People's Needs Defining Change

HEALTH SERVICES CHANGE GUIDE

www.hse.ie/changeguide

Human Resources
Leaders in People Services

Source and Referencing

People's Needs Defining Change – Health Services Change Guide has been developed following a detailed consultation process and written by Caitríona Heslin and Anne Ryan, Organisation Development and Design, Health Service Executive (HSE), Kells, Co Meath. It represents the second edition of *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive (2008)*.

Material from this Change Guide should be referenced as:

Health Service Executive – Human Resources Division – Organisation Development and Design (2018). *People's Needs Defining Change – Health Services Change Guide*. Kells, Co Meath, Ireland: Health Service Executive.

Acknowledging sources

In developing the *Health Services Change Guide* we have gathered and adapted information and knowledge on change from many sources. We always seek to do this in a way that respects the work of other people and acknowledges the source of the content. If you feel that we have not adhered to this principle, please contact us. We will either modify the content or remove the item.

Data Protection

In gathering data, particularly regarding service users, citizens, communities and staff, please ensure that you adhere to the requirements of the relevant legislation. This includes the Data Protection Acts 1998-2003 and the General Data Protection Regulation 2018.

Accessing the Change Guide and Additional Supports

▶ The *Health Services Change Guide* is available to use online or to download at www.hse.ie/changeguide.

▶ The **Additional Resources** in Appendix A signposts users of the Change Guide to other helpful supports in the system. It will be updated periodically and can be accessed at www.hse.ie/changeguide. The following symbol 🛈 indicates that other helpful information is available in Additional Resources.

▶ The **Change Hub** (www.hseland.ie) provides access to all of the documentation, templates, tools and methodologies referenced.

▶ **Bibliography references** in the document are noted as follows: [number] and relate to literature reviewed by the authors available at www.hse.ie/changeguide.

▶ This work is also supported by a **literature review** completed by the Centre for Health Policy and Management, Trinity College Dublin: *Understanding Change in Complex Health Systems – a review of the literature on change management in health and social care 2007-2017* available at www.hse.ie/changeguide.

▶ **Further information and feedback**
We are always open to feedback to help us continually improve the guidance and resources available. If you would like to contact us for further information or with feedback and comments, please email us at changeguide@hse.ie.

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Note: electronic version of above documents is available at: **www.hse.ie/changeguide**

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Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES

DELIVER ⬆
⬆ DESIGN
DEFINE ⬆

CHANGE ACTIVITIES

People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff

Practice Collective Leadership

Understand Personal Experiences

Support Behaviour Change

Invest in People & Teams

Engage & Communicate

Model Shared Values

Use Evidence & Lever Technology

Be Accountable for Performance

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People & Culture Change Platform
⬆ CREATING READINESS ⬆

Human Resources
Leaders in People Services

Introduction by Chief Executive Officer

I am very pleased to commend to you *People's Needs Defining Change – Health Services Change Guide* as the policy framework and agreed approach to change. It is signed off by the HSE Leadership Team and by the Joint Information and Consultation Forum which represents the Trade Unions. It is the overarching policy that guides and connects all our approaches to change. We must now work together to actively address the following:

Change is about people's needs

The Change Framework prioritises *people's needs defining change* as the central theme and positions an informed understanding of **people and culture** as the core platform for delivering sustainable change. The Change Guide specifically focuses on 'how' to work with service users, families, communities and staff to co-design service improvements based on people's needs and experiences.

Change leadership is our shared responsibility

The Change Guide translates the very best of evidence and practice into a 'how to do change well' guide and provides all of the resources needed to support teams to drive service improvement and build change capacity.

Measure for success

We must continually focus on the impact of our change efforts and demonstrate improvement in people's lives through robust measurement of our performance and the delivery of outcomes.

Connect and provide direction

The Change Framework provides us with an opportunity to align our existing initiatives in order to benefit from our combined efforts through a more cohesive approach. It unifies people and culture focused initiatives with process and project steps – Define, Design, Deliver to achieve Safer Better Healthcare and Staff and Public Value.

Become more 'change able'

Our ambition is to have more people doing change well so that as an organisation we are more 'change able' to deliver for our service users and meet the challenges in a complex system such as health services. The Change Guide strengthens our capacity to implement *Sláintecare*, *People Strategy 2019-2024*, *Our Public Service 2020* and our corporate priorities.

I look forward to working with you all to implement good change, to relentlessly focus on improving our change capacity at organisation and team level and to successfully deliver on sustainable service improvements and system reform.

Paul Reid
Chief Executive Officer, HSE

June 2019

Our **V**alues
Care **Compassion** **Trust** **Learning**

Building Capacity for People and Culture Change

The *Health Services People Strategy* [170] sets out the direction for people services and identifies the key performance targets to deliver safer better healthcare. As public service organisations we have a responsibility to put citizens at the heart of what we do and to continually improve our performance every day in meeting people's needs. The capacity of our people to lead change and improvement at every level is directly related to our overall performance in delivering on this ambition. *People's Needs Defining Change – Health Services Change Guide* is a significant offering that will enable us to strengthen our change capacity, support the ongoing implementation of the Health Services People Strategy and deliver on the challenging policy and reform agenda across the health and social care system. It complements all legislative and regulatory frameworks and arrangements across the system. The people and cultural approach prioritised in the Change Guide is supported by evidence which suggests that major transformation efforts underestimate the 'human factor'. Research highlights that organisations need to focus on the 70:20:10 ratios – 70% on people, 20% on processes and 10% on systems [260].

People are central to change at all levels – the key to successful change is creating commitment to a shared purpose through early and ongoing engagement. We are committed to working with our staff as 'internal customers' to deliver improved service user experiences at the frontline. We also have a responsibility to support and develop our staff so that together we can take pride in what we deliver, be accountable for our performance, innovate for our future and adapt to challenges.

We need to fully utilise and resource the implementation of the Change Guide to assist us to become an organisation that is ready and agile to embrace new directions and policy change. We need to focus on building change capacity so that our staff are able to work with and embrace change as an enabler of better outcomes for service users and local communities.

The Change Guide is founded on evidence and good practice that applies to all our contacts and relationships internally and externally. This includes our contacts with service users, families, staff, contracted services, voluntary bodies and partner organisations. We welcome the involvement of our Trade Union colleagues through the Joint Information and Consultation Forum as co-sponsors of the Change Guide. We are committed to working with them and all our partners to progress implementation and develop an engagement culture that respects diversity – where service users, service partners, communities and staff are valued as co-producers in transforming our health service.

Rosarii Mannion
National Director of Human Resources, Health Service Executive

Maintaining Commitment to Engagement and Consultation

On behalf of the Joint Information and Consultation Forum[1], as co-sponsor of *People's Needs Defining Change – Health Services Change Guide* we welcome that health sector employers and unions, jointly reaffirm their unconditional commitment to engagement and consultation. This is a core foundation for best change practice. It is underpinned by our public service responsibility and legislative obligation to comply with and exceed the requirements of the Protection of Employees (Information and Consultation) Act, 2006 and the *Health Services Information and Consultation Agreement 2006*. This was agreed between the health service employers and the Trade Unions and sets out the process for engagement and consultation with the Trade Unions and their members, as outlined in Figure 1. These requirements should always be complied with from the outset of change initiatives. The *Health Services People Strategy* further endorses this approach and identifies engagement as a strategic priority. In the years ahead, the health service will continue to add pace to these developments and ensure that service user, community and staff voices are central to planning, service design and decision-making.

We must be honest and learn the lessons from the past where change was not managed appropriately, resulting in outcomes which did not deliver the intended results for the community, patients, staff and the health service. Therefore, the contents of this agreement buttress the requirements for union engagement on change as set down in national agreements, legislation and the *Health Services Information and Consultation Agreement 2006*.

Collective bargaining is the process by which employers and recognised Trade Unions seek to reach agreement through negotiation, on issues such as pay and terms and conditions of employment. It is expected that well-implemented information and consultation procedures and this Change Guide should support and strengthen existing industrial relations processes. The existing processes and structures for addressing collective bargaining issues remain unaltered and cannot be superseded by this Change Guide. We welcome the employer's commitments in this regard. The Trade Unions expect this Change Guide to be rolled-out with a clear implementation plan outlining training requirements within the service and ensuring that all staff and managers are fully aware of their obligations when handling change. This will ensure this Change Guide is fully implemented.

Tony Fitzpatrick
On behalf of National Joint Council – Staff Panel of Trade Unions

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[1]   The Joint Information and Consultation Forum (JICF) followed on from the Health Services National Partnership Forum as a key union management consultative forum.

