Promoting Innovation and High Performance

The Impact of Partnership Approaches to Change in the Irish Health Service

Foreword

In recent times the health service in Ireland has been undergoing unprecedented and unrelenting change. The pace of change however, is once more set to accelerate. These changes are driven by the needs of the patients and citizens who, rightly, have high expectations of the health service. At the heart of these reforms are the people who work in the health service and the workplaces and organisations throughout the sector. The research and case studies outlined in this report, tell inspiring stories of how change has been managed successfully and how organisations can be truly innovative when people work together.

Achieving and maintaining high performance within organisations is critical to embedding the change that is underway at present. A key objective of the current reform programme must be to develop workplaces that are flexible, adaptable and open to change; quality, performance and results driven, accountable and providing value for money, focused on patients' needs. Workplaces in the health sector must be able to harness and utilise knowledge through advanced technologies and human resource practices that recognise employees as a unique source of knowledge, skill and experience.

None of this can be achieved without high levels of management, staff and trade union ambition and commitment to the achievement of high performance workplaces and high quality services.

It should be noted that as a result of the current reform process, some of the organisations mentioned in the case studies will no longer exist from 2005. Nevertheless, the hundreds of staff, management and trade union representatives who worked to achieve the outcomes described here will continue to make an important contribution to the Irish health service on a day-to-day basis. In this way, the learning and experience contained in the six projects will remain in the health service.

The NCPP hopes that this publication will both celebrate the success of the work done to date, and also contribute to a broader understanding of the potential that partnership approaches to change have to unlock innovation and creativity at organisational level.

The Health Services National Partnership Forum funded this research project. I would like to thank its members and staff for their support and advice and to thank all of the organisations and individuals who participated in this project. I would also like to take this opportunity to thank the staff of the NCPP, the research team of Alison O'Neil and Valerie Whelan, and in particular, Lorraine Glendenning, who provided overall direction and leadership to the project.

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Executive Summary

The Irish health service is currently undergoing a period of reform, transition and change. A major challenge is to operate more efficiently in a cost conscious environment and deliver more effective services, while at the same time improve the quality of working life for staff and enable them to embrace change for the future.

Organisational innovation and high performance

Organisational innovation, adaptability and openness to change are the keys to success and improved services in a twenty first century health service. However, these are not characteristics that are innate to most organisations. They are traits that need to be deliberately developed and encouraged through changes in thinking, organisational structures and work practices.

Organisational innovation encompasses any aspect of workplace change that can deliver improved performance through: new ways of working, new management practices, the use of new technology, new business processes and investment in human resources. People and human resource management practices are central in this regard. Processes relating to learning, employee involvement, diversity, management of change and workplace relations are key potential sources of organisational innovation.

National and international evidence suggests a strong positive link between the application of these workplace practices, organisational innovation and high performance. Research shows that the Irish health service has a relatively low application of work practices proven to have a link with innovation and high performance.

The benefits of a partnership approach to change

Partnership is critical to an improved health service. It can deliver organisational innovtion and high performance. The case studies show that effective partnership can create a culture that embraces change and innovation.

Partnership is characterised by activities such as effective communication, shared understanding, employee involvement and joint problem solving, all of which build trust and facilitate organisational innovation. The outcome of partnership activity, as experienced by the organisations in the case studies, is the development of a culture that

embraces change and innovation. In this way, partnership is critical to an improved Irish health service. Partnership approaches to change and innovation have however not yet become best practice, or even common practice across the health service.

Improved service delivery is dependent on a number of external and internal factors. This report is focused primarily on the internal factors that help organisations to meet this objective. They include: the improvement of standards of patient care, increased organisational efficiency and improved quality of working life.

Partnership approaches to change encourage and facilitate innovation in key areas of the workplace people management and development, working practices and business processes. In many cases, this innovation results in substantial change, leading to improved service delivery. In this way, the individuals, organisations, concepts, practices and values that operate and collaborate as partnership are contributing to the achievement of the key objectives of the health service.

Service users benefit because:

- They are better informed
- They are more involved in decision-making
- There is a more flexible approach to service delivery
- There are improved links with the community.

Organisations benefit in a number of ways. Firstly, they experience increased efficiency through the implementation of practices that promote:

- Cost-neutral innovation
- Cost reduction
- Staff more open to change
- More effective service delivery
- Top down support for bottom up change.

Secondly, organisations develop an improved capacity for learning and problem solving through:

- Development of participative approaches to organisational challenges
- Development of an evaluation-based approach to improving quality
- Improved transfer of knowledge and expertise
- Development of a co-ordinated approach to innovation.

Thirdly, organisations experience a new approach to human resources management through:

- Increased focus on HR issues at senior management level
- A more people-focused organisational culture
- Improved relationships with trade unions.

In addition, staff benefit from partnership approaches to change and organisational innovation in the health service. The main benefit for staff is improved quality of working life, due primarily to:

- Involvement in problem solving and decision-making
- Increased employee autonomy, leading to increased job satisfaction
- Improved communication leading to reduced stress
- Increased trust between staff, trade unions and management.

Barriers to a partnership approach to change

Organisations must improve their capacity to implement good practice partnership approaches to innovation and high performance. Key barriers to a partnership approach include:

- Management ability to implement progressive human resource policies
- Low levels of consultation and feedback
- Hierarchical and bureaucratic organisational structures
- Low application of performance management systems in organisations
- Unwillingness of management, staff and unions to change
- Low levels of trust in organisations.

A good practice approach to partnership

The six case studies published in this report highlight good practice behaviours that enable organisational innovation and help overcome barriers to change. The NCPP believes that if these practices are implemented more widely – mainstreamed – in health service organisations, they will build capacity for change and contribute to the development of a culture that embraces innovation and change.

Good practice approaches that overcome barriers relating to the health service's capacity for mainstreaming partnership include:

- Encouraging learning and development among all staff
- Communicating effectively with staff
- Putting resources in place – time, people, money
- Measuring the impact of innovation on service delivery.
- Developing new ways of working together
- Encouraging creativity and harvesting ideas
- Building trust – the pilot project
- Ensuring representation and employee voice to get agreement for change.

One of the emerging outcomes of the Forum on the Workplace of the Future (FWF) is that a new workplace model is needed in order to create the flexible, innovative organisations that will be successful in the future. According to the FWF, the key features of these new organisations will be:

- A highly participative approach to work and management aimed at creating genuine opportunities for employees to contribute their views and ideas
- A strong focus on learning and skills at all levels of the organisation
- Practices designed to encourage and reward high performance
- Promotion of workforce diversity for sound business reasons as well as reasons of social responsibility
- Considerable investment in developing a collaborative approach to workplace relations.

NCPP recommendations for future action

The NCPP recommends the following actions to facilitate a partnership approach to change across the health service:

- Focus on organisational innovation – the HSNPF should focus more of its resources on overcoming barriers to change by promoting organisational innovation in four key areas:
  - Strengthening management ability to implement progressive human resource practices
  - Further development of consultation and feedback processes
  - Further modernisation of organisational structures
  - Additional trust-building measures in organisations.
- Mainstream capacity for partnership approaches to change – the HSNPF has undertaken excellent work in developing the health service's capacity for partnership approaches to change. As a result, there are substantial pockets of experience and expertise around the health service (due to the completion of over 400 projects to date). However, the size and complexity of the health service creates difficulties for dissemination or mainstreaming good practice. The HSNPF should build on its success to date by focusing additional resources on the development of a system to disseminate learning more effectively throughout the health service.
- Further develop the evidential case for partnership – the HSNPF should contribute to the development of the evidential case for a partnership approach to change and innovation by undertaking a major research project to measure the impact of partnership approaches to change on organisational performance.
- Enable organisations to benchmark their performance – the HSNPF should further develop current benchmarking tools (including Learning by Monitoring) to enable individual organisations to track their performance against national and if possible international trends.
- Link workplace partnership with strategic change – the HSNPF should continue its role in combining incremental change at local level with strategic change at national level, including its current role in supporting the reform process in the health service.

CHAPTER ONE

Rationale for a partnership approach to change

Ireland's economy succeeded in increasing its levels of innovation and organisational performance in recent years, with very positive effects on our society as a whole. The public service, through its policy development and service delivery, contributed to Ireland's achievements in no small way. However, the country is now in a critical period of transition and once again employees, managers and trade unions across the public sector are facing into a significant period of change. This provides an impetus for increased productivity across the sectors generally, and to improved service delivery and high performance in the health service.

There are opportunities now to further improve standards of service delivery by linking financial, clinical and human resources to the strategic goals of the health service, and to meet the needs of patients and a changing workforce by modernising how health service organisations are structured and managed. A major challenge for the Irish health service is to operate more efficiently in a cost conscious environment and deliver significantly more effective services, while at the same time improve the quality of working life for staff and enable them to embrace change for the future.

Organisational innovation, adaptability and openness to change are the keys to success and improved services in a twenty first century health service. However, these are not characteristics that are innate to most organisations. They are traits that need to be deliberately developed and encouraged through changes in thinking, organisational structures and work practices. A new paradigm in workplace relations is also needed, based on the idea of a relationship where employer, trade union and employee work together to create the organisation of the future. This relationship should be marked by high levels of employee involvement in organisational change, improved internal communications and joint problem solving.

This new paradigm will ultimately benefit workers in terms of rewards, work satisfaction and lifestyle. It will benefit employers in terms of creating a new way of working designed to deal with a new way of delivering high quality services. Most important of all, it will benefit patients and service users in terms of improved health outcomes.

The importance of organisational innovation

Organisational innovation encompasses any aspect of workplace change that can deliver improvements, such as: new ways of working, new management practices, use of new technology, new business processes and investment in human capital. People and human resource management practices are central in this regard. Processes relating to learning, employee involvement, diversity, management of change and workplace relations are key potential sources of organisational innovation.

The Forum on the Workplace of the Future (FWF) has been established by the NCPP at the request of the Irish Government. The FWF fosters in-depth discussion on the ways in which change in the workplace can support Ireland's transition to a high value-added, knowledge based economy. The FWF has engaged and consulted widely with employers, employees, managers, unions, labour market and organisational change experts and all those with an interest in shaping the workplace of the future. Throughout, the FWF has heard extensive evidence that suggests a strong positive link between organisational innovation and high performance.

The NCPP examined health sector research evidence from the UK and from Australia that highlights a strong positive link between progressive HR policies and organisational performance (see Table 1). The evidence outlined in the table shows that key HR practices – teamworking, performance appraisal and employee involvement – are closely linked to high organisational performance including lower levels of patient mortality. However, according to the FWF's survey of employees, these types of responses to this pressure for change are uncommon in the Irish health service.

The Irish health service has a relatively low application of work practices proven to have a link with innovation, increased quality of care, and reduced levels of patient mortality. The NCPP/ ESRI, on behalf of the FWF, undertook surveys of the workplace attitudes and experiences of almost 7,000 Irish employers and employees.[1] Less than half of Irish organisations employ staff appraisals or performance reviews (48.6%). In the health sector, the figure is slightly less at 44.5%. The FWF's survey of employees asked respondents whether they were involved in 'participation', which included work teams such as problem solving groups, project groups, quality circles, continuous improvement programmes or groups. Almost forty per cent (38.6%) of health service employees stated that such practices existed in their organisations, just above the overall workplace average of 37.5%. However, it is well below the figures for other public service sectors – e.g. Education (52%) and Public Admin and Defence (47%).

In addition, the FWF's survey of employees states that health workers score 1.41 (on a scale of <-2 to 2) on levels of autonomy, which is slightly below the public sector average of 1.45, and well below highly autonomous sectors such as Financial & Business services (1.61) and Education (1.60). However, levels of autonomy are closely linked to job type, with senior managers and professionals experiencing higher levels.

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1. The Changing Workplace: A Survey of Employers' Views and Experiences is a survey of almost 2,000 public and private sector workplaces undertaken on behalf of the Forum on the Workplace of the Future by the NCPP, in association with the ESRI. In addition, The Changing Workplace: A Survey of Employees' Views and Experiences documents the views of over 5,000 public and private sector employees on a wide range ofworkplace-related issues. Both publications provide an interesting analysis of the type of change issues facing the Irish workplace.

Table 1 International evidence linking human resource strategies with high performance in health service organisations

Extensive national and international research has been undertaken on the issue of high performance in organisations and to a great extent, this research has proved that there is a significant link between organisational performance and human resource strategies and policies. The extent to which this research has focused on human services, and in particular health services is quite limited. However, research undertaken in the British NHS[2] found a relationship between good people management practices and lower levels of patient mortality.

In the research, human resource directors from sixty-one acute hospitals in England were questioned about HR practices and procedures, including staff appraisal, training and development and the level of team working in the organisation. Data on patient mortality levels in each hospital was also collected. The findings revealed strong associations between HR practices and patient mortality generally. The extent and sophistication of staff appraisal in hospitals was particularly strongly related to lower levels of patient mortality.

In Australia, the National Institute of Clinical Studies issued a literature review which outlined the factors deemed necessary for high performance in health care organisations.[3] According to the study:

> *Health care organisations planning to improve performance, including organisational change and innovation performance, in the first instance require relevant human resource practices that build on goal-setting and feedback (such as performance appraisal and reward and recognition) that are supported by effective leadership.*

There were also links with training and with the level of team working in the hospital. The UK research suggested that 25% more staff working in teams in a hospital is associated on average with 275 fewer deaths following emergency surgery per 100,000 patient admissions. This led the researchers to observe that 'hospitals are working communities that operate best when all the team – managers, medical and ancillary – work together to a high standard.'

Another UK-based research project[4] identified team working as an indicator of innovation and effectiveness in primary health and community care teams, and also that the presence of multi-disciplinary teams was strongly associated with innovation in patient care in primary healthcare.

