THE ROLE OF PLANNING IN CHANGE MANAGEMENT
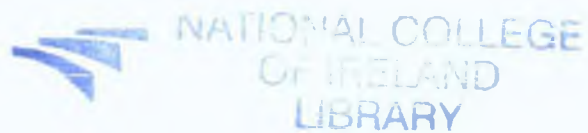
A Study of the Planning Process involved in a Change

Management Project

BY

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DECLARATION

I declare that this thesis submission represents my own work in all respects and that

no part of it has been previously submitted to any University, College or Institution of

Learning in respect of any degree or other academic qualification.

Signed: _Tim Kennelly_   Date _23 April 1998_
Tim Kennelly

ACKNOWLEDGEMENTS

DEDICATION

I wish to dedicate this work to Susan, Stephen and Deirdre, for their co-operation and understanding. I would also like to dedicate it to all change planners who believe that organisational change can be a stimulating if sometimes a seemingly endless and an un-attainable task.

THE ROLE OF PLANNING IN CHANGE MANAGEMENT

BY

T. KENNELLY

ABSTRACT

Major organisational change has to be carefully planned, to ensure that factors which are likely to impact on change processes are taken into account. These factors will revolve around the organisation's business, people and structure. They will include culture, politics, inter group trust, power bases and fear of change. They can pose major problems for change processes and the organisation must assess the likely impact of each.

The change process should be planned and documented, following consultation with and the involvement of all the intended participants. Awareness of what is at issue and of what needs to be done is a vital ingredient. Commitment will also be vital because the intended participants, if they are not fully committed to the process will lack sufficient interest to help it through difficult times. If the plan is not documented, even though these factors may be taken into account initially, there is likely to be slippage over time in the awareness levels of these factors. The matter of who influences the process and to what degree they do so, will also be crucial.

The planning process itself should be based on recognised models for planning change, otherwise the plan will not be properly grounded and will lack the necessary direction to achieve success. All the participants should have some knowledge of how organisations function and of planning techniques, even if it is not realistic to expect professional non managerial groups to devote significant amounts of their time to gaining detailed knowledge of matters which are not normally part of their duties. The planning process should ensure that some levels of knowledge of these matters is made available to these groups in a simple format so that they at least have basic knowledge of what is likely to confront them.
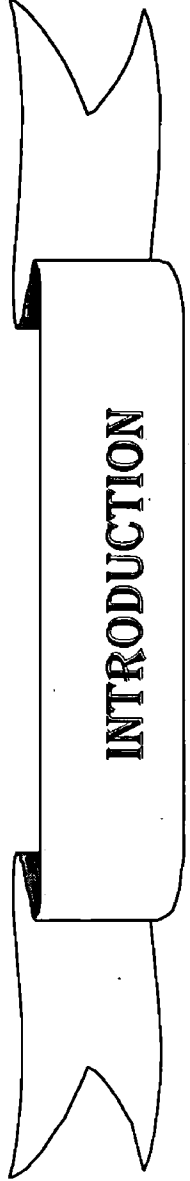
INTRODUCTION

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FOCUS:

This research study is focused on the process of planning major organisational change. It explores the issues which are likely to be involved, first through a literature review on planning organisational change and then through research on how change is being planned by hospitals in relation to the involvement of doctors and nurses in hospital management. While the research concentrates on the planning of change in the hospital context, the study believes that any lessons to be learned or best practices identified through the research should be equally relevant to planning change in any organisational environment.

It is hoped that those involved in the process of planning the involvement of doctors and nurses in hospital management would consider the macro aspect of the change process, i.e. the planning of change in the overall context as well as the micro aspect relating to their own individual hospitals, which is likely to be of greater interest to them.

The study is primarily concerned with the planning of change as distinct from its actual implementation. While the planning of change could go on forever, implementing the change and the resulting outcomes will be an acid test of measuring how successful the planning process has been. The consequences of change which is not managed could be detrimental for the organisation. The thought put into planning change can help to avoid this situation and can contribute significantly to achieving a successful outcome.

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The study does not attempt to evaluate the progress being made or the merits of the approach in any individual hospital. It considers why doctors and nurses should be involved in hospital management, what managerial roles are expected of them and what planning models might be appropriate to bring about this involvement.

There have been a number of models proposed as being particularly suitable for involving doctors in hospital management. For example, the Clinical Directorate model involves a medical discipline or disciplines being managed as an entity, generally with one consultant acting as Clinical Director or Lead Clinician with a number of other managers providing the necessary back up support and managerial expertise. Functional Service Department structures involve individual departments managing their own resources, generally under the supervision and direction of the department head, not necessarily a doctor. An evaluation of any of the models would require a different focus and the study does not go into such evaluation. If the planning is done properly and adequately, successful implementation should be attainable irrespective of what management models are involved.

BASIS AND PURPOSE:

The reasons for undertaking the study are: (i) a particular interest in the topic of planning change; (ii) currently planning the greater involvement of doctors, nurses and para-medical grades in hospital management activities; (iii) currently re-focusing the management structure in a hospital; (iv) a belief that it is vital to involve nurses as well as doctors in the process of hospital management. Real multi-disciplinary management would also involve other grades of staff such as Para-Medical staff.

The main thrust of the Department of Health's approach heretofore, has concentrated on the involvement of doctors in the process. There is as yet, no great emphasis being placed on the involvement of Para-Medical staff in hospital management and therefore the study did not include them in the research. The Department of Health commissioned reports looked at in Chapter One, placed almost exclusive emphasis on the need to involve doctors in hospital management.

The other reports looked at in the same chapter clearly voice the need to involve nurses in the process and this study is based on the premise that it is important to involve both doctors and nurses. Including nurses broadens the perspective of the study and better reflects what true multi-disciplinary management should involve. An example of the differing views that exist on the degree to which nurses should be involved in the management process arose at the 1997 Annual Conference of the Institute of Health Services Management (I.H.S.M.), when significantly differing views were expressed by Macara and Hancock respectively, [Health Services Journal p:14]. Macara's view was that "Clinical Directorates are a good idea and they should always be managed by doctors." The opposite view was put forward by Hancock who argued that there was "virtually no evidence to support this and the idea that Clinical Directorates should always be managed by doctors has been entirely based on the experience of one U.S. hospital in a time of expansion and this is different to situations of expenditure contraction." In Hancock's view [:14]:

> "Clinical Directorates in their pure form should be about scanning the horizon for technological and research developments and in such situations the manager's role should be held by doctors. However, if their role was simply to be part-time managers of bits of hospitals, then nurses were probably more suited to the job through their training than doctors."

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From the planning perspective it would be important in light of this differing of views that hospitals decide which groups and what level of multi-disciplinary management they intend to adopt. This study is clear in its view that multi - disciplinary management in the hospital situation, should involve both doctors and nurses as a minimum and agrees with Hancock's view [:14], that:

> "Nurses in particular, have an overview of patient care which is shared by no other member of the health care team. Unlike doctors, nurses are educated and develop their careers in multi-professional teams. They understand the contribution of each member of the health care team."

These differing views offered by Macara and Hancock suggest that there is a gap between the thinking of doctors and nurses on this issue. This emphasises the importance of planning in the process.

THE NEED FOR PLANNING:

The study argues that if the planning process in any major change project does not meet a number of requirements, there will be significant adverse effects on the outcome when the process has been implemented. These requirements are:

1. The task of implementing major change requires a comprehensive plan which clearly sets out the change objectives involved, the stages and time frame within which implementation is envisaged and the process to be followed.

2. The plan should be documented, otherwise,it will be difficult to have mechanisms and procedures in place to ensure the full and continued involvement of all the intended participants. A documented plan will allow for review, evaluation and adjustment. It will also ensure that important organisational features and factors such as, Culture; Fear of Change;

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Organisational Politics; Inter Group Trust and Power Bases, are specifically considered and included in the planning process. These issues impact on change programmes and if they are not provided for in the planning approach, the chances of success will be significantly diminished.

3. The planning approach adopted will have a major bearing on the plan as it is likely to reflect the organisation's philosophy and is also likely to determine the levels of awareness; involvement; commitment; evaluation and influence that are present in the planning process. The plan itself has to reflect recognised planning methods and planning models, to ensure that the on going process is structured and controlled.

4. Ideally, the process should be piloted in line with strict criteria in appropriately selected situations to test, monitor and review progress. The pilot sites should be carefully chosen, as each pilot site should have something definite to offer to the process. There should be certain parameters of action specified for the pilot sites to ensure that the following aspects, which the study suggests are of major significance to the planning of change, are considered, viz. **awareness; involvement; commitment; evaluation; and influence.**

PILOTING CHANGE PROCESSES:

The Department of Health's approach for involving doctors in hospital management has been to establish four pilot sites, without being prescriptive as to how these pilot sites should bring about this involvement. The study believes that establishing pilot sites to begin the process of involving doctors in managing hospitals, without some overall direction as to how they should actually set about the process, is not an

effective basis for planning the change process in question. The pilot sites should be used to develop models and approaches which could be assessed as to their appropriateness and relevance for other hospitals. In particular, the absence of a clear time frame is one obvious omission and leaving the planning up to individual hospitals increases the risk of missing out on an overall comprehensive approach.

The intended participants have to be aware of what the process is about, what their roles are, what stage the process is at and what time frames have been set along the way. They will have to be committed to the process, if they are to contribute positively through their involvement. The level of commitment is likely to be dependant on the degree of their involvement. It would be difficult to expect participants to be very committed to a process if they are not fully and actively involved in it. They should be able to evaluate their intended roles as well as the factors and issues that will impact on the process. They should also have to assess how much they need to know about what is involved in planning and implementing change.

The study believes that the pilot sites could be expected to be more advanced in the process of involving doctors in hospital management than hospitals which are not pilot sites. However, if these pilot sites are not adopting soundly based approaches to planning the process, they could be trailing hospitals which have adopted soundly based planning approaches, even though they have not been accorded the status of pilot sites.

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If a number of hospitals are involved in planning similar change, it seems logical that they should do so jointly rather than have each of them trying to re-invent the wheel. The study considers that a detailed plan should be developed, first in each hospital through the input of all the intended participants and then across all the relevant hospitals, so that the plan is representative, provides a good framework and takes account of issues that are likely to be present when organisations are planning change. These organisational issues have to be addressed in the plan because they will inevitably be factors in the implementation process.

TERMINOLOGY:

There are a number of titles and terms used in the study which need a brief explanation as they are used interchangeably in many instances:

* **Doctors** refers to senior medical personnel, usually referred to as "**Consultants**".

* **Health Board Hospitals** are those hospitals controlled by one of the eight statutory Health Boards set up under the 1970 Health Act. Their culture is relatively new compared to Voluntary hospitals and an important consideration is that ultimately all aspects of how they function are controlled by the Department of Health.

* **Managers, Administrators, Administration and General Management**, relate to managers who are not members of either the medical, or nursing workforce in the hospital.

* **Matron, Director of Nursing, Nurses** and **Nurse Management** relate to the overall nursing services manager in hospitals.

* **Multi-Disciplinary Management** and **The Process** are both intended to relate to the involvement of doctors and nurses along with managers/administrators in hospital management.

* **Voluntary Hospital** is used to refer to all non Health Board public hospitals, even though this is not strictly correct. Included in this group are the true Voluntary Hospitals which were mainly established under Acts of Parliament or Charters prior to 1900 and hospitals with Corporate Body status established under the Health Corporate Bodies Act, (1961). The latter are generally considered to be more closely aligned and have philosophies similar to Voluntary hospitals rather than Health Board hospitals. Four of the biggest general hospitals in the country are non - Health Board hospitals.

APPROACHES:

The study looked at both the theoretical and practical aspects of planning change. The introduction sets out the basis, aims and purpose of the study. Chapter One examines what is involved in the process of planned change and it identifies a context for the study. Chapter Two looks at organisations and at theories and approaches for managing them, including issues that determine how organisations react to change. Chapter Three identifies approaches and models for planning change and considers their relevance to the change process in question. The study believes that

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it is important for change planners to look at the theoretical aspects of organisations and approaches for managing organisations. Many of the theories will have been covered by managers in particular in formal learning situations. However, exploring them as theoretical concepts is not the same as relating them to specific projects. Many doctors and nurses may not be familiar with the theories and this could be a significant handicap when they become part of a process. For example, if one is aware of the major influence that culture can have it is more likely that culture will be considered in the planning process.

The Research Approach is detailed in Chapter Four, which involves choosing the topic, drafting the Research Instrument, outlining the time frame and analysing the responses to the questionnaires. The research set out to ascertain if the hospitals chosen had documented plans in order to initiate and implement the process. It sought to examine the attitudes of doctors, nurses and managers to the issues involved in planning and their attitudes to each other.

The research analysis is carried out in Chapters Five - Eight. Chapter Five considers the response to the questionnaires issued to managers and analyses them under a range of headings to identify trends. It gives consideration to these trends and attempts to relate them to the issues which the study focuses on. Chapter Six analyses the responses to the questionnaires by doctors and nurses. Chapter Seven looks at the situation from an organisational perspective by looking at what is happening in practice.

Chapter Eight summarises the study and lists key points which are suggested as being essential ingredients in any planned change process. It sets out the reasons why these proposals are advanced and justifies their appropriateness and relevance to the process in question. It also identifies deficiencies in the planning process highlighted in the responses and considers if particular deficiencies seem to be a common feature across the broad spectrum of hospitals looked at.

CHAPTER ONE

CHAPTER ONE

PLANNED CHANGE

Hospitals are relatively large systems and "large systems do not change instantaneously" [Coghlan 1995:2-3], who in his talk to operating room nurses on the topic "Change - the O.R. Challenge" refers to three critical elements involved in change for individual employees; Perception - Assessment - Response. He saw the period of time between the realisation of the need for change and having the change in place as the transition phase. These elements in effect constitute the process of change management but the study would prefer to regard them as; identification (what has to be done), planning (how it should be done), and implementation (actually doing it).

Coghlan referred to Bridges'[1991], "useful framework for helping people manage the transition state in organisations - 4Ps; Purpose, Picture, Plan and Part to play". The purpose of the change has to be explained, employees will need to see the picture of what the change will be in practice, the plan will outline what will be involved in dealing with the transition and employees are likely to be committed to the plan if they have a meaningful part to play. This study is focused on the third step in the 4 Ps; the plan.

There are numerous definitions of planned change and Goodman and Kurke [1988 :4], say that "planned change involves a set of activities designed to change individuals, groups and organisation structure and processes". The intention to

involve doctors and nurses in managing hospitals encompasses all that is implied in this definition. There is a difference between planned change and enforced change in that the latter is not activated through internal planned processes. Any type of enforced change could be regarded as "organisational adaption which involves modifying all or parts of an organisation to fit or to be adjusted to its environment " [Boyle and Joyce 1988:4], rather than being a planned and owned process, which would determine the pace, direction and progress from within.

Pressure for change, according to Keleher and Cole [1988:167], "typically originates externally and one of the principal responses by managers to this organisational turbulence is the management of change". Planned change should have a definite aim or purpose. It should be geared towards altering or affecting the organisation as a whole or specific constituent parts of the organisation. In order for planning to be effective, it must be based on a clear understanding of the factors that can affect the process and the proper planning of change is a pre-requisite to achieving success.

Planned change is distinguished from other types of change in that it entails "mutual goal setting, an equal power ratio (eventually) and deliberateness on both sides" [Bennis et al. 1970:154], while enforced change can come about without any of these three factors. Planned change, if it is to be successful, will require that these three ingredients are present. The multi-disciplinary aspect of involving managers, doctors and nurses in hospital management will require mutual goal setting, equality of involvement will result from an equal power ratio and the level of progress will reflect the degree of deliberateness coming from all the participants.

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Can managers, doctors and nurses set mutual goals? To do so, trust will be essential between the three groups. Even with that trust, are their respective goals mutual in any event? Is an equal power ratio attainable? One of the main reasons advanced by doctors for their involvement in managing hospitals is that it is doctors, through their professional judgement and skill, who really determine how health care resources are used. If they are to be given a major say in resource usage then they will have to accept that accountability should be a natural consequence. Will accountability weaken their clinical independence and professional status? Accountability could be equated to an equalisation of power but is it one of the mutual goals that can be achieved? If it is, will it happen as a matter of course or has it to be planned through deliberateness on both sides? The study proposes that proper planning allied to deliberateness and mutual involvement can successfully bring about meaningful multi-disciplinary hospital management.

A planning process must, according to Rathwell [1986:56], "have a strategy for implementation" and he adds that there are three ingredients essential to facilitating strategic change,

* settling the institutional strategy;

* gearing up the organisation;

* continuing the process of managing change.

The institutional strategy is set by ensuring that the overall aims, objectives and policies of the organisation are fully and widely understood. The matter of involving doctors and nurses along with managers in managing hospitals requires settling the institutional strategy. The task of gearing up the organisation involves allocating

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tasks and functions in accordance with the organisational structure and within clearly defined guidelines in order to establish the latitude and limitations associated with each task. Will hierarchical bureaucratic structures allow for the allocating of such tasks? It will require decisive management at all levels in the organisation to continue the process of managing change, rather than change being seen as a once off individual task.

If these three ingredients are as essential as Rathwell views them to be, then the necessity for some overall documented plan based on sound planning principles, starts to become obvious. Bennis [1970:33], says that:

> "One element in all approaches to planned change is the conscious utilization and application of knowledge as an instrument or tool for modifying patterns and institutions of practice".

This makes a cogent argument for the need to plan change and Chin [1970:65], viewed planned change as:

> "A linkage between theory and practice, between knowledge and action and the process of planned change involves a change agent, a client system and the collaborative attempt to apply valid knowledge to the client's problems".

In that context, this study attempts to ascertain if there is a linkage between the theory and what is actually happening, between the knowledge that should be there and what is being done.

The attainment of goals through a process of planning and management must be based on a strategy, but there is often an "unfortunate separation of planning from management, whereas in reality they are inextricably linked " [Rathwell 1986:54].

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There is a need to create linkages between planning and management in a strategic way and strategic management should involve strategic vision and effective implementation in a three stage process of planning - review - change. Lee [1988:129], proposes that:

> " A strategic plan is generally accepted as having two main aspects; (i)
> It is an attempt to state general aims and policies that should guide the
> development of the services in the coming 10 years; and (ii) it contains
> a quantified statement of the changes in service levels, capital, revenue
> and manpower resources."

The study sought to find out if a strategy such as this for planning change existed and if so, was it documented?.

THE ROLE OF MANAGEMENT:

Redwood [1995:1], saw true management as being "about walking the wards and motivating the doctors and the nurses". Perhaps, this is over simplifying the task, but it injects a practical note into the issue. In situations where more than one discipline is managing an area, walking the ward may be a vital component, as plans may too readily concentrate on the grand design and forget about the daily situations and issues that will be present. This "walking of the wards" can also be a state of mind and philosophy rather than a daily task. There is a danger in hierarchies that the top managers may not consider it appropriate to do such a mundane (and perhaps subservient) a task as walking the wards.

Marples and Mittler [1996:4], reported that Bournemouth and Christchurch NHS Trust in reviewing its performance over a number of years felt that its successes might have something to do with good management but could not be sure of this without

measuring managerial performance in some way. Marples and Mittler argued that "as managers, we cannot forever espouse the benefits of standards for others without applying them to our own performance" (p:4).. They established a process involving seven stages for evaluating performance. The seven stages are:

* a managerial delayering;

* linking every post to one of five levels;

* identifying the skills, knowledge and required competencies for each level;

* matching individual's skills and knowledge to standard sets;

* identifying how all managers could achieve required standards;

* delivering required education and assessing competence;

* demonstrating that performance in the things managed is better than when they were started.

The concept of "managerial delayering" is along similar lines to the aim of flattening management structures. This study sought to establish how doctors, nurses and managers view existing management structures and if they consider that they needed to be changed. The typical management structure in most hospitals has a wide range of administrative reporting relationships across different functions and a layer(s) of managers who tend to operate in vertical reporting relationships. It may not be easy for doctors and nurses to easily fit into this type of structure and if this is the case, the multi-disciplinary management process will be adversely affected. The study does not propose how the present structures should be changed, but in the research

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it attempted to identify if they are seen as being suitable for the process. If they are seen as unsuitable, then whatever planning process would be embarked upon should pay due attention to this.

THE NEED FOR MANAGEMENT DEVELOPMENT:

The study believes that the levels of management development will impact on the change management process. One of the features of the performance of top managers in the health service has been the claims of major increases in workload and that this in turn encroaches on the time available to them to pursue their personal and their managerial development. Where do managers learn most of their skills? Is it through on the job experience or through formal education and learning? These claimed increases in workload should not be justification for leaving personal or managerial development suffer. Planning and scheduling opportunities for such development is [Wigley 1989 :255], essential as:

> "The oriented organisation provides opportunities for its members to use their talents and abilities which are intrinsically satisfying and which advance a purpose or goal to which the individual is personally committed".

Davies and Easterby-Smith [1984], found that managers developed most from their experiences at work rather than from any specific education or training they received. Planning management development strategies and structures must allow for this and ensure that what is planned/advocated is also practised. In essence, management development cannot isolate training and education from the need for and benefits of assessment and planning. If this is how managers learn most, then their development has to ensure that they understand the influences of culture, politics and organisational behaviour in planning change.

In looking at the issue of management development for top managers, Attwood [1992:21], felt that the:

> "Needs of individual senior executives are linked inexorably to those of the organisation that he or she manages and failure to pay attention to this will place in jeopardy the ability to build individual and organisational capability to sustain the changes necessary, if the reforms are to enhance patient care".

If doctors and nurses are to take on more management responsibilities than they have had heretofore, then appropriate management development to equip them for this task is equally important. It is in this context that the study sees the matter of management development as being very important if doctors and nurses are to be actively and successfully involved in hospital management. Consideration has to be given to how management development programmes are structured and implemented. There may be a tendency to send managers or potential managers to conferences and/or to have them pursue formal academic study. This is more management education than management development and while the two are not necessarily the same thing, equally they are not mutually exclusive.

> "The problem with management education is that it usually starts with a notion of desired end-behaviour and the problem with management development is the difficulty in defining the desired end-behaviour" [Edmonstone 1988:159].

The aspiration to develop management in a specific way or for a specific purpose is meaningless if it is not followed up by planned action with clearly identified goals based on identifiable planning principles. Schofield [1986:60-61], set out to identify principles of effective management development in the public sector. The principles he identified were:

*   Managerial Objectives to be fully effective, need to be directed towards clearly stated goals.

*   The Climate must be supportive of time, energy and financial support.

*   A Systematic Approach, requiring a comprehensive plan which states the key elements and priorities allocated to the various tasks to be completed, must be adopted.

*   It is necessary to set the pace by recruiting from outside the organisation to bring in young people with potential to add to the pool of management expertise.

*   Appraisal is important in order to be able to show managers that they are making progress and that the development process is a continuum, not a once off or occasional project.

How do these five principles link into the two issues examined in the study?. There is the opportunity for both ownership and unity of purpose as both doctors and nurses are seeking involvement in the management process. The climate seems to be right for this involvement, which satisfies the second of Schofield's principles. The third principle is the one that links the first two principles to the last two; i.e., the systematic approach. It may be difficult to set the right pace without a systematic approach and the outcome may also be uncertain without it. Schofield, [:61], suggested that:

> "Every new management task, every shift in priorities, every vacancy in the management structure should be seen as an opportunity for management development. There is a need for flexibility, both in the structure itself and in the role specification for any particular job. This will enable the organisation to change its shape both to meet outside circumstances and also to accommodate the talents that are developed within it ".

If hospitals were to approach management development with this philosophy and if the remit given was to reflect Schofield's sentiments, then a strategic plan incorporating both would be of significant benefit to the organisations involved.

This study proposes that management development cannot take place unless it is well planned and is cognisant of what should be expected from effective management development in the public sector where:

> "There are two additional factors which increase the challenge of management development. The first is the essentially political nature of the public services, which necessitates either the drawing up of new service objectives every few years or else that they are unstated or fudged. The second complicating factor is that in many parts of the public service the professional sector is stronger than the managerial", [Schofield:60-61].

The study sees these two factors as having a major bearing on the process of involving doctors and nurses in the process and if they are not given due recognition in the planning phase they cannot be successfully managed. The matter of management development as a model or vehicle for planning change is looked at in Chapter Three and Chapter Seven looks at the Department of Health's follow through on the need for a management strategy, as instanced in some of the reports listed, in **"A Management Development Strategy For The Health and Personal Social Services in Ireland" 1996.**

THE NEED FOR MULTI-DISCIPLINARY CONSENSUS:

The huge cost of health care delivery has lead to a clearly stated recognition, (as voiced in the reports on which this study is based), of the need to involve doctors in particular and nurses in managing the delivery of hospital services. The medical

profession maintains that decisions taken by doctors significantly govern expenditure patterns and doctors therefore should have a say in how resources are managed and utilised. The reports have linked the giving of this responsibility to doctors with the necessary accountability that goes with such responsibility. It is essential that doctors themselves accept that responsibility must also involve accountability in order to ensure that the patient ultimately benefits and "doctors and managers should recognise that they are all part of the same process - the care of patients" [Macara 1995:2], who adds;

> "It is the culture of consensus, which needs to become the pre-
> dominant culture and so break the vicious cycle of recriminations, which
> I fear, continues to dominate in vital quarters".

This inter action will involve the bringing together of what have been traditionally conflicting cultures and philosophies.

One difficulty in marrying the mind set of managers with those of doctors and nurses could be the factor of managers being "best fitted to a hierarchical structure, while professionals, including doctors, operate more on a colleague basis" [Blau and Scott 1970]. A number of references are made in the study to the stated intention to flatten management structures as a requirement to successfully bring about the changes sought. Ellis [1990:265], felt that:

> "The old style managed hospital as a non-autonomous facility, seeks to
> achieve efficiency, is not managed horizontally, focuses on doing things
> right, examines proposals from a business perspective, has a
> preponderance of committees and tends to be reactive".

Ellis [:265], suggested a different style of organisation that should:

* be concerned with effectiveness as well as with efficiency;

* be driven by corporate goals and objectives;

* be focused vertically for management purposes;

* recognise that doing the right things is as important as doing things right;

* ensure that the organisation adopts a strategic perspective;

* see that accountability and responsibility rests with the individual;

* ensure that the organisation is pro-active and sets its own agenda.

How do these principles relate to the study?. The objective of involving doctors in the management process to achieve both effectiveness and efficiency has been identified as an essential corporate goal.   Ellis does not make it clear if his "vertical management focus" is or is not advocating a hierarchical perspective, but the study considers that in view of his other principles, the focus he has in mind involves leadership, overview and achievement. The need to do the right things should be recognised in the strategic perspective adopted. The giving of responsibility and accountability to the individual has to be a prime feature of multi-disciplinary management. Hospitals, like other organisations, have to be pro-active, but they cannot necessarily be allowed to set their own agenda as some cohesion and unity of approach is necessary to offer the possibility of structured progress. The non-prescriptive approach of the pilot sites is an example.

Responsibility and involvement for the management and use of resources has to include accountability for actual use and performance. The Administrative Manager heretofore has been the person who has had overall responsibility for all management and administrative functions and the sharing of this with professionals is likely to be major change. Yet, in the multi-disciplinary scenario, both the individual and collective participation of each of the three groups will be essential. Sunney [1996:3], says that "the manager is the co-ordinator of the whole team who will manage change pro-actively and indeed, sell its benefits". Griffiths [1997:20], sees doctors as:

> "The most powerful, influential and necessary people in the health system. This is the first thing that Chief Executives and their boards need to understand if they are to forge successful partnerships with their medical colleagues. .... They should recognise that the priorities for doctors are their patients, clinical practice and the hospital - in that order. They will only value any involvement in management if it contributes to their prime interests."

The multi-disciplinary approach is seen as the best way of managing hospital resources. However, it would, according to Dearden [1990:224]:

> "Be unwise to regard this approach as being entirely trouble free and problems can nearly always be traced back to at least one of the following three major problems; opaque or absent linkages between inputs and outputs; inadequate results orientation and uncertain accountability for clinical resource use; the counter-productivity of bureaucratic excesses".

The concept of linkages between inputs and outputs in the health service can embrace nearly all aspects of the service. A documented plan should address the question of adequate results orientation and also the establishment of clearer accountability for clinical resource use. The attempts at flattening management structures or the "delayering" that has taken place in the Bournemouth and Christchurch NHS Trust, could address the matter of possible bureaucratic excesses.

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BACKGROUND FACTORS PROMPTING THE NEED FOR CHANGE:

Increasing economic difficulties in the early to mid 1980's focused attention on the need to control public expenditure. As the Health Services accounted for a significant proportion of that expenditure, they too and specifically public hospitals, were targets for cut backs. The rationalisation of acute hospital services in 1987/1988 saw the closure of a number of public Voluntary Hospitals which had histories going back into the seventeen and eighteen hundreds. Within the context of the earlier definitions of planned change and enforced change, the rationalisation involved the latter.

Reports commissioned by or associated with the Department of Health in the period 1987 -1996 examined a wide range of issues in the health services. They did not concentrate exclusively on the hospital sector but they did make many recommendations as to why the management processes in hospitals should be changed. The reports from this period, relevant to the study are:

* **Consultative Statement on Health Policy, (1987).**

* **Report of the Commission on Health Funding, (1989).**

* **Review Body On Higher Remuneration In The Public Sector, Report No. 32, (1990).**

* **Reports of the Dublin Hospitals Initiatives Review Group, (1990/1991).**

* **A Strategy for Effective Health Care in the 1990's, (1994).**

* **Review Body On Higher Remuneration In The Public Sector, Report No. 36, (1996).**

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The first four reports in particular, contributed significantly to the setting of the agenda for involving doctors in managing hospitals as well as identifying the need for management development. Other reports undertaken in the period 1992-1996 attached importance to the involvement of nurses in hospital management. These reports were either commissioned by nursing interests or directly related to the nursing profession:

* **The Way Forward: The Irish Matrons' Association, (1995).**

* **Pathway To Progress, The Irish Nurses' Organisation, (1995).**

* **Creative Career Paths In The N.H.S.: Senior Nurses, (1995).**

CONSULTATIVE STATEMENT ON HEALTH POLICY, (1987).

This statement looked at the health services from a broad perspective and can be regarded as the starting off point for many of the subsequent reviews and reports. There was little detailed reference to management structures other than that a management system based on personal accountability and more explicit reporting relationships, should be developed. While the concept of this management development was not expanded on, it was clearly advocated.

REPORT OF THE COMMISSION ON HEALTH FUNDING, (1989).

This report was an extensive review of all aspects of the funding and management of the Irish health services. While it concentrated on the funding aspects it did highlight the need to involve doctors in the management of hospitals and also the need for management development [:249]:

> "The co-operation of clinical personnel in the management of resources is crucial to ensuring they are used efficiently. ...... We recommend the development of a more professional and highly skilled hospital management on the basis of fixed term contracts which would clearly specify their responsibility for the Hospital's performance in terms of measurable criteria which would remunerate them appropriately for this responsibility".

This highlights the wish to involve doctors in the management process and on the need for management development. The proposal for having fixed term contracts has since been realised as many Health Chief Executives are now on fixed term contracts.

REVIEW BODY ON HIGHER REMUNERATION IN THE PUBLIC SECTOR, (1990), REPORT NO. 32.:

A contract for consultants has been in place since 1981, usually referred to as the Common Contract. This contract was revised in 1991, following the report of the Review Body. The terms of reference given to the Review Body were *"to examine the remuneration and the terms and conditions of employment of consultant medical staff"*. The Review Body looked at the employment relationship and advocated [:26], "a process of regular discussion and exchange of information between consultants and management". It considered the question of consultants in management in relation to the enormously increased resources consumed by hospital medicine, as requiring;

> " Considerably more management expertise than was required twenty or thirty years ago when hospital medicine was a simpler and less expensive business" [:26].