Figure 1: Information and Consultation Agreement between the health services and Trade Unions, 2006 (Extract)

Extract: It is acknowledged that change should be managed in the most effective and efficient way possible to serve the best overall interests of the health services, their staff and their broad client base. This agreement is based on the acceptance by the parties that effective change management is founded on the need:

1. to identify the parties likely to be affected by proposed change

2. to provide information about the proposed change to those likely to be affected

3. to consult with the parties likely to be affected by proposed change

4. where appropriate, to carry out a change impact analysis, the purpose of which is to identify the effects (both positive and negative) of introducing the proposed change

5. to take due account of the possible impact of the proposed operational and/or strategic changes on established workplace practices and terms of employment, and the (associated) need to consult with employees' representatives

6. for the parties and/or their representatives to fully engage with the preparation for and implementation of change

7. to provide opportunities for staff and their representatives to contribute ideas, views and solutions within the change management process, adding value and improving the quality of decision-making and outcomes.

Source: *Please refer to the full text of the Information and Consultation Agreement between the health services and Trade Unions, working under the auspices of the Health Services National Partnership Forum (2006).* [206]

https://www.hse.ie/eng/staff/Resources/HR_Agreements/Health%20Service%20Information%20and%20Consultation%20Agreement%202006.pdf

The above agreement is further strengthened by **Labour Court Recommendation NO.LC R 19152** (15 Feb. 2008) [238]

The agreed approach set out in *People's Needs Defining Change – Health Services Change Guide* as the successor to *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive (2008)* is also a condition in the *Public Sector Agreement 2010-2014 (Croke Park Agreement)*, *Health Sectoral Agreement*, Section 2.12 and its successors, the *Public Service Stability Agreement 2013-2016 (The Haddington Road Agreement)*, the *Public Service Stability Agreement 2013-2018 (The Lansdowne Road Agreement)* and also the *Public Service Stability Agreement 2018-2020 (Extension of The Lansdowne Road Agreement)*.

Preface

More people doing change well

Change is ever-present in health and social care services and is less of an event to be 'managed' than an ongoing 'way of being'. It challenges us to create a movement for change where everyone is involved, service improvement initiatives are connected and we have more people doing change well.

Change is everyone's responsibility

Change is, at its core, a people process. We all have a responsibility to support change and are challenged to:

▶ engage purposefully with service users, families, citizens, communities and staff

▶ successfully intervene in complex systems.

People's Needs Defining Change – Health Services Change Guide addresses these challenges and assists leaders and staff at all levels to take responsibility to improve service user and staff experiences. This work is based on an organisation-development approach. It is also founded on the principles of co-production, acknowledging that people who receive and deliver services are best positioned to guide change. Multiple cycles of engagement are central – actively involving people from the outset in designing change. This leads to a much greater chance of success as 'people support the change they help to create'.

Collaborate for change

We look forward to continuing to collaborate with colleagues to build capacity for change across the system and hope that in doing so we can offer practice-based supports to managers and staff who are actively engaged in delivering and transforming services throughout the system.

Caitríona Heslin and Anne Ryan, Authors
Organisation Development & Design, HSE, Kells

Development Process

This Change Guide was developed through a collaborative process and informed by the applied experiences, learning and practice wisdom of many individuals, groups and organisations. We wish to acknowledge the work of thought leaders and practitioners across a range of behavioural and human science fields who have contributed to the process. In particular we wish to acknowledge the involvement of staff and service users. We are grateful for their generosity in sharing learning, insights and resources.

This work is supported by a literature review completed by the Centre for Health Policy and Management, Trinity College Dublin: *Understanding Change in Complex Health Systems – a review of the literature on change management in health and social care 2007-2017* [12] www.hse.ie/changeguide. The Change Guide complements approaches to change/project management, quality/service improvement, organisation development and design, leadership, education, and talent development in the system and focuses on the people and cultural components of change.

> ℹ **Details of the development process are outlined in Appendix B: Development Process**

Acknowledgements

▶ **Rosarii Mannion**, National Director of Human Resources, for her foresight and initiative in commissioning this work with HSE Leadership colleagues as a key contribution to people and culture change.

▶ Members of the **Joint Information and Consultation Forum (JICF)**, the **HSE Leadership Team** and the **HR Leadership Team**, for their oversight and support of the development process.

▶ Members of the **National Staff Engagement Forum** who provided valuable insights on their experiences of change and guided communication and implementation plans.

▶ **Tara O'Rourke**, Administrative Support OD&D, who worked tirelessly on all of the administrative aspects of the development process, including detailed document work, coordinating consultation sessions and follow-up.

▶ **Patricia Blunden**, Change Hub Administrator, Change Management Resources, Advice and Support, who supported the development process from the early initiation stage through coordinating submissions, managing the organisation-wide broadcast and associated data gathering, accessing resources, making connections in the system and providing detailed feedback.

▶ **Anne McMurray**, Organisation Development Consultant, who supported the creation of the conceptual framework and provided guidance on the process of development and content of the Guide.

▶ **Dr Sarah Barry**, Assistant Professor of Health Services Management, Centre for Health Policy and Management, Trinity College Dublin, who engaged so willingly in supporting the creation of the evidence base, and who provided research guidance and editorial oversight of the literature review.

▶ **Anne Colgan**, Colgan and Associates, who worked on the editorial aspects of the Guide and ensured a consistent focus on its core purpose.

▶ **Colleagues** working in Organisation Development & Design, Quality Improvement, Service Improvement, Leadership, Education and Talent Development, Programme/Project Management who supported this work, provided detailed feedback and shared their knowledge and expertise.

▶ **Staff and service users** – we wish in particular to thank people from across the system who participated in reference groups, attended consultation sessions, made submissions and actively supported the co-production process.

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www.hse.ie/changeguide

Change Guide is **interactive!**

Go to **page 7** and click on any element of the **Change Framework** OR navigate from the **Contents** section (pages i-v).

Access all of the Essential Templates and Additional Resources.

People's Needs Defining Change – Health Services Change Guide

Introduction
and Context

Introduction and Context

The Irish health and social care system is prioritising person-centred care – more choice, more personalised care, and real empowerment of people to improve their health and wellbeing. This 'shift in power' moves us from a service that does things to and for its service users to one which is service user-led, where the service works with people to support them with their health and social care needs. [82]. Our public service accountability to deliver safer better healthcare in a context of increased demands and finite resources requires healthcare staff to find innovative ways to develop services collaboratively with citizens, service users and staff and to create public value. Change, uncertainty and development are now very much part of our reality.

Key Drivers for Change

From 2018 to 2028 the health system will continue to navigate and plan to address the following key drivers for change. These include high level changes in thinking about the nature of best practice in service provision and national health policy drivers, as well as a range of practical factors with the potential to impact directly on provision:

1. **Changing role of the State** – the shift in thinking about the role of the State from a 'welfare state' to an 'enabling state' [61] categorised by:

   ▶ a focus on providing public value

   ▶ moving from the 'centre' to 'local' service delivery units

   ▶ moving from individuals as recipients to co-producers of health

   ▶ shifting from 'representation' to 'participation'

   ▶ increased focus on prevention and responsibility taking

   ▶ services being provided through the community, voluntary and private sectors

2. **Move to needs-driven services** – services that are person-centred and informed by citizen, community and staff engagement; empowered leadership at the frontline to build capacity, improve quality, safety and outcomes.

3. **Policy and reform agenda** – the recommendations of the Committee on the Future of Healthcare in the *Sláintecare Report* (2017) [217], *Our Public Service 2020* [94], *Healthy Ireland: A Framework for Improved Health and Wellbeing* [82] and the *Health Service Capacity Review* (2018) [85] all set out a challenging agenda for reform, public accountability and greater productivity.

4. **Standards and regulation** – driving quality, service improvements and accountability.

5. **Applying evidence and knowledge** – an emphasis on learning from people's lived experiences, research, practice wisdom, demonstrating better ways of delivering outcomes.

6. **Levering e-health and technology** – bringing improved population wellbeing, health service efficiencies and economic opportunity through the use of technology enabled solutions.

7. **Increased demands** – increased public expectation for improved patient and service user experiences, demographic and epidemiological changes requiring more responsive delivery systems.

8. **Resource pressures** – finite capacity to meet demands, expectations and service developments means re-configuration, innovation, adding value, leveraging e-health and accelerating digital fluency and delivery.