The UK NHS Task Force on Staff Involvement,[5] published by the Department of Health in 1999, states that:

> *Employers in the NHS that involve staff in decisions, planning and policy making improve patient care through better service delivery, manage change more effectively, and have a healthier, better motivated workforce and reduced staff turnover.*

2. *West, MA, Borrill, C, Dawson, J, Scully, J, Carter, M, Anelay, S, Patterson, M and Waring, J: The link between the management of employees and patient mortality in acute hospitals: International Journal of Human Resource Management 13:8 December 2002 1299 – 1310, 2002 Taylor and Francis Ltd.*

3. *National Institute of Clinical Studies (2003), Factors supporting high performance in Healthcare Organisations. Prepared by the Health Management Group at La Trobe University, NICS, Melbourne, Australia*

4. *Borrill, C, West MA, Shapiro D, Rees, A (2000), Team working and effectiveness in health care, British Journal of Health Care, 6: 364 – 71*

5. *Department of Health (1999), Report of the NHS Taskforce on Staff Involvement, United Kingdom*

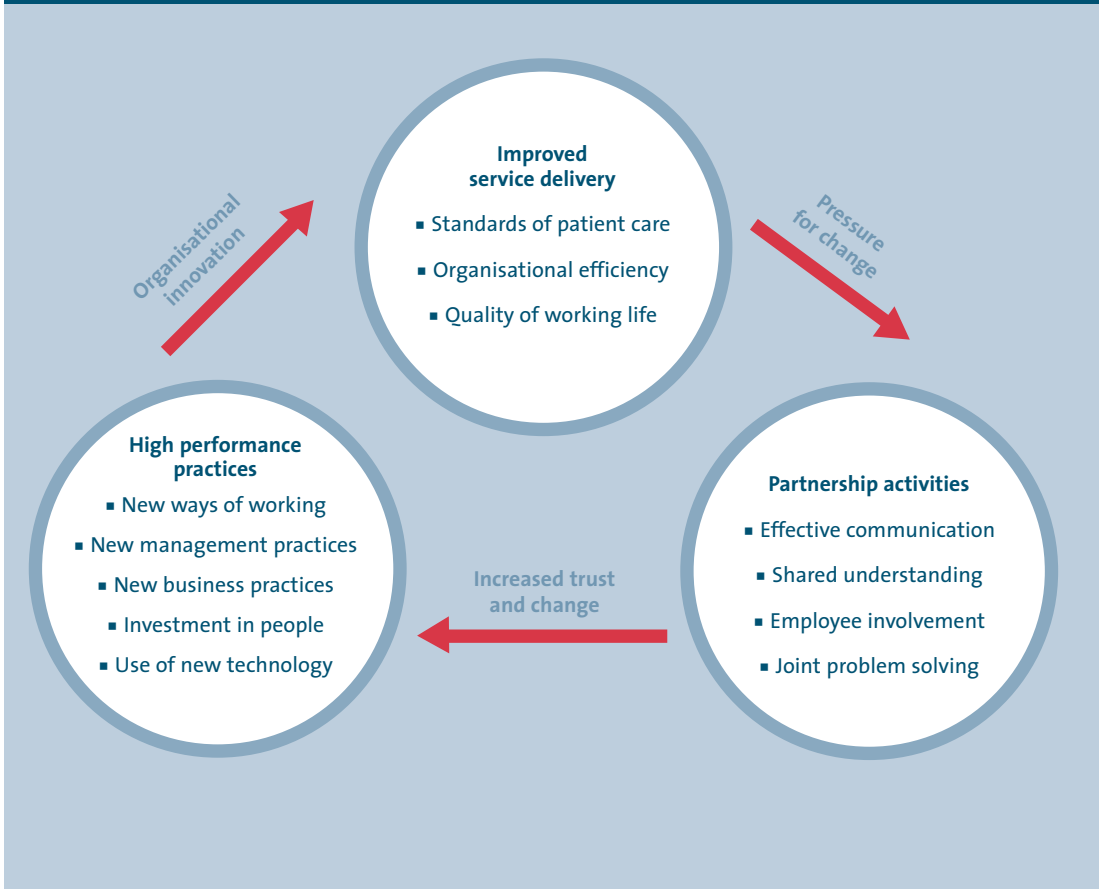
Partnership activities enable organisational innovation

The existence of partnership activity in the health service enables employers, employees and trade unions to apply concepts, practices and values linked to employee involvement activities concerned with managing change. These include:

- Joint problem solving
- High levels of communication leading to a shared understanding of change
- Employee involvement in change.

When these concepts are applied in a consistent, measured and more intensive fashion, as an agreed approach to change, they lead to organisational innovation. Often when management and workers agree new ways of working together, investment in skills development and learning increases and new business processes and technologies are adopted. The outcomes of innovation benefit everyone, they include improved levels of patient care, increased organisational efficiency, and an improved quality of working life. These outcomes result in improved service delivery and high performance. In this way, partnership is critical to an improved Irish health service (see Figure 1).

Figure 1 A partnership approach to organisational innovation and improved service delivery



Partnership in the health service

Partnership in the health services is about a new and active relationship in managing change. It is characterised by employee participation and consultation, the development of joint objectives, co-operation and trust and the delivery of patient-focused quality health services. The Health Services National Partnership Forum (HSNPF) is a joint employer/trade union organisation that leads, supports and enables the building and deepening of workplace partnership throughout all health agencies in Ireland. HSNPF supports and facilitates health agencies to achieve high quality outcomes, added value and the highest standards of patient care and workplace relationships.

This case study research project was undertaken by the National Centre for Partnership and Performance (NCPP) with the support and assistance of HSNPF. Six case studies of good practice were completed in a broadly representative sample of the diversity of organisations operating in the health service.

Quality and Fairness: the health strategy states that the overall objectives of the health service are better health for everyone, fair access, responsive and appropriate treatment and high performance. The aim of the project is to identify how partnership style approaches to change contribute to these objectives.

Outline of the report

This report argues that partnership approaches to change encourage and facilitate behaviours that lead to innovation in key areas of the health service, e.g. standards of care, organisational efficiency and people management. In many cases, this innovation results in substantial change, leading to improved service delivery and high performance. In this way, the individuals, organisations, concepts, practices and values that operate and collaborate as partnership are contributing to the achievement of the key objectives of the health services mentioned above.

The HSNPF has produced excellent guidelines on how to develop effective partnership structures and through its work has developed people to operate those structures efficiency. In addition, practices such as joint problem solving, information and consultation are being developed across the health service under the auspices of HSNPF. This document aims to inform management, employees and unions about good practice partnership across the health service in the hope that it will be implemented in a more widespread fashion.

Chapter 2 of this report draws on evidence outlined in the case studies to highlight the benefits of using a partnership approach to change. In particular, it shows how increased employee involvement in service planning and delivery contributes to improved standards of patient care, organisational efficiency and improved quality of working life.

Chapter 3 looks forward, drawing from the qualitative data gathered in the case studies interviews and quantitative data sourced in national and international research. It identifies the key pressures for change impacting on health service employers and employees, and outlines the challenges facing organisations trying to adopt partnership approaches. Finally, the NCPP makes recommendations on how those challenges might be overcome in the health service.

Chapter 4 presents case studies of six health service organisations that form a broadly representative sample across the diversity of organisations operating in the health service. Each of the organisations studied uses a partnership style approach to increase its levels of organisational innovation (see Table 2).

Table 2 Partnership approaches to organisational innovation – six examples of good practice

- **A new HR strategy through partnership** is an account of how a consultative approach underpinned the development of the Action Plan for People Management. Published in 2003, the APPM is the first HR strategy applicable to all health service staff. It emerged from a number of consultative workshops with health service staff and was prepared, on behalf of a larger Steering Group within a short time frame, by a small team of employers' representatives, HR managers and trade union representatives.
- **Have you a good idea for quality** is the story of how an employee ideas initiative resulted in a number of creative responses to patient needs in the Western Health Board. In particular, the development of a specialist Leg Ulcer Clinic in Elphin, Co. Roscommon has resulted in improved patient care, cost savings for the health board and increased job quality for the staff involved.
- **Communicating for better job quality** is the account of how the Midland Health Board is meeting its commitment to improve communication with its 6,000 staff, and improve their quality of working life through developing information and consultation practices, management communication skills and increasing staff involvement.
- **Introducing Smartwork** is a case study of the South Eastern Health Board's drive to involve staff in the service planning process, through a train-the-trainer programme and the rollout of a staff development programme. Through increased staff involvement in organisational innovation, the health board is able to implement cost-neutral measures that improve service delivery.
- **Piloting flexibility** is the account of a pilot scheme that introduced flexible working hours into the Engineering Department at St. James's Hospital in Dublin. The key outcome is that increased flexibility offers benefits to the hospital and to its employees.
- **Implementing personal outcomes** is the story of how the Western Care Association implemented a personal outcomes measure system that measured the quality of their services. The personal outcomes approach led to a realignment of the organisation's services and processes with the changing needs of its service users, and increased integration with the community in which the Association operates.

CHAPTER TWO

The benefits of a partnership approach to change

Improved service delivery is dependent on a number of external and internal factors. This report is focused primarily on the internal factors that help organisations to meet this objective. They include: improved standards of patient care, increased organisational efficiency and improved quality of working life.

The NCPP believes that adopting a partnership approach to change increases levels of organisational innovation and improves service delivery and performance. This benefits service users, staff and organisations. Table 3 summarises the benefits experienced by the organisations in the six case studies. The main benefit for service users is improved standards of patient care.

For organisations they are: increased efficiency, improved capacity for learning and problem solving and a new approach to human resources management. The main benefit for staff is an improved quality of working life with increased job satisfaction.

Table 3 Benefits of a partnership approach

Benefits for service users		Benefits for organisations		Benefits for staff
Improved standards of patient care	**Increased organisational efficiency**	**Improved capacity for learning and problem solving**	**A new approach to human resources management**	**Improved quality of working life**
■ Better informed service users ■ Increased focus on service user involvement in decision making ■ More flexible approach to service delivery ■ Improved links with the community	■ Cost-neutral innovation ■ Cost reduction ■ Staff more open to change ■ More effective service delivery ■ Top down support for bottom up change	■ Development of participative approaches to organisational challenges ■ Development of an evaluation-based approach to improving quality ■ Improved transfer of knowledge and expertise ■ Development of a co-ordinated approach to innovation	■ Increased focus on HR issues at senior management level ■ More people-focused organisational culture ■ Improved relationship with trade unions	■ Increased employee autonomy and job satisfaction ■ Improved communication leading to reduced stress ■ Increased trust between staff, trade unions and management

Improved standards of patient care

The partnership approach taken by the organisations in the case studies allows employees to have more involvement in change which results in organisational innovation and improved patient care. This benefits service users because they are better informed, more involved in decision-making and there is a more flexible approach to service delivery. In addition, links with the community and with GPs improve.

- ***Better informed service users***

A survey by the Midland Health Board found that health service staff are the main source of information for service users. The implementation of an internal communications strategy in the Midland Health Board means that the information provided to service users is more accurate. Through the commitment to improve internal communication, service users are better informed because staff, who are their prime source of information, are better informed.

- ***Increased focus on service user involvement in decision-making***

Involving service users in decision-making can help to improve standards of patient care. Prior to the introduction of the Personal Outcomes Measures system in the Western Care Association, the organisational focus was on how the system operated, with service users: "slotting into processes because that's what was on offer". Now service users are asked what they want from the organisation and service delivery is centred around providing this. Service users are involved in identifying services and how they should be delivered. The 'one size fits all' approach has been superseded by a personalised service and this has been achieved through working in partnership and involving all staff.

- ***More flexible approach to service delivery***

The provision of flexible services that suit service user needs is an important element in improving standards of patient care. The day to day operation of the Elphin Leg Ulcer Clinic is managed by the nurses who run it. As they are best placed to understand patient needs, they can adapt the service accordingly. For example, they can change clinic opening times if patients so require.

- ***Improved links with the community***

Patient care can be enhanced by improved links with the community and with primary care personnel such as GPs. At the Western Care Association, the refocusing of the organisation on delivering services that service users want, led to a deeper integration with the community. More staff members now work in the community as facilitators, and service users are more integrated into the communities in which they live. This less institutionalised approach to service delivery has a significant impact on standards of patient care.

In Elphin, links with primary care have improved as local GPs and consultants can refer patients to the Leg Ulcer Clinic.

Increased organisational efficiency

Involving staff in making changes and problem solving, benefits organisations because it unleashes their ideas. The case studies show that a partnership approach to change can result in increased efficiency due to: cost-neutral innovation, cost reduction, staff who are more open to change and more effective service delivery.

- ***Cost-neutral innovation***

Staff are often best placed to find cost-neutral ways to improve services. The development of Smartwork in the South Eastern Health Board prepared staff to identify cost-neutral innovation and integrate it into service planning. The focus of staff training in service planning is on how services can be improved without using additional resources.

▪ *Cost reduction*

The introduction of a flexible working system in the Engineering Department at St. James's Hospital reduced labour costs as flexible working lessened the need for staff to work overtime. Staff can choose to work earlier in the morning and/or finish later in the evening. They can take time off in lieu of extra hours worked instead of overtime pay. The trade-off for staff is better work/life balance. For example, they can drop their children to school before coming to work.

▪ *Staff more open to change*

The case studies have shown that involving staff in decision-making fosters a positive attitude to change. Through the Smartwork approach at the South Eastern Health Board staff are more involved in service planning and receive feedback on their suggestions. They are now more open to change because they are involved in planning it.

▪ *More effective service delivery*

The Engineering Department at St. James's Hospital was run more effectively after the introduction of flexitime. Staff can work late to complete jobs that they have started and begin work early in the morning without waiting for the foreman to arrive. Four new units have opened at the hospital since flexitime was introduced but it has not been necessary to employ any new engineering staff. Many staff members view this as evidence that the Department is operating more effectively.

The establishment of a Leg Ulcer Clinic at Elphin is a more productive way of delivering care to patients. Nurses are able to see more patients each day because they no longer spend time travelling to patients' homes.

After the introduction of Personal Outcomes at the Western Care Association, staff aims and objectives have became more closely linked to overall organisational objectives. The organisation now has greater clarity with regard to its core goals. Staff, management and unions are all 'facing the same way'.

▪ *Top down support for bottom up change*

The health service is experiencing intense pressure for change and is responding to those pressures at corporate and local level. Corporate, or 'top down' responses are initiating changes to meet institutional challenges for example Quality and Fairness, the Action Plan for People Management (APPM), the reform programme and the commitments in *Sustaining Progress*.

However, the case studies show that employee-driven, or 'bottom up' responses are also tackling substantive change issues. Interestingly, in some of the case studies outlined in this report, both approaches were combined to develop a partnership approach to innovation that provides top down support for bottom up change.

