

**The Role of Workforce Planning during Transformational Change
in a Hospital Setting: A Case Study**

By

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**A dissertation submitted in partial fulfilment of a BA (Hons) in
Human Resource Management to the National College of Ireland**

2014

Abstract

Title: The Role of Workforce Planning during Transformational Change in a Hospital Setting: A Case Study

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The purpose of this study is to examine and understand workforce planning practice and how it can influence transformational change within a hospital setting from the perspective of key stakeholders in the process. Change is a constant feature of today's working environment and factors such as the race for innovation, globalisation and the 'war on talent' is creating urgency to change processes. Significant global workforce shortages across health sectors as reported by the World Health Organisation need immediate attention for the future of a sustained health service, both at home and abroad. The practice of workforce planning can support organisations in building capacity in a structured and planned way and to develop its workforce to meet future demands.

The research question asked how can workforce planning influence organisational transformation. It also asked what is the role of workforce planning in a hospital setting and was it practiced during a transformation process. Research was conducted through the method of semi structured interviews with five senior clinical and non-clinical executives. The findings suggest that although employees are aware of workforce planning and its role within a hospital setting, the current practice is limited and isolated. The findings also highlighted where there is an absence of workforce planning, that internal factors such as leadership and communication are inhibiting its true potential and influence.

This suggests that workforce planning cannot be viewed as a solution to workforce issues, it is a tool that can provide support during a change process and but it is important that key structures and roles are clearly defined to maximise its influence.

Author Declaration

I hereby certify that this material, which I now submit for assessment of the programme of study leading to the award of BA (Hons) in Human Resource Management is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: Geraldine Sweeney

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Dedication

To Dessie, without your endless support, patience and feeding, this project would not have been accomplished. Thank you.

Acknowledgments

This project was one of the greatest challenges I have undertaken in a long time and without the support and help of the following people it would not have been possible.

- Firstly, to my family, for their many months of support and the never ending supply of tea and lemon cake. Special thanks to Caroline, for without your amazing help. Thanks to Jackie and Karen for their advice and proofing.
- To all my fellow classmates, for their support and laughter. Special thanks to Steph who was always there for me providing laughs, counselling and advice.
- To my friends, who kept me sane outside of this project and helped me remember that life goes on! Thanks to Breda for your help.
- Finally, to my work colleagues who supported me all the way through this journey and who were always on hand for advice. Special thanks to all who participated in the research.

Abstract

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Acknowledgments

Table of Contents

CHAPTER ONE – INTRODUCTION 1

1.1 Dissertation Topic 1

1.2 Purpose of Study 2

1.4 Philosophical Framework and Research Design 4

1.5 Background to the Researcher’s Personal Interest in the Topic 5

1.6 Relevance of Study 6

1.7 Structure of Remainder of Dissertation 6

CHAPTER TWO – LITERATURE REVIEW 8

2.1 Introduction 8

2.2 Organisational Change Theory 8

2.3 Types of Change 9

2.4 Why do organisations change? 10

2.5 Organisational Development 11

2.6 Organisational Transformation 12

2.7 Theoretical Change Models 13

2.8 Leading and Managing Change 17

2.9 Management versus Leadership 18

2.10 Transformational Leadership 19

2.12 Triggers of workforce planning 25

2.15 Discussion 28

CHAPTER THREE – SECTOR CONTEXT 30

3.1 Introduction 30

3.2 The Health Sector Transformation 30

3.3 HSE Change Model (Figure 3) 32

CHAPTER FOUR – METHODOLOGY	34
4.1 The Research Paradigm	34
4.2 The Research Design	34
4.3 Collection of Qualitative Data	36
4.4 Primary Research	36
4.5 Interview Questions	37
4.6 Interviewee Response Rate and Ethical Considerations	38
4.7 Data Analysis	39
4.8 Limitations of the research design	40
4.9 Conclusion	41
CHAPTER FIVE – ANALYSIS AND FINDINGS	42
5.1 Introduction.....	42
5.2 Interviews.....	42
5.3 PESTLE Analysis	53
5.4 Summary of Findings.....	64
CHAPTER SIX - CONCLUSIONS	65
6.1 Purpose of Research Recalled.....	65
6.2 What is the role of workforce planning in a hospital setting?.....	65
6.3 Was workforce planning practiced during the transformation process?	67
6.4 How can workforce planning influence organisational transformation	67
6.5 PESTLE Analysis	69
6.6 Discussion.....	71
Bibliography	77
Appendices	
Appendix A - PESTLE Analysis on Organisation.....	82
Appendix B - Organisation Chart – Clinical Directorates	83
Appendix C - Diagnostic Directorate Organisational Chart	84
Appendix D – Email Invite to Participants	85
Appendix D – Transcribed interviews	86

Glossary

ADON	Assistant Director of Nursing
ANP	Advanced Nurse Practitioner
CD	Clinical Directorate
CEO	Chief Executive Officer
COO	Chief Operations Officer
CNM	Clinical Nurse Manager
ED	Emergency Department
EWTD	European Working Time Directive
HR	Human Resources
HRM	Human Resource Management
HSE	Health Service Executive
MAP	Manpower Application Process
OD	Organisational Development
OECD	Organisation for Economic Co-operation and Development
OHM	Office for Health Management
OT	Organisational Transformation
WHO	World Health Organisation

CHAPTER ONE – INTRODUCTION

1.1 Dissertation Topic

The topic for this dissertation is Organisational Transformation. It is a contemporary concept relating to planned change that alters an organisation's fundamental way of conducting business. The purpose of transformation is to enable people to build and develop their capabilities and level of engagement while further establishing their purpose and meaning within the workplace.

It must be considered that there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things.

(Machiavelli, 1469-1527)

It is well documented how change can be mismanaged and often fail. For some, it can be regarded as a 'quick fix'. (Gill, 2003) Despite the abundance of information, research and theories available on this topic, one in three change programmes can fail. The literature also recognises that there is no one method that fits all but rather an accumulation of different models and approaches. McKinsey (2010) creates an analogy between an individual's health and the 'health' of an organisation. On an individual level this can be somewhat measured by the type of diet and level of exercise that one can have. In the context of an organisation, its capabilities and resources can define how healthy

it is and it is this element that McKinsey argues creates long-term value for all stakeholders and enables an organisation to remain adaptable to changing times.

One method of ensuring long lasting change is effective workforce planning. For a large acute hospital, this can range from identifying the current and future needs of key health care professionals, to staffing levels and skill mix to the utilisation of hospital equipment and facilities. (HSE, 2010) Such issues are all very pertinent in light of the challenging economic environment over the past six years that has seen significant budget cuts, and recruitment and promotional moratoriums. Workforce planning is not limited to filling vacancies or reviewing services, it is a long term strategic approach to understanding the needs and desires of an organisation. Previous case studies such as, The Courts Services Ireland and Dublin City Council, further demonstrates how proactive and effective workforce planning has a significant role within organisations

1.2 Purpose of Study

The purpose of this study is to examine and understand workforce planning practice and how it can influence transformational change within a hospital setting from the perspective of key stakeholders of the process.

The unit of analysis in this study is workforce planning and the researcher endeavours to seek common threads and patterns through interviews with key stakeholders of the transformation process that began in a large acute hospital where the researcher is employed.

1.3 Research Question

The research question “...states the specific line of enquiry the research will investigate and attempt to answer.” (Collis & Hussey, 2009) The research question proposes the need to understand the concept of workforce planning. It is commonly found in the literature that organisational transformation (OT) requires the development of a clear strategy. Covey describes strategies as “road maps of a changing terrain in which a compass (vision) is needed.” (cited in Gill, 2003, p.312) Workforce planning represents an organisation’s strategy or ‘road map’ towards transformation and beyond. It is concerned with the development of required core skills and competencies, the ability to attract, deploy and retain staff with the needed skills and competencies. It also ensures that solid leadership is in place over time and that succession plans exist for key positions. (HSE, 2010)

Similar to OT, workforce planning is a relatively new concept but has increasingly become a strategic priority aligning workforce and business plans. The OECD *‘Review of the Irish Public Services’* (2008) recognised and recommended that the Irish Public Service should better develop long-term workforce planning. The government then incorporated it into their reform programme, *‘Transforming Public Services’*. From this evidence, it is clear that workforce planning is ultimately deemed at government and HSE level as “a proactive, strategic process to plan, align and manage the human resources needed to achieve the mission and goals of the health service.” This evidence poses a number of questions for the researcher, one being; are national strategies

of workforce planning working in tandem with workforce planning at the local level?

Thus arising from my review of the literature I have formed the following key question as the basis of my research: **What is the role of workforce planning in a hospital setting? Was workforce planning practiced during the transformation process? How can workforce planning influence organisational transformation?**

1.4 Philosophical Framework and Research Design

There is an abundance of theories and research on organisational change, change models and leadership but there is a distinct lack of empirical research and evidence on the concept of workforce planning within an OT process. Therefore, the research will be exploratory as the aim of this type of study is to look for patterns rather than testing or confirming a hypothesis.

A case study methodology is used to “explore a single phenomenon (the case) in a natural setting using a variety of methods to obtain in-depth knowledge” (Collis & Hussey, 2009 p.82) In keeping with the interpretive paradigm, a qualitative approach was adopted through semi-structured interviews with a number of key stakeholders. The methodology and rationale are discussed in more detail in Chapter Three.

1.5 Background to the Researcher's Personal Interest in the Topic

The researcher is employed within the health sector as a HR Generalist in a large acute hospital for the past eight years. Throughout the 2000's the Irish health system, as a result of numerous commissioned reports, transformation processes were initiated and this cascaded down from sector to local levels, impacting all institutions of the health service.

One aspect of the transformation process in the health service was the introduction of the clinical directorate (CD) model. This structural transformation established "...a new model of hospital service delivery based on appropriately trained doctors providing patients with the highest quality service using available resources as equitably, efficiently and effectively as possible." (O'Shea, 2009) This transformation process was first introduced in the researcher's organisation in 2006, embedding this structure has been an evolving process which has yet to be fully functional eight years later. During this time, the hospital has had six Chief Executive Officers (CEO) each with their own particular strategy and vision in the application of the CD model. These recurring changes in leadership have notably impacted on the hospital's transformation process. Furthermore, during these years also, the hospital experienced the HSE moratorium on recruitment and promotions as well as severe financial constraints.

From researching and analysing the literature on this topic, the researcher, an employee of the organisation is unable to identify any specific change models

used or organisation wide workforce planning techniques or activities applied as tools or methods to transform the organisation. Equipped with the knowledge of evidence based practice on change management and workforce planning, the researcher is curious to examine and understand if they were in fact absent and if so how that impacted the organisation.

1.6 Relevance of Study

There is a timely significance to this study. Notwithstanding, the fact that the transformation of the researcher's organisation has already transformed from a portfolio driven structure to that of clinical directorates, it is well known within the health sector that further transformations are looming on the horizon towards hospital groups. (Organisational chart available at Appendix A)

The researcher has already noted that change is a constant feature of the working environment however factors such as the race for innovation, globalisation and the 'war on talent' is creating urgency to change processes. (Hay Group, 2010) Global health care professional shortages across health sectors as reported by the World Health Organisation (WHO) need immediate attention and the literature has identified workforce planning as a means to tackling this issue.

1.7 Structure of Remainder of Dissertation

The remainder of the dissertation is divided into five chapters. Chapter Two examines the literature sourced by the researcher pertinent to the topic and research question and aims to find common themes by authors or studies while

addressing any gaps in the literature. Chapter Three provides context and insight transformation within the Irish health sector. Chapter Four will describe and explain the methodology and research design chosen by the researcher relevant to addressing, and critically analysing the research question. This chapter will also provide the rationale for the chosen methods and explore how the researcher collected the data relevant to answering the research question. Chapter Five will present and discuss the analysis of the data and their results. The last section, Chapter Six, will present a summary of the findings and limitations of the research and suggestions for future research.

CHAPTER TWO – LITERATURE REVIEW

2.1 Introduction

Change is regarded as the only constant feature of our work environment. Organisational change may be defined as “new ways of organizing and working” (Dawson, 2003). McAuliffe and Vaerenbergh recognise that “change is difficult to control” and that a “new approach to organisational change has been gaining ground in recent years” (2006, p. 29)

All organisations need to continuously renew their structures to ensure contemporary fit with changes in their environment. By understanding the organisation, the required type of structure and the most appropriate and effective model to achieve its purpose, it can then achieve a ‘natural harmony’ (Mintzberg, 1983). McAuliffe and Vaerenbergh (2006) explain that in order to exist in a competitive environment an organisation needs to consider its strengths and weaknesses relative to the external environment.

2.2 Organisational Change Theory

Miles *et al.*, (1978) define an organisation as “both an articulated purpose and an established mechanism for achieving it”. They refer to how this mechanism is ever evolving and constantly re-evaluating its roles, relationships and process to achieve its purpose.

Morley *et al.*, (2004) recognise the necessity for change when a performance gap arises, which is a discrepancy between what the organisation is trying to achieve and what it is actually accomplishing or intends to accomplish.

Organisational change can be simply described as the movement by an organisation from one desired state of organising and working to another. (Hardiman, 2010) The origins of change management can be traced back to post World War II when the management and development of organisations became more complex. Stemming from this many theorists wanted to improve the dynamics and management practices of an organisation, which incorporated disciplines such as psychology, philosophy, and sociology. (French, Bell & Zawacki, 2005) What emerged were various concepts approaches and techniques to address organisational issues.

2.3 Types of Change

Hardiman (2010) stresses the importance that the first step in change management is to understand the various types of change. Deciding on the most appropriate will influence an organisation's preferred approach, techniques and model that the organisation can adopt. It is important to note also that underlying all this are the assumptions or beliefs of the nature of change adopted by individuals in the organisation. Hayes (2002) categorises changes as:

- **Planned or emergent:**

Change that occurs following strategic planning and analysis or change that occurs by chance, more suitable to fast-moving unpredictable situations

- **Episodic or continuous:**

Change that is a one off and time limited or change that occurs over an extended period of time

- **Developmental, transitional or transformational:**

These changes are concerned with a particular range of planned change that has certain outcomes. Both developmental and transformational are pertinent to this study and are therefore further explained.

The latter types of change are relative to this study and therefore require further expansion;

- **Developmental:**

This type of change can be planned or emergent. It is concerned with enhancing or correcting aspects of the organisation such as staff increases, organisation relocation or expansion.

- **Transformational:**

This is a form of radical change and has been referred to as 'second order' change in the literature. It can result in an organisation changing its structure, vision, values, culture and strategy which can ideally further lead to an organisation that continuously learns, adapts and improves.

2.4 Why do organisations change?

Oakland and Tanner (2007) identified that the major drivers or triggers of change fall mainly into two categories: external and internal. Internal triggers can be

categorised into formal and informal (Senior, 2002). Formal triggers represent technology, strategy, operations and structure of the organisation. Informal triggers refer to more intangible elements such as leadership and culture. It was found that internal triggers were considered to be a manifestation of the external trigger for change. (Oakland and Tanner, 2007) A recent example of this is the recruitment moratorium introduced by the government in 2009 which in turn was a trigger of change within each public and health care organisation.

Kotter (1995) outlines how change efforts can begin with an organisation identifying issues or problems that then require a change that can range from technological trends, financial performances and / or emerging markets. An important aspect of change is to identify the ‘who’ and ‘why’ which can be translated to stakeholders and the context of change. Research indicates that two of the most important steps to leading and managing change are the identification and management of the key stakeholders that have the potential to influence change and understand the need for change in the first instance. Beer, Eisenstat and Spector (1990) imply that the first step to understanding the type of change applicable to an organisation is to clearly identify a business problem.

2.5 Organisational Development

OD is regarded as an improvement strategy that can lead to increased organisation effectiveness. It is one of two planned change efforts that is ‘system wide’, meaning it involves the entire organisation. This implies it is not only concerned with the development of the organisation but its individuals too.

The aim of OD is to help people *and* organisations and people *in* organisations function better. This is can achieved by teaching and developing the competencies of individuals to make an organisation's structure, processes and culture more effective. (French, Bell & Zawacki, 2005)

The common elements in many of the OD definitions state that it is long lasting and should be managed from the top and at this level there must be a shared commitment to achieving the goals and objectives as outlined in the plan for improvement. It is a strategic process that empowers its individuals by developing their competencies in order to improve an organisation's performance (French, Bell & Zawacki, 2005; Beckhard, 1965) OD enables an organisation to renew and to adapt to external environmental factors such as technological advances, changes to the markets, shortage of labour and financial constraints.

2.6 Organisational Transformation

The study previously referred to one variety of planned change interventions; organisational development. The second is referred to as organisational transformation (OT). Compared to OD, OT is a relatively recent concept and regarded as an extension to OD that concerns itself with change theory and practices that affect large scale paradigm-shifting organisational change. Where OD is described as 'first order' change, OT is referred to as 'second order' change. OD emerged as change programmes were designed for more radical, fundamental changes in organisation. (French, Bell & Zawacki, 2005)

Where OD concerns itself with “incremental adjustments that do not affect the organization’s core” or on transactional and systemic levels, OT is more ‘cutting edge’ and involves a more profound change in organisations that affects deeper structural levels of organisation such as values, missions, purpose and beliefs (Old, 1995; Gray, 1995).

OT represents the more contemporary response to organisational change as much of the OD tradition saw change as best taking place incrementally. Dunphy and Stace claim that OD was lacking in the contextual or environmental elements which gave rise to the significance of OT in an approach to organisational change (cited by Ashburner *et al.*, 1996). Aiken and Keller state “in today’s business environment, companies cannot settle for incremental improvement, they must periodically undergo performance transformations”.(McKinsey, 2007) Similar opinions are littered across the literature on OT. In general long-lasting transformation aims to enable organisations to be proactive rather than reactive. This is particularly relevant in our current work environment where demands on organisations are intensified, adapting to economic and political changes, trends in technology innovations, changes to consumer behaviours and demands and the impact of globalisation.

2.7 Theoretical Change Models

Instigating change is a challenging task and requires careful management. The use of change models and framework allow organisation to carefully map out and manage their change initiatives. Over the years frameworks and models have been created and evolved to complement the various types of change. Extensive research has been conducted on the various change models available including the approach and

steps to implement the proposed change. Among the literature are two key models, highly regarded and extensively used: Lewin's (1951) three stage change process and Kotter's (1995) eight step process for leading change.

- **Lewin's 3-Step Model (Figure 1)**

When researching the theory of change and change models is it important to recognise Lewin's model. It is viewed as a particularly seminal piece of work and many authors on change management have attempted to development and expand upon it. The three steps are: *unfreezing* the status quo, *moving* to a new state, and *refreezing* the new state to make it permanent. Lewin identifies a 'steady state' in organisations held by equal and opposing forces. Such forces can influence or drive the need for change as previously referred to as internal and external drivers of change.

Furthermore, Lewin identifies resisting and restraining forces that can hinder the desired change such as custom and practice, culture and trade unions. For organisational change to occur the forces for change should be stronger than those that resist. The theory suggests that there is an increased chance of change occurring if the level of resistance is reduced and this can be achieved by effective leading and management of the change process.

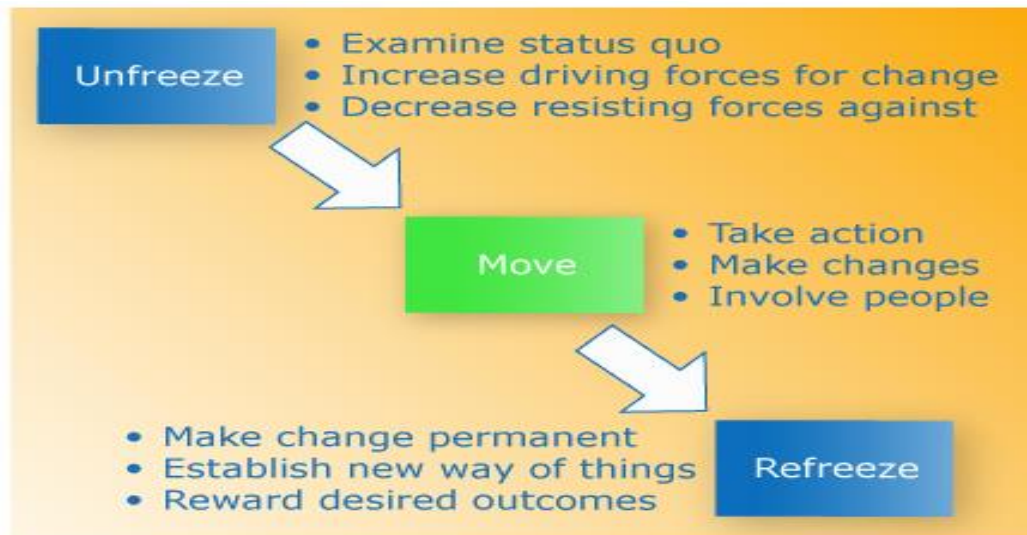


Figure 1: Lewin (1951) 3-stage change process.

○ **Kotter's 8 Step Model (figure 2)**

Kotter (1995) presents a direct and usable format to approaching and implementing change based on his own experience of change initiatives in over 100 organisations. Authors of change 'step' models emphasise the importance of the sequence to their steps and according to Kotter "skipping steps creates only an illusion of speed and never produces a satisfying result".

EIGHT STEPS TO TRANSFORMING YOUR ORGANIZATION	
1. Establishing a Sense of Urgency	<ul style="list-style-type: none"> • Examining market and competitive realities • Identifying and discussing crises, potential crises, or major opportunities
2. Forming a Powerful Guiding Coalition	<ul style="list-style-type: none"> • Assembling a group with enough power to lead the change effort • Encouraging the group to work together as a team
3. Creating a Vision	<ul style="list-style-type: none"> • Creating a vision to help direct the change effort • Developing strategies for achieving that vision
4. Communicating the Vision	<ul style="list-style-type: none"> • Using every vehicle possible to communicate the new vision and strategies • Teaching new behaviours by the example of the guiding coalition
5. Empowering Others to Act on the Vision	<ul style="list-style-type: none"> • Getting rid of obstacles to change • Changing systems or structures that seriously undermine the vision • Encouraging risk taking and non-traditional ideas, activities, and actions
6. Planning for and Creating Short-Term Wins	<ul style="list-style-type: none"> • Planning for visible performance improvements • Creating those improvements • Recognizing and rewarding employees involved in the improvements
7. Consolidating Improvements and Producing Still More Change	<ul style="list-style-type: none"> • Using increased credibility to change systems, structures, and policies that don't fit the vision • Hiring, promoting, and developing employees who can implement the vision • Reinvigorating the process with new projects, themes, and change agents
8. Institutionalizing New Approaches	<ul style="list-style-type: none"> • Articulating the connections between the new behaviours and corporate success • Developing the means to ensure leadership development and succession

Figure 2: Eight steps to leading change. Kotter (1995)

This framework has obvious benefits; by providing a coherent ‘common sense’ approach to the change process. Furthermore, the human resource aspect can be identified across this framework in the following key phrases and words; *forming a powerful guiding coalition, creating and communicating a vision, empowering and planning*. For an organisation to ensure the delivery of each of Kotter’s steps, an effective cohort of people with the appropriate skills and competencies are instrumental to its success.

Critics have labelled Kotter's and Lewin's models as too static and rigid and too slow to react to change. McAuliffe identified an issue with some of the step models because, "change is occurring at such a rapid pace....that it is unrealistic to expect stability or any kind of equilibrium to be reached". She elaborates on how "more recent integrated models....have a more realistic view of the difficulties of predicting outcomes....and that unexpected behaviour patterns can emerge at any stage of the change process" (cited by McAuliffe and Vaerenbergh, 2006, p.14)

2.8 Leading and Managing Change

Organisational change is not limited to changes to strategies, processes or systems, but incorporates the entire organisation; its vision, culture, leadership, values and management. (Kotter, 1995)

Organisational leadership can also be categorised and Burns does so into transactional and transformational leadership (as cited by Bass and Riggio, 2006). Transactional leadership relates to the 'transaction' or the 'social exchange' between leaders and employees and this leader sets out clear goals, understands the needs of employees and selects appropriate and motivating rewards. In contrast transformational leadership engages employee commitment to a shared vision and values. (Bass and Riggio, 2006) This is an important component for leading change as it involves a relationship of mutual trust between leader and followers. Bass *et al.*, describe transformational leaders as visionary and influential, empowering others to develop into leaders by aligning objectives and goals of the individual employee,

the leader, the department and the organisation. It is also regarded that transformational is an extension of transactional leadership.

2.9 Management versus Leadership

Interestingly the term transformational leader has been used to distinguish between management and leadership. The main difference between management and leadership as outlined by Halligan (2009 p.64) is that “their function, purpose and focus are very different” and vision has been identified as the key difference between both. According to Gill (2003, p.308) management concerns itself with “the technical aspects of the process; procedures, goals, methods and deadlines”, whereas leadership requires “vision, strategy, the development of a culture of sustainable shared values that support the vision and strategy for change and empowering, motivating and inspiring those who are involved or affected”. Gill also attributes leadership to the difference between successful and unsuccessful change.