9. **Multi-generational workforce** – meeting the needs of our diverse workforce, competition for talent, attracting, recruiting and retaining high calibre people.

10. **Increase in social movement** – citizens mobilised, digitally connected to global influences, investing in and becoming co-producers of health and social gain.

Why is a Health Services Change Framework Needed?

This Change Framework aims to provide a coherent conceptual foundation and practice-based support for the major change programmes which the health services are already undertaking or are about to embark upon. The approaches to managing change which have informed the Change Framework include:

- ▶ the changing nature of change itself
- ▶ new models of power relationships that prioritise engagement and empowerment
- ▶ the need to create a receptive environment for change that understands local needs and context
- ▶ new understandings of complexity in health and social care systems

Change is changing

Approaches to change management are changing. It is now well recognised that 'systematic' change approaches using methods such as programme and project management need to be coupled with a strong focus on the people and cultural factors in order to increase the likelihood of success. [12]

The new 'normal' – understanding 'new power'

The Change Framework reflects the fact that the wider environment in which we now deliver services has evolved and has become what is often termed 'volatile, uncertain, complex and ambiguous'. Power is changing and being replaced by new power systems where the influence in organisations is shared by many, based on relationships and networks, and focused on an emotional connection to a shared purpose (Figure 2). New power systems will need to co-exist alongside the more traditional hierarchies and develop communications and working arrangements that balance reliability and agility. Organisations and systems that embrace the skills of new power – building shared purpose, diversity of thought and experience, connectivity, relationships and empathy, communities of practice – have greater potential to achieve better outcomes. [276, 286]

Figure 2: Understanding 'New Power'

'New power' players increasingly expect to actively shape or create many aspects of their lives. That expectation gives rise to a new set of values centred on participation.

Old Power → ← **New Power**

Old Power	New Power
Power through hierarchy	Power through connection
Mission and vision	Shared vision and purpose
Making sense through rational argument	Making sense through emotional connection
Leadership-driven (top down) innovation	Viral (grass-roots driven) creativity
Tried and tested, based on experience	'Open' approaches, sharing ideas and data, co-creating change
Transactions	Relationships

Adapted from: Heimans, J. and Timms, H. (2014, 2018) [208, 209]; School for Change Agents (2017c: 36) [336]

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Creating a receptive environment for change

Leaders are challenged to create a receptive environment where change can occur, to help people make sense of what is happening, to find order in chaos and work with people to find creative solutions. Understanding the context for change and associated cultures and subcultures is critical, with locally generated innovations promoted and supported. Current thinking (Figure 3) frames change less as something to be 'managed' and more as a 'social movement' to be facilitated, a facilitation in which everyone has the opportunity (and the responsibility) to tackle the most challenging issues impacting on the provision of healthcare. This contemporary approach to change is incorporated in the Change Framework.

Figure 3: The Third Curve of Change

Getting to the Third Curve

OUTCOMES

Keeping power — New Public Management Targets, sanctions, inspections

Sharing power — Quality Improvement

Ceding power — Mobilising Social Action

CO-PRODUCING
QUALITY IMPROVEMENT
PERFORMANCE MANAGEMENT

TIME
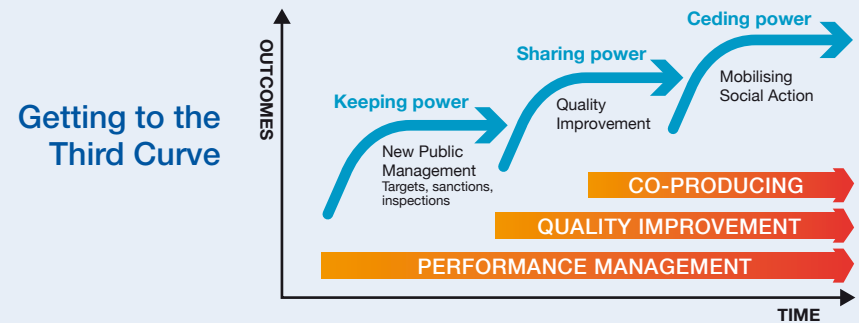
Source: Leitch, J. and Feeley, D. (2017) [242]

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Health and social care as a complex adaptive system

Acknowledging that health and social care is a complex adaptive system is an important foundation of the Change Framework. It is unique in its complexity, purpose and reach, often called a 'system', but more accurately described as a melange of systems not necessarily working in concert [96]. The Change Framework encourages healthcare leaders to move away from traditional approaches to managing change and organising systems (i.e. silos of care) and to work with complexity by focusing on relationship building, organisational values and culture, social networks and widespread participation, rather than tight integration, formalisation, and centralised decision-making (Figure 4). Linear models of change must be tempered with cyclical approaches, allowing for emergence and widening engagement, responding flexibly to emerging patterns and opportunities [312].

Figure 4: Complex vs Traditional Systems Comparison of Organisational System Characteristics

Traditional systems	Feature	Complex
Are mechanistic	Metaphor	Are living organisms
Are controlling and predictable	Order	Are unpredictable
Are rigid, self-preserving	Culture	Are adaptable, flexible, creative
Control behaviour	People	Tap creativity, continuously learn
Find comfort in control	Style	Embrace complexity, share knowledge
Reorganise parts	Development	Evolve continuously, attend to transitions
Held by a few	Power	Made by many

Adapted from: *Centre for the Study of Healthcare Management (2003).* [51]
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Health Services Change Framework

The Health Services Change Framework in Figure 5 anchors the activities outlined in *People's Needs Defining Change – Health Services Change Guide* and:

▶ gathers the collective wisdom from practitioners, thought leaders, service users and staff combined with evidence into a coherent and integrated Change Framework to enable service managers and staff become change leaders in health and social care services.

▶ sets out an informed understanding of people and culture as the core platform for delivering sustainable change.

▶ the Change Guide provides practical assistance through the use of guidance, templates and resources that can be adapted and applied to a local context. It directs people to helpful assistance in the system. Elements of the Change Framework and Change Guide may be used at different times or in a different sequence depending on the nature, scale and stage of change.

The **Change Framework** is set out as follows:

▶ **People's Needs Defining Change**: Working with stakeholders, i.e. service users, families, citizens, communities and staff, understanding their needs and supporting ongoing engagement throughout the change process.

▶ **Create People and Culture Change Platform**: the need for an integrated approach that collectively mobilises the people and culture priorities and creates a receptive environment for change is central to the approach. These priorities are interconnected and require consistent and sustained focus at all stages. Accountability for performance and outcomes is positioned as a core governance requirement throughout the change process.

▶ **Define, Design, Deliver – the Change Activities**:

    ▶ **Define**: Initiate change by defining the purpose, assess the context and scale, explore readiness and get prepared.

    ▶ **Design**: Determine the detail, plan and test feasibility, identify resources and agree a change Action Plan.

    ▶ **Deliver**: Implement change, measure outcomes and support sustainability.

▶ **Change Outcomes**: To deliver safer better healthcare, and staff and public value.

Figure 5: Health Services Change Framework

Click diagram to navigate

FUTURE VISION

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CURRENT SITUATION

Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES

DELIVER
DESIGN
DEFINE

CHANGE ACTIVITIES

Practice Collective Leadership

Understand Personal Experiences

Support Behaviour Change

Invest in People & Teams

People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff

Engage & Communicate

Model Shared Values

Use Evidence & Lever Technology

Be Accountable for Performance

Network & Partner

People & Culture Change Platform
CREATING READINESS

Section 1

People and Culture Change Platform

The purpose of Section 1 is to:

▶   introduce culture as a key influencer of change

▶   outline the change priorities which assist service managers and staff to address the elements that work together
to shape culture and deliver sustainable change

Successful cultural change efforts **connect** *with people through* **meaningful conversations**, *capture the hearts and minds of people around a* **shared purpose** *and support them to* **behave** *differently to deliver* **desired outcomes**.

'To inspire meaningful change you must make a connection to the heart before you can make one to the mind.' (Couros, G., 2015) [68]

1.1 Understanding Organisational Culture

Understanding organisational culture, i.e. the context for change, is a core component of an organisation-development approach. When people talk about what organisational culture is, they typically see it as 'the way we do things around here'. However, culture is deeper and more dynamic – it shifts incrementally and constantly in response to internal and external changes. Culture is implicit in people's minds and conveys a sense of identity. It provides a sense-making device to guide behaviour. Culture is primarily a result of the following influences [397, 398]:

▶   Founding values of the organisation

▶   Early experiences and thereby acquired values, norms and behaviours of those joining the organisation

▶   Behaviour of leaders

Culture operates at different levels: the **artefacts**, which are the most superficial shared understandings of what we see; **values**, which represent what we attribute intrinsic worth to; and **assumptions** (beliefs), which operate at a deeper level and are much harder to access as they underpin our day-to-day choices and assumptions.