The APPM is a 'top down' approach to change in that it is an outcome of the National Health Strategy. It is co-ordinated by the Department of Health and Children and the HSEA and the trade unions, through the APPM Implementation Monitoring Committee. However, it was developed using a 'bottom up' or partnership approach that began with employee consultation workshops and was undertaken by a steering group that represented the key stakeholders – managers, employers, trade unions and HR professionals.

The Midland Health Board communications strategy was originally formulated to help deliver an improved service to clients. However, a staff quality of working life survey highlighted lack of internal communication as the key cause of work-related stress. Subsequently, a working group on communications was formed to ensure

employee input into the implementation of the communications strategy.

It can also be stated that these and many other case studies across the health service indicate that the application of practices that facilitate employee-led innovation enables a common sense approach to an issue to become common practice.

Improved internal capacity for learning and problem solving

The partnership approach adopted by the organisations in the case studies helped to develop their capacity for learning and problem solving through: developing participative approaches to organisational challenges, improving quality through increased use of evaluation, improving the transfer of knowledge and expertise around the organisation and, in some cases, the development of a co-ordinated approach to innovation.

- ***Developing participative approaches to organisational challenges***

Through working in partnership, some of the case studies developed participative approaches to organisational challenges. The challenge faced by the Midland Health Board was to improve quality of working life, particularly internal communication. Staff, management and trade unions are involved in developing solutions through the establishment of six Action Teams that are tackling specific issues of concern.

- ***Development of an evaluation-based approach to improving quality***

Some of the case studies show the impact of an evaluation-based approach to quality. The introduction of the Personal Outcomes Measures system in the Western Care Association means that service planning, delivery and evaluation is quality based. Therefore, performance is measured through measuring quality. The Action Plan for People Management has a strong evaluation focus, with measurable targets and deadlines. The Smartwork initiative in the South Eastern Health Board is based on SMART objectives, that is: Specific, Measurable, Achievable, Realistic, Time bound.

- ***Improved transfer of knowledge and expertise***

Facilitating the sharing of knowledge and expertise between staff is an important element of organisational problem solving. Working in partnership has enabled a transfer of expertise and knowledge between staff in many of the case studies. Working in a multi-disciplinary team to develop the Action Plan for People Management assisted in the sharing of expertise between diverse group members. Working together in a clinic-based setting at Elphin is facilitating the transfer of expertise and knowledge between public health nurses.

An important element of transferring knowledge and expertise is the 'train the trainer' approach, where staff train each other. This has been developed successfully in the South Eastern Health Board through the Smartwork initiative.

- ***Development of a co-ordinated approach to innovation***

Through working in partnership, many of the case study organisations have developed a co-ordinated approach to innovation. In the Midland Health Board the six Action Teams dealing with quality of working life issues are encouraged to work together on

complementary issues to develop 'joined-up' thinking. A co-ordinated approach to innovation was also an outcome of the development of the Action Plan for People Management. The group who drew up the Plan were from different areas of the health service and through working together they were able to see the 'big health service picture' rather than focusing on their own areas of concern.

A new approach to human resources management

The HR management function is particularly important in the health service because of the critical role that staff play in achieving organisational objectives. It is therefore important that HR operates at a strategic level. Adopting a partnership approach to innovation has increased the focus on strategic HR in the case study organisations through: an increased focus on HR issues at senior management level, a more people-focused organisational culture and improved relationships with trade unions.

- *Increased focus on HR issues at senior management level*

The case studies have demonstrated that increased levels of partnership activity can increase the focus on HR issues at senior management level. At the Midland Health Board, quality of working life and internal communications issues are now a management priority. The Action Plan for People Management is a key health service policy initiative and through its implementation the profile of human resource management as a core organisational process is being raised.

- *More people-focused organisational culture*

Partnership can develop a more inclusive approach to change which leads to a more open organisational culture. In the Engineering Department at St James's Hospital, the culture changed after the introduction of the flexitime system. Staff have more autonomy in organising their day and management no longer monitor staff absence, but record attendance.

Through the introduction of Personal Outcomes, staff at the Western Care Association are empowered to personalise services for patients. Their roles have changed to become more facilitative and as a result the organisation has become even more people focused.

- *Improved relationships with trade unions*

The case studies have demonstrated that relationships with trade unions can be improved by adopting a partnership approach. Involving the health service trade unions in the development of the Action Plan for People Management has encouraged more staff to buy into it. The involvement of trade unions in a partnership approach to the introduction of flexitime in the Engineering Department at St James's Hospital gave them more ownership of the change and helped to smooth its implementation.

Improved quality of working life

Using partnership to achieve innovation and change benefits staff because they become more involved in decision-making. This improves the quality of working life through: increased employee autonomy and job satisfaction, improved communication leading to reduced stress and increased trust between staff and management.

- *Increased employee autonomy and job satisfaction*

Autonomy among the nurses that run the Leg Ulcer Clinic at Elphin has increased because they are responsible for managing the service. They can, for example, decide

how many sessions they need to operate to meet patient demand.

Increased opportunity for staff to use their initiative and to be creative is also evident at the Western Care Association and the South Eastern Health Board. The focus on implementation of Personal Outcomes in the Western Care Association means that staff can be creative in seeking to implement the system. In the South Eastern Health Board staff involvement in service planning has enabled them to be more creative in improving service delivery. Also, the group that developed the Action Plan for People Management were encouraged to be creative by the multi-disciplinary nature of the group.

Generally, higher levels of autonomy are linked with higher levels of job satisfaction. In the NCPP/ESRI survey of employees, there is a strong positive link between levels of employee autonomy and job satisfaction.

- ***Improved communication leading to reduced stress***

Involving South Eastern Health Board staff in service planning gives them a forum to suggest improvements to services and to receive feedback on suggestions which improves communication and reduces stress. Prior to this, staff had limited opportunity to feed into service planning.

The quality of working life initiative in the Midland Health Board is concerned with reducing levels of work-related stress through improving internal communications.

- ***Increased trust between staff, trade unions and management***

The adoption of a partnership approach has helped to build trust between staff, management and trade unions in many of the case studies. The introduction of the flexitime system in the Engineering Department at St. James's Hospital is a good example. Not all workers wanted to adopt flexitime, so it was agreed that 50% of staff would undertake a pilot project. This inclusive approach to changed hours has increased trust and now 90% of staff are involved in the initiative.

Conclusion

It can be concluded that partnership approaches to change encourage and facilitate innovation in the workplace – people management and development, working practices and business processes. In many cases, this innovation results in substantial change, leading to improved service delivery. In this way, the individuals, organisations, concepts, practices and values that operate as partnership are contributing to the achievement of the key objectives of the health service.

CHAPTER THREE

Implementing a partnership approach to innovation in the health service

Previous chapters have outlined the link between partnership, innovation and high performance in organisations generally and in the health service. In addition, the benefits of a partnership approach to change have been outlined in detail, drawing on the experience of the six case study organisations described in Chapter 4.

This chapter examines the need for change in the health service in a little more detail. Firstly, it identifies the key pressures for change impacting on the health service. It draws on the evidence produced in two major NCPP/ ESRI surveys on the workplace, undertaken on behalf of the Forum on the Workplace of the Future, which included interviews with employers and employees in the health service.

Secondly, the chapter identifies the barriers to change and the challenges facing health service organisations that wish to adopt a partnership approach to change and innovation.

Thirdly, the chapter draws on the experiences outlined in the case studies and outlines a number of good practice approaches that will build capacity for innovation and mainstreaming good practice and develop a culture that embraces change and innovation.

Finally, the NCPP makes some recommendations as to how HSNPF might support Irish health service organisations in this area.

Pressures for change in the Irish health service

Along with other key sectors in the Irish economy, the Irish health service is experiencing intense pressure for change from a number of sources. An examination of the views of health service employers and employees contained in NCPP/ESRI surveys highlights a general consensus around the need for change. In addition, pressures for change, which can be clustered around key objectives of the health service include:

- The need to improve standards of patient care
- The need to improve quality of working life for health service staff
- The need to increase organisational efficiency across the health service.

Pressure to improve standards of patient care

In the NCPP/ ESRI employer survey, almost three quarters (73%) of health sector respondents felt that demand for increased standards of service is a key external pressure for change (see Table 4). This compares with 70% in the civil service and 70% in the Irish workplace overall.

Another key finding in the NCPP/ ESRI survey of employers is that almost two thirds of health sector employers (63%) felt that scrutiny by the media is an intense external pressure for change. This is slightly higher than the civil service (60%). Scrutiny is often focused on issues that relate to standards of patient care. In addition, although 'finding suitably qualified staff' was considered an intense pressure by only 14.4% of public service managers overall, that figure increases to 32% in relation to the health sector. This issue has a direct impact on standards of patient care.

Pressure to improve the quality of working life

The NCPP/ ESRI survey of employers highlighted a number of pressures for change relating to the effectiveness of current human resource practices in the health service (see Table 5).

Almost all health sector respondents in the employers' survey stated that staff demands for greater say was causing intense (17%) or some (82%) pressure for change. The civil service and local government sectors are experiencing similar levels of pressure. Interestingly, the Forum's survey shows that employees who report higher levels of consultation with regard to decisions that affect their work are more likely to be willing to accept change.

Fifty seven per cent (57%) of health sector employers responded that equality and diversity issues were causing intense pressure for change, as opposed to 21.3% of public service employers overall. It is believed that effective diversity management can add value to organisations, particularly with regard to improved customer service.[6]

One in four (25%) health sector employers felt employee needs and preferences for flexibility were causing intense pressure and 75% felt it was causing some pressure, making this a widely experienced change pressure.

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6. See the submission made to the Forum on the Workplace of the Future by the Equality Authority at www.ncpp.ie

Table 4 Perceptions of factors generating external pressures in the health service

Regulations	Intense pressure	Some pressure	No pressure	Total
National legislation/regulations	49.5	50.0	0.4	100.0
European/International regulations	8.7	90.0	1.2	100.0
Legislation-equality in workplace	21.7	76.9	1.4	100.0
Service Provision				
Demand for increased standard of service delivered	73.0	26.0	1.0	100.0
Requirement for efficiency in delivery of services	60.9	38.3	0.7	100.0
Need to change opening/closing times	27.9	65.2	6.9	100.0
Providing new services for users	25.4	71.6	3.0	100.0
Co-ordination with services of other depts, organisations	14.7	80.8	4.4	100.0
Increases in size of target of client base	38.9	56.4	4.8	100.0
Accountability				
Scrutiny by the media	63.3	32.6	4.1	100.0
Freedom of information	15.6	79.8	4.6	100.0
Public Service				
Public Service modernisation agenda (PSMA)	44.4	51.0	4.6	100.0
Budget constraints	73.6	25.9	0.4	100.0
Achieving balanced regional developments	8.4	67.9	23.8	100.0
Adhering to social partnership agreements	18.8	71.2	10.0	100.0
Availability of appropriately qualified staff	32.2	66.8	1.0	100.0

Pressure to increase organisational efficiency

In the NCPP/ESRI survey of employers, respondents stated that budget constraints create intense pressure for change across the public service. In the health sector, 73.6% of respondents stated it was an intense pressure for change, as opposed to 80% of survey respondents overall.

Sixty per cent (60%) of health service respondents felt pressure for increased efficiency was intense. This is lower than other sectors – e.g. 80% in the civil service and 70% overall. Only 28% of health service respondents felt that 'need to change opening hours' was an intense pressure for change, although 65% of respondents felt it created some pressure.

In addition, over half of health sector employers (53%) reported that the introduction of new technology is causing intense pressure, compared to an overall public service figure of 35%.

Finally, meeting the requirements of national/international regulation was exerting intense pressure according to half of the survey's health service respondents. This is much higher than the overall public sector figure of 40% and may be linked to the impact of the Working Time Directive on costs and other resources in the health service.

There are significant external and internal pressures for change operating in the Irish health service. When asked their views on the need for change and reform, health service managers and employees agreed strongly with the need for change to meet strategic objectives.

All health managers, when surveyed, strongly agreed (26%) or agreed (74%) that reform of the public service is needed. There was also a consensus on how reform might be approached. All health service managers strongly agreed/agreed that responses to change that promoted innovation and the introduction of new ideas were very important/important (see Table 6). This includes new technology, training and development, developing service quality and customer service plans.

Three quarters (75%) of respondents in the NCPP/ESRI survey of employees stated that they would be willing to take on increased responsibilities, increased use of new technology and increased skill requirements if necessary.

Table 5 Perceptions of factors generating internal pressures within health service organisations

	Intense pressure	Some pressure	No pressure	Total
Employee needs and preferences for flexibility	23.6	74.5	1.9	100.0
Demand for staff for greater say	17.2	82.0	0.8	100.0
Demands for better pay	22.9	76.1	0.9	100.0
Demands for new reward system	0.0	67.3	32.7	100.0
Introduction of new technology	54.3	41.8	3.9	100.0
Equality and diversity	57.5	32.7	9.8	100.0

Table 6 **Percentage of health service organisations indicating importance of various responses to pressures, currently and over next 3 years**

	Currently			Next 3 years		
Structural responses	Very important	Important	Not important N/A	Very important	Important	Not important N/A
Public-private partnerships	12.6	62.1	25.4	26.2	61.2	12.6
Making the organisation less hierarchical	12.7	66.0	21.3	44.0	33.4	22.6
Implementing organisational performance measurement	38.6	59.7	1.7	80.4	19.6	0.0
Benchmarking with other organisations	23.2	72.0	4.8	56.9	39.3	3.8
Outsourcing	3.4	35.5	61.1	4.2	47.2	48.6
Creation of new agencies	22.2	32.7	45.0	44.8	16.1	39.1
Working on an inter-departmental basis	17.7	80.6	1.7	23.8	74.4	1.9
Innovation and standards						
Introducing new technology	53.2	43.0	3.8	65.0	30.7	4.3
Developing service quality standards	48.6	51.2	0.2	80.8	19.2	0.0
Developing customer service plans	58.6	36.7	4.7	74.9	21.0	4.2
Employee-oriented work practices						
Improving information flows and consultation	57.4	42.6	0.0	90.7	9.3	0.0
Meeting employees' needs for work/life balance	45.3	54.4	0.3	59.8	39.9	0.3
Moving to a team based approach to work	25.4	65.7	8.9	22.4	68.9	8.8
Allowing individuals discretion in managing and organising their own work	6.7	86.9	6.4	35.0	59.0	6.0

	Currently			Next 3 years		
	Very important	Important	Not important N/A	Very important	Important	Not important N/A
Employee-oriented work practices *contd.*						
Explicit policy on equality/diversity	43.1	51.8	5.2	42.0	49.3	8.7
Human resource policies						
Open recruitment in the Public Service, all grades	38.9	34.6	26.5	69.6	22.4	8.0
Freedom to adjust employee numbers	46.9	50.5	2.6	47.3	50.8	1.8
Increased use of contract or temporary staff	0.7	41.0	58.3	13.4	40.4	46.2
Training and development for management	60.1	39.6	0.3	64.6	35.1	0.3
Training and development for employees	60.2	39.6	0.3	64.6	35.0	0.3
Performance related pay, increment is related to annual review of performance	15.3	41.9	42.8	44.1	47.8	8.2
Partnership and involvement						
Build trust between staff and management	33.3	66.7	0.0	81.3	18.7	0.0
Formal partnership agreement	43.2	54.8	2.1	47.4	50.7	1.9
Informal partnership style arrangements	49.5	47.6	3.0	48.4	48.7	2.9
Arrangements for direct involvement of employees in decision-making and problem solving	35.1	59.2	5.8	38.5	53.3	8.2

In addition, a partnership approach to change was considered to be important. Ninety per cent (90%) of health service managers strongly agreed/ agreed that responses around partnership and involvement are very important/ important responses to change in the public service.