The Review Body recognised that there were difficult issues involved in formulating structures which satisfy the needs and safeguard the rights of both consultants and management. It stated [:27], that:

> "Consultants are dubious of the capacity of non-medical management to perform this task because of their alleged sensitivity to, or a lack of understanding of, the nature of clinical medicine. If, as the consultants argue, management requires not just financial and administrative expertise but clinical expertise as well, then the only solution is for consultants to become involved in the management process".

The Review Body added that, while it was not within its scope to specify the precise details of consultant involvement in the management process, it did recognise that the issue needed to be addressed at two levels, (i) at the individual consultant level; and (ii) at the corporate management level. The Review Body saw the onus as being:

> "On management in the first instance, not on consultants, to develop appropriate structures. Different arrangements would have to apply in different hospitals, ... Management would need, therefore, to develop a variety of model schemes for different sizes of hospital" [:28-29].

The concept of Pilot Sites could be seen to emanate from this report, which was clearly leaving it to management to develop the necessary structures to allow for consultants to be involved in the management process. This is a reasonable approach to adopt if it is the intention not to draw consultants away significantly from their primary function, i.e., medicine. However, if management is not approaching the issue in a planned and positive way, then a successful outcome may not be achievable. The Department of Health has set up four pilot sites which are intended to be stand alone institutions where all aspects of management are catered for on site. This is different to the situation that has existed heretofore in Health Board hospitals, where all major support functions are/were provided from a central location.

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The setting up of pilot sites in four relatively similar type hospitals is questionable if the views of Leonard-Barton and Kraus [1988], are taken into account. They saw two reasons for establishing pilot sites; (i) they should serve as an experiment and prove technically feasible, (ii) they should serve as a credible demonstration model. However, Leonard-Barton and Krause felt that these two reasons are not always compatible;

> "If innovation must succeed at the pilot site in order to survive politically, the implementation manager must chose a site that poses virtually no risk and if the pilot site is to be a credible test, it cannot take place among the most innovative" [:232].

The authors add that it is necessary to be clear about the purpose of the test site, "is it to be experimental or demonstrational?, then choose the site that best matches the need". These two contrasting scenarios put a significant obstacle in the way of pilot sites. The four pilot sites chosen by the Department of Health could be seen to have been chosen because they were large and therefore, should lead the process. Leonard-Barton and Kraus suggested that it is necessary to be clear whether the purpose of the test site/project is to be experimental or demonstrational? They advised [:232], to "choose the site that best matches the need".

Becoming a pilot site could signify enforced change for Health Board hospitals in that they are, in effect, becoming self-governing hospitals, (in a way they are moving to situations similar to what has always existed for Voluntary hospitals). Ellis [1990:263], proposed that "hospital accountability is multifaceted and the need to balance these various accountabilities is why autonomy and self-governance are essential". Such a reasoning has not been so clearly articulated in the Irish situation

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and Ellis was referring primarily to his experiences in the U.K. and Canada. He viewed such self-governing institutions as being different from those in a centralised hierarchical model.

REPORTS OF THE DUBLIN HOSPITAL INITIATIVE GROUP - (1990/1991).

This group was formally established by the Minister for Health to report specifically on Dublin hospitals and it issued four reports. The Interim Report which was published in June 1990, pinpointed the need to address the issue of involving clinicians in hospital management:

> "A number of models have been developed abroad which involved the medical profession directly in critical issues of resource allocation and we believe that there is scope for considerable improvement in the present arrangements to harness more effectively the talent on both the medical and the management sides " [:6].

> "Whatever the structural arrangements, it is essential that the complex tasks of managing and delivering a modern hospital service be undertaken by staff with appropriate training and expertise. We are satisfied that, despite the goodwill and experience which is evident among hospital staff of all disciplines, there is an urgent need for better management training for those exercising management functions in the medical, nursing and managerial streams. We believe that progress on these issues, even on an experimental basis, should proceed in advance of structural or organisational development" [:48].

The final report of the Dublin hospitals initiative group, (1992), noted that a fundamental characteristic of the hospitals reviewed was that they were not organised to identify and respond directly to the demands placed upon them.

> " Their services have tended to develop on the basis of individual clinical practice or as a result of institutional or academic pressures. If the planning and management of the acute hospital service are to be effective, then clear service objectives and targets related to the major demands made on the hospitals must be given a high priority" [:6].

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This report also saw hospitals as being production driven rather than market driven but Mintzberg [1996:75-78], was critical of applying the business notion of the consumer to health care and other complex professional services. His criticisms centred on the myths:

* that politics and administration can be neatly separated;

* of measurement, which asserts that only that which can be quantified is of value;

* that the professional manager can solve everything.

Mintzberg viewed politics and administration as inextricably intertwined in all kinds of complex ways, even though managers persist in believing that it is both possible and desirable to separate them. The Commission on health funding in its report referred to the present administrative structure [:152], as " largely confusing the political and executive functions". The research sought to find out if the respondents felt that politics would be a factor in planning the process. If they are inextricably linked, as suggested by Mintzberg, then the planning approach will have to allow for this. The need to measure various aspects of health service delivery in meaningful ways is a common and recurring theme in many health services. However, from the perspective of planning change, can culture for example, be measured? The same could be said for trust; commitment; politics and other organisation features. If the difficulty in measuring these factors were to lead to the attitude that it was not worth doing so, the consequences for planning change would be immense.

The third myth that the professional manager is able to solve everything will arise if it is believed that further training and education is all that is needed for managers to solve all the current ills. The final report of the Initiative Group [:15], said that:

"In order for the hospitals to make the best use of the resources at their disposal, there is an urgent need for a programme of management development for both management staff and clinicians. The quality of management in the hospitals must be developed to match the scale of the challenge posed by the demands of a busy acute hospital".

A STRATEGY FOR EFFECTIVE HEALTH CARE IN THE 1990's, (1994).

This strategy, aimed at the provision of effective health care in the 1990's, is the culmination of the other reports listed. The Strategy [:5], refers to the ongoing process of change:

"The acute hospital service has been streamlined to meet changing needs. This has meant the closure of some older hospitals with the transfer of their services to more modern facilities. Developments over recent years in medical treatments and surgical techniques have lead to a major shift in the nature of the services which the acute hospitals provide".

The Strategy identified the development of a model of hospital management where the inter-relationship of the Clinicians and Administrators would be increasing and where the professionalism of the management had to be developed as a key task. It proposed that these new models should be looked at in a number of pilot sites but again did not advocate a standard or prescribed approach for any of the pilot sites. The research looks at the experiences in these pilot sites and compares them with other hospitals in the belief that this non prescriptive approach is ill advised.

The Strategy also outlined the need for management development in order to strengthen management capacity throughout the system. In addition to strengthening general management, specific importance was attached to the necessity of involving medical, nursing and other professions in the process of managing hospitals.

The reports dealt with above would appear to have consciously kept away from the specifics of bringing about this involvement and left them up to the individual pilot sites. This undoubtedly places major tasks on these institutions, as such a wide remit means that those persons entrusted with planning this change have to consider all aspects of the change process without having clear guidelines on how it is to be done. A further potentially significant problem is that with different pilot sites being chosen, it could happen that there is no clear commonality of planning or approach. It is likely to be more difficult to plan change in a rational and meaningful way if experiences in other hospitals are not looked at and assessed in order to reap some of the benefits.

REVIEW BODY ON HIGHER REMUNERATION IN THE PUBLIC SECTOR, REPORT NO. 36, (1996).

This report is particularly relevant to the matter of involving doctors in the management of hospitals and is discussed in Chapter 7 where the results of the research are brought together and considered in conjunction with what progress this report feels has taken place in relation to the matter of involving doctors in hospital management. Its predecessor, Report No. 32, was quite specific on the need to involve doctors to a greater degree in hospital management and **Report No. 36**, examines what progress has been made in the intervening seven years.

OTHER REPORTS:

The foregoing reports placed almost exclusive emphasis on the need to involve doctors in hospital management. However, the following three reports outlined why nurses should be involved in the process. These were produced by nursing interests in the case of the first two and the third directly related to nurses. They all highlight the need to identify the true role of nurse managers and the degree to which they should be involved in the management process.

THE WAY FORWARD (1995).

The Irish Matrons' Association in this report stated [:4], that:

> "As a member of senior management in a hospital the primary responsibility of senior nurse managers must be to general management objectives. ... When new management structures are introduced, overlap in role definitions may exist".

If one subscribes to these views, the role and degree of involvement must be identified at the planning stage [:5], because;

> "A vital component of hospital services is the key interface between nurses and doctors. This interaction ensures effective use of resources collaborative patient care programmes, achievement of discharge policies and objectives, effective bed management and cultivation of a climate of excellence and quality patient care. The General Manager must ensure that the senior nurse manager is a member of the Hospital Management Executive Team".

In considering this interaction between doctors and nurses, the report voices similar views to those expressed by Hancock, as quoted in the Introduction, [:3]. If one accepts the views that nurses have key roles to play in the management process, it

suggests that the reports commissioned by or in association with the Department of Health missed out to a large degree in identifying the full picture by not adequately recognising the importance of nurses in the management process.

PATHWAY TO PROGRESS (1995).

The Irish Nurse's Organisation in this report, expressed the belief that changes in health systems, organisations and structures, clearly affect nursing. It quoted [:15], from a National Nursing Association (N.N.A.) report in 1990:

> "Nursing structures cannot stay unchanged when the broader health services around them are organised and function differently. Nursing managers increasingly must understand and be a central part of the wider health service".

If the nursing profession is gearing up for greater involvement in the planning, delivery and management of health services, it would be most undesirable if the overall planning aspects do not recognise and use these assets.

CREATIVE CAREER PATHS In The NHS (4): Senior Nurses.

If nurses want to be involved in the management process is this necessarily good for the nursing profession? This study looked at the career paths for senior nurses in the N.H.S.. Crail [1995:10], says that:

> "Senior nurses see prejudice against their nursing backgrounds as the main obstacle preventing them moving into general management. Nurses interviewed in a study funded by the U. K. Department of Health expressed fears that the route from clinical nursing into management will be closed off as Trusts adopt flatter hierarchies and cut out middle management jobs".

It is worth noting the perceptions regarding the negative impact that flattening management structures could have on promotional opportunities. It is not readily apparent how much consideration Crail gave to the view on this reduction of opportunities and it may well only be an observation, but it does raise an issue that the proponents of the flattening process may not have considered. The reference to flattening hierarchies rather than flattening management structures may also be just a simple difference in words, but when considered, suggests that the former is a more accurate description. The belief that flattening management structures will see the total end of hierarchies could be very far from the truth and may be no more than a description of what is intended.

While the Irish Matrons' Association "**The Way Forward**", is reflecting a widely held view that nurses want to be involved in the management process, the views put forward by Crail above highlight possible future misgivings. There have also been questions raised about the benefit of this involvement in any event and Wall [1994:17], states;

> "In the 1970's, nurses sat as equals with their managerial and medical colleagues. They had scaled to the top of the pyramid, as envisaged by Salmon a few years previously,...... the introduction of General Management was bad news for most senior nurses".

The point being made by Wall was that Nursing Managers had become the managers of nurses rather than the managers of nursing and could in a way [:17], "be seen as having abrogated their responsibility to manage their own profession". This should at least, make the Irish nursing profession reflect in some detail before going headlong into the general management process.

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The type of integrated management structure being adopted by individual hospitals could determine the extent of the role of nurses in the process. The *Clinical Directorate* model could place too much emphasis on the doctors role although where a nurse would act as the business manager, the possibility for nurses having a counter balancing role to the doctors role would be greater. Myles [1995:4], says that:

> "Nurses have the potential to make the best business managers, because of the experience they bring to the role and my experience has shown that the relationship with nursing staff within the directorate is enhanced when the business manager is a nurse".

This reflects the positive part that nurses can play in the management process as viewed by a speciality manager in a trust in the U.K.. Britnell [1995:5], suggests that;

> "Aspiring managers from a non-clinical background are facing real problems in overcoming the experience hurdle as many provider organizations are seeking to merge roles and rely on a sound clinical knowledge base".

Again in the planning process, consideration has to be given as to which categories of staff and why, would be most likely to synergise the whole management process while being conscious of the obstacles that can arise; the cultures involved - levels of hierarchies - inter group trust.

The exchange of conflicting views between Macara and Hancock, as recorded in the introduction [:3-4], shows the divergence in thinking between doctors and nurses in relation to their respective involvement in the management process. This emphasises the importance of a comprehensive plan if both doctors and nurses are to be so

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involved. In the almost exclusive emphasis expressed in the Department of Health commissioned reports on the need to involve doctors in the process, the apparent ignoring of the need/benefit of involving nurses in the process is at least unfortunate. The study believes that the involvement of nurses is important and if the responses to the questionnaires support this view, then not planning for their inclusion and not including them in the planning is a major deficiency.

SUMMARY:

While there was a range of issues raised by the reports, the need to involve doctors and nurses in hospital management and the need for management development were recurring ones. Davies and Easterby-Smith [1984], found that managers developed most from experiences they had at work and not from specific training or education they received. .If this is the case, even if all the disciplines involved in multi-disciplinary management had the time to pursue significant further education and training, the findings of Davies and Easterby-Smith suggest that it would not necessarily be of great value.

Probably, one of the few areas where knowledge can only be gained from experience is the political dimension to management and Wood [1988:162], argues that "managers need to know that political influences are part of the management scene and be able to cope with them". The questionnaire sought to ascertain the degree to which politics was thought to be a potentially significant factor in planning the process. If the response suggested that there was a keen awareness of this factor,

then Wood's concern that managers need to know the political influences would be satisfied to some degree. If the response suggested the contrary, then the necessity for the planning process to take that into account is even more pronounced.

Involving doctors and nurses in hospital management will not guarantee that better and more effective management automatically follows. The competency of each of those involved will be a deciding factor in the outcome. Some measurement tool or scale must be available to assess performance. The reports referred to do not suggest any specific tools or scales for such measurement. True multi-disciplinary management must have equality of involvement if the process is not to become the preserve of one group of the participants. If this were to happen it would only be replacing the previous structure of individual management with another. Britnell [1995:5], refers to the possibility that "the management tier may become the preserve of individuals with a clinical background". If this should happen, then we may be as far from multi-disciplinary management as we were when the process started. This is another challenge to ensure that the planning involved is comprehensive and reflects vision. Lloyd and Bamford [1995:6], suggest that " the partnership model of clinicians and managers is the key". The study proposes that the partnership of all relevant participants is essential.

One of the significant aspects of the reports referred to and of the literature reviewed, is that the same themes arise. This should offer some comfort to those who are going to be participants in the process. It should not simply be a matter of heading into the unknown but rather of charting already well established territory and a

documented plan is suggested as the best way of doing this. Can a number of grid references be put forward to help in finding the co-ordinates for management development and the achievement of multi-disciplinary management? The study proposes that there can be.

Whatever approaches are taken, people and organisations will be two constants and over time the organisation will be shaped by its people through their cultures, fears, attitudes and competencies. This shaping will be done in various ways and in various guises for both rational and political reasons. If the shaping is to be controlled and influenced for the betterment of the organisation, it has to be done in some systematic way and a documented plan seems to be the best way of doing it. The plan is necessary to get the planning co-ordinates right. The key factors, the issues and the participants will affect the pace of getting there. The quality of the plan should then control this pace and determine the outcome.
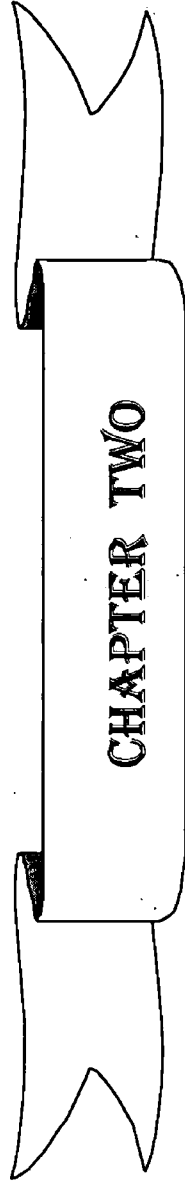
CHAPTER TWO

CHAPTER TWO

UNDERSTANDING ORGANISATIONS

The study proposes that it is not possible to change any of the fundamentals underpinning an organisation without changing the organisation itself. This in turn requires that those planning a change programme/process should understand how organisations function and how different management philosophies are likely to impact on the process. This chapter looks at organisational structure and organisational management under the following headings:

1. The composition of organisations;

2. The management of organisations;

3. The key elements in Planning organisational change;

4. Managing Organisational Change.

1. THE COMPOSITION OF ORGANISATIONS:

The involvement of doctors and nurses in hospital management will lead to changes in these organisations, for many reasons. Firstly, the sharing of managerial functions with doctors and nurses will result in greater levels of reporting to groups where this did not previously happen, e.g., administrative staff reporting to nurses who are business managers in Clinical Directorates and/or to doctors who are Clinical Directors. Long established beliefs, values, and work practices will be affected. The same will hold true for the other two groups in a number of ways. As organisations are made up of people and the changes that will be brought about for individuals will

also happen for the organisation, it is logical to argue that the planning advocated in chapter 1, must take account of organisational issues. The planning and subsequent management of change is in turn a component of managing the organisation as a composite unit.

Organisations need to be managed pro-actively and "all organisations have to make provision for continuing activities directed towards the achievement of their aims" [Pugh and Hickson 1976:374-396]. Organisations are complex structures and while it may not be easy to evaluate how successful ones own organisation is, Fletcher [1991:160], offers the following suggestions:

> "First, you have to decide what business you are in. Second you must get the structure right for your particular business. Third, you get the people right. So three things to consider; *the business, the structure, the people*".

The *business* should dictate the type and structure of the organisation. For example, hospital structures should reflect the purposes for which the hospital exists, i.e. the provision of appropriate hospital services to its patients. However, if the structures begin to be shaped by rigid organisational theory and by over complication of management structures, rather than by the business, then these in turn could result in loosing sight of what the business really is.

The *structure* will largely depend on the management philosophy. Planning organisational change should not be significantly different to any other management function within the organisation, but the managerial philosophy in place will impact to a major degree on the outcome. The type and structure of organisations will not change simply because of new ideas and concepts, but through planned processes.

The *people* are the third vital ingredient as all interactions will affect them and the people will be guided by issues such as culture; power; leadership; levels of trust; and politics, which together can be major influences in assisting change or alternatively bringing about resistance to change. In relation to planning change, the people in the organisation could be broken into three groups; the change sponsors; the change agents/planners and the change targets. Jowett [1995:2], argues that;

> "For any management initiative to work, or for an organisation to achieve the maximum benefit from change, you should aim to gain the support of twenty to thirty percent of the employees and such support can only be assured if the planning process allows and aims for it. There is likely to be a similar twenty to thirty per cent that we might call the change fearers or, more unkindly, the Dinosaurs".

If there is likely to be twenty to thirty per cent of the organisation who will offer resistance in some form or other, it is essential that this is dealt with in the planning process.

The American management guru, Rosabeth Moss Kanter, addressing the 1993 Annual Conference of the Institute of Health Service Managers, likened managing change [Health Services Management 1993:12], to "water polo in that managers know all the moves but are trying to do them in an unfamiliar environment". She added [:12] that:

> "Organisations that will survive change will focus on services they are good at, will be fast moving and able to incorporate new ideas, will be flexible and able to change direction quickly, will be friendly and collaborate with other organisations and will be fun to work for. Tall hierarchies should be abolished as by the time a strategy reaches employees at the base of the chain, it does not mean anything".

She exhorted managers to look across their organisations to see what could be done better, to look outside their organisations to see what could be adopted from elsewhere and [:12];

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"Everyone in the organisation should be encouraged to come forward with suggestions for improvements because when staff see that their suggestions are being adopted, they will react more positively to change".

Kanter saw change coming with bold strokes and long marches. The bold strokes must come from the centre or the top and the long marches will be about getting the staff on board. Both aspects are vital if the process of involving doctors and nurses is to be successful. Attempting to involve them without a documented plan is likely to be more of a reckless stroke than a bold one. The bold stroke will involve the acceptance that a plan is necessary, the confidence to develop it, the depth of vision to assess the likely factors and issues that will arise and having all the participants develop the necessary levels of trust to ensure that the plan can be implemented. The success of the long march will depend on the degree to which all aspects of the bold stroke, i.e. the planning process has been attended to.

The Business:

In considering the many classifications that can be found in the literature on the subject of organisations, a number are worth referring to. Of five basic configurations put forward by Mintzberg [1979], a hospital could be: a Professional Bureaucracy, a Machine Bureaucracy, or a Simple Structure. Blau and Scott [1970:40-42], saw the crucial problems of the service organisation " as the provision of professional services and the welfare of their clients which is presumed to be their chief concern". The reports proposing the involvement of doctors in hospital management emphasise the professional role of doctors and the degree to which they influence expenditure on the care of patients.

The Structure:

Structure involves matters such as levels of authority and responsibility, the location of decision making and the implementation of proper communication patterns. Bennis [1970:34], argued that "the social structures of organisations of the future will have some unique characteristics. The byword will be temporary. They will be adaptive, rapidly changing, temporary systems". Kanter supported the idea of the innovative organisation and classified organisations [1983:27-28], as being "integrative or segmentalist" and saw the integrative organisation as having:

> "The willingness to move beyond received wisdom, to combine ideas
> from un-connected sources, to embrace change as an opportunity to
> test limits. This type of organisation is pro change and is innovative.
> The segmentalist type is anti change-oriented and prevents innovation".

Hospitals will have to become integrative organisations if they are to cope with the type and degree of change that will be involved in multi-disciplinary management. Kanter [:13], saw successful change as requiring, "those people and organisations adept at the art of anticipating the need for, and of leading productive change".

The People:

Blau and Scott [1970:40-42], proposed that four basic categories of persons can be distinguished in relation to any formal organisation: (i) the members or rank and file participants; (ii) the owners or managers ; (iii) the clients, or more generally the public in contact e.g. patients; (iv) the public at large, i.e. the members of the society in which the organisation operates. The management of organisational change will

require some of these people to tackle the key functions of planning and implementation. The Organisation has to contend with a variety of needs relating to change. It has to adapt to change and may also have to overcome resistance to the change process.

2. THE MANAGEMENT OF ORGANISATIONS:

Managing complex structures involves a wide range of skills and Peters and Waterman [1982:3], felt that:

> "Much more goes into the process of keeping a large organisation vital and responsive than what policy statements, new strategies, plans, budgets, and organisation charts can possibly depict".

Griffin, Butler and Weightman [1990:266], in looking at management competencies at Thaemside and Glossop Health Authorities, found from their research analysis, that management seemed to involve four kinds of work;

(a)   running something or strategic jobs;

(b)   managing people or operations jobs;

(c)   technical work or professional jobs;

(d)   administration management jobs.

The authors did not see these as being in any way hierarchical, but what really distinguished between the jobs was the sort of work that had to be done and the group competencies required to do them. They classified these competencies [:267] as, *Generic; Strategic; Operational; Professional;* and *Administrative. Generic*

competencies are common to all groups in the multi-disciplinary context and would require that the organisational plan should ensure that they can be activated in the planning process. *Strategic Group Competencies* relate to managing the organisation and making things happen. *Operational Group Competencies* are mostly to do with managing people and keeping the show on the road. *Professional Group Competencies* are concerned with the technical work and the clinical independence philosophy of doctors could severely test the actual workings of the multi-disciplinary team approach. *Administrative Group Competencies*, may have some managers regarding this as the real management function.

The planning and management of change will require the interaction of all these competencies. If all of them are held by the three groups to satisfactory degrees, then with a realistic approach, it should be possible to achieve a multi-disciplinary management structure in individual self-governing hospitals. One of the ways suggested for involving clinicians in management is the -Resource Management- approach, which according to Coe-Legg [1990:178], is:

> "Based on the development of more sophisticated information systems upon which to base informed management decisions. However, enforcing a particular management structure is not compatible with true resource management which revolves around the willingness or otherwise of clinicians to get truly involved in making management decisions".

This suggests that ownership of the process by all three groups is vital.

In her report on experiences at the Pilgrim hospital, Boston, the question that Coe-Legg saw as important [:178], was whether budget responsibility should:

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"Be put dead on clinicians which presumes that consultants are leaders in the use of public money, or should they be put within the sphere of the behavioural influence of the consultant committing resources".

This is directly related to the emphasis being placed on the involvement of doctors in the management process, particularly on the emphasis for Clinical Directorates which are managed by lead clinicians.

The planning of change requires some knowledge and recognition of approaches to and theories of managing organisations and the study looks at three separate recognised approaches to the study of organisational management; (i) the **Classical Management** approach; (ii) the **Human Relations** approach; and (iii) the **Contingency** approach. Other writers have identified and classified these in different terms as representing different phases of management theory.

(i) The Classical Approach:

Classical management theory approached organisation management as a scientific matter where there is "a one best way" of rationally managing organisations. Can such an approach be exclusively applied to the process of involving doctors and nurses in hospital management, if organisations are more than task-oriented, technical structures? Ham and Hill [1984:79-83], see most prescriptions for improving organisation management and policy processes as being based on a model of rational decision making:

> "In essence rational decision making involves the selection of the alternative which will maximise the decision makers values, the selection being made following a comprehensive analysis of alternatives and their consequences".

The Rational approach has a number of stages: (i) defining the problem; (ii) deciding what the important objectives are; (iii) searching for and evaluating the various ways of achieving the objectives; (iv) selecting the most promising of the options evaluated; (vi) implementing the selected option; and (vi) evaluating performance relating to the problem defined in stage one. The Rational model in a bureaucratic structure "will operate within the constraints that organisational operation allows and busy managers locked into a bureaucratic system may find it difficult to respond quickly to new situations" [Key 1988:164]. Five possible constraints which could affect the bureaucratic model, according to Allison [1971], are:

(1)   It will have many standardised operating procedures which tend to be slow and ponderous;

(2)   Sequential attention is favoured by the many committees which are likely to exist in such organisations and often the most pressing need or demand is not the one that gets priority. Sequential attention allows for empire building which is not in the best interest of the organisation and is disposed to be anti change;

(3)   Groups within bureaucratic organisations may opt for coalition and co-operation instead of conflict.

(4)   While an organisation can learn and change through serious performance failures, the bureaucratic organisation is unlikely to do so.

(5)   An organisation learns (and changes) from change experience including past failures, but the bureaucratic organisation generally tries to ignore or forget about failure.

These characteristics are liable to weaken the responses needed to plan change and it is reasonable to doubt the all round usefulness of the *Rational Model* as organisations often fail to behave in ways expected by managers or change agents. Organisations are commonly slow to adapt to change and they are often rigid in the implementation of rules and procedures. They were seen by Thomas [1988:29], as "often plagued by arguments and disagreements between their constituent parts". Another difficulty about adopting a rational approach to dealing with change is that people within the organisation may not always behave rationally. This can happen because people will perceive facts differently and they may find it difficult to separate rationality and politics. The task of identifying and evaluating alternative strategies may be beyond the scope of many people and there may be practical/technical obstacles present.

(ii) The Human Relations Approach:

The Human Relations approach also involves a "one best way" approach. One criticism of this approach is the over emphasis on sentiment and the neglect of the very important matters of planning and co-ordination. It could be argued from these criticisms that a Human Relations approach to planning the process would not be one to choose as it possibly places too much emphasis on sentiment and relegates the organisations structure to the background. Again, it is necessary to consider if this approach reflects one's own organisation.

(iii) The Contingency Approach:

The Contingency approach is multi-dimensional and proposes that it is necessary to take specific circumstances or contingencies into account when looking at organisational and management systems. From these contingencies the theory has developed that there is no one best way of dealing with problems, making decisions or managing an organisation but specific decisions or actions are contingent on specific circumstances. The contingency approach differs from "the one best approach" theories of the Scientific Management and Human Relations approaches. The Contingency approach proposes that organisations consist not only of tasks that have to be performed, but also of people that have to perform them. Both have to exist in the same environment and one major contingency in organisations is likely to be its politics.

The Practical Perspective:

If organisational behaviour is not fully explained by the Rational, the Social or the Contingency approaches, or if any one model of organisational behaviour on its own does not adequately describe how an organisation might function at different times and in different instances, all the possible influences that could affect the situation, have to be considered. If the structure of the organisation is complex, a strategy has to be developed to assist in understanding it. Chandler [1962] proposed that structure followed strategy and if the strategic plan was down on paper, then the right organisation structure would be easily and readily identified.

From looking at the various organisation models, it is clear that on their own, each one is inadequate. A Political model, which will take people, politics, resistance, power and culture into account could be an alternative, because:

(1)   Real bargaining will be on parochial and very tangible issues. In the hospital context, parochial and tangible issues could include relationships between individuals and groups, the fear of losing power and position (managers) and also the fear of losing income (doctors).

(2)   Debating and bargaining hinge partly on ability and personality but very often rely on formal status and knowledge. This could be particularly relevant in the case of doctors.

(3)   Organisations seldom make major changes in direction but prefer to take small steps, thus not moving far from their existing position. Does this incremental approach tie in with what is required to implement the multi-disciplinary management process?

If the organisations politics will be crucial to dealing with change, then it is essential to look at how politics manifests itself and to look at the question of power within the organisation; who has it?; within what parameters does it exist?; how can it be harnessed and directed? Any potential change situation involves a whole range of interplay and interaction between opposing forces.

3.   THE KEY ELEMENTS IN PLANNING ORGANISATIONAL CHANGE:

Boyle and Joyce [1988:11-19], identified three key elements in the process of planned change:

"Roles are taken by or imposed upon different groups of people.. Perspectives on how organisations work affect the reaction of these groups to change. Stages are passed through as the change process moves from original idea to completion".

(A) ROLES	(B) PERSPECTIVES	(C) STAGES
change sponsor	technical	analysis/planning
change agent	political	initiation
change target	cultural	implementation

SUCCESSFUL PLANNED CHANGE
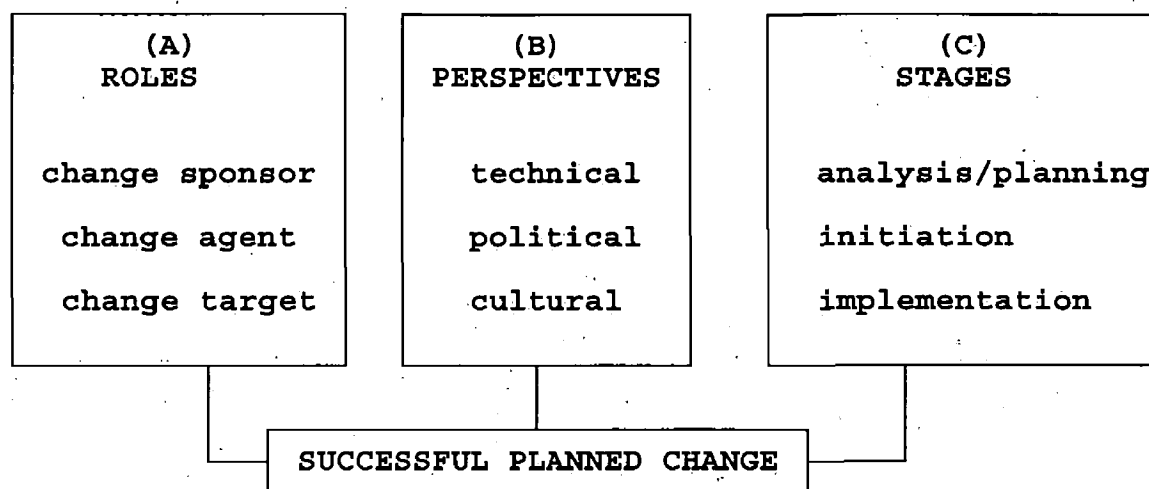
[source: Boyle and Joyce 1988:13].