ⓘ   **(People and Culture Change Platform: Organisation-Development Approach and also Person-Centred Practice Framework).**

1.1.1 Organisational culture and subcultures

The complex nature of health services with multiple sectors, a mix of public, private and voluntary providers, and multi-professional and discipline teams means that assuming there is only one culture within an organisation oversimplifies the reality. Leaders need to acknowledge the existence of a patchwork of complex cultures and loyalties that exist within health and social care organisations and develop an informed understanding of how these subcultures shape and influence work practices and day-to-day delivery of services. There are many factors that create subcultures including discipline and team alignments, professional affiliations and loyalties, service delivery locations, and legacy factors where services have been merged or redesigned, etc.

1.1.2 Addressing cultural change

Organisational culture is complex and some would argue that you cannot 'manage cultural change'. It is not a 'destination' that can be reached – it is the 'sum total' of change at subcultural level. It requires a much more nuanced, holistic and connected approach. It recognises the need for sustained collaborative approaches which support organisational and social learning and that can change patterns of practice and behaviour over time.

Leaders can influence behaviour and by doing so shape the culture of the organisation. Focusing on shared values and on the people factors that underpin how a service organises itself to deliver services are powerful shapers of cultural change. Leadership behaviour is not enough by itself, however; it needs to be supported by other organisational approaches such as governance arrangements and service design – the systems and procedures, the rituals, the design of physical space, the stories and narratives that are told about people and events, and the statements of organisational intent.

Positioning culture as an outcome rather than as a starting point to 'fix' a problem or address a service issue is helpful, i.e.

▶ Focus on the purpose of the change and the outcome you want to deliver rather than on 'cultural change' per se.

▶ Why are you change-orientated in the first place? What is the change/service 'problem'? What needs to be improved?

In this approach the outcome is achieved through a collective set of behaviours and actions that can deliver a 'better service outcome'. Being clear about the critical and collective behaviours that represent the desired culture is essential. Creating a receptive environment to enable people to embrace these behaviours is also important. The People and Culture Change Platform represented in the Change Framework identifies the key priorities that shape culture, mobilise change and deliver better outcomes – these priorities are now outlined.

1.2 People and Culture – the Change Priorities

The change priorities that together create the People and Culture Change Platform are now outlined:

▶ Practice collective leadership

▶ Model shared values

▶ Engage and communicate

▶ Understand personal experiences

▶ Support behaviour change

▶ Invest in people and teams

▶ Network and partner

▶ Use evidence and lever technology

▶ Deliver public value and be accountable

1.2.1 Practice collective leadership

The most important influence on organisational culture is leadership and the leader's ability to create an enduring team and to lead in an increasingly complex world. Leaders who share responsibility and are personally accountable are needed at all levels to build a coalition for change and to inspire others to become involved. They work collaboratively towards a shared purpose, creating a caring and compassionate culture and inspiring innovation, creativity and excellence throughout the organisation (Figures 6, 7). The leaders' task is to build commitment through influence rather than by 'enforcing compliance'. Leaders help to make sense of complexity, work with others to 'find order in chaos', support risk taking and build networks of support in the system. They set direction, build trust and promote a values-based approach that embraces courage and a 'service orientation'. This calls for a blend of humility, curiosity, patience and perseverance.

Figure 6: Collective Leadership

Collective leadership is the interaction of team members who share leadership roles. It means everyone taking responsibility for the success of the service as a whole – not just for their own jobs or work area. Responsibility and accountability function simultaneously at both individual and collective levels. It is not solely the role of the formal leader and is not defined by position or status. It is a dynamic team occurrence where leadership power is distributed and allocated to wherever expertise, capability and motivation sit within an organisation or team.

Adapted from: *West, M. et al (2014)* [397] *and McAuliffe, E. et al (2017)* [257]
People's Needs Defining Change – Health Services Change Guide

Figure 7: Model of Collective Leadership

Source: *Department of Health – Northern Ireland (2017: 9)* [89]
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Change Actions

1.2.1.1 Be self-aware

▶ Self-awareness is the greatest agent for change. Change starts with me – focus on your own emotional self-awareness and motivation. Use your own personal 'agency' to make a positive difference.

▶ Challenge your own perspective and biases and how you see the world and others and how others see you – be open to feedback on your performance and behaviour.

▶ Be aware of unintended messages you convey by your words and actions.

▶ Be conscious of your own reactions to change – leaders are not exempt from anxiety during uncertain times.

▶ Develop humility and personal resilience, and attend to your own personal development.

▶ Monitor how well you demonstrate the principles of engagement and co-production in your behaviour and communication.

1.2.1.2 Role model the change

▶ Consciously decide how you can role model the values and behaviours you want to see in others and the change you want to deliver.

▶ Model learning, human vulnerability and the importance of personal change.

▶ Be visible and accessible to services, be present and listen with curiosity and interest.

▶ Actively promote the change, adopt new practices, demonstrate behaviours that signal the change is real and use positive influence to challenge the status quo.

▶ Acknowledge, appreciate effort and facilitate others to get involved.

▶ Encourage learning from mistakes. Support individuals to speak out if they have concerns.

1.2.1.3 Communicate with integrity and purpose

▶ Share personal experiences as a way of connecting with people and sharing your passion and belief that there is something different and better worth striving for in moving towards a vision for a better future.

▶ Build trust and develop effective working relationships among all key stakeholders through transparent information sharing, honest communication and a compelling narrative.

▶ Identify and communicate key themes that people can relate to and that will make a big difference.

▶ Be conscious of your own communication style and tone including its impact on others, and use language that people can relate to.

▶ Listen attentively and be open to feedback on the credibility and success of communication efforts.

▶ Recognise that you don't have all the answers, welcome challenge and seek different views.

1.2.1.4 Nurture collective leadership activity

▶ Empower and help others to develop as leaders and managers, to 'share power', hold each other accountable and work towards a shared purpose.

▶ Create a positive team culture by coaching others to work collaboratively with colleagues, strengthen peer relationships and encourage both personal and collective responsibility for change.

▶ Assist people to reach a common understanding about change issues and solutions through active engagement.

▶ Recognise the importance of frontline/middle managers who are the critical catalysts of change. Support them to translate and mediate change.

▶ Commit resources to support change including professional and personal development and support development interventions targeted at team members as co-leaders addressing real-time issues.

▶ Prioritise building a cohort of 'digital-ready' leaders that understand the organisation context to enable innovation, growth, risk taking and knowledge sharing. [79, 267]

ℹ **(Practice Collective Leadership: HSE Health Service Leadership Academy).**

1.2.1.5 Build relationships and create networks

▶ See the bigger picture by focusing on the whole system and work with team members to understand overall culture and subcultures.

▶ Take time to connect and collaborate with service users, citizens and staff who are closest to the point of service delivery – make a personal investment by making yourself available to visit services locally, observe and listen.

▶ Make connections and sustain relationships with others to lever change and broaden experiences by using both formal and informal networks, crossing service and organisational boundaries.

▶ Recognise the value of mobilising social action, and develop an informed understanding of how best to utilise this energy for change within an organisational whole system context.

▶ Focus on new ways of working within networked, team-based models that embrace digital opportunities.

1.2.2 Model shared values

Values are at the core of understanding and bringing about cultural change. They govern behaviour and action and signify why the organisation and its members behave and act the way they do. Values describe the beliefs that have stood the test of time and represent what the organisation stands for and what the team or service believes in (Figure 8). Being explicit about the desired values that an organisation or service aspires to is key – more importantly, seeing values in action through behaviour is central to successful change. Our public service is centred on delivering services to citizens, local communities and adding 'value'. Reconnecting with our public service values and the unique motivation of working towards the collective good is a significant enabler of change.