The case studies published in this report present evidence that partnership approaches can tackle the pressures for change outlined above. Examples of improved patient care include:

Elphin Leg Ulcer Clinic – the development of a specialised Leg Ulcer Clinic in Elphin, Co. Roscommon provides a more flexible service for clients in the Western Health Board. The team working aspect of the clinic increases expertise among staff, which is leading to improved results in the treatment of leg ulcers in the county.

Western Care Association – the Western Care Association developed a client-focused quality standard that facilitates personal outcomes. It is leading to improved patient care and a better quality of life for service users and their families.

Smartwork – the South Eastern Health Board's Smartwork project has widened knowledge of service planning among health board staff and is yielding increased innovation with a focus on cost neutral service improvements.

Again, the case studies published in this report highlight how a partnership approach to change can result in improved quality of working life. Examples of this include:

Western Care Association – the introduction of Personal Outcomes Measures system increased the level of teamworking in the organisation.

Midland Health Board – the management focus on communications and improved quality of working life will reduce levels of work-related stress.

Engineering Department, St. James's – the introduction of a flexitime system increased the level of autonomy among employees.

At organisational level, partnership approaches to these pressures for change are tackling challenges relating to organisational efficiency in the health service.

Smartwork – the South Eastern Health Board Smartwork programme is concerned with promoting cost neutral innovation in service planning.

Engineering Department, St. James's – the Engineering Department at St. James's Hospital piloted a flexitime system that extended the opening hours of the Department, met the needs of internal customers more efficiently and reduced the need for external trades people and made more efficient use of trades people's time, thus saving costs.

Barriers to change in the health service

Knowledge, experience and models of good practice are being developed and maintained across the country. The establishment of the Performance Verification Group, which monitors the fulfilment of commitments in *Sustaining Progress*, has stimulated the collection and collation of extensive data on these practices and their outcomes. Substantial efforts are being made to disseminate good practice around the health service. However, partnership approaches to change and service innovation have not yet become best practice, or even common practice across the health service. The NCPP has examined the barriers to a widespread application of these practices and the values that underpin them.

The NCPP/ ESRI survey of employers asked health service managers about their views on a number of potential barriers to addressing change pressures in the public service. The majority of the respondents stated that external barriers, particularly budget constraints (75%), were a 'major barrier to change'. However, the survey also highlights internal issues such as management ability, performance management systems, organisational structures, and attitudes to change that are creating internal barriers to change in the health service (see Table 7).

Table 7 **Barriers to change – percentage of organisations within health sector indicating the extent to which each of the items represents a barrier to addressing pressures facing the organisation**

	Major barrier	Barrier	No barrier/NA	Total
Management and organisation				
Management structures within your organisation	1.4	59.7	38.9	100.0
Ability and experience of management	14.9	18.3	66.8	100.0
Willingness of management within the organisation to change	4.6	41.0	54.4	100.0
Hierarchical nature of the organisation	3.3	70.7	26.0	100.0
High levels of bureaucracy	5.5	77.1	17.4	100.
The promotions process	0.0	59.7	40.3	100.0
The level of responsibility devolved to individuals or work teams	0.9	39.0	60.1	100.0
The extent to which one can deal with under-achievement	55.2	40.5	4.3	100.0
The extent to which one can award high performance	42.5	53.2	4.3	100.0
Willingness of staff within the organisation to change	13.9	67.8	18.4	100.0
Willingness of unions within the organisation to change	31.0	62.7	6.3	100.0
Lack of local flexibility in industrial relations negotiations	38.7	44.2	17.1	100.0
External constraints				
Budget constraints	70.6	29.2	0.2	100.0
Centralisation of public service resource allocation and finance decisions	43.8	50.4	5.7	100.0
Centralisation of public service human resource systems	35.1	48.9	16.0	100.0
Political considerations	48.1	39.5	12.4	100.0

These barriers are significant. At an international research conference hosted by the NCPP[7] in November 2003, Professor Peter Lazes, Cornell University, who has worked with and studied Irish and US health care organisations, stated that "implementation is critical and consistently missing" in partnership activities, and that a key challenge was "to move to a system approach". Innovation is taking place in the health service – the six case studies outlined in this report are exemplars of the good practice occurring in organisations around the country. However, a whole system approach to implementation of innovation seems to be problematic for a number of reasons (see Table 8).

7. http://www.ncpp.ie/dynamic/docs

Table 8 Perceived barriers to change in the health service

- Need to improve management ability to implement progressive human resource policies
- Low levels of consultation and feedback
- Hierarchical and bureaucratic organisational structures
- Low levels of performance management
- Unwillingness of management, staff and unions to change
- Low levels of trust in organisations

The NCPP examined the capacity of the health service to implement good practice approaches to change. Firstly, it examined the system's capacity for leadership in a number of key areas, such as management, training and development, and information and consultation.

The NCPP/ ESRI survey of employers showed that 43% of health service managers felt that the ability and experience of management was a barrier to change. In addition, the survey reported that relatively low incidences of feedback to employees and training and development (outlined earlier in this report) were also barriers to change.

Health service workers interviewed for the NCPP/ESRI survey of employees were asked how regularly they feel they are informed about a number of work-related issues, including: budgets, service improvements, new technology, or changes to work practices. Their responses were aggregated and a single score produced along a scale from 0 – 2 (where 0 is hardly ever and 2 is regularly). Health service employees scored 0.9, which matches the overall average score for all sectors.

When asked a series of questions about the level of consultation in their workplace, health sector employees scored 2.5 (on a scale from 0–4 where 0 is 'never' and 4 is 'almost always') which is the average score for all sectors.

Secondly, the NCPP examined the factors affecting structural capacity in health service organisations. Over half of the health service respondents (55%) in the NCPP/ ESRI survey of employers stated that the hierarchical nature of the organisation was a barrier to change. In addition, almost two thirds of respondents (63%) stated that high levels of bureaucracy in health service organisations created a barrier to change.

However, three quarters (75%) of those respondents also stated that management structures were 'not a barrier' to change in health service organisations, and 62% stated that the level of responsibility devolved to individuals and work teams was 'not a barrier'. These figures are quite interesting, as they contradict the findings outlined above. However, the fact that the respondents are all senior managers in health service organisations should be taken into consideration.

The lack of performance management in the health service was seen as a barrier to change. Forty two per (42%) cent of managers stated that inability to deal with underperformance was a 'major barrier' as was inability to reward high performance (37%).

The NCPP/ESRI survey of employers asked health service managers if they felt that relating increments to an annual review of performance was an important response to change. Only 15% felt that it was currently a very important response to change pressures, however, that figure increased to almost 45% when asked to consider its importance over the next three years.

The NCPP also examined the health service's attitudes to change and innovation. The NCPP/ ESRI survey of employers showed that half of respondents in the health service (49%) considered willingness of management to change an intense barrier to change. When asked, the respondents also stated that staff (63%) and trade union (64%) willingness to change were also 'barriers'.

Trust is a key component of any organisation's response to change. In the NCPP/ ESRI survey of employers, one in three health managers felt that building trust between staff and management was a very important response to change, and 67% felt it was 'important'. In addition, informal partnership style arrangements (49.5%) and formal partnership agreements (43.2%) were also considered important responses to change.

Overcoming the barriers to change

One of the emerging outcomes of the Forum on the Workplace of the Future is that a new workplace model is needed in order to create the flexible, innovative organisations that will be successful in the future. According to the FWF, the key features of these new organisations will be:

- A highly participative approach to work and management aimed at creating genuine opportunities for employees to contribute their views and ideas
- A strong focus on learning and skills at all levels of the organisation
- Practices designed to encourage and reward high performance
- Promotion of workforce diversity for sound business reasons as well as reasons of social responsibility
- Considerable investment in developing a collaborative approach to workplace relations.

Table 9 Factors associated with high performance in health care organisations (NICS research)

Prerequisites	Enablers	Drivers
Goal-setting & feedback	Climate	Organisational learning & knowledge transfer
Leadership	Culture	Quality management
Human resource management		Training & development

The Australian National Institute of Clinical Studies (NICS) literature review of the factors supporting high performance in health care organisations identified a number of factors for high performance (see Table 9). These factors are quite similar to the emerging characteristics of the workplace of the future identified by the FWF.

The case studies also highlight a number of good practice behaviours that enable organisational innovation. If these practices were implemented more widely – mainstreamed – in health service organisations, it would reduce the barriers to change and increase capacity for innovation and high performance across the health service (see Table 10).

Table 10
Good practice approaches to organisational innovation

1. Encourage learning and development
2. Communicate effectively with staff
3. Put resources in place time, people, money
4. Measure impact of innovation on service delivery
5. Develop new ways of working together
6. Encourage creativity and harvest ideas
7. Build trust the pilot project
8. Ensure representation and employee voice to get agreement for change

- ***Encourage learning and development***

Learning that is applied to achieve organisational development can create a virtuous circle within which innovation can take place. For example, in the Midland Health Board, the idea for a staff Quality of Working Life survey came from a manager who had attended a master class on employee stress. Subsequently, the survey provided learning for the organisation with regard to the concerns of staff. In particular, it highlighted poor internal communication as a source of work-related stress. One of the organisation's responses was a management development programme to encourage more effective communication.

- ***Communicate effectively with staff***

The issue of communication was raised in all the case studies. It is a complex area that covers issues such as information, consultation about change, goal-setting and feedback, and employee involvement in service planning and delivery. There are different approaches to all these areas of consultation that need to be undertaken in health service organisations. For example, when the Action Plan for People Management was being prepared, consultation workshops were held with a wide range of staff. When it was launched in October 2002 HR, managers, unions and staff from around the health service ran information sessions to tell other employees about the plan. These sessions included workshops and presentations on how the APPM would be implemented and measured. As a result, the APPM has been accepted by staff and unions and is quite widely known across the health service.

- ***Put resources in place – time, people, money***

In most of the case studies, individuals engaged in partnership style activities spent time working outside of normal roles and sometimes outside of normal hours. A good practice approach to change should ensure that innovative activities are integrated into staff's core duties and core hours. For example, in the South Eastern Health Board, a significant investment of time and personnel, as well as financial resources, was made in developing trainers to deliver service planning training to every employee in the health board. This involved recruiting individuals and training them to design and deliver training, ensuring their 'normal' workload was covered while they were engaged in training activities, and planning delivery so that staff members who work shifts were included when it was convenient for them.

- ***Measure the impact of innovation on service delivery***

A key outcome of these case studies is that measured innovation delivers long-term change more effectively. This is because staff and managers can see the impact of their work on service users. For example, the Western Care Association's Personal Outcomes Measures system can measure the impact of innovative service delivery on the quality of life of each of its service users. In this way, staff members have a very explicit knowledge of the impact of their contribution to the organisation's objectives.

- ***Develop new ways of working together***

The research outlined earlier in this report highlights the importance of teamworking for standards of patient care. The case studies also show the impact of teamworking on patient care, on quality of working life and on organisational efficiency. For example, in the Midland Health Board, six cross-functional teams have been established to meet the challenges outlined in the Quality of Working Life Survey. The teams include skilled professionals who can bring their experience in service delivery to bear on the needs of employees (e.g. a psychologist is chairing the team on stress, a social worker is chairing the team dealing with diversity).

In addition, employees involved in these teams are developing new skills in team working and leadership.

- ***Encourage creativity and harvest ideas***

A key element of innovation is finding ways to encourage creativity and harvest ideas. For example, in Roscommon Community Services, a quality initiative – Have you got a good idea for quality? – was held to encourage innovation in the organisation. Managers promised they would implement as many of the ideas as possible. The idea for a Leg Ulcer Clinic in Elphin is just one of a series of ideas being implemented and the initiative is now in its second year.

- ***Building trust – the pilot project***

Lack of trust can often block innovation so it is important to engage in measures that will increase trust. In St. James's Hospital, the Engineering Department piloted flexitime with a number of staff in order to enable innovation. Not all staff wanted to be involved from the start, so their wishes were respected and they were encouraged to sign up to the new system once they had seen whether it provided real benefits for employees.

- ***Ensure representation and employee voice to get agreement for change***

All of the case studies emphasise the importance of the role of partnership in formalising staff involvement in change. For example, in the Western Care Association, the Personal Outcomes Measures system was piloted in a small part of the organisation initially. A sub-group of the Partnership Committee was established to oversee the pilot programme. This ensured formal trade union involvement and employee voice.

When the Action Plan for People Management was being developed, two workshops were held to consult with health service staff and trade union representatives. In addition, the overall steering group for the APPM, as well as the project team that drew up the plan, was made up of representatives of all the key stakeholders in the health service. This resulted in agreed change and increased buy in to the principles and objectives of the health service's first human resource strategy.