Kotter is in agreement stating that “management produces orderly results which keep something working efficiently.....leadership creates useful change” (Kotter, 2001) However, some of the literature views management and leadership as mutually exclusive (Gill, 2003; Kotter, 2001) and Gill argues that there is “necessary coloration between both management and leadership in a change process.” (Gill, 2003) Halligan (2009) refers to how the theories “do not provide a clear explanation of how the roles of management and leadership are interrelated and how they jointly affect outcomes”. This is particularly important in respect to certain sectors such as health. Mintzberg and Glouberman (1996) recognise that a health system is “one of the most complex systems known to contemporary society.....and hospitals in

particular are considered to be extraordinarily complicated organizations.” Therefore it can be concluded that health care organisations have different demands from other organisations and furthermore the transferability of such theories may not be fully successful.

2.10 Transformational Leadership

Gill (2003) argues that the failure of change efforts can be attributed to a lack of necessary expertise: knowledge and skills. Transformational leadership is not as extensively researched as it is a relatively new concept. However, the researcher has noted that despite this, there is an abundance of literature on ‘effective leadership’ which extends to a version of transformational leadership.

Transformational leadership involves a leader transforming a vision into an objective which is shared by all stakeholders. The literature presented a number of similarities across the various schools of thought on transformational leadership. These similarities enabled the researcher to identify important aspects of such a leader that are vital to the OT process. A transformational leader is framed by the following competencies:

- **Vision**

By definition vision is “something seen vividly in the imagination, involving insight, foresight and wisdom” (Oxford English dictionary). Gill states that the foundation of effective leadership is “an appealing vision of the future”. Kotter emphasises the importance of vision, in that it must appeal to all stakeholders. It needs to be “meaningful, ethical and inspiring”. Effective visions are “imaginable, desirable, feasible, focused, flexible and communicable”. Kotter also reports from his

experience with numerous organisations, that failed transformations are as a result of no vision, a number of plans and directives but no vision. In terms of transformational leadership, leaders need to be ‘visionary’. Leaders must be clear and concise in their understanding and delivery of their desired vision which will then equip individual employees with a cohesive understanding of the transformational process which is instrumental to the success of the goals and objectives of the desired vision.

Throughout the literature it is commonly found whereby the role of the CEO is identified as the key player or driver of the OT process. According to Aiken and Keller (2007) and Kotter (1995) success of the process depends considerably on the leader. However, Kotter also believes that OT cannot be achieved by one person alone but with the engagement of a ‘coalition’; a group of people that work towards a “shared commitment to excellent performance through renewal”. Therefore it can be determined that numerous transformational leaders are necessary for OT, each equipped with the skill to achieve a vision as well as be visionary, through empowering and influencing others to act on the vision.

- **Motivation & Inspiration**

Aiken and Keller (2007) suggest that organisational energy; collective motivation and enthusiasm, is a “crucial ingredient of a successful transformation”. Motivation and inspiration are both recognised by seminal authors as key indicators of effective leadership. Gill (2003) plainly expresses that “effective leaders motivate and inspire people to want to do what needs to be done”. Kotter (2001) explains how motivation and inspiration demonstrated by leaders, energises people by recognising their

achievements, enhancing self-esteem and creating a sense of belonging for people and in turn provoking a powerful response from a workforce. Such a response can inspire and can lead to a culture of leadership and change. Leaders that motivate and inspire can help employees understand and achieve the organisation's vision this can be achieved by enabling professional development through feedback, coaching and role modelling (Kotter, 2001). Motivation can be linked to reward and in many cases this relates to remuneration. However, depending on the sector this is not always viable and managers need to be more creative in these cases. Motivation can lead to increased job satisfaction and job enrichment and this can be achieved through methods of "autonomy and involvement in decision making" McAuliffe and Vaerenbergh (2006). Trahan *et al.*, (1997, p19) state that regardless of the nature of the organisation, leaders should strive to create passion and energy in the workforce and "an emotional bond between your people and your company's mission. If you do, you'll find that people will cross rivers for you". It can be concluded that motivation and inspiration are what distinguishes management from leadership. Achieving a vision requires that act of motivating and inspiring.

- **Empowering**

Gill (2003) expresses empowerment as the ability to give people the "knowledge, skills, opportunity, freedom, self-confidence and resources to manage themselves and be accountable". This important component to leadership captures the essence of how leaders need to be innovative which is particularly appropriate given the nature of the current work environments. This is further conveyed by Gill as he specifies how to achieve empowerment requires "stimulating people's intellects and imagination, in particular their creativity in the change process".

- **Strategy**

Porter (1996) refers to strategy as “creating fit among a company’s activities”. We have already touched upon the importance of vision as a component but “without strategies for change, vision is a dream” (Gill, 2003 p.314). McAuliffe and Vaerenbergh indicate that a strategy “sets out how the organisation or system will accomplish its mission over the next 3-5 years”.(2006, p.20) Porter conveys how there is a correlation between developing a clear strategy and leadership. Porter recognises that leadership is more than operational improvements and states “it is broader, more important”. Kotter argues that “setting the direction of change is fundamental to leadership....and the direction setting aspect of leadership does not produce plans; it creates vision and strategies”. (2001, p.5) The literature further demonstrates the difference between management and leadership which is an important component to the OT process for organisations.

2.11 Workforce Planning

The term ‘workforce planning’ is essentially a recent construct but its roots are found in human resource planning. Human resource planning has been established in human resource management (HRM) vocabulary for some time. However, traditionally this practice was embedded into HRM activities and driven by human resource (HR) practitioners. In more recent years, human resource planning has developed into a more contemporary strategic framework that is integrated across an entire organisation and aligned with business strategy and objectives and from this workforce planning emerged.

To describe it in simple terms it is the process that can determine the right number of people, with the right skills in the right place at the right time. In practice, it can involve a variety of activities and practices including succession planning, recruitment and retention planning, job design, flexible working, skills gap analysis and training and development. An organisation's goals, objectives, strategies and performance measures associated with workforce planning should present key workforce priorities. (Washington State HR, 2014) As such, workforce planning has become a vital component of business strategy across sectors. The OECD recognises that workforce planning is "...an essential tool for anticipating possible future development.....and the current economic, financial and demographic context demands careful workforce planning" (OECD, 2011)

As a result of economic and environmental factors organisations are expected to 'do more with less' and

- Meet diverse client needs and expectations
- Work within very constrained budgets
- Operate with reduced staffing levels overall
- Address competition from other sectors for potential employees
- Respond to changing models of care

Studies and research into strategic management are extensively documented and recognise that to establish the competitive advantage of a company, it is important to define its resources and competencies. Both will help to develop an organisation's capability and "it is capability that is the essence of superior performance." (Grant, 2010) Resources are assets that are owned by organisations and competencies are

what they can do well. It has been found that an organisation's most 'valuable' resource is its human resources and key to superior performance.

Workforce planning is concerned with an organisation's human resources or 'talent' but workforce planning can offer much more than 'talent needs', it also can predict and assess IT, training and financial needs. (Smith, 2012) The principal behind human capital is as an asset it can be enhanced through investment and every investee wishes to see a return on its investment. As the value of the asset increases so does the performance of the organisation which then adds value for clients and stakeholders. Therefore to maximise this, policies, procedures and practices should be designed and aligned with achieving the organisation's vision and objectives. (Smith, 2012)

The literature states that workforce planning has become significantly more prominent as a result of the global financial crisis. (O'Riordan, 2012) The shifts across economic landscapes presented challenges for many employers and in some cases were plunged into unprecedented waters. The term 'to do more with less' became a regular addition in business discourse referring to how organisations due to financial constraints were operating to intensified needs and expectations. Workforce planning equips employers with a strategic tool that acknowledges the unpredictable nature of the economy and external markets forcing employers to plan more strategically for the future.

Research and studies into strategic planning processes, highlight the necessity for both managers and planners. While planners have analytical techniques and time in

their favour, managers have the authority and access to information. Collaboration by both can ensure effective strategic planning. (Mintzberg, 1994) Mintzberg's research is emphasising the process as one of collaboration and integration. Workforce planning has evolved to also represent a collaborative and integrative approach to planning that should not be just a HRM activity. (O'Riordan, 2012) Drawing from this it can be established that workforce planning is much more effective when it is not just quantitative in nature with a focus purely on staffing levels and analysis of such data. Its effectiveness is in the synthesis of both quantitative and qualitative, where qualitative is the descriptive and explorative analysis of internal and external factors or phenomena that impact an organisation's workforce. It is imperative that the information sourced can create and drive critical thinking decision making. (Bechet, 2012)

2.12 Triggers of workforce planning

Emerging trends in our changing workplace from internal and external forces constitute triggers for workforce planning, meaning the forces that impact how an organisation provides a service, who it serves and who it employs to provide this service. (O'Riordan, 2012) By examining such trends and forces, an organisation can determine and recognise the need to be prepared to ensure it has the appropriate resources to achieve the vision, mission, goals and objectives of its strategy.

Internal triggers can entail workforce trends, structure, strategy, culture and employee behaviour. External triggers can come from changes in the environment such as skills shortages (economic), qualifications, skills and competencies (social), new equipment (technological) employment legislation (legislation). (O'Riordan,

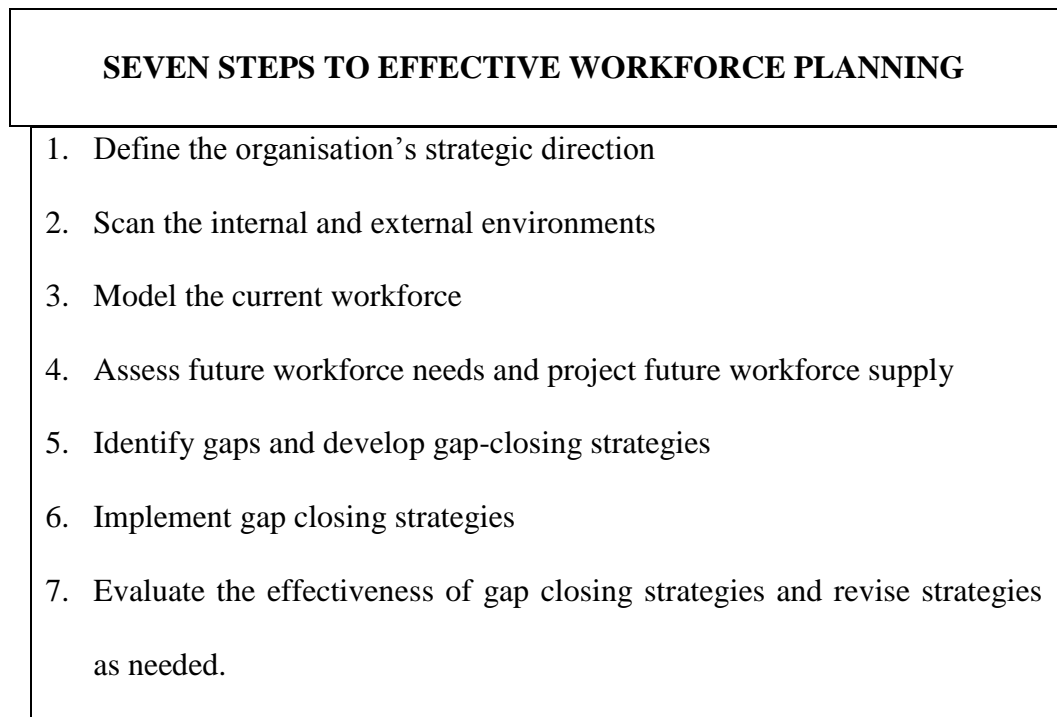
2012; HR Washington State, 2014) Such environmental triggers influence labour supply and demand and the demand for services and products. O’Riordan emphasises how both internal and external factors must play a significant part in workforce decisions which makes workforce planning imperative to organisations.

There is a direct coloration in the literature between workforce planning and change management. The literature on workforce planning emphasises the importance of first defining the nature and scope of the issues before developing workforce policies and strategies. Cotton draws on how the leadership role is critical to successful implementation. (cited in O’Riordan, 2012) O’Riordan further draws on this stipulating; “as with any change initiative, good leadership is necessary to communicate to staff the importance of implementing the proposed strategies and engaging and motivating them in respect of the change process.” (2012, p.23)

2.13 Models of workforce planning

As workforce planning is a recent construct and gaining more momentum in recent years, the literature on distinct workforce models is limited. As this process is defined as a strategic practice or activity, frameworks or models can vary between organisations. Despite the variations in terminology and activities undertaken, many models are similar. (O’Riordan, 2012) Much of the literature on workforce planning focuses on the steps to its implementation. Similar to Kotter’s 8 steps, Cotton (2007) developed the ‘*Seven Steps to Effective Workforce Planning*’ (illustrated in figure 3 below)

Figure 3



Source: Adapted from 'Workforce Planning in the Irish Public Service', O'Riordan, 2012

It is important to note that models such as Cotton's as outlined above can be described as consecutive stages but for successful implementation and depending on the organisation the framework that is adopted must be flexible and stages and "must be implemented in the right way in order to reap benefits". (O'Riordan, 2012, p.17)

2.14 Theoretical Framework

The theoretical framework creates an outline of a collection of theories and models from the literature which underpins this interpretative study. (Collis & Hussey, 2009)

Successful change efforts begin when a problem or issue is identified and can be in various forms including budgetary constraints, labour market trends and service and product performance. (Kotter, 1995) In order to clearly identify a business problem it is imperative to understand the driving forces from internal and external environments. As with any successful change initiative, effective workforce

planning must be grounded in the strategic objectives of an organisation, its financial position and the competencies of its workforce. (O’Riordan, 2012)

Both organisational transformation and workforce planning encompass an organisation’s mission, vision and strategic plan. Firstly it is important to assess and analyse what is likely to impact these elements from the external environment. A ‘PESTLE’ analysis identifies the political, economic, social, technological, legislative and environmental factors that have the potential for impact. PESTLE is regarded as an analytical tool that audits the environmental factors for the purpose of using this information to drive and steer strategic decisions and activities such as workforce planning.

2.15 Discussion

The responsibility lies with an organisation to identify and develop effective human resources and activities that have the potential to lead and manage change within its workforce. The various researchers and theorists have suggested that for successful transformational change, the process requires leadership and more specifically transformational leadership. The literature provides many opportunities to learn the theory of leadership and the tools that support leadership. An organisation has the potential to lead and manage change through the implementation of workforce planning.

By allowing leaders the opportunity to learn the theory, practice and management of change, it minimises the risks associated with planned and unplanned change. However, organisations need to be mindful of the fact that transformations are

continuous and not a singular event and require a succession of leaders and according to Frackleton *et al.*, believe that when building a transformation team, the key stakeholders during this process (senior leaders, HR etc.) need to collaborate to “...craft a career path for people to join the team.” (2014, p.82)

Workforce planning provides organisations with the possibility of “better managing workforce reductions and coming to a more strategic and evidence based approach to staffing.” (O’Riordan, 2012, p10) There is limited empirical research and evidence to support workforce planning during a change process its influence on OT change, models and leadership. Therefore the researcher endeavours to address this gap by using a qualitative approach to the research based on semi-structured interviews with key stakeholders within an OT process through the introduction of clinical directorates in an acute hospital.

CHAPTER THREE – SECTOR CONTEXT

3.1 Introduction

Within healthcare, change is ever present and the management of this is a key challenge for all managers. Emerging technologies, new drug discoveries and evolving models of service delivery are all part of the unplanned change that health services throughout the world are undergoing. Attributable to this changing landscape are shifts in the legislative environment, advances in technology and pharmaceuticals, and increased public expectations and demands. (Vaerenbergh & McAuliffe, 2006)

3.2 The Health Sector Transformation

Since the establishment of the Health Service Executive (HSE) in 2005, the Irish health system has experienced a number of transformational changes. These significant changes can be attributed to a desire to improve the quality of clinical service as early as 1998. The Office for Health Management (OHM) commissioned the Clinicians in Management (CIM) initiative with one primary objective: to improve the involvement of clinician's in the planning and management of health services. The initiative sought to create partnership between the professional groups, with a common focus. (O'Shea, 2009)

CIM was designed to provide a way to respond to and manage the rapid pace of change in the health care environment. Across the 2000's a number of reports were published with significant findings and recommendations leading to transformation

of the health system including; the Brennan Report, the Hanly Report, Transformation Programme 2007 and Integration Programme 2009.

Following on from this, the introduction of the revised Consultant contract in 2008, led to further restructuring of the health service and the establishment of the clinical directorate model with stand-alone business units led by clinicians or clinical directors. This was a revised approach by the HSE to the CIM initiative that was originally implemented. The Public Service Stability Agreement 2013-2016, also known as the ‘Haddington Road Agreement’ represents an austerity measure introduced by the government to reduce the general government deficit across the public system. It was preceded previously by the Public Service Agreement 2010-2014 but the parties involved believed that further measures were required to achieve the level of savings required. It is important to recognise the impact of these agreements on the health service as both ultimately are viewed as key external drivers of further change in the system.

Hardiman (2010) summarises the health service transformation; as a desire to shift health care from purely hospital based to ambulatory to, where possible, community/home based. She outlines how the more patient focus approach to care is challenging the “traditional hospital-centric approach to care delivery”. This new approach also indicates that there is a requirement for “stronger governance structures.....change and role expansion for some health care professionals; and fundamentally a visionary change in the delivery of health care in Ireland” (p.236).

3.3 HSE Change Model (Figure 3)

The HSE created a change model specific to the health service and the researcher therefore deemed it necessary to review. This model is based on elements of different planned models such as Kotter's eight steps. However, unlike Kotter and Lewin, this model recognises the element of unplanned change and incorporates feedback step back into the process. Furthermore, this model allows for the fact that change is non-linear and therefore can initiate revision at various stages. The HSE Change Model (2008) is a planned step model of Initiation, Planning, Implementation and Mainstreaming and recognises that change is "a continuous process in which all stages and steps interrelated and influence each other" (Heslin & Ryan, 2008, p.16)



Figure 3: HSE Change Model. Source: The Change Hub – www.hseland.ie

The subject of change and change programmes in the health system and how it has experienced an exponential increase in change programmes in recent years has been previously discussed in this study. Notable changes such as work practice reform

agendas, the extending working week, the expansion and development of clinical roles such as nursing and roles required for clinical directorates. It is important to note that these changes have been achieved with relatively little organised industrial action.

In a broader sense, health care is under threat from health care shortages. The World Health Organisation (WHO) reported global shortages of 7.2 million and that figure could rise to 12.9 million by 2035. (WHO, 2013) With an ageing population, an increasing demand for health care, health care professional shortages nationally and internationally, workforce planning has never been more required for a sustainable health service. Manpower planning recognises the challenges that face health care workers and specifically managers within such a dynamic environment and equips them to act accordingly. This can be attributed to various strategies and programmes developed by the Department of Health and HSE; *The National Health Strategy* (2001), *HSE Corporate Plan 2008-2011* and more specifically the *Integrated Workforce Planning Strategy for the Health Services 2009-2012*.

CHAPTER FOUR – METHODOLOGY

4.1 The Research Paradigm

According to Collis & Hussey (2009, p.55) a research paradigm is a “philosophical framework that guides how research should be conducted”. The literature more commonly refers to two paradigms; positivism and interpretivism. Positivism is based on a deductive approach to the research and it is concerned with “explanatory theories to understand social phenomena.” (Collis and Hussey, 2009, p.56) Interpretivism involves an inductive process with a view to providing interpretive understanding of social phenomena within a particular context.” (Collis and Hussey, 2009, p.57)

4.2 The Research Design

Vogt states that research design is the “science (and art) of planning procedures for conducting studies so as to get the most valid findings.” (cited in Collis & Hussey, 2009) The interpretive approach derives from “exploring the complexity of social phenomena with a view to gaining interpretive understanding” (Collis & Hussey, 2009 p.57) It is understood therefore that interpretivism seeks to explore and describe the phenomena which derives from qualitative rather than quantitative. Quantitative concerns itself with the quantification of data collection analysis and the testing of theories. Therefore the qualitative approach to collection of data was used. There are various methodologies associated with the social sciences and can be categorised according to the research paradigm identified. As this study will be based on an interpretive approach, the following are the main methodologies related

to this paradigm: hermeneutics, ethnography, participative enquiry, action research, case studies, grounded theory and feminist, gender and ethnicity studies (Collis & Hussey, 2009). Hermeneutics, ethnography and feminist, gender and ethnicity studies were not considered as this study is not concerned with historical forces, the observed patterns of a group or understanding phenomena from the specific perspective of woman or ethnic groups. Participate enquiry was not considered as this methodology is not based on the full involvement of a number of participants in the study. While action research and case studies are closely related, the researcher did not consider action research as it is concerned with identifying and solving a problem and introducing change as a result. As this study aims to provide a more enhanced understanding of the topic, the overall objective and parameters of this study is not to necessarily bring about change. Therefore, the method of case study was decided as the most suitable for this topic.

A case study methodology is used to “explore a single phenomenon (the case) in a natural setting using a variety of methods to obtain in-depth knowledge.” (Collis & Hussey, 2009, p.82) The literature elaborates further on the different types of case studies that can be used; exploratory, descriptive and explanatory. Yin (2009) explains that there are three consideration to choosing one; type of research question, extent of control of behavioural events and the degree of focus on contemporary events. It is said that case studies is the preferred method when examining contemporary events and its techniques include interviews of the persons involved in the events. Thus the case study methodology is the most appropriate method for this study.

4.3 Collection of Qualitative Data

There are several methods available for collecting qualitative data for a case study including documentary analysis, observations and interviews.

4.4 Primary Research

It was initially considered to forward a short questionnaire across the organisation to secure data from a cross section of the workforce on their understanding workforce planning which influence and structure the interview questions. However upon reflection, the researcher was unable to identify the additional benefits that the questionnaires would bring to the process that the interviews could not provide alone. Also data collection through the method of questionnaires is not traditional method associated with qualitative research and therefore the method used in this research is was interviews.

Yin (2009) outlines how interviews are one of the most essential sources of case study information because they are a study of human affairs or behavioural events. Arksey and Knight describe interviews as a method to understanding “data on understandings, opinions, what people remember doing, attitudes, feelings and the like that people have in common” (cited in Collis & Hussey, 2009, p.144) Case study methods of interviews can be in-depth, focused or structured and for this study the focused or semi-structured as it is also referred to as (Collis & Hussey, 2009) approach was adopted. This approach was critical to the study because by nature qualitative interviewing should be flexible in order to retrieve rich detailed answers. (Bryman, 2008) The semi-structured approach allowed the researcher to apply an ‘interview guide’ with a list of questions pre- prepared that allowed the interviewee

leeway in how to reply while also allowing avenues of enquiry where necessary for the interviewer. The researcher has originally anticipated interviewing ten people to further demonstrate the validity of the research and data collected. However, due to time constraints and the availability of participants due to the holiday season, the researcher decided upon eight. The eight participants were chosen because of a) their management capacity within the organisation b) because of their capacity, there high level exposure to processes and c) their level of management means that they can make decisions or influence decisions across the organisation which could provide for descriptive and exploratory discussions.

The interviews were conducted face-to-face in a quiet private setting. Probing and comparative questions were often used by the interviewer to elicit further insight as the interview evolved. Transcribed interviews are available in appendix D. The interviews were between 40 minutes and one hour depending on the information provided by the interviewees and the allocated time possible for the interviewee.

4.5 Interview Questions

‘PESTLE’ analysis provided the theoretical framework for this study and was therefore considered when devising the interview questions. PESTLE is an acronym that stands for; Political, Economic, Social, Technological, Legislation and Environmental and is an analytical tool that audits the external environment under each heading. Each heading represents forces that may support or impede change within an organisation which then enables through various activities or practices how an organisation can respond to these forces. Workforce planning is considered as an

activity that when implemented and practiced effectively, can benefit organisations greatly.

4.6 Interviewee Response Rate and Ethical Considerations

Eight people were selected for interview and contacted by email as it was the quickest mode of communication. The invitation was based on voluntary participation and provided an outline of the topic, the aim and length of the interview. (Invite to interview is available in Appendix C) Permission to record the interviews was requested and anonymity of all participants was confirmed. Seven responded positively however one did not respond. The interviewer followed up by telephone to agree a mutually convenient time and a meeting room was booked. Unfortunately during the interview stage, one participant was very difficult to secure a convenient time with due to their heavy work demands and another was unable to attend due an emergency situation and as a result both were not part of the process. A breakdown of interviewees is detailed in Figure 4 below.

Figure 4

Interviewees in order in which interviews were conducted:		
Interviewee 1:	AC	Diagnostic Business Manager
Interviewee 2:	LM	Medical Manpower Manager
Interviewee 3:	JC	HR Director
Interviewee 4:	BC	Assistant Director of Nursing
Interviewee 5:	AM	HR / OD Manager

4.7 Data Analysis

Collis & Hussey (2009) identify the difficulty with studies under the interpretive paradigm while seeking depth and richness of data, is limiting the scope of the data collected. To limit the scope of a study one can apply the following features;

- Reducing the data – through a systematic way of selecting the data e.g. coding
- Restructuring the data – using a pre-existing theoretical framework or one that emerges through the data
- Detextualizing the data – summarising the data in a diagram (Collis & Hussey, 2009, p.167)

Thematic analysis was applied to determine the important themes relevant to the research question. This form of analysis is justified as the interpretative approach to analysing qualitative data features reducing, restructuring and detextualizing data as outlined above which can reveal patterns and concepts. Morse outlines three stages to approaching qualitative data analysis: comprehending, synthesizing and theorizing. (as cited in Collis & Hussey, 2009, p.168)

The process consisted of multiple rounds of analysis of the data provided by the five interviewees. The first round consisted of the researcher fully *comprehending* the data while reflecting on the research question and categorising data under internal and external environmental factors. PESTLE headings (political, economic, social, technological, legislation and environmental) provided the outline of the analysis in line with this study's theoretical framework. The second stage of analysis consisted of *synthesizing* the different themes and concepts. During this stage, the data was

reduced and sifted and grouped to give a general explanation of what was happening or felt by the interviewees. These groups formed major themes. The final stage of analysing the data consisted of theorizing which is the development and manipulation of the data while linking it back to the literature.