Figure 8: HSE Values as an Enabler of Change

Bringing the organisational values of **care, compassion, trust and learning** to life in the health services is key to providing safer better healthcare, better workplaces for staff and to delivering better experiences for the people who use our services. Leaders that embody these values create compassionate cultures where people flourish and give of their best. In practice, we need to:

▸ demonstrate our values in the way we work with and treat each other

▸ use our values to guide the decisions we take

▸ identify and address behaviours that cause offence to others

▸ be responsible for the way we work and not just the work we do

Adapted from: HSE (2015b: 4) [136]
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Figure 8: HSE Values as an Enabler of Change

Our Values
Care Compassion Trust Learning

Values

Care
▸ We will provide care that is of the highest quality
▸ We will deliver evidence based best practice
▸ We will listen to the views and opinions of our patients and service users and consider them in how we plan and deliver our services

Compassion
▸ We will show respect, kindness, consideration and empathy in our communication and interaction with people
▸ We will be courteous and open in our communication with people and recognise their fundamental worth
▸ We will provide services with dignity and demonstrate professionalism at all times

Trust
▸ We will provide services in which people have trust and confidence
▸ We will be open and transparent in how we provide services
▸ We will show honesty, integrity, consistency and accountability in decisions and actions

Learning
▸ We will foster learning, innovation and creativity
▸ We will support and encourage our workforce to achieve their full potential
▸ We will acknowledge when something is wrong, apologise for it, take corrective action and learn from it

Change Actions

1.2.2.1 Understand personal values

▶ Take time to understand and discover your personal values and those of staff and service users through a process of enquiry.

▶ Share perspectives on what motivates people 'to do a good job.'

▶ Connect emotionally with people by talking about what really matters – their hopes and fears for the future, their sense of pride, commitment and purpose.

1.2.2.2 Connect on a noble goal – add public value

▶ Engage with people's sense of public service ethos and social responsibility as a key lever for change, recognising the need for shared purpose, shared values and a sense of community.

▶ Take time to understand how your values and those of others connect or conflict with organisational values and with the change, understanding that staff motivation and sense of belonging is greater when there is compatibility between personal and organisational values.

▶ Focus on connecting service values with personal values through personal stories or narratives as this will lead to committed action. [286]

ℹ **(Model Shared Values: Public Narratives).**

1.2.2.3 Translate values into action

▶ Clarify how values will be reflected and role modelled in behaviour and actions and aim to bridge the gap between values and behaviours (Figure 9). Build on initiatives such as Values in Action to support this work.

▶ Work with colleagues to model and promote behaviour that is respectful and that creates a culture of care and compassion.

▶ Harness the power of peer-to-peer exchanges and feedback to support behavioural change, create new ways of working and translate values into service improvement actions.

▶ Demonstrate how values reflected in behaviour are connected to service outcomes and the delivery of safer better healthcare and public value.

ℹ **(Model Shared Values: Values in Action** [141, 157]**).**

Figure 9: Connecting Values to Action

If we want people to take action, we have to connect with their emotions through values

Adapted from: Ganz, M. (2011a: 276) [110] *cited in Bevan, H. (2017d:4)* [23]
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1.2.2.4 Monitor performance in line with values

▶ Acknowledge and affirm behaviours that reflect shared values, respect difference, encourage openness and embrace a wide range of views and ideas.

▶ Demonstrate how decisions will be proofed against values and how performance outcomes will be measured based on 'living the values.'

▶ Use measures that reflect 'value-based outcomes' as well as activity-based measures.

▶ Seek feedback from service users and staff about the impact of decisions and behaviours that reflect agreed values at individual, team and service levels.

▶ Use agreed values as a way of shaping 'ground rules' and as an anchor to support decision-making, particularly at times of uncertainty.

▶ Agree how behaviours that do not reflect core values will be addressed (see 1.2.5: Support behaviour change).

1.2.3 Engage and communicate

Empowering people who have a significant interest and stake in the change involves building trust and understanding. This is achieved through active engagement from the outset, and open and honest communication, enabling people to take personal and collective responsibility for change. Engaging with service users, families, frontline staff and clinicians and mobilising support through networks and connections will enable people to be co-producers in a modern healthcare system (Figure 10). Facilitating meaningful conversations and listening to the narratives and stories of people will help to keep the change focused on outcomes that add value to people's lives [115].

Figure 10: Service User and Staff Engagement

Service User Engagement: Engaging and involving service users in the design and delivery of care and services demonstrates a commitment to person-centred practices. It ensures care is appropriate to an individual's needs and is respectful of their preferences. Engagement builds a culture of listening to and learning from the experiences of service users and their families.

Source: Framework for Improving Quality in our Health Service (2016) [195]

Staff Engagement: Staff are engaged when they feel valued, are emotionally connected, fully involved, enthusiastic and committed to providing a good service – when each person knows that what they do and say matters and makes a difference.

Source: HSE National Staff Engagement Forum (2016) [139]

Trade Union Engagement: Refer to the Information and Consultation Agreement between the health services and Trade Unions (2006). [206]

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Change Actions

1.2.3.1 Involve service users, families, citizens, communities and staff

▶ Identify and work with key people as co-producers of change – learning from peoples' lived experiences and from those who are closest to the 'frontline'.

▶ Identify the formal and informal influencers and voices that people listen to and engage with them to develop communication messages and engagement methods that are credible.

▶ Engage representative bodies such as Trade Unions, professional associations, patient/service user/advocacy groups and other service providers from the outset and throughout the change process. Refer to the Information and Consultation Agreement between the health services and Trade Unions to inform best practice. [206]

1.2.3.2 Address people's needs to enable engagement

▶ Aim to understand the importance of connecting with people's basic needs in order to motivate people to want to become fully engaged.

▶ Use a framework such as Maslow's hierarchy of needs (Figure 11a) to think about what motivates people across a range of activities and align this motivation to staff engagement.

▶ Attend in particular to people's need to be treated fairly, to be included, to have a direct influence over outcomes and to feel competent to embrace changes.

▶ Address key factors that support engagement including meaningful work; a sense of purpose; clear, transparent goals and performance feedback; supportive management; positive work environment; opportunities for growth and development; and trust in leadership.

▶ Consider the factors that will support service users and citizens to engage and work from a shared understanding of what will sustain engagement over time.

Figure 11a: Hierarchy of Needs Aligned to Personal Engagement

Self-fulfilment

ENGAGEMENT AND INNOVATION
Empowerment, ownership embracing one's role in a way that allows them to reach their true potential

INDIVIDUAL ACHIEVEMENT
Pride, self-esteem, confidence, sense of an individual contribution to the greater whole

Psychological needs

TEAM CAMARADERIE
Belonging to a team, positive workplace relationships, trust, psychological safety

SECURITY AND STABILITY
Job security, organisational and team stability, a safe work environment free from threats of physical or emotional harm

Basic needs

WORKSPACE
Workspace, furniture, supplies, technology, basic resources to do their job

Source: Borysenko, K. (2017) [30]
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1.2.3.3 Tap into clinical and other frontline experiences

▶ Involve clinicians and other frontline staff as multi-disciplinary team members who are critical to the success of change initiatives.

▶ Support clinicians to take personal responsibility to use their influence, expertise and knowledge to deliver change.

▶ Acknowledge that clinician loyalty tends to go to the patient first; build on the strength of this motivation to improve outcomes for services users and patients as a core enabler of change [77].

1.2.3.4 Mobilise widespread involvement

▶ Use the network of peer-to-peer interactions to stimulate change conversations.

▶ Create momentum through building connections and inspire people to 'own' and progress the change together.

▶ Tap into the collective wisdom through consultative forums and build a critical mass to support change while remaining alert to 'group think'.

▶ Aim to understand the needs and interests of diverse groups and respect the 'rebel voice'.

▶ Connect and coordinate people with different perspectives and across levels and backgrounds in the system, allow people to lead from the edge and support people to stay engaged.

▶ Build a spectrum of allies both with like-minded people who will provide positive energy, and also with divergent or opposing voices to build trust, common ground and to inspire creativity.

1.2.3.5 Develop a plan to engage and communicate

▶ Recognise that the success of a change effort is directly related to the quality of communication and engagement (Figure 11b).

▶ Prioritise face-to-face communication and engagement and use language that is accessible for people [167].

▶ Provide clear and consistent messages regarding the rationale for the change, future vision, benefits and honest feedback on progress.

▶ Share information in a timely manner and address emerging issues, opinions and experiences.

▶ Be adaptable to change your communication and engagement efforts as needed and use communication methods that can reach the widest number of people.