NCPP Recommendations for future action

The NCPP recommends the following actions be undertaken to facilitate a partnership approach to change across the health service:

- Focus on organisational innovation – the HSNPF should focus more of its resources on overcoming barriers to change by promoting organisational innovation in four key areas:
  - Strengthening management ability to implement progressive human resource practices
  - Further development of consultation and feedback processes
  - Further modernisation of organisational structures
  - Additional trust-building measures in organisations.
- Mainstream capacity for partnership approaches to change – the HSNPF has been involved in over 400 projects to date and has undertaken excellent work in developing the health service's capacity for partnership approaches to change. As a result, there are substantial pockets of

experience and expertise around the health service (due to the completion of over 400 projects to date). However, the size and complexity of the health service creates substantial challenges for dissemination or mainstreaming. The HSNPF should build on its success to date by focusing additional resources on the development of systems to disseminate learning more effectively throughout the health service. Key elements of this approach should include:

— Application of information and communications technologies to the challenge of mainstreaming

— Increased networking, with other organisations, and between health service organisations, building on existing good practice in this area

— Identification of good practice approaches in other sectors, in other countries, and in particular, in multinational companies that have developed approaches to communicating in a multi-site environment.

- Measure the impact of partnership approaches to change and benchmark the performance of individual organisations.

  — Develop further the evidential case for a partnership approach to change – extensive data on the outcomes of partnership approaches to change has been collected by the HSNPF on behalf of the Performance Verification Group established under *Sustaining Progress*. The NCPP believes that this data should be analysed to promote the evidential case for a partnership approach to change, and to measure the impact of partnership on levels of organisational innovation in the health service. The HSNPF should undertake this major project in association with a suitable third level institution.

  — The HSNPF should also consider further developments of its benchmarking tools (including Learning by Monitoring) for partnership, organisational innovation and improved organisational performance in Irish health service organisations. This project could include an international element and could be undertaken with organisations and networks from other countries that are currently undertaking similar work. The NCPP is undertaking work in this area and could support the work of the HSNPF.

- Link workplace partnership with strategic change – the HSNPF should continue its role in promoting a combined approach to change – supporting incremental change at local level and linking it with strategic change at national level. This should encompass its current role in supporting the reform process in the health service. In its publication *Building a Coalition for Change: Implementing the Health Strategy using a partnership approach*, the NCPP made a number of recommendations for action in this area. The HSNPF has implemented many of these recommendations e.g. delivering training, celebrating successful innovation, exploring new ways of working together, explaining and advocating a partnership approach to change. The NCPP recommends that the future work of the HSNPF should continue to be driven by a commitment to providing 'top down support for bottom up change' and should continue to promote this approach to change across the health service.

CHAPTER FOUR

The Case Studies

This chapter presents case studies from six health service organisations that form a broadly representative sample across the diversity of organisations operating in the health service. Each of the organisations demonstrates how a partnership style approach that involves management, staff and unions in joint problem solving can increase levels of organisational innovation and improve service delivery.

A new HR strategy through partnership

The development of the Action Plan for People Management

A joint problem solving, team-based approach to developing the Action Plan for People Management, a key objective of *Quality and Fairness: the health strategy*.

Why was it undertaken?

One of the six frameworks for change outlined in *Quality and Fairness* was developing a Human Resources (HR) action plan to strengthen the role of HR in delivering high quality services. There was also a need to develop a co-ordinated HR approach and to increase the levels of consultation and employee involvement in the health service.

Although *Quality and Fairness "recognises that while there has already been a shift towards the more contemporary Human Resource Management approach to people management"* it stated that *"further work needs to be done to complete the switch from the traditional personnel administration model"*. It recommended developing the Action Plan for People Management (APPM) to facilitate this process.

One of the key strengths of the APPM is that it is measurable. It includes time frames and key performance indicators.

A partnership approach was undertaken to get the views of managers, staff and their representatives, to lead by example and to ensure the linking of strategic and operational issues.

> *"The APPM approach was a joint approach to project delivery, from design to implementation".*

Who was involved?

> *".... there was no one architect of the APPM".*

The development of the plan was the responsibility of the Department of Health and Children and the Health Service Employers Agency in consultation with the Health Services National Partnership Forum (HSNPF). Other stakeholders included the Office for Health Management, the human resource directors of the Health Boards and the Eastern Regional Health Authority and the human resource managers from the Dublin Academic Teaching Hospitals. Overall, approximately 40 HR managers and staff from the Department of Health and Children and four trade union representatives were involved in drawing up the APPM.

When was it undertaken?

The time frame for the development of the APPM was very narrow, from the commencement of the development process in February 2002 to the October 2002 publication deadline. All of the content emerged over a period of four to five months.

How did it happen?

The Department of Health and Children established a large plenary group representing the stakeholders mentioned above. A facilitator was hired to help develop consensus within the group. Following the first few meetings it became apparent that the group was unwieldy due to its size and the many different interests represented, so a smaller steering group was established to undertake development work and report-back to the plenary group on a regular basis.

Two major consultative workshops – designed and facilitated by HSNPF – were organised to hear the views of HR professionals, union officials, line managers and staff across all agencies on what the APPM should contain. Over 400 staff attended the workshops and discussed the seven themes of the APPM as outlined in Quality and Fairness (see Table 11 for a list of the themes).

Table 11
The seven themes examined by health service staff at APPM consultative workshops

- Manage people effectively
- Improve the quality of working life
- Devise and implement best practice employment policies and procedures
- Develop the partnership approach further
- Invest in training, development and education
- Promote improved employee and industrial relations in the health sector
- Develop performance management.

The output from these consultations proved to be the crucial element in formulating the plan:

"That's really where we got the bread and butter stuff".

"We wouldn't have developed the plan we have without the workshops – a lot of that is down to the creativity and the imagination we encountered on the day [of the workshops]."

Following the consultation workshops a sub-group on each of the seven themes was established (referred to as 'tiger teams') chaired by a member of the steering group or the plenary group. Each team undertook research and consulted others to elaborate thinking around the various issues and to inform the group. The teams drafted papers for consideration by both the steering group and the plenary group.

An all day 'think in' was held in Tullamore in July at which controversial issues around industrial relations and performance management were discussed. Due to the well structured, focused and multi-disciplinary nature of the steering group, these issues were worked through and a consensus document was brought back to the plenary group for discussion:

"Even though we were poles apart, we managed to overcome this and develop a shared understanding of what we could do. Everyone got to air their views."

The steering group held its meetings in the early morning at the Office of Health Management and did a lot of work in the evening because members were continuing to meet the demands of their full-time jobs outside of the project.

The APPM was launched in October 2002. HR managers and staff from around the health service ran sessions designed to inform health service employees about the plan in December 2002. These sessions included workshops and presentations on its implementation. Funding of €850,000 was made available to progress its implementation at a local level. This money was channelled into 26 projects.

What were the challenges?
Time was the key constraint as the process had to be completed by the end of September. A small group of people completed the work as well as having full-time roles outside of the project.

As time was a key constraint many representatives did not have sufficient time to devote to the teams. Added to this time pressure was scepticism amongst some staff about the committee process and what committees could achieve which made it difficult to entice people to work on the teams.

There were challenges around the operation of the plenary group. Due to the large size of the group and the many different interests represented, it proved to be unwieldy. It was evident that the plenary group would not achieve the development of the APPM within the timeframe.

Case Study 1 | Action Plan for People Management *continued*

There are also challenges around implementing the APPM. The primary challenge was a lack of continuity because the members of the implementation committee were not involved in developing the plan.

Local HR managers are partly responsible for implementing the APPM at local level, but this is hampered by their limited involvement in its development. They did not go through the same learning process as the project team or engage with the debate to the same degree.

Amongst staff there is a lack of awareness about the APPM that has proved problematic for implementation, as has the small implementation budget of €850,000.

Outcomes have proved challenging to measure because some of the key performance indicators are overly ambitious and precise. This is compounded by the absence of a history of measurement of this type of data in the HR side of the health service. Also, the funding is not related to the key performance indicators.

What were the success factors?
What did we learn?
Although the process could have been completed in a shorter timeframe had no consultation taken place, those involved believe that the final document was immeasurably better because staff and unions were consulted.

The speech given by Professor Bill Roche at the consultation workshops gave the consultation process momentum and engendered a creative and innovative spirit in the participants: "He provided us with intellectual leadership".

At the workshops it emerged that both managers and trade unions held similar views on the HR and industrial relations practices that needed to be improved. This 'shared understanding' of the issues was key to the success of the project.

> *"I suppose in some ways it was an unexpected bonus that the process worked so well – we proved that involvement with others from different backgrounds could come up with a cohesive document [sic]. I knew we were gambling, I didn't think it would work. But by the time we got about half way, I thought it would work."*

The work of the steering group was central to the success of the project. It was small, carefully chosen and well co-ordinated which is partly why it worked so well. Its members were committed and worked on the project voluntarily even though they also had full-time 'day jobs'. They encouraged each other and were very focused and committed.

The group demonstrated an ability to drop its baggage at the door:

> *"Putting the baggage at the door and challenging ideas from a number of perspectives, not just from the representative point of view, that was the key".*

The group facilitated creative thinking and a culture of learning from each other and provided a space where innovation was encouraged. Through this culture it introduced the members to different mindsets and ways of thinking that increased creativity and built consensus. Collective learning helped to increase the quality of the content and resulted in an ability to see things in a much broader way than at the beginning.

The two one-day consultation exercises were hugely important in generating ideas and themes. Listening to and encouraging staff to be innovative was crucial to the success of the project and provided much greater impetus than the plenary group.

The process facilitated the development of a shared understanding amongst the participants and fostered a culture of trust, which was a major factor in overcoming problems.

The involvement of both the plenary group facilitator and the HSNPF facilitators in the consultation process was very helpful and smoothed over many difficulties.

Key Project Outcomes

"I didn't expect the output to be as good as it was. I didn't expect the reception to be as good as it was. And I certainly didn't expect the group dynamic and the network that was developed to be as strong as it was."

Good interpersonal relations developed between the participants on the steering group who were all from different areas of the health service. The culture of territorialism that existed at the start of the process was replaced by one of trust.

There was a good level of 'buy-in' into the final plan amongst staff who were aware of it. This was a result of the extensive consultation and the inclusion of the views of staff.

The input from unions was very important in ensuring that the APPM was not seen as a management agenda. Also, including the unions as authors of the plan means that they take joint and public ownership of it.

The process has shown how partnership can work and achieve tangible benefits at a strategic level in the health service.

The training fund is managed by HR managers, which is good for the profile and status of HR. It helps to professionalise HR in the health service.

There has been limited impact on service delivery as yet partly because of problems around implementation and funding. These issues have led to the absence of a coherent implementation strategy. Also the focus on the Health Service Reform agenda has stalled a lot of innovation. Due to the problems around implementation the information contained in the first annual report produced by the original members of the steering group (the APPM Implementation Monitoring Committee) is patchy. Single, annual budgeting is a barrier to planning and makes it difficult to promise long-term funding to innovative projects.

Have You a Good Idea for Quality?

Nurse-led, Community Leg Ulcer Clinic, Health Centre, Elphin

A staff satisfaction survey initiated by the Local Partnership Committee resulted in the identification of a number of quality improvement projects one of which was the establishment of a nurse-led, Community Leg Ulcer Clinic at the Health Centre in Elphin, County Roscommon.

Why was it undertaken?

Against the backdrop of a general movement towards making the Western Health Board a better place in which to work, a staff satisfaction survey was conducted in Roscommon Community Services in 2002. The survey revealed that staff wanted a greater say in service planning, and several strategies were explored to enable this. One such strategy was a quality initiative *"Have You a Good Idea for Quality"*. This initiative invited suggestions from staff members for the improvement of services. The management team committed itself to implementing as many of these ideas as possible.

Prior to the quality initiative, leg ulcer treatments were administered by peripatetic Public Health Nurses (PHNs) in patients' own homes. However, the treatment of leg ulcers in a clinic is common practice in many community care regions and is considered to be conducive to best clinical practice. A purpose built consultation room offers advantages that cannot be enjoyed in a patient's own home. The idea for a clinic was submitted as an quality initiative by two PHNs.

Who was involved?

A sub committee of the Roscommon Community Services Local Partnership Committee was formed to conduct the staff survey. The Quality Co-ordinator collated and analysed data from the survey. The Quality Co-ordinating Committee organised the *"Have You a Good Idea for Quality" initiative for staff*.

- A sub group was formed to assess submissions using agreed criteria
- All staff throughout community services were invited to put forward submissions.

The management team of Roscommon Community Care Services committed themselves to doing everything possible to see the suggestions through to completion.

The Director of Public Health Nursing in Roscommon was involved in managing the establishment of the clinic along with the nurses who made the original suggestion.

A North Western Health Board Public Health Nurse who had been involved in establishing similar clinics in the NWHB provided an education programme for six nurses on leg ulcer assessment and management.

When was it undertaken?

The staff satisfaction survey was conducted in late 2002 and results were published in March 2003. The *"Have You a Good Idea for Quality"* initiative was run later in 2003. The measures taken to establish the clinic began shortly thereafter and the clinic opened in March 2004.

How did it happen?

The staff satisfaction survey was administered anonymously to employees. The Quality Co-ordinator analysed the data and the findings were reviewed in a workshop attended by the management team. A plan of action, which included the quality initiative, was endorsed at that workshop.

The *"Have You a Good Idea for Quality"* initiative was organised by the Quality Co-ordinating committee. All employees were invited to submit a proposal to either improve the workplace, or develop services. Prizes were awarded to all participants at an awards ceremony held to acknowledge staff contribution to quality improvement.

The Management Team then reviewed each submission and developed an implementation plan that was communicated to all staff.

Within the Public Health Nursing Department a steering group was established to advance the establishment of a Leg Ulcer Clinic. A site visit was undertaken to an established facility in the North West Health Board area and the Maintenance and Accounts Departments got involved in equipping and stocking the facility in Elphin.

The Leg Ulcer Clinic was established by the health board's Public Health Nursing Department. They liaised with a Public Health Nurse who had established leg ulcer clinics in the North West Health Board regarding design and preparation of the clinic and staff training.

What were the challenges?

The partnership sub-committee had to consider the practicalities of conducting an anonymous survey among a relatively small organisation of 230 employees. They had to make absolutely sure that the survey guaranteed anonymity. There were also issues concerning the resources needed to administer the survey.

The *"Have You a Good Idea for Quality"* initiative proved difficult to adjudicate because there was no template for submissions. The first round of submissions ranged from a single line on a page to a detailed business proposal.

