in mind that for most senior posts (e.g. HR director, Finance Director, etc) there were four displaced candidates from the four trusts which were being merged and only one post, this was always going to be a contentious issue. The organization took the view that some form of assessment centre offered the best means of (a). ensuring that the right people with the right skills ended up in the right roles and (b). making the process as equitable and evidence based as possible. This said, there was also an emphasis on getting it roughly right quickly, rather than absolutely right too late.

In total, almost four hundred candidates were placed into over three hundred senior management positions within a period of eighteen months. The process was by no means perfect but what struck us was the relatively small number of controversial decisions. The focus was on getting the competences required to run the new organization right from the outset and the assessment centre offered a means of achieving this outcome. The willingness of well qualified, experienced and senior staff, in some cases with 20 or 30 years experience in the organization, to participate in the assessment centre process

was a significant marker. One senior and experienced candidate said that the assessment centre was “a different process for very many of [us] senior folk.”

Achieving the Right Balance of Internal and External Expertise

NHS GG&C did have HR and OD experts at its disposal. For reasons of capacity or lack of specific areas of expertise, the organization did however engage external consultants. Finding the right balance between the internal resource and outside help was critical. The evident complexities of the organization, its culture and the sensitivities around the demarcation between different professional groupings made it a very difficult setting for external consultants to achieve credibility. Therefore, most tasks had to be led or overseen by someone from within the organization. It was not possible for example, to sub-contract the development of the assessment centre process completely. The counter argument however, was that it was equally important to recognize the limits of one’s own expertise. The notion of a “plucky amateur, helping out in their lunch hour” was not tenable. Professional guidance was sought where it was required, but usually in the context of a partnership agreement which allowed the right blend of local knowledge and outside expertise. This was all the more important given that the world did not stop turning whilst the reorganization went ahead. Rather, the tricky business of running a high profile organization whilst being scrutinized on the process of changing it co-existed. Elsewhere, this has been described as the dual tensions of the “organization of production” and the “production of organization” (MacIntosh and Romme, 2004).

Paying the Communication and Consultation Tax

Most research on change arrives at the conclusion that communication is vital. John Kotter argues that most change programmes fail because they “under communicate by a factor of 10” (Kotter, 1995). In this case, significant effort went into the attempts to communicate the reasons for the change and the merits of the proposed organizational arrangements. From meeting individuals and clinical groups, to community representatives and public consultation meetings, the Chief Executive of NHS GG&C put an enormous amount of time into the attempt to engage key stakeholders. Not everyone was enthusiastic and there were many, many detailed questions that had to be dealt with or followed up. This was an exhausting process for those individuals centrally involved, particularly when placed on top of the demands to continue to execute on the day job.

In fact, the communication and consultation burden rested very heavily on a limited number of key individuals. “[we] were reflecting on this last week. I think at some key points in the development of this there were probably too few members of my senior team out there selling this, meeting groups of staff, talking them through it. That became a very big ask when [name of colleague] and I were meeting 30 [name of staff grouping] not once but twice, three times, with seven rounds of meetings with the senior clinical staff at [name of hospital] to talk through the implications of moving toward more community based services.” Perhaps something more could have been done to share this burden more evenly amongst board members. In practice though, these were very delicate discussions where both the consultors and the consultees felt that it was necessary to speak with the most senior management team members. If nothing can be done to change the need for seniority and gravitas in those conversations, more could

have been done to ease the burden of the day job. Astute delegation of key tasks during this critical phase, which lasted only a few months, is essential if the communication and consultation tax is not to take too heavy a toll.

Learning Lessons Across the Public – Private Sector Divide

About six months after the new organizational arrangements were put in place, we hosted a research seminar with participants drawn from the boards of two other major public sector organizations and two FTSE-listed corporate companies. The intention of the event was to help the senior management team in NHS GG&C think through the challenges ahead in the change process. Perhaps, the unspoken assumption was that lessons could be learned from the private sector.

This process of external comparison highlighted some interesting points. First, NHS GG&C had achieved a great deal in very difficult circumstances. A board member for one of the private sector firms commented that this was all the more impressive because “politics runs through everything [you do] ... with a big and a little P.” Both private sector firms indicated that equivalent processes internally would have produced far higher levels of turnover in staff, either through redundancies or through “performance managing people out of the business.” Both private sector firms could point to evidence that staff “regarded the business as being run by management, not the unions, and that no-one will tolerate being managed by someone who isn’t up to the job.” In contrast, those with long experience of the NHS were troubled by the fact that it still felt like the organization was run by the doctors for the doctors and that no-one would think to ask whether they were being managed, let alone whether they were being managed well. Most strikingly, all five organizations represented at the seminar reported that the opportunity to calibrate their own progress against that of others was hugely valuable. Though each organization faced very different environments and challenges, each was facing similar problems and each had excelled in different phases of the change process. These organizations are now participating in a wider research forum involving over 25 different public and private sector organizations which offers some indication that such collaborations are fruitful.