Figure 11b: Levels of Communication and Engagement
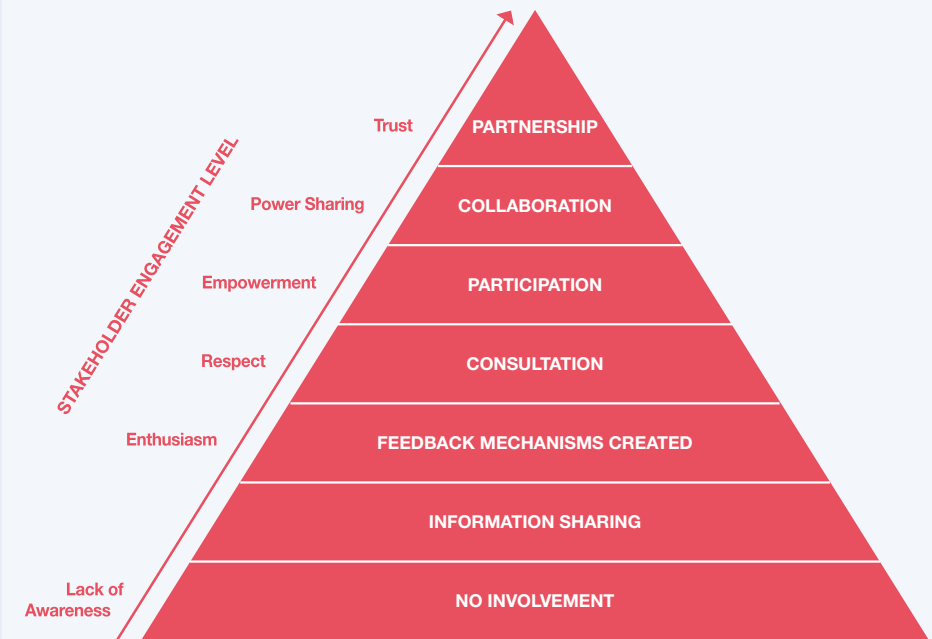
Source: HSE-PHSI (2018: 102) [415] and HSE-OD&D (2008: 13) [186]
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1.2.4 Understand personal experiences

Change is personal and all change is viewed through the personal lens of how it impacts on each individual. People's experiences and their emotional reactions will be different. It is natural to feel challenged by change and uncertainty as it represents the unknown. Establishing trust is a first step towards building understanding and creating the safety and space to support change. Understanding the 'human dimensions of change' and addressing concerns sensitively will assist people to engage with change as a more positive experience over time. Understanding personal experiences will help in addressing factors that support people with making transitions to new work practices and routines (Figure 12).

Change Actions

1.2.4.1 Facilitate transitions

▶ Support people to recognise the stages of transition at an individual level, to prepare for and understand their reactions to change as they occur throughout the change process (Figure 12).

▶ Provide opportunities for people to understand the current situation and why change is necessary, support them in letting go and attend to 'endings', and assist people when things are in flux and confusing.

▶ Provide skilled leadership to enable people to embrace the new beginning, new identity, new energy, new connections and a renewed sense of purpose.

▶ Encourage and support individuals to step outside their comfort zone and move towards the new situation.

▶ Work with disruption as a positive force for change by remaining open and alert to integrate new information and absorb the impact into the change process.

Figure 12: Managing Personal Transitions

Managing Personal Transitions – making the most of change

1. ENDING, LETTING GO
Help people deal with their loss by...

- Identify who is losing what
- Acknowledge the reality of people's losses
- Accept signs of loss and grieving
- Give people information regularly
- Define what's changed and what stays the same
- Treat the past with respect
- Mark endings
- Focus on the continuity of what really matters

2. NEUTRAL ZONE
Critical personal adjustment and re-patterning happens here...

- Key signs to look for:
  - Low motivation and anxiety
  - Self-interest and resentment
  - Polarised thinking
- This is also a creative time
- Provide support for innovation and discovery
  - Embrace losses, setbacks and failures as starting points to new ways of working
  - Give people time and resist the push for early closure
- Set short-term goals
- Strengthen connections between groups
- Communication is key... personal stories are particularly useful

3. THE NEW BEGINNING
Time for new identities, new energy and a new sense of purpose

- Timing of 'roll out' is key
- Focus on shared purpose
- Create the picture to bring it to life
- Make sure Action Plan is clear
- Agree ways people can continue to contribute and participate
- Reinforce the new beginning:
  - Be consistent
  - Ensure quick wins
  - Make new identity visible
  - Celebrate the new beginning

Adapted from: Bridges, W. et al (2017) [35] and Weld, S. (2017) [396]
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1.2.4.2 Understand personal responses

▶ Focus on understanding the experiences of change for the people for whom it matters most.

▶ Remain visible and present and keep conversations open, actively listening to and engaging with staff regarding their concerns, fears and frustrations at individual and team level.

▶ Attend to how people are feeling and experiencing change by listening to their perspective; empathise with them when they are overwhelmed and struggling, so as to enable you to respond authentically as a leader.

▶ Build trust through acknowledging the validity of concerns, and give reassurance about support and belief in an individual's capacity for learning and adaptation.

▶ Seek to understand people's previous experiences of change, as these can give rise to both positive and negative associations.

▶ Remind people about what is not changing. Be honest about elements of the change that are difficult to accept.

▶ Acknowledge the individual nature of people's responses by providing different kinds of support, as one size does not fit all. Help people to reduce distress by providing them with practical help to do the job they want to do and give of their best to the people they serve [397, 398].

ℹ **(Understand Personal Experiences: Kübler-Ross Change Curve).**

1.2.4.3 Create the safety and space to support personal change

▶ Provide a full range of human resource responses to strengthen the overall ability of individuals to engage with the change and to develop and practice new behaviours. Prioritise coaching for leaders, managers and key stakeholders.

▶ Create psychologically safe spaces and the conditions for conversations to take place by asking questions that are focused on future possibilities, by inviting diversity into the system and by respecting challenge.

▶ Ensure that development and change staff are actively engaged in working with individuals and teams to address development needs using a blend of approaches.

▶ Assist staff to co-design relevant training, development and engagement processes so that they are confident and competent in the new ways of working.

▶ Acknowledge the challenges of frontline and middle managers as key change leaders and assist them in supporting staff at local level.

▶ Prioritise staff health and wellbeing and ensure people are aware of the supports available.

1.2.4.4 Understand and work with resistance and personal readiness

▶ Take time to understand why people may be resisting the change – it may be related to a person's level of readiness and an experience of loss. Challenge assumptions you may have about why people are not engaging (Figure 13).

▶ Recognise that resistance to change may relate to perceived self interests, including fear of loss of power, income, flexibility, job security or additional workload; resentment of those sponsoring the change; change fatigue; or frustration with the myriad of decisions and directives that can flow from 'management' in the course of a change project.

▶ Understand group resistance that can stem from changes to group structure, social norms, or power base and use it as a useful source of feedback.

▶ Invest time in creating readiness for change including mandate from significant leaders so that supports can be put in place to increase capacity and capability.

▶ Balance perspectives by engaging with service users, service providers, referral sources and others in your community impacted by the change, as this 'outside view' can help to keep the focus on benefits for service users and citizens as well as on benefits for staff.

ℹ️ (Understand Personal Experiences: Finding the Reason Behind the Resistance – Framing Questions).

Figure 13: Working with Resistance to Change

Resistance behaviour is a good indicator of missing relevance. (Schirmer, H. 2015) [333]

Resistance to change should be seen as a dynamic energy that can bring about real and lasting change. It is a natural reaction and should be embraced as a normal part of change. Mark Jaben [24] assists us to understand resistance and challenges the concept of 'buy in' where we traditionally go to people with the solution and ask for their support for change. Looking for people to 'invest' in change is a more dynamic concept where we involve people in co-design in the first instance. Engagement begins at an earlier stage, focuses on the desired outcome, helps to increase readiness and reduces resistance.