The competition generated some very good ideas for the improvement of services. The challenge to management has been to fulfil its commitment to see them through to completion. The Leg Ulcer Clinic is one of a series of initiatives being implemented as a result of the initiative.

There were various practical challenges in establishing the clinic, many of which, the nurses believed, related specifically to establishing a sound basis for good clinical practice, for example:

- Obtaining the necessary equipment and supplies required initial expense for which approval had to be sought and gained
- Engaging in the relevant leg ulcer management training over a six week period was an essential element of this initiative
- Flexibility was required in the rearranging of nursing work schedules in order to staff the clinic
- Receiving appropriate patient referrals from doctors in the catchment area was another challenge for those involved
- The success of the clinic generated unanticipated referrals, which led to challenges around managing patient intake.

The operation of a clinic involves extensive paperwork in the form of referral letters, acknowledgement of referrals, appointment letters and letters to the patient's GP confirming that the patient is being treated.

Case Study 2 | Western Health Board – Roscommon Community Services *continued*

What were the success factors?
What did we learn?

The partnership sub-committee responsible for administering the survey looked to other surveys that had been conducted in the Health Service. On the basis of lessons learned from that exercise they opted for an anonymous postal questionnaire. Two hundred and thirty staff members received the survey questionnaires by post and a response rate of 60% (139) was achieved which was deemed a successful result.

Since 2003, the administration of the *"Have You a Good Idea for Quality"* initiative has been improved and this has helped to manage the disparity in the submissions received. A template for submissions was developed through careful consideration and evaluation of last year's process. This template has been used successfully in this year's initiative.

Some of the practical challenges overcome in the establishment of the Leg Ulcer Clinic have been outlined above. A key learning from this process is that working together for a common cause is a very effective way to achieve quality delivery of services. A significant factor in the success of the project was that everyone involved was committed from the outset. This includes the Management Team, the Partnership Committee, the Quality Co-ordinating Committee, the Director of Public Health Nursing, the PHNs, the workmen who refurbished the facilities, the local doctors and consultants who refer patients and the patients themselves.

One of the reasons why a team environment is important in the delivery of a comprehensive service to patients is that it facilitates the dissemination of best practice procedures and the sharing of expertise. Such benefits are more difficult to achieve under the peripatetic system where nurses effectively deliver treatment in isolation from each other.

The clinic is managed by the nurses who enjoy high levels of autonomy in operating the clinic with support from senior management. This means that the clinic can operate flexibly, extending opening hours when necessary to deal with excess demand for treatment.

Key project outcomes

While patients' views have not been formally surveyed, anecdotal evidence suggests significant improvements in the management of leg ulcers in Elphin. The nurses believe that healing rates are quicker because treatment and care is more consistent which is conducive to healing, although no empirical studies have been undertaken at this stage. Several immediate benefits are associated with the clinic:

- Relief from the pain, discomfort and worry caused by leg ulcers, and restoration of the ability to walk comfortably and undertake social outings.

- Patients attending the clinic are empowered – they make an appointment at their convenience and so do not have to wait for a nurse to arrive. Patients make a conscious effort to attend the clinic and some health professionals feel that gives the patient an input into the healing process.
- Patients tend to comply with treatment procedures more readily when they attend a clinic rather than when the PHN treats them at home. Receiving treatment at a clinic lessens the potential for patients to be distracted by issues in the home.

The installation of a specialised treatment chair in the clinic has reduced the level of manual handling required, for example there is less lifting of patients' legs involved. This reduces the risk to nurses of back injury.

Nurses at the clinic report increased job satisfaction because they believe that the treatment they are administering is more effective than that provided in patients' homes.

The experience that nurses gain from working in a clinical setting improves their general skill levels because they learn from each other.

The opening of the clinic has reduced the travel time spent managing leg ulcers in the community. This has resulted in a net increase in the time available for nursing duties. Treating patients is considered a better use of nursing time than travelling between patients' homes.

Staff members believe that the establishment of the clinic has enhanced the general public's perception of Roscommon Community Services.

This clinic has demonstrated how working in partnership can improve the management and delivery of quality services to patients. It also serves as an example of the merits of staff involvement in service planning.

Evidence shows that the healing time is reduced for each patient because treatment is more effective when administered in a clinical setting. Therefore, in the longer term, more patients can be seen and treated effectively. This amounts to an improvement in services for patients and better value for money for taxpayers.

Economy of scale can be achieved in the use of treatment dressings and other supplies, which will save money long term.

There are plans underway to establish and staff a second clinic, and to further develop the skill set of the nurses involved.

Communicating for better job quality

Improving the quality of working life by improving communications in the Midland Health Board

A major occupational survey of quality of working life among health service employees was conducted in 2002 – 03. The results highlighted that lack of consultation with staff in relation to work issues which affected them, as well as lack of communication were among the most important causes of work-related stress. Subsequently, a number of actions were taken to improve the situation, through the implementation of the Board's communications strategy, a management development programme, and a commitment to increasing the quality of working life in other areas.

Why was it undertaken?

Communication began to be addressed at a strategic level by the Midland Health Board on the appointment of the Communications Director in 1998. Following that, a survey of health board clients found that most rely on health service staff for information on services. Thus, it was decided to develop an organisational communications strategy, which was launched in 2002.

The appointment of a Director of Corporate Fitness in 2001 led to an increased awareness of the importance of staff welfare. A staff survey was commissioned to identify how the working lives of staff might be enhanced.

The Quality of Working Life (QWL) Survey found that, although most stress suffered by staff comes from outside work, lack of consultation and communication were key sources of work-related stress. Specific problem areas highlighted in the survey were: information, consultation on change, joint problem solving, input into decision-making, access to HR, feedback from line managers regarding performance, and communication around organisational change.

Who was involved?

The process was a three-way partnership between staff responsible for communications, corporate fitness and partnership. It was supported by senior management. Approximately 400 staff attended focus groups on the development of the communications strategy and a broad range of staff representatives were appointed onto the six teams that were set up to implement the findings of the QWL Survey. Trade union representatives were also very involved

When was it undertaken?

The Director of Communications was appointed in 1998 and began to focus on internal communications in 2000 at around the same time that the Partnership Facilitator was appointed. The Director of Corporate Fitness was appointed in 2001 and initiated the QWL Survey in November 2002. The issues around internal communication and staff consultation and involvement gathered momentum as each person came on board and there is now a team of people working on these issues. The communications strategy was also launched in 2002

and Action Teams to address the issues raised in the QWL survey were established in 2003.

How did it happen?
Following her appointment, the Communications Director improved the staff magazine, in consultation with health board staff. Through that process it came to light that internal communication was an issue: staff felt that they were not consulted – that they were 'left out'. A group was formed to address the issue and to develop a communications strategy. The group was representative of the geography and service elements of the Health Board.

In light of complaints regarding low levels of staff involvement, a partnership approach was adopted. The development and implementation of the communications strategy was funded by HSNPF. The group published an article in the staff newsletter asking for staff to submit their views on communications.

Focus groups were held at eight venues at which staff were asked questions relating to communication, such as 'Are you being communicated with? How?' Approximately four hundred staff attended these meetings. Some of the issues that emerged were lack of access to information, particularly access to computers, as well as problems with line managers passing on information to their staff.

Following its completion, the Communications Strategy was disseminated among staff along with the message that if communication was to improve that staff had to 'own' the strategy.

An implementation process followed.
In order to increase access to the Board's website, the communications strategy group looked at the way in which Information Points had been developed in the Southern Health Board. They were established at eight locations around the Midland Health Board and are considered a key information channel for staff. The health board website and intranet were also developed and enhanced by a specially recruited staff member.

The Quality of Working Life survey was undertaken shortly after the publication of the Communications Strategy. One of the survey's findings was that internal communication was the main work-related stressor for staff. This had an obvious link with the Communications Strategy and was one of six key action areas identified as an outcome of the survey. When six Action Teams were established to tackle the issues raised by the survey, communications was one of them (see Table 12 for details).

Through the QWL Survey it emerged that information was not cascading down from management to staff, it seldom moved beyond middle management: "getting stuck somewhere in the pipeline". Thus communication is an important element of the management development programme as are consultation and team working.

Table 12 **Action teams established as a result of the QWL Survey**

1. Communication – implementing the strategy
2. Management development – implementing a training programme in people management skills
3. Back management – development of healthy back management and implementation of a treatment programme for injured staff members
4. Work/life balance – a holistic approach to mental health promotion focusing on work/life balance
5. Equality/diversity and anti-racism – develop guidelines for employees and service users
6. Bullying – continued implementation of the anti-bullying policy

What were the challenges?

The Midland Health Board is a very complex organisation with 179 locations spread across four counties. It is the biggest employer in the Midlands. The structure and size of the organisation make it extremely challenging to communicate effectively with staff. The complex structure of the organisation coupled with a tendency for: "the urgent takes over from the important", also made it challenging to implement the communications strategy.

The health board is a '24/7' organisation with employees on different shifts and schedules which makes it very challenging to communicate and to introduce team-working. Employees working traditional office hours, 9-5, tend to be more able to have team meetings than departments that are '24/7'.

Some staff members are not IT literate and due to time pressures find it difficult to attend courses. It is challenging to communicate with them in an era of IT-based communications solutions.

The area of communications is very new for a lot of Health Board staff and there can be a perception that it is an issue to be handled by the communications staff. Some staff do not realise that it is their responsibility:

> *"It is everybody's responsibility to communicate, and if you are not being communicated with, why don't you ask why?"*

Some managers in the health board needed to develop more effective communications and feedback skills. The perception that consultation slows down decision-making resulted in some managers being reluctant to adopt a partnership approach.

There was no extra time or resources, apart from the funding and facilitation services provided by the HSNPF. Everyone involved in the exercise had other jobs to do – their work on the project was in addition to their other work.

What were the success factors?
What did we learn?
The linking of the Quality of Working Life agenda with the existing Communications Strategy will drive the implementation of the strategy across a number of key areas. This will be done using the QWL teams established last year. For example, as well as being an issue for the communication team, communication is also an issue for the management development team and the anti-bullying team. A group to oversee the operation of the six teams has been established and it meets four times a year to facilitate the complementary elements of the teams. The desired outcome is for the six teams to develop 'joined-up' thinking on complementary issues.

There is recognition that the end product is better because staff were consulted. Staff members were also consulted on the health strategy and both processes have strengthened the image of consultation in the health board:

"I'm not saying it [consultation] is done all the time, or that it's done well all the time, but it's there now, and it will get better, because people expect it now and you can't get away without doing it."

Use of a partnership approach gave the process credibility, the link to the partnership committee increased staff buy in:

"I felt when we went out to talk to people in different locations that it [link to the partnership committee] made a difference."

In establishing the Action Teams there was a desire to make use of existing staff skills and experience and to ensure that the Teams were multi-disciplinary. For example, a member of staff who works with Travellers and has extensive knowledge of diversity issues chairs the Equality/Diversity and Anti-Racism Team.

Key project outcomes
There is a growing recognition of the importance of communicating. The Communications Strategy has been advanced through its connection with the QWL agenda and communications has moved to the centre of the organisation.

The Management Development Programme is underway and HR and communication skills are being developed. A formal induction programme for new staff has been introduced:

"As a result of the Communications Strategy, it's better. I was in one of the first groups to have an induction programme – after four months in the job. It was good in that it gave me an overview of the rest of the organisation. It gave me a feeling of being wanted and of being part of an organisation. And you got to know new people."

Information channels such as the website, Information Points and the staff magazine are in place. It is not certain, however, if these are being fully used. Through the process, both younger and more junior staff members were encouraged to get involved.

Case Study 3 | Midland Health Board *continued*

'Joined up' thinking is evolving through the process, for example issues around improved communication and consultation are part of the management development programme.

The benefits of working in multi-disciplinary teams and harnessing internal resources are being realised:

> *"The driving force is empowerment of the people – the organisation is empowered to do it properly, rather than differently".*

The concept of operating through consultation is slowly becoming embedded in the organisation:

> *"We've really only started down the road of effective consultation. It's patchy. There are good spots and bad spots".*

The priority given to the QWL agenda has furthered the belief that the well-being of staff directly impacts on quality of patient care. The Health Service Action Plan for People Management is another important step in creating a climate where quality of working life issues are seen as important.

The process will be evaluated after five years. The outcomes of the next QWL survey will be the key measurement tool used by the health board to assess how effective this work has been.

Case Study 4 | South Eastern Health Board

Introducing Smartwork

Train-the trainer – a Smartwork approach to service planning in the South Eastern Health Board

The Smartwork project developed a train the trainer method to educate staff on service planning procedures in the South Eastern Health Board. It also introduced the concept of Smartwork – low cost or cost neutral changes that improve service delivery in the health board.

Why was it undertaken?

Under *Sustaining Progress* all health service organisations must demonstrate:

> *"...significant examples where the partnership process has contributed to improvement overall. One such example should focus on the service planning process."*

The South Eastern Health Board developed a system of service and operational planning with a view to achieving long-term sustainability in planning efforts, in light of the re-structuring of the health services.

Service planning in the future must focus not only on initiatives requiring additional resources but must plan for improvements to service delivery without increases in funding. This means looking at changes to existing work practices and routines, to improve service delivery.

Each unit or department is responsible for operational planning within its own area of work. Operational plans translate the corporate objectives and actions as set out in the corporate service plan, into tasks for each unit or department. The operational plans should influence (and be influenced by) the overall corporate objectives and actions as set out in the service plan.

The work of making explicit links between the operational plans and the corporate service plan is critical so that staff understand how the work they do is connected to the corporate 'contract' with the Department of Health and Children.

The aim of the system developed by the South Eastern Health Board was to provide an educational programme that would inform and enable all staff to participate in the service planning process. This entailed training a group of trainers to deliver educational programmes to all members of staff and management within their own sections, units and departments.

In tandem with the 'train-the-trainer' programme, a move was also being made to adopt what is referred to locally as a 'Smartwork' approach to service planning, that is: Specific, Measurable, Achievable, Realistic and Time bound (SMART) as 'What gets measured gets done'.