(A) THE KEY ROLES:

(i) Change Sponsors;

These are the persons or groups who are responsible for authorising the change. Change sponsors may, once the approval is given, remain at arms length during the planning and implementation stages and simply monitor progress. In some cases, change sponsors and change agents may have overlapping roles. In a hierarchical structure, a line manager may be the change target in one instance and the change agent in another. Also, in the context of the study, it is not always clear who the overall change sponsors are; is it the Department of Health or individual Health Boards and individual hospitals?

(ii) Change Agents:

Bringing about change requires interventions by managers or change agents who intervene through; developing a need for change; establishing the change relationship; diagnosing the problems involved; examining alternatives; implementing the change; and arranging for continuous feedback. They look at the amount of pressure necessary to bring to bear on the targets for change and whether these pressures are to be mild or severe. Change agents can be either internal or external and the role of the change agent can be undertaken by a variety of individuals from within or outside the organisation.

Change agents should possess well developed inter-personal skills, as communication plays a vital part in the process. Inadequate or unacceptable levels of communication regarding possible or intended change will be a major difficulty to implementing that change. Proper communication is an essential in ensuring that different groups are successfully involved in a multi-disciplinary process. The questionnaires sought to establish what levels of communication was present in individual hospitals vis a vis the intended participants having a knowledge of, (i) what was the situation relating to the process, (ii) what planning stage had been reached and (iii) what were the organisation's objectives in relation to involving doctors and nurses in the management process. It was anticipated that the responses from the three groups would give indications about all three.

The management and decision making involved in change must examine the interventions necessary to bring about the change. External change agents can be more objective at diagnosing problems, because of obvious advantages, unbiased,

broad base of experience, specific skills, etc. External change agents work with change sponsors rather than working for them and interface between change sponsors (top management) and change targets (employees), to determine how decisions are made, to collect the necessary data and to diagnose problems. The results of external change agent's work may have a greater impact on the following than would the work of the internal change agent:

(a)   changing the organisation's culture;

(b)   changing managerial strategy;

(c)   changing the way work is done;

(d)   adapting to changes in the environment;

(e)   changing communications and developing trust.

It will be necessary at the planning stage to assess the relative benefits of external versus internal change agents.

(iii) Change Targets:

Change targets are the persons or group(s) whose tasks, attitudes or behaviour is to be changed. The targets will generally be the organisation itself and individuals and organisational groups within it. There are a number of perspectives which need to be considered as affecting the inter-action between the change agent and the change targets. Resistance is one response which may be forthcoming from the change targets and the reasons and the factors influencing this resistance must be understood.

The change targets in this study are primarily, the doctors and nurses who are to be directly involved in the management process. While they are change agents in one sense in that they are an integral part of bringing about the change, they are also targets in that general managers may be consciously trying to change them in order that they will adapt to conventional administrative thinking.

(B) KEY PERSPECTIVES:

Within a large organisation such as a hospital, one has to cope not only with the behaviour of individuals but also with the behaviour of groups and the behaviour of the organisation itself. The organisation may act like a rational individual, having specific goals and objectives. In order to meet these goals, the rational organisation will look at alternative courses of action and consider the consequences of each of the alternatives before finally making a choice. Rational behaviour recognises that goals can conflict but it believes that it can resolve these conflicts. Allison [1971], suggested that these types of organisations have certain characteristics and tendencies:

* **Technical:** they have standard operating procedures and they give sequential attention to problems that arise;

* **Political:** they form coalitions rather than resolve conflicts, they avoid uncertainty;

* **Cultural:** they learn, but they do it slowly.

In proposing that any organisation has four interacting variables "Task, Structure, Technology, People", [Leavitt 1965], outlined that each of these can give rise to different approaches to dealing with change. Boyle and Joyce [1988:14], in their

three perspectives, viz. Technical, Political and Cultural, went on similar lines. The *Task* approach aims at improving solutions to tasks and improving decision making. The *Structure* approach looks at the organisation itself. The Technology approach occurs outside of the work group and in most instances is triggered off by the environment. The *People* approach involves group working, attitude training and change in styles of management.

> "Planned change may alter the nature of an organisations tasks, or the way these tasks are carried out. The reactions of individuals and groups may be based on their perception of how the change will affect their performance in achieving the tasks they carry out in the organisation" [Boyle and Joyce 1988:14].

The study proposes that Change Sponsors and Change Agents need to have a range of political and rational skills to ensure success in their role and they need to develop an understanding of the social, economic, political and technological influences and constraints within which the organisation and individuals within it are active. They need to assess their strengths and weaknesses in relation to the political climate and they need to develop the skills to use elements of the Rational and Human Relations Models when appropriate within the context of the political realities at both macro and micro levels.

4.   MANAGING ORGANISATIONAL CHANGE:

Bennis [1970:67], proposed eight types of change programmes, of which the following are of relevance to this study:

(1) Exposition and Propagation:

Exposition and Propagation assumes that knowledge is power. The study does not attempt to measure the respective power positions of any of the three groups but advocates that their power bases have to be borne in mind in the planning process, because they are likely to influence the progress and the outcomes. If the idea of "exposition and propagation" is followed, whose knowledge and power is in question in planning multi-disciplinary management? Knowledge of what is involved in planning would be a valuable asset while using knowledge to protect power bases would not be an asset.

(2) Having An Elite Corps Lead The Change:

Who are the elite corps going to be? Ideas by themselves do not constitute action, irrespective of what any elite group might think and a strategic role is a necessity for ideas to be put into action. The matter of key roles is looked at in some detail in this chapter and the change agents mentioned could very well fulfil this function. If either the managers or the doctors were to see their roles as being the elite corps, the likelihood of success would be minimised.

(3) Human Resource Training and Staff Programmes:

Human resource training should not be regarded as a completely separate matter to management development, but should be directly linked in to the management development process. Staff programmes which observe, analyze and plan rationally, will be key factors in planning the process.

(4)   Circulation of Ideas to the Elite:

The circulation of ideas to the elite, those people with power and influence is vital both strategically and politically because these people are likely to be power brokers in implementing the process. It will be a matter for each change agent to decide who are "the elite".

(5)   Developmental Research and Action Research;

Developmental research is directed towards a particular problem and is concerned with implementing the plan and controlling the, programme of events. Action research involves looking at other organisations involved in similar projects or processes and would include benefitting from the experiences in other hospitals, similarly involved in such planning.

Bennis [:68], saw four biases with these types of change programmes which could seriously affect their outcome; (i) a *rationalistic bias;* (ii) a *technocratic bias;* (iii) an *individualist bias*; and (iv) an *insight bias.* A *rationalistic bias* does not guarantee successful implementation as knowledge about something does not lead automatically to intelligent action. There is acceptance of the need for change, all three groups would appear to have the required knowledge to become actively and successfully involved. The *technocratic bias* ignores any spirit of collaboration. The *individualist bias* of any of the three groups would pose serious problems for the process. The *insight bias* could lead to an ignoring of the external factors, which could be detrimental to the chances of a successful outcome.Two crucial aspects involved in the actual management of change will be the levels of support and resistance that

exist. The level of support for the change will have a major bearing on how successful the outcome is going to be. While resistance to change may in many respects, be a natural response, Lippitt [1982], felt that research shows it is possible to change people and that people actually like change but the reason they resist is due to the methods which managers use to put change into effect. The study strongly agrees with Lippitt's contention and feels that this again reflects the need for a comprehensive planning process, which ensures that support for and acceptance of the change process is encouraged.

Overcoming resistance to change is vital if the change process is to be successful. Part of the planning involved in the management of change must set out to overcome this resistance, which generally arises through some or all of the following; non-involvement; ignoring the status quo; personal fears; vested interests; the people proposing the change are not liked; and change can be seen as a process of laying blame. Proper planning and assessment of the likely reactions to change could pre-empt much of this resistance.

In relation to resistance to change it is very important to recognise that factors such as culture, power, leadership and politics all contribute to resistance to change. The literature review identified many ways in which these factors affect change and why/how they lead to resistance. Progress is seen as a good thing as long as it doesn't effect individuals and this holds also for organisations. Change can be a threat to the change targets while it can be used by change sponsors and change agents as an opportunity to make progress. Kolb, Rubin and McIntyre [1984], argued

that resistance to change can have a positive function. This could be the case where it would cause those proposing the change to re-examine and re-assess their proposals more carefully and modify them where necessary. Barriers or change resistance can arise at both the individual and the organisation levels but it is often difficult to pinpoint the exact reason for this at either level".

(a) Individual Resistance:

Reasons for individual resistance to change can, in some cases, be based on the individual's apparent rational thinking about the change. Individuals will be affected by tradition, culture, fear and uncertainty. It may be relatively easy to overcome individual resistance because individuals are likely to be responsive to pressures, whether they are group or organisational pressures. Individual resistance often leads to group resistance through the formation of either formal or informal groups. Formal groups in the context of the study would be doctors, nurses or managers acting as separate homogenous group, working for or against the change. Such groups would still be expected to act within accepted patterns of behaviour. It would be likely that informal mixed groupings of any two or more of the participants would be more difficult to manage.

(b) Group Resistance:

Change may be seen as a threat to the power or influence of certain groups within the organisation, such as their control over decisions, resources or information. For example, managers may resist the introduction of new structures because they see this as increasing the role and influence of non-managerial staff, and a threat to the

power in their own positions. Where a group of people have, over a period of time, established what they perceive as their 'territorial rights' they are likely to resist change and be unwilling to concede power. The "territorial rights " established by managers and doctors will have to be surrendered to varying degrees if the process of change is to be successful. In the new scenario, each group would have to be willing to surrender some of the powers and rights which they previously had.

(c) Organisational Resistance:

There are many reasons for organisational resistance. Organisations, especially large-scale ones, pay much attention to maintaining stability and predictability. The need for formal organisation structure and the division of work, narrow definitions of assigned duties and responsibilities, established rules, procedures and methods of work, can all result in resistance to change.

Factors Affecting Resistance To Change:

Two factors which are likely to play a part in the process in question are (i) power and (ii) culture. Weber [1947], defined power as the probability that an individual or a group will be able to carry out its own will even against resistance. Culture will include such matters as tradition, fears, beliefs and practices.

(i) Power:

Power can exist in many ways within the organisation and Handy [1985:115-140], lists a range of such powers; *Physical*; *Resource*; *Position*; *Expert*; *Personal/Charisma* ; and *Negative* power. In the context of this study, managers who have held both

Resource and *Position* power heretofore, will have to release at least some of it in a multi-disciplinary management structure. This is likely to lead to resistance. Doctors, in particular, have had significant *Position* power heretofore, although this has been through their profession rather than as part of a bureaucratic or hierarchical situation. Due to their training and expertise, they also have *Expert* power and the matter of clinical autonomy is the most easily recognisable display of this. The nursing profession could be said to have no clearly recognisable power base in the overall management context, although within the profession itself senior nurses have had significant authority in a very hierarchical setting.

(ii) Culture:

Individuals, groups and organisations tend to develop values and understandings, which mould people together in identifiable cultures. While all change will inevitably alter attitudes and lead to changes in behaviour and styles of management, it is very important to bear in mind that ultimately it is individuals who are first and who are most affected by change. People do not like change as comfortable routines may have to be altered and there maybe no guarantee at the outset that the new system will work as well as, let alone better than, the old one. No one person has a predominant right to demand acceptance of his/her culture,

> "It is the culture of consensus ....which needs to become the predominant culture and so break the various cycle of recriminations which continues to dominate in vital quarters. Some of my colleagues (doctors) in the past, wielded undesirable control and influence in some areas, but that should not be replaced by a get your own back- attitude from managers" [Macara 1995:2].

Organisational culture can be a very forceful weapon. It has been described as the hidden hand guiding the organisation. Schein [1983:22-24], defined culture as "the collected and shared wisdom of the group as it learns to deal with the environment as well as learning to manage it's own affairs". For the change agent, culture must be appreciated and must be understood to ensure that its many pitfalls can be avoided in the planning and management of change. Wilson [1991:25-47], refers to an on-going theme of consultants and theorists who claim that if the culture is changed, the majority of current organisational problems will be solved. Handy [1985:115-140], identified four types of organisational culture, viz,

* Power Culture;

* Role Culture (or) Bureaucracy;

* Task Culture;

* Person Culture.

A culture unused to change will find it more difficult to cope with major change than a culture which has been conditioned by incremental change. The change agent in assessing culture should try to convince people of a need to change and should not try to uproot culture completely but rather advance it step by step. For the change agent it is important to tailor strategy to the culture rather than the other way around. Culture, when it is left alone has an inherent self sustaining mechanism.

If major change impacts to a greater extent on static organisations then on organisations which have undergone even minor change and development, those that have undergone some change are likely to be better equipped to deal with major change. Planned change will allow for the adoption of a strategic approach whereas unplanned change requires a more ad hoc approach. The culture existing within the

organisation will have a major bearing on how change is implemented. While change and culture may not go hand in hand, successfully managing and bringing about change may over time bring about a "change culture". It is vital in considering change to consider and appreciate the culture that exists in the organisation and realise that in many instances this culture will act as an obstructive force.

Schofield [1990:169], in assessing the "radical changes" taking place in the N.H.S. looked at "Professional Tribalism". He saw this as " the most fundamental problem, the origins of which lie in the historic development of independent professions on a largely self-determined basis". Such tribalism may not only be inflexible and inefficient, but it may also lock those who are part of that system into an attitude of unresponsiveness and resistance. Involving doctors in the management of hospitals could offer the chance for them to show "the Bureaucrats" how hospitals should really be managed. If this attitude were to play any role, then the change certainly would not be effective and the organisation would be no nearer to achieving a corporate culture of shared values.

Managing Culture:

Managing organisational culture is as important as all other management tasks in the organisation. If the culture of the organisation is desirable and viable then do not initiate action to change it at this time. Alternatively if the culture is considered undesirable or not viable then initiate efforts to change it.

SUMMARY:

What relevance and benefits are to be had from having an understanding of how management approaches impact on how organisations function. Jowett's three (simple!) criteria look at the total organisation, its *business*; its *structure*; and its *people*. Some of the difficulties and problems associated with each of the three factors immediately suggest that plans to change any or all of them will not be trouble free. In the hospital setting, is the organisation integrative or segmentalist? Kanter proposes that the integrative organisation is willing to embrace change. It would therefore be important for change planners to ascertain if their hospital possesses this willingness, but to do so will require the ability to recognise if the organisation is integrative.

The clients or customers in hospitals are different to those of non service organisations. Health, per se, is not a "good" in the normal sense because the clients/customers do not have full knowledge of which and how much health services they require. The fact that doctors can largely determine this, (e.g., through "Physician Induced Demand"), means that the normal market forces do not act as an influence in how the organisation is managed. The power that doctors can get from their knowledge and expertise may be an obstacle to the real sharing of responsibility and accountability which will be necessary in a multi-disciplinary management situation. The planning process will have to recognise and plan how this can be overcome.

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The complexities involved in managing organisations can be seen from the range of theories and approaches adopted. The drawing up of a plan to manage the organisation must take account of all of these, even if it is only to decide that any particular approach is unsuitable for the task in hand. This is a complex enough matter in a straight forward management process, but when other groups are introduced into the equation, such as doctors and nurses, then an approach which might be considered very suitable for managers may not be suitable for doctors and/or nurses.

The need to identify the key elements in planning change is vital i.e., the roles, the perspectives and the stages. The calibre of the change agent will be a major factor so that the subsequent perspectives and stages are planned. The political influence must be given due recognition and those issues that can lead to resistance must also be addressed. How is the culture going to be managed so that it will be a positive rather than a negative influence? Who are the likely power brokers and what is the true level of commitment to the process?

This study proposes that any plan to introduce and manage change must allow for them and that if this is not done that the change process will not be successful. Different circumstances or situations may require different planning models or combinations of planning models, but if planning models are not considered the planning process will, in all probability, be unsuccessful.
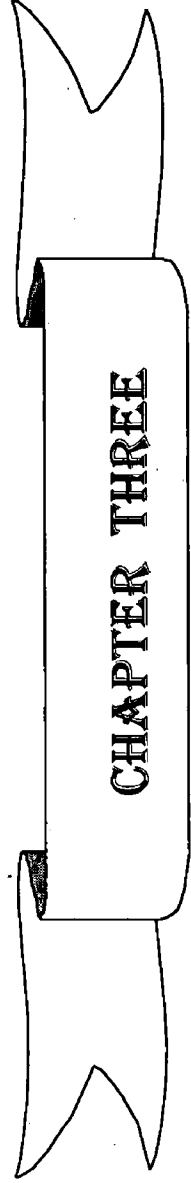
CHAPTER THREE

CHAPTER THREE

MODELS FOR PLANNING CHANGE

This chapter looks at models for planning change from both the theoretical and the

practical perspectives in order to assess if they could be significant determinants in

the planning and implementation processes. The chapter is structured in the

following way:

1.   It looks at different approaches to planning;

2.   It considers a number of planning methods;

3.   It looks at key stages in the planning process;

4.   It examines different theoretical planning strategies/models;

5.   It looks at planning models from the practical perspective;

1.   PLANNING APPROACHES:

Planned change requires interventions by change agents and decisions as to the

tactics to be adopted. However the style of intervention may vary and the tactics may

or may not be clearly defined. Co-operation is more likely to be achieved if the

people affected by the change, (the change targets), co-operate in its implementation

and are not stimulated to resist. If co-operation is unlikely to be forthcoming, the

resulting non co-operation or possible resistance will have to be overcome. If the

resistance is active, the task of planning the successful implementation of change will

be much greater.

Rules were prescribed by Cohen & March [1974], about the style and tactics of intervention, (i) spend time; (ii) persist; (iii) exchange status for substance; (iv) facilitate opposition participation; (v) overload the system; (vi) provide garbage cans; (vii) manage unobtrusively and (vii) interpret history. It is essential when planning organisational change to bear in mind the ways in which organisations can behave. If organisations find it difficult to change there is a likelihood that organisational change will come about much too late in situations of serious resistance. Therefore, change sponsors and change agents should bear in mind that:

1. Organisations cannot be taken apart and re-assembled differently as and when required;

2. Organisations have political aspects as well as rational approaches. Reactions to change processes must be examined from the rational perspective in relation to how it will affect work patterns, jobs, career prospects, and also from a political perspective, how it will effect power bases, status and prestige.

3. People in organisations operate in the Rational and the Political spheres of the organisation;

Interventions:

Greiner [1972:119-130], proposed that change agents tend to adopt one of three styles of intervention, (i) *unilateral action*; (ii) *sharing power*, and (iii) *delegated authority*. He believed that *unilateral action* may fail to generate commitment and the *delegated approach* may fail to provide the necessary guidance and support to achieve the change objectives. In relation to the planning process in question, if

unilateral action was a realistic intervention the objective of involving doctors and nurses in the hospital management process would most likely have been accomplished by either managers or doctors. It could be argued that the *delegated approach* has already been tried in the non-directional approach in the establishing of Pilot Sites.

Greiner saw "a *power sharing* strategy encompassing shared participation as offering the likelihood of avoiding these dangers and the possibilities of the unleashing of new surges of energy and creativity not previously imagined". This approach seems tailor made for multi-disciplinary management but it will not happen by chance. It will require careful planning involving all the participants and an appreciation and understanding of the potential baggage that each participant may bring to the process.

However, a *power sharing* approach may not work where radical change is at issue as a sharing of power may only help to weaken and lead to the loss of most of the initial objectives by the time the change is implemented. The study regards the introduction of multi-disciplinary management as a major change. To overcome the possible dangers of weakening the initial objectives, Hage [1980:243-245], suggests that:

> "A strategy of strategic replacement - recruiting a team of new occupational specialties and individuals with a shared change value set may be more effective. In accepting the strategic replacement argument, perhaps the best approach to achieve a radical change programme is to create a new organisational unit with new personnel and its own source of resources loosely tied to other parts of the organisation".

Hage's suggestion about creating a new organisational unit focuses attention on the importance of recognising that major change is likely to need the creation of new structures. The study does not set out to evaluate or criticise either of these view points. They are referred to in order to identify and highlight for change agents and change planners that the actual change task or project in hand may require a range of approaches.

Tactics:

The tactics used for planning change are likely to be very important. Legge [1984:26], argues that:

> "Whether a participative or authoritarian style is advocated in part rests not on the change agents assumptions but whether those involved are predisposed to co-operate or resist".

Greiner [1972:119-131], argued that change programmes are more likely to achieve success when their initiation, implementation and routinization follow a distinct series of steps in a logical sequence. These steps he identified as:

(a) pressure and arousal;

(b) intervention and re-orientation; .

(c) diagnosis and recognition;

(d) invention and commitment;

(f) experimentation and search;

(g) re-enforcement and acceptance".

Legge [:27), prescribed the following approach for managing change programmes based on these steps outlined by Greiner:

* do not attempt to introduce a change programme unless there exists a widely felt need for it;

* follow each step in the change process in a logical order and do not skip initial stages;

* always involve top management;

* always pilot a proposed programme;

* use a participative approach.

The need to change the way hospitals are managed has been clearly voiced in the reports referred to in Chapter One. The second step is the one which relates to this study, i.e., the need for a logical and planned approach. Top management is proposing the change in this instance, therefore it is involved from the outset as the change sponsor. The establishment of four pilot sites reflects the fourth stage proposed by Legge. The fifth stage involving a participative approach is at the core of the process as the aim is to involve different groups in the management process.

The study believes that planning change it is necessary to take both rationality and politics into account. Thomas [1988:29], says that:

> "Large organisations often fail to behave in ways expected by managers or change agents. Organisations are slow to adapt to change and as a result are rigid in implementation of rules and procedures. The task of identifying and evaluating many alternative strategies is beyond the scope of many peoples intellect, especially given the time constraints which most people are expected to work within".

The views expressed by Thomas are of importance for change planners as both group and individual choices are inevitably value laden and such subjective values may largely determine the objectives and the criteria to be used in judging which

means should be adopted in the planning approach. Rational decision making should not have to take a back seat to political expediency, but that can easily happen. The use of *prescriptive models*, (how things should be done) to the exclusion of *descriptive models* (how things actually are done), could result in an ignoring of the political aspects of organisations. If change planners do not recognise that different groups and levels in the organization operate in the Rational, the Occupational and the Political systems at different stages, then any likely resistance will not be dealt with in a positive manner.

The planning of change should, depending on the circumstances, reflect some or all of the different theories of organisations and of organisational management. Individual philosophies will either directly or indirectly shape the approach to planning change. The manager or change agent who is a believer in the combined Rational/Political approach, is unlikely to use or rely solely on any one method for planning change in the organisation.

2. PLANNING METHODS:

Theoretical approaches or models have to be considered, as it is very difficult to embark on any management venture without having some theoretical framework to use as a starting off point. However, as theories may not readily translate into practical application, practical models have to be developed from the theoretical approaches. Lee [1988:130-131], proposes that;

> "Apart from the subject matter, or content of plans, there are three broad methods of planning, **(i) Comprehensive Rational Planning; (ii) Planning for Uncertainty; and (iii) Modular Planning"** .

(i) Comprehensive Rational Planning:

The advantage of this method, according to Lee [:130], is that it is:

> "Comprehensive and rational and as far as possible, it takes account of all known factors. It is rational in that it starts with ultimate needs and goals and ends up with implementation and effectiveness".

In chapter Two, some of the strengths and weaknesses of the Rational Approach to managing organisations was considered. However, the Comprehensive Rational planning approach advocated by Lee relates more to the actual planning approach rather than to its implementation.

(ii) Planning For Uncertainty:

This method is concerned with planning for the future. However, the further one looks into the future the greater is likely to be the level of uncertainty. Again, Lee [:130-131], suggests that in terms of planning for uncertainty:

> "The contents of the plan should contain a careful analysis; a statement of the general aims and objectives; forecasts of what is likely to happen in the future; and a structural framework that identifies, in so far as possible, the decisions that will need to be taken".

This type of planning offers a framework for future decisions, but the plan itself does not attempt to take these decisions. The emphasis in this approach is understanding the present and the issues to be addressed. However, Lee makes the point that this type of planning is really not planning at all, because planning is concerned with making decisions about the future, even though one does not know what the future will bring.

(iii) Modular Planning:

The task of drawing up a comprehensive plan is a daunting one and modular planning starts of from the premise that it is impracticable and that high levels of uncertainty will make it much more difficult to realistically plan on a grand scale. Advancing in modules allows for flexibility and also allows for review and updating of the plan at regular intervals. This will in turn, require all the participants to be fully involved in the process. Lee [:131], refers to the very serious situation where "clinicians and members of the professions are potentially in conflict with managers". In this scenario the emphasis must be on getting all sides to collaborate with each other. This will require a planning framework that allows participation and involvement by all three groups.

The study believes that each approach has some relevance to the planning process at issue but equally any one of the three approaches would not be adequately comprehensive. The Comprehensive Rational Approach can be a good starting base, the Planning For Uncertainty approach can provide the framework and Modular Planning can be translate the plan into action.

3.   KEY STAGES IN THE PLANNING PROCESS:

The study considers, based on the literature review, that the following points and views have to be borne in mind when planning change:

* change should never be for change sake;

* good communication is essential from the outset;

* an awareness of the need for change should be created;

* a designated group of people should be asked to undertake the planning process;

* it may be necessary to accept something that is less than perfect;

* it may be a slow process to introduce complete change and it may be necessary to accept incremental progress if it will result in effective change;

* the necessary changes must not be let disappear under a cloud of lethargy.

Boyle and Joyce [1988:22], examined the progression from one state to another in managing change, i.e. from the existing state to the desired or outcome state, where the existing state reflects the current status/position of the organisation and the outcome state shows the intended results, after the change intervention. They proposed that to get from one state to another involves:

(i) moving from existing state to implementation stage, by analysis and planning;

(ii) moving from initiation stage to implementation stage by high level commitment;

(iii) moving from implementation stage to outcome state through review and evaluation of the results.

The outcome state will depend on the levels of success achieved in the implementation and on the effectiveness of the change. These stages in the planning process are important and it would be beneficial to approach them in the stages suggested by Boyle and Joyce. If analysis does not take place, the change planner

cannot know what needs to be done. The analysis should show up some deficiency before change is seen as necessary. In management terms, such a deficiency would be a gap between actual and expected performance. Once the gap is recognised some planning has to be initiated if it is to be rectified. The plan has to be credible if it is to stand any hope of being successfully implemented.

The initiation stage requires that there is commitment to the plan at a sufficiently high level to ensure that the necessary willingness is present to give it the needed impetus. It is also essential that resources are made available if the plan is to succeed. If the right climate does not exist, then planning change will not be regarded as an essential task. Schofield, saw the need [1986:60-62], for having a systematic approach and the right strategy. The systematic approach calls for a comprehensive plan of how the management development programme is to be tackled and carried out. The strategy is about setting the right pace so that there is a regular inflow of young people, particularly of graduates, to ensure that there is a fast track of managers heading for the top.

4.   PLANNING STRATEGIES/MODELS:

Models offer guidelines or parameters to change agents, but there is no one definitive strategy to implement any one of these models. Prescriptions about change strategies according to Legge [1984:23], focus on three issues:

(1)   Leverage Point, (where should you intervene?);

(2)   Mode, (what style of intervention should you adopt?);

(3)   Tactics, (what steps should the intervention involve?).

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Among the writers who have referred to the leverage strategy is Leavitt [1965]. His "Task, Structure, Technology and People" variables, are largely prescriptive and provide that a change agent can intervene in any one of these variables even though they are taken as individual factors. However, it would not be realistic to propose that intervention or planned change to any one of the variables would not have a knock-on effect through unplanned change in another, unless, those knock-on changes are anticipated and planned for. Because of these repercussive effects, [Legge 1984:25]:

> "Change strategies in one area will have implications for the others, a strategy may be used as a means to a further change rather than as an end in itself".

Reference has already been made about planning models being either (a) Prescriptive or (b) Descriptive, but it could be argued that some of them are in ways, both prescriptive and Descriptive. Legge proposes [:16], that:

> "There is a choice about whether change may be viewed as a subjective or an objective reality. There is a further choice about whether a normative perspective is adopted - about how best to achieve different outcomes, or a descriptive one - about the dynamics of becoming".

(a) PRESCRIPTIVE MODELS:

(i) Rational Scientific Models:

The term planning according to Legge [:19], suggests that the process "involves choices or decisions about goals and objectives and the course of actions necessary to achieve them". Such a definition suggests a rational approach to decision making. Legge then argues that to achieve rationality, requirements which have to be met

requires decision makers who will, (i) make clear their values and express them as a consistent set of goals and objectives; (ii) generate and examine all the alternatives available for maximising goal achievement; (iii) predict the necessity, utility and probability of all the consequences that will follow from the adoption of each alternative; (iv) compare the consequences in relation to the agreed set of goals and objectives; and (vi) select the alternative whose consequences correspond to a greater degree with goals and objectives.

(ii) Incremental Models:

Advocates of the Incremental approach could argue that incremental change or incremental development in organisations is not only inevitable but logical as decision makers are likely to plan through limited comparisons and incremental decisions rather than the one grand plan. It is logical that managers may pursue an incremental approach to deal with complex issues when they are aware that it is not possible to know or foresee all the influences that could effect their organisation in the future. Incrementalism also takes into account that organisations are political entities in which trade offs between different groups are necessary and such compromises mean that it is not possible to arrive at the optimal goal or strategy. This incrementalism can take two forms; a *Logical Incremental* strategy; and a *Disjointed Incremental* strategy. A *Logical Incremental* strategy according to Johnson [1993:60]:

> "Is a feature recognisable in many organisations. We need to be careful about building too much upon what managers espouse, because they espouse the idea of logical incrementalism does not necessarily mean they behave in such ways. It does not mean that we can build normative models of management upon such espousal".

A *Disjointed Incremental* model presents an alternative to the rational decision making model. In this model decision makers make a series of not necessarily linked incremental decisions. The Disjointed Incremental model suggests that there should be no attempt to be comprehensive, as it is not possible to look into all the hypothetical alternatives. Planning should try "to achieve marginal improvements on the existing state of affairs rather than goals towards which to move" [Braybrooke and Lindblom 1963:104]. The concept of staggering through a problem taking one disjointed incremental step after another may not be very appealing and is not in line with the concept of innovation as proposed by Kanter [1983], and Peters and Waterman [1982].

(iii) Bounded Rationality :

Planning has to be in some way rational if it is to achieve its objectives. It is reasonable to regard planning as being "concerned with deliberately achieving some objective and it proceeds by assembling actions in some orderly sequence" [Hall 1974:4]. Planning has to involve choices and decisions about goals and objectives and the actions necessary to achieve them. However, decision makers will not always be able to agree on objectives they wish to achieve and decision makers will not always be capable of evaluating all of the alternatives and choosing one which will maximise the expected utility of each alternative. In real life a Rational Comprehensive approach to decision making according to Legge [1984:20]:

> "Can only be found where decisions are highly routine, where means/ ends relationships are already known and consensus exists about outcome preferences".

However, if the Rational Comprehensive model is not attainable because of "bounded rationality " [Simon 1957], planners will have to settle for being satisfied with what is attainable rather than attempting to attain their maximum goals. This "Bounded Rationality" approach suggests that in most circumstances Change Sponsors and Change Agents will not have full knowledge of all alternatives open to them and the consequences of each alternative.

(iv) The Mixed Scanning Model :

In some circumstances the Rational Comprehensive model and the Bounded Rationality model "may not only be unrealistic but they are actually inappropriate for complex planning" [Legge:20]. As the Rational Comprehensive models, the Incremental models and the Bounded Rationality models of planning are seen to have these flaws, a compromise Prescriptive model has emerged i.e. one of "Mixed Scanning". This model according to Legge [:22], provides prescriptions about:

(a)   collecting information - "Scanning";

(b)   allocating resources;

(c)   looking at the relations between the two by "dichotomising the planning progress".