Mark Jaben on the science behind resistance to change

What NOT to do *(but what we usually do)*	What TO do
Issue	Issue
↓	↓
Desired outcome	Desired outcome ➜ Shared outcome
↓	**Engage people here**
Options	↓
↓	Options
Choice — **Engage people here**	↓
	Choice
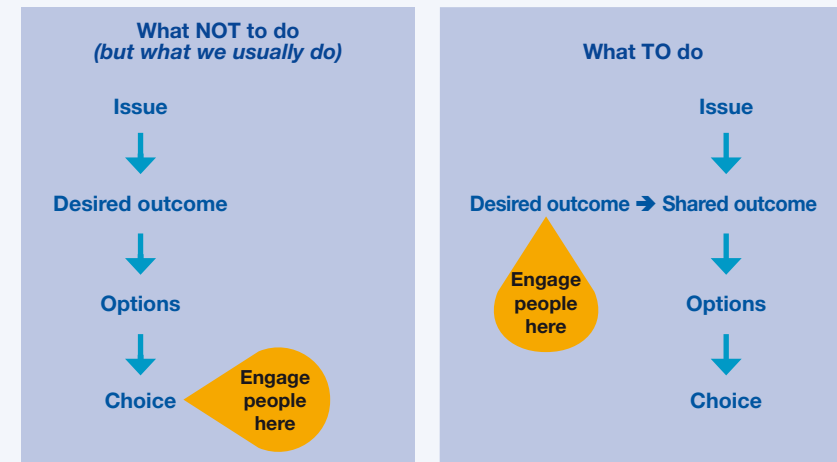
We don't need buyers (who "buy-in" to change)   We need investors

Adapted from: Bevan, H. (2017e: 17) [24]

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1.2.5 Support behaviour change

Change requires action – this action needs to be reflected in mindset and behavioural change at individual and team levels. Changing patterns of behaviour requires the development of trust, honest relationships and a learning culture. It requires a focus on addressing power, conflict and patterns of decision-making. Understanding the factors that can assist in bringing about sustained behavioural change will help leaders to make progress and engage with staff and teams in a respectful and meaningful manner. Positive working relationships, social interactions and peer influence are essential to gaining commitment to behaviour change.

Figure 14: Stages of Change – Model of Behaviour Change

Adapted from: *Prochaska, J.O. et al (1992)* [317]
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Change Actions

1.2.5.1 Understand behaviour change

▶ Many change efforts do not intervene at the level people are actually at in terms of their own personal readiness. Aim to understand readiness, appreciate individual 'starting points' and intervene appropriately (Figure 14) [307].

▶ Address factors that support behaviour change – having a compelling need, role modelling values and the change you want to see, acknowledging desired behaviours, building capability and developing supportive relationships and networks.

▶ Attend to developing new ways of thinking, new capabilities, new skills and new ways of knowing if performance is good or could be improved so as to develop people's confidence to embrace behaviour change (Figure 15).

▶ Build on the power of social movements as a key driver of behaviour change, taking an integrated approach to addressing the key people and cultural priorities outlined in the Change Framework.

ℹ **(Model Shared Values: Values in Action).**

1.2.5.2 Focus on emotional connections

▶ Look to connect at an emotional level to support behaviour change – to win the hearts and minds of people. Rational explanations alone will not work. Support people to connect to beliefs, values, identity and a sense of purpose (Figure 15).

▶ Consider how best to strengthen personal relationships, social networks and the informal system to reinforce and build the capacity for sustainable behaviour change.

Figure 15: Interventions at all Levels of Change

Bringing about real and lasting change requires intervention at a number of levels. Tapping into people's beliefs and values and their sense of identify and purpose has the greatest chance of success. This requires connecting with people on an emotional level. Assisting people to develop the capabilities for change is essential. This combined approach will support and sustain behaviour change. Leaders also need to develop a receptive environment for innovation, improvement and change.

Shared purpose

Personal identity

Personal beliefs and values

Personal capabilities

Support behaviour change

Create psychologically safe environment

Adapted from: NHS Institute for Innovation and Improvement (2005: 36) [280]; Bateson, G. (1972) [15]; Dilts, R. (1990) [97]

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1.2.5.3 Support and affirm mindset and behaviour change

▶ Recognise that mindset changes and behavioural aspects of transformation take time. Avoid rushing the phases where people are feeling negative or uncertain about change as this can lengthen its duration.

▶ Affirm and support people to sustain behaviour change through regular feedback and acknowledgement.

▶ Acknowledge people's efforts and address their concerns; take time to review progress, showing the team and others how far they have come, helping to develop team pride and the confidence to keep going.

1.2.5.4 Challenge unacceptable behaviours

'If you have chosen to work for an employer, you've made a conscious choice to sign up to the norms and rules that govern how that organisation works. If you contravene them, there are consequences – that's the deal. The problem is that too many organisations either aren't clear on their culture or norms or lack the confidence to interpret them.' [291]

▶ In upholding the preferred culture and shared values, address behaviour that causes offence to others and is damaging to the trust the organisation is seeking to promote.

▶ In line with best HR practice put in place processes to support people to challenge behaviour that disregards agreed values or ground rules.

▶ Create a psychologically safe environment to support people 'calling out others' when values are compromised.

▶ Pay particular attention to employees' sense of fairness in dealing with situations that arise, and formally and explicitly make it clear that disrespectful and offensive behaviour will be addressed.

▶ Engage with HR staff to develop required competencies and develop working understanding of relevant people management policies including performance systems at individual and team levels.

1.2.6 Invest in people and teams

Organisational, team and personal capacity and capability[2] will determine the pace and quality of change outcomes. Early and sustained attention to strengthening knowledge, skills and confidence through targeted learning programmes, coaching, peer-to-peer and group learning, and practice development needs to be prioritised, easily accessed and resourced so that the 'right' resources are in place. Building change and improvement capability among staff, teams (Figure 16), service users and communities is a long-term investment that will yield positive gains. Prioritising needs-driven, co-designed interventions targeted at team members as co-leaders will improve team performance and impact on improved service outcomes. Supporting a culture of organisational learning, continuous evaluation and knowledge transfer is also a core enabler of change.

Change Actions

1.2.6.1 Support personal learning

▶ Assist staff to identify knowledge or skill gaps and co-design interventions recognising the demands of change, particularly on frontline staff and middle managers.

▶ Equip people with the core skills to become effective change agents, to work collaboratively, build confidence and develop resilience.

▶ Support individuals to problem solve, learn from experiences and 'survive' in an uncertain, volatile environment.

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2 Capacity (right number and level of people); capability (confidence, knowledge and skills) required to support the change.

▶ Use a range of learning and development interventions such as coaching, mentoring, supervision, continuing professional development (CPD), personal development planning (PDP) and collective team interventions. Use e-learning approaches to supplement face-to-face interventions.

▶ Provide opportunities for staff to practice new skills and connect with colleagues to reinforce and support their efforts.

▶ Ensure that all appropriate wellbeing services are available in a way that makes access an easy and natural support mechanism for those who wish to seek further personal support.

ⓘ **(Invest in People and Teams: Joint Declaration on Continuing Professional Development (CPD) and Life-Long Learning (LLL) for All Health Workers in the EU).**

1.2.6.2 Prioritise effective team working

▶ Foster a team culture of responsibility taking to address issues and problems where colleagues work together to generate solutions, reflect on their learning, share good practice and build collaborative relationships.

▶ Prioritise development interventions which represent the common purpose shared by different health workers, professionals and disciplines.

▶ Build on naturally occurring activities – team meetings, learning and development events, peer-support groups – working where possible with existing or 'intact' teams to build collective leadership capacity.

▶ Provide dedicated team support in terms of change facilitation, and use action learning approaches and quality improvement interventions as change platforms to support teams to work with complexity and ambiguity.

▶ Support inter-team working and activities that enable integrated care/service planning, recognising the challenges of working across boundaries and matrix arrangements.

Figure 16: Model for Effective Team Working

PURPOSE
Shared
values, purpose
and outcomes

ROLES
Collective leadership
Clarity regarding role and responsibility
Clear reporting relationships

PROCESSES
Focus on how the team works
Communicates and makes decisions
Resolves conflicts/problems • Manages group dynamics
Policies, procedures and pathways
Performance and accountability arrangements

INTERPERSONAL RELATIONSHIPS
Level of trust and respect • Impact of individual styles
Giving and receiving individual and team feedback

INTER-TEAM RELATIONSHIPS
Cooperation and coordination • Collaboration or competition
Levels of interdependency between teams and networks

Adapted from: Heslin, C. and Ryan, A. (2010: 28) [212]
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1.2.6.3 Support a learning culture

▶ Support continuous organisational evaluation and knowledge transfer and work with teams to distil learning and actively share it as 'improvement knowledge', creating ripple effects and supporting new thinking and behaviours.

▶ Mutually reinforce change and learning across multiple processes and subsystems in order to address interdependencies and support a whole system approach.

▶ Enable staff to connect through different networks, have conversations, learn through applied experiences and develop communities of practice.

▶ Engage with service users and communities, listen and respond to their experiences and use their narratives to inform service improvements [130, 165].

▶ Acknowledge service improvement as a collective learning process that supports experimentation, problem-solving and a solution-focused approach [96].

▶ Recognise and celebrate success, acknowledge lessons learned and the efforts of all involved, and seek opportunities to support teams to profile their services.

1.2.6.4 Resource the change

▶ Build the case for resources and secure organisational commitment by connecting the required change capacity and capability with the delivery of change outcomes and improved experiences for service users and staff.