Case Study 4 | South Eastern Health Board *continued*

Who was involved?
It is an organisation-wide initiative that originated following consultation between Corporate Management and the Regional Partnership Committee. The Regional Partnership Committee agreed a 'train-the-trainer' model. The trainers, nominated by General/Hospital Managers, then worked with the Planning and Evaluation Unit General Manager and the Regional Partnership Facilitator to design and develop the educational programme. The trainers delivered the educational programme in their own work locations. Service planning in the South Eastern Health Board now requires input from everyone.

When was it undertaken?
The project began in early 2003. The initial nomination and training of trainers took place in July 2003. The educational programme began shortly thereafter and is an ongoing process. The draft service plan for 2005 is being prepared, supported by this model.

How did it happen?
It was recognised that staff should become more involved in service planning in the health board, and that they needed training in order to maximise their contribution to service planning. It was decided to engage in consultation on this issue by adopting partnership. Through the partnership structures a decision was taken to develop and implement a partnership approach to service planning throughout the South Eastern Health Board region.

Existing training programmes from other organisations were examined to identify good practice. It was decided to take the best elements of other courses as necessary and combine them in a tailor-made train the trainer programme. It was focused on the kind of one-to-one coaching that was necessary to delivery a service planning training programme to all staff. Under this programme a core group of trainers would be trained to act as internal service planning consultants to all staff in the South Eastern Health Board.

The proposal was brought to the management team who agreed that each regional manager would nominate two suitable staff members to join this core group of approximately 30 trainers. Regional managers were aware that nominees would be required to engage in public speaking and group facilitation and be available to devote the necessary time to the work. It was important that nominees came from grades neither too close to management nor too far away from the 'coal face' of service provision. The train the trainer programme was developed and rolled out.

The trainers were involved in developing and delivering the educational programme. The purpose of this training programme was to impart the skills required for the service planning process to all personnel. Everyone was to be fully versed in the business of operational and service planning using a partnership approach.

A consultation and development process took place whereby the trainers, Service Planning Manager and Partnership Facilitator met monthly for several months to develop an educational programme. Training in the delivery of the educational programme took place and skills such as public speaking and delivering presentations were included.

What were the challenges?
Time management was an issue. Some trainers were expected to deliver the educational programme during working hours. For some this involved training during time they were on the roster for ward duty. This seems to have been the most significant challenge for the small number of trainers that were employed on a shift work basis.

Communication was a challenge: there was no single medium that worked for all 5,500 staff members. For example, not everyone had access to email.

Structures in some areas of the Board were more favourable to the introduction of a participative approach to service planning than others. For example, in Wexford General Hospital the 'Directorate Model' of management promotes a participative approach to patient care that proved conducive to introducing a partnership approach to service planning.

Some managers and unions were hesitant to buy into the process. In particular some managers were reluctant to relinquish control of the service planning process while some unions did not want their members taking on management responsibilities.

Attendance at public information meetings was sometimes poor. In some instances staff members were not motivated to become involved.

There was a general lack of familiarity with the concept of service planning. There was a widespread perception that service planning meant the creation of a 'wish list' for equipment and facilities. Previous experience led people to believe that improvement meant purchasing new equipment.

There was some scepticism and cynicism about the partnership process.

For the trainers, some of the technicalities in the service planning process were challenging to communicate to staff, for example: costings for proposed new developments.

What were the success factors?
What did we learn?
The dedication and enthusiasm of trainers, along with the support they received from colleagues must be acknowledged as a major factor in the success of this project. Together the individuals involved overcame time management issues by simply working above and beyond what was reasonably required of them. This included working outside normal working hours and agreeing to cover for absent colleagues.

Perseverance was the key success factor when it came to the communication challenges within the Board. Some of the methodologies used to draw people in included:

Case Study 4 | South Eastern Health Board *continued*

- Sending emails to all staff members who use email
- Asking those who received emails to print out and pass on the message to others.
- Asking line managers to post notices in staff rooms and common areas
- Attending team meetings in places of work to deliver the educational programme
- Delivering educational programmes in the evenings to facilitate day staff
- Delivering a session on each day of the week, staggered over a few months to facilitate the attendance of staff on seven day rosters/ flexible work arrangements.

Internal resistance to the initiative was overcome because of the connection with the partnership agenda. It was also inclusive for all staff.

The trainers that were involved in the programme were predominantly staff officer grades. When the education programme was delivered to staff groups that included middle and line managers, it became a populist initiative rather than a management directive.

Breaking the process into operational units capitalised on the specialised local knowledge of trainers. Locally based people were well placed to adopt creative solutions to the challenges that faced them. Examples include: attracting indifferent staff members to meetings and generating an interest in the process, and overcoming the scepticism of local managers reluctant to engage with a participative process.

Adopting a 'Smartwork approach to the service planning process continues to be a key element in this programme. Smartwork involves identifying solutions that are SMART, which do not require additional resources to improve service provision, for example: reorganising rosters to ensure that maximum resources are allocated at the time of maximum demand.

Staff members at the point of service delivery are equipped to see where the changes can be made on a day-to-day basis and therefore are best positioned to say where effective change can be achieved.

Key project outcomes

In the past, staff members have had simple and cost effective solutions to problems; they now have a forum for suggestions.

Good ideas are being harnessed and talent is being utilised. Resources are being used to full capacity.

Anecdotal evidence suggests that capital spending is being reduced as staff members become more aware of the benefits of cost neutral initiatives.

Staff members are getting feedback about their ideas and there is a general perception that this has a morale boosting effect at many levels. There is more openness and transparency in the operational and service planning process.

There is now a general awareness among staff about the issues associated with operational and service planning. There is a better understanding on the part of management about the nature of work at the 'coal face' as these issues are now being brought into the service and operational planning process.

Staff members are starting to think in terms of good practice and changing their working behaviour in order to improve service delivery.

There is greater accountability generally: staff members are recording what they are doing in order to feed into the service plans.

There is a greater economy of effort: service delivery is now based on the principle of identifying needs and matching needs to the appropriate responses.

Piloting Flexibility

Introducing flexitime in the Engineering Department of St. James's Hospital

This initiative extended the working hours of the Engineering Department in St. James's Hospital, as well as improving staff work/life balance, by introducing a flexible working system.

Why was it undertaken?

Prior to the introduction of the flexitime system, the Department operated from 8.30am to 5.00pm on weekdays, closing at 4.00pm on Thursdays and Fridays. There were two key drivers of this initiative: a general need had been identified for the extension of the engineering services, and there was a need among some staff for flexible working hours.

The Engineering Department had a very traditional organisational culture: time keeping was strictly adhered to with formal break times factored into the working day. Task distribution was hierarchical with a foreman assigning duties at the start of the day. It was uncommon for staff members to use their own initiative in the management and completion of work duties. Disciplining staff members for lateness was a common practice.

As the overall objective was to find a situation that worked equally well for both staff and management, a partnership style approach was decided on, due to its focus on consultation and staff involvement in problem solving.

Who was involved?

Those involved in this initiative were electricians, plumbers, fitters, carpenters, painters, a plasterer and management in the Engineering Department. The Partnership Facilitator was also involved.

When was it undertaken?

The system was introduced in late 2003 and was extended beyond a six-month pilot phase which ended in March 2004.

How did it happen?

The idea to introduce flexible working arrangements in the Department emerged from a staff survey. There was also a belief that it might be beneficial to both departmental staff and the wider functioning of the hospital. An ad-hoc group was formed with some union representatives and management to discuss the possibility. There was no facilitation or systematic union representation on the group, although the underlying approach was one of partnership. A proposal was drawn up detailing the specifics of a possible flexitime system. Due to the lack of systematic representation, the proposed system did not reflect the needs of all parties and so no agreement was reached at that time. Some union members involved had concerns over loss of earnings for their

members, particularly in relation to loss of over-time and a reduction in 'on call' duties, and called for a significant re-drafting of the proposal.

At this point the Partnership Facilitator became involved. She suggested using the flexitime system operated by hospital administrative staff on the basis that it might be more likely to move through the industrial relations process. This was not favourable to all unions as concerns over loss of earnings continued to be a fundamental 'sticking point'.

It was in this context that management agreed to put the system on trial for six months if 50% of staff agreed to work with the new system. The remainder could continue to work as before.

An implementation group was established to oversee the pilot project and deal with any difficulties arising. Each of the relevant unions and the IT team were represented on the group, which was chaired by the manager of the Engineering Department. All staff members taking part in the pilot phase were obliged to be in attendance between the core hours of 9.30am to 12.30pm and 2.00pm to 4.00pm (Monday to Friday). Their flexitime system allowed them to choose to work their full week between 8.00am and 5.30pm. In addition, they had to guarantee that a craftsman would be on site until 5pm. This is arranged informally between the staff.

A time capture software system and electronic clocks were purchased and installed in the Engineering Department. They are supported by the Information Management Services Department and a maintenance contract with a software company. The system has been configured in line with a flexitime agreement. Each staff member was issued with a staff card containing a magnetic strip and a chip that uniquely identifies the employee and records time electronically. Staff members log onto the system by flashing their staff card at a sensor. Once on the system, individuals can view a personalised record of their hours worked and apply for annual leave at their convenience. Supervisors can respond to these requests at their convenience using the same system.

What were the challenges?

The culture of the Engineering Department presented a particular challenge. It was dominated by practices that had not been changed for many years. Staff members were not expected to be flexible in their hours of attendance or in the nature of the work they completed: they worked set times each day, performing whatever tasks were assigned by the foreman. Anyone arriving early could not start work until the appointed time and work outside normal working hours was treated as 'overtime'. Any initiative that changed the working conditions in this particular department had to do so in the context of that environment.

There was also a challenge around getting both management and staff to trust each other's interest in the system. In order for it to work, management had to trust staff to get on with their work without supervising

them while the staff members, who had previously been very tightly controlled, had to get used to being trusted to organise their own work.

A major challenge was getting agreement to introduce the system in the first instance. Through agreeing to pilot the flexitime system with 50% of staff members, the initiative could be put to the test with a meaningful number of staff. Staff not wishing to be directly involved did not prevent others from getting involved, nor were they themselves forced to participate.

There was also a logistical challenge from the outset. St. James's is the largest acute general hospital in the country with approximately 780 beds and 3,500 staff. The Engineering Department consists of 45 staff members who provide daily and ongoing maintenance of the forty or so buildings occupied by the hospital on campus. A system was required to ensure that work was being carried out effectively and that the engineering services provided to the hospital were efficient.

It was necessary for the hours worked by staff to be recorded in some way to allow workers to keep track of the hours they had worked and any time off in lieu they were entitled to take. It was also to enable management to monitor working hours and overtime and to see which staff members were at work on any given day.

Some staff did not understand the partnership approach, being used to the old adversarial system of industrial relations. There was no training for staff on the partnership process.

What were the success factors?
What did we learn?
The introduction of a computerised system of clocking in and out proved to be an essential factor in the success of this initiative. It gave management the ability to take a hands-off approach to monitoring the number of staff on duty at any given time and gave staff autonomy over their own working hours.

The willingness of 50% of staff to pilot the system, despite not having the agreement of all staff, was an essential success factor. It must be acknowledged that those not involved also played an important role in its success by allowing it to go ahead without their participation.

The emphasis in the department was changed fundamentally from one where absences were recorded, to one where attendance is recorded. This has resulted in a change in thinking, an increased dignity for workers, and improved levels of trust between workers and management. It has been a fundamental element in the success of this initiative.

Looking to other initiatives and learning from others was an essential element in the process. There was a flexitime system in use in another section of the hospital that provided a model for the Engineering Department.

There was greater 'buy in' to the initiative because of the use of the partnership model with its emphasis on a 'win-win' situation for both staff and management:

"Partnership implied trust, understanding, goodwill and confidence."

Key project outcomes

Four new operational units have been opened during the pilot phase of the project but there has been no need to employ additional technical staff. Some staff members view this as evidence that the Department is more productive and more efficient.

Morale in the Engineering Department has improved.

A partnership approach to change and innovation has been demonstrated be able to move an issue forward and break down fears.

Ninety per cent of the staff of the Engineering Department are now on the flexitime system.

The former 'paternal' model of supervision has been eliminated and staff members enjoy more autonomy over their working lives. Workers who arrive early in the morning can start work on jobs that have come in through the 'help desk' without waiting for the supervisor to assign duties for the day. They may also return to jobs that they had been working on the previous day and finish jobs that they are doing before leaving for the day.

So long as staff members are present during core hours they can arrange their day to suit personal and family commitments or extracurricular activities. For example, they can now drop their children to school before coming to work. They can also take up to one day per month in lieu of time worked above normal working hours.

Management time is no longer taken up with ensuring that staff members are on site, the computerised system allows them to see who is on site.

There has been a notable shift in the culture of the Department, with staff members

"...thinking for themselves, working on their own initiative and accepting a degree of independence...working to make St. James's a better hospital by maintaining it better..."

Implementing Personal Outcomes

A service-user-focused quality system implemented in the Western Care Association, a voluntary organisation that works with individuals with learning disabilities and their families

Western Care Association is a voluntary organisation that provides services for people with learning disabilities in Co. Mayo. In 2002, the Association achieved accreditation in the Personal Outcomes Measures system, a US-based quality system that evaluates the person-centredness of human services based on a range of personal outcomes.

Personal outcomes are the priorities and preferences across the major quality of life domains e.g. work, involvement in the community, rights and personal freedoms, safety, or health. Within each quality of life domain, the person individually defines the meaning and importance of the issues that arise for them e.g. one person's definition of a good social life will be entirely different from another's.

Organisations are required to discover the personally defined outcomes of their service users and to address them on a person-by-person basis. The personal outcome measures system evaluates total organisational performance in terms of how well the organisation addresses the priorities of the people served. Implementation of Personal Outcomes Measures requires substantial changes to culture and challenges staff, management and unions to work towards a common goal while addressing change.

"It looks upwards at the organisation to see how every aspect, every strategy of the organisation is aligned to deliver the outcome at the front line. Everything in the organisation has to converge to deliver the result."

Why was it undertaken?

The quality agenda was a key element of the 1994 National Health Strategy. This motivated Western Care Association to "get ahead of the posse" in terms of identifying a best practice approach to quality. The Association wanted to build on a strong commitment to the person (the service user) that already existed in the organisation and develop new models of service delivery that could be measured for their effectiveness in delivering a person-centred approach – i.e. to fit the organisation's services around the needs of users, rather than asking service users to fit in with existing services.