Mixed Scanning according to Legge involves looking at the overall picture in a rational way and also looking incrementally at situations where similar proposals have been looked at in order to get a better idea of the approaches to take. Legge proposes that when incremental decisions are made within the context set by the overall decisions framework, it requires scanning at a highly detailed level and

selecting alternatives in realistic way. Mixed scanning "represents a realistic description of the strategy used by actors in a large variety of fields" [Etzioni 1973:223], and in the context of this study it could be related to the overall rational objective of involving doctors and nurses in hospital management and using the experiences in individual hospitals as a guide.

(b) THE DESCRIPTIVE MODELS:

The Rational approach is likely not to give due recognition to the political aspects of organisations. The process of planning change involves a complexity of strategic issues which may lead to uncertainty within the political environment of organisational systems. "In such circumstances the tenets of Scientific Management, whilst providing needed conceptual models, may be of less assistance in managing strategic change" [Johnson 1993:59]. If Rational models dominate approaches to the concept of strategic management, other models may better describe how strategies are actually formulated and implemented in organisations.

The Prescriptive Models have to reflect to some degree how planning actually takes place and Legge [:29], outlined that:

> "The *Disjointed Incremental* and *Mixed Scanning* models are claimed by their authors, (i.e. Lindblom and Etzioni respectively), to represent or reflect what actually occurs during decision making, as well as being models of how decisions ought to be made. Similarly the proponents of the Bounded Rationality model also claimed that as well as being normative models they also have some descriptive basis".

Cohen et al. [1976], put forward a *Descriptive Model* of how decisions are made in what they called the "Garbage Can" model. In this model, decision making situations are seen as being appropriate to "a garbage can into which various problems and solutions are dumped by participants" [:26]. They argued that in situations of options or choices, while the main concern may be with making decisions, other activities may be seen as equally important. These other activities could include fulfilling previous commitments, justifying past actions, laying blame or cementing loyalties. As a result, choosing an option or choice situation could be used as an opportunity for airing issues and feelings rather than a rational problem solving opportunity. Cohen et al. [:25], believed that the reason why planning processes may bear:

> "More resemblance to the "Garbage Can" than to the orderly logical procedures specified in the rationalistic normative models, is because rules are often problematic, means and relationships are often unclear and participation often uncertain".

They further suggested that their *Garbage Can* model of decision making represents or describes "how decisions are made when goals and means/ends relationships (that is how to achieve the goals) are problematic". Legge [1984], looked at all four models i.e. Mixed Scanning, Bounded Rationality, Disjointed Incrementalism and the Garbage Can, (as descriptive models), to see what actually takes place in given situations. She saw [:33], that "the more political the environment the more likely it is that planning will resemble the *Disjointed Incrementalism* and *Garbage Can models*".

5. PLANNING MODELS IN PRACTICE:

It is a matter for the Change Planners and the Change Agents to decide whether their approach is Prescriptive or Descriptive and if they overlap, as suggested, it may be advisable not to overly concentrate on this aspect. They could all be regarded as relating to the Initiation stage of the planning process and all have something to offer to the planning process.

The matter of Implementation also has to be addressed and the planning approaches, methods processes and models might be regarded as equivalent to the many parts and components of an engine, which when functioning in unison result in an instrument for propulsion and movement. The following models are suggested as possible ways of achieving this movement, but it would be a matter for individual organisations if and how they could be used in their respective change programmes.

(i) Force Field Analysis:

Pedler et al [1978], identified the idea of "Force Field Analysis". This concept outlines a number of stages through which a manager can work in planning and managing change. These stages are:-

(1) Define and analyze the change problem;

(2) State specifically how you would like to change the situation;

(3)   Identify the pushing forces (which are likely to help you bring about the desired change) and the resisting forces (which would probably hinder the implementation of the change;

(4)   Rank or weight, the various pushing and resisting forces as high, medium or low according to how powerful or decisive you think they are likely to be;

(5)   Prepare and evaluate a strategy which will help to implement the desired change, bearing in mind the various ranked or weighted forces identified in stages three and four.

The forcefield surrounding the contemplation of change is seen as involving driving and restraining forces. If the sum of these opposing forces is equal or approximately equal there will be no movement away from the status quo. For change to occur, either the pushing or driving forces must be increased and/or the pulling or restraining forces reduced.

(ii) Unfreezing/Changing/Re-freezing:

Lewin [1951], advocated this process which begins by un-freezing the existing equilibrium and creating a motivation to change. Once this step is accomplished, the second step of implementing the change moves people towards new behaviour patterns. The third step of re-freezing involves experimenting with new behaviours and receiving feedback to confirm if they are appropriate before fixing them. Where the change process is a continuing one, the concept of re-freezing would be a means of securing the progress made while the process would start again at a planned time.

(iii) The Prince System:

Ruchelman [1985:31-38], advocated the "Prince System" of implementing change by:

* identifying the relevant groups and organisations involved in a particular problem issue or proposed change;

* assessing the current attitude of each group and whether they are likely to support or oppose you in your effort to implement a particular change;

* assessing the degree of power of each group;

* setting out an assessment in tabulated form to clarify your judgement as to whether you are likely to be swimming with or against the stream in implementing this particular change at this time.

(iv) Political Strategies:

Lee and Lawrence [1985], developed a range of political strategies to help managers to increase their influence in various situations including the management of change:

* push strategies;

* pull strategies;

* persuasion strategies;

* preparatory strategies;

* preventive strategies.

Push strategies involve actions which cause change targets to feel that pressure is being placed on them. To a certain degree, this involves waving the big stick. Pull strategies on the other hand involve the carrot approach involving motivation etc.

Persuasion strategies attempt to change attitudes, opinions, beliefs and values through training or negotiation. Preparatory strategies involve managers or change agents attempting to create the right environment for other strategies to be more successful such as choosing or creating the right moment. Preventive strategies involve various forms of non-decision making manoeuvres. While each of these strategies have their own advantages and disadvantages, they do provide a framework on which managers can draw when managing change.

(v) Strategic Management:

Strategic Management as an activity, comprises three steps; Strategic Review, Strategic Planning and Strategic Change and these three steps must occur in a continuous and fluid process.

```
STRATEGIC REVIEW
*   Identify
*   Evaluate
*   Assess


STRATEGIC PLANNING          STRATEGIC CHANGE
*   Objections              *   Indicate
*   Options                 *   Allocate
*   System Support          *   Evaluate
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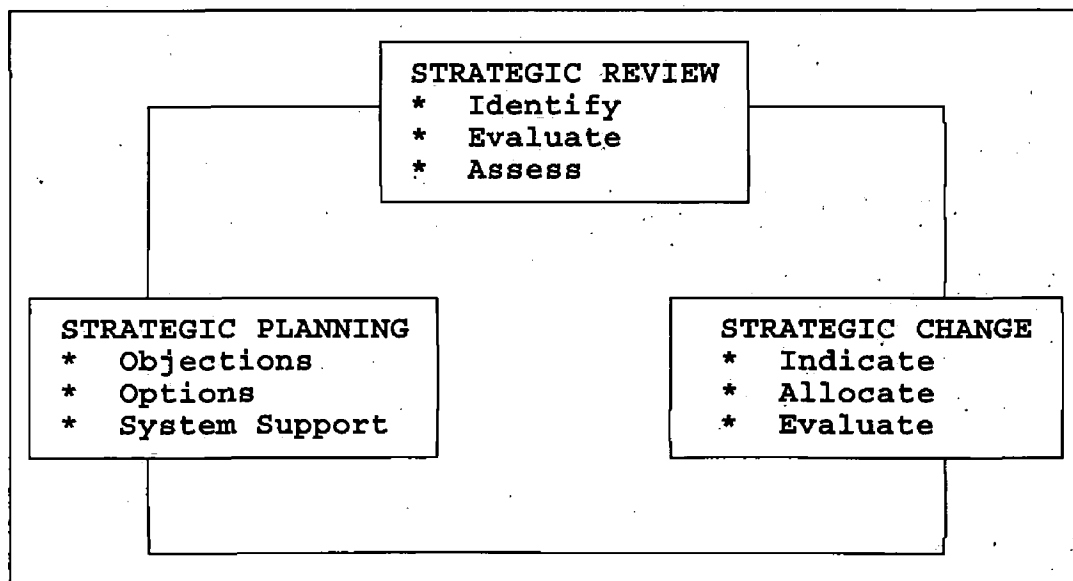
[Source: Health Services Management, June 1988].

The first of the three stages, *Strategic Review,* must identify the strategic problems and involve consideration and evaluation of the environmental factors associated with the problems. *Strategic Planning* begins with the selection of the objective to be pursued. Once the objectives have been selected, it is necessary to look at the means and the medium by which policies or objectives are put into practice or brought about. At the level of *Strategic Change,* it is necessary to cultivate and nurture the climate for change and to settle and institute the strategy. *Strategic Change* requires that tasks are allocated in line with the organisational structure and most importantly that the management of change must be a continuing process.

(vi) The Four Factor Model:

This model for managing change was put forward by Keleher and Cole [1988], in the context of the then impending changes being contemplated in the British National Health Service and provides according to Keleher and Cole [:169]:

> "A framework which takes account of the vital elements and their interactions which are essential in implementing effective change. Whatever the change effort, at whatever level and of whatever scope, there are four essential factors ., which are critical for success, (i) Practicalities - resources, skills and structures; (ii) Politics - power bases and behaviour etc.; (iii) Promotion - relating the organization to it's markets; (iv) Perception - seeing what really happens".

(vii) Organisation Development.

Organisational Development (O.D.), can play an important role in many organisational activities including change management and is according to Bennis [1970], a response to change and a complex strategy intended to change the beliefs, attitudes, values and structure of organisations so that they can better adapt to new technologies, markets and challenges, and to the rate of change itself.

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This suggests a direct links between Organisational Development (O.D.) and the planning of change. O.D. can be used to design and plan the introduction of specific changes. The objective of involving doctors and nurses along with administrators in hospital management is a form of organisational renewal. Lippitt [1982:xiv], saw organisational renewal as:

> "The process of initiating, creating and confronting needed changes, so as to make it possible for organisations to become or to remain viable, to adapt to new conditions, to solve problems -and to learn from experiences".

Harrison & Robertson [1985:125-129], in proposing the O.D. approach as a way of enabling organisations to become more effective at anticipating, planning and implementing change, used a model that identified several levels of managerial activity which must receive attention in any organisation if it is to continue to operate effectively.

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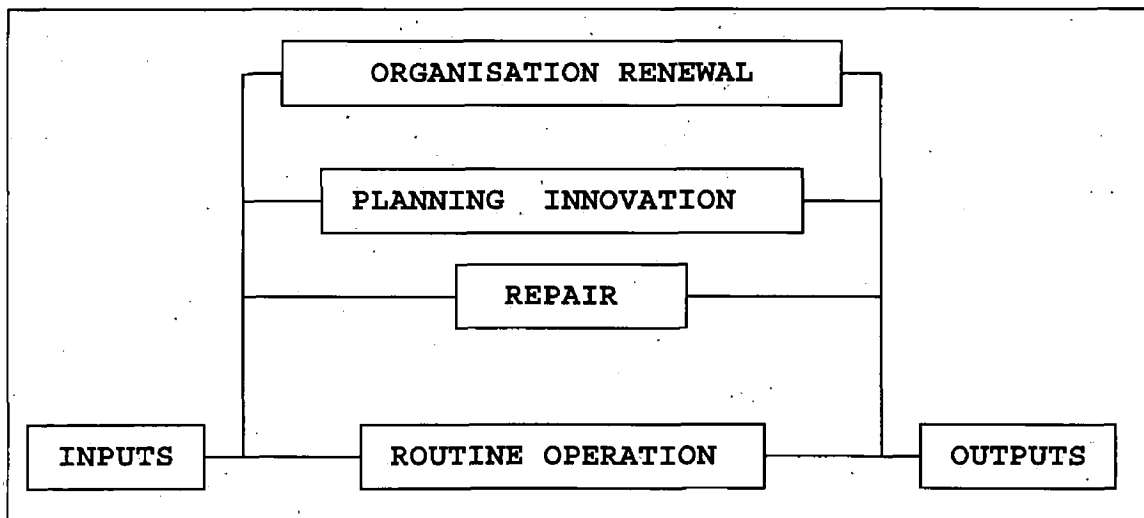
Model of Managerial Levels (as used by Harrison & Robertson)

Organisational development also aims to build the confidence an skills needed to make effective changes. However, even where O.D. is used as a tool for planning change, there are many reasons why it might fail:

(a)   Top management is not committed;

(c)   Impatience for quick results;

(d)   Lack of co-ordination between the individuals involved;

(e)   Over-dependence on outside help and/or on inside specialists;

(f)   ·Poor communication between top management and middle management;

(g)   Trying to fit a major change into an old structure;

(h)   Confusing good relationships as an end rather than a condition;

(i)   The search for ready-made solutions. Off-the-peg remedies don't necessarily work;

(j)   Applying inappropriate intervention strategies simply because they worked in other situations.

(viii) Management Development:

The reports referred to in Chapter One, repeatedly refer to the need for management development. Reference has also been made to the management development initiative being undertaken by the Department of Health in the setting up of the **Office For Health Management** and by producing a report, "Management Development In The Personal and Social Services", which is looked at in Chapter Seven.

Attwood [1992:21], felt that "many top managers have been tempted to neglect their own development in the face of massive agendas". The N.H.S. Training Directorate has worked with managers to support the effective management of change. One of the messages coming from these situations was that the needs of senior managers are linked inexorably with the organisations they manage. If this finding or message holds true in the Irish situation then any management development initiative embarked on cannot ignore or be separate to the needs, plans and development of the organisation. In reality, organisation development and management development are not mutually exclusive. Implementing a management development strategy "will depend upon an emerging understanding within the service" [Attwood:23], so that **corporate policy,** the search for and realisation of corporate identity, and **management development**, the search for and realisation of individual identity can feed each other in a mutually developing process" [Burgoyne 1988].

SUMMARY:

Planning Approaches:

The study proposes that in the planning approach, consideration has to be given to the style of intervention and to the tactics to be used. The importance of planning approaches was outlined by Greiner (1972), Hage (1980), Legge (1984) and Thomas (1988), among others. Hage suggested that the type of change at issue could determine the type of approach that needed to be adopted. He saw radical change as being possibly weakened by shared participation, but Greiner saw such an approach as unleashing new surges of energy and creativity not previously seen in the organisation. To resolve this possible dichotomy, Legge suggested that choosing

between a participative and authoritarian style in part rested on whether the change targets were pre-disposed to co-operate or to resist and not on the Change Agent's assumptions. This shows how involved the process of change can be and why change has to be analyzed and planned in detail.

Planning Methods:

Once the approach, style of intervention and tactics have been worked out, it is necessary to consider different planning methods. The literature review identified three methods; (i) *comprehensive rational planning*; (ii) *planning for uncertainty*; and (iii) *modular planning*. It will be a matter for each hospital to assess and decide which planning method best suits its situation, but planning cannot be done without some assessment of what method should be adopted.

Key Stages In The Process:

Boyle and Joyce (1988), identified the different states involved, i.e. the existing state prior to the change process and the outcome state following implementation of the change. They identified the key stages of initiation and implementation in this movement from one state to the other. The change plan should examine the existing state before initiating the change and decide what outcome state is hoped for when the change has been implemented.

Planning Strategies and Models:

The willingness to accept the validity of models for planning change should lead to attempts to put them into practice. It is unlikely that any one approach will address

all the issues through which the change process can be planned and implemented. Therefore, the planning model or models to be used must be carefully considered. If a *Prescriptive* approach is being used, the choice of model will rest between; *Rational Scientific, Incremental, Bounded Rationality* and *Mixed Scanning*. If a *Descriptive* approach is being taken the *Disjointed Incremental* and *Mixed Scanning* models as well as the *Garbage Can* model (suggested by Cohen et al) can be used.

Planning Models In Practice:

The change sponsor(s) and change agent(s) must consider how the change is to be implemented. This will be dependant on how much rationality can be applied to implementing the change and to what degree this will be affected by the politics in existence. For instance, Pedler's "Four Skill Analysis" approach offers very little scope for the external change agent. It can define and analyze the change and outline how the change should ideally be brought about. While Pedler's approach can identify in general terms the pushing and resisting forces which will be present, it cannot rank or weight the various pushing and resisting forces as being high, medium or low and therefore cannot prepare a detailed strategy to implement the change. Ruchelman's "Prince System" may be too subjective and judgemental to be used by external change agents who are not familiar with the nuances and cultures that exist. The political aspects of the organisation and of the change process need to be considered and Lee and Lawrence through their five political strategies, also offered a framework for planning change. The Strategic Management and Four Factor models both include/involve political aspects.

The combined strategies of Management Development and Organisational Development could be a very practical approach to take as together they would involve combinations of many of the methods, styles and models discussed. This combined approach would require wide participation and it would be working towards identified goals. The pilot sites could be used to examine the aspect of organisational development and the Department of Health's intended initiatives into management development could be used to compliment this.

This chapter is intended to give change planners as broad a view as possible of what can be involved in a change process. It does not attempt to advocate any one approach, concept or model as being the one to adopt. The situation in individual organisations should be looked at and then the individual experiences gained should be shared and evaluated by organisations involved in the same or similar change processes.
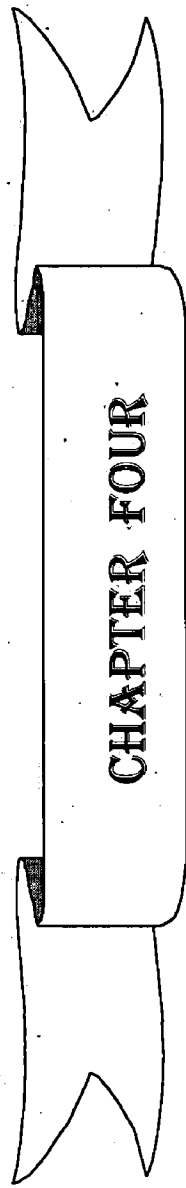
CHAPTER FOUR

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

The approach to carrying out the research and the subsequent analysis of the research must be structured and planned. Research Design refers to how research is carried out, while Research Methodology is the theoretical study of the logical basis of research, of collecting data and interpreting and analysing the findings.

RESEARCH DESIGN:

The Research Design adopted was to use questionnaires to gather the information required. This approach was used in the belief that interviews would be difficult and would not offer a comprehensive approach because of the likely difficulties in getting the required time to conduct the interviews, particularly with the doctors. McNeill [1990:14], says that:

> "In relation to Research Design, nearly every study uses more than one method, though there is often a strong preference for either survey-style research or participant observation. Misgivings are often voiced about the use of questionnaires. The postal cost can be a limiting factor and the general response rate to questionnaires is regarded as being generally between thirty and forty per-cent, while interviewing generally has a response rate of between sixty and seventy per-cent".

The response rate in this study was expected to be high because of personal contact and acquaintance with the managers and in the hope that enthusiasm for the process would guarantee a high response from doctors and nurses. The postal cost was spread out over four phases and was not a limiting factor from the perspective of issuing the questionnaires and stamped addressed envelopes were provided for the respondents to return the questionnaires.

RESEARCH METHODOLOGY:

Research Methodology "involves the important concepts of "*Reliability, Validity* and *Representativeness*" [McNeill:14]. The concept of *Reliability* relates to the need to ensure that the method of collecting the information/evidence must be reliable so that any other person using the same method, or the same person using it at another time would come up with the same results. In other words the research must have repeatability. The questionnaire used in this research was designed to result in standardised answering.

The concept of *Validity* refers to the problem of whether the data collected is a true picture of what is being studied. This is not to suggest that respondents to questionnaires deliberately tell lies, but one has to consider if actual observation would be likely to produce a different picture?. The study considered this as a potential problem, because respondents might answer "yes" rather than "no" to questions for many reasons. It might be regarded as the political thing to do, theory might be confused with fact and the theoretical acceptance of a situation might mistakenly be classed as representing the actual situation. The respondents might answer questions positively in order to create the impression that their organisation was taking an active part in the process.

The concept of *Representativeness* relates to the degree to which the research findings are representative between situations, organisations and respondents. The matter is dealt with in the research approach through the issuing of questionnaires

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to all general hospital managers, whose responses in turn would identify the doctors and nurses who should be included in the study. This approach was intended to ensure maximum representativeness.

THE RESEARCH APPROACH:

The research involved was intended to be both descriptive and explanatory in that it sought to describe peoples views and perceptions which in turn would explain their attitudes to planning. It sought to examine what effect or impact these views and attitudes could have on the planning process and also what effect existing planning processes could in turn have on these views, perceptions and attitudes. McNeill [:10], says that:

> "The distinction between descriptive research and explanatory research
> is often blurred. Any explanation requires description and it is difficult
> or perhaps impossible, to describe something without at the same time
> explaining it".

If the planning of change requires a documented plan, as proposed by the study, then it would be reasonable to suggest that the approach to carrying out the research should also document the steps that have to be taken. There must be identifiable stages in a research study to reflect the concepts of *Reliability*, *Validity*, and *Comprehensiveness*. The stages which the study saw as being appropriate to the research were: (i) choosing the topic; (ii) the literature review; (iii) identifying the population to be surveyed; and (iv) finalising the research instrument.

(i) Choosing the Topic To Be Studied:

Generally, the choice of topic would come before the Research Design and this in turn greatly influences the Research Design. The choice of topic must be well thought

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out and ideally should be of interest to the researcher. In the case of this study, the interest in the topic prompted the study and it was a matter of designing the research to meet the objectives of the study.

(ii) The Literature Review:

It is very important to look at what other people have written about the topic under review. It can give ideas about Research Design and about the key issues and methods of collecting data. It is also part of the process of increasing one's knowledge. . The literature review should lead to the forming of hunches and hypotheses which is essential to give the researcher ideas as to which questions to ask and which avenues to follow.

(iii) Identifying the Population To Be Surveyed:

Once the topic was chosen, the matter of identifying the population to be surveyed was relatively simple. The managers were readily identifiable and their responses would in turn identify the appropriate doctors and nurses. From a research perspective, this could be classed as *multi-stage purposive sampling* in that the responses from the first population sample (the managers) identified the next sample (the doctors and nurses) and the particular groups chosen were the intended populations.

(iv) Drafting the Research Instrument:

The literature review plus the reports which prompted the study were used to frame the questions. The first questionnaire (Appendix One), which was issued to

managers, was piloted with a small number of the managers to assess if the questions were clear to the respondents and also if they were being answered as intended. The questionnaire was issued via post with a covering letter stating the purpose of the questionnaire. This questionnaire contained twenty five questions. The responses from the managers were anticipated to identify which doctors and nurses should be issued with questionnaires at the second and third phases respectively. Thirteen of the questions were targeted at hospital mangers to find out particular facts and were considered as not being relevant to the doctors and nurses. This meant that only twelve of the twenty five questions needed to be included in the Questionnaire issued to the doctors and nurses, (Appendix Two).

RESEARCH TIMEFRAME AND SCOPE:

The research was carried out in four stages from December 1995 to March 1997. Stage one involved sending questionnaires to the managers in twenty seven acute, (i.e. short stay) hospitals, fifteen Voluntary (twelve general and three maternity) hospitals and twelve Health Board (general) hospitals. Included in the twenty seven hospitals were the four pilot sites referred to in chapter one and the three Dublin maternity hospitals were included because they each have the same unique management system where one of the consultants acts as "Master" for a seven year period and is then replaced by another consultant who assumes that role for a further seven year term and so on. The "Mastership" situation dates back to the Eighteenth century and limiting the term of appointment to seven years looks a very modern concept when one considers the current trends to have top managers and the Secretaries of Government Departments employed on fixed term contracts. Turner

[1996:22], saw doctors taking up the role of managers as the future of effective health care and added that " once again, one has to marvel at the strategic vision of the Rotunda's Dr. Bartholomew Mosse in Dublin in 1745". However, the study does not regard the "Mastership" concept as representing multi-disciplinary management and does not see it as a model for such management.

The most direct way to find out if individual hospitals were or would be involved in the process was to ask the managers. This in turn was intended to facilitate stages 2 & 3, by identifying the hospitals where nurses and doctors should be issued with questionnaires. Stage 4, involved sending a questionnaire to the managers of the hospitals identified in stage 1, (see Appendix 3), who had indicated that they were involved in the process and had a documented plan to implement it. The questionnaires set out to identify and assess the degree to which the various stages in planning the change process in question had taken account or were taking account of factors and issues which the literature review identified as being important.

The study is based on the premise that organisations will function within certain parameters of action. The literature review showed that organisations are entities or organisms that have to be shaped, managed, developed and controlled. In order to do this successfully, it is essential that the people entrusted with these tasks, fully understand what is involved. This assumes even greater importance when not alone are the traditional managers involved, but participants new or relatively new to the process, i.e., doctors and nurses, are also involved. The questionnaires were intended to assess and evaluate views and attitudes relating to the involvement of

doctors and nurses in the management process and also to ascertain how the implementation of this change process was being planned. They were not intended to assess and evaluate to what degree and how successfully the planning process was progressing. It framed questions based on different theories of organization management and change planning. The population involved was relatively small, readily identifiable and fairly easily contactable through questionnaires.

As the subject matter of the study is the planning process, the approach to formatting the questionnaires was also done on a planned and structured way. The study believes that there are essentially five main aspects to be considered in any successful planning task, (i) **awareness**; (ii) **involvement**; (iii) **commitment**; (iv) **evaluation**; and (v) **influence**. The questionnaires were structured around these five issues although not specifically identifying the questions to the respondents as falling into these categories. The study proposes that these five aspects are worth considering for the following reasons:

1.   Those who are to be involved in any change process must be aware that such an exercise is under way and they must be equally aware of its purpose. If this awareness is not present it is not realistic to expect that the intended participants will deliver on the other four aspects.

2.   All the key players must be involved in the planning process. If they are not involved, their views will most likely be overlooked, their input will be lost and they will not have a sense of ownership which will be particularly vital to take the process through the difficult times. Furthermore, if they are not involved, the remaining four aspects will most likely fall short of the intended objectives.

3. Commitment to the overall objectives is also essential because if the participants are not full committed to it, it is liable to break down when the going gets tough. Those involved in planning the process will have to be accountable for the outcomes of the plans and also accountable for their own contributions to the process. Such accountability will not happen automatically, it will have to be mentioned in the plan to ensure that it will take place.

4. It will be vital that the planning process can be evaluated on an on going basis, because irrespective of how well defined the plans are, there will have to be ongoing evaluation and modification as the planning will have to be altered or adjusted to meet changing circumstances.

5. The degree of influence which individuals and groups will have on the planning phase and when the process is in place, will be a major factor. Perceptions of this likely influence will impact on how much each participating group will put into the planning process.

ANALYSING THE RESPONSES TO STAGES 1 - 3 :

Table 4.01 at the end of this chapter analyses the response rates from all three groups, i.e. twenty seven managers, sixteen matrons and forty doctors. The Health Board hospitals are shown on a shaded background in each and every table. The questionnaire issued to the doctors and nurses contained only twelve questions as against twenty five questions asked of the managers. These twelve questions either directly or closely replicated twelve of the questions asked of the managers. The questions not included in the questionnaires issued to the doctors and nurses were

not asked because they were: (i) only asked of managers to find out factual background information; (ii) they were considered relevant only to the managers; (iii) they were considered un-necessary following a review of the responses from the managers.

The reasons for asking the questions are set out hereunder and the numbers of the questions on the respective questionnaires are also detailed, (a) indicates the managers questionnaire, (see Appendix 1) and (b) the doctors/nurses' questionnaire, (see Appendix 2). This format is followed through on in the actual analysis and the responses are also tabulated under the five listed headings. The analysis done in Chapters 5 and 6 is not intended to be empirical, but rather it is intended to illustrate patterns and trends as well as showing that organisations and groups will act and respond differently to given situations and proposals. Neither is the analysis intended to look at every possible interpretation, but the tabulated responses allow for a wide range of comparisons, depending on the particular interest involved. Some examples of this are;

* comparisons between individual hospitals;

* comparisons between combinations of the three groups;

* comparisons between individual groups in Health Board and Voluntary hospitals;

* comparisons between hospitals with different planning approaches.

These are only some examples and the study believes that the research findings, because of this flexibility and usability, offer the opportunity of wide and extensive analysis across a range of factors and issues.

(i) AWARENESS:

Qs.(a) 1/2/6 & Qs.(b) 3:

These questions were asked to establish which hospitals were or would be involved in the process of involving doctors and nurses in hospital management. The responses would determine which hospitals would be further included in the research process. The responses were intended to highlight situations where one or more of the three groups believed that their hospitals did not have such a plan. Awareness of factual situations can only come about where there are proper levels of communication, which in itself is a factor in organisation management. Good communication will not simply happen as a matter of course and it should be an important item on the change planner's agenda. The study expected that each of the pilot sites would have a documented plan. If other hospitals also had such plans it would indicate that the planning process was getting attention.

(ii) INVOLVEMENT:

Qs.(a) 3/5/7/11/12/13 & Q.(b) 7:

If the involvement of the three groups was seen as important by the managers, it would be very encouraging, in that the first two aspects mentioned, i.e., awareness and commitment would be present from the outset and augur well for the planning process. Ultimately, if all three groups are not equally involved, it could raise a major question about the overall commitment to meaningful multi-disciplinary management.

(iii) COMMITMENT:

Q.(a)14 & Qs.(b) 1/6:

True involvement requires genuine commitment from the change sponsors/planners/ agents as well as from the change targets. Without this commitment the change is most likely to be unsuccessful. The matter of commitment will be affected by cultures, vested interests, lack of knowledge of what is intended and the calibre of the change agents. In the context of multi-disciplinary management, the sharing of power will be important. For instance, any of the groups could be fully committed to the process, but not on the basis that the other group(s) would be equal partners in the process.

(iv) EVALUATION:

Qs.(a) 4/8/9/10/15/16/17/22/23/24/25 & Qs. (b) 2/4/5/8/9:

These questions were asked of the three groups and were intended to find out their views on the need for planning; if the considered it necessary to have some knowledge of planning techniques; and if they saw the need to have some knowledge of organisations and how they work. They also listed some of the factors involved in managing organisations in order to find out the perceived relative importance which each manager attached to them.

If doctors and nurses believe that managers do not accept that they can play an important role in hospital management, the process is faced with major obstacles from the outset. Professor Kanter's views about flattening hierarchical structures have been looked at. The study has made the observation that because managers espouse this process does not necessarily mean that this alone will bring it about.

It will take planned and positive action to do it and again the importance of proper planning is regarded as a must. The study has already referred to the establishment of four pilot sites for involving doctors and nurses in hospital management and to the apparent deficiency of they not sharing a commonality of approach. The study sees it as vitally important that change planners would examine the progress in and the planning approaches adopted by other hospitals in order to maximise the possible benefits of their individual experiences.

The study believed it would be interesting to assess the degree to which it was felt that the level of planning would affect the process. The actual impact of implementing the process will be all important in the final analysis and the study sought to establish the degree to which planning the process was considered as being likely to affect the outcome, the likely effect of different planning approaches and if the responsibility to plan the process should be shared equally. Acceptance that some form of accountability is necessary for identifying progress at designated stages, would indicate an acceptance of ownership of the process as well as acceptance of responsibility for its implementation.

Any significant wish or view that the process should be planned outside of all three groups would indicate that the respondents might not appreciate what is involved in multi - disciplinary management or alternatively that they do not want to get involved for some reason(s). If the process were to be planned outside of all three groups, the role and influence of the external change agent has to be considered and this has already been looked at by the study [:51]. The aim of the study is not to propose that

any one approach is better than another, perhaps the external change agent might be more successful in some situations and the internal change agent in others. The change sponsor(s) must assess the situation and base the planning approach around whichever is chosen.

(v) INFLUENCE:

Qs.(a) 18/19/20/21 & Qs.(b) 10/11/12:

The matter of assessing influences is subjective, but in the context of organisations it is very important, as each group is unlikely to have the same level of influence by virtue of the factors listed.

ANALYSING THE RESPONSES AT STAGE FOUR:

The fourth stage of the research involved sending a further questionnaire (Appendix Three), to the eight managers who had stated that their hospital had a documented plan for the involvement of doctors and nurses in hospital management. This questionnaire sought to establish specific information about their plans and how they had been developed:

* Did it specify the objective of involving doctors and nurses;

* A description of the plan;

* Who was involved in drawing up the plan;

* Did it identify specific stages in the process;

* Did it have specific time scales/time frames;

* Was it based on some planning model;

* Did it consider organisational development and management development as suitable mechanisms for implementing the process;

* Did it consider such aspects as culture; structures; resistance to change; inter group conflict; levels of trust; and organisational politics.

* Were doctors and nurses involved in assessing these aspects and was it realistic to expect doctors and nurses to learn and allow for these aspects.

The questions were asked to assess the documented plans in relation to the literature review and responses to the questionnaires returned by managers, doctors and nurses. They were focused directly at planning matters and issues. They also set the scene for looking at what is happening in practice and the linking of the theories advanced about planning change with what was actually happening.

Also included at this stage was Ireland's newest hospital, (Tallaght), where a specialist group was established to plan for the greater involvement of doctors in the management of the hospital, [Irish Medical Times 1997]. Tallaght had not been included in the first three stages as it was then still under construction. The study sees Tallaght as a very interesting situation because the planning referred to was taking place before the organisation itself was a functioning entity. The normal features and issues normally existing in an organisation should not yet be a feature. However, as four other hospitals were being amalgamated onto the Tallaght site, this would be likely to result in all those features and issues being brought as baggage. As the study is not about coping with change in particular situations it did not try to look at the Tallaght situation other than in relation to the involvement of doctors and

nurses in the management process. However, one of the four hospitals destined for the Tallaght site had been included in the first three stages and the responses could be used to compare the new corporate approach from the centre with that from one of the constituent parts. The study sees the Tallaght situation as also being somewhat unique in that the lines between Change Sponsors, Change Agents and Change Targets significantly overlap. The Tallaght situation is specifically looked at in Chapter Seven.

TABLE 4.01

No	Type	STAGE 1 - MANAGERS		STAGE 2 - MATRONS		STAGE 3 - DOCTORS	
		Retd.	Involved	Issued	Retd.	Issued	Retd.
1	Vol	✓	✓	✓	✓	✓ (4)	x4
2	"	✓	✓	✓	x	✓ (6)	✓2
3	"	✓	✓	✓	✓	✓ (4)	✓2
4	"	✓	✓	✓	✓	✓ (4)	✓3
5	"	✓	x				
6	"	x					
7	"	✓	x				
8	"	✓	x				
9	"	x					
10	"	✓	✓	✓	✓	✓ (2)	1
11	"	✓	✓	✓	x	✓ (2)	✓1
12	"	✓	x				
13	"	✓	✓	✓	✓	#	
14	"	✓	✓	✓	✓	✓ (1)	1
15	H.B.	✓	✓	✓	✓	✓ (4)	4
16	"	x					
17	"	✓	✓	✓	✓	*	
18	"	x					
19	"	✓	✓	✓	✓	✓ (2)	x2
20	"	✓	✓	✓	✓	✓ (3)	✓1
21	"	✓	✓	✓	✓	✓ (2)	x2
22	"	✓	✓	✓	✓	✓ (2)	1✓
23	"	✓	✓	✓	✓	✓ (2)	x
24	"	✓	✓	✓	✓	✓ (2)	✓2
25	"	x					
26	"	✓	x				
27	"	x					
		✓21 x 6	✓16 x 5	✓16	✓14 x 2	✓40	✓18 x22

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NOTES TO TABLE 4.01:

\#   Denotes where the manager personally undertook to ask up to six consultants to complete the questionnaire, but did not do so.

*   Denotes where the manager, who had completed the questionnaire issued to him as a manager, refused to provide the names of doctors in his hospital to whom questionnaires could be sent. His reason was that the hospital was then at the planning stage in the process to involve doctors in hospital management and he considered that "it was too sensitive a time to approach the doctors in question.
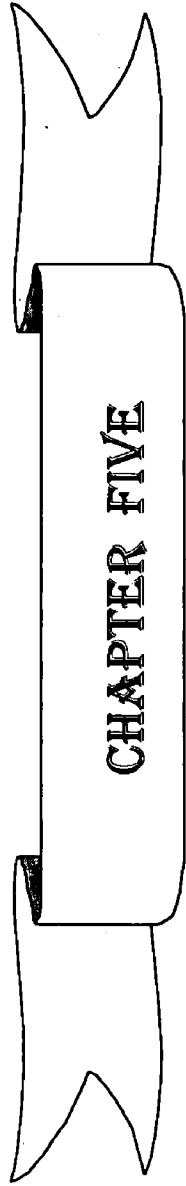
CHAPTER FIVE

CHAPTER FIVE

ANALYSING THE MANAGERIAL RESPONSE

The study considered itself to be constrained/restricted on a number of fronts and in a number of issues in looking at the situation in hospitals generally and in individual hospitals in particular. Bearing in mind the relative small size of the acute hospital sector and the need to maintain continuing good working relationships, the study consciously avoided questions which could be seen as being critical of individual situations or individual hospitals. For example, the study avoided taking a close look at the pilot sites, as the matter of identification could easily arise.

It also did not look in any detail at the approach of the Department of Health to the process, particularly how and why it selected the four pilot sites and the degree to which it was monitoring the situations on an on going basis. It did not seek to examine the documented plans in the hospitals which claimed to have them and accepted the managers' responses as being accurate and comprehensive. The study set about avoiding these difficulties by adopting an approach which identified questions which might be asked concerning planning approaches in general and the particular approach in individual situations.

The first questionnaire was issued to hospital managers and of the twenty seven questionnaires issued, twenty one (84%) were returned. This is a high percentage response to a questionnaire issued by post as the normal response to postal questionnaires [McNeill 1990:10], is between 30% and 40%. The response rate for

Voluntary hospitals was 85% (12/14) and 69% (9/13) for Health Board hospitals. One very positive outcome was that the managers of most of the major hospitals completed and returned the questionnaires. The questionnaire listed twenty five questions in numerical sequence without group subject headings, but the questions were designed to ascertain in particular:

1. Which hospitals were/would be involved in the process of involving doctors and nurses in hospital management; which hospitals believed that a documented plan was necessary for implementing the process; which hospitals had a documented plan and who had been involved in drawing up the plan?;

2. Was there a perceived need that the participants should have some knowledge of planning techniques and also of how organisations function;

3. The perceived impact that issues such as culture; politics; professional tribalism; fear of change; and levels of trust were expected to have on the process.

Of the twenty one responses received, five hospitals confirmed that they were not already involved in the process of involving doctors and nurses in hospital management and neither were they planning it for a future date. These five hospitals comprised of four Voluntary and one Health Board hospital. Apart from a brief look at their particular situations, the study did not include them in further research.

The analysis was done under the five headings listed in Chapter 4, **(i) Awareness; (ii) Involvement; (iii) Commitment; (iv) Evaluation;** and **(v) Influence** and the study feels it is important to reiterate why it adopted this analytical approach. Awareness

is essential in order to provide a basis and focus for embarking on any change process as is the necessity for the participants to be aware of the actual situation relating to the change process,i.e. what stage is at and who is involved, as well as the likely impact of different factors/issues on the process. It is essential to decide who should be involved and to put mechanisms in place for bringing about this involvement. The intended participants must be committed to the planning objectives to ensure their on going and active involvement.

The planners must evaluate the objectives, the awareness, the commitment, the planning process and the different influences that will be present. Whoever has the greatest influence on the planning process will determine the rate of progress, the direction and the outcome. If the process is to be truly multi-disciplinary, no one group should have the greatest influence. Having any one of the participant groups holding the greatest influence would put them in a position of potentially being able to control the process. In a shared multi-disciplinary situation intended to reflect equal involvement, no one group should be able to influence the situation more than others.

THE HOSPITALS NOT INVOLVED IN THE PROCESS:

All five indicated that no steps were currently being considered by them to involve doctors and nurses in the management process on a multi - disciplinary basis. Their responses are briefly looked at under the same five headings relating to planning approaches.

(i) Awareness:

All five were aware of the situations in their own hospitals regarding the (non!) involvement of doctors and nurses in the management of the hospital at that time and in the foreseeable future. This could be regarded as a negative awareness in that they accepted the process was taking place in other hospitals and was being widely advocated, but would not be happening with them. The study feels that this situation clearly demonstrates the need for the planning process to be co-ordinated at a central level as it seems unwise to allow some hospitals to opt out of a process which has been identified as essential for the future management of hospital services. They were also aware of organisational aspects that could impact on the process. Four of the five rated the calibre of the change planners as likely to have the greatest impact on the process and these four rated an agreed comprehensive plan as being next most important. The matters of culture, internal politics and the management expertise of the participants rated lower in all cases. When rating the likely impact of people issues on the process, lack of trust and professional elitism were considered to be those issues that would have most impact.

The study sees two important views relating to awareness coming from the responses of these five managers. On the organisational front, they came down in favour of the planning approach. They did not regard the issues of politics and culture as important. Of course, it would be reasonable to argue that if the change planners are capable and develop comprehensive plans, such issues will be dealt with in the planning process.

(ii) Involvement:

The five managers were of the view that where the process was being introduced, all three groups should be involved in planning it. If this is a true response, it is regrettable that such a positive outlook will not have an opportunity of being put into practice as there are no plans for these five hospitals to become involved in the process.

(iii) Commitment:

Three of the five managers believed that all three groups were committed to the idea of multi-disciplinary management, the fourth believed that only administrators were committed and the fifth did not answer the question. The fact that three out of the five managers believed this indicates that they would be starting off from a good base if they were to become involved in the process.

(iv) Evaluation:

None of the five managers were of the view that the process should be planned collectively by the three groups and two managers felt the process should be planned outside of all three groups. This thinking would reflect "organisational adaption" rather than "organisational change" [Boyle and Joyce 1988:4], where involvement and ownership of the change are not taken into account.

All five managers felt it would be very important that the three groups would have some knowledge of planning techniques and also have an understanding of how organisations function. The study believes that if there were to be some central

control of planning the process, it would encourage individual hospitals to activate/implement measures which would ensure that the participants would be given overviews, at least, of planning techniques and of how organisations function.

(v) Influence:

Three of the five hospitals believed that one group should have the greatest influence, two opting for administration and one for doctors, while the other two hospitals did not. However, all five felt that one group would have the greatest influence, three saw this as being the doctors and two saw it as being the managers. None of the responses saw nurses as having the greatest influence, which could be taken as suggesting that managers consider nurses as being of less importance to the process than managers and doctors. It also suggests that managers not yet involved in the process are not be fully conscious of what multi-disciplinary should entail.

SUMMARY:

There are a number of important aspects coming through from the responses of these five hospitals. The absence of centrally driven planning approaches is leading to a lack of direction and involvement. One example is the perceptions on influence. The majority believed that one group should not have the greatest influence, but all believed that one group would have the greatest influence. If this belief is reflected in what actually happens it will pose significant obstacles in implementing the process. The matter of culture has been looked at in Chapter 3, in relation to beliefs

and values, how they are formed and how they impact on situations. Beliefs and values will have to be reshaped where they are anti-change or are likely to be obstacles to change because this reshaping will not happen by chance.

THE HOSPITALS INVOLVED IN THE PROCESS:

Detailed analysis is shown in tabulated form at the end of the chapter. Sixteen hospitals, (76% of those which responded and 59% of those issued with a questionnaire), indicated that they were or would be involved in the process. The study believes that this level of response should give a good representative view of what needs to be considered in planning the involvement of doctors and nurses in the management process. Again, the responses were analyzed in the specified format.

(i) Awareness - (Table 5.01):

All sixteen respondents were aware of the situation in their own hospital in relation to the existence or intended introduction of multi-disciplinary management. Thirteen (81%) of the sixteen indicated that their hospital was already involved in the process, (including three of the four pilot sites). Twelve of this thirteen were also planning the further introduction of multi-disciplinary management and four hospitals were approaching the matter for the first time. One hospital was already involved in the process but had no plans to further introduce it. Seven (54%) of the thirteen said that their hospitals had documented plans to implement the process, four Voluntary and three Health Board. Two indicated that they intended to draw up plans in the future. The three hospitals approaching the issue for the first time indicated that they either did not attach importance to the need for a documented plan, (one hospital), or did not know if it was a documented plan was important.

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(ii) Involvement - (Table 5.02):