Qualitative data analysis software assists interpretists to manage their research allowing them to enter and prepare data for analysis. Software such as ATLAS.ti can assist researchers in this way. However, this was not applied for this study as the researcher felt that without it allowed for more time for exploration and reflection of the data.

4.8 Limitations of the research design

- **Validity**

The validity of the research was supported by carefully considering the participants for the interview stage. Consideration was given to their capacity within the organisation and the level of input each would therefore have in organisational transformation and workforce planning. Interview questions were constructed baring the theoretical framework in mind and advice was sought from organisational peers regarding their ability to retrieve descriptive and informative data further supporting the validity of the research. The interpretive approach to research provides for a higher level of validity compared to the positivist where there is a possibility that validity is low.

- **Reliability**

Yin (2009) outlines that the goal of reliability is to minimize errors and biases in the study and this can be reduced through the use of a case study protocol which the researcher was aware of throughout the study. The researcher was also aware that under the interpretive paradigm “reliability is of little importance or may be interpreted in a different way.” (Collis & Hussey, 2009, p64)

- **Generalizability**

Thomas (2009) describes generalizability as the extent to which the research findings can be applied to other settings and this is based on how much is representative of the population. As this is a single case study, the level of generalizability is reduced. It may be implied that the research findings could be generalised within the same sector but each organisation is unique due to the impact of internal and external forces.

4.9 Conclusion

This chapter discussed the research paradigm and design. It provided rationale for why this study was conducted under the interpretive approach using inductive qualitative data collection. Research as conducted through method of a case study with the aim of understanding the phenomena that is organisational transformation and the role of workforce planning during this process. Interviews were conducted aiming to provide information, leading to comprehending, synthesising and theorising this information so that the study contributes to understanding as to:

How can workforce planning influence organisational transformation. The findings from this are discussed in the next chapter.

CHAPTER FIVE – ANALYSIS AND FINDINGS

5.1 Introduction

The purpose of this study is to examine and understand workforce planning practice and how it can influence transformational change within a hospital setting from the perspective of key stakeholders of the process. During the course of the process, the research question was applied;

What is the role of workforce planning in a hospital setting? Was workforce planning practiced during the transformation process? How can workforce planning influence organisational transformation?

The researcher applied an interpretive approach and findings to the research questions were sourced by collecting qualitative data in the form of semi-structured interviews with five key stakeholders relating to the topic and unit of analysis within the organisation.

5.2 Interviews

All interviews were held individually in a private setting apart from one which was conducted by telephone as the participant was on annual leave during this time. As outlined in the methodology chapter, interviews were conducted in a semi-structured approach with interview questions underpinned by the research question and theoretical framework. The interviewer has a good working relationship with each of the interviewees which allowed for comfortable open conversations and further exploratory questions where necessary. The interviewer noted that there was no

distinctive body language exuded during the conversations, all interviewees appeared calm and engaging. All interviews were recorded and transcribed immediately after. The research provided various experiences and understandings of the topic and unit of analysis under question. During these accounts, emerging themes were evident which allowed the researcher to apply these themes to the theoretical framework.

What is the role of workforce planning in a hospital setting?

Findings indicated that all interviewees were aware of workforce planning in the organisation. It emerged that workforce planning is generally practiced using a workforce planning tool which senior management use to determine staffing levels now and in the immediate future.

“It’s a very black and white tool, it simply says this is the number people you who have right now and this is the number of people you have next month and the month after that.”

“allows us to identify over the coming months which staff are physically actually working in the departments and those who are on maternity leave, on long term leave or on long term sick leave etc.”

“It’s a tool that’s used to facilitate decision making at the committee level around the replacement or recruitment of individuals but to my knowledge it’s not used in broader sense”

All interviewees agreed that there are limitations to it as it fails to provide management with information on the workforce apart from staffing levels in quantitative form.

“No because we are just blankly looking at numbers and vacancies that we have. If you look at any of the stats we use, it’s our starters and our leavers and nobody is talking about the experience in these. Also it’s a very crude way.”

“I think there is room to improve but you can’t do it in isolation”

Interviewee 1 described its limitations due to the fact that it is purely quantitative in nature and does not supply information in any other form which allows for a loss of valuable information on the workforce which could help improve decision making.

“So the tool is very quantitative in measurement, it’s not in any way qualitative”

“It’s limited because it doesn’t give an indication of the skill mix of the people who have actually left”

While all interviewees agreed that workforce planning has a role in the organisation, it emerged that it is mostly conducted by one or two groups of the organisation’s workforce.

“I think I’m aware that it’s possibly happening at Nursing”

“We do have a lead in work force planning at the moment for nursing staffing levels”

“It is but something for the doctors and nurses, it’s national, cascaded down to us here in the hospital.”

This indicates that workforce planning is not integrated across the organisation which further suggests that it is not grounded in the overall strategic objectives of the organisation.

The exception to this was Interviewee 5 referring to a particular incident that forced the organisation to conduct a workforce review which led to subsequent changes in

the organisation. It is unclear however from this if it was a continuous process or an isolated event due to the critical situation.

“We had a critical incident here at the hospital following which there were major reviews done. As part of the reviews that took place they identified that the structure needed to be reviewed. There were several different avenues saying the hospital needed to transform”

Nevertheless, following further probing it emerged that the review in question was conducted in line with the organisation’s change process into clinical directorates.

“This would have worked hand in hand with clinical directorates”.

Some of the interviewees indicated towards a formal meeting where decisions are made regarding workforce planning

“There are meetings held with the clinical director the Business Managers and line managers with the CEO”

“What I would always do is to go through our MAP process here”

“A submission is forwarded to the MAP committee which is the manpower appointments team and he would put that forward with a business case. The executive management team approved the posts and decide if have they the money for it”.

“I think that it’s very constricted. I think the whole form filling part of it, you don’t always get to fill out the level of detail you require”.

The findings indicate that the role of workforce planning in the organisation emerges in two formats; 1) a workforce planning tool indicating current staffing levels incorporating staff that are on sick and maternity leave and in some cases include

business cases 2) MAP (manpower application process) meetings consist of senior executive management that are presented with the data from the workforce planning tool and MAP form which decide on the filling of vacancies and new posts in line with finances.

- **Was workforce planning practiced during the transformation process?**

The research findings presented conflicting information from the interviewees on the evidence of workforce planning during the Hospital's transformation process into clinical directorates.

“I'm not clear that there was ever a project team or a designated group to manage the introduction of clinical directorates”

Interviewee 4 despite not recalling the practice of workforce planning in the early stages of the introduction, does recall how new appointments for this new structure were created and filled.

“No. As far as I'm aware, not in the initial parts of the clinical directorate”.

“Well to be honest for the first set of people that I'm aware of there were people just nominated into posts so there wasn't an interview process that I was aware of.”

Further findings from interviewee 4, establish that for some appointments during this stage a transparent recruitment process was followed but this did not extend to all appointments.

“For the Clinical Directors yes there was an interview process. For the first set of the Lead ADON's they were nominated into post. As far as I'm aware that

Business Managers were nominated into post. So there wasn't any recruitment process around that"

These findings suggest that activities of workforce planning such as recruitment and selection were implemented on an 'Ad Hoc' basis rather than consistently in line with Hospital policy and procedure. Such practices were confirmed by Interviewee 3 during the initial stages of the Hospital's transformation process.

"The nursing ones were more straight-forward in that there were natural leaders in place that were good fits in terms of lead nurse positions. In terms of business managers it was a bit more difficult because you had to get the right fit, but you had to identify the role, so it was kind of a mixture of how they were filled in the organisation."

○ ***How can workforce planning influence organisational transformation?***

Interviewee 3 acknowledged how workforce planning is conducted at national level due to legislative forces which in turn cascade down to the individual health organisation, presenting challenges to workforce planning and change management.

"It's national, cascaded down to us here in the hospital. For us to meet European working time directives, to actually change the manpower planning aspect is quite difficult because you are dealing within the parameters or framework of a national allocation of resources"

Interestingly however, interviewee 1 regards such forces as positive forces that can facilitate the organisation during its transformation process which can ultimately impact the workforce and service in a positive manner. Many organisational

decisions can be heavily underpinned by financial constraints but such legislative forces can eliminate these obstacles for the better of the workforce and service.

“A lot of external forces aren’t necessarily negative. For instance the introduction of the enforcement of European working plan directive is actually requiring the hospital to increase its staffing of non-consultant hospital doctors in some areas.”

The findings suggest that the interviewees are aware of the benefits of workforce planning but that it is limited in its practice, with room for improvement.

“I think there is room to improve but you can’t do it in isolation.”

Findings also indicate that that most of the interviewees that have furthered themselves in the academic sense are equipped with the knowledge of effective change management and workforce planning activities. However, despite this, there is a distinct gap within the organisation between awareness and implementation. Interviewee 4 demonstrates this where additional practices of workforce planning could influence a change process but as a result of resource constraints, the possibilities of such activities are limited and not applied.

“Do you mean coaching and mentoring someone? Certainly I would consider trying that but what staff are saying to me is that they are barely surviving on a day to day basis and therefore even with the best will in the world, you don't have the time to be mentoring somebody”

“For real life experience for mentoring people for releasing them to go for further education, although we want to do it we can’t at the moment because it’s very difficult to release staff to facilitate that.”

Interviewee 5 discusses how ‘valuable’ workforce planning activities can be for organisation during changing workforce trends.

“I think tacit knowledge is very valuable. A lot of it was transferring tacit knowledge because sometimes it’s not about academic knowledge; it’s about how you do your job. People have all that knowledge acquired over years and years, its expertise, and then they walk out the door and no one knows how to do that job.”

The findings suggest that despite there being a clear understanding of the positive influence of proactive workforce planning, many ideas and practices do not come to fruition. Interviewee 5 indicates how workforce planning exercises are not fully implemented or integrated mainly because of inconsistent leadership at senior level.

“There was a transfer tacit knowledge tool devised and it was piloted in performance and planning and they thought it was a very worthwhile exercise”

“A tool was developed, it was implemented in one area who went back and said it was a success and then it stopped. I think that person left. Again the person who bought into the idea left the organisation so the idea stopped in its tracks. And I think there was a changeover in CEO again”.

The findings suggest that inconsistent leadership at CEO and senior management level has resulted in a loss of opportunity that could be gained from consistent change management and workforce planning which creates a ‘weakness’ in the embedding of change in the organisation.

“Yes, it’s the sustainability of changes; the embedding of changes there’s a weakness.”

“There’s maybe a lost opportunity to build a unit of people who manage change within the organisation and who at a higher level have been through the change management process and the experience of how to manage change in best practice.”

“Lack of awareness by some managers about what’s required to make a change stick”

All interviewees have expressed their feelings towards this resulting in an overall lost faith and respect in senior management.

“I think it’s there as an aspirational thing and I think lip service would be paid to it but when it comes to putting in the resources to give somebody the training I’m not sure we do that”

“I would say the biggest failure is communication or acknowledging people’s concerns.”

“There was a lot of unrest in the organisation and people didn’t really know who was coming or going next”

However, interviewee 5 explains how the organisation is gradually trying to improve upon this through education and training. It has been established that leadership and is key to effective workforce planning and particularly so during change management.

“The Masters in Leadership which is limited to six places a year and that is some attempt to develop leaders for the future but it’s small in scale”

Earlier findings from interviewee 5 on role and responsibilities provide an insight into how the organisation is proactively working towards improving certain areas, suggesting that gaps are identified and gap strategies are initiated for future developments.

“The second one is a building resilience program which is focusing on staff wellbeing and initiatives to improve the same.”

“I’m designing a bespoke executive management team leadership program with the Royal College of Surgeons. I’m also looking at how we can introduce leadership training at the middle management level”

These findings present conflicting attitudes to work planning therefore obstructing its benefits which can then lead to ineffective or failed workforce planning practices. Interviewees described situations in the organisation where conflicting attitudes and practices towards workforce planning have had negative consequences on the workforce.

“I have historical problems that I’m dealing with in areas where people were just put in because there was nobody else”.

“If you don’t have the right person managing and making sure that targets and standards have been met, there are serious consequences for the organisation.”

“I am involved currently in a significant change project within my own directorate. There is a constant level of fire-fighting to identify who the appropriate people are and often the decision is made based on the individual’s contract in respect of the hours they work as opposed to them being the most suitable person for the post.”

All interviewees have suggested alternatives to the current practice and how workforce planning activities could positively influence a certain profile of the organisation.

“The key is ensuring that the training provided within the hospital is not letting people fall behind because of their age.”

“Making sure there’s an appropriate level of training across the board, so as new technology comes on board the people who perhaps have been long term employees who haven’t had the opportunity to go out and do additional education and being kept up to date with what’s going on.”

Interviewee 4 expressed how elements of workforce planning, while they may be acknowledged by management as good practice, are not executed.

Question: “Is the ability to train and develop staff to increase their skill and competencies at the forefront of the organisation’s business plan?” Answer: “I think it’s there as an aspirational thing and I think lip service would be paid to it but when it comes to putting in the resources to give somebody the training I’m not sure we do that.”

“So much is going on we don't have the time ourselves or the capacity to do that but you're right, it's what should be happening”

5.3 PESTLE Analysis

As previously outlined the theoretical framework for this study is PESTLE analysis. Organisations do not operate within a vacuum and preparing for contingencies from both internal and external environments can allow an organisation to strategically manage and minimise adverse impacts. Kotter's (1995) step model to leading change and Cotton's (2007) workforce planning framework both emphasise the importance of assessing the external environment. PESTLE is an acronym for political, economic, social, technological, legislation and environmental.

Findings from the research indicate that a number of external factors have impacted the organisation during its transformation into clinical directorates. Each interviewee has indicated as to how certain factors have created obstacles or opportunities to workforce planning practice. The following analysis offers the most dominant factors from the external environment presented by all five interviewees. (PESTLE analysis is available in appendix A) By assessing and understanding these factors and the impact that they may have can explain the role of workforce planning and how it can influence.

- **Political**

The influence of political issues on public sector organisation defines their business strategies. For this reason the impact is immediate and depending on government objectives, significant.

All interviewees describe situations that refer to political factors that have impacted decision making and practices in the hospital and the consequence it has on workforce planning.

“Another example would be the Nurse Graduate Programme where it’s a national initiative to save money but the reality is that we would have to recruit less experienced staff from outside of the country to replace staff who have left because their salaries have been reduced.”

“As I recall it was the board trying to drive the executive management team to see when we could have these posts in place”

“I think it was possible that the incident that occurred around Radiology and Orthopaedics and the findings of the ‘Hayes Report”

“From CEO level and executive management team that was the key player really and probably from you know a bigger level from that it was something [clinical directorates] that the HSE wanted in hospitals”

“I have to ensure that if there are any new change initiatives in relation to Haddington Road or national agreements”

From the findings it can be concluded that political fractions such as the Department of Health & Children, HSE and Board of the Hospital can have a significant impact on the organisation particularly surrounding decisions on resources both human and financial and work practices. Considerable changes from political factors are a

direct result of government intervention into the area of remuneration due to austerity measures as referred to with the Nurse Graduate Scheme and the Haddington Road Agreement.

Interviewee 3 recognises that there is considerable influence from the political environment but also implies that they can also contribute greatly to issues from a national level such as workforce shortages.

“The best way to influence those [staff shortages] is through national input. That input can be through my role as HR Director, feeding into the HSE”

- **Social**

Interviewee 1 encapsulates the social issue where by the lack of appropriate qualification, skills and competencies are impacting the delivery of change across the organisation. Without determining and assessing the appropriate allocation of resources to drive change, workforce planning becomes redundant and has no influence on organisational transformation.

“There is a lack of people who have been trained in the area of change management and understand the significance and importance of introducing change management effectively through using processes and change models”

Interviewee 5 explores how the organisation will focus on such gaps in skill and competency leading to the understanding that the changing needs and expectations of employees are addressed by gap closing strategies from workforce planning.

“I think there is a will to change, the executive leadership team, there will be training intervention and change management will be part of that”

Interviewee 4 presents a clear image of how ineffective workforce planning can lead to negative consequences for the organisation and employees. In some cases this can be exacerbated by others such as economic forces.

“With leave they are looking for example for parental leave which is a big issue.... we can't accommodate them..... because of the staffing levels I couldn't give that and yet we have staff that would leave as a result of that”

Flexible working opportunities and changing employee's needs such as parental leave requests are issues that management are finding difficult to provide due to insufficient staffing levels. Furthermore this leads to employee dissatisfaction and in some cases as outlined above resignations.

- **Legislation**

The majority of the interviewees addressed legislative forces as leading to both negative and positive connotations for the organisation.

“There are factors that sometimes facilitate us which are external. We're recruiting an additional Specialist Registrar in July of this year because of the

issue around EWTD so that's actually supporting us and that's an external factor supporting us."

Changes to employment legislation have resulted in a number of shortcomings in relation to staffing levels and service requirements for the organisation as outlined by some of the interviewees.

"From the Consultant point of view major drawbacks to get Consultants to apply in Ireland at the moment is the new salary scale..... they have taken a massive pay cut, 35%."

In this instance, interviewee 2 explains how these obstacles can be overcome through more innovative ways to workforce planning such as during the recruitment process.

"One of the initiatives I have done this time round is advertising in Australia, New Zealand trying to attract people back...Spain is in recession and a couple of other countries so we tried to contact their medical councils which are like mini councils around the region to see if they would send out information to their doctors"

- **Economic**

The economic crisis has resulted in substantial damage on finances with sector wide austerity measures implemented in the form of remuneration cuts and workforce reductions.

Interviewee 1 describes how such measures are still prevalent within the organisation.

"There has been a significant drop in the whole time equivalents, even in the two years I have been working in the department... from Clerical to Scientific to Radiography the entire lot we've had a reduction in staffing levels."

From the findings it appears that pay cuts in skilled areas are creating skills shortages.

“Major drawbacks to get consultants to apply in Ireland...they have taken a massive pay cut, 35%.”

“For instance where in one area of the directorate like Radiology where we are having issues being able to recruit staff even when we have the authorisation to do so”.

In some cases this means sourcing the skills and expertise from other countries and employing less experienced or skilled as referred to by interviewee 3.

“The Nurse Graduate Programme where it’s a national initiative to save money but the reality is that we would have to recruit less experienced staff from outside of the country to replace staff who have left because their salaries have been reduced.”

Interviewee 2 implies that there is reform at national level in order to deal with such economic implications.

“There is a group looking at the salary scales nationally to try to recognise that but I think it’s running already about 18 months and there’s still no outcome.”

The Internal Environment

While PESTLE analysis of the external environment provided the theoretical framework for this study, the researcher found upon analysis of the findings that certain other themes emerged from the data that did not constitute as external factors.

Some of these themes emerged so dominant that the researcher therefore concluded that it was necessary to this study to include them. The researcher's believes that this will increase the validity of the research and provide a deeper insight into the role of workforce planning during a transformation and how it can influence this process.

- **Theme 1: Communication**

This was the most dominant theme throughout the entire research and was cited by all interviewees as most influential to the organisation regardless if were practised in a positive or negative manner.

“I think that if there had been a change model being used, it may have been done so but it wasn't being communicated that that was the specific model being used”

“Therein lies the problem, I believe for me certainly it is the communication.

Maybe there was a plan, maybe there was a strategy maybe but I just don't understand it”

“I don't feel there is enough two way communication there regarding the directorate.”

“It was just conversations I was aware off as opposed to there being an informed communication strategy around it”

“Probably not always and different leaders over that timeframe had different communication strengths and weaknesses”

Many of the findings presented a very negative outlook on the practice of communication and the communication structure within the organisation. It is clear from the findings that an improvement is on the agenda for the future success of the organisation. When the interviewees were asked the question: ***“What can we learn from our current change process that would benefit the hospital going forward with the hospital group model?”***

All interviewees cited that the one area that the required improvement was communication.

“I think the key is going to be around the introduction of hospital groups is to get the communication processes in place as soon as possible”

“Communication, communication, communication! Simply put”

“The vision for the way the communication system is going to work and I think communication overall. They will need to hone in on that very clearly and how the lines of responsibility and accountability are going to feedback up”

The impact of an ineffective communication can run deep and can create a suspicious and adverse culture. Interviewee 5 elaborates on this.

“Lack of communication breeds a level of mistrust within an organisation”

“Communications is the responsibility of the line managers at every level. Research shows that fact to face is what people prefer. Line managers have stepped back because they have no good news stories for their staff”

Education emerged as a sub theme under the theme of communication. It was not a dominant theme but it did appear in connection with communication from a learning perspective.

“They really need to have a huge amount of education coming out talking about the groups, how they are going to be structured.”

“When really when you think back to the time a lot of people may not understand what a lead clinical director was and what his function was.”

“You come across people who say, I didn’t realise that that change had occurred.”

Overall, the interviewees cited how the current practice of communication across the organisation is frustrating and confusing particularly during times of change. Such practice can breed distrust between management and employees as described by interviewee 5. It appears that the breakdown of communication is suffered by certain levels more than others during changing times. This implies that the multiple changes at CEO and senior executive level can impact middle and senior management more than the rest of the organisation also suggesting a distinct disengagement between senior levels and the remainder of the workforce.

“For my nurses, they don't really; they feel it doesn't really change anything for them once they can come to me with their issues”

“I think where it does make a difference is at line manager level and supervisory level... probably means more to line managers than to a grade three in health records or a grade four in clerical services or someone on the helpdesk in IT or someone at a grade four level within HR”

Interviewees cite how communication happens in certain pockets of the organisation but overall there is a lack of integrated communication whereby the organisation's goals and objectives towards change and workforce planning are not shared which can leave staff feeling ill-informed regarding the organisation's vision and direction and ill-equipped to appropriately manage workforce planning.

“I would say so there's communication in one way when it needs be”

“So I don't know what the original goals were so it's difficult to know whether or not they have been achieved or not”

“The difficulty is because of a lack of a clear project management model or a change model....there is a constant level of fire-fighting to identify who the appropriate people are and often the decision is made based on the individuals contract in respect of the hours they work as opposed to them being the most suitable person for the post”

○ **Theme 2: Leadership**

Leadership was presented as a strong theme throughout the research. Interviewees recognised it as an important factor during transformation and workforce planning and it was referred to in both positive and negative forms. Variants of leadership are evident across the findings and interviewees expressed their feelings towards the multiple changes at senior level and the lasting effect this has had on the workforce and workforce practices.

“It has had an unstabling effect on the organisation”

“I would say change management processes occurred but I would say it was haphazard and probably slower than it could have been if one CEO, with one plan, with one vision that was articulated and implemented in sequential way”

“Definitely there was a lot of unrest in the organisation and people didn’t really know who was coming or going next.....trying to make the system work because you are thinking that the next guy is going to change this completely so why are we wasting our time trying to put structures in place.”

In general the findings suggest that there is a sense of ‘lost opportunity’ with regard to the multiple changes of leadership at CEO level. For interviewee 2 these changes have had a lasting effect on the culture leading to a loss of identity for the organisation. Interviewee 5 describes a situation where a workforce planning tool was devised, it was regarded as worthwhile by senior management but it did not progress beyond the pilot stage. Interviewee 5 believed this was as a result of changes at senior level; *“so the idea stopped in its tracks. And I think there was a changeover in CEO again”*.

Compared to other interviewees, interviewee 4 cited considerable more frustration suggesting mistrust and a lack of confidence in the organisation’s leadership.

“....trying to make the system work because you are thinking that the next guy is going to change this completely so why are we wasting our time trying to put structures in place.”

The findings suggest that the attitudes towards leadership in the organisation is partly due to the lack of transparency in the recruitment and selection process of leadership roles and the subsequent lack of skills and competencies in the delivery of effective leadership.

“For the first set of the Lead ADON's they were nominated into post. As far as I'm aware the Business Managers were nominated into post. So there wasn't any recruitment process around that”

“He's standing up there and we are all just sitting there as if we are in a classroom as if we are told what's what”

The general consensus from the findings propose that there is a distinct lack of consistent leadership at senior level and this is having serious implications on employees and work practices. Effective leadership that is required to carry out change management and workforce planning is lacking and there is dissatisfaction and distrust surrounding the appointments of leadership posts.

5.4 Summary of Findings

Research findings from all five interviews have shown that the external environment can have a significant impact on the process of workforce planning during a transformational change. The PESTLE analysis demonstrated what factors from the external environment impacted the most. It was found that political, social and legislative forces were the most dominant. In addition, the researcher discovered that certain internal environmental factors were even more prominent across the research. Despite the internal environment not originally incorporated into the theoretical framework, the researcher believed that the data from these findings were valuable to ascertain more about the topic and research question. What emerged from the internal environment were dominant themes such as communication and leadership. The implications of these findings are discussed in the final chapter:

Conclusions

CHAPTER SIX - CONCLUSIONS

6.1 Purpose of Research Recalled

The purpose of this study is to examine and understand workforce planning practice and how it can influence transformational change within a hospital setting from the perspective of key stakeholders of the process. For recall purposes, the research questions applied are:

What is the role of workforce planning in a hospital setting? Was workforce planning practiced during the transformation process? How can workforce planning influence organisational transformation in a hospital setting?