Engaging with the Academic Community

Finally, it is worth reflecting on the potential research value of such situations. When faced with significant organizational challenges, practicing managers might look to the university sector for support and advice. The practitioner’s set of obstacles and challenges could equally be seen as the researcher’s empirical resource. There are ongoing concerns over the relevance of research outputs to the practitioner community. In this case however, the presence of academic researchers served several purposes. Undoubtedly, there are areas of expertise in most business schools which practitioners could tap into. Such collaboration occurs in the context of a different relationship than that struck with a management consultant because the process is explicitly bi-lateral. Rather than there being a one-way flow of information or advice, a strong relationship between practitioners and researchers can foster circumstances where both sides engage in a genuine dialogue to resolve practical problems and generate research insights. Such

forms of knowledge co-production are sometimes called opportunities for “engaged scholarship” (Van de Ven, 2007).

In cases where the research develops over a longer time frame, as was the case with NHS GG&C, the academic researchers can play a role in which people feel more comfortable to express views and concerns. The anonymity of the research process affords those with concerns to speak to someone who is seen as an “independent auditor” of the change process. Of course, this is not straightforward because trust is required on the part of all concerned. Equally, there is much that theory can learn from practice. The rich dialogue which can be built around the translation back and forth between theory and practice plays a central role in the conduct of good research. It is important to regard theoretical prescriptions as frameworks for strategic thinking, rather than inflexible rules that must be followed.

Is the Change Working ?

We have said already in this article that the change process is on-going. The train may have left the station but the journey is incomplete. Nevertheless, there are some evaluative judgments which can be made because the new structures are almost at the end of their first full year of operation. Our research with staff members indicates that the change has had a significant impact on daily life for those working in the organization and that the new structures are seen as “creating opportunities for positive change.” The major concerns over both organizational and clinical governance have abated and the first eleven months of operation have passed without major difficulties on that front. The key performance indicators have all been met in the first year and this is a major achievement given that this has been achieved with a new team of managers leading a new organization. Achievements in the first year of operation include:

- Integrating a significant element of the disaggregated Argyll and Clyde Health Board into the new, single system structures described above
- Continued financial stability including a breakeven plan to resolve the inherited deficit resulting from the merger with the neighbouring Argyll and Clyde board
- A successful first Annual Review highlighting accomplishment of key performance indicators such as waiting times and delayed discharge targets
- Solid progress on a major programme of new hospital builds and refurbishments
- Launch of a single Board Inequalities Action Plan
- 10 newly established Partnership organizations with Glasgow City Council and other local authorities
- A recognized and established approach to Organisational Development supported by an agreed governance structure and framework
- An established management cohort of over 500 managers with a growing sense of identity
- A single system approach to Corporate Planning linked to a structured Individual Performance Management and Development process for managers
- Design and development of an innovative on-line Individual Performance Management and Development system

Conclusions

This short article offers the briefest glimpse into one organization's change challenge. The research conducted with NHS GG&C points to a number of conclusions. First, speed is a relative not an absolute concept when applied to organizational change. A process spanning between 1 and 2 years in duration actually felt frenetic. Obviously, factors such as organizational size and complexity play a part in calibrating your thinking about the pace of change. Management teams can become exhausted by the communication and consultation burden that change brings. It is crucial to find creative ways to run the day-to-day business whilst simultaneously changing said business. In many ways these two related but distinct tasks draw on different skill sets and need to be separated for a time at least if the change effort is not to be swamped by daily operational pressures. Using external resources to target specific gaps in expertise can help to maintain momentum though there are always difficulties with both securing the funds to use external help and in implanting external advisors into complex organizational contexts. Looking beyond the narrow confines of your own organizational setting can offer both sources of reassurance and inspiration. The NHS managers in this project derived real benefits from full and frank discussions with colleagues in other public and private sector organizations. Finally, framing your change challenge as a research problem might allow you to draw on resources in the business school community and to craft a fruitful collaboration both with academics and with other practitioners.

References

- Kotter, J P (1995) *The New Rules: how to succeed in today's post-corporate world*. Free Press
- Lewellyn, S (2001) Two Way Windows: clinicians as medical managers, *Organization Studies* 22(4) 593-623
- MacIntosh, R and Romme, G L (2004) Exploring the Nature of Order Generating Rules. Strathclyde Business School Working Paper, 200403
- Van de Ven, A. H. (2007). *Engaged scholarship: A Guide for Organizational and Social Research*. Oxford University Press.

1. Achieving an organisation in which the component parts work together to shared aspirations and objectives, not competing ones, and managers and clinical leaders work in teams with shared values and priorities.
2. The senior team and organisation contribute to leadership on health improvement and tackling inequalities.
3. Focusing on service improvement and equipping and supporting frontline staff and first line managers to help us deliver it.
4. Moving away from functional systems of management to general management with managers at all levels responsible for the quality of service delivered to patients and professional staff developed into management and leadership roles.
5. An organisation where people take responsibility for their area of work and for the wider performance of the organisation.
6. An organisation focused on learning and development, as individuals and collectively, to improve our performance.
7. A culture of clear objectives, accountability and performance management at all levels.
8. Driving integration of acute and community and health and social care services to improve the experience of patients.
9. Leaders and managers who have a value base of public services, acting in the interests of patients and the communities we service and behave in a collaborative not competitive way but constructively challenge each other.

Table 1: The Nine Transformational Themes for NHS GG&C