The thirteen who were/would be involved in the process said that the three groups, viz. doctors, nurses and administrators were/would be involved and that the process should actively involve all three groups. The seven who had documented plans all reported that the three groups had been involved in drawing up the plan. Fourteen of the sixteen respondents said that each group should have a clearly defined role in the multi-disciplinary management process. The degree of actual involvement in the process is very important. Two hospital managers felt that each group should not have a clearly defined role in the process and surprisingly, this hospital had a documented plan and all three groups had been involved in drawing it up. Four of the sixteen had not looked at the situation in other hospitals, including one with a documented plan and interestingly, five of the seven who had looked at the situation in other hospitals did not have a documented plan.

The existence of a documented plan drawn up with the involvement of the three groups could better clarify the involvement levels and involvement interests of each group. A debate on the motion *"doctors in management are required to take responsibility for unpopular health policies but have no power to change them"*, [Health Service Journal October 1993:127], noted that:

> "Theoretically, more doctors are becoming involved in managing health services on a decentralised model, but in practice, doctors are merely shouldering responsibility for managers' budget-driven decisions to reduce activity".

One of the participants in the debate relayed a view expressed to him by a Chief Executive that the thinking of managers in relation to having doctors in management "was to stick the buggers in clinical directorates, teach them how to count and tell

them to make cuts". If managers as a group were to hold this view, the process would be facing major problems from the outset. If proper plans are drawn up involving the three groups, these can help to ensure that this attitude does remain as a belief.

The responses relating to nurses involvement were more encouraging. Possible reasons for this divergence of belief could be that there are greater levels of conflict between doctors and managers than between nurses and managers. Also, managers may have less trust in the motives of doctors than in nurses' motives. There may have been (as believed by the study), too much emphasis placed on involving doctors in hospital management and too little emphasis placed on the involvement of nurses. While some or all of these reasons could be accurate, the message coming through is that some work still has to be done in relation to the benefit of involving nurses in the management process.

(iii) Commitment - (Table 5.03):

This question sought to ascertain how managers rated the commitment of managers, of doctors and of nurses to the process. Perhaps not surprisingly, all sixteen managers (although was not sure), believed that they themselves were fully committed, all sixteen (with two question marks), believed that nurses were fully committed, but two of the sixteen believed that doctors were not fully committed and another five were not sure. The study sees this as confirming that simply advocating the involvement of any group will not in itself ensure that they will be committed to the process. The levels of commitment of any one group are likely to be formed by cultures and possible prejudices; levels of trust/distrust. These findings signal

potential major difficulties for the process because of the belief of so many managers that doctors are not fully committed, if the level of commitment to the process will be a key factor in achieving a successful outcome.

(iv) Evaluation - (Tables 5.04 - 5.08):

The study proposes that all the participants should have some knowledge of planning techniques and also have some knowledge of how organisations function. How effective can the involvement and contributions of any of the participants be if they do not have some knowledge of these issues? If the planning framework is not identified and known to all the participants, they may be operating outside of this framework or even basing their approach on a contradictory or different strategy and approach. An example would be where the plan is based on one planning approach or model and one or more of the participants is/are using a different planning model/approach:..

Fourteen of the sixteen (table 5.04), saw it as necessary to have a documented plan, one was not sure and one felt that it was not necessary. All sixteen felt that the participants should have some knowledge of both planning techniques and of how organisations function. Gaining some knowledge of planning techniques and understanding how organisations function are not skills that are likely to be picked up over night. It would seem both unreasonable and unproductive to have doctors and nurses devote a major portion of their work to acquiring these skills as it would not be their primary function. However, appropriately focused management development would be a logical and practical way to allow these skills to be learned, but such focused management development will not happen without it being planned and on going.

Question 10 (table 5.05), looked at the organisational aspects that could affect planning processes and the awareness of managers to the likely relative impact of each. The study expected variations in views expressed in answer to this question, because of the different histories and cultures of the Voluntary hospitals and the Health Board hospitals.

The responses did not clearly divide between the two groups and there were also differences within each group. The responses were broadly analyzed by the most frequently occurring ranking.

Voluntary Hospitals: (i) an agreed comprehensive plan; (ii) the organisation's culture; (iii) the participant group cultures; (iv) the organisation's internal politics; (v) the participant's management expertise; (vi) the calibre of the change planners; and (vii) the structure of the organisation..

Health Board Hospitals: (i) the organisation's culture; (ii) the organisation's internal politics; (ii) the structure of the organisation; (if) the participant group cultures; (v) the calibre of the change planners; (vi) the participants' management expertise; and (vii) an agreed comprehensive plan.

The major discrepancy centres on the importance of an agreed comprehensive plan. Four of the eight Voluntary hospital managers rated it as likely to have the greatest impact, while none of the eight Health Board hospital managers rated it as being

important. In fact, three rated it as likely to have least impact, another three rated it as of second least importance and the remaining two as of third least importance. However, apart from this major difference, the other six issues seemed to get similar rankings.

The existence of a comprehensive plan will allow for attention to the other six aspects. An analysis of the organisations culture will identify the group cultures and how they interact with and are part of the organisation's structures. It is interesting that the matters of internal politics and the calibre of the change agents scored similarly, because the study sees them as intertwined. The complexity of the internal politics will determine to a significant degree how successful the change agent is likely to be and in turn the political understanding of the change agents will help them in implementing the change process.

Rating the participants' management expertise so low by both Health Board and Voluntary Hospital managers might, at first glance appear surprising but irrespective of how expert the participants might be in terms of management capability, this aspect should not be the primary task of doctors and nurses. It also highlights the importance of understanding the issues rather than simply knowing the process of management.

The study (table 5.06) then looked at the managers' perceptions of the likelihood of achieving multi-disciplinary management and also the importance of organisational structure and planning. All sixteen believed that multi-disciplinary management is

achievable and perhaps somewhat surprisingly, twelve felt that multi-disciplinary management is achievable within hierarchical management structures. Only one manager thought that it was not achievable (Voluntary) and three (two Voluntary and one Health Board), were not sure. This response from managers would not appear to be in line with the many statements and proposals for the need to do away with or flatten existing hierarchical management structures. The study does not make any value judgement on these apparent contradictory views, but believes that it is a matter which has to be evaluated before the process is embarked on. Thirteen of the respondents felt that real attempts are being made to "flatten" hierarchical management structures, but two Voluntary Hospital managers did not. All sixteen managers felt that the level of planning would affect the outcome.

Question 22 (table 5.07), looked at the managers' assessment of different planning approaches. This question paralleled question 10, which sought to ascertain the perceived effects of particular organisational aspects. The questionnaire at this stage did not refer to particular planning models but referred to planning approaches which would reflect different planning models, in the sequence listed: **(i) "Rational Comprehensive"; (ii) "Incremental"; (iii) "Mixed Scanning"; (iv) "Garbage Can"; and (v) "Bounded Rationality".**

The responses from both groups of managers ranked the different approaches that might be adopted in the following order:

1. **A flexible approach - "Incremental" planning;**

2. **A political approach - "Garbage Can" model;**

3.   **A contingency approach - "Mixed scanning";**

4.   **Settling for less -**   **"Bounded Rationality;**

5.   **A prescribed approach - "Rational Comprehensive".**

The responses showed very little divergence in rating the order of importance of each approach which suggest that the managers thinking on this matter is practical and flexible enough to allow for input by the other two groups. In the final phase of the research, (stage 4), the managers of the hospitals which had documented plans were asked which of these planning models most closely reflected how their plan was framed.

Irrespective of the planning approach being used, the responsibility that each group will have for planning the process is also crucial, (table 5.08). Nine managers (five Voluntary and four Health Board), felt that each group should be equally responsible for the planning process, one (H.B.) was not sure and the remaining six (three Voluntary and three Health Board) said that this should not be the case. Of these six, five Health Board (one not fully sure) and one Voluntary, felt that managers should have the main responsibility for planning the process. One Voluntary Hospital manager (who was not or would not be involved in the process), felt that doctors should have the greatest responsibility for planning the process and none of the managers felt that nurses should have the greatest responsibility. All sixteen managers felt that there should be mechanisms available to identify progress at various stages, and none of the managers thought that the entire process should be planned outside of the three groups.

(v) Influence, (Tables 5.09 - 5.10):

There were some significant differences in perceptions as to which group would have

the greatest influence in the planning process as distinct from which group was likely

to have the greatest influence. Only five of the sixteen (three Voluntary and two

Health Board), believed that one group should have the greatest influence in the

planning process; four felt it should be managers and the fifth felt it should be

managers and doctors jointly. None of the five felt that nurses should have the

greatest influence in planning the process.

Only four managers (two Voluntary and two Health Board), thought that no one group

would actually have the greatest influence, but the other twelve (six of each), felt that

managers would have the greatest influence. This strengthens the argument for the

need to address all aspects of management and organisational issues when planning

the process, as the very concept of multi-disciplinary management would run counter

to the views that one group should have the greatest influence. The majority belief

that one group actually would have this level of influence emphasises the importance

of the organisational features that the study proposes as likely to be major factors in

influencing the outcome, i.e. culture, power bases, attitudes, levels of trust. It also

pinpoints potentially serious difficulties arising in that all of the managers (Q.5 table

5.02) believed that doctors and nurses should be involved in the process of multi-

disciplinary management, but five believed that managers should have the greatest

influence and all but two believed that managers would have the greatest influence.

Do the manager's perceptions of influence reflect the perceived power bases of the

different groups? Does it bear out the earlier quoted remark [:120], of a N.H.S. chief

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executive!, "that the thinking of managers in relation to having doctors in management was to stick the buggers in clinical directorates, teach them how to count and tell them to make cuts".

It is unlikely that groups will readily surrender power and power bases have been identified as a source of resistance to change. These findings raise questions about the likelihood of equal involvement and ownership of the process by the three groups. It could be argued that what may really be at issue is the question of power and influence rather than the intention and objective of improving the way hospitals are managed by involving the main groups on a joint basis.

Question 20 (Table 5.10), looked at some of theses features and the responses rated as follows:

Voluntary hospitals: (i) professional elitism; (ii) lack of trust and levels of commitment; (iii) managerial attitudes; (iv) inadequate resources; (v) unequal involvement; (vi) high levels of bureaucracy.

Health Board hospitals: (i) professional elitism; (ii) lack of trust and levels of commitment; (iii) managerial attitudes; (iv) unequal involvement; (v/vi) high levels of bureaucracy and inadequate resources.

This analysis shows that both groups of hospital managers rated the likely influences practically the same. The Voluntary hospitals rated inadequate resources as no. 4, while the Health Board hospitals rated it as having the least influence. This could

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reflect the difference in funding arrangements, where Voluntary hospitals are funded directly by the Department of Health through one overall budget, whereas individual Health Board hospitals get their budgets from central Health Board funds, which could allow for greater flexibility in distribution. It could also indicate that Health Boards attach greater importance to this matter and as a result make more resources available. These ratings also suggest that for managers, organisational features and issues are likely to be very significant factors in determining how successful multi-disciplinary management is going to be.

SUMMARY:

The managers and hospitals that were involved in the process appeared to be aware of the need for a plan and the need to involve all three groups in drawing up the plan. The issue of commitment will play a key role in implementing the plan and in this area there was a significant level of belief among the managers that doctors are not fully committed to the process. Can real progress be made if this view persists, whether or not it is true? If it is true, then the task is even more daunting. The study believes that this issue must be considered in the planning phase because if it is not, the managers are likely to distrust the motives and intentions of the doctors. Having an agreed comprehensive plan was rated as likely to have the greatest impact.

The view of some managers that managers should have the greatest influence in the process probably reflects the position they are coming from as does the view that one group would have the greatest influence. People in change situations are likely to have their views formed by the practices and situations that they are used to. One example is the view that it was not necessary to change existing management

structures to bring about the involvement of doctors and nurses in the management process. Great emphasis has been placed on the need to "flatten" hierarchical management structures but the managers views suggest that it might not be easily achieved. If the doctors' and nurses' responses were to be the same or very similar,it would raise two questions. First, if all three groups did not think it was necessary, would it be possible to change existing management structures and second, would it be necessary. It is a fairly fundamental issue in the process and it is a matter which has to be evaluated and planned if considered to be necessary.

(i) Awareness:

No		Q.1	Q.2	Q.6		
		Q.1 Has your hospital introduced multi-disciplinary management? **Q.2** Is your hospital currently planning its introduction? **Q.6** Has your organisation a documented plan?				
No		**Q.1**	**Q.2**	**Q.6**		
1		√	√	x		
2		√	√	√		
3		√	√	√		
4		√	√	√		
10		√	√	√		
11		√	√	x		
13		√	x	x		
14		√	√	x		
15		√	√	x		
17		√	√	x		
19		x	√	x		
20		√	√	√		
21		√	√	x		
22		√	√	√		
23		x	√	x		
24		x	√	√		

Table 5.01

(ii) Involvement:

Q.3	Which groups are/will be involved in the process?
Q.5	Should all three groups be involved in drawing up this plan?
Q.7	Were all three groups involved in drawing up the plan?
Q.11	Should each group have a clearly defined role in the process?
Q.12	Does each group have such a role?
Q.13	Were the experiences in other hospitals involved in the same process, looked at?

No.	Q.3	Q.5	Q.7	Q.11	Q.12	Q.13
1	✓	✓	x	✓	x	✓
2	✓	✓	✓	✓	✓	✓
3	✓	✓	✓	x	x	✓
4	✓	✓	✓	✓	✓	✓
10	✓	✓	✓	✓	✓	✓
11	✓	✓	x	x	✓	✓
13	x	✓	x	✓	✓	x
14	✓	✓	x	✓	✓	✓
15	✓	✓	x	✓	x	✓
17	✓	✓	x	✓	✓	✓
19	✓	✓	x	✓	x	x
20	✓	✓	✓	✓	x	x
21	✓	✓	x	✓	x	✓
22	✓	✓	✓	✓	✓	✓
23	✓	✓	x	✓	x	x
24	✓	✓	✓	✓	✓	✓

Table 5.02

(iii) Commitment:

Q.14	Do you believe that each group is fully committed to participating as an equal partner in the process?, i.e., (a) Managers, (b) Doctors, (c) Nurses.				

No		a	b	c		
1		√	?	√		
2		√	√	?		
3		√	√	√		
4		√	√	√		
10		√	√	√		
11		√	?	√		
13		√	√	√		
14		√	?	√		
15		√	x	√		
17		√	?	√		
19		√	√	√		
20		√	√	√		
21		?	?	?		
22		√	x	√		
23		√	√	√		
24		√	√	√		

Table 5.03

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(iv) Evaluation:

Q.4	Is it necessary to have a documented plan to successfully bring about multi-disciplinary management?
Q.8	How important is it that those involved in the process would have some knowledge of planning techniques?
Q.9	How important is it that those involved in planning should understand how organisations function?

No		Q.4	Q.8	Q.9		
1		√	√	√		
2		√	√	√		
3		√	√	√		
4		x	√	√		
10		√	√	√		
11		√	√	√		
13		?	√	√		
14		√	√	√		
15		√	√	√		
17		√	√	√		
19		√	√	√		
20		√	√	√		
21		√	√	√		
22		√	√	√		
23		√	√	√		
24		√	√	√		

Table 5.04

(iv) Evaluation:

Q.10 Rate in order from 1 - 7 (1 = most effect), the effect the following aspects could have on the outcome: (i) participants' management expertise; (ii) participant group cultures; (iii) the organisations' culture; (if) the organisations' internal politics (v) structure of the organisation; (vi) the calibre of the change planners; (vii) An agreed comprehensive plan.

No	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)
1	5	3	7	6	4	2	1
2	5	2	1	4	3	6	7
3	6	5	2	3	7	1	4
4	5	3	2	4	1	6	7
10	1	4	5	3	7	6	2
11	4	5	2	6	3	1	7
13	5	6	3	4	7	2	1
14	4	3	2	6	7	5	1
15	6	3	1	2	4	5	7
17	7	4	1	3	2	5	6
19	7	1	2	6	3	4	5
20	6	4	2	1	3	5	7
21	4	3	2	5	7	1	6
22	5	4	1	2	6	3	7
23	4	4	5	6	3	7	6
24	7	1	2	6	3	4	5

Table 5.05

(iv) Evaluation:

Q.15	Is multi-disciplinary management achievable?
Q.16	Is it possible to achieve multi-disciplinary management within Hierarchial Management Structures?
Q.17	Are real attempts being made to "flatten" hierarchical management structures in order to successfully involve doctors and nurses in the process?
Q.21	To what degree will the level of planning affect the outcome?

No		Q.15.	Q.16	Q.17	Q.21	
1		✓	✓	x	✓	
2		✓	x	x	✓	
3		✓	✓	✓	✓	
4		✓	✓	✓	✓	
10		✓	✓	✓	✓	
11		✓	?	✓	✓	
13		✓	✓	✓	✓	
14		✓	?	✓	✓	
15		✓	✓	✓	✓	
17		✓	✓	✓	✓	
19		✓	✓	*	✓	
20		✓	✓	✓	✓	
21		✓	✓	✓	✓	
22		✓	✓	✓	✓	
23		✓	✓	✓	✓	
24		✓	?	✓	✓	

Table 5.06

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(iv) Evaluation:

Q.22	Please rate in order of importance (1 - 5) the following approaches as a means of planning the process; (i) a rigid prescribed approach; (ii) a flexible approach; (iii) a contingency or ad-hoc approach; (if) a political approach; and (v) settling for less than the optimum.

No		(I)	(II)	(III)	(IF)	(V)
1		5	1	4	2	3
2					1	
3		5	3	2	1	4
4		5	1	4	2	3
10		5	1	3	2	4
11		5	1	3	2	4
13		5	1	3	2	4
14		5	1	2	3	4
15		4	1	3	2	5
17		5	1	2	4	3
19		4	1	3	5	2
20		5	1	2	3	4
21		5	1	2	3	4
22					1	
23		2	4	3	5	1
24		5	2	3	1	4

Table 5.07

(iv) Evaluation:

Q.23	Should each group have equal responsibility for planning the process? and if <ins>no</ins>, rank responsibility (from 1 - 3).
Q.24	Should there be mechanisms available to identify progress at various stages?
Q.25	Should the entire process be planned outside of all three groups and if yes, by whom?

No	Q.23	Q.23a	Q.23b	Q.23c	Q.24	Q.25
1	x	b	a	3	✓	x
2	x	a	b	3	✓	x
3	✓				✓	x
4	✓				✓	x
10	x				✓	x
11	✓				✓	x
13	✓				✓	x
14	✓				✓	x
15	x	a	b	c	✓	x
17	✓				✓	x
19	✓				✓	x
20	x	a			✓	x
21	✓				✓	x
22	✓				✓	x
23	x	a	b	b	✓	x
24	✓?	a?			✓	x

Table 5.08

(v) Influence:

Q.18	Should any one of the three groups have the greatest influence in the planning process; (a) Managers; (b) Doctors; (c) Nurses?
Q.19	Will any one group have the greatest influence in the process; (a) managers; (b) doctors; (c) nurses?

No	18(a)	18(b)	18(c)	19(a)	19(b)	19(C)
1	✓			✓		
2	✓			✓		
3	x	x	x	x	x	x
4	x	x	x	✓		
10	✓	✓		✓		
11	x	x	x	x	x	x
13	x	x	x	✓		
14	x	x	x	✓		
15	x	x	x	✓		
17	x	x	x	✓		
19	✓			✓		
20	x	x	x	✓		
21	x	x	x	✓		
22	x	x	x	x	x	x
23	✓			✓		
24	x	x	x	x	x	x

Table 5.09

(v) Influence:

Q.20 Rate in order of influence (i= greatest influence), the following as potential barriers to achieving a successful outcome; (i) Professional Elitism; (ii) Managerial Attitudes; (iii) High Levels of Bureaucracy; (if) Less Than Full Commitment; (v) Unequal Involvement; (vi) Inadequate Resources; and (vii) Lack of Trust between groups.

No	(I)	(II)	(III)	(IF)	(V)	vi	(Vii)
1	3	4	5	1	6	7	2
2	1	3	5	2	4	6	7
3	7	5	4	1	6	3	2
4	1	2	6	5	7	4	3
10	3	4	2	6	7	1	5
11	2	6	7	1	4	5	3
13	1	5	6	3	7	2	4
14	4	5	7	6	3	1	2
15	6	3	1	2	4	5	7
17	2	3	6	1	5	7	4
19	1					2	3
20				3	2	1	1
21	1	3	7	6	2	5	4
22	4	5	6	2	1	7	3
23	3	3	3	5	4	5	7
24	4	6	5	2	3	7	1

Table 5.10
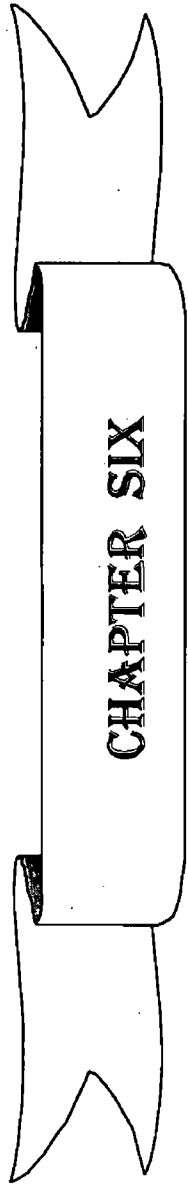
CHAPTER SIX

CHAPTER SIX

ANALYSING THE PROFESSIONAL RESPONSES

The Questionnaire issued to doctors and nurses was broadly similar to the one issued to Managers. The number of questions was reduced to twelve, because many of the questions asked of managers sought to find out factual information about the hospitals and once answered did not need to be asked again. The responses from managers had identified sixteen hospitals which were or would be involved in the process. It was easy to issue questionnaires to the Matrons/Directors of Nursing as they could be readily identified. The response rate from them was very high as fourteen of the sixteen questionnaires were returned (87.5%). This level of response was practically the same as that of the managers and suggests that the nursing profession is both aware of and responsive to the process.

It proved more difficult to identify the appropriate doctors to whom the questionnaires should be sent. The approach used was to write to the sixteen managers who had stated that the process was or would be taking place in their hospitals. This aspect of the study was dependant on these managers being prepared to give this information, so that the appropriate doctors could be issued with questionnaires. It was anticipated that the number of doctors involved in the study would be greater than for the other two groups because in the large hospitals there was likely to be a number of consultants involved and even a limited response from the sixteen hospitals would be likely to have a greater number of doctors answering the

questionnaire. Fourteen managers supplied the information requested and the number of doctors involved in these fourteen hospitals ranged from one to six. In total, forty questionnaires were issued to doctors and eighteen responded (45%). This was a much lower response rate than that from the other two groups.

One hospital manager (No. 13), undertook to personally ask "five or six" doctors to complete the questionnaire, but this never happened. Another manager (No. 17), stated that he was not prepared to provide the names of doctors involved in the process in his hospital, to whom questionnaires could be issued, on the basis that "consultations, discussions and seminars" were then being conducted on the process and he considered "that it was too sensitive at that time to approach the doctors involved" to complete the questionnaire. This manager had already completed and returned the manager's questionnaire without any apparent equivocation. It had been possible to send a questionnaire directly to the Director of Nursing in that hospital without having to contact the manager. She had responded very quickly and fully completed the questionnaire.

That hospital (No, 17), was not followed up on further, even though it would have been very appropriate to do so, if as reported, it was at that time actively involved in preliminary discussions about the process. It would have given useful insights on a hospital planning this change process without a documented plan. Allowing for the potential sensitivity of the situation, if the questionnaire were to lead to some questioning of the approach being taken or of the progress being made, that should be regarded as something positive. After all, if all three groups are to be fully

involved in the process, any issues that might lead to tensions and concerns should be addressed sooner rather than later. In addition, it meant that one Health Board area was not included in further analysis, as the manager of the other major Health Board hospital in that Health Board area did not respond to the original questionnaire.

There was a response from more than one doctor in a number of hospitals and these were contradictory in some instances within the group and also contradictory relative to the responses from the managers and from Matrons/Directors of Nursing in those hospitals. The responses from the doctors and nurse managers were analyzed under the five aspects listed in the introduction i.e. **Awareness; Involvement; Commitment; Evaluation and Influence.** Tables 6.01 - 6.11 at the end of this chapter analyze the responses from the nurses and doctors respectively.

(i) Awareness - Table 6.01 Nurses/Doctors & Table 6.02 All three groups:

Fourteen of the sixteen matrons (88%), issued with a questionnaire responded and all fourteen thought that a documented plan was necessary to implement the process. All but one of the eighteen responding doctors felt that a documented plan was necessary. This indicates a high level of awareness of the need for a documented plan among the doctors and nurses who responded.

Seven of the fourteen matrons (50%), thought their hospitals did not have a documented plan whereas two of the managers in these seven hospitals, (two Voluntary) said that they had a documented plan. A further sign of confusion is that two matrons said their hospitals had a documented plan when the managers had said

that they did not. This raises serious doubts either about the adequacy of the communication channels in these hospitals and about the degree of involvement that is taking place for the nurse managers. Overall, in four hospitals, the matrons and managers said that their hospitals did have a documented plan, but in four hospitals the matrons and managers said that their hospitals did not have documented plans. This means that in ten hospitals out of fourteen (71%), both the matrons and managers were aware of what the position was in relation to having documented plans.

Ten of the eighteen doctors (56%), stated that their hospitals had a documented plan, six Voluntary and four Health Board, but for two hospitals (one Voluntary - No. 4 and one Health Board No. 15), where three and four doctors respectively responded, two and three respectively believed that they did not have a documented plan. In two hospitals, the doctors believed that their hospitals had documented plans, whereas the two managers in question said that they did not. In the case of one hospital, the matron and one of the four doctors who responded, believed their hospitals had documented plans but the two managers said they did not.

The foregoing indicates a good deal of confusion among the three groups and suggests that the levels of awareness are much less than they should be. If these hospitals are acting on the main objective of involving doctors in the process and not involving nurses, then they appear to be successful in this. However, as fifteen of sixteen managers believed that doctors and nurses should be involved in the planning process, the low level of awareness as to whether a documented plan existed

points,in the study's view, to the lack of recognition of the nurses role in the process and also to the lack of adequate planning. A documented plan in itself, should ensure that all the intended participants would be fully aware of what the aims and objectives are.

Eight of the doctors said their hospitals did not have a documented plan. In the case of no. 4, the manager had said "yes" and the matron had said "no", two of the three doctors had also said "no" and one had said "yes". In no. 15, the manager had answered "no", the matron answered "yes" and three of the four doctors answered "no". In no. 22, the manager and the matron said the hospital had a documented plan but the doctor who responded said that it did not.

Clear communication between the three groups has to be one of the key factors in making the process successful and if the intended participants are not aware of the situation, they cannot be fully involved. Only forty three per-cent of the matrons and fifty six per-cent of the doctors believed that their hospitals had documented plans and in the case of four matrons and five doctors these beliefs were incorrect, if the managers' responses are accurate. This confusion and these differences in levels of awareness indicates that there are major communication problems in many hospitals. Proper levels of communication are essential to make people/groups aware of what is going on and what is expected of them. The foregoing responses clearly suggest that communication is not adequate and it is a matter which a documented plan should/would address.

(ii) Involvement - Table 6.03 Nurses & Doctors:

All fourteen matrons, although no. 23 was not fully sure, believed general managers accept that doctors and nurses can play an important role in hospital management. Seventeen of the eighteen doctors also believed it and this response is seen as very encouraging, if it signifies that nurses and doctors accept the bona fides of managers when they say that they want doctors and nurses involved in hospital management. The one doctor respondent who did not accept the managers' bona fides was one of four from no. 15, who responded and this was another of the many contradictory views from this hospital.

Looking at the N.H.S., Marnoch [1996:6], says that:

> "Doctors have an ambivalent relationship to the management process
> .... this is due partly to a lack of agreement over what management
> actually is".

If this is true it would prove a major obstacle to involving them in the management process. Marnoch adds that "conflict is increasingly taking place over the process of management rather than the outputs of management" and the whole objective of involving doctors in the management process is to improve outcomes. It is not necessary for doctors and nurses to get deeply immersed in process theory and the organisation's plan has to ensure that it does not happen. The plan has to bear in mind at all times what its objectives are if they are to be achieved.

The question of involvement has to be looked at from an overall perspective. The involvement that is taking place seems to be, for the most part, within the Clinical Directorate model. The study does not attempt to argue the pros and cons of this

model but there is one aspect that is relevant from the involvement perspective. Clinical Directors are intended to have managerial control over nurses and para-medical staff. The study sees this as narrowing the broad thrust of the reports listed in Chapter 1, where the involvement of nurses was also promoted. If some hospitals go the Clinical Directorate route that is a matter for them and they are likely to have a narrower focus than the multi-disciplinary approach. The study believes that it is even more important in planning the Clinical Directorate model to be conscious of the issues of culture and resistance to change, because the focus might be primarily on the doctors and due consideration may not be given to the other groups who will be involved in the process at a significant level.

(iii) Commitment - Table 6.04 nurses and Table 6.05 doctors:

All fourteen matrons felt that their Boards were fully committed to involving doctors and nurses in hospital management and perhaps not surprisingly, all fourteen felt that nurses were fully committed to the process. Their responses about the other two groups were slightly different. Twelve (86%), believed that managers were fully committed and two were not sure. Only six matrons (43%), thought that doctors were committed to being involved, three thought they were not and five were undecided. Most of the advocates of the involvement of doctors in managing hospitals see doctors as being the key players. If the matrons' views reflect the real situation, it would certainly raise doubts as to how successful the process is going to be. If the central thrust of the process is to involve doctors and as over half of the matrons believe that doctors are not fully committed to the objective, the importance of a documented plan to overcome or resolve this gulf becomes more urgent.

Fourteen of the eighteen doctors (77%), believed that their hospitals were committed to the objective of involving doctors and nurses in hospital management, three did not and one was undecided. The three doctors who believed that their hospitals were not fully committed were all from hospital no.15 and are supposed to be involved in the process there. The study believed it was a reasonable assumption to make that doctors might not accept that managers in particular were committed to the process and eight of the eighteen (44%), believed that managers were not fully committed. These eight represented only three of the ten hospitals which meant that the other seven would seem to have overcome this hurdle. Fourteen of the eighteen believed that nurses were fully committed and this reflected positively for eight of the ten hospitals.

Comparing the perceived commitment of the three groups to the process, the majority of managers believed that doctors were fully committed to the process, but less than half of the nurses did. As nurses have a lot more frequent contact and involvement with doctors than managers have, they could be expected to have a better idea of the doctors likely commitment to the process than managers would have. If this is the case, then there is a lot to be done to convince nurses on this score. This involves issues previously touched on, i.e., professional attitudes , cultures and organizational issues. Any problems in these areas will have to be addressed and this will not happen without adequate planning. Very surprisingly, one third of the doctors who responded also believed that doctors were not fully committed to the process. This could be regarded as surprising because the group which sees itself and is also seen by others as being vital to the process does not itself wholly believe that it is committed.

The study sees these responses as showing that there is a lot of work to be done in getting the respective groups to accept that the other(s) are committed and the major area of doubt centres around the level of commitment of the doctors. The Matrons, with two exceptions felt general managers accept that doctors and nurses can play an important role in managing hospitals. This is an important aspect as the level of contribution which each group can make to the process will be vital as it will allow all the participant groups to feel valued in the process, which in turn is likely to result in greater commitment, a greater sense of involvement and a greater sense of ownership. These are the factors which will avoid/overcome resistance and the influences of cultures and politics.

(iv) Evaluation - Table 6.06 nurses & Table 6.07 doctors:

On the issues of having a knowledge of planning techniques and of having some knowledge of how organizations function, all the respondents saw both of these issues as being either very important or important. The study sees this as very encouraging in that such eminently educated and skilled professionals might be perceived to look upon them as unnecessary or a waste of time. The only danger is that the positive responses could have been made because it was seen as the right thing to say.

Planning and introducing change will be affected by the existing organizational structures. Ten of the fourteen Matrons (71%), felt it was possible to achieve multi-disciplinary management within the existing management structures and ten of the fourteen felt that real attempts were being made to change existing management structures to allow for this involvement. However, three of the eight health board Matrons felt that it was not possible to do so, but the acceptance that real attempts

were being made to do so, is encouraging. Only six of the eighteen doctors felt it was possible to achieve multi-disciplinary management within established management structures.

There have been many references in the study on the apparent need to change the existing hierarchical management structures and the responses highlight this. Three quarters of the nursing responses and three quarters of the doctors responses believed that real attempts are being made to change existing management structures to allow for their involvement. These views are in stark contrast to those of the majority of managers who believed that it was not necessary to change the existing structures. The study would argue that involving doctors and nurses in the process of hospital management automatically requires some change in the existing management structures and therefore it cannot understand why managers would not see this.

(v) Influence - Tables 6.08 - 6.09 Nurses & Tables 6.10 - 6.11 Doctors:

The **Report of the Commission On Health Funding (1989)**, suggested that the process should be non-prescriptive in the various pilot sites. The attitude of the participants could reasonably be expected to play an important influence and therefore the approach to planning the process is very important. This aspect of non-prescriptiveness is one of the central points that the study addresses. It proposes that any planning process cannot really be viewed as such if the organisations driving the change do not play an active part in the planning. The response from the Matrons clearly highlights this. Five felt that the planning process should be influenced primarily by one group and all five suggested Hospital Boards for this.

However, while twelve of the fourteen saw one group as actually having this type of influence, there was no consistency in their views, two opted for administration, three for doctors, two for nurses and five for the hospital board. The study dealt in Chapter 1, with the aspect of nurses being involved in hospital management and whether this was good for the nursing profession. Equally important is, if it would be a good thing for the overall management process itself. If nurses cannot influence the process, their own roles will be diminished and their added value to the process is likely to be less than is required.

Chapter Two, looked at organisational issues and how they impact on changing any aspect of an organisations structure. Attitudes were seen as having significant influence and the responses from both Managers and Matrons showed a belief that doctors might be less than fully committed to the process. Four of the matrons saw a lack of trust between the groups as being the greatest barrier to achieving a successful outcome and another three saw it as the second greatest barrier. Professional cultures of doctors and nurses; management attitudes; and internal politics are all key factors leading to lack of trust, so in essence, seven of the twelve matrons saw lack of trust or factors affecting trust as being potentially the greatest barriers to achieving a successful outcome. Two of the four who placed lack of trust as the greatest barrier, had documented plans while two had not. Two of the three who ranked lack of trust as the second greatest barrier had documented plans, while the third did not. This suggests that having a documented plan will not guarantee that the trust issue is addressed unless the documented plan specifically addresses and allows for the factors that will have a big bearing on the level of trust to be addressed.

At the other end, one response rated lack of trust as being potentially the least barrier to a successful outcome, a second rated it as number four, i.e., not being of any great influence. A third did not rate it as a factor at all. Interestingly, none of the three had a documented plan and inadequate resources were rated as the greatest barrier. The matrons placed lack of trust or the factors that lead to a lack of trust as being the potential greatest barrier to success.

A slight majority of doctors (twelve of eighteen), believed that no one group should have the greatest influence in the planning process. For anybody espousing real equality of involvement and equality of responsibility this would have to be the case. However, power and influence are not matters which those who have them are likely to readily surrender and it will not be easy to get ready acceptance from the other parties involved that this will happen. This is reflected in seventeen of the eighteen doctors believing that one group would have the greatest influence. Eight (44%), saw managers as having the greatest influence; six (33%), saw the Board as having it. Perhaps, surprisingly, only two doctors saw doctors as having the greatest influence. The doctors clearly believed that the greatest influence on the planning process would be a combination of managers and external planners. Naturally, this is likely to make doctors apprehensive and wary of the process and reflects the notion of enforced rather than planned change.

In relation to organisational issues, only one doctor rated professional culture as likely to have the least influence and another three rated it as likely to be the second greatest influence, while nine doctors rated lack of trust as likely to have the greatest

influence and another three rated it second in the order of influence. Seven doctors rated inadequate resources as likely to have the greatest influence. The study believes that the doctors responses to these influences as worth noting. The majority saw their own professional cultures as having little influence but lack of trust as having the greatest influence. However, if levels of trust are affected by professional cultures, the would appear to be failing to make the link between both.

SUMMARY:

After looking at the responses from the nurses and the doctors as individual groups, a comparison between the two groups under each of the five headings shows:

(i) Awareness:

Four of the fourteen nursing responses (33%), stated that their hospitals did not have documented plans for the process, while the managers of those hospitals stated that they had. The situation was similar for the doctors who responded, eight said their hospitals did not have such plans and two did not know. This finding suggests that their are serious deficiencies in the matter of communication in these hospitals. If the intended participants do not know this basic information how can they be meaningfully involved in the process?.

(ii) Involvement:

The level of trust by doctors and nurses of managers seemed to be higher than the managers had for them, particularly for the doctors. Another inverse view related to

the matter of it being possible to achieve multi-disciplinary management within established management structures. The majority of doctors and nurses believed that it was not possible to do so, but accepted that attempts were being made to change these existing structures. The majority of managers however, had stated that it was possible to do this. This is a serious difference in perception and the aim has to be to get all three groups around to the same view, irrespective of what that view is. If this does not happen, there will be a major gap between their respective positions and this will hinder progress. A documented plan developed in conjunction with the three groups would have to address the issue and have it resolved.

(iii) Commitment:

On the matter of commitment to the process, while all the respondent matrons believed that their Boards were fully committed to the involvement of doctors and nurses in hospital management, eleven of the fourteen believed that managers were committed to participation on an equal footing but only six of the fourteen matrons believed that doctors were committed to this equal involvement. These responses indicate a lack of trust and the study repeatedly makes the point that trust is an important factor and that the planning process has to ensure that it is taken into account.

This issue of trust also comes through in the doctors responses, in that almost one half of them did not believe that managers are committed to the process. However, more than two thirds of the doctors believed that nurses are committed to the process, which suggests that doctors trust nurses more than they trust managers. Most surprisingly, one third of the doctors believed that doctors themselves are not

committed to the process. If there is general agreement that doctors have a key role to play in hospital management, the responses from the doctors suggest that it is not sufficient to simply take this perceived commitment as accurately reflecting the real position. Perhaps, the doctors views are shaped by bad experiences with managers, or through inaccurate perceptions of what management is all about, or because the doctors who responded thus are actually reflecting doctors real views in relation to their involvement in the management process.

(iv) Evaluation:

Both the doctors and nurses considered it necessary to have some knowledge of planning techniques and some knowledge of how organisations function. Management education and management development can address both issues if, as suggested in the study, management development is used as a vehicle for implementing change in general and this change process in particular. However, the majority of both groups felt that it is possible to achieve multi - disciplinary management within the established management structures, which the "flattening" proponents maintain should be changed.

It is not within the remit of the study to argue the pros and cons of the issue, but the findings again highlight the need to evaluate issues during the planning phase. Pascale [1990:19-22], referred to "the sheer variety of *faddy* managerial fixes" which management gurus have put forward in the last twenty years. Marnoch [1996:6], says that:

"These are hot ideas which form the products sold by less reputable management consultants. It has been pointed out that they have a shelf life in the business world roughly equivalent to a supermarket lettuce in some cases".

Marnoch [:8], warns of the dangers of public service managers clutching at the latest fix-all technique, while in his experience (sic), doctors prefer to be ignorant of the latest fad. The study is not suggesting that abolishing hierarchies is a result of faddy managerial fixes or that the likely lifespan of the "flattening" philosophy will be that short. Maybe it will, but a fundamental lesson might be to ensure that doctors and nurses are not bombarded with never ending theory.

(v) Influence:

The responses showed that both doctors and nurses believed that one group would have the greatest influence on the process, although there was no consistency in these views as to which group this would be. From an organisational perspective, this could be seen as suggesting fear of change as well as lack of trust. If any individual or group wants to maintain power bases which they might have, their levels of influence will have a direct bearing on this.

Individual influences may affect individual situations but should not affect the whole process. Group influences will affect the situation in a number of ways. First, each hospital should assess the situation from within the organisation and decide how best to channel the influences of the three groups so that it supports the change process. As doctors and nurses as groups are going to be influenced in their thinking by their respective professional organisations, "group think" from outside the organisation also has to be considered in the planning process.

The study has already made the point that the approach to the establishment of pilot sites where planning and progress were being left to individual hospitals was not a good approach to take. The responses from the doctors and nurses would seem to bear out this. Influence must be managed and cultivated so that it can be applied for the betterment of the process.

(i) Awareness: Nurses & Doctors

Q.2	Is a documented plan necessary?
Q.3	Has the hospital a documented plan?

No	Nurses		Doctors	
	Q.2	Q.3	Q.2	Q.3
1	✓	x		
2			✓	✓
			✓	✓
3	✓	✓	✓	✓
			✓	✓
4	✓	x	✓	✓
			✓	x
			✓	x
10	✓	x	✓	x
11			✓	✓
13	✓	x		
14	✓	x	x	x
15	✓	✓	✓	x
			✓	x
			✓	x
			✓	✓
17	✓	?		
19	✓	x		
20	✓	✓	✓	✓
21	✓	✓		
22	✓	✓	✓	x
23	✓	x		
24	✓	✓	✓	✓
			✓	✓

Table 6.01

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Q.(a) 4 & Q.(b) 2   Is a documented plan necessary?
Q.(a) 6 & Q.(b) 3   Has the hospital a documented plan?

No	Managers Q.4=2	Q.6=3	Nurses Q.2	Q.3	Doctors Q.2	Q.3
1	✓	x	✓	x		
2	✓	✓			✓	✓
					✓	✓
3	✓	✓	✓	✓	✓	✓
					✓	✓
4	x	✓	✓	x	✓	✓
					✓	x
					✓	x
10	✓	✓	✓	x	✓	x
11	✓	x			✓	✓
13	?	x	✓	x		
14	✓	x	✓	x	x	x
15	✓	x	✓	✓	✓	x
					✓	x
					✓	x
					✓	✓
17	✓	x	✓	?		
19	✓	x	✓	x		
20	✓	✓	✓	✓	✓	✓
21	✓	x	✓	✓		
22	✓	✓	✓	✓	✓	x
23	✓	x	✓	x		
24	✓	✓	✓	✓	✓	✓
					✓	✓

Table 6.02

(ii) Involvement: Nurses & Doctors

Q.7	Do general managers accept that doctors and nurses can play an important role in managing your hospital?			
	Nurses	Doctors		
No.	Q.7	Q.7		
1	√			
2		√		
		√		
3	√	√		
		√		
4	√	√		
		√		
		√		
10	√	√		
11		√		
13	√			
14	√	√		
15	√	√		
		x		
		√		
		√		
17	√			
19	√			
20	√			
21	√	√		
22	√	√		
23	√?	√		
24	√	√		
		√		

Table 6.03

(iii) Commitment: **Nurses**

Q.1	Is the Board committed to the objective of involving doctors and nurses in managing the hospital?
Q.6	Is each of the three groups fully committed to participating in the process on an equal footing? (a) managers; (b) doctors; (c) matrons

No	Q.1	Q.6a	Q.6b.	Q.6c
1	✓	✓	✓	✓
3	✓	✓	✓	✓
4	✓	✓	✓	✓
10	✓	✓	x	✓
13	✓	✓	✓	✓
14	✓	?	?	✓
15	✓	✓	x	✓
17	✓	✓	?	✓
19	✓	✓	?	✓
20	✓	✓	x	✓
21	✓	✓	?	✓
22	✓	✓	✓	✓
23	✓	?	?	✓
24	✓	✓	✓	✓

Table 6.04

(iii) Commitment: Doctors

	Q.1	Q.6a	Q.6b	Q.6c
Q.1	Is the Board committed to the objective of involving doctors and nurses in managing the hospital?			
Q.6	Is each of the three groups fully committed to participating in the process on an equal footing? (a) managers; (b) doctors; (c) nurses.			

No	Q.1	Q.6a	Q.6b	Q.6c
2	✓	✓	✓	✓
	✓	x	x	x
3	✓	?	x	?
	✓	✓	✓	✓
4	✓	✓	✓	✓
	✓	✓	✓	✓
	✓	✓	✓	✓
10	✓	?	?	?
11	✓	x	x	?
14	✓	✓	?	✓
15	x	x	✓	✓
	x	x	x	?
	x	✓	✓	✓
	✓	x	x	x
20	✓	x	x	x
22	?	x	✓	✓
24	✓	✓	✓	✓
	✓	✓	✓	✓

Table 6.05

(iv) Evaluation: **Nurses**

Q.4	Is it important that doctors and nurses would have some knowledge of planning techniques?
Q.5	Is it important that doctors and nurses would have some knowledge of how organisations function?
Q.8	Is it possible to achieve multi-disciplinary management within established management structures?
Q.9	Do you believe that real attempts are being made to allow for this involvement?

No	Q.4	Q.5	Q.8	Q.9
1	✓	✓	✓	✓
3	✓	✓	x	✓
4	✓	✓	✓	✓
10	✓	✓	✓	x
13	✓	✓	✓	✓
14	✓	✓	✓	x
15	✓	✓	✓	?
17	✓	✓	x	✓
19	✓	✓	✓	✓
20	✓	✓	x	✓
21	✓	✓	✓	✓
22	✓	✓	✓	?
23	✓	✓	x	✓
24	✓	✓	✓	✓

Table 6.06

(iv) Evaluation: **Doctors:**

Q.4	**Is it important that doctors and nurses would have some knowledge of planning techniques?**
Q.5	**Is it important that doctors would have some knowledge of how organisations function?**
Q.8	**Is it possible to achieve multi-disciplinary management within established management structures?**
Q.9	**Do you believe that real attempts are being made to change existing management structures to, allow for this involvement?**

No	Q.4	Q.5	Q.8	Q.9
2	√	√	√	√
	√	√	√	√
3	√	√	?	√
	√	√	x	x
4	√	√	?	√
	√	√	√	√
	√	√	√	*not needed
10	√	√	√	?
11	√	√	x	√
14	√	√	?	√
15	√	√	x	x
	√	√	x	√
	√	√	x	x
	√	√	x	x
20	√	√	√	√
22	√	√	x	x
24	√	√	x	x
	√	√	x	√

Table 6.07

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(v) Influence: **Nurses:**

> **Q.10**   Should any one of these groups have the greatest influence in the planning process?
>
> **Q.11**   Will any one of these groups have the greatest influence in the process?
>
>   (a) Managers; (b) Doctors; (c) Nurses; (d)External Planners; (e) Internal Planners; (f), Hospitals/Boards?

No.	Q. 10	Q. 11
1	x	√(a)
3	x	√(b)
4	x	√(f)
10	x	√(f)
13	√(f)	√(f)
14	x	√(f)
15	x	√(a)
17	x	x
19	x	√(f)
20	x	√(b)
21	√(f)	x
22	x	x
23	x	x
24	x	√(f)

Table 6.08

(v) Influence: **Nurses**

Q.12	Rate the influence of; (i) professional cultures; (ii) management attitudes; (iii) internal politics; (iv) inadequate resources; (v) lack of trust - as potential barriers.

No	(i)	(ii)	(iii)	(iv)	(v)
1	5	4	3	2	1
3	1	5	4	2	3
4	2	4	2	3	4
10	3	4	2	5	1
13	3	4	2	5	1
14	4	2	3	1	5
15	2	3	4	5	1
17	1	5	4	3	2
19	4	5	2	1	3
20	3	5	1	4	2
21	1	2	4	5	3
22	4	5	3	2	1
23	2	1	3	4	5
24	3	1	4	5	2

Table 6.09

(v) Influence: **Doctors**

Q.10	Should any one of the three groups have the greatest influence in the planning process?		
Q.11	Will any one of the three groups have the greatest influence in the process?		
	(a) Managers; (b) Doctors; (c) Nurses; (d) External Planners; (e) Internal planners; (f) Hospitals/Boards?		

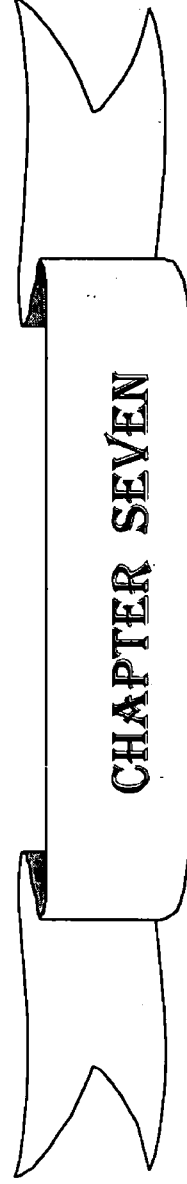| No		Q.10	Q.11	
2		x	√(b)	
		x	√(a)	
3		√(e)	√(e)	
		x	x	
4		x	x	
		x	√(a)	
		√(f)	√(f)	
10		x	x	
11		x	√(e)	
14		√(b)	√(a)	
15		x	√(e)	
		x	√(e)	
		x	√(e)	
		x	√(a)	
21		√(b)	√(a)	
22		x	√(a)	
24		√(b)	√(e)	
		x	√(a)	

Table 6.10

(v) Influence: **Doctors**

Q.12	Rate the influence of; (i) professional cultures; (ii) management attitudes; (iii) internal politics; (iv) inadequate resources; and (v) lack of trust as potential barriers.

No	(i)	(ii)	(iii)	(iv)	(v)
2	5	3	2	1	4
	3	1	5	4	2
3	1	2	4	3	5
	2	1	3	5	4
4	4	5	3	1	2
	3	3	3	1	1
	3	4	2	5	1
10	2		3		1
11	3	4	2	5	1
14	5	3	4	2	1
15	5	3	2	1	4
	4	3	2	2	1
	5	2	4	1	3
	3	4	2	5	1
21	5	3	2	4	1
22	5	4	3	1	2
24	2	3	4	1	5
	4	3	2	5	1

Table 6.11

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CHAPTER SEVEN

CHAPTER SEVEN

THE DOCUMENTED PLANS

A good planning framework should clearly identify the issues involved as well as identifying and setting out the desired end objectives. The study proposes that a plan should be assessed along the lines of the following criteria:

* Does it identify the purpose for which it was drawn up?

* Is it based on some recognised planning models?

* Does the plan allow for all participant groups to be involved?

* Are methods and stages identified for monitoring progress?

* Does it set out time scales as to pace at which the plan should be implemented?

* Does it have clearly identified time scales for implementation?

* Does the plan consider organisational issues which are likely to impact on the process?

From the twenty seven hospitals originally targeted in the study and from the twenty one responses received from managers, the study identified sixteen hospitals which were or would be involved in the process of involving doctors and nurses in the management of these hospitals. This allowed comparisons to be made between managers, doctors and nurses in relation to the various factors and issues covered in the questionnaires.

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The responses from the managers had indicated seven hospitals, four Voluntary and three Health Board, which claimed to have documented plans. However, in some cases, the doctors and the nurses had indicated differently, either that hospitals had a documented plan where managers had said that they did not or that they did not where managers had said that they did. The manager of one of the four pilot sites had indicated that the hospital did not have a documented plan (at that time!), although the matron and some of the doctors said that it had. The other three pilot sites had stated that they had such a plan, and this allowed for comparisons between individual planning approaches, between pilot sites and non pilot sites and also between Voluntary and Health Board hospitals.

A questionnaire was issued to the manager of each of the seven hospitals (Appendix 3), to check what was happening in practice against the various theories and approaches advocated. This questionnaire was intended to ascertain what planning approaches had been adopted, if planning models had been used and if the organisational issues suggested as factors affecting change had been identified in the plan. Tallaght hospital was included in the research for the first time at this stage. The results of the study up to this point indicated that the process of involving doctors and nurses in hospital management, while being widely advocated, was apparently approached without any definite planning, and without any significant degree of collaboration. This is surprising because the literature review suggested quite clearly that planning, if it is to be successful, must involve basic planning principles and an understanding of how organisations work.

The contract for consultant medical staff introduced in 1991 and which was referred to in Chapter Two, clearly identified the need to involve doctors in hospital management. It would be reasonable to expect that some progress would have been made in this between 1991 and 1996. The 1991 contract was heavily influenced by "The Review Body On Higher Remuneration In The Public Sector - Report No. 32, 1990, (Gleeson), which is referred to and quoted from in Chapter 1. A further review, "The Review Body On Higher Remuneration In The Public Sector, Report No. 36", 1996, (Buckley) [:4], referred to "the need to put in place as a matter of urgency, hospital management structures which entail real authority and accountability for consultants". The emphasis placed on the process in this report is not any greater than in "Report No. 32" (The Gleeson Report), or the other reports referred to, despite the elapse of many years.

One of the theories put forward at the outset was that a documented plan was essential if meaningful progress was to be achieved in this task. Was this progress made in Buckley's estimation?. This question is clearly answered in paragraph 1.11 [:5];

> "We were dismayed at the lack of progress in this regard over the past five years. With some noticeable exceptions, hospitals in this country generally do not have management structures and processes which enable consultants and non-medical management to work together on a common agenda of delivering high-quality care to patients effectively and efficiently within available resources".

This view, if correct, points to serious problems somewhere along the line in the planning process. Despite the reports, despite the acceptance of the need for this involvement by health planners; by consultants and their representative organisations;

by the Department of Health; by Health Board managements; and by Voluntary Hospital managements, there has been very little progress in **Buckley's** estimation. Obviously, either real commitment has not been there to implement the process or the planning has simply not been adequate to do it. Verbal support for the process has been regular and frequent and the responses to the questionnaires suggest that those responding were committed to the idea.

It would be reasonable to ask who should be responsible for leading the process? It is worth recalling that none of the managers believed that the entire process should be planned outside of the three groups and this suggests that this leadership has to come from within the participant groups. However, six of the fourteen matrons believed that the Department of Health would have the greatest influence in the planning process, which means that if nurses are to be involved in the process, they see this external influence as having a major say. The study has looked at the matter of change being planned internally [:12], and at organisational adaption where change is planned by outside forces. **Buckley** [:5], states that:

> "We found no evidence that the Department of Health is leading and shaping a change programme designed to implement such structures and processes in a predictable and consistent manner throughout the health services within an agreed timescale".

Should the Department of Health adopt this role? The study has already referred to the apparent absence of a common prescribed approach by the Department of Health in establishing the four pilot sites and **Buckley's** assessment of the situation appears to bear out this. However, if one were to favour the idea that change can most successfully be planned from within the organisation, it would be necessary to

consider the degree to which individual organisations should be the prime movers in initiating and implementing the process, rather than simply waiting for the Department of Health to do it.

One of the very interesting aspects of the responses from the three groups, was the relatively high incidence of views that consultants are not fully committed to the process. Two of the managers believed that they were not and another five were not sure. Three of the matrons thought that they were not committed and another five matrons were not sure. Almost one third (5/18) of doctors themselves thought that doctors were not committed to the process and two doctors were not sure. **Buckley** [:5], also considers this issue:

> "Consultants are, at best, ambiguous about their commitment to involvement in management ..... a complete change of attitude on the part of all concerned is needed if any real progress is to be made".

How can this change of attitude be brought about if after almost six years and in four pilot sites, little or no progress has been made?

> "To date, just four pilot sites have been selected by the Department of Health to develop and evaluate models of clinician involvement in management which would be suitable for application in Irish hospitals. Three of these pilot sites are still at a very early stage. The pilot projects appear to have been established with no milestone bench marks or success criteria identified at the outset and no defined timescale for bringing them to a conclusion" [**Buckley**:8].

This view of the situation suggests the absence of a comprehensive and structured plan which would have, (i) clearly defined objectives; (ii) a clearly identified structured approach to deal with the key stages of initiation, implementation and outcome evaluation; and (iii) clear signposting of such possible obstacles as: culture; politics;

trust; fear of change; professional tribalism; and power bases. The questionnaire issued to the managers in those hospitals who had indicated that they had documented plans, was intended to examine this aspect. As well as three of the four pilot sites getting as far as this stage of the analysis, four other hospitals were also at this stage and comparisons could be made between the three pilot sites, the other four and Tallaght.

The study has already referred to the new hospital at Tallaght, which is due to open in 1998. Four existing hospitals will be amalgamated into the Tallaght structure, which could involve high scale activity in relation to cultures, fear of change, inter group tribalism, levels of trust. The Board of Tallaght hospital recruited a Chief Executive from the Canadian health/hospital system and very soon after that appointment there were many reports of the setting up of new management structures involving doctors in particular. From the study's perspective, this offered the possibility of an interesting comparison with the other hospitals which had responded to the questionnaires. The Chief Executive was asked to complete a questionnaire, which was practically identical to the second questionnaire issued to managers, the only difference being that it specifically mentioned the cultures of the four hospitals.

ANALYSING THE DOCUMENTED PLANS:

The study has not indicated which hospitals are the pilot sites and the reasons for not doing so have been set out in Chapter Five [:113]. The individual tables identify whether the hospitals are Voluntary or Health Board by showing the Health Board

hospitals with a shaded background. The questionnaire for stage four, (Appendix three), was issued to the seven managers who had stated that their hospitals had documented plans as well as to the Chief Executive of Tallaght hospital. While the study guaranteed to all other hospitals that they would not be identified, because of the unique nature of the Tallaght situation this would not be possible. It was pointed out to the Chief Executive that if he responded to the questionnaire, it would be assumed that he had no difficulty with this identification. He completed the questionnaire within days. All seven managers in the other hospitals also completed and returned the questionnaire.

This questionnaire was designed to specifically look at the planning approaches and planning models used by each of the eight hospitals. All eight hospitals answered in the affirmative when asked (Q.1), if their hospital's plan specified the objective of involving doctors and nurses in the management of their hospitals. The analysis then looked at the documented plans under the headings listed hereunder. The analysis shows the situations in the individual hospitals and in the hospitals within their respective groups i.e., Voluntary and Health Board hospitals. However, when comparing the pilot sites and non pilot sites, the hospital numbers are omitted as this would make it relatively easy to identify the pilot site responses.

1.   **Planning Approach - Table 7.01.**

2.   **Planning Models Used - Table 7.02.**

3.   **Involvement in drawing up the plan - Table 7.03.**

4.   **Identification of the stages involved/Timescales - Table 7.04.**

5.   **Mechanisms for implementation - Table 7.05.**

6. **Impact of organisational issues** - Table 7.06.

7. **Involvement in assessing this impact** - Table 7.07.

1. PLANNING APPROACH:

The analysis first looked at the types of plan which the eight hospitals had. The questionnaire issued to the eight asked them to tick which one of four types of planning approaches best described their plans. This question was asked with a view to assessing if the approach in any way related to the planning models used. Three of the eight responses ticked only one of the four descriptions listed, four ticked more than one and the Tallaght response had ticked all four. On an individual basis the approaches were as follows:

(i) A general statement of intent:

While five of the eight hospitals had "general statements of intent" in some way or other, only two hospitals (2 & 24), had exclusively used this type of approach. Hospital no. 2 saw its plan as representing a **"Rational Comprehensive"** model and was the only hospital to claim it had used such a model. No. 24 saw its plan as an **"Incremental"** model.

(ii) A comprehensive statement of Board policy:

No hospital had solely used a comprehensive statement of Board policy, but hospital no, 4, reflected this approach along with a "general statement of intent". It regarded that the planning model represented in this approach was one of **"Mixed Scanning"**.

(iii) A general plan without specific details:

One hospital (no. 3), had used this in conjunction with a comprehensive structured plan and it regarded the approach as being one of **"Mixed Scanning"**.

(iv) A comprehensive structured plan:

Four hospitals had used this approach, two had used it on its own (10 & 22), one (3), had used it in conjunction with a general plan and another one (20), had used it in conjunction with a general statement of intent. No. 10 & 20 saw their plans as being **"Incremental"** and no.22 saw it as reflecting **"Bounded Rationality"**.

(v) Tallaght:

This hospital had used all four approaches and it regarded its planning model as representing **"Bounded Rationality"**.

From the perspective of Voluntary versus Health Board, there were no significant differences. One from each group had solely used a "general statement of intent" approach. One Voluntary had combined a "general statement of intent" with a "comprehensive statement of board policy". Two from each group had a comprehensive structured plan, either on its own or in association with one of the other approaches. Two of the three pilot sites had a " comprehensive structured plan while one pilot site had a plan which was a "general statement of intent".

2.   Planning Models used:

Following on from the four different individual approaches listed and the combinations

of approach used, the planning models used were:

* **Rational Comprehensive - no. 2;**

* **Incremental - no.s 10, 20 & 24;**

* **Bounded Rationality - no. 22 and Tallaght;**

* **Mixed Scanning - no.s 3 & 4;**

* **Garbage Can - none;**

* **None Of Above - none.**

Each of the eight hospitals had used some planning model and three of them

(37.5%), saw their plans as being Incremental ones. Two, including Tallaght

considered that they had used a **Bounded Rationality** model and two (3 & 4), saw

their plans as being a **Mixed Scanning** model. Only one claimed to have used a

Rational Comprehensive model and none of the eight saw its plan as representing

the **Garbage Can** model.

Does the type of approach adopted and the type of plan used have any apparent

bearing on the other five aspects listed? It is important to bear in mind that the

typology of plans and of planning models used is the respondent's assessment in

each case. The study believes that where these assessments are not accurate that

this would reinforce the need for the participants to have some knowledge of planning

techniques.

The Rational Comprehensive Plan:

The hospital with this approach in this questionnaire indicated that it had only involved general management and the Department of Health in drawing up the plan. However, in the first questionnaire the manager had stated that all three groups had been involved. This could be a simple error or could suggest an element of confusion and the study believes that it will be difficult to achieve a successful outcome with this confusion. The manager indicated that the plan had identified the three stages listed in the questionnaire i.e, moving from the existing stage to implementation; from initiation to implementation; and from implementation to review and evaluation. It was reported as having time scales for these stages. It had considered both management development and organisational development as mechanisms for implementing the plan.

In relation to the features and issues listed in the questionnaire, the plan had considered individual and organisational culture as well as the type of management structure and organisational politics. It had not considered resistance to change, possible inter group conflict and levels of trust as likely factors. The Rational model believes that everything will work out in a rational and orderly sequence and therefore would assume that conflict and levels of trust would not impede the progress. This hospital had involved doctors and nurses in assessing the likely impact of the features listed and expected that it is realistic to expect doctors and nurses to learn about and to allow for these features. The fundamental question is how did this involvement come about and how can doctors and nurses do this learning if they were not involved in drawing up the plan? The "general statement of intent" approach would appear to be limited and inadequate.

The Incremental Plan:

Three hospitals (one Voluntary - no. 10; and Two Health Board - 20 & 24), indicated that they had used an "incremental planning model". Two of the three (10/20), saw their plan as being a comprehensive one, while the third (24), saw it as a general statement of intent. All three stated that the three groups had been involved in drawing up the plan, no.s 10 & 20 had involved planning specialists, no.s 20 & 24 had involved their Boards and no.s 10 & 20 had also involved the Department of Health. Only one of the three had considered the matter of review and evaluation of the plan (20), and no.24 had not identified any of the three stages listed, in its plan. The study believes that implementing the process will be difficult if the plan has not identified these stages. Hospital no. 20 had included time scales in its plan for these three stages.

There was no consistency among the three in relation to using management development and organisation development as implementation mechanisms. Two of the three, no. s 10 & 24, had considered a management development strategy and no. 22 had considered a detailed organisation development strategy. There was also a lack of consistency in relation to the features/issues listed in question 8. The hospital's culture had not been considered by no.s 10 & 24 and individual cultures had not been considered by no.s 20/24, although all three had considered the management structures. The Voluntary hospital had considered resistance to change as a factor and no. 20 had considered levels of trust and organisational politics. All three had involved doctors and nurses in assessing these features/issues but one hospital (10), did not think it realistic to expect doctors and nurses to learn about them.

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Two of the three are pilot sites and the study believes that these are a good example of where the type of plan and planning approach show significant differences in relation to other aspects of the planning process. The hospital with the " general statement of intent" appears to be approaching the process from a weaker basis than the other pilot site which had a comprehensive plan. Examples of this are that the comprehensive plan had:

* involved planning specialists;

* involved the Department of Health;

* identified two of the three stages listed at question 4;

* identified time scales for these stages;

* considered four of the seven organisation issues listed at question 8, while the pilot site with the "general statement of intent" approach had only considered the type of management structure.

There are significant differences between two pilot sites and the non pilot site in this group of three. The non pilot site had a comprehensive plan and was more in line with the pilot site with the comprehensive plan than the other pilot site was. The study believes that this is another indication that the type of plan and the type of planning approach used does play a significant role.

The Bounded Rationality Model:

Two hospitals saw themselves as having adopted this model, hospital no. 22 and Tallaght. Neither are classed as pilot sites and both stated that they had a comprehensive plan. Hospital no. 22 saw its plan as being exclusively comprehensive whereas the Tallaght plan had linked all the approaches listed.

Hospital no. 22 had not involved either planning specialists or its Board, but had involved the three participant groups and the Department of Health in drawing up the plan. Tallaght had involved all six groups.

Tallaght had identified the three stages listed (Q.4), but no. 22 had not identified the matter of review and evaluation and both had identified time scales for the stages they had considered. On the question of using a management development strategy and an organisation development strategy as mechanisms for implementing the process, Tallaght had considered both while no. 22 had only considered a detailed organisation development strategy.

The greatest disparity arose in relation to the possible impact of the seven features/issues listed in question 8. Tallaght had considered all except organisational politics and as that hospital was not yet open at the time, this could be regarded as understandable. Hospital no. 22 had only considered the type of management structures and this was the same as one pilot site whose plan represented a "general statement of intent". It would be reasonable to expect that a hospital with a comprehensive plan would have considered more organisational features/issues than just the type of management structure.

Whatever the reasons why hospital no. 22 differed so much from Tallaght on this issue, interestingly, it was in line with one pilot site whose planning approach differed completely and whose plan represented a general statement of intent. Perhaps, hospital no.22 did not have a comprehensive plan even though it had indicated that it had.

Both hospital no. 22 and Tallaght had recruited managers from outside the Irish health services, hospital no. 22 from the U.K. and in Tallaght's case, from Canada. Both could be regarded as "external change agents". The study [:54-55], has looked at the role of external change agents and saw them as being more objective at diagnosing problems, because of obvious advantages such as lack of bias; broad base of experience and having specific skills. However, external change agents (the study believes!), are unlikely to readily change their own management styles and experiences, in these instances those of the U.K. and Canada. If this is the case, the planning process should, when it is looking at other situations or systems, whether these be within or outside their own systems, assess how similar and how relevant they may be. External change agents are also unlikely to readily absorb the organisation's politics and political climate.

The study suggests that these may be reasons why hospital no. 22 differed so much from Tallaght on the matter of not considering organisational issues other than the type of management structure and was closer to the views of the only pilot site that had approached the process with a general statement of intent, rather than a comprehensive plan. As both hospital no. 22 and Tallaght believed that their plan reflected **Bounded Rationality**, their concepts of what rationality is in relation to such important organisational features/issues would appear to have very different boundaries.

One other related aspect is that while hospital no. 22 had indicated that doctors and nurses had been involved in assessing the likely impact of these features/issues and that it was reasonable to expect doctors and nurses to learn about them, both it and

the pilot site had not included them in their plan. This suggests that the did not consider the issues as important and if this is the case the study believes that this is a serious deficiency and one which hospitals with a comprehensive plan would not/should not overlook.

The Mixed Scanning Model:

No.s 3 & 4 had used this model and no. 3 saw its plan as "leaning towards the Bounded Rationality model". No, 3 had involved the three participant groups and no. 4 had involved all groups except the Department of Health in drawing up the plan. Both had not identified the review and evaluation stage and only no. 4 had time scales for the two stages which it had identified. No. 3 had considered both a management development strategy and a an organisation development strategy as being mechanisms for implementing the process but no.4 had only considered a management development strategy as a mechanism. No. 3 had considered all of the features/issues listed except individual cultures and no.4 had not considered possible inter group conflict, levels of trust and organisational politics. Doctors and nurses had been involved in assessing the likely impact of theses features/issues in both hospitals and the managers felt it was realistic to expect doctors and nurses to learn about them.

The Garbage Can Model:

None of the eight hospitals saw their plans as representing this model. This suggests that these hospitals are clearly focused on the objective of involving doctors and nurses in the hospital management process and are not looking at side issues which proponents of this model have identified. Cohen et al [1976:26], suggested that in

situations where options or choices exist, while the main concern may be with making decisions, other activities may also be seen as important such as fulfilling previous commitments, justifying past actions, laying blame or cementing loyalties. None of these aspects are appropriate or relevant to the objective of involving doctors and nurses in hospital management and such a model would not be desirable in that context.

SUMMARY:

Does the foregoing analysis demonstrate any views or observations as to the quality of the documented plans? Primarily, the study believes that it shows a good deal of confusion exists and demonstrates the need for some overall direction and control of the planning process. The study also believes that the type of plan adopted has a greater impact than whether a hospital is a pilot site or not. The study is of the view that allowing the pilot sites to plan in an individual fashion is unwise. The study considers that the responses do not indicate any major divergence of approach between the two groups of hospitals i.e., Voluntary and Health Board and that this again shows that it is the type and comprehensiveness of the plan that matters. As it is possible to make comparisons between the two groups, individual aspects or groups of aspects can be looked at, as required.

One of the aims of the study is to make change planners conscious of the different planning approaches that can be followed and of the different planning models which can be used. The study is not advocating any one approach or model as it sees this as a matter to be attended to by each individual hospital when embarking on the

process. The study considers that the responses in the questionnaire issued to the hospitals with documented plans indicates that comprehensive plans appear to allow for broader consideration of the aspects and issues involved in the planning process. If the study is correct in this assumption, the planning approach and type of plan are what is most important in the process.

1. The Planning Approach:

| Q.2 | Which of the following best describes your hospital's plan?: (i) a general statement of intent; (ii) a comprehensive statement of Hospital/Board policy; (iii) a general plan without specific details; (iv) a comprehensive structured plan with specific stages,; phases; time scales; and review mechanisms?. |

No.	(I)	(II)	(III)	(IV)		
2	✓					
3			✓	✓		
4	✓	✓				
10				✓		
20	✓			✓		
22				✓		
24	✓					
Tallaght	✓	✓	✓	✓?		

Table 7.01

2. The Planning Models Used:

Q.6	Which of the following planning models most closely reflects how your plan was framed? (a) "Rational Comprehensive"; (b) "Incremental"; (c) "Bounded Rationality; (d) "Mixed Scanning"; (e) "Garbage Can"; (f) none of the above.

No.	(a)	(b)	(c)	(d)	(e)	(f)
2	√					
3				√?		
4				√		
10		√				
20		√				
22			√			
24		√				
Tallaght			√			

Table 7.02

3. Involvement in Drawing Up Plan:

Q.3	Please indicate which of the following were/will be involved in drawing up the plan; (a) General Management; (b) Doctors; (c) Matrons; (d) Planning Specialists; (e) The Board; (f) The Department of Health.

No.	(a)	(b)	(c)	(d)	(e)	(f)
2	✓					✓
3	✓	✓	✓			
4	✓	✓	✓	✓	✓	
10	✓	✓	✓	✓		✓
20	✓	✓	✓	✓	✓	✓
22	✓	✓	✓			✓
24	✓	✓	✓		✓	
Tallaght	✓	✓	✓	✓	✓	✓

Table 7.03

4. Identifying The Stages and Timescales Involved:

Q.4 Does your plan identify stages in the process? (a) Moving from the existing stage to initiation; (b) From initiation to implementation; Management; (c) Review and evaluation.

Q.5 Does your plan have timeframes/timescales for the stages listed at Q.4?

No.	Q.4(a)	Q.4(b)	Q.4(c)		Q.5	
2	✓	✓	✓		✓	
3	✓	✓	x		x	
4	✓	✓	.x		✓	
10	✓	✓	x		✓	
20	✓	✓	✓		✓	
22	✓	✓	x		✓	
24	x	x	x		x	
Tallaght	✓	✓	✓		✓	

Table 7.04

5. Mechanisms for Implementation:

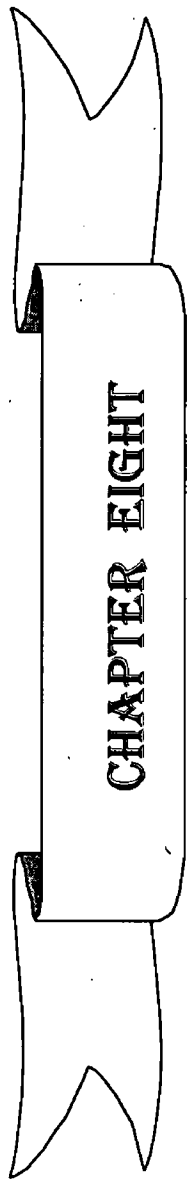| Q.7	Does your plan specifically consider the following as suitable mechanisms for successfully implementing the process? (a) a detailed management development strategy; (b) a detailed organisation development strategy.			
No.	(a)	(b)		
2	✓	✓		
3	✓	✓		
4	✓			
10	✓	x		
20		✓		
22		✓		
24	✓			
Tallaght	✓	✓		

Table 7.05

6. Organisational Issues Considered:

Q.8	Which of the following features/issues are specifically considered in the plan? (a) hospital's culture; (b) individual cultures; (c) type of management structures; (d) resistance to change; (e) possible inter group conflict; (f) levels of trust/distrust; (g) organisational politics.

No.	(a)	(b)	(c)	(d)	(e)	(f)	(g)
2	✓	✓	✓	x	x	x	✓
3	✓	x	✓	✓	✓	✓	✓
4	✓	✓	✓	✓	x	x	x
10	x	✓	✓	✓	✓	x	x
20	✓	x	✓	x	x	✓	✓
22	x	x	✓	x	x	x	x
24	x	x	✓	x	x	x	
Tallaght	✓	✓	✓	✓	✓	✓	x

Table 7.06

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7. Assessing The Impact Of The Organisational Issues:

Q. 9	Were doctors and nurses involved in assessing the likely impact of the features/issues listed at question 8?			
Q,10	Is it realistic to expect doctors and nurses to learn about and allow for the features/issues listed at question 8?			

No.	Q.9	Q.10		
2	√	√		
3	√	√		
4	√	√		
10	√	x		
20	√	√		
22	√	√		
24	√	√		
Tallaght	√	√		

Table 7.07

CHAPTER EIGHT

CHAPTER EIGHT

·CONCLUSIONS

Multi-disciplinary Management - Who Should Be Involved?

The study focused on the planned involvement of both doctors and nurses, along

with administrative managers, in hospital management. Multi-disciplinary

management could also be concerned with involving para-medical and other grades

of staff, but the study did not include these grades in the research, primarily because

there were no specific references to them in the reports used as a basis for the study.

Involving doctors (particularly) and nurses in the management process should lead

to they being more accountable in the use of scarce resources. "Experience in the

U.K., suggests that action is needed on a number of fronts to make this happen"

[Joyce and Ham 1990:15], e.g.;

> "Hospital information systems must be developed to give doctors and
> nurses accurate and timely information on the cost and quality of
> services; budgets for clinical services must be devolved to doctors and
> nurses and workload agreements must be agreed with budget holders;
> hospital management structures must be developed whereby doctors
> take responsibility for the planning and control of their services".

The study believes that it is a task for general managers to introduce mechanisms

and structures to bring about this accountability. However, the different perceptions

among the three groups as to the respective levels of commitment of each of the

other two groups suggests that the necessary accountability may be difficult to

achieve.

It would be advisable, when talking about involvement in the management process, to evaluate if management in this context means the same thing to the three groups. International experience of managing clinical practice suggests that " in large organisations, it is possible to draw a distinction between two different but quite critical types of management responsibility". Best [1990:8], addressing a conference on "Clinicians and the Management Process", spoke of the experiences in Guy's hospital in London. He argued that senior managers in large public sector organizations will in general [:8]:

> "Be more concerned with the external political environment than their private sector counterparts. It is crucial for public sector managers to guide their organizations through the minefield of continually changing external circumstances".

This Best termed "guidance management" and he argued [:8-13], that "as one moves down the various tiers of management, managers may become less concerned with organization wide issues and become much more involved with delivery issues". This is a fundamental question. If clinicians are likely to be more concerned with delivery issues and delivery issues are more relevant to the lower tiers of management, does it suggest that clinicians may not be suitable for involvement in management at the highest level. This is a provocative view in that doctors see themselves at the top levels of the management process. However, is it an aspect that should be given greater consideration?

Bazalgette and Crooke [1997:28], argued that the "N.H.S.'s idea of management is outdated. It needs a broader, more integral understanding that recognises the management skills of nursing". From the perspective of nurse education, they saw

managing as being more about processes than controlling people through the manipulation of financial resources. This is an important perspective because the thrust of many of the proposals for the need to involve doctors (and nurses), in hospital management centres around the use of resources. While this is a very important aspect, nevertheless it may not on its own, be sufficient on an ongoing and long term basis to anchor doctors and nurses into hospital management. This directly goes back to the objective of involving doctors and nurses in the process. Are the objectives clearly enough thought out and set out in the individual plans?

The study proposes, that change planners in trying to involve clinicians in hospital management should assess the degree to which their respective views of this involvement are compatible. Best in his paper [:8-9], went on to say that:

> "In large organizations which provide or arrange the provision of human services, the tension between guidance and delivery management is particularly important and like all human service organizations, those that attend to the delivery of health care must attend to the guidance/delivery tension. In health care however, there are additional complications because the tension between guidance managers and delivery managers tends to revolve around the issue of clinical freedom".

Multi-Disciplinary Management - What Is Involved?

Chapter Two looked at organisation management and the possible relevance of different organisation theories to the task of involving doctors and nurses in the management process. Some of Mintzberg's standard classifications of organisations were looked at. Harrison [1992:14-17], argued that "scientific management principles were never viable in a field of activity dominated by highly skilled professionals", who according to Marnoch [1996:92], "require a structure which allows them the discretion

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to act as they see fit to particular contingencies as they arise". This is clinical freedom which according to Best (as quoted above), causes tension between managers and doctors. Will it be easy to overcome these tensions? The research analysis shows differing attitudes about the perceived levels of commitment and also about who is likely to have the greatest influence on the process.