This section aims to provide answers to the specific questions outlined in the research question that underpins this study.

6.2 What is the role of workforce planning in a hospital setting?

From the findings, the practice of workforce planning in the hospital is defined by a workforce tool that was devised by the HR Department and supplied to all line managers. This data is fed into formal workforce planning meetings (MAP) where a committee consisting of senior executive management decide upon the replacement and new roles across all areas in line with finances.

Despite this, all interviewees agreed that the current practice is limited and not without fault. Some of the interviewees deemed it constrictive and it fails to provide a true reflection of the workforce, making forecasting and management of future

situations difficult. However, one interviewee did explain that the current process and practice is a massive improvement upon the previous and how the hospital's transformation process into the clinical directorate structure now allows for key relevant people to have a larger role in decision making on resources. The findings suggest that although there is an awareness of workforce planning and its benefits, there is no integration and organisation wide education of it. It appears that the role of workforce planning is heavily focused on the one or two practices such as the tool or MAP meetings but both the findings suggest it is only exercised by senior levels of the workforce.

Robinson and Hirsh (2008) explain how workforce planning is 'meaningless' if it is not grounded in the strategic objectives of the organisation. It is clear from the interviewees that goals and objectives are not clearly communicated and that any indication of change was given as a directive rather than in consultation. Many of the interviewees were unable to answer how the organisation's goals and objectives were set and achieved during the transformation process due to poor communication.

O'Riordan (2012) draws similarities between the workforce planning process and any change initiative where effective leadership, good communication, appropriate resources (human and financial) and clarity around roles and responsibilities are all imperative to successful implementation and practice. All interviewees are aware of the current role of workforce planning in the Nursing and Medical (Doctors) areas but none were able to confirm if workforce planning was practiced in the initial stages of transformation. This implies that workforce planning was not considered during one of the biggest change initiatives the organisation has ever experienced.

Furthermore there is no evidence of a workforce plan or strategy then or now from the findings. This suggests that activities of workforce planning are conducted on an 'Ad Hoc' basis. This has led to some of the interviewees feeling frustrated and without a sense of control as decisions and practices are carried out an ad hoc basis and with no transparency or procedure being followed.

6.3 Was workforce planning practiced during the transformation process?

None of the interviewees were able to confirm if workforce planning was practiced in the initial stages of the transformation process. However, as some of the interviewees pointed out the transformation process in the organisation is still on-going. It is clear from the findings that workforce planning is currently practiced in some areas namely the Nursing and Medical areas.

Upon further analysis of the findings it was evident that common workforce practices such as appropriate recruitment and selection was not applied during the filling of new roles in line with the new structure. From this it could be concluded that the organisation did not assess future workforce needs and project future workforce supply. By doing this, skills and competencies required for key roles and functions cannot be identified which is a key step in workforce planning that allows future projections on workload and what is needed to meet those requirements. (O'Riordan, 2012)

6.4 How can workforce planning influence organisational transformation

Despite the general consensus from the interviewees that the current activities of workforce planning require improvements, each have demonstrated the benefits and

potential that workforce planning can have. This awareness has mostly been achieved by four out of the five interviewees through their experiences of additional academic study at various levels. As a result each are equipped with the knowledge of best practice and have identified obvious gaps in process such as their references to the lack of set goals and objectives, an absence of vision and direction, ineffective leadership to drive and communicate plans or strategies and the impact that this can have on a workforce during transformational change.

It is clear from the findings that the interviewees appreciate the strategic importance of workforce planning but in a limited way. Only two of the interviewees referred to succession planning, coaching and mentoring and talent management as alternative activities within the workforce planning remit. Interestingly, workload demands and reduced staffing levels were mentioned as reasons why these activities could not be conducted. Such conflicting practices of workforce planning can reduce its influence. The Institute for Employment Studies argue that effective workforce planning focuses on key activities and certain areas rather than the entire workforce and by doing so can affect areas of higher risk and this is regarded as the most efficient way to workforce planning. (cited by O’Riordan, 2012) It has already been established that this is the case with Nursing and Medical and this relates to the current health care shortages experienced in these areas. As to the level of influence that these practices have had, there is little evidence from the findings.

From the findings we can establish that certain activities such as exit questionnaires and tacit knowledge transfer can influence during the hospital’s transformation process and allow for sustained change. However, in the case of exit questionnaires,

there is no evidence to suggest that this is part of workforce planning and the interviewee is unaware if this information is correlated and used for any specific purpose. In the case of tacit knowledge transfer, this was devised to proactively capture skilled knowledge and competency that can occur after many years of experience so that in the event of resignations or retirements, a transfer of skills can be applied.

6.5 PESTLE Analysis

External Environment

The literature states that a key stage to any change initiative and workforce planning is an understanding of any contingencies that could prevent the organisation from meeting its goals. (O’Riordan, 2012) Contingencies can come from factors from the external environment. Previous case studies (The Courts Service of Ireland and Dublin City Council) confirm that assessments of these factors can have a significant impact on how effective workforce planning can be which can lead to higher performance.

From the research, the dominant factors relate to political, social and legislative issues. The findings imply that the organisation’s approach is more reactive rather than proactive. Without a clear workforce planning strategy that is coherently communicated and aligned with the organisation’s goals and objectives, it can be assumed that a more reactive approach is adopted. In some cases, the interviewees acknowledge external forces that can impact the workforce such as the Haddington Road Agreement, directives from the HSE and Hospital Board, incentivised early retirement and redundancy schemes and changes to employment legislation.

However, there is little evidence from the findings to suggest that there is a clear understanding of the connection between external factors and workforce planning and its subsequent influence within the organisation.

Internal Environment

Although not originally included in the theoretical framework for this study, following analysis it transpired that important findings emerged from internal factors that could provide for a more informed study.

The main dominant factors that emerged were communication and leadership. Overall both themes emerged stronger than any of the external factors suggesting that the internal environment can be more influential on the practice of workforce planning and change management in this organisation. The current practice of communication and leadership are regarded negatively by most of the interviewees, the exception being interviewee 3. In this instance, this interviewee demonstrates the importance of communication and leadership to change and workforce planning practices. However, these findings are not supported by the other interviewees and this suggests a contradiction between best practice and actual practice within the organisation.

Findings suggest that this is further impacting upon the culture within the organisation. An effort to improve leadership is evident from one of the interviewees indicating increased options for training and development and education through affiliated institutions. Some of the interviewees alluded to how communication has improved due to restructuring and new reporting structure as a result of the

transformation process into clinical directorates but findings from other interviewees suggest otherwise.

6.6 Limitations of this Study

The researcher had proposed to interview eight people but unfortunately due to circumstances out of her control, the final number of participants was five. This was very disappointing for the researcher as the three who did not participate were from clinical backgrounds and would have balanced the levels between clinical and non-clinical. Yin (2009) refers to interviews as verbal reports only and as such responses are subject to bias, poor recall and poor or inaccurate articulation. Due to this the researcher is aware that this study would have further benefited from corroboration with other sources of data through process of triangulation. However, access to additional information was difficult.

6.7 Discussion

The health sector is contending with unprecedented economic obstacles due to severe austerity measures on public finances. Public sector aims and objectives are embedded in the ‘do more with less’ strategy which has brought workforce planning more into practice in recent years. Various evidence based research has shown that successful change efforts can be traced back to a number of important elements. These elements entail defining a clear strategy or vision for change, effective leadership, communication and the appropriate allocation of supporting resources. (Kotter, 1995; O’Riordan, 2012) The research findings suggest that while such elements are acknowledged and relate to best practice there is a clear absence of best practice put into actual practice. This is clearly communicated by the interviewees

who when questioned, were not aware of any change model or strategy used throughout the hospital's transformation process. There was a distinct lack of communication around vision which would clarify the direction in which the organisation was moving towards. The result of such was implied by interviewees where it was felt that they were ill-informed and ill-equipped to manage the change process. The literature advises that it is essential that workforce adjustments deriving from organisational change are performed within a 'sound framework' of strategic workforce planning. (OECD, 2011)

It appears from the findings that the organisation's decision not to apply evidence based practice in relation to change management has also extended to the practice of workforce planning. Without a clear strategy and vision and communication of same, it is difficult to understand and adhere to the organisation's goals and objectives and most interviewees claim that goals and objectives were not communicated to them and therefore were not aware of them. The literature on workforce planning advises that for the successful implementation and practice of workforce planning it requires strategic alignment with business goals and objectives. (O'Riordan, 2012) The findings do not support this which has resulted in workforce planning practice isolated to certain pockets of the organisation such as Nursing and Medical, the frontline areas.

The literature address the importance of drivers of change or 'change agents' that can lead change by inspiring and motivating others through a shared vision. The literature fails to address the issue of unexpected behaviour patterns such as multiple changes at CEO and key leadership roles. It could be argued that effective

workforce planning practices could prepare the organisation for such contingencies but without clear aims and objectives and what the appropriate resources to ensure the delivery of change into clinical directorate model, the influence of workforce planning is reduced. It is clear that such changes have had a lasting effect on the organisation with interviewees citing lost opportunities towards workforce planning and a lack of confidence towards the organisation's leadership.

Effective leadership holds significant importance for successful change initiatives and workforce planning. It is important to nurture employees in order to develop leaders so that current practice can be sustained. In the case of 'The Courts Services Ireland' (O'Riordan, 2012) one of its key elements to successful workforce planning was effective leadership from the top. This case study highlights how leadership encouraged employee commitment for change in location and roles while also addressing the need for new knowledge and skills during a time of considerable restructuring and reorganising. The major difference between the Court Service case study and this study is the level of engagement and consultation with staff prior to proceeding with restructuring. This information obtained from consultations allowed for the formation of a workforce strategy. While findings from this case study's research suggest that skill gaps at leadership level are being addressed, it is also clear that the current leadership are not engaging with staff. The literature confirms how leaders that engage with their staff by motivating, inspiring and empowering can instil a culture of change and have higher levels of employee commitment towards change practices (Gill, 2003; Kotter, 1995)

The most common theme amongst all the literature on change management is communication. It is perceived as the critical success factor to any change process. Heathfield emphasises that “people who are afforded clarity, honesty, dignity, understanding, and compassion have a greater openness to change,” (cited by Vaerenbergh and McAuliffe, 2006, p.88) The consequence of poor communication is misunderstanding and lack of trust towards those advocating the change and towards the change itself. The findings suggest that there is theoretical awareness of the necessity for good communication but there is evidence that shows that best practice is not applied. The findings suggest that decision making around workforce planning is regarded more negatively than positively and more specifically in the area of recruitment and selection; where there is a level of mistrust towards decisions and procedures.

The recommended practice of workforce planning states that, due to its complex and challenging nature it requires sufficient resources and consensus around the workforce plan. (O’Riordan, 2012) The common mistake that organisation’s make is that workforce planning is concerned only with the filling of vacancies and reviewing services. To reach its full potential it needs to be regarded as a sustained strategic approach to understanding the needs and desires of an organisation. Conflicting practices of workforce planning towards achieving change is discovered in the findings. It was found that managers wishing to engage in practices such as coaching and mentoring or succession planning cannot due to insufficient resources to support these practices. Insufficient staffing levels are preventing managers and employees in engaging in additional practices that would benefit the workforce now and in the future. In the area of nursing where workforce planning is practiced

regularly and is resourced with a workforce planner, there is little evidence to suggest that the practice does not extend beyond the data collection of staffing levels and filling of vacancies.

It is important at this juncture to address the link between the health service transformation and that at local level. It has been established that the driver of change in this case study came from external political forces (HSE) deciding that clinical directorates were the most appropriate structure for health care organisations to deliver care. National strategies such as those outlined in the *Integrated Workforce Planning Strategy for the Health Services 2009-2012* are driven down to local levels. However, it is vital for an organisation to have ownership of goals and objectives that also fit with the overall vision or national plan. Without ownership organisations run the risk of unsustainable change which affects the overall performance of the organisation and ultimately health service delivery and patient care: the focus of this transformational change.

The findings of this report give an interesting insight into the practice of workforce planning during a change process in a complex environment. The health sector has entered into turbulent times with increasing demands on care and customer expectation coupled with significant budgetary constraints and dramatic health care shortages at home and abroad. As a result workforce planning despite being a recent concept, has a substantial role to play in the future of health care. The results from this report can contribute to further developments and studies where much is lacking particularly within the Irish context.

On a personal level, this study has greatly benefited me. As an employee within HR, it has been an insightful learning experience that I know will encourage me to expand my HR practice within the department and across the organisation.

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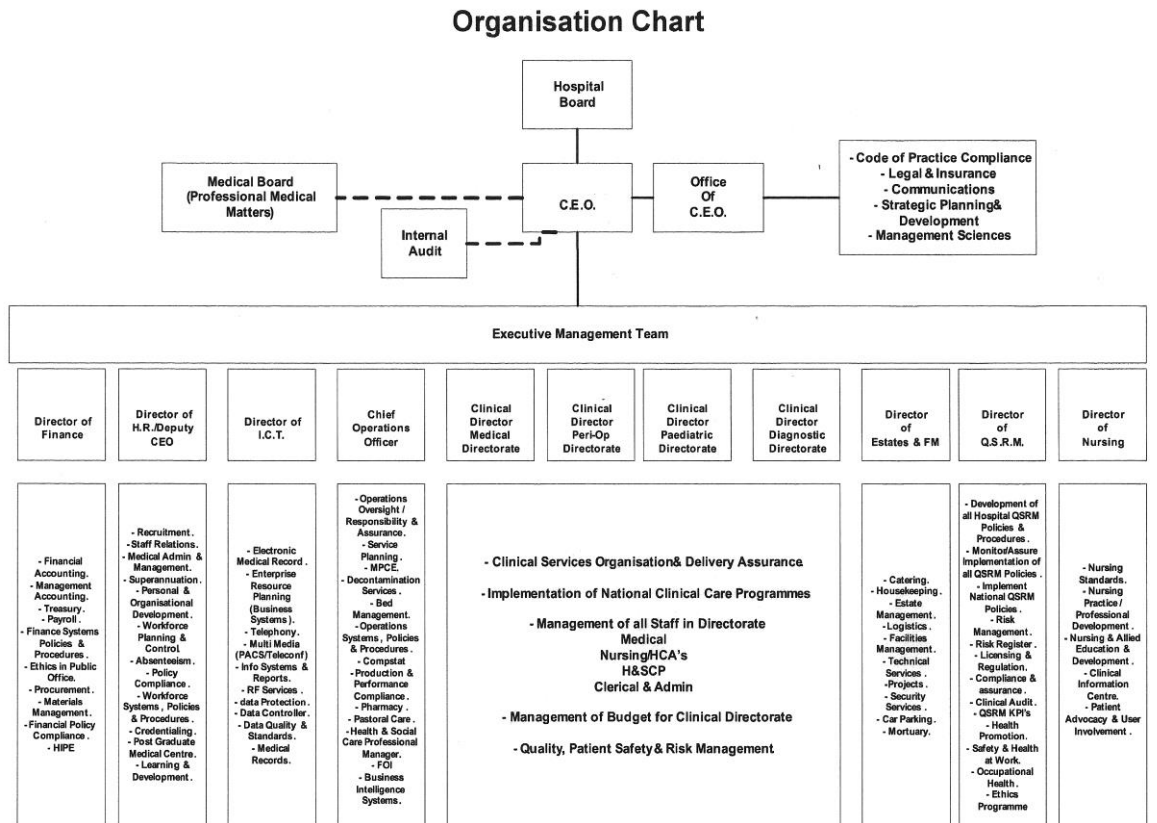
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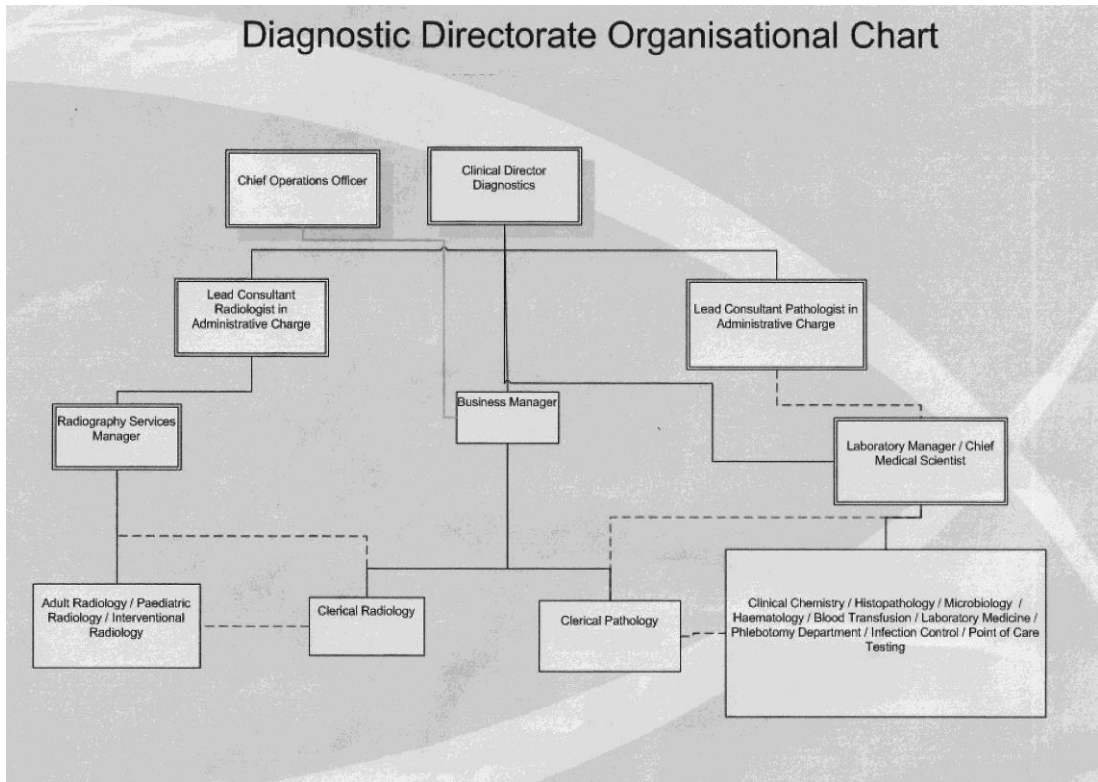
Appendix A - PESTLE Analysis on Organisation

	PESTLE Analysis on organisation
Political	Increase of retirement age Change to Clinical Directorate structure Development of Hospital Groups Government interventions – Haddington Road Agreement Revised consultant contract in 2008
Economic	Reduced budget and resources Funding of new capital equipment Skill shortages Global Financial Crisis Increase in graduate & intern programmes
Social	Increase in hospital activity Increasing aging population & elderly care Changing attitudes & behaviours Changes to qualifications, skills and competencies Increase in patient advocacy complaints
Technological	Introduction of SAP E-rostering Communication
Legislative	European Working Time Directive (EWTD) Changes to employment contracts and salary scales
Environmental	Building of new extension in Radiology and Emergency Department

Appendix B - Organisation Chart – Clinical Directorates



Appendix C - Diagnostic Directorate Organisational Chart



Appendix D – Email Invite to Participants

From: Geraldine Sweeney
Date: 1st July 2014
To:
Subject: Interview Request

Dear X,

I am currently completing a dissertation for partial fulfilment of a BA (Hons) in Human Resource Management with the National College of Ireland. The topic of my dissertation is “Organisational Transformation” and I wish to discuss the topic with key stakeholders during the process. The research aims to examine workforce planning practice and how it can influence the transformation process within a hospital setting.

I plan to interview a number of people and I would be obliged if you could participate. Interviews should take no longer than 40 minutes and will be conducted face-to-face with myself.

I would request permission to record the interview on an iPhone to facilitate transcribing afterwards. The name of the organisation and names of all interviewees will be withheld.

I would be delighted if you would agree to participate and would ask that you let me know by return email. If you are willing to participate, I will then contact you by phone to arrange a time and place to meet.

Many thanks for your consideration.

Regards

Geraldine Sweeney

Appendix D – Transcribed interviews

Interview One

Interviewee 1: AC

Employee Level: Business Manager

GS: Briefly bring me through your role and responsibilities

AC: I'm the Business Manager for the Diagnostics Directorate I am responsible for the business aspects of a clinical directorate and I work directly for a clinical director and for the chief operations officer. The director that I support is a respected diagnostics so those include both the pathology side and the radiology. Within my role and my sole responsibilities I have the budget for the clinical directorate, I have to work with finance with respect for that budget and insuring that we keep within the budget allocated to us to identify cost saving initiatives to introduce new business plans, cost up service development etc. Another part of my responsibility is managing the risk register within the directorate, so working with the cautious safety and risk directorate in respect of managing risks, identifying risks, reporting risks and then identifying action plans to mitigate the risks. I also have responsibility to work with the Human Resources department in respect of the management of whole time equivalence within the directorate. I have to ensure that if there are any new change initiatives in relation to Haddington Road or national agreements around radiography services agreements or laboratory agreements that I am working with the line managers and Human Resources to roll them out. I also have responsibilities for submitting map applications which are for the replacement of consultants or any of the non-consultant hospital doctorate positions within the directorate. Then a range of other roles within the directorate.

GS: Is change management a large part of your role?

AC: A significant part of my role and actually one other thing I do also have a responsibility, I'm actually the line manager for the clerical staff within the directorate also, so it equates to approximately about thirty five/ forty whole time equivalence between both laboratory and the radiology department.

GS: When the hospital first implemented the change process into the clinical directorate model, what were the significant changes for you?

AC: At the time that the clinical directorate model was being introduced into the hospital, I was working in the human resource department. I suppose the role that I played at the time had a significant in respect to the fact that I was working as a personal assistant to the Director of Human Resources and so therefore was able to see some of the workings in respect of how they were

putting the clinical directorates together. I was introduced to the representative from the Belfast Trust who was in the hospital at the time who was helping with the structure and roll out of clinical directorates. I also attended a meeting where we had a lecture from the finance director of the Belfast Trust who also spoke to us about the management of financial management and clinical directorates. I think then a key role was being involved with the meetings where the clinical directorates, the directors themselves were discussing the positions of Business Manager and the structure of the job description around that position.

GS: Do you recall an official change management process being followed then?

AC: I don't. I wasn't aware that there was an official change management process, there may have been one discussed at an executive management team level but I wasn't privy to any documentation or any meetings where there was a discussion of a specific process being used for the roll out of clinical directorates. I was aware that there had been an individual who had introduced clinical directorates in the Belfast Thrust and that he had been invited into supervise the process but I was not aware he used any specific model or process.

GS: Do you recall the role out of a strategy across the hospital?

AC: The strategy seemed to be to my understanding that the first two directorates to be created were the surgical and medical directorate, subsequently the Paediatric directorate and finally the diagnostic directorate. The role out was managed in that order. I understand significant discussion around the allocation of resources to the directorates in respect of the Human Resources around division of nursing staff, whether or not allied health staff be included in the directorates etc. But as to how the model or decision making process were made around that I'm not clear.

GS: How do you think the goals or objectives of the change process were set or achieved?

AC: Well I suppose the very explicit ones were in respect of the introduction of clinical directorates and those clinical directorates were introduced, new reporting structures were put in place, there have been a movement towards the devolving of budgets which is a key part of the introduction of the clinical directorates which is being facilitated through the introduction of SAP's finance program. I'm not clear about what the original objectives are but from an international standard the objectives around setting up clinical directorates would include full devolution of budgets which haven't been achieved yet and it would include the full responsibility and ownership of whole time equivalence within your directorates. So, that for instance if you were allocated 500 whole time equivalents and you had a budget of €30 million therefore it would be up to you to choose whether or not the clerical staff left would you replace some with a medical scientist but that level of

ownership has not been devolved down to the clinical directorate level and the management of whole time equivalents and staffing is still very strongly controlled through the MAP Committee and ethics executive management team level.

GS: Do you recall any other types of activities or practices that were implemented during the transformation into clinical directorates to ensure that the goals and objectives were met?

AC: I don't have a clear understanding that that was in place, having said that I also was on leave for parts of the process due to maternity leave so there could have been other activity happening in the organisation that I wasn't made aware of. I am aware that further into the introduction of the clinical directorates when they started to transfer their responsibility and the line management of clerical staff to the business management that there was certain leads processed in respect of that there were discussions held for both the medical and the surgical directorates but for one reason or another that process wasn't used or appeared to with the diagnostics directorate. With the one that I was involved in, there was an instruction to have a transfer of responsibility for a clerical staff to the business management but there was no process or discussion held in respect of that.

GS: When you say instruction, how was that instructed or communicated?

AC: The instruction on that came clearly from the Director of Human Resources. It wasn't, and the reason I can say without question that there hadn't been a process involved because when the discussion then was subsequently held with the clinical director there wasn't full agreement around the changes of responsibility.

GS: Was there resistance?

AC: There was resistance, yes.

GS: How was that dealt with?