As the implementation of this approach would result in substantial organisational change, it was agreed between management and the trade unions that the project should be piloted and mainstreamed using a partnership approach. A sub-group of the Partnership Committee was established to oversee the project and the HSNPF funded the substantial costs of the pilot project, which was implemented in 2001.

Who was involved?
The organisation's CEO and the training and evaluation manager represented the organisation in the initial National Federation of Voluntary Bodies search for good practice quality systems, in consultation with the rest of the management team.

The organisation's trade unions became formally involved when a working group of the partnership committee oversaw the implementation of the pilot project in 2001. Staff, service users and their parents in the pilot sites were involved in learning how individuals define their personal goals from an early stage. When the decision was made to implement the system across the Association, all staff, service users and their families became involved.

When was it undertaken?
After identifying Personal Outcomes in 1998, the organisation underwent a period of immersion and learning in order to prepare for its implementation. The approach was piloted in February 2001 and rolled out to the whole organisation in February 2002. The organisation underwent its first accreditation process with the Council on Quality and Learning in May 2002 and was reaccredited for a further two years in May 2004. Personal Outcomes Measures is now the biggest quality system in learning disability or any other human service in Ireland.

How did it happen?
In association with the National Federation of Voluntary Bodies, the Department of Health and Children and the National Association for the Mentally Handicapped in Ireland, representing families, the Association researched quality systems nationally and internationally. This activity formed the foundations for the Association's decision. One system identified was the Personal Outcomes Measures system, which is developed and accredited by the Council on Learning and Quality, based in Maryland, USA. Personal Outcomes is an approach to quality that measures achievements in twenty five areas of an individual's life, such as living, working, learning, and meeting people (see Table 13).

Table 13 **Personal Outcomes Measures system – how does it work?**

The Personal Outcomes Measures system measures person-centredness in an organisation. This means that the organisation should have the capacity to identify, understand and facilitate the achievement of an individual service user's personal goals. The system also enables the organisation to measure how successfully it does this.

The organisation listens to service users and identifies the gaps in service provision. Staff members hold an annual 'semi-scaffolded conversation' with each service user, ensuring that they facilitate him or her to communicate his/ her needs as effectively as possible. For example, photos and other visual images can be a useful tool. The results of this consultation are scored under the Personal Outcomes Measures system of twenty five outcomes 'if you have fourteen outcomes you have a really good life'.

Then, staff work with each service user to achieve a wide range of personal outcomes that will result in an improved score over time:

"Not that we would be delivering services and hoping that they (individual) would fit in, but that we would find out what they want and deliver it".

After each interview an Individual Plan is drawn up for each service user. In order to co-ordinate delivery of Personal Outcomes to clients using more than one service, a specific member of staff, referred to as a Named Staff, is appointed to each client. This staff member is responsible for ensuring that the individual's personal outcomes are met. For example, if a service user wanted to get a job, the staff member would liaise with all the other relevant Association staff to ensure that this could be facilitated.

Sometimes, the individual's families would need to get involved in ensuring that the outcome is achieved:

"There are things like people having their own money, choosing their own clothes, choosing to come in later if they want. When we started asking people about their routine, they said 'we don't have a choice.' They did, we just never told them about it. So then we had to go to the transport manager and say how do we facilitate this? There was a lot of negotiation between staff."

Before a final decision was made on a quality system, it was decided to consult with staff on their preferences. A conference was held to examine a wide range of quality systems (including ISO and E.F.Q.M.) and staff members were asked to choose their preferred approach. A large majority chose Personal Outcomes as being most suitable for a human services environment.

Between 1998 and 2000, Western Care Association underwent a period of immersion and learning in preparation for the formal adoption of a person-centred approach to service provision. The Association worked to improve its capacity for person-centredness by redesigning five key business processes:

- Providing training in the competencies necessary for a person-centred approach
- Redesigning individual service planning to take cognisance of a person-centred approach
- Redesigning the role of managers and leaders, who would have to support staff in new ways of working
- Aligning risk management processes with a person-centred approach
- Building the organisation's capacity to make evidence-based decisions.

Individually, these changes were not having a marked impact on organisational performance, so it was decided to implement a: *"multiple and simultaneous systems-wide intervention in one area at the same time".*

The diversity of the organisation was reflected in the pilot sites. Firstly, the Central area was chosen because it was small enough to make the process manageable and yet its range of service is sufficiently broad to experience most of the challenges associated with implementing the system. In addition, twelve other pilot sites representing the diversity of the Association were chosen.

The Partnership Committee established a working group to oversee the implementation of the project schedule and budget. Management, unions and staff were represented on the working group. The group met on a regular basis to evaluate progress and support the pilot site as necessary. Group members developed an informal social support system whereby before and after meetings they could approach others with issues where they needed help. The group communicated with the wider staff through line managers who were responsible for communicating with their staff. It was hoped that any problems would feed back to the sub-group through the same channel.

In addition, a round table multi-disciplinary support group was established in the pilot sites. This group created a partnership between organisational support staff (e.g training and development, health and safety) and direct services staff (managers and front line staff).

All staff in the pilot area underwent extensive training to familiarise them with Personal Outcomes and to develop the competencies necessary to implement it, for example, listening and facilitation skills. In this way, staff began to re-orientate their roles to meet the needs of Personal Outcomes.

Case Study 6 | Western Care Association *continued*

Eight months after the pilot phase began, the Association achieved two results that had been identified as critical indicators of success – Personal Outcomes Measures scores went up in the pilot area, and staff demonstrated real commitment and leadership in problem solving and managing change. Staff confidence in the approach and the evidence of achievement was a key to getting the buy in from staff who were not directly engaged in the initial pilot area or associated sites. Subsequently, the system was rolled out to the whole organisation.

The system was pretty widely known at this stage. Through 'informal percolation of knowledge', staff members had been adopting it for their own use across the organisation. A 'roll-out day' was held for all staff at which they heard from those involved in the pilot project. Staff spoke of their experiences of the system, positive and negative. Managers spoke about the challenges around co-ordinating work on a large number of Individual Plans. The training department gave feedback on procedures, risk management and safety and outlined the supports available to staff in the changeover period. The manager of Central reported on what the key learning had been. In addition, a video had been made of the pilot project, which was available to everyone to watch.

Every staff member then underwent the same training as those involved in the pilot phase and the system was implemented in the same way. As the time for the Association's first accreditation approached 'runners in the field' were sent around the organisation to ensure that staff were supported in overcoming any difficulties they encountered. These were trainers and staff with experience of the pilot phase who helped to 'bed' in the message, to deal with obstacles where they were arising and to ensure that there was support for staff attempting to come to terms with a new approach to service delivery.

Service Users reacted with enthusiasm:

> *"People with severe disabilities and challenging behaviour are prepared to sit through two hours of an interview because they have a sense that they know it is about them. We've had people getting out of hospital beds to do interviews."*

The outcome of the May 2002 accreditation process is that the Association now has a quality system in place. The organisation's work is focused on improving its performance in areas where accreditation has identified a gap in service delivery. For example, the Association has established a committee to improve its score in the area of human rights.

> *"There are a lot of challenges to people's rights. For example services tend to place a lot of rights restrictions on individuals without really thinking it through. These are limitations that we would not tolerate such as a forty-year-old having to ask for their pocket money."*

The Association was preparing for its second accreditation visit when the researcher undertook the case study. They achieved accreditation and increased their scores in a number of key areas in May 2004. The Council can also benchmark the Association against international best practice and identify future challenges so that the Association can prepare to meet them.

What were the challenges?

One of the main challenges was the huge change in organisational culture needed to deliver person-centred, flexible services. One of the main requirements was the need to support changes in staff practice through a structure of additional guidelines and procedures particularly in the areas of person centreed planning and personal risk management. Also all existing organisational procedures had to be revised to ensure they were aligned with person centreed values and practices. Because of this, the rate of procedural change was very fast and staff members were under pressure to meet the challenge.

Managing the duplication and extension of work that occurs when organisational processes are being changed was a major challenge. The changeover increased the amount of paperwork in the organisation substantially, as the organisation tried to formalise new practices.

Some staff were reluctant to get involved in the process, as they found the changing culture challenging. There was fear of the size of the challenge among some of those involved. Effective internal communication was a constant challenge, there is an over dependence on managers' ability to communicate effectively with staff and this does not always happen: *"A lot gets left out, a lot slips through the line"*.

In addition, since Personal Outcomes Measures was implemented, more staff members are working as facilitators in the community and it is challenging to both manage and communicate with these staff.

The Named Staff co-ordinating Individual Plans for service users accessing a number of different services faced a particular challenge. For example, many service users could attend a workshop, live in a group home some or all of the time, and make use of community workers and other services. Co-ordinating every aspect of the Association's relationship with the service user was very time-consuming. In addition, some staff members were uncomfortable in the Named Staff role if it involved them having to request a more senior staff member to implement part of an Individual Plan.

The Named Staff member has to get to know the service user very well and to have contact with him or her regularly in order for Personal Outcomes to work.

What were the success factors?
What did we learn?

The organisation had a history of a partnership style approach to problem solving prior to the advent of Personal Outcomes, or even partnership. They had managed to successfully avoid strike action because of this culture. The partnership approach formalised the change in organisational culture and ensured that consultation was structured and representative of all parties. In addition, some of the activities in the partnership committee contributed to building trust in the organisation. For example:

- There was a rule that problems could only be raised at a partnership committee if a solution was offered. This worked very well in developing a joint problem solving approach
- Appointing a joint chair onto the partnership sub-group gave the unions more ownership of the process
- The partnership facilitator was very helpful and very skilful at facilitating conversations in a constructive manner and ensuring that all views were given equal weight

Case Study 6 | Western Care Association *continued*

- As concerns about change were expressed in a partnership context, people's views did not get polarised.

Progressing the implementation of the system through partnership was crucial in building staff trust:

"A partnership group can take the issue into a safe place and tease the issues out in a way that increases staff voice and gives a better sense of ownership to the staff".

Piloting the system before rolling it out to the whole organisation was crucial to its successful implementation. In addition, the communication and training aspects of the project were crucial elements in its success:

"Training was very important for a lot of people. They had a different idea about whether people with learning disabilities wanted the same life as us. The training changed their minds."

Highly visible senior management prepared to put the time and effort into consensus-building is vital. In addition, good local management was key in the successful implementation of the approach:

"Where management is good, the approach is working really well and staff are happy with it".

During the early stages of the project, implementation of the Individual Plans focused on those that were easier to implement and this gave staff a sense of achievement and thus a belief that the system could work.

Working first with staff that were interested in taking part in the process resulted in the more reluctant staff 'buying in' once they saw what could be achieved.

Key project outcomes

Organisational learning and training programmes changed and became more aligned with organisational goals. This means that real learning takes place, particularly with regard to staff roles and the needs of service users. Service delivery has improved:

"We all know what we're doing with that person, our role, what we're working on. So it is better from that point of view."

The whole organisation is pointing the same way now, in a direction that focuses resources on meeting individual needs rather than fitting people into services. This approach to the organisation's work is apparent in areas of the Association such as Administration, even though they are not 'front line' service providers:

"We make sure people in administration see their role is in delivering the product and the product they deliver is the outcome to the service user ..... So it's total corporate cohesion."

The organisation is less self-contained or insular in its provision of services to individuals and their families, and extends more into the community for the delivery of services:

"Integration and inclusion were big challenges. So instead of us always providing services we started looking outwards. That was a big change, we were very self-sufficient before."

As a result, the organisation is becoming more innovative and discovering ways to provide increasingly personalised supports. More staff members work in the community as facilitators and service users are more integrated into the communities in which they live.

The organisation has learned that staff social capital, in terms of their social networks, has proved very important in introducing service users to local networks and links. Staff members feel more empowered and valued, they are more aware of their rights and their voice is stronger. They are more satisfied with their jobs. Trust within the organisation has increased.

The role of staff has changed and become an enabling role. Named staff have to be more creative and resourceful to find solutions to service users' wants. The process empowered staff to become more person-centred, giving them the resources and support they needed to learn what they wanted. For example, the focus changed from 'being in a cookery programme' to 'choosing what you want to learn to cook':

"I did feel people were slotting into processes because that's what was on offer and not because it was their life goal. For example, you'd have cookery, but it wasn't survival cookery it was making a Christmas cake."

There was an immense feeling of pride amongst all involved when the Association got accreditation:

"It was great when we got accreditation. We felt very proud. You could feel it in the organisation – we had brought this to a stage where it would actually work. If we hadn't got it people would have been devastated because we had put so much into it."

Communication in the organisation has improved and the Association now publishes a newsletter called Our Shout:

"There is more communication in the organisation. It is easier to find out what is going on. Often when you're on the ground, you don't really know what it's all about."

The result of the project highlighted the role of partnership as a mainstream organisational process and raised awareness of its capacity to drive organisational innovation:

"I didn't know what partnership meant at the time. I was very involved on the ground and that was what I was focused on. Now, I think it's important to be in touch with what's happening in the organisation. So I think it's good to have everyone working together and talking about things."

Case Study 6 | Western Care Association *continued*

The partnership approach is becoming aligned with organisational priorities. Projects are now partnership proofed:

"Partnership will not take away the right of management to manage, or the unions to organise and represent, but I think a lot of what is going to happen here is hopefully, will happen [sic] through partnership."

"Partnership can offer reassurance. Partnership puts a word on something that otherwise could get lost."

Western Care Association now has a partnership working group examining job descriptions. Many are outdated and need to be realigned to take account of the shift towards Personal Outcomes.

"It used to be really hard, because we had to figure out how to do our job and Outcomes. Now we know that Outcomes is our job."

Table 14 **The 25 Personal Outcomes**

1	People choose personal goals
2	People choose where and with whom they live
3	People choose where they work
4	People have intimate relationships
5	People are satisfied with services
6	People are satisfied with their personal life situations
7	People choose their daily routine
8	People have time, space and opportunity for privacy
9	People decide when to share personal information
10	People use their environments
11	People live in integrated environments
12	People participate in the life of the community
13	People interact with other members of the community
14	People perform different social roles
15	People have friends
16	People are respected
17	People choose services
18	People realise personal goals
19	People are connected to natural support networks
20	People are safe
21	People exercise rights
22	People are treated fairly
23	People have the best possible health
24	People are free from abuse and neglect
25	People experience continuity and security