The matter of the Innovative organisation was referred to in Chapter Two, when some of Kanter's views were outlined. Marnoch [:101], sees innovative organisations as organic ones;

> "Whose structures are created to respond to the highly unpredictable technological advances and boundless market opportunities that characterise their business environments".

On first reflection, hospitals might not immediately suggest themselves as innovative organisations. However, in the context of the change process under consideration, innovation is called for on many fronts. Structures will have to change to some degree in order to facilitate the involvement of doctors and nurses, prejudices and entrenched views will have to change, dependency on elite managerial leadership and elite medical leadership will have to end if the two groups are to work effectively together. Marnoch evaluated various organisational types from a medical perspective [:103], and rated the innovative organisation as being high in relation to outcomes orientation and the involvement of doctors at operational level, while scoring low in relation to cost control; energy consumed in the management function; and dependency on elite medical leadership. This suggests that it would be beneficial if the planning process were to consider innovation from an organisational perspective as possibly being an effective way of bringing about the involvement being sought.

McCartney [1990:55-56], in looking at resource management in a particular hospital, proposed that "when taking on major change such as this is, it was necessary to pay attention to the following points":

1. understand peoples fears;

2. adopt a positive attitude to change;

3. give as much information as you can about the changes;

4. know the work of the department in which you are making changes;

5. resist the temptation to overstate benefits;

6. allocate sufficient time to the careful planning and implementation of changes;

7. don't lose your nerve;

8. training for change is essential;

9. improve work environments.

These points are very important in the whole planning process and if they are ignored or not given adequate attention, it will be more difficult to successfully implement the change. The levels of communication present in the hospitals looked at appears to be less than adequate. McCartney's proposal that as much information as possible should be given does not appear to be widely followed. Some extreme examples of this deficiency were manifest in a number of hospitals. In one pilot site, the manager, the matron and the doctors who responded, were completely at odds about the very basic fact of whether the hospital had a documented plan to implement the process.

While new concepts abound about changing structure and different views are discussed about approaches to management, the nine points mentioned by McCartney are not revolutionary. They are about organisational issues that are always present, such as, Culture; Trust; Management; Planning; Tribalism; Group Interactions; Fear of change; and various aspects of preserving Self Interest. A recurring theme from the returned questionnaires was the belief that one or other of the groups was not fully committed to the process. Lack of trust was a significant factor and unless the planning process takes this into account and specifically addresses it, the likelihood of success must be lessened.

Management Development:

This topic has been looked at in this study solely in relation to the role it can play in planning the involvement of doctors and nurses in the management of hospitals rather than the wider perspective of management development in general. What role can management development play in managing change? Langlands [1997:12], saw the rate of change in the N.H.S. as usually being:

> "Determined by a subtle interplay between context (the environment in which we are operating), content (the substance of what we want to do) and the process of change (how we set about it). It is this sort of approach that enabled us to take forward our research and development programme".

This study is proposing something similar. It looked at the context/the environment, it identified the content/substance of what is intended and it then concentrated on the process of change. Five of the eight hospitals with documented plans had specifically considered management development as a mechanism for successfully implementing

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the process. Implementing and continuing the process of managing change will require ongoing research into best practices, new developments and the other variables associated with change.

Another feature of changes that have taken place in Irish hospitals relates to the belief that managers should be on fixed term contracts, generally up to five years. The theory behind this is that managers become less productive and less developmental when they stay in the same organization for too long a period. However, Crail [1997:11], wonders if the days of the mobile manager may be coming to an end and he instanced where:

> "Recent graduates of the NHS management training scheme were told by top managers within the NHS that unless managers stay in post long enough to see a job through, they will not enjoy the confidence of doctors or of the public".

The study referred to the "Mastership" situation in the Dublin maternity hospitals where the term of office is seven years, and quoted Turner who referred to the enlightened concept of this system in terms of the current proposals to limit top managers to a seven year contract. The study does not accept that simply fixing such limits for managers is a ready made panacea and that it would be unwise to make it a corner stone in planning the process.

The graduates were warned by Peter Griffiths, King's Fund College Director [:11], that "any of you who don't have political skills won't survive; any of you that don't take the doctors with you won't survive". The study looked at the matter of politics in detail and if Griffith's view as quoted is correct, then managers without the political skills to

take the doctors with them will not be able to meaningfully involve them in managing their hospitals. Therefore, management development for these managers must involve the development of political skills and the plans for achieving multi-disciplinary management must recognise that politics will be a major element. Everybody involved in the process or concerned with the issue should reflect on what they want from and why they want to involve clinicians in the management process. Report no. 32, (The Gleeson Report), [:27], referred to:

> "The compelling advantages for consultants, for hospital authorities and for the longer term efficiency and effectiveness of the hospital service generally, of initiating a process leading to a fuller integration of consultants into the hospital management process".

The study has proposed that developing some managerial skills and expertise among each of the three groups is essential, but this development will not simply just happen.

The reports which suggested the study, repeatedly mentioned the need for management development. The Department of Health engaged a group of management consultants to look at this issue and they issued a report "**A Management Development Strategy For The Health Personal and Social Services in Ireland**". While they looked at management development from a very wide perspective, they did look at the matter of professionals in management. In reference to **Shaping a Healthier Future**, they referred [:20], to "specific initiatives which anticipated specific initiatives in relation to the involvement of medical, nursing and other professions in management". They saw the transition to management [:21], as requiring "particular support when it concerns moving from a professional or technical role into general management. They advocated [:21], that to do this:

"Professional training should help professionals to recognise that the organizational context within which they will work both facilitates and constrains their practice", and " For both administrators and professionals, the transition to management involves assuming a new occupational identity. This is particularly marked for professionals...... making this transition from concern with the individual to concern for a service or client group, can be stressful".

Organisation Development:

The growing recognition of the key role of the clinician in the overall performance of the health care system requires such development. Hurley [1990:66-70], looked at what had to be done in practical terms and he saw three important factors to be taken into account:

1. the need for organisational development to facilitate and stimulate medical leadership;

2. the need for adequate and appropriate information;

3. the need for developing reasonable mechanisms of accountability.

Six of the eight hospitals with documented plans had considered management development as a mechanism for successfully implementing the process. The role of organisation development was suggested as a vehicle for implementing change in Chapter Two and Hurley's reference to it, re-emphasises its importance. The task of organisation development will necessitate a much wider look at multi-disciplinary management than simply looking at individual situations if real multi-disciplinary management is to be introduced. Perhaps, one of the underlying messages is that managers and doctors need a partnership that strengthens them both.

While it is easy to promote the concept of doctors in management;

"We cannot start to fit consultants into an organisation without first examining the assumptions and deeply held beliefs within society about the role of the doctor. Society's view, as well as that of doctors is that a consultant is in charge of his (sic) own practice". [Kennedy 1990:212].

If cultures and professional tribalism/elitism is likely to influence the process it is important that it is an aspect that is considered. The analysis of the managers responses in both the Voluntary and the Health Board hospitals rated it as likely to have a major influence. The matrons also rated it as important, while the doctors did not attach as much significance to it. Of the eight hospitals with documented plans, three had not considered the hospital's culture, four had not considered individual cultures, five had not considered possible inter group conflict, five had not considered levels of trust/distrust and five had not considered organisational politics. The study believes that one cannot, as Kennedy suggests, examine assumptions and beliefs about doctors without looking at these issues. The responses from the eight hospitals who are most involved in the process shows that these issues are not being looked at.

If managers, doctors and nurses must appreciate and accept the roles that they each have, they must put aside traditional beliefs and assumptions. Kennedy believed [:211] that:

> "Those general managers who think that they can achieve their objectives better by reducing the power of consultants have lost sight of the main purpose of their business. On the other hand, consultants who think that their involvement will diminish the importance of full time managers are naive about their capacity to run large organizations".

The questionnaires suggest that "Professional Tribalism" is seen as a problem and therefore consideration must be given to it so that its effects can be lessened. This is borne out by Schofield, [1990:169], who saw:

> "The most fundamental problem of the N.H.S. is professional tribalism, the origins of which lay in the historic development of independent professions on a largely independent basis. The point about this tribalism is not just that it is inflexible from a consumer perspective, or inefficient from a managerial perspective, but it is also limiting to the staff who are trapped in this model".

This suggests that those planning management structures involving professionals and administrators must give due regard to this issue as it has real and significant long term implications for the success of the process.

Do professional characteristics inhibit change processes? Schofield [:169], believed that they do because:

> "Internal professional relationships are not geared to the skills and knowledge of staff, nor an assessment of what the customer needs, but to professional requirements; sometimes educational and sometimes simply protectionist".

It would be unwise to overlook this protectionist attitude and "forcing unwilling players to take on budgetary responsibility would not be resource management but resource miss-management", [Coe-Legg 1990:178]. The aspect of protectionism could also be a factor for managers in that they have carved out positions in an area such as health where they are not regarded by the end user as being of vital importance. Kennedy [:211], as already quoted was of the view that before consultants are fitted into an organisation it is necessary to examine what the perceived role of the consultant is.

The importance that each group recognises the need to co-operate cannot be overstated. Many of the managers who responded to the questionnaire, while believing that no one group should have the greatest influence in planning the process, felt that consultants would. However, some managers felt that while consultants would have the greatest influence, they (the managers themselves), should have it. This again emphasises the need for full co-operation, commitment and acceptance that all groups are needed to participate.

> "While managers may never be able to compete with doctors and nurses in the process of public sanctification, there is no doubt in my mind that the major factor in the enormous progress which has been made in the introduction of the N.H.S. reforms and maintaining the service meanwhile has been the key role played by N.H.S. managers" [Fletcher 1991:161].

The Planning Process:

The positive belief that managers had on the need for a plan, the need for the involvement of all three groups in drawing it up and the need for mechanisms to monitor its implementation and success, is encouraging. Rathwell, [1986:55], refers to the planning system as providing "a common framework for the analysis and assessment of the strategic problems identified which begins with a selection of the objectives to be pursued". Rathwell, goes on to emphasise [:55], the crucial role of planners in this:

> "Because planning tasks and responsibilities are generally spread amongst several individuals, it is important that each one knows who does what, why and if appropriate, how".

The research suggests that each of the participants do not know who does what, why and how. The most obvious examples of this are the hospitals where each of the three groups had different views in relation to their own hospitals' plans.

Rathwell adds that "equally the plan itself must be planned which means that there should be a document or plan drawn up which outlines in sequence, the targets to be achieved in quantitative and temporal terms". This is the thesis with which the study started and Schofield [1986:60], stresses that:

"Without a plan there is the possibility that the investment in the process will not be maximised, as there will be parts of the organization which the messages do not reach and conversely, there will be instances where the investment is duplicated or not directed at the critical path"

The study fully supports this view. Only seven out of the twenty one hospital managers who responded to the first questionnaire had a documented plan. This shows that a process which has been promoted and encouraged for a good length of time has not spread beyond the larger hospitals and even in these seven, there appears to be many gaps and deficiencies, which raises some questions about the adequacy of their plans.

SUMMARY:

The study first put the subject in context by looking at the situations and reports that had identified the ways in which the management of hospitals should be improved. It then looked at the factors that exist in and relate to how organisations function. The next stage in the process was to look at planning theories and evaluate them as to their appropriateness for planning change in hospital management. It is worth noting that none of the reports or studies looked at, adopted a consciously prescriptive approach as to how professionals could be involved in the process. One aspect considered was the belief that hierarchical structures were not a suitable base from which to progress. "Busy managers locked into a bureaucratic system may find it hard to respond quickly to new situations" [Key 1988:164], and so the need to flatten structure is seen as an important ingredient in the process.

Of paramount importance is the necessity for doctors, nurses and managers to communicate positively with each other. This is not always easy bearing in mind the different cultures and training that they undergo and "it remains a fact of management life that any decisions about resourcing have to be taken within a public arena" [Christie 1988:32]. As a result, professional health care workers will not be as concerned with the politics of decision making as managers are. Therefore, in the relationship between doctors and managers, "communication between the two groups is continually hampered by our lack of a common language" [Christie :32]. The study believes that inadequate communication is the most noteworthy aspect coming from the research. It is particularly evident in the different beliefs and perspectives that the three participant groups have in relation to what is happening in their own hospitals. An extreme example was where the manager in a pilot site said that the hospital did not have a documented plan. The matron believed that it had and the majority of the doctors in that hospital who completed the questionnaire also believed that it had.

Planning change requires an organizational culture that fosters change and Attwood [1992:21], argued that:

> "Many top managers have been tempted to neglect their own development in the face of massive work agendas. Failure to pay attention to this will place in jeopardy the ability to build individual and organizational capability to sustain the changes necessary".

Attwood was writing on a project designed and implemented by the N.H.S. Training Directorate in 1989 (NHSTD), which embarked on an action learning programme. The aim of action learning according to Attwood, "is to bring people together and get them

to work on the problems and issues facing them and to learn from that process" [:21]. That study showed that those who were able to communicate organisational values and direction created a much more effective climate for change than those who did not. It also showed the significance of the impact of the top managers on the climate for learning and change in their organisations.

Is there such a thing as "a strategy for change"? The responses to the questionnaires suggests that there is practically a one hundred percent commitment to accepting that change has to be planned, that it should involve all participants in drawing up a documented plan to tackle the change objectives and that the plan has to be monitored. There may be some difficulties in rigidly applying theories of organisational change whereby they become over time, synonymous with the management of change. Scott and Jaffe [1990:21], propose that:

> "A major lesson in leadership is that you cannot move through change and keep previous levels of tight control over your staff".

They proposed the following as basic guidelines for managing change:

(1) have a good reason for change;

(2) involve all the appropriate individuals/groups;

(3) have a respected person in charge;

(4) create transitional management teams;

(5) provide training for the participants;

(6) bring in outside help if necessary;

(7) establish symbols of change,(logos slogans, etc.);

(8) acknowledge the contributions made and reward in some way.

The good reason for change has been identified and is accepted by doctors, nurses and administrative managers as being necessary. This study explains why it is vital to involve all the appropriate individuals and groups. It also puts the roles and responsibilities of the change sponsors and of the change agents into perspective. The existence of a documented plan should provide for the creation of transitional management teams, detail the training that should be done and ensure the bringing in of outside help, if necessary. Political sensitivity may would be very important in relation to the establishing of change and subsequent recognition and reward.

Scott and Jaffe [:60], in setting out guidelines for achieving change, suggested that the objectives involved should be "S.M.A.R.T.":

    S --- Specific;

    M --- Measurable;

    A --- Attainable;

    R --- Results Oriented;

    T --- Time Limited.

How realistic is it to expect that doctors and nurses will have the time and inclination to consider all the different aspects and issues involved in planning change? Those managers who had documented plans felt that it was realistic to expect doctors and nurses to learn about planning and all that goes with it from an organisational perspective. It is important that the organisation planning change would consider all of these aspects and having a documented plan would allow for an on-going awareness of them. The logical approach might be for each hospital to establish a

tightly knit planning group which could attend to the detailed planning aspect, while adopting something akin to the S.M.A.R.T. approach when explaining the plan to the individuals in the multi-disciplinary groups..

The majority of respondents across the three groups felt that:

* it was essential to have a documented plan;

* all three groups should be involved in drawing up the plan;

* it was important that the participants would have some knowledge of planning techniques;

* it was important for the participants to understand how organisations' function;

* organisational issues and factors could affect the process;

* each group should have a clearly defined role;

The need for a documented plan should not be confused with over emphasis and over reliance on detailed planning. The abolition of hierarchies would not be compatible with building up huge planning departments:

"Abolishing its planning department, might be the best thing a company could do for its shareholders - or so says a report from management consultants at ...Deloite Haskins and Sells. Looking at total returns made to shareholders over the past three years, the report shows that firms without central planners tend to produce higher returns...The main problem seems to be that firms with a planning department are more likely to build empires". ["The Economist" February 18,1989: from Liberation Management by Tom Peters 1992:470].

While there are fundamental differences between production firms and service organisations such as hospitals, nevertheless, efficiency and effectiveness would be equally important to the service organisation. If planning departments tend to build empires, as suggested in the management consultant's report, it would be most unfortunate if an over emphasis on centralised planning by hospitals was to create, rather than reduce, the hospitals' hierarchical tendencies. The plan should exist and should be structured in a way to allow for:

* analysis of the situation;

* the involvement of all intended participants;

* a plan that is simple and straightforward;

* the setting of realistic objectives and time frames;

* review and update, following continuous evaluation and assessment;

* mechanisms to allow for evaluating the progress and outcomes;

If progress is slow and difficult, the motto should be; do not despair; be prepared for this and include some contingencies in the plan to overcome such difficulties. It is unlikely that the plan will account for all the factors from the outset. It may not be easy to have doctors and nurses deeply involved in consideration of issues such as culture, organisational politics because their primary task should remain caring for patients. Equally, they should not be expected to become full time planners because that too would be unrealistic. The study believes that administrative managers should be or should be among the lead planners and that doctors and nurses would contribute to the development of the plan and consciously participate in its implementation.

The study quoted from Kanter's speech at a national conference, [:42-43], where she referred to "bold strokes" and "long marches". These two concepts were picked up on by Fritchie [1997:26], who saw that "five years into the reforms, the long march fatigue is very evident". Among the stresses and strains she saw as causing real concerns were the proximity of politics and politicians; and uncertainty about next steps in direction and strategy. The crucial role that politics, both externally and organisationally, can play in the change process has been dealt with at some length in the study and the need to be able to manage these political situations has been stressed.

The development of managers so that they will be able to cope with 'politics' is very important and Peck [1997:22], saw the 1990s as having led managers into becoming "politicians' partners" in imposing change on the service which called for loyalty without granting security. Peck argued [:22], that:

> "In such circumstances, the absence of an ethical code, a fixed point to which managers can turn in an ever changing and uncertain world, has led them to lose integrity".

Peck believed that "under the discipline of performance management the N.H.S.s' corporate culture is becoming increasingly dishonest". He felt it was important to draw attention to the ethical problems that appear inherent in current management methods, and their implications for the relationship between managers and clinicians, patients and public.

This study is in not suggesting that the ethical deficit which Peck saw as existing in the N.H.S., exists in the Irish situation. However, if such were to arise in the Irish situation, it could pose serious problems for the process in the long term, whether this

ethical deficit was a feature of the involvement of one or of all the groups. The establishment of a code of practice to which all the participants would subscribe might be a very important factor in planning the process, although it might look out of place in a written plan. Again, the benefit from looking at what is happening elsewhere can help on this issue. The Institute of Health Services Management (*I.H.S.M.*), has drawn up a draft code of professional conduct designed to give practical support to managers. Aird [1997:18-19], says that:

> "Management in the health service has changed beyond all recognition in the past twenty years. The Public Sector values that used to underpin all decisions are no longer sacrosanct and have in many cases been tossed aside by market forces. Managers need guidelines and a framework of reference by which they can judge whether the decisions they are making are ethically and professionally sustainable".

Public sector values have played an important part in how hospital managers have carried out their duties heretofore, albeit in situations where politics has always been a feature. Market forces may not feature to the same degree in the Irish Health service as it does in the U.K., but increasing emphasis on efficiency, quality and client/customer needs has impacted to some degree. Will doctors and nurses have the same public sector values? Perhaps, they will, but it is likely to be from a different emphasis. Doctors can claim that everything they do and the resources they use are all related to necessary individual clinical decisions and as an integral part of the management structure they will be in a greater position than heretofore to influence the decision making process. Nurses may have similar views. The study is not suggesting that the values of the doctors and the nurses are not as sustainable as those of managers, but it is trying to emphasise that the greater involvement of doctors and nurses in hospital management will lead to the putting forward of different values.

Should the documented plan consider and address the issue of professional managerial ethics? The draft code of the Institute Of Health Services Management [1996], was drawn up by a working party that included representatives from medical and nursing bodies. If doctors and nurses are to become managers in addition to their chosen professions, a code of professional managerial ethics will also be relevant to them. The "Code of Professional Conduct" deals with the areas of:
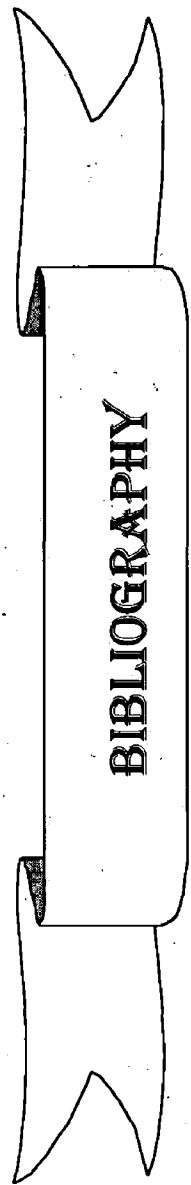
*   Personal Responsibilities, which include maintaining and developing professional competencies;

*   Responsibilities to the organisation;

*   Responsibilities towards individuals;

*   The overall provision of health care;

*   Enforcement procedures.

This matter was not addressed in the questionnaires because it had not come to light in the literature reviewed, but the study believes that it is a very important issue and should be addressed by each hospital in its plan . It is an issue which will affect each of the three groups in a way which may not have arisen until now.

The final suggestion which this study is putting forward is that while a documented plan is seen as being essential to bring about the involvement of doctors and nurses along with administrative managers in managing hospitals, the integrity of the plan and commitment of all of the participants is of crucial importance to achieving successful multi-disciplinary hospital management. Each organisation will have to examine its own situation and assess what structures, planning approaches and

planning models it should adopt. The organisational factors which the study considers as likely to impact on the process will differ from one organisation to the next. The management philosophies and personalities will also differ. Choosing the appropriate planning approach will require assessment of the different planning approaches that could be used. Either the Department of Health or some central agency should plan and drive the process or else it will be dependant on the varying capabilities of individual hospitals in an un-controlled way.

Hospitals will have many of the features of any other organisations. If they are to be regarded as just individual organisations, they will perform as such. It is doubtful that many large corporations with many subsidiaries would act in such a manner. However, in essence, the Department of Health is a large corporation with hospitals as subsidiaries, (even though the same levels of ownership do not exist), which provide services on its behalf. The study strongly believes that this emphasises the need for comprehensive, centrally directed planning. Finally, the study sees the deficit in communication as the issue that has to get priority attention. If this deficiency is not overcome, it will not be possible to make real progress and the process will continue to be an objective going nowhere.

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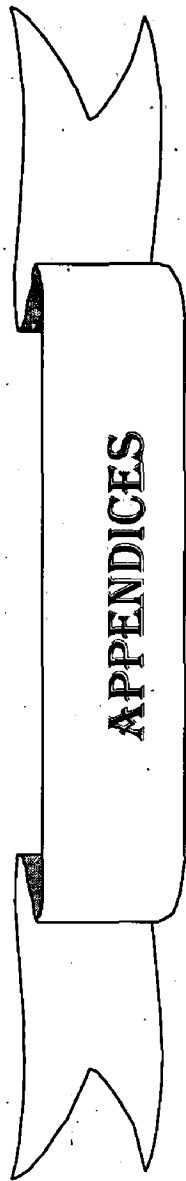
APPENDICES

APPENDIX ONE

QUESTIONNAIRE ISSUED TO HOSPITAL MANAGERS

This questionnaire forms the research part of a thesis on the planning aspect of managing change. It is designed to cover a number of scenarios relating to the introduction of multi-disciplinary hospital management, viz.;

- already in place
- due to come into place / being planned
- no plans at this stage to introduce it

GUIDELINES FOR COMPLETING QUESTIONNAIRE:

It is designed to be easily completed and the data furnished will not be used to identify any individual or institution. Please insert your name and title in the spaces provided at the start of the questionnaire. Your co-operation will be greatly appreciated and should you wish to add comments, please do so.

HOSPITAL : _____

NAME : _____

TITLE : _____

1

√or number appropriate box(es)

1. Has your hospital already introduced multi-disciplinary hospital management?

    (a)   Yes ☐   →   hospital level   ☐

                                             department level ☐

                                             directorates ☐

    (b)   No ☐

---

2. Is your hospital currently planning the introduction or the further introduction of multi-disciplinary management?

    (a)   Yes: ☐   →   hospital level   ☐

                                               department level ☐

                                             directorates ☐

    (b)   No ☐

√ or number appropriate box(es)

3. Please indicate which of the following groups are/will be involved in the planning process?

    (a)   Administrative:
- Chief Executive / Manager ☐
- Designated Project Planner ☐
- Business Manager ☐

    (b)   Medical:
- Clinical Director ☐
- Clinical Co-Ordinator ☐
- Department Head ☐

    (c)   Nursing:
- Director of Nursing/ Matron ☐
- Directorate Manager ☐
- Department Manager ☐

4. Is it necessary to have a documented plan to successfully bring about multi-disciplinary management?

    (a) Yes   ☐
    (b) No   ☐
    (c) Don't know ☐

5. Should all three groups be involved in drawing up this plan?

    (a) Yes   ☐
    (b) No   ☐

6. Has your organisation such a documented plan?

    (a) Yes   ☐
    (b) No   ☐

7. Were all three groups involved in drawing up the plan?

    (a) Yes   ☐
    (b) No   ☐

8. How important is it that those involved in the process would have some knowledge of planning techniques?

   (a) very important ☐

   (b) important ☐

   (c) not important ☐

9. How important is it that those involved in planning should understand how organisations function?

   (a) very important ☐

   (b) important ☐

   (c) not important ☐

10. Please rate in order from 1 - 7, (one = greatest impact), the effect the following aspects could have on the outcome:

   (i) Participants Management Expertise ☐

   (ii) Participants Group Cultures ☐

   (iii) The Organizations Culture ☐

   (iv) The Organizations Internal Politics ☐

   (v) Structure Of The Organization ☐

   (vi) The Calibre Of The Change Planners ☐

   (vii) An agreed comprehensive plan ☐

11. Should each group have a clearly identified role in the planning process?

   (a) Yes   ☐
   (b) No   ☐

12. Does each group have such a role?
   (a) Yes   ☐
   (b) No   ☐

13. Were the experiences in other hospitals involved in the same process, looked at?

   (a) Yes   ☐
   (b) No   ☐

14. Do you believe that each group is fully committed to participating as an equal partner in the process?

		Administration	Medical	Nursing
(a)	Yes	☐	☐	☐
(b)	No	☐	☐	☐
(c)	Don't know	☐	☐	☐

15. Is multi-disciplinary management achievable?

(a)	Yes	☐
(b)	No	☐
(c)	Don't know	☐

16. Is it possible to achieve multi-disciplinary management within Hierarchial Management Structures?

(a)	Yes	☐
(b)	No	☐
(c)	Don't know	☐

7

17. Are real attempts being made to "flatten" hierarchical management structures in order to successfully involve doctors and nurses in the management process?

    (a)   Yes   ☐

    (b)   No   ☐

18. Should any one group have the greatest influence in the planning process and if yes which group?, (1 = most influence).

    (a)   Yes   ☐ → Administrators   ☐

                                             Doctors   ☐

                                             Nurses   ☐

                                             External Planners   ☐

                                             Internal Planners   ☐

                                             Hospital Boards   ☐

    (b)   No   ☐

    (c)   Don't know   ☐

19. Is any one group likely to have the greatest influence in the planning process and **if** yes which group?, (1 = most influence).

    (a)   Yes   □ →   Administrator   □

                                            Doctors   □

                                            Nurses   □

                                            External Planners   □

                                            Internal Planners   □

                                            Hospital Boards   □

    (b)   No   □

    (c)   Don't know   □

20. Rate in order of influence from 1 - 7, (1 = greatest influence), the following as potential barriers to achieving a successful outcome:

    (i)   Professional Elitism   □

    (ii)   Managerial Attitudes   □

    (iii)   High Levels of Bureaucracy   □

    (iv)   Less than Full Commitment   □

    (v)   Unequal Involvement   □

    (vi)   Inadequate Resources   □

    (vii)   Lack of Trust between Groups   □

21.　To what degree will the level of planning effect the outcome?

　　(a)　major degree　　☐

　　(b)　minor degree　　☐

　　(c)　no effect　　　　☐

22.　Please rate in order of importance from 1 - 5, (1 = most importance), the following approaches as a means of planning the process?

　　(i)　　A rigid prescribed approach　　　　　　　　☐

　　(ii)　　A flexible approach　　　　　　　　　　　　☐

　　(iii)　　A contingency or Ad-Hoc approach　　　　☐

　　(iv)　　A political approach (people & situations)　☐

　　(v)　　Settling for less than the optimum　　　　☐

23.　Should each group have equal responsibility for planning the process? and if **no**, rank responsibility (from 1 - 3):

　　(a)　Yes　　☐

　　(b)　No　　☐　➔　　Administrative　　☐

　　　　　　　　　　　　　Medical　　　　　☐

　　　　　　　　　　　　　Nursing　　　　　☐

24. Should there be mechanisms available to identify progress at designated stages?

    (a)   Yes   ☐
    (b)   No   ☐

25. Should the entire process be planned outside of all three groups and if yes, by whom?

    (a)   Yes   ☐   →   Professional Planners   ☐

                                    Department of Health   ☐

                                    Hospital Board   ☐

                                    All three   ☐

    (b)   No   ☐
    (c)   Don't know   ☐

APPENDIX TWO

QUESTIONNAIRE ISSUED TO DOCTORS AND NURSES

This questionnaire forms the research part of an M.A. thesis on planning organizational change as it relates to the issue of involving doctors and nurses in the management of hospitals. It is a follow up to a similar questionnaire that was issued to hospital managers. Its objective is to get the views of Director's of Nursing / Matrons and of Doctors in hospitals which are planning or which are already involved in such a process.

Guidelines for Completing Questionnaire:

The Questionnaire is designed to be easily completed and the data furnished will not be used to identify any individual or institution. Please insert your name and job title in the spaces provided at the start of the questionnaire, for reference purposes only. Your co-operation will be greatly appreciated and should you wish to add comments, please do so.

HOSPITAL : _____

NAME : _____

JOB TITLE : _____

1. Do you believe that your Board is committed to the objective of involving doctors and nurses in managing your hospital?

    (a) Yes   ☐

    (b) No   ☐

2. Is a documented plan necessary to achieve this goal?

    (a) Yes: ☐

    (b) No: ☐

    (c) Don't Know: ☐

3. Does your hospital have a documented plan to co-ordinate the involvement of doctors and nurses in managing your hospital in association with the general management?

    (a) Yes   ☐

    (b) No   ☐

    (c) Don't know ☐

2

4. How important is it that the doctors and nurses involved would have some knowledge of planning techniques?

    (a)   very important   ☐

    (b)   important   ☐

    (c)   not important   ☐

5. How important is it that these doctors and nurses would have some knowledge of how organizations function?

    (a)   very important   ☐

    (b)   important   ☐

    (c)   not important   ☐

6. Do you believe that each of the three groups is fully committed to participating as an equal partner in the process?

		Administration	Medical	Nursing
(a)	Yes	☐	☐	☐
(b)	No	☐	☐	☐
(c)	Don't know	☐	☐	☐

7. Do you believe that general managers accept that doctors and nurses can play an important role in managing your hospital?

    (a)   Yes   ☐

    (b)   No   ☐

    (c)   Don't know   ☐

8. Is it possible to achieve multi-disciplinary management within the established management structures?

    (a)   Yes   ☐

    (b)   No   ☐

    (c)   Don't know   ☐

9. Do you believe that real attempts are being made to change existing management structures to allow for this involvement?

    (a)   Yes   ☐

    (b)   No   ☐

    (c)   Don't Know   ☐

10. Should any one group have greater influence than others in the planning process and if yes which of the following groups?

    (a)   Yes   ☐ → (a)   Administrators   ☐

                               (b)   Doctors   ☐

                               (c)   Nurses   ☐

                               (d)   External Planners   ☐

                               (e)   Internal Planners   ☐

                               (f)   Hospital Boards   ☐

    (b)   No   ☐

11. Is any one group likely to have a greater influence in the planning process and **if** yes which group?

    (a)   Yes   ☐ → (a)   Administrators   ☐

                                         (b)   Doctors   ☐

                                         (c)   Nurses   ☐

                                         (d)   External Planners   ☐

                                         (e)   Internal Planners   ☐

                                         (f)   Hospital Boards   ☐

    (b)   No   ☐

12. Please rate in order of influence from 1 - 5, (1 = greatest influence), the following as potential barriers to achieving a successful outcome:

    (i)   Professional Cultures of doctors and nurses   ☐

    (ii)   Management Attitudes   ☐

    (ii)   Internal Politics   ☐

    (iv)   Inadequate Resources   ☐

    (v)   Lack of Trust between Groups   ☐

APPENDIX THREE

QUESTIONNAIRE ON PLANNING THE INVOLVEMENT

OF DOCTORS AND NURSES IN HOSPITAL MANAGEMENT

1. Does your hospital's documented plan specify the objective of involving Doctors and Nurses in the management of your hospital?

		Yes	No
(a)	Doctors	☐	☐
(b)	Nurses	☐	☐

2. Please tick which <u>one</u> of the following best describes your hospital's plan.

   (a)   a general statement of intent;   ☐

   (b)   a comprehensive statement of hospital/board policy;   ☐

   (c)   a general plan without specific details;   ☐

   (d)   a comprehensive structured plan with specific stages; phases; time scales; and review mechanisms.   ☐

3. Please indicate which of the following were involved in drawing up the plan.

   (a)   General Management;   ☐

   (b)   Consultants;   ☐

   (c)   Nursing Management;   ☐

   (d)   Specialist Planners;   ☐

   (e)   The Board;   ☐

   (f)   Department of Health;   ☐

4. Does your plan identify specific stages in the process e.g.

		Yes	No
(a)	moving from the existing situation to initiating the process;	☐	☐
(b)	proceeding from the initiation stage to implementation;	☐	☐
(c)	after implementation, reviewing and evaluating the outcome results.	☐	☐

5. Does your plan have time scales/time frames for the stages listed at No.4?

	Yes	No
	☐	☐

6. Which of the following planning models most closely reflects how your plan was framed?

(a) A "Rational Comprehensive" model which assumes everything will work out in a rational and orderly sequence of events.   ☐

(b) An "Incremental" model which seeks to attain the stated objectives through a series of successive incremental decisions rather than through one grand plan.   ☐

(c) A "Bounded Rationality" model where the plan attempts to be as rational as possible but accepts that it is necessary to achieve the objectives that are possible rather than deciding that all the objectives have to be achieved.   ☐

(d) A "Mixed Scanning" model which compromises between (a), (b), (c) depending on circumstances.   ☐

(e) A "Garbage Can" model where likely problems and possible solutions are all considered and where the decisions to be taken could also be used to attend to other issues/situations; e.g. fulfilling previous commitments, justifying past actions, scape-goating or cementing loyalties.   ☐

(f) None of the above   ☐

2

7. Does your plan <u>specifically consider</u> the following as suitable mechanisms for successful implementation of the process?

                                                                Yes   **No**

(a) A detailed Management Development strategy to ensure the involvement of Doctors and Nurses in managing the hospital? ☐ ☐

(b) A detailed Organisation Development strategy which looks at the structure of your organisation with a view to adapting it to facilitate the involvement of Doctors and Nurses in managing the hospital? ☐ ☐

---

8. Please tick which of the following features/issues, is/are specifically considered in the plan:

*(a) The culture of the hospital; ☐

(b) The cultures of individual staff groups; ☐

(c) The type of Management structures which would be appropriate to the process?. ☐

(d) Resistance to change by individual staff groups/hospitals; ☐

(e) Possible conflict between Managers/Doctors/Nurses; ☐

(f) Levels of trust/distrust that may be present; ☐

(g) "Organisational Politics"; ☐

* For Tallaght, this question read "the Cultures of each of the four hospitals.

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9. Are Doctors and Nurses involved in assessing the likely impact of the features/issues listed at Question 8?

                                                                Yes **No**

                                                                 ☐   ☐

---

10. Is it realistic to expect doctors and nurses to learn about and allow for the features/issues listed at Question 8?.

                                                                 Yes **No**

                                                                 ☐   ☐

Questionnaire Completed by: _____

Hospital: _____

Title: _____