AC: The resistance was dealt with through a process of discussion between myself the Business Manager and the clinical director and I created an organisational structure to clarify exactly what the responsibilities were and we agreed that although there was a line management responsibility for the clerical staff there was also a key significant that the clerical staff also liaised with and worked closely and reported to the line managers within radiology and pathology. That's where the work base was led from.

GS: Did you feed this back into a change management team or senior management?

AC: No. There wasn't a process available to me to feedback in respect of that. I understood was just to implement the change that was requested as opposed to identify any issues in respect of that change.

GS: **Were there incentives or motivators provided to limit the resistance and work towards achieving the goal and objectives?**

AC: Not that was identified to me. I wasn't aware of any motivating factor in respect of it. I was led to understand that the process had already been implemented in the other three directorates and therefore it was now natural succession and that it would now be implemented in my directorate.

GS: **Do you recall a key player(s) during that process?**

AC: I would say that it was the very clear driver of the process was the Director of Human Resources who had previously been the Acting CEO and previous to that the Deputy CEO. His role was very clear in respect of leading out all the clinical directorates. He was the one who advised the appropriateness of moving the clinical directorate model. I think it was possible that the instance that occurred around Radiology and Orthopaedics and the findings of the Hayes Report. Clinical governance also supported the move towards the clinical directorate model in respect of identifying who had clinical governance responsibility within the organisation but I think the key instigator of the change, the key leader of the change was the Director of Human Resources.

GS: **Do you think that the HR Director was solely leading the change process?**

AC: I don't know if he was solely leading it. I think he was the key change initiator, but I think that the model of clinical directorate had been recognised across the country in respect of being the appropriate model for managing hospitals.

GS: **Do you think that the multiple changes at CEO level over the years, has had an impact on the change process?**

AC: I think that and this is personal opinion, I think that the multiple changes at CEO level have resulted in the, I think what's happening is, that there's maybe a lost opportunity to build a unit of people who manage change within the organization and who at a higher level have been through the change management process and the experience of how to manage change in best practice. I think that because there has been a significant change, not just at CEO level but almost the entire executive management team as well. We don't have perhaps the experience of some other hospital of managing change over a period of time.

GS: From your own experience of change management, do you think that is appropriate?

AC: No. I would think that the use of an appropriate change model with a backdrop of supporting communications strategy is certainly a much more effective way of introducing change into any organisation. I think that that was lacking to say the least because I think if there had been clear objectives set at the beginning I certainly don't feel that they were communicated effectively across the organisation to all parties within the organisation as to what the change was and what the objectives were and why it was being brought about. I think that if there had been a change model being used, it may have been done so but it wasn't being communicated that that was the specific model being used. I think that the more open you are the more effectively you will manage that the more change can be introduced without as much resistance, with a better ability to be effective. I think that the area of change management is actually relatively young in respect. I know it's been in America for the last sixty years, but I think as an actual idea or theory in relation to Irish health care, I think the actual structure of change management is relatively new and I think potentially there is a lacking of people who have been trained in the area of change management and understand the importance and significance and importance of introducing change management effectively through using processes and change models. Independently of my role I am familiar with the HSE change model but I've never seen any dissemination of information around the HSE change model through the organization through the hospital. I wonder perhaps is there an opportunity for the HSE itself to ensure that its communications strategy around change management be improved.

GS: How did the organisation, during the many changes at senior executive level, ensure appropriate resources were in place during the transformation process?

AC: I'm not clear that there was ever a project team or a designated group to manage the introduction of clinical directorates and therefore it was somewhat more organic and perhaps that actually facilitated the continuous change at executive management team level because rather than it being a set group of people who perhaps lost their leader once the CEO left it was much more of an on-going organic change which suited itself to the change in leadership. I think that change is an on-going process that the replacement of one individual at CEO level doesn't always have the same impact that may otherwise be thought of because generally whatever the decisions the CEO has put in place maybe on going after they have left and so therefore I think probably the big thing, the consonant that has been in place the individual who was the initiator of the change has been there the whole way through, so he had managed to hold the process together to some extent.

GS: As a manager how do you ensure the right people are in the right job with the skill mix and competencies at the right time?

AC: With great difficulty to be perfectly honest with you because I am involved currently in a significant change project within my own directorate which is the introduction of a new IT system. I'm not the project lead but I sit on the steering group. The difficulty is because of a lack of a clear project management model or a change model the warnings needed or the timelines created would allow the identification of the appropriate resources are not in place and therefore there is a constant level of fire fighting to identify who are the appropriate people are and often the decision is made based on the individuals contract in respect of the hours they work as opposed to them being the most suitable person for the post because in some worlds you need somebody who's available five days a week who doesn't work part time. In other cases you can only give somebody who is part time when you need somebody who works five days a week.

GS: What happens when you can't fill a role?

AC: When you can't fill the role you absorb the additional activity onto the department and then you see what starts happening the more you absorb the more that the work requirements are left on those remaining. An increase that you will then see constantly on the absentee level within your department.

GS: Is this fed back into the clinical directorate or management team?

AC: Yes there is on-going discussion with Human Resources department and then as a Business Manager I would relate the same to the clinical director as well. The thing is you have to allow for the fact that project will come to an end and at that point you will be able to look at the longer term management of the team.

GS: Do you think there are any forms of analytical tools or analysis of internal or external factors completed to identify gaps?

AC: We use a work force plan which is essentially a modelling plan which allows us to identify over the coming months which staff are physically actually working in the departments and those who are on maternity leave, on long term leave or on long term sick leave etc. That really is the only structure tool that were using at the moment, that modelling tool.

GS: Is that within your own department or your own directorate or are you aware of it hospital wide?

AC: That's a tool used across the hospital. It was a tool created by the Human Resources department, it was devolved to all line managers to use across the hospital and it's used in addition when you were applying for the replacement or recruitment of an individual. That's a handy tool but the difficulty is its limited because it doesn't give an indication of the skill mix of the people who are actually left. It doesn't indicate the individuals for instance you have twenty whole time equivalent and five of them happen to be on maternity leave, it doesn't indicate whether or not the five who are on maternity leave are the most experienced people in the department who have the best skill

mix, who are the most transferable to different areas within the departments etc. So the tool is very quantitative in measurement it's not in any way qualitative. It doesn't bench mark; it doesn't allow you to bench mark against other areas in the organisation or against other hospitals.

It just simply says, it's a very black and white tool, it simply says this is the number people you who have right now and this is the number of people you have next month and the month after that.

GS: So you are saying that it doesn't integrate wide an organisation wide work force plan?

AC: Exactly. It's a tool that's used to facilitate decision making at the committee level around the replacement or recruitment of an individual but to my knowledge it's not used a broader tool in repeat of for instance stating well this particular area is now significantly under staffed compared to any other area in the hospital, it just says this particular area is significantly under staff to how it was two months ago.

GS: You mentioned how limited the workforce planning tool is, are there other practices or activities that could capture workforce trends.

AC: It would seem that would be appropriate to do that in some way but the only other way I have seen that they have incorporated to some extent is by identifying what the grades are. Occasionally what you'll do is in addition the two of you submit a breakdown of what the grades are. The grades of an individual don't always reflect their skills or abilities. You can have people on a lower grade but because the embargo in placed on recruitment haven't had the opportunity to be promoted in the way they would have done automatically in previous years. So the grades don't always reflect the skill or ability of the individual involved. In relation to succession planning, I'm not aware of any structured succession planning within the organisation. I've taken on responsibility as the Business Manager in my directorate to request reports from the Human Resource Department to identify the ages of all staff in my department so I know who the likely staff are to retire in the coming years and identify hotspots where there are areas where we might have a significantly higher number of staff retiring which could impact on the service itself. But I'm not aware of any structure or plan within the clinical directorates or the hospital to manage succession planning.

GS: Have you received any training or developing in workforce planning?

AC: Yes and no. I worked in the Human Resources department before I took on the position of Business Manager so there is some of the skill mix comes from understanding the recruitment and retention process in Human Resources. It comes from understanding the pension process and understanding the management of whole time equivalence within the organisation. Separately to that I am undertaking a masters myself externally to be role of Business Manager, partially funded by the organisation and within that role we have touched on work force planning but not in any in-depth way. In relation to specifically my role as Business Manager I certainly

haven't received any in house training in relation to work force planning and I'm not aware that any of my colleagues in the other directorates have received any training in relation to work force planning. So I have not been given any training in the area of work force planning specific to my role. I have been given guidance on the use of the tools that are available, for instance, the work force planning tool and the map application tool. I have not been given any guidance at all in succession planning or of change management processes or in overall work force planning. A lot of that just comes from what I see a gap that needs to be addressed and then I will pursue that.

GS: What do you think are other practices or activities that should be part of this process that may or may not be actually used across the organisation?

AC: I think the first thing that is clearly needed is a tool that will allow me to actually identify the appropriate whole time equivalence needed in any area to manage the area because of a lot of it is based on historic, this is what we've had, this is what we should have and so I understand from work force planning there are tools that can be used to actually categorise parts of a day in terms of the actual work load and to identify the appropriate number of staff required to manage that. I think that it's a significant body of work that needs to be done but if it was done and done properly then it would allow line managers to have a real and true understanding of the staffing required and then when those staffing numbers fluctuate to be able to manage in and around that. That's not currently taking place, certainly not in a clinical directorate level. I think I'm aware that possibly happening at nursing.

GS: Are you aware of health care shortages across the organisation?

AC: Without question, yes. There has been a significant drop in the whole time equivalence, even in the two years I have been working in the department directorate. Both at skilled and unskilled staffing levels, both at the level of medical scientists to staff across from clerical to scientific to radiography the entire lot we've had a reduction in staffing levels.

GS: Apart from using your workforce planning tool, how can this be tackled?

AC: There are meetings held with the clinical director the Business Managers and line managers with the CEO. Particularly where there is a service development or new staffing requirements for service development. If there are issues, for instance where in an area of the directorate like Radiology, we are having issues being able to recruit staff even when we have the authorisation to do so. I am of the understanding that around Radiography staff there is a national shortage of Radiography staff. Within the NCHD side of it which is actually one would be discussed nationally around the shortage of non-consultant hospital doctors not so much an issue within my directorate, we have small numbers NCHD's. It tends to be there all at specialist Registrar levels so not so difficult to fill.

GS: Without a change model or framework, how does the organisation manage external environmental forces?

AC: There are factors that sometimes facilitate us which are external. A lot of external forces aren't necessarily negative. For instance the introduction of the enforcement of European working plan directive is actually requiring the hospital to increase its staffing of non-consultant hospital doctors in some areas. For instance were recruiting an additional Specialist Registrar in July of this year because of the issue around EWTD so that's actually supporting us and that's an external factor supporting us. The other thing that plays heavily into our favour is the fact that we are a large teaching hospital. Compared to other smaller hospitals around the country we don't tend to find it much of a problem recruiting staff particularly doctors that smaller hospitals would find an issue.

GS: How are we preparing for future shortages due to an aging population for example?

AC: We have an aging population but the government is litigating against that somewhat by actually extending the age of retirement. The key is ensuring that the training provided within the hospital is not letting people fall behind because of their age. That was making sure there's an appropriate level of training across the board so as new technology comes on board the people who perhaps have been long term employees haven't had the opportunity to go out and do additional education and being kept up to date with what's going on. We also have a responsibility to be the best possible workplace we can be. There's so much evidence out there that if you have happy employees you've got happier safer patients. The key thing is at the end of the day that we are providing the best quality of service to the patients we can and if we don't have happy flourishing employees I think that's somewhat impossible to do. I think the area of training is going to be key but I think we need to look at the organisation as a whole and make sure whatever were doing as an organisation we present ourselves as a really good place to work because if we don't people are just not going to bother and there's so many opportunities globally now let alone locally, there is no reason why people will stay. We have that responsibility to make sure we are doing the best we can.

GS: Would you say we operate within an integrated process between local, regional and national?

AC: No, I don't think we do at all. We are very isolated in terms of the process that we use.

GS: Do you think that's a problem?

AC: I do think it's a problem for smaller hospitals certainly. I don't think it's a problem right now but I can start to see its becoming a problem for us, in relation to the radiography staff where were finding it difficult to fill those posts because a lot of these trained individuals have moved abroad. I don't

think as a rule that we've had as much of a problem with it as say hospitals in the regional areas.

GS: Hospital Groups are on the horizon for the health service. What can the hospital learn from the current change process that would benefit the hospital going forward with the hospital group model?

AC: Without question. I think the key is going to be around the introduction of hospital groups is to get the communication processes in place as soon as possible so that we know what is coming down the line. I think the change management process if it's going to be managed at an executive management team level, the process model needs to be devolved right down so that individuals at local level can start communicating with their counter parts in the other hospitals in a structure that is unilateral across the board. I also think that there's a lot of fear and resistance to the change that'll be brought around the hospitals because there is a lot of fear that people will lose their jobs. That there will be efficiency of scale whereby you'll have support services which will no longer be required individually in each organisation. That works similarly for diagnostics because of the concern that the larger hospitals would subsume the work of the smaller hospitals etc. Even a large hospital like ours is concerned about how we stand in relation to a larger hospital like St. James'. From a change management process point of view the key is going to be making sure what ever model or decision is used at the very top level, that its actually devolved to every bodies so that everybody can manage within a similar process and were all talking the same language when we come to meet and have these significant discussions around how we manage the service.

GS: Do you think that we have led a successful transformation process?

AC: It's difficult to answer that question simply by nature of not knowing what the initials goals were. I can say that yes the hospital has successfully moved from what the previous model to the clinical directorate model in some respect. It's moved in relation to setting up the four clinical directorates to appointing four clinical directors to appointing four Business Managers. It's divided the clerical staff. It has allocated the nursing staff. It's appointed lead nurses to the directorates. The structure is now embedded within the executive management team but there are many aspects of clinical directorates which are recommended internationally have not been achieved in our hospital particularly around the devolution of budgets, the devolution of responsibility around whole time equivalence etc. So I don't know what the original goals were so it's difficult to know whether or not they have been achieved or not. From an international standard we are only half way in terms of implementing clinical directorates.

GS: Is there anything else you would like to add?

AC: Having learnt about change management externally through the masters I am doing, there are so many tools available out there and so much work and evidence which has stated the benefits of actually managing change process through an appropriate tool and to see so much work around change management and creating its own tool that I think there is a big problem in the fact that that's not being brought down to hospital level and down further to the staff to facilitate them in managing change. We've had lectures in the masters from people from the HSE on the change model, they are very supportive of it but I'm not aware of any particular change that has happened in this hospital which has used the change model. I have never seen the poster, it's very recognisable if you got it up on the wall. I don't recall ever seeing it in the hospital or heard mention of it being used in the hospital. I think it's a pity that we have a support organization like the HSE which is doing all this work in the background but the work doesn't seem to be coming down to the hospital or staff level.

GS: Thank you AC. That concludes the interview

Interview Two

Interviewee 2: LM

Employee Level: Medical Manpower Manager

GS: Briefly bring me through your role and responsibilities

LK: My current role is that I am medical manpower manager. What the medical man power function is we recruit in particular all the junior hospital doctors for the hospital and consultants in all specialties. There are four directorates, Medical, Surgical, Paediatrics and Diagnostics. We also look after all the doctor's registration that are professionally qualified and registered with a professional body. Also look after payments. So setting them up on the pay role and if they are entitled to additional payments we would ensure that there all set up verified and paper work in process that if were audited everything is in place.

GS: Is change management a large part of your role?

LK: It would be and I suppose where the doctors are concerned, the change function comes at a national level rather than a departmental hospital level. All consultants would have a national contract and so would junior hospital doctors. But in relation to change within the hospital, a lot has changed with the European work in time directive, doctors have to be compliant in working minimum number of hours and there are different standards that have to be meet with different timelines. Change has come across all the specialties in different roster but what we do with change is we have for the junior hospital doctors there is a NCHD forum where change is discussed and they would have lead NCHDs that would be the lead for discussions on what things to implement or not implement or fix for them.

G.S: When the hospital first implemented the change process into the clinical directorate model, what were the significant changes for you?

LK: I'm in the job about 18 months but certainly within the HR directorate there would have been a drive to bring HR medical division, what use to be called the Medical Administration Department into the HR Directorate and absorb it into recruitment into the general side with nursing the whole lot across the board but actually it's a lot more complex type of recruitment. Not very different the standards of legislation is the same but the nature of NCHDs is very complex and what the requirements are so actually having a designated Medical Administration Department for want of a better description or HR Medical Division is actually worthwhile within a HR Directorate rather than the specialty and I know certainly nursing has an awful lot of generic stuff that would go through. So you would have your Staff Nurse you would have

your CNMI, CNMII, Clinical Nurse Specialist. On the general side you will have everything from the catering assistant the house keeper all the way up to the chief executive so it very broad. Recruitment is very specialized in each of those. With the junior doctors they transfer from Paediatrics into Anaesthetics into ED so that's where the complexity comes into it and for different posts they need to for this six months they might need to have what they call an ACLS course if there an ED, that wouldn't be the requirement if there working respiratory medicine in the next six months so therein lies the complexity of the schemes in how they qualify within their medicine specialty down the line.

G.S: Did you see it just purely as a system and structural change?

LK: You might not like the answer to this but I don't actually believe the clinical directorate model had really impacted on HR as of yet. I think the ethos of it is absolutely there but I don't know whether its staffed personally, I don't believe it's staffed to what I believe the clinical directorate model that would work well. As part of the commissioning the hospital we spoke about clinical directorate models and I'm going back to 1996 where you would have recruited a HR Manager for a clinical directorate with the finance support but even the porters would be belonging to that directorate. This was 1996 where the hospital didn't open till June 1998 and this is where my whole belief and my answer to you might be very different to somebody else's answers. My understanding of the clinical directorate model is a small business within the organisation so that paediatrics will be its more or less independent entity as would diagnostics as would surgery and medicine. But the processes would all be the same the standards would all be the same with those supports. From a HR point of view although our structure has changed significantly because I often say 'ah sure nothing ever changes' but actually when you look back so much has changed hugely. Where now we do have Business Partners we have Business Managers but certainly if I look at the medical recruitment division in an ideal world we would be part of that directorate. I believe if you were in the true clinical directorate model that the NCHD's and the clinicians were really part of that true business partner model or clinical directorate structure the Business Manager would know all them people.

G.S: When you say that the directorates are not at its full potential do you recall an official change management process being followed then?

LK: I would say the whole role out certainly with the clinical directorates. Dr. X was the lead clinical director and that was a number of years ago could be five to seven years ago but again we put people into business posts not recruiting them for the post because of the moratorium on recruitment. They have in my opinion evolved very slowly rather than in a structured way.

G.S: Would you say that was that because there was no role out of a strategy across the hospital?

LK: I would yes.

G.S: **If there was no clear strategy or plan rolled out across the organisation, how do you think the transformation happened?**

LK: Therein lies the problem, I believe for me certainly is the communication. Maybe there was a plan, maybe there was a strategy maybe be I just don't understand it. I certainly don't understand where my function lay within it. There probably was but not in an informed way. Probably an email to say Dr. X has signalled the post to lead the clinical director. When really when you think back to the time a lot of people may not understand what a lead clinical director was and what his function was. I remember at one stage in my other role as a recruitment manager I was asked to recruit, to put job descriptions together and recruit for clinical directors. I remember quite clearly been given the job description and at the time the process, the job description were approved at a HR managers level and they were given to me once approved, they were given to me to recruit. I ended up speaking to the HR director at the time who asked me could I put a schedule together for the interviews and I said I'm looking at the job description, what am I recruiting? As a recruitment manager I couldn't even decipher what the role was going to be.

GS: **Who do you recall as being the key drivers of this change?**

LM: It would have come from board level.

GS: **So the board were the main drivers of it?**

LM: Yes, they would have been with the executive management team so I don't know whether they worked probably in collaboration with the executive management team of the day and the board. As I recall it was the board trying to drive the executive management team to see when we could have these posts in place and that's where I came into it. The clinical directorate model wouldn't be a new initiative; it would be in the national health system for many years. Our sister hospital St. James' and the model there was working very well as I understand it. The clinical director role would be a consultant who holds a 2008 contract that's what they need to be eligible to apply for the post. They would be interviewed by the board or by the chief executive of the day at that level. The executive management team would be in charge of interviewing the person. What they are doing is stepping out of their clinical role into the management role and if you think about consultants they are answerable to the chief executive but from a line management point of view they really are quite automatous in what they do. So the clinical directive role would be to get changed through at a clinical level. The clinical director role is the one that brings that change about and liaises with the consultant colleagues with that directive.

GS: Were there were directives given rather than a consultations?

LM: There may have been a consultation given but only at executive management team level not hospital wide. That's my understanding of it and that's the way the business of the hospital tends to run in a sense of it cascades down.

GS: Does it cascade down?

LM: Well it should but I wouldn't say it often does.

GS: Is that a breakdown of communication?

LM: I would say so there's communication in one way when it needs be and that's where you need a clinical director with the consultant body under my reemit of a medical man power manager because of their contract and Haddington Road, some of them would be members of the IHCA who are still in debate with the HSE and have not signed up so this is where the change lie in one way they don't report to me.

GS: If a gap in resources has been identified during the transformation process is there a forum you could feed this information back to?

LM: There is a forum. For the junior hospital doctors we have the NCHD forum and for the consultant body we have a consultant appointments team now this really should be about consultant appointment and forward planning and service planning for the organisation and it does work very well and the approval is there and the relevant stake holders are around the table. Change such as Haddington Road can be discussed at that because it's a HSE circular and it would be an agenda item. The other body that can be very useful for the consultant body is the hospital medical board. Every consultant that has sessioned here at the hospital is eligible to be a member of the hospital medical board and that has an elected chairperson and things are communicated via the chair person. If I wanted to let them know about a change to sick leave policy I have a mechanism there. They don't go through like any other staff they go through the medical board for approval of probation.

GS: Do you recall a particular change model or framework being adopted by the executive management team?

LM: No.

GS: How do you think the goals or objectives of the change process were set or achieved?

LM: I can't answer that but what I'll say is I look at the HR Division here and I think about maybe appointing into my role. We had HR business partners that commenced, rolled out, staff were asked to put themselves forward for consideration and then the whole recruitment was changed about. Do I believe that the right people are in the jobs? I certainly don't believe it of myself because what happened was the HR business partners support the clinical directors with the Business Managers and then our HR managers become the day to day support to the staff or recruitment contracts payroll all of that. I don't believe they are necessarily the experts in the area of recruitment. I would be the expert in recruitment and because of that change I was requested to into the role of medical man power manager. While I have some expertise in recruitment I wouldn't have expertise. So do I think it's planned with the moratorium and recruitment it sometimes needs must.

GS: Are you aware of the MAP process?

LM: Yes when filling up vacancies or new corporate appointments. If we have a situation certainly in the medical side but I know for nursing too, if we have a new change or new initiative lets say in Rheumatology we have a new consultant on board and he might want a ? or an additional doctor or a clinical nurse specialist he would have to put forward a submission to the map committee which is the man power appointments team and he would put that forward with a business case so the people that would sit on that would be the executive management team they have approved the post, have they the money for it. Is it in line with corporate strategy and all that. The other than would be replacement posts. I had an interview last week would have been pure replacement, people that were leaving, old for new.

GS: What happens when you can't fill a role?

LM: It's very difficult because they must meet particular standards to be considered for consultant appointment. What we have done in the past with the European working time directive is maybe reorganise shifts like the more hard to fill roles. One of those roles at the moment is paediatrics. Another one would be the medical registrars. So we have tried to make the shift more attractive.

GS: How do you encourage or influence this?

LM: As you know we are an academic teaching hospital so we would have links with quite significant schemes. We would have an anaesthetic, surgical, medical and GP scheme. I'm also a member of national medical man power manages group. It's a very useful available group because often you would get circulars and trying to decipher so having a body of like-minded people to share the knowledge is very helpful.

GS: How did the organisation ensure appropriate resources were in place during the transformation process?

LM: Well we talked earlier about map but that's a crude instrument. I'm not on map for approval.

GS: What does that involve and who is that with?

LM: All the HR managers would be at attendance to a certain degree or the business partners who ever the designated person is for the specialty. For myself I still go to the meetings because again the complexities of what I do and the business partners are relatively new in their posts so we have agreed that I will stay involved in it. I had a doctor who was looking to recruit a research junior hospital doctor. He has money he has everything he has the hours. He is giving a letter but because the cheque wasn't with it, that's rejected and yet as map I have explained everything. We end up with bad communication, the consultant is screaming at me why have map with that person I gave them everything there looking for. If that was part of the corporate clinical directorate model everybody would have known about it not just someone within a small speciality within a directorate going off and doing their own thing.

GS: What happens when there is no funding?

LM: At a very high level then the powers to be would go off and try seek funding from the HSE. You have different layers of somebody fighting their business case so you have it coming up so in some way it goes back down the cascade but it comes up. Somebody might have a very good idea and they have done in the past come forward with it but there isn't the money there. It is the directorate finance of the chief executive has to go to a higher entity.

GS: Do you think the process would work more effectively is budgets were devolved?

LM: I think it might be a better system. Do I think it would be achieved, I'm not sure the expertise is there on a business model at this moment in time.

GS: What do you think are other practices or activities that should be part of this process that may or may not be actually used across the organisation?

LM: Maybe the training needs have been identified had they been addressed I wouldn't be so sure. If you are a clinical director who is an expert in his specialty of whatever they didn't go into it for management. That's not their area of expertise and yet they are very good managers. They manage their own service they manage their own out patients, waiting list and their team. They do it from a clinical point of view not even a HR point of view. I would have a doctor come into me with his cert and it needs to be signed off by a consultant and they will tell me they sent me over to you. They don't see themselves as the NCHDs line manager. Which is exactly what they are.

GS: Do you think that is resistance to the change?

LM: It's not even resistance, I just don't think they see it as part of their duties. There is massive gap.

GS: Do you think if there was a clear change strategy or change management process the organisation would be in a better position?

LM: That's a hard one to some degree. How do you summarise. These people have been around the world, these clinical directors that are here in this organisation and possibly in any organisation. They have seen where it has worked well. There in the States most of them would all done fellowships at some stage in their career. They are used to the ticket box. Is that done, no you can't go to B unless A is completed etc. It's accepted i think in Ireland that it's slower. It's my opinion the whole model in a sense, I sat at a meeting with the clinical director whose colleague was off and she is carrying her own and his work load and trying to keep up the job as clinical director. We can't expect them to do it all. We expect them to be managers we have to give them the time to manage. But you see again they are clinical people they like to keep their hand in but when we are appointing people in these roles maybe we need to be looking at if you apply you have to give 50%. At the moment they are doing it in addition to their role. That's unfair to ask anyone to do.

GS: From your own experiences then what were the key activities or practices that can lead an organisational to successful and sustained change?

LM: There has been so much change. My own experience is change happens. You come in on Monday and a decision was made on Friday and by the way we're not doing that any more. Certainly in my own area like the recruitment of NCHD's I'm the manager now I'm very confident my staff are doing it correctly because they know their stuff. As a manager if I was to do it tomorrow am I sure of the new process, I'd have to read every step of it. Do I believe it's correct because somebody higher than me when I wasn't around took a decision and it was implemented. So I wasn't even involved in it.

GS: Do you think that the multiple changes at CEO level have had an impact on this change process?

LM: It has had an unstabling effect on the organisation, it can't not have. From my own personal perspective I remember X being successful to the role and I was also very sad of my own director at the time who was acting chief executive and you know you have those selfish reasons but like that she was dynamic and she came on board. We all at the organisation level thought, breath of fresh air, ok felt sorry for in your own corner for want of a better description but by the same token was that kind of feeling of a buzz because we had been unstable for quite some time with interim CEO, temporary CEO and things like that. Personally if that was going to be the sea change that's when the sea change happened, people felt great and actually that didn't come to fruition. If I remember around the October time with the moratorium, recruitment and change there was a lot of things said, nothing was happening. A lot of promises but turned out promises were put on the back burner so that whole taught and the breath of fresh air we'll move forward now and get us back.

GS: Did this new CEO introduce a new strategy and vision to the hospital?

LM: No, I have to say personally I think unfortunately for X, Y came from St. James's and we had a new director of finances from James's. I think there was another post so it became a case of another James's person. Where the culture in St. James's would have been perceived was reality one thing, or was it the James' model. When things weren't happening what we thought were going to happen when they came, we are morphing into James's and that's where the culture I believe has changed.

GS: Do you think the organisation lost its identity in some ways?

LM: Yes definitely. I suppose staff and patients at this hospital believe it to be their hospital. That a very unique. The hospital was called the Adelaide and Meath Hospital Dublin incorporating the National Children's Hospital; it was ever known as Tallaght Hospital because the people of Tallaght believe it is their hospital. In fairness to the groups of hospitals like the National Children's Hospital and the Adelaide and Meath Hospital they met for years

before this hospital ever opened. They had user groups set up, they knew each other. They had invested a lot of time and effort in Tallaght hospital so there is a huge ownership of staff coming out here. A lot of time and energy invested to make this work. Down to our mission vision and our values and they believe those values. So I suppose where the change of cultural, the values the whole ethos seemed to change.

GS: Was it was business as usual? Were previous practices revisited?

LM: You're asking me something there and I think they might have been but do I know the answer to that question, I don't and that the communication. I actually think somewhere in my sublimable mind I do recall some sort of a group that were going to look at that.

GS: Are you aware of an integrated workforce planning strategy?

LM: A difficult one to answer but certainly something I would look at and i think it's an opportunity for the hospital and hospital groups have a huge opportunity with the junior hospital doctors, most definitely. Were going to be part of St. James', ourselves, Naas, Tullamore if I remember correctly. Peamount is not part of our Dublin mid Leinster group but this is where we have a huge opportunity to recruit for streamlining the recruitment of junior hospital doctors. Peamount, there's a particular on call up there and this is why clinical directors in some ways don't work and some ways hoe they could work. Although Peamount is not part because of a legal entity there, there still are patients up there, our clinicians and junior hospital doctors go up there. They have two junior hospital doctors on call, one tonight one tomorrow every second night they are on call and the hospital has to pay them what we call a one and two rota because they are on call from home. With a very sick patient if a nurse rings about a sick patient if they can't deal with it over the phone they will have to be transferred to Tallaght. Those doctors should be on our on call rota and we would service Peamount from sight. That would bring our rota down saving the hospital money so it's all those simple things being missed. They have a HR person in Peamount, they have two in Naas, could you imagine if that team got together and recruited for all the junior hospital doctors, one person looking after all those Garda vetting instead of me doing it for six months here at Tallaght and somebody else doing it for six months that you would be doing it for the group and its valid for the period of their scheme. With the nature of where we are located, were right between Naas and Tallaght, Peamount isn't too far of the tracks so if some people might opt to say yes to shifts.

GS: Are you aware of health care shortages across the organisation?

LM: Health care shortages particularly now a days I'm aware of them from a nursing perspective, there is a health care shortage from a doctors perspective.

GS: How is this tackled?

LM: For the consultant point of view major drawbacks to get consultants to apply in Ireland at the moment is the new salary scale. This is out since 2012.

GS: Is that an incentive?

LM: No, they have taken a massive pay cut, 35%.

GS: We have shortages at that level?

LM: Our hospital doesn't but there is a shortage nationally. So there is a group looking at the salary scales nationally to try to recognise that but I think it's running already about 18 months and there's still no outcome. The junior doctor thing the HSE has in the past looked at different ways, there's a national shortage in paediatrics and in anaesthesia.

We're looking at them in a sense of we've been fortunate, the paediatrics are just not there. That has to look at a college commission and look at what their career path will be. There are people looking at that. We are trying to recruit out of the country. One of the initiatives I have done this time round is advertising in Australia, New Zealand trying to attract people back from those places. I contacted all the not quite like medical councils there in Spain because Spain is in recession and a couple of other countries we tried to contact their medical councils which are like mini councils around the region to see if they send out information to their doctors.

GS: Are you aware of skill shortages anywhere else in the rest of the organisation?

LM: With my own staff I feel I have to fight. One person in my department looks after the junior hospital doctors, she is a mind field of information. The majority of our posts for junior hospital doctors would be training posts, consultants by their very nature do succession planning they train as they go so you would have doctors on the SPR, they are on a path way to being consultants. We could learn a lot from the likes of that model. Nursing probably has some of it as in their scope of practice. So if specialise in a particular area like asthma, even if I'm a general nurse I tend to be show and

teach on the ward because of the complexity of cases I learn through my scope of practice. If you at it from a general side, I look at the likes of X or Y and people like that they have years of experience, now x is fine because of the age profile but x will be going very soon.

GS: Is the department working towards succession planning?

LM: I have been advocating for it and I thought I got a replacement for someone who went on a career break and I have been told recently that person will be moved yet again. While she is trying to depart and train and up skill that person and for her to share her knowledge. I think that's just dangerous.

GS: Do you think this is common place outside of this department?

LM: In my own experience as recruitment manager there was a department of four staff and I was part time the volume of work was just the same. I had to take somebody in. A chap started with me in December, I was out in January and he was expected to understand how to run the place. There is no plan or support for that person, although there was when the perverbeable hit the fan but there is no formal plan for that training because were always doing everything by the seat of our pants. You asked me earlier on about maternity leavers. If you look at the nursing service area people go on maternity leave and they are back filled. I understand the corporate agreement is its back filled by 0.5 WTE but the person is gone so half their job didn't go on maternity leave with them. With the nature of the work do they really get to show, do and teach before that person goes off possibly not because you don't have the luxury to remove the person from their own job to up skill them.

GS: So the process essentially backfills by grade alone regardless of the knowledge and skill of the previous incumbent?

LM: Absolutely. I think that is across the board because I know that from my recruitment days. The person would be long gone before I recruited the replacement.

GS: Is there anything else you would like to add?

LM: No, thank you.

GS: Thank you LM. That concludes the interview

Interview Three

Interviewee 3: JC

Employee Level: Director of Human Resources

GS: Briefly bring me through your role and responsibilities

JC: My role is Director of HR. I've responsibility for all people issues in the organisation so that people get paid appropriately, people on the appropriate grade, that we've plans in place to make adequate staffing in the hospital, managed within the budgets and so-forth, and I suppose that people feel engaged within the organisation.

GS: Is change management a large part of your role?

JC: Yes, a significant part of it would be change, whether it's on an individual basis or departmental or organisational basis.

GS: When the hospital first implemented the change process into the clinical directorate model, what were the significant changes for you?

JC: I think you're trying to develop a structure that involved clinicians in the decision making process, because prior to that you had what is called 'silos' where the management of the hospital struggled to control the budget. The clinicians were disconnected from that process and didn't even see it, so they didn't even observe the process or the pressures involved in that. So in developing clinicians in management or clinical directors as they're called, you're trying to develop a process where they got an insight, got more involved with the management of the hospital, so they were involved in change management problem solving, budgetary matters and so forth.

GS: And did you have an active role in this change process?

JC: Yes, in the various different roles that I played in the organisations. When clinical directorate was rolled out initially you were looking to try and embed them in a way that was digestible for the individuals and the organisations, so you couldn't go from a situation where they weren't involved at all, to when they were fully involved in decisions and so forth. So you're trying to ease them into it and try and get the structures right.

GS: Were you working with a change management team?

JC: I was working initially with the medical director and the management team.

GS: Was that a change management team or was it more the executive management team?

JC: It was more about the change management deal leading out at that level. You had in a very tight resource situation you had to identify the clinical director in the first instance and put a process in place to identify who that individual was and to get them on board because the first iteration (?) of clinical directors was about them being selected by their peers. It wasn't like a normal interview process. You had to look at how you were going to resource them with nurse manager, Business Manager, clerical support and so forth.

GS: Was there planning behind identifying new roles for this new structure?

JC: In terms of resourcing it? I suppose there was against the backdrop that you couldn't just create these positions and go out and recruit. We had to look internally in terms of how people were deployed within the organisation, and was there a way of freeing people up so you could get them to take on the new roles.

GS: And was there for example, skills gap identified, that then led to training and development or were you picking people that already met the criteria?

JC: You identify that the roles were there. The nursing ones were more straight forward in that there was natural leaders in place that were good fits in terms of lead nurse positions. In terms of Business Manager it was a bit more difficult because you had to get the right fit, but you had to identify the role, so it was kind of a mixture of how they were filled in the organisation. Some were ready-made solutions in terms of individuals who had the skill set. There were others where individuals had developed maybe not to the point of being the finished article but where they could take up the role and develop in the role.

GS: Being a member of the executive management team, was there an official change management process devised or strategy rolled?

JC: The first thing that happened was that we looked at other areas and other places where clinical directorates were rolled out. So they were as diverse as St James Hospital here who would have been seen, at least in the Republic at least as the market leaders in terms of clinical directorates. In Castlebar, the Mayo county hospital, they had clinical directorates in place, they were an exemplar site for the HSE, a smaller hospital than ourselves but again, we looked at what way they did it. The third place we looked at was the Royal Hospital Group in Belfast where we met with clinical directors and HR directors.

GS: Was there an external consultant assisting with the change process?

JC: At different times we had external consultants helping us. We had one individual helping us because he had expertise in rolling out clinical directorates, particularly in Northern Ireland which is very similar to here.

We engaged with him and he was involved in the process. His role was in the change process when we had determined who the people were and they were selected by their peers and we had Business Managers in place, it was more about role clarity of different components of the Clinical Director and to give them a sounding board through the process. It was always going to be a development, that we were going to get to stage one. There were two years in stage one which was the start of clinical director and the clinical director getting comfortable in their role.

GS: How were goals and objectives achieved?

JC: Yea. We also had to modify our goals and achievements, so we had this great notion in terms of devolving budgets down. And while it has happened at this stage, at that stage it was too early. We were a little premature in terms of rolling that out in terms of expecting people to take that on that responsibility. It hadn't really in effect been devolved throughout the hospital anyway, it was centralised. It was a learning process for us as well about being too ambitious. What visiting Belfast showed us is what the future looks like, where you want to get to. We're not fully there yet, we're on the journey. The cycle is coming up again where clinical director are coming to their end terms and so forth. So you hope and plan on the basis that the next iteration of clinical director would be even more involved. I think the one thing we're struggle with throughout each of the iterations as they've gone through is to get that balance right between the expectation and level of expectation of a clinical director in comparison of what they can actually do. What I mean by that is that everybody wants them to come to every meeting and they have to be selective in what are the most important ones. We haven't managed to recruit locums. Most of them are entitled to half a locum and we haven't been successful in recruiting that half locum that would allow them to be released more in terms of their CD responsibility.

GS: Was there a particular change model or framework used?

JC: It was more incremental, so it wasn't like Kotter's. It wasn't a big burning platform in terms of change. Because of the scale of the change and the cultural change involved, it was felt that the more incremental approach was going to give us the best results. I think that's correct as I don't think its something that you can bounce people into. Cultural change of that magnitude is something that needs to be worked through. You make a change, then you make another gradual change. You get to the point where we are now. There is devolved budgets, there is responsibility, people are comfortable in that space.

GS: What was the focus of the transformation process – system/structure or cultural change?

JC: I think it's both. The easy thing to do is change the structure, in terms of just drawing up a new structure and saying that that's the new structure we're working to. The harder part is to make that work effectively, and that's where culture comes in, in terms of understanding the organisation. There's an

awful lot to be said about changing the culture or the organisation. If the organisation wasn't ready for devolved budgets, for clinical director, or staff in general, its best to recognise that and finding a way of getting them into a comfortable space.

GS: How would you judge the difference between resistance and not ready?

JC: I think clinical director themselves were very clear on that. They just didn't want to become budget holders in a declining funding situation, so everything they touched they had to answer no to. They wanted to get involved in efficiencies but not in a situation where they automatically became the gatekeeper in day one and were rejecting everything that was coming before them. That's not where they were coming from. They were coming from a very patient, centric culture where the budget will take care of itself, we need to take care of the patients, to trying to get them into a space to say, actually if you work with us and we work as a team we can do both. We can do it efficiently, but equally you can have the greatest clinical input. I think if you talk to the clinical director that's probably the biggest impact they can see. We might make a decision to crudely stop something because of a funding issue but they can make a more informed decision to allow it go ahead but what controls should be put in place in order that you can be assured that whatever spend you are talking about is appropriate and directed directly towards the patients. It works well from that point of view, I would say.

GS: Do you think that communication on goals and objectives was appropriately channelled across the organisation?

JC: I think that there is an understanding from the very start as to how difficult it is to communicate something like that and how much you have to repeat the same message again, and again, and again. That was one of the biggest learning's of the whole exercise is that you were certain because you are clear who reported to who. You come across people who say, I didn't realise that that change had occurred.

GS: What happened in those cases?

JC: I think in lots of instances it came back up to the clinical director and they identified and wanted clarity in terms of, do these people actually report to me, or how do the report to me? Then when we went to the next stage, that became very obvious because you were looking at the integration of clerical staff and you were looking at the integration of staff like the measuring technicians into the clinical directorate structure. So you had to make calls and to made calls you discovered things that were out of kilter, that this was the opportunity to correct them. To give an example, just by virtue that the individual had worked in the area, you had someone who was in charge of surgical staff but also had oncology also. And that was just because she worked in the area and held on to it. So that was an opportunity to rectify that and get them into the appropriate directorate and reporting correctly into the medical directorate.

GS: Then, were goals and objectives instructed from top down?

JC: Yea there was top down but there was also cry and need at the other level in terms of how it operated. In terms of clerical staff, yes a decision from the top but it was driven by a requirement at the coalface. Decisions were being made yet these people were saying, well I don't report to you so I'm not sure if I can carry that out. So it was the next stage in the development of CD's was the integration of clerical staff. While the direction came from the top and the requirement was indemnified at ground level, an awful amount of work went into it, a lot of communications and communication meetings, and writing to everybody, identifying that the change was about to occur. Here were the issues that people highlighted.

GS: Were staff happy with that process?

JC: I think they were in the end of the day because that's where the clarity prevailed because that's generally why it came about, and what the demand was from the bottom up. That people need clarity. If I'm the surgical director, yet I report to a different director, how do I relate to the clinical director who's saying that he wants to organise the outpatients this way or that way. It was natural after the CD's had bedded in, nursing had bedded in to it, it was natural we were going to look at other areas like clerical staff, measurement technicians and how we integrate those in.

GS: Who do you recall as being the key driver(s) of this change?

JC: I'd say Professor Graham (cardiology) was an early mover in terms of CD's. He had the concept of a Business Manager and a lead nurse in cardiology

GS: And where did he come from?

JC: I think he was just watching developments. I think CD's started in 'John Hopkins' in America, born out of budgetary requirement and involved in a budget issue. And as he got involved and began to understand what the management needed, the management also got to understand what the clinician needed and they decided to develop it. So he would have seen this, he would have had a lot of international experience. He would have seen this and been a very early supporter of CD's.

GS: Was Prof Graham on an advisory team?

JC: Yea, certainly. He was on the board as well. So certainly at a very high level he would have been in discussions with the CEO and giving his blessings, because he was very influential, to clinical directors and what they would hope to achieve.

GS: Did this organisation have an individual vision and mission to accomplish this transformation irrespective of the fact that it was a national directive?

JC: Initially under Michael Lyons he would have had a desire to move into CD's but he would have been very nervous of the concept. What would it bring? Would management lose control? We did a lot of the spade work while he was CEO in terms of looking at the different models and seeing what would be best for Tallaght, best fit size wise, St James's Hospital at ten CD's, we thought that was too many yet the HSE were thinking one. We thought that was too few. It was really when Gerry Fitzpatrick became CEO that it really got momentum. He being the clinician, he understood it. He worked with me as the architect of CD's, so he got it underway.

GS: Do you think that was related to his specific leadership quality?

JC: I think so. 1) He had really strong peer support because they liked the idea of a clinician being CEO. 2) He was very good at communicating with people, very patient in terms of working through things. He listened, remodelled the proposal, went back and listened again, remodelled it again, came up with variants. He looked at the disease model rather than the structural model. A nice balance is what we came up with is diagnostic, paediatrics, surgery and medicine. In other organisations you'd have emergency medicine, and ICU in a directorate. We felt four was a good balance in terms of a hospital of this size.

GS: Do you think that the multiple changes at CEO level, has had an impact on the change process?

JC: It obviously has in that everybody brought their own style to it and brought their own experience to it. We've had some clinicians in charge of the hospital, some lay people and people from clinical backgrounds. Everybody brought their own styles and brought what they felt was needed.

GS: Did the new CEO's introduce new a vision or strategies to the organisation?

JC: I think it was more of a natural development in that people recognised that there were very strong pillars and they had really strong support from their peers and from the organisation, that it was working so that you could tweak it but nobody had the desire to dismantle it. So it was all about improving it, so everything anybody did to it brought it on another leap and bound.

GS: Was that communicated across the organisation?

JC: Probably not always and different leaders over that timeframe had different communication strengths and weaknesses. Some leaders were very good at communicating the vision they had and how they saw it plan out and what innovations they would bring to it. Others maybe weren't as clear and that clarity maybe not have existed for everybody. I think the one lesson that everybody would say is how many times you'd have to communicate the fact, that you have to repeat the communication again and again to be able to bring people with you.

GS: Do you think if there was consistency at CEO level we would be at a different position in the process?

JC: Possibly but I think there would have need a natural development curve that is comfortable with the culture of the organisation in terms of the development of CD's. It's at a pace that people could absorb. A lot of changes occurred when CD's turned over and even though it might have been the same person coming back again, it just allowed for that natural change in emphasis or delivery in terms of how they contributed.

GS: In terms of your own experience, what are the activities and practices that can lead an organisation to successful and sustained change?

JC: I think the big one as I've said is communication. Unless you've a very clear message and people can see a benefit in it, whether it's a patient benefit, benefit for them as an individual, or an organisational benefit, they have to be able to see what the benefit is, like why are we doing this. It's about being out externally and communicating that at every opportunity, in terms of what you're trying to achieve, why it would be better this way. And it's about the influence of the leaders in the organisation, not just senior managers but leaders in the organisation that influence people, knowing who they are and getting them to buy in.

GS: What can be done to influence that?

JC: I think we have quite an effective communication strategy around it so the strategy was face to face, meeting with middle managers, staff and departments and conveying that message about we're trying to achieve. I think electronic communication, things like the electronic Q&A when it was in vogue, notice boards, communication out from management from the management team as to what they decided. There used to be pulses circulated at that time, so people had an idea of what was happening. And then the face to face of town halls all contributed to communicating what it was all about.

GS: How did you ensure the right people are in the right job with right skills and competencies at the right time?

JC: The analysis had taken place and the structural change has taken place so what you were looking for was people to walk the walk. It was about supporting people in the roles, making it clear from the clinical director, identifying quick wins in terms of what they could get immediately, painting the canvas in terms of where to go next and how they would be supported so that they wouldn't have to do everything themselves, they would have a Business Manager, a lead nurse and so forth. In the perioperative directorate a good example was identifying the transformation of theatre project and so you had the CD as sponsor, the lead nurse took the lead and delivered the project but it became a team focus in terms of delivering an efficient theatre, we brought in technology to support them in terms of picking a quick win.

That was something that galvanised the preoperative directorate, they all knew what was happening with theatre, there was good communication and they saw the leadership from the CD. It's a very tangible example, it didn't stop anybody doing anything, it was making things more efficient so people could do more. Bed protection was another one, ring fencing of beds working with the CD. The clinicians on the ground, the nurses on the ground could see this working. Management are listening to what we have to say, we're not banging our heads against a brick wall. That conduit was the clinical director who was saying, give me the beds for a certain amount of time and I'll make sure what I mean in terms of the efficiencies that we can bring to this. They introduced another project called 'admission on the day of surgery' and had a target to achieve 75% of patients to be admitted on the day of surgery, which prevented the protecting of beds because you knew you were guaranteed to get your bed for your patient. So again the clinical director was able to make the case of, trust us, give us the beds and we'll show you how to turn them over efficiently where we won't have patients in the night before or a week before an operation. It was an opportunity for the clinical director to lead, the clinicians to feed into that, to push them to meet the targets but they get the benefit of having their beds protected.

GS: Without a change model or framework, how does the organisation manage external environmental forces?

JC: I think that's learning. When they would have come first they would have looked at the HSE, not quiet in awe in the sense of being afraid them, but in awe in the sense of how can they arrive at a decision like that. The more they are involved, the more they see that you can have those external shocks that change things. Up to February/March this year you had a situation of, make sure your waiting list are on time and make sure patients are being dealt with efficiently, and keep an eye on the budget. After March that changes to keep an eye on the budget and don't overspend, then see what you can do for patients. So they see that and can make judgements and contributions to say, that's not very efficient, you think you are saving money by closing those beds, what would be more productive would be to do X or Y. It's them seeing those external shocks and it being a case where the management weren't coming to them and saying, I can't do this because the HSE said... The actually go to meaning with the HSE and see what the HSE logic is in terms of some aspect of patient care that's designed to save money or be more efficient. And they can contribute to the more efficient ones and challenge the saving money ones in terms of defending the patient.

GS: What about the external factors such as health care shortages. How do we prepare for that?

JC: Again you have the benefit of working with the clinicians very closely in terms of re-sourcing. So you hear from them from the meeting that they are having with either the national clinical director or the national leads in terms of medical manpower or nursing manpower. You hear directly from them, the opportunities that are there and also the downsides that are coming. You have a much better information stream in terms of developing work force plans.

You've much more cohesion of information and they're much more flexible.

GS: So is workforce planning practiced across the entire organisation?

JC: It is but something for the doctors and nurses, its national, cascaded down to us here in the hospital. For us to meet European working time directives, to actually change the manpower planning aspect is quite difficult because you are dealing within the parameters or framework of a national allocation of resources. That's where the challenge is that's its not responsive enough. Another example would be the Nurse Graduate Programme where it's a national initiative to save money but the reality is that we would have to recruit less experience staff from outside of the country to replace staff who have left because their salaries have been reduced.

GS: Is there anything the organisation can do within workforce planning to manage situation like that

JC: I think there are but I think the most effective way is to contribute nationally and get national policy influenced. Whether that's to suspend the nurse graduate programme for a few years and see if we can resource better without it. Or look at a better way to do medical re-sourcing. Six months and we had a changeover. In another six months we'll have another change over again. It shouldn't be beyond the bounds of possibility to make that seamless yet every organisation gets into this paralysis of changeover, yet this could be planned out on the basis for the next three years in terms of training. The best way to influence those is through national input. That input can be through my role as HR Director, feeding into the HSE. It's also very effective for clinical directors to feed into the national clinical director and seek the same thing but from a different point. You can do your own thing but not as effective as influencing national policy.

GS: It's been said that the current process of workforce planning is a little limited and mostly quantitative Do you think there is room to improve?

JC: I think there is room to improve but you can't do it in isolation. You need multi annual budgets so you can plan and say you know what my budget is going to be for the next five years, give or take one or two per cent. Then you can look at your resources and say, if that's what the budget is going to be in five years' time, here what I'm thinking about doing. You can plan on that horizon. Currently we're going from year to year. We still haven't got the service plan of the HSE and we're in July and that supposed to tell us what activity we're doing this year. We're doing all this activity this year, we don't know if we're up or down against what we should be doing and therefore very hard to plan with resources against that backdrop.

GS: So how does the organisation capture workforce knowledge and skill?

JC: I think we could do a lot better in that regard. I couldn't point to specific interventions where we're saying that exactly what we're doing. There's

probably isolated pockets of great practice that are occurring and there instanced that we could quote. But there would be isolate instances rather than any great coherent plan. Really it should be about looking at your catchment area and what are the needs and what needs are you going to satisfy in your hospital, because you can't satisfy every need. When you know what the need is and you have your service plan, you can then resource against it. And say it's going to go up 5% in cardiology in the next three years, so we're going to have to plan and resource against that. But when you have a situation with the HSE saying, this is all you are funded for, you are not to do anymore than that, yet the people are walking in the door. It's in a vacuum that you're operating in. The structure around it has to get much, much better in terms of what you're being funded for, what your being asked to do and what's going to happen the people you don't have the funds to treat.

GS: Was a workforce planning strategy developed and implemented?

JC: For the CD's?

GS: Yes

JC: It was more on an hoc but it wasn't freefall. It was planned on the basis of getting the directors in place, getting their teams in place and then about shaping the various teams in place, making sure they had a structure, making sure meeting were taking place, that all the clinicians were attending, that nursing were attending, that HR were attending. Making sure that they got the basics right and then out of getting the basics right, getting the structure right, getting their financial right, not to control their budgets but to allow the know what expenditure they have in the budget. It gave the opportunity to make choices. You're saying that I can fill that nurse's position that's fallen vacant, but what if I wanted to put in a Registrar and it cost the same, could I do that. You're giving them those decisions to make, and they're coming forward in identifying the needs.

GS: Is this an integrated process across the multi-disciplinary?

JC: When we looked at it up the North and saw down the road, they're still a good 5/6 years ahead of us in terms of their development. We now caught up. When you look at it the greatest challenge would be in the area of nursing. The nursing assistant directors would have an inclination to report into the director of nursing, whereas you asking them, yes professionally you'll still do that but you're asking them operationally to report into the clinical director. That's an area there's going to be a lot of work in, in the next iteration, firming that up and saying nursing director actually focuses more on the external, patient advocacy, patient rights, patient access, rather than running nursing. Nursing then has to turn more to the clinical director and operate on that basis.

GS: What happens when you can't fill a role?

JC: Again, there are instances where you could sight and say, actually we're very innovative around things like that where we identify and role and how we go about filling it. How to identify the individuals and how to find the best way to fill particular certain roles. There are instances where we've been very good and I think there are other instances where people aren't actually that bothered and the say, we couldn't fill that role, we couldn't get anyone, there's no one out there. In one instance which we're currently dealing with we were told that there is no one out there yet we never went out to find out is that or isn't that the case. If that is the case then we're going to have to come up with some innovation. If you take health care assistants, we train them on FETA but then we wouldn't allow them to do first vital signs. Now we are. That was leadership or lack of leadership that we train these people yet we were willing to let them go. You have that generally in the health sector where I want to take on a worker of higher value and increase my potential and skills, but I don't want to leave anything behind because I don't believe those people are capable of taking on those roles. That would be across the board no matter what disciplines you look at, from medical, to nursing, to health care assistants. When you look at it in hospitals where it worked really well, it was multi-disciplinary approach. And you see it here as well but when you see it working well, everyone is a valued member of the team whether you're a health care assistant or a consultant. That's the measurement of success with CD's, when you get to that point.

GS: Hospital Groups are on the horizon for the health service. What can we learn from our current change process that would benefit the hospital going forward with the hospital group model?

JC: I think they have learned because they are going to have a lead clinical director, so they've learned the value of having lead clinicians at the table in terms of where the most senior decisions are made and the input they can have. Its inclusiveness in terms of having as many people as possible having an input into what's the best design and the best structure in terms of CD's. I think that in itself is a sign of maturity that we've learned, that it's going to be built by people with varying inputs. That's the first thing and the second thing is around the financials, there's always going to be a challenge in the financials. There's more capacity for more efficiency but its back to leadership. We need to lead out and say we can reach better outcomes for patients with a bit more efficiency. We lost out about ten years in technological terms by not embracing technology in health care. Embracing technology and supporting CD's will advance it even further within that parameter of restricted budgets. There's still €13 billion being spent in health, so it's a lot of money.

GS: Is there anything else you would like to add?

JC: No

GS: Thank you JC. That concludes the interview

Interview Four

Interviewee 4: BC

Employee Level: Assistant Director of Nursing

GS: Briefly bring me through your role and responsibilities

BC: Ok, so I'm an Assistant Director of Nursing and so my responsibility is the management of the services that I am assigned too. So I would be looking after nursing service so as part of a role it does extend out further than that, it looks at processes, process improvement. The role I believe is very wide and broad so you look at staffing levels you're looking at rosters, you're looking at disciplinary actions, you look at education and professional development of staff, management of nursing complements within the various areas, so that would be a brief taste. Then during the day we deal with complaints, you deal with conflict resolution and then any other issues that arise as part of the service you deal with so literally the ward area I look after would be the Dayward, Pre-assessment, Endoscopy, Endoscopy Pre assessment GU OPD, Adult OPD, Colposcopy, Lynn Ward, Gogarty Ward and Lane Ward.

GS: So would you say that change management and change practices are a large part of that role?

BC: They are, they should be a large part of the role but what I would actually say based on, on I think the wider remit that you have and the other things that keep being pushed upon you, I'm not sure you get a huge of time to actually focus on you know the changes and looking at process as you actually would like to.

GS: When the hospital implemented its own change process into the clinical directorate model what were the significant changes for you?

BC: Well if I was to be honest then did the hospital introduce the change as to how they introduced it and how successfully that a different debate for another conversation so it was announced that there was going to be changes in the directorate model and certainly at the beginning although we were told that things would be pushed through the directorate in practice it didn't work like that and also the senior managers and senior exec's still encouraged various fractions to go to them with their various problems instead of going through the directorate model which would be a clinical directorate your Business Manager your Lead Nurse Manager /Lead ADON so any issues that I would have instead of going probably going to the Director of Nursing directly I would actually I would try to go to the Lead ADON and sometimes

you know you would still end up having to bring the Director of Nursing into it and I definitely feel that a lot of the doctors still went to the CEO to try to push through their interests if they weren't getting what they wanted through the directorate.

GS: Do you recall if a change management process was followed?

BC: I don't really, I didn't feel so, I feel it was just announced by the organisation and I certainly don't feel that people on the ground were prepared or fully aware of the roles

GS: How was it communicated?

BC: I think it was more a directive. I don't think there was enough selling of it, to get buy in from you know the people on the floor who really you know, I don't think so.

GS: How do you think goals and objectives were set and achieved?

BC: Well I don't think they were achieved and I still think if I was to say now are clinical directorates working effectively, I would have to say no, not in the manner which they're intended to do. We have it in name but we try to actually push things through the directorate but there is still a bit of the two tier system going on of you know direct going into the CEO by various fractions. Now I think from the nursing point of view and this is just my feeling on it, from a nursing perspective you really try to push things through your directorate so I would go to my lead ADON with issues and I keep my director of nursing informed but I really would be actually trying to push it through the directorate. I don't feel and this is no criticism of the people in place it is done with constraints. I don't feel there is enough, I don't feel that it has gelled, I don't think there is enough communication in the directorate, I don't think there is enough formal meetings within the directorate, you know for the key people involved. And when they do happen that sometimes the clinical director is standing up and he is a very nice man but he's standing up there and we are all just sitting there as if we are in a classroom as if we are told what's what. I don't feel there is enough two way communication there regarding the directorate.

GS: Do you recall the use of a particular change model or framework?

BC: No we were just told I think it was at one of the town hall meetings that there is going to be that directorates were going to be introduced on a specific date, interviews happened for the clinical director and then I think the lead ADONs, the first set of lead ADONs were selected by the Director of Nursing and the Business Managers then I believe were nominated. So it was

all you know driven from probably the senior exec to the way that they actually wanted it introduced and an idea was put up you know, a presentation was given how they thought it would work and that was literally about it and people were just left to get on with it and run with it.

GS: What was the focus of the transformation more structural / systems based?

BC: Yea, on the floor. Besides it would affect me you know for my nurses, they don't really, they feel it doesn't really change anything for them once they can come to me with their issues, that I will obviously escalate on up through the directorate. For them it doesn't make a huge difference compared to how I know it works in order organisations, where there is much more communication between the business managers and let's say the CNM's where they would have monthly meetings going through spend etc. so I don't I personally don't believe that that level of work went into it. And I know there are a lot of hospitals the same where there was just an announcement of structural change as opposed to really bringing in the change in a proper manner and that's just a personal opinion.

GS: How was feedback on the process managed at senior level?

BC: Well there was no change management team. It was literally the directors were just there and they actually arrived so if anyone had issues from the nursing service I would actually direct them on up, if I couldn't actually deal with them I would tell them I will bring them to the directorate meetings or to my lead ADON and try and get resolution or some kind of problem solving way in that particular instance but other than that no there wasn't anybody, any team that I saw that actually assisted the smooth transition of this major change.

GS: Who do you recall as being the key driver(s) of this change?

BC: From CEO level and executive management team that was the key player really and probably from you know a bigger level from that it was something that the HSE wanted in Hospitals and other organisations so obviously it was coming from that as well and it was something that was perceived as something that we had to move and to change along with what the HSE.

GS Was there leadership providing a vision or strategy for the change?

BC: I don't think so.

GS: Even at your level?

BC: Well at that level and you know that was a number of years ago that this started, so I am trying to remember. I would say that the Director of Nursing would have been positive about it and would have tried to sell it as something that really was going to work that was going to you know bring positive things for us and obviously I read it about myself so I know what should happen and it should be devolved you know responsibilities in all of that so certainly in the early stages we just didn't see that. No I probably think in the last year or two that there probably is more of an understanding around the whole structure but certainly at the beginning part I really feel that it was a bit chaotic really.

GS: Do you think the multiple changes at CEO level have had an impact on the change process?

BC: Yes probably has because definitely there was a lot of unrest in the organisation and people didn't really know who was coming or going next. Even as well trying to make the system work because you are thinking that the next guy is going to change this completely so why are we wasting our time trying to put structures in place.

GS: When say that new roles were identified as part of the new structure. How did the organisation decide on the right people for those roles?

BC: Well to be honest for the first set of people that I'm aware of there were people just nominated into posts so there wasn't an interview process that I was aware of. For the Clinical Directors yes there was an interview process. For the Lead ADON's the first set and this is not a criticism of anyone, I'm just telling it how it was, for the first set of the Lead ADON's they were nominated into post. As far as I'm aware that Business Managers were nominated into post. So there wasn't any recruitment process around that.

GS: Do you recall an organisation wide workforce planning strategy?

BC: No. Not that I am aware of. Also even as well the configuration of the directorates themselves, it was a matter of trying to put areas into the correct one because you only had your four directorates. So there was the matter of trying to push and shove to see what area was going to be in what specific directorate and then there is always the conflict that goes with the medical directorate thinks it's bigger than the surgical directorate and who's going to be in what directorate. For myself for a while I actually had areas between both directorates so I was trying to go medical and surgical directorate meetings and it was a bit disjointed.

GS: How was conflict dealt with?

BC: For my specific issue then the nursing responsibility changed so most of my areas ended up in the surgical directorate so i would literally feed into the surgical directorate at the moment. So for the others ones, there are still some areas that are unclear, I'll give you an example; Outpatients as far as I'm aware it sits in the surgical directorate but even the other day when I was trying to get stuff signed off and I was going to go to the clinical director but I was told that no that actually doesn't fit under them as surgical director it's really the COO who is going to sign that off and yet here I am as senior nurse manager and even at that I was under the misapprehension it was actually clearly under the directorate. I still think that it is not yet clear. I think for some of the ward areas if you are medical or surgical wards it is very very clear but in some other areas there is still a little bit of uncertainty regarding pushing stuff through.

GS: From your own experiences then what are the key activities or practices that can lead an organisation to successful and sustained change?

BC: I think you really need to be prepared for the change. I think a lot of work needs to go into the introduction part of the change, that there is really a clear knowledge of the directorates and how they were going to work. I think transparency regarding who gets these particular roles that there is a clear interview process, competition process and that people feel that the right people are actually in the job. I really think that is key because otherwise they just think this is just 'jobs for the boys'.

GS: How does the organisation prepare for impacts from external factors?

BC: I think that we really need to think outside of what we are doing at the moment. In areas where clinical directorates are successful and to look to see how are they managing the communication part right down to the various levels. Here at clinical directorate or Business Manager and ADON level they are working ok but then to get the information down regarding budgeting responsibilities, strategy all of that kind of stuff, to make sure that we are actually striving to get everybody involved. We are doing more in recent times so from my experiences more CNM's being invited into the directorate meetings but are directorate meetings only happen every three or four months. So that is not a lot when there is so much happening in the organisation all the time.

GS: Can this breakdown in communication be escalated?

BC: You would say it informally but to be honest, I don't know is it because people are under so much pressure and workload but it is not happening. I have said it before and it is not happening.

GS: Nothing is actioned?

BC: It's not that nothing is actioned. They are so busy trying to actually manage the business of the day. I also feel the whole it is the way the structure is organised. From my understanding of a successful directorates and you look at John Hopkins Hospital and all those places, the clinical directors are actually 0.5 doing their clinical work and 0.5 doing the directorate work and certainly in my experience in our current directorates our clinical director is doing full time clinical work and he is trying to fit the CD work around that. In my opinion that just doesn't work.

GS: So in summary are you saying that the organisation has failed to allocate sufficient resources for this new structure.

BC: Yes I think so.

GS: How do you ensure that the right people are in the right job with the right skills and competencies at the right time?

BC: What I would always do is to go through our MAP process here, identify when I have a vacancy and then I would for the most part. I would always try to have an internal competition be it internal or external depending on what is required at the moment and depending on the moratorium. In some instances if it's a very short project and I have a suitable candidate that has expressed an interest in that. I'm thinking of a project that I have on-going at the moment with external funding but the funding is only until the end of the year if I was to go through the whole interview process I actually wouldn't get somebody in it in time because by that time the project would be finished. So in that instance I have actually nominated somebody myself in that particular instance. That is only because it is a short term project. For anything that is going to be long term vacancies substantive post I would always internal competition and an advert to make sure it is transparent and that you are actually picking from the pool of people to give you the best candidate to actually manage the job.

GS: What happens when you can't fill a role?

BC: So if I can't fill a role depending on the role that it actually is I certainly wouldn't just appoint somebody because I have nobody else. I think that's the worst thing that you could actually do and I have historical problems that I'm dealing in areas where people were just put in because there was nobody else. So I would prefer to leave a post vacant or somebody covering acting capacity that knowingly put in the wrong person.

GS: What's the consequence for the area if there is an unfilled vacancy?

BC: Well if it's a key person in the area that's a big problem because if you don't have the right person managing and making sure that targets and standards have been met, there is serious consequences for the organisation.

GS: Is this escalated to senior management?

BC: Yes, it would be at all our meetings. For example with the moratoriums sometimes we were actually asked just to advertise internally but if I don't get the right candidate then I would go back to say I have tried this we need to widen the pool, we need to actually get an external ad in so we get a wider pool of talent.

GS: Do you think there are other practices or activities that we could be brought into the process that would improve it?

BC: Do you mean coaching and mentoring someone or like if you had somebody who could do every effort to actually recruit and you can't. Then you have somebody who's maybe nearly there and with a level of support and coaching and monitoring that they might actually reach the standard that we require. Certainly I would consider trying that but what I am very worried about at the moment is I just think that people are just what staff are saying to me that they are barely surviving on a day to day basis and so therefore even if with the best will in the world if you don't have the time to be mentoring somebody and monitoring them then they'll actually slip through they'll past probation and you'll have the wrong person in post.

GS: Do you know of an organisation wise work force planning strategy?

BC: We do have a lead in work force planning at the moment so they will be assisting us looking at the numbers of competent staff but also would ask sometimes would ask for review regarding the nursing staffing level because the levels maybe historical and the needs of the service have grown so much that it's not fit for purpose any more so certainly i would put in a request then to say could I have department x could they actually have a work force planning review based on the numbers they currently have, their activity, their acuity and to have a look at it to see what our staffing are actually like.

GS: Do you recall if there was such a strategy in the initial stages of the transformation process?

BC: No. As far as I'm aware not in the initial parts of the clinical directorate.

GS: Do you think that was a breakdown of process?

BC: I think it was a breakdown of process but I think at that particular time I personally believe it wasn't one of the key roles that they were actually looking at. I think what they were looking at the moment for the directorates were at control and probably from a budgetary point of view to kinda do a cost containment I think that was probably the key driver behind the introduction of the clinical directorates.

GS: You mentioned the MAP process and the work force planning that is evident across nursing, do you it is a limited process?

BC: Yes, I do. I think that it's very constricted. I think the whole form filling part of it you don't always get to out in the level of detail you require and now there are pre MAP meetings and I would always put in my submissions to the pre MAP group highlighting in the specific area why a particular post needs to be filled. It is very constricted so for example in the area that I am looking for a scanning nurse and because back in the past they could only get someone who could do 29 hours but really you do need someone there for the full service. It's very difficult and it's literally put in your MAP and you hope you'll get a replacement like with like so that if you have a staff nurse resigning you will be allowed to get replacement. Up until recent times everything was being turned down anyway. I find sometimes I'm not sure that the key people are there around the table when they are discussing it I'm just wondering is there any forum that the person who is put in for the job is there to answer the specific questions regarding why they need that particular post filled.

GS: Like with like?

BC: I even mean the number of hours, that literally even things like the way the blanket thing so you put in for maternity leave and it's across the board 0.5 that is replaced except of course in very specific high level offices. Other than that it's just a 0.5 and you are supposed to try and run a service with key people, less hours and still provide 24/7 cover. It just becomes impossible.

GS: The original reason why hospital structures changed into clinical directorates was due to budget constraints. Do you think the new structure has helped the hospital's financial situation?

BC: No I think the MAP is something that is probably driven from the senior management office. You do have your representation there at the pre MAP meeting where you would have the two lead ADON's and you would have the director of nursing and somebody from HR your HR Business Manager and they are supposed to get effectively they would be representing you/me in that meeting as to why I need a particular post filled and then it goes onto another meeting. Actually that's not going through a directorate process that's going through a central MAP committee it's not integrated with the directorates.

GS: Does the organisation capture workforce knowledge and skill?

BC: No, because we are just blankly looking at numbers and vacancies that we have. If you look at any of the stats we use it's our starters and our leavers and nobody is talking about the experience in these. Also it's a very crude way and some of it is external forces such as the moratorium for example in OPD where I would have had a high level of retirements and I haven't been able to replace those staff nurses. I have literally almost lost 50% of the staffing and yet I'm supposed to run clinics now I can't there's a lot of clinics were left without nurses and there are a lot of complaints from the consultants. There is nothing I can do about that. What happens then is certain areas get hit harder than others, there's not an actual focus on where is the level of need how can you share the pain if you want to say it that way and level it out a little bit. You could have some departments being totally annihilated and other departments are not too bad.

GS: Is this recognised at senior level?

BC: Yes it is recognised and it's constantly said but in that example I gave you because of the OPD is not a 24/7 care, what's required the wards do get. From my experience of trying to work with work force planning issues that they would have to staff them first and in certain clinics I would identify that were not going to have a nurse. In that instance we would try to look at work force planning issue and looking at the role of the health care system can that be expanded. Our problem is with our head count and numbers there's restrictions on that. But through the directorate model although you will highlight that through the directorate I feel that if some of it is a financial control there is very little they can actually do. What they would say to me is identify other areas that maybe I could freeze a post in one post send it to another but its very difficult to do that, everybody has a role you usually not

in post unless its require we would look at that but you wouldn't have any areas that you can just freeze.

GS: Are you aware even across other areas of the organisation, where they are capturing workforce knowledge and skill? For example exit questionnaires.

BC: If someone resigns actually it's not for any other they get an exit questionnaire and I would always speak to the staff and I have a resignation of asking them why they are leaving and to see if there is anything I can do if it's an issue maybe with hours. With leave they are looking for example parental leave which is a big issue because we have nurses who would like to take more parental leave than we can give them, we can't accommodate them. Now I know you have to give parental leave but only have to give it as a block where as we have staff who would like it flexible for example one day a week. This time because of the staffing levels I couldn't give that and yet we have staff that would leave as a result of that because you can't give the parental leave. At my level I would identify with some of own in formal exit meetings and I have escalated that further. Interestingly enough through the directorate who didn't have the power and then through the CEO but they felt that that was not something they could assist us with.

GS: Would you say then that the process is quite limited and restrictive?

BC: I think everything gets blamed on the economic downturn and the moratorium all of that gets blamed and were not looking at that I'm aware off even though those exit interviews happened both informally with myself and I know the director of nursing does send out a questionnaire, I'm not sure where we correlate all that information and feed it back, I'm not sure that it does. You would have an incident like the odd time I do recall where there might be a lot of resignations for a particular area and that might be questioned by the director of nursing to see if there's a specific problem with management in a specific area. As a formal report and looking at that data I don't have a recollection of that happening.

GS: Have you received any training or development in workforce planning?

BC: I suppose in management courses that I would have done myself, yes I would have received training. It would just be management courses that I would have done myself previous to this. But I know we have the work force planning at the moment and we do have good trackers and all that but regards that information and I know at the moment the work force planner is trying to get a detailed level of seniority of staff and qualifications and experience.

That information is being inputted at the moment but its not complete at this time. That's to the nursing service I'm talking about.

GS: Is the ability to train and develop staff to increase their skill and competencies a priority for the organisation?

BC: I think it's there as an aspirational thing and I think lip service would be paid to it but when it comes to putting in the resources to give somebody the training I'm not sure we do that. We are very good for providing study days with staff and were getting better at the funding because we've had more excess to funding for masters etc. For real life experience for mentoring people for releasing them to go for further education, although we want to do it we can't at the moment because it's very difficult to release staff to facilitate that.

GS: Does the hospital in any way recognise the fact that employees have further developed themselves, is it taken on board at a local level or within the directorate?

BC: Depending on it, for example we would have a lot of people who have done their Masters and are going for ANP roles, so yes I think so that sometimes you would try work closely with the staff to make sure the further education that we are supporting and that their aspirational to do is relevant to their particular area. You would like me lot of people at the moment that I am supporting through screening programs, for masters with a view to ANP, for people who are now successful ANPs because they have gone through the whole educational process. There is a big part working really well and I think our nurse practice development department is a huge assistance to that as regards the staff.

GS: Do the staff see the benefit of furthering themselves?

BC: I do think they do because certainly both, for themselves the promotional posts and for education regarding their own role, we would have a lot of people who would have done further education in tissue wound care and they are using that in their roles.

GS: Are you aware apart from nursing are you aware of health care shortages across the organisation?

BC: Yes I would be aware. I would hear that at the directorate meetings particularly medical cover, shortages in clerical, medical teams complaining that they don't have enough on their team to provide full cover and on call service.

GS: How is it being tackled?

BC: Yes, I would hear them try to put forward business cases to resolve that. Looking at the rosters to see how can they make it more effective and to get the doctors to start on time and finish on time. Sometimes with the doctors if they still have jobs to do they will try to stay to finish those as oppose to passing them onto the next team. A lot of shortages in the clerical which has a big impact and I think that's not often recognised that if you don't have clerical the impact it's going to have all across the service.

GS: Are there motivators or incentives?

BC: We would feed them back to our clinical director and senior team within directorate to bring forward to the executive management team and you would put it on the risk register if it's something you have identified and gone forward and if we're not getting a resolution we would put it on the risk register as well.

GS: Is that integrated back into the nursing workforce plan?

BC: I don't think so.

GS: More changes on the horizon in the form of hospital groups. What can we learn from our current change process that would benefit the hospital going forward with this model?

BC: They really need to have a huge amount of education coming out talking about the groups, how they are going to be structured. The vision for the way the communication system is going to work and I think communication they will need to hone in on that very clearly how the lines of responsibility and accountability are going to feedback up to the directorate to make sure that we are very clear about the service we are providing. Who we go to when we have problems and issues? Not even that just from a strategic point of view so hospitals know who they are supposed to be servicing and their plan. Instead what we have at the moment is we'll take every single service under the sun instead of looking strategically to see that service would be better able to be provided in x hospital and try and divide the work load more clearly than what we are doing at the moment.

GS: Over all do you think we have led a successful transformation process?

BC: I would have to say no. Once again this is not meant to be critical for anybody it's just I really feel that the whole vision and the whole way how directorates could be working and should be working hasn't really worked for us and I think as well that if they had at some of those town hall meetings or communications about it, if they had people from other areas to talk how they managed the change what the key for them making it successful.

GS: Is there anything else you would like to add?

BC: No, thanks

GS: Thank you BC. That concludes the interview

Interview Five

Interviewee 5: AM

Employee Level: HR Manager

GS: Could you briefly bring me through your role and responsibilities?

AM: My role at the moment is I'm Human Resources Manager working in the area of organisational development. This involves projects that are designed to improve the organisations effectiveness and is concerned with issues that affect the whole organisation as opposed the individual. Currently I have five areas which I am working on. One is the SAP organisational management piece which is concerned with the organisations design. The second one is a building resilience program which is focusing on staff wellbeing and initiatives to improve the same. The next area I'm looking at is leadership development and that is at many levels I'm designing a bespoke executive management team leadership program with the Royal College of Surgeons. I'm also looking at how we can introduce leadership training at the middle management level and I'm also engaged with the program with the RCSI where six staff members are participating in a Masters in Leadership and six more students are coming on this September. I'm also involved in the development of a creativity and innovation program at Tallaght hospital which is linked to the Innovation Academy that's attached to Trinity College Dublin. We're hoping to open a branch of that innovation centre here which will be the first innovation centre in health care facility in Ireland. They are my current areas of interest.

GS: Would you say change management is a large part of that role?

AM: Yes. Change management in my previous role as a HR Manager working in operations I would have been involved in change at the front line and a lot of that would have been looking at ways that work was organised. An example I would give there would be in the clerical service area we would have a team structure where you'd have four or five staff members designated to one discipline. There was very much a culture of empire building in that consultants would lobby for resources for their discipline. As the down turn started and resources began to deplete there wasn't a culture readiness to release people from one team to another so you could have two teams working side by side, one would be fully staffed with five and then there could be a team of five with two vacant posts where there would be three and logic would take one person would transfer over to redistribute but in practice there was resistance to this. Instead people tried to hoard and hold onto their resources rather than think of the organisational level. That in a way was a reaction to the downturn and things have improved and haven't improved since that time which would have been a few years ago probably around

2008/09. That was my involvement in change at a personal level and trying to make changes in response to organisational requirements.

GS: When the hospital implemented its own change process the clinical directorate model, what were the significant changes for you?

Not significant at that point in time because the HR Manager role was really a reactive role in that it was reacting to systems rather than leading or changing the systems. That was my experience at that time and the introduction of clinical directorates was something that was happening at senior level. A lot of talks and discussions and we weren't all together involved in it really at that stage and time when I was working in operations. You knew something was going on, you were aware of it. You knew about the clinician and management program and you understood what it meant but it hadn't actually happened. It wasn't until 2008 when the consultant contract came in to being, that was the document to realise the transience to clinician of management, it brought in the clinical director role.

GS: Did the process change then within those two years?

AM: Not that I am aware off. My early recollection of it would have been around 2006 and there was a lot of discussion around it. I remember over hearing talk about clinician management.

GS: Was there formal communication?

AM: Not that I recall. It was just conversations I was aware off as opposed to there being an informed communication strategy around it. It was more hearing about different views and models of clinical directorates. Should we have one clinical director sitting on the management team or should we have many. There was also politics at play I think that there was a certain amount of post approved by the HSE and there was a view taken locally that perhaps there should be more. So there was a lead clinical director then there was going to be a few clinical directors, lots of talk around what way should it look. It was more by hearing these conversations by accident as opposed to it have been, I think it was an emergent change if I were to look back at it now. At the time it wasn't a plan change it was more of an emergent change. There wasn't a formal structure around it.

GS: If though you feel it was not planned do you think the hospital dealt with it in a more emergent way?

AM: Yes, and reactive so there was talk about in 2006 then when the consultant contract came out in 2008 it gathered momentum so it was involving

emergent change as opposed to us been driving it locally. How are we going to implement locally what was coming out nationally and how that was happening? So I would say it happened incrementally and emergent as opposed to structured something were driving. But that changed a bit as the years and momentum gathered it began to have more of a plan around it.

GS: Do you recall the use of a specific model or framework?

AM: This is hearsay because I never saw a document that outlined a project initiation document that was followed, there may be one but I never saw it, it never came to my level. It could have been available at a more senior level but I do believe at one of the CEOs at the time I heard was using the Kotter model. Having said that while there was no model used, all the models are very similar. I would say I saw elements of all the models happening at different times like communication phases, but was there a stage plan was there stage driver? I don't think so but then again there may have been. If there was one we weren't made aware of it. We could have been subject to it but not aware of it.

GS: Considering the level of change that was initiated, do you think it was strange that HR Management were not aware of a model or framework?

AM: I think what could have been key really that we were at the behest of whatever leadership was in place at the time so there was so many changes in leadership. We had five or six CEOs one after the other each at different times so to a certain extent each of those people would of had a different view on what clinical directorate were and what they should look like. I'd say that impinged any formalised planning and implementation of any planning in any way. I know that one CEO had specialist interest in clinical directorates. It was the subject matter of her thesis of her own education achievements and when that person arrived definitely there seemed to be a whole drive towards imbedding, restructuring and aligning and I would say at that stage we were probably at the real implementation of work that had been on going over five/six period. One CEO definitely did make a difference there. I would nearly say it was the implementation phase happened during that CEO-ship.

GS: Do you recall the focus of the transformation process – structural /systems or cultural?

AM: I think in the initial stages that in some ways clinicians in management suggests that the clinicians in management are there for management alongside clinical ability but people in general coming into those roles if they haven't been through formal management training you are asking somebody to perform a role that their background there not a specialist yet. In initial stages the whole driver was to bring clinicians to the table but clinicians were there in mostly a clinician capacity. They were explaining at the table the input from the clinician side but I think now it's moving on more so, its

evolving towards clinicians are now acquiring and becoming moving into the field of management. They are adopting and evolving into that so I think there was two rounds of clinical directors here at the hospital. The first time they were there in one capacity, clinicians at the table with managers and the second time I see it evolving into clinicians actually getting into relevant management personally themselves though I would suggest that at sometimes they would dual hat and it can be a conflict of interest for them in that role.

GA: How do you think the goals and objectives of this process were set and achieved?

AM: They were achieved incrementally. I think it has got there and I think there is more work to be done.

GS: Who do you think established them?

AM: Different CEOs. I think the barrier here is the best practice would say that you have a change model, you have a plan, you've a project team and you implement. What stopped that happening here is the changes in leadership back to back. No one stayed long enough to put all those mechanisms in place that you normally would. So you had somebody picking up the legacy of the second person. This is why it happened that way. I would say all elements of all change, the communications piece the engagement stakeholders piece all those pieces happened at various times in various ways under various CEOs. So I would say change management processes occurred but I would say it was haphazard and probably slower than it could have been if one CEO, with one plan, with one vision that was articulated and implemented in sequential way. There would have been resistance to change along the way and there would have been management of that but again it was nearly like if you were to stand over it all and look back at it over the six years, yes we do have clinical directorates here now, but it happened in a roundabout backwards and forwards way.

GS: Were you aware of different steps or stages along this process?

AM: I was aware of different steps for example in HR, we configured our HR information system into clinical directorates but that took a lot of work and there was disincentives in some areas where this happened under realm of one particular CEO and there wouldn't have been an agreement about where there was outliers where there was a certain groups of people that didn't fall in anywhere and they tend to left to one side. That caused confusion in the system. I think that reporting relationships changed in certain cases and there was resistance to that in some cases. I think was managed but has it ever been followed through, I'd say there probably still areas where we need to work on where change did happen, clinical directorates did come in, HR were engaged in the point of view of designing the system. I think we have brought in the business partners who support the clinical directorate model that's changed as well, the structure has been redesigned in house to support that. The way we

communicate has changed. We had the portfolio director structure so you had the structure where you would communicate via the management team as it was now it's the executive management team. So again different people are at the table and I do think in some ways I would say the communications have probably disappointed a little because people are not quite as certain how to negotiate the system as they were in the old structure. I think there has been an unsettling in the organisation as a result of it. Probably part of the change process and probably part of the normal in a way but how to get things done isn't as clear as it used to be, people are uncertain in the directorate structure.

GS: It has been said that for some employees there has been no change or that it hasn't really affected them or they are not fully aware of it? What do you think about that as an employee of the hospital?

AM: I think it's good and it's bad. It's good in that it shows on some level there isn't an unsettling of the organisation. I think where it does make a difference is at line manager level and supervisory level. Where the clinical directorates come into its own is that an example I gave before was clerical services, they sat as a group together under the medical director but the medical director at the time would have also had a clinical work load and also looked after consultants and doctors so he had an extremely broad remit. When they want to engage or lobby or look for resources their voice was limited now they're divided out into the directorates. If they have an issue it's within the directorate and they have key people, they have a team at the top they have a Business Manager, a HR Business Partner and a lead clinician and a lead clinical director that they can bring their issues so they have a greater chance of getting to the top more quickly rather than they say across the organisation come under one area in a limited capacity because of time. I don't think the clinical directorate structure in that way probably means more to line managers than to a grade three in health records or a grade four in clerical services or someone on the health desk in IT or someone at a grade four level within HR.

GS: Do you think that's natural or do you think it's the result of bad change process being followed?

AM: I think that communication is key to successful change projects and if people don't know something has changed well then the change hasn't occurred from their lens so it's a very obvious one but it's one that's always missed and it's one of the key reasons change programs fail. But does that create three or four grade person do their work less effectively because of it, possibly not so I do think that stability in organisational stability is key and everybody understanding their role, the strategy of why we're here, their purpose, the values of the organisation and that they're shared and held intensely. From a change perspective if everybody in the organisation isn't aware of their role within it and how they contribute to it I think that's a weakness. But do they come in and not do their work effectively on a daily basis? I would probably say not. So you have two answers there in a way.

GS: The original reason why hospital structures changed into clinical directorates was due to budget constraints. Do you think the new structure has helped the hospital's financial situation?

AM: Yes. I think they have the potential to make a huge difference. At the end of the day the consultant is the person that drives a lot of the costs in the organisation through their choices. It can be a simple choice before if they cancelled a clinic for a reason they had no awareness of the impact from cost perspective of the cost to the organisation of the point of view of rescheduling time. If theatres aren't productive if somebody doesn't turn up on the day to attend a list the impact there, the cost there. There was this gap completely where clinicians focused on health outcomes which is the right way to have them but there's also a cost associated with that and I think its improved things from the perspective that there were costs they still might make the same decision but they are aware the cost. There is a limitation to the cost. No longer is the day where every September organisations run out of money and they apply to the department of health and got a top up, those days are gone. So in that context I do think it makes a difference but ultimately they put the patient first and that's right but they have awareness now of the decisions that they make that maybe there is less waste and its empowering from that way.

GS: Considering this skill gap, do you recall if appropriate training and development was provided?

AM: There was training provided. I couldn't comment on whether it was appropriate or not because I didn't participate but they did attend training in Northern Ireland, the first round of clinical directorates I don't know if it was subsequently, but there was training in the North. Again how the sense of it was or valuable it was they would have to comment but I would say they are learning by experience because no matter what theoretically you learn its only when you go and do the job that you start to learn how to do and what works and what doesn't. I'm also seeing as well that there wasn't an awful lot available the fact that the first clinical directors had to go to the North, there wasn't a lot available in Ireland for them to go to for that kind of role. I noticed recently that the health management institute have a clinical director training program on their website so the health care educational providers are identifying this gap and putting in training programs.

GS: Do you know if any of the hospital's employees are involved in this?

AM: I don't know but I actually plan because it falls within my remit in some way with this executive programme. I will engage with the HTMI as part of working with the RCSI to see if there is any value in that programme as well and/or. What we are doing locally is having a look at the skills and competencies of the executive management team and then seeing what the gaps are, and then trying to put in modular-based interventions that will fit around their schedule.

GS: How did the organisation ensure the appropriate and sufficient resources to carry out the change process?

AM: Several things happened. We had a critical incident here at the hospital following which there were major reviews done. There was an enquiry, there was also a turnaround report done on the hospital by one of the big four consultancies and we also had HIQA here at the time so there was a major review going on simultaneously and one of the major outcomes of that review was the recommendation to establish the performance planning unit. This was really where the planning was meant to line with it. We brought in a senior executive from the HSE who had headed up the forms and planning units there so the person with the right skills was brought in to lead this and a complete focus was put on process improvement. Also there was a consultant hired to look at the health stat and the key performance indicators of the hospital. So there was planning.

GS: Do you think that was more in response to that situation?

AM: This would have worked hand in hand with clinical directorates. Clinical directorates itself to my knowledge there was no team assigned around a table to bring in the clinical directorates. As part of the reviews that took place they identified the structure needed to be reviewed. One of the consultancies did a whole anagram of the whole hospital and came back with that. There were several different avenues saying the hospital needed to transform- not all of it was linked to clinical directorates. Change was needed in all realms. That is what they said. Clinical directorates were the structural piece and that came at conditions and management so I think the focus wasn't all on the clinical directorates. It was about hospital performance, it was about safety and it was about standards. It was about processes. So the transformation in one sense was that the clinical directorates were just one piece of a bigger story and a framework that the change could be made through.

GS: What are the key activities and practices that the organisation undertakes to ensure that there is sufficient resources in the organisation?

AM: That's a huge challenge we have. There is a staff ceiling and there is an obligation to continually reduce staff numbers while maintaining the same level of services. So what the HSE are looking for is for people to constantly review their work practices and reduce the amount of time or improve the way we do the work so that we can cope with less people doing the same level of service. This is a challenge to say the least. We also are at the mercy of skills deficits. Doctors are qualifying and leaving the country and that is a serious threat to the future because if we don't have clinician to lead clinics in specialist areas we will not be able to deliver health care safely in the future at all. That is a huge risk.

GS: Do you know how the hospital is tackling that?

AM: The hospital isn't really tackling that personally. That would be more national problem than a hospital problem. We have recruited abroad to seek specialist skills and will continue to do that which is what happened back in the 90s when we had skill shortages? The hospital will do what it can to try and attract people to work here but it's a national issue the whole skill? And again we can only just really try and fill the post the best way we can. Internally, we don't have internal talent management or succession planning program except for the masters in Leadership which is limited to six places a year and that is some attempt to develop leaders for the future but its small in scale when you look at 3,000 people. Then there's the union aspect, the talent management succession planning there's risks or the unions will be very nervous about this because first of all you have to be fair to people and if they're going to be limited opportunities in certain categories of staff by a certain network of talent management succession planning you don't want to be creating exploitations where there may not be promotional opportunities. The other side of it is that when it comes to competitions if you have a talent management program and if people are participating in it and others were excluded from it and then there's a competition you are creating the basis for a challenge to a competition in that somebody was given a benefit over another and maybe an unfair advantage over other people at a competition so it's a loaded one from a trade union cultural perspective but at the same time if people want to develop we might have to offer a voluntary program and see if everybody has access to it then it's the people who take up on it. My concern is that were creating expectations. In the private sector if somebody performs or goes the extra mile you have the facility to reward that person, you don't have that here. Were limited in what we can do.

GS: Are you aware of workforce planning practices in other areas of the hospital?

AM: I know there is a huge amount of work being done in the nursing area in relation to work force planning and up skilling. I'm not privy to what's going on specifically compare to myself, I will find out more about it.

GS: Is that just associated with nursing alone?

AM: Yes it is.

GS: It's not integrated?

AM: It's not and it should be really because again we have to look at the transferability of skills. For example in Dietetics there is a task that could be performed as part of nurse registration that nurses are resisting and dietetics wants it to happen so there still is a resistance to skill transferability.

GS: Why do you think that is?

AM: Cultural, sometimes.

GS: Do you think that if the right communication was there from the beginning there would still be resistance like that?

AM: You need to engage in your stakeholders. You need to identify the people that have either something to win or to lose from a change. That's where you start because they're the people that are going to be best of interest. Though people do say there on the? Of either end of the spectrum and the majority of people are in the middle and that where you should target your effort is go with the majority. I would on some level possibly not but I do think because I came across an article in NHS where they were reviewing all the reform that they took place over the past fifteen to twenty years and they said really one of the most important things they learnt is to take the politics out of health reform because it's the changes in politics that actually stop the growth and the reform and you need five key things to make it happen and one is that as you said its stability and leadership. We've not had either so that's a major problem for us. You need stability and leadership. You need to identify the goals. They need to be articulated to the organisation and then there needs to be a named system for making them happen. Whether that's Kotter's change model, whether that's PDSA any of the HSE change models it doesn't matter but these are our goals and this is the way you do it. Once everybody knows and understands that everybody works there common purpose.

GS: You're painting a picture by which people can follow easily and understand and that can be half the battle.

AM: And consistency of message. In Ireland because there's so much change and we are in an unprecedented time of turbulent change where the country was going through a very big crisis. One concern I would have for the future to look back on were doing so much at the same time national and that implemented locally, is it being implemented locally? How successful will it be? Too much at the one time I would suggest but then again the circumstances were put in with the Troika maybe we didn't have a choice.

GS: Do you think the hospital is correctly analysing external factors?

AM: So much is going on we don't have the time ourselves or the capacity to do that but your right it's what should be happening. If you look at hospital groups coming down the tracks one major question is like the HSE has historically had national policies but if you look at the clinical directorate

model in the NHS every trust writes its own policies and I think that the right way to do it. If you are talking about inter trust competition and there being competition in health care to deliver services you should have the freedom to write your own policies you shouldn't be bound by a national one. Culturally that hasn't happened till now so I'd be interested to see will trusts be allowed write their own policies because if that's the case that empowers the trust to be competitive. One thing I will say we are a country the size of Manchester. We look at Australia we look at Canada, we should be looking at Manchester like for like to deliver health care properly and I think that's missed as well.

GS: Ok, so just a quick summary, what activities or practices can the organisation do that's leads to successful and sustained change?

AM: I think definitely go with the NHS. We need to decide what we're doing. We need to communicate that effectively to staff get buying. Manage resistance and stick to the plan. Have a named process for delivering the change. Just one process, we nearly have change fatigue at this stage everything changing all the time in different circles in different directions. At this stage change is the new constant. It's not altogether good. Change for the sake of change. Change is not always an improvement. Change can be a step backwards. One other thing I feel really strong about is as well as change is leadership. Leadership is bogged down in writing papers for boards. Leadership should be away from the table and engage walk around talk to people and actually acknowledging the difficulties people are facing at the front line rather than denying them.

GS: Do you think that's a common feeling across the organisation?

AM: No, I think at the moment there's an awful lot going on at senior level where there caught up in that and I think maybe with time things will settle down a bit. I think leaders need to be out leading should be at all levels within the organisation but at least two days a week should be spent walking around talking to all the staff and leading them and motivating them and making them feel supported. Making them feel they have a voice. Engaging with them on a one to one way. Not as a tokenism but twice a week, Monday and Friday go talk to everybody, how was your week? What's facing you?

GS: Is the hospital developing its leaders and planning for future leaders?

AM: We are in a small way. When we have a leadership post we advertise externally. If you were to do a straw poll it would more often than not be external, although internals do happen. So on some levels it good because new blood brings new ideas and fresh perspective. It can also be demoralising for staff that have worked here for a long time and know the hospital very well. There is a lower expectation, they might feel they are never a prophet in their own land and they'll have to leave the organisation to progress.

GS: Does a work force planning strategy where people are aware there are practices in place where they can be developed and it can lead to something. Yes we do bring in externals but we also bring in our own.

AM: I think it has happened in different departments at different levels and at different times over the years. Is it done collectively by HR? No. There was transfer tacit knowledge and it was piloted in performance and planning and they thought it was a very worthwhile exercise. It was a self-assessment of all their ability in relation to all their tasks in that department and they identified all the gaps and they put in measures to remedies them. A lot of it was transferring tacit knowledge because sometimes it's not about academic knowledge, it's about how you do your job. People have all that knowledge acquired over years and years its expertise, and then they walk out the door and no one knows how to do that job. It wasn't implemented in this department although it was developed in this department. It was used in only one department, performance and planning which has since been disbanded. It was used there and they presented it to the CEO. Everyone who participated thought it was a very worthwhile exercise.

GS: And it didn't go any further than that?

AM: Exactly. A decision was made. A tool was developed, it was implemented in one area who went back and said it was a success and then it stopped. I think that person left. Again the person who bought into the idea left the organisation so the idea stopped in its tracks. And I think there was a changeover in CEO again. It's the sustainability of changes, the embedding of changes there's a weakness, because that was a good exercise, it did produce results and would have protected the organisation had it been implemented organisation wide.

GS: It has been touched upon in the research for this study that current practices are quite limited because the focus is on quantative data rather taking in the experience of people.

AM: I do think that is not the way to do things. I think tacit knowledge is very valuable. There are ways you can go about it. First of all when talking about development and everyone being multi skilled you would implement the transfer knowledge tool that I developed. Secondly, another way to capture it is the writing of standard operating procedures. Everyone's job would probably be a 200-page document. It's worthwhile doing this sort of work because I'd say there a huge amount of variation. There probably is a better way of doing things. If everybody was to write down their way of doing things and then come together and say, we'll do this and this, you'd end up with a better process. If you bring in standardisation it does make it easier to slot into jobs. The down side to that is people like to do thing their own way, there has to be some sort of freedom of expression. We're not robots. Here, I'd say, and I'm talking about the department, not the hospital, I'm not privy to the whole hospital and some departments protect their own information.

GS: Do you think the failing of the process is because it's not integrated?

AM: Absolutely. I always think an organisation like this isn't really one organisation; its twenty sister companies working under one roof with varying level of effective communications between them. I would say that a little of the legacy is gone but we had three hospitals come together, so you had the practices and cultures of these three different hospitals coming into each of these departments and then in each of these departments you had adaptations of different ways of doing things. In the early stages you would have bits of every process coming together and the one time. Back at the time of the opening of the hospital it was one of the most successful mergers in terms of there was very little IR. People were so busy getting up and running to help the patients, sitting down and evaluating the processes at the start was probably not a priority, getting people treated might have been more of their focus.

GS: Have you received any training or development in change management or workforce planning?

AM: Yes. I'm doing a Masters in Leadership and that have a whole module in change. I've already taken a BA in HR management so I'm fairly familiar with the steps required to lead a change process. Do I see them being applied on a daily basis? Probably not. I would say the biggest failure is communication or acknowledging people's concerns. I do see people sending out emails saying, please do A,B,C, and then there is no follow up, there's no plan around how it's supposed to happen, no real conversation. Then a month or two later someone realises that it hasn't been done and then a meeting takes place. It's all retrospective and people are so busy, unless you put the hand up and say, we're making a change and it's very important and this is why it's important. Unless someone stands up and says those word, the chances of it happening through an email is very limited.

GS: Why do you think that has happens?

AM: Lack of awareness by some managers about what's required to make a change stick. Lewin's iceberg model, there is a timeframe, week eleven or twelve, you plan the change, you communicate the change, you initiate the change, you implement and freeze it. There is a time where there most likely be slippage and if you are doing a change management process you'll put that in your diary and you will then go look at it and remind people why we are doing this, so you have to monitor the change process to make sure it embeds. And to review because we may decide it's not something we want to do. Even after the change has been implemented there needs to be a monitoring process that needs to go on for a period of time with someone focused on it.

GS: If workforce planning is practiced in some way, why are there gaps at leadership level?

AM: I think there is a will to change, the executive leadership team, there will be training intervention and change management will be part of that. Some

would have experience of that and other wouldn't. Then in terms of workforce planning, the MAP committee is there, it looks at resources, it does try to balance but it's quite hard, you've competing priorities at that level. How do you decide whether you need one clinician or another? Which service is more important? Which presents a greater risk to the service or patient?

GS: Are the key people at the meetings?

AM: Now yes, over the years that would have changed. There is input from a clinical perspective there but again, they're all important roles. When you only have €50,000, how do you compete in priorities? There's no right answer. You've workforce planning but services are driven by the demands of the demographic, the population.

GS: If the hospital had followed a workforce strategy do you think it would have been able to better manager difficult decisions such as that?

AM: Absolutely, and like you said earlier there is workforce planning going on but if it's not multi-disciplined, it's not taking in doctors, all the allied health, the clerical people that are affected by it. But what about the directorates.

GS: You mentioned the hospital groups, so more changes are on the horizon for health service. What can we learn from our current change process that would benefit the hospital going forward?

AM: Communication, communication, communication! Simply put. And engagement. The two go hand in hand. If your staff are engaged, they'll buy into the change more readily. Lack of communication breeds a level of mistrust within an organisation.

GS: Do you think we led a successful transformation to date?

AM: It happened, its happening. I would say it's probably typical. Change is always a challenge. Here it's more reactive. Maybe if we were to look at it more strategically and make our own plans. Ok, were subject to national change and we've to role with that but that doesn't mean we shouldn't have our own ideas. Communication should take place and sometimes strategic communication should take place. Sometimes people think communications is the responsibility of the communications dept. Communications is the responsibility of the line managers at every level. Research shows that fact to face is what people prefer. Line managers have stepped back because they have no good news stories for their staff. I think to some extent they have pulled away from the meetings because they are the focus of frustrations being vented on them. Ownership of communication, engaging with staff and support of staff.

GS: Thank you AM. That concludes the interview