▶ Be explicit in relation to return on investment and modify the change plan taking account of capacity to deliver within the context of service realities.

▶ Consider strategies to create additional capacity for change – examine current utilisation of resources and possibilities to re-distribute, put activities on hold or access additional supports both internally and externally.

▶ Put in place targeted supports to enable staff to become digitally fluent in order to remain relevant and connected to innovative practices.

1.2.7 Network and partner

Safer better healthcare cannot be delivered in isolation. The best outcomes are achieved when all parts of the system work collaboratively. The health sector must assume both a stewardship and advocacy role to support other sectors to focus on the population's health needs and to pursue health and wellbeing. Building networks and relationships is an essential value-added activity in the delivery of change. Sharing information on the vision for change and engaging a wide spectrum of allies will assist in anticipating the implementation issues that need to be addressed and opportunities to resolve challenges. Mobilising social action, partnership working and active citizen engagement to support co-production of change in health and social care will enable improved understanding of issues, more effective management of differences, increased decision-making capacity and will improve transparency and trust (Figure 17).

Change Actions

1.2.7.1 Develop capacity for co-production

▶ Empower people to take personal and shared responsibility for change and work towards a meaningful partnership approach – sharing information, knowledge and reaching mutual agreement on goals and outcomes.

▶ Afford people dignity, respect and compassion and empower citizens to be partners in the creation of health and wellbeing, becoming co-producers working in partnership with health and social care staff.

▶ Enable citizens to participate by embedding and formalising participation and engagement methods and processes.

▶ Clarify expectations, roles, responsibilities and levels of accountability so that co-production can be realised (Figures 17, 18).

Figure 17: Citizen Engagement, Community Participation and Co-Production

Citizen engagement: Being an active citizen means being aware of, and caring about, the welfare of fellow citizens, recognising that we live as members of communities and therefore depend on others in our daily lives. Citizen engagement is a process which provides private individuals an opportunity to influence public decisions and is a component of the democratic decision-making process.

Adapted from: Taskforce on Active Citizenship (2007: 2) [363]

Community participation is one element along the spectrum of service user involvement and empowerment in health. It exists along a continuum of participation from information, consultation and partnership to full delegation and control. Core to successful community participation initiatives is the active participation of local people through processes of community development, which result in the empowerment of local communities to address health within a broader framework of the social determinants of health.

Source: Pillinger (2010) [309] cited in HSE – Regional SUI Implementation Group (2011: 4) [205]

Co-production is the active involvement of citizens in service planning, design and delivery including the direct involvement of users in the production, at least in part, of their own services.

Source: Wallace (2013) [393] cited in Colgan, A. et al (2016) [61]
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Figure 18: Journey to Co-production

CO-ORDINATION

CO-OPERATION

CO-PRODUCTION

I can give you this

OK I will take it

I have a space over there

Proposed outcome

Wished for outcome

Shared Resources, Capacity & Skills Creative Thoughts, Design, Respect, Fairness, Mutuality

Coordinating people to work together in predetermined ways

Willing to give and receive help

What could we create together to meet our needs – **A very different conversation**

Adapted from: *The Edge NHS (2016)* [370]

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1.2.7.2 Lever partnerships to influence health and social gain

▶ Work through partnership arrangements to place the determinants of health and wellbeing at the centre of a broader development agenda.

▶ Include multiple partners from the community in the process of designing and improving services and supporting ongoing partnership arrangements.

▶ Support processes such as 'social prescribing' which seeks to address people's needs in a holistic way and aims to support individuals to take greater control of their own health and wellbeing.

1.2.7.3 Value connections and use social networking

▶ Tap into all available networks from the outset; connect with communities of practice, thought leaders, academic partners and business sectors to increase the pace of change and extend the reach in terms of ownership to support delivery.

▶ Value the significant role played by voluntary and community sector organisations and build on their local knowledge and expertise.

▶ Share resources and information and work across service and organisational boundaries so that joined-up creative solutions can emerge.

▶ Facilitate third party advocacy for change and draw on learning from different perspectives.

▶ Use social networking technology and platforms to enable information sharing and expand contacts with individuals, groups and communities. (Google+, Twitter, LinkedIn, etc.).

1.2.7.4 Commission and partner for public value

▶ Use the opportunities provided by formal partnerships including service level agreements to engage and contract for good change practice and best possible outcomes.

▶ Improve organisational capacity to commission effectively including the development of skills to negotiate assertively, develop robust contracts and strongly manage provider performance. [184]

▶ Develop partnering capacity in core business functions, strengthening the capacity and agility of core functional services to work in a business partnering model – human resources, HBS, finance services, ICT services, estates, quality and patient safety, risk management.

▶ Provide business support services close to the point of service delivery and involve functional supports at all stages of the change process.

1.2.8 Use evidence and lever technology

Healthcare delivery is predominantly a clinical and human science based activity where evidence and outcomes are central to effective practice. Change needs to be evidence informed from many sources. This creates the case for improvement, informs decision-making and provides feedback on progress acknowledging that better data leads to better decisions. How evidence is used and communicated is critical to building a coalition for change, challenging the existing situation/status quo and engaging hearts and minds in the change effort. Data gathering, measurement and evaluation systems to demonstrate the benefits and impact of the change need to be in place from the outset (Figure19). The potential of technology as a critical driver of change also needs to be fully embraced – technological changes that represent innovation, efficiency and a future focus are key motivators for staff. Levering e-health solutions will improve population wellbeing and our health services and will support economic development requiring significant organisational commitment and investment. [12, 88, 204]

Figure 19: Evidence Informed, Outcomes, Measurement for Improvement

Evidence informed is used to describe practices based on the integration of experience, judgement and expertise with the best available external evidence from systematic research. This approach involves sifting information gleaned from research and other sources such as practice wisdom, policy, and consultation with users and experts.

Source: Centre for Effective Services (2011b: 4) [48]

Outcomes describe from the perspective of the key people involved what can be reliably demonstrated or measured at the end of a change initiative. They relate to the results you see that take you toward your ultimate goal or vision for the service. Outcomes can also be defined as changes that can be reliably demonstrated or measured in a person, group or population which come about as a result of something else having changed or been provided (e.g. an intervention or a service). They can be short-term, medium-term or long-term and are described from the perspective of the stakeholder. Outcomes must be clear, agreed and capable of being measured.

Adapted from: Hayes, C. (2016) [128]*; HSE – PHSI (2017a)* [188]

Measurement for improvement is the analysis and presentation of quantitative and qualitative data to identify opportunities for improvement and to demonstrate if change has resulted in an improvement. Its purpose is to drive better decision-making and support sustainable improvements in the quality of care.

Source: HSE – QID – Measurement for Improvement (2017) [204]
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Change Actions

1.2.8.1 Use evidence to influence change and demonstrate outcomes

▶ Use evidence to help articulate why change is needed, to inform the vision and change outcomes and to support the Business Case.

▶ When presenting data, use the occasion to build trust and create understanding by connecting the data to service issues.

▶ Ask if the change is benefiting service users and communities and ask the questions: 'Have we the evidence to support better outcomes? Is the data credible?'

▶ Disseminate evidence including research findings in a way that communicates succinctly and links to the original change issue.

▶ Aim for transparency in the measuring, sharing and reporting of information. Display information in a manner that influences behaviour [201].

1.2.8.2 Gather data and knowledge from multiple sources

▶ Establish a baseline of 'the present' and source examples of good practice that represent 'the future'.

▶ Start data gathering with the service challenge in mind: 'What is the issue that this change needs to address? What does it need to change to?'

▶ Draw on multiple sources and gather a blend of qualitative and quantitative data for best results.

▶ Streamline and automate requests for information in order to reduce the burden associated with information gathering and measuring targets.

▶ Curate knowledge – access knowledge through conversations and social relationships based on people's experiences and learning from 'doing'. Translate it into 'explicit knowledge' through sharing with others to support a learning culture.

▶ Continuously learn from service user and citizen narratives through active listening and engagement including the co-design of feedback sessions as an established part of how services are delivered and improved.

▶ Use comparable evidence to supplement internal analysis, inform change actions and apply it to service improvements.

1.2.8.3 Engage in robust measurement and analysis

▶ Ensure outcome measures are established from the outset of the change process and used to inform the collection of relevant data.

▶ Provide support for teams to identify and describe outcomes that can be measured and tracked, and that are in line with public service and organisational requirements.

▶ Measure only what matters and balance the focus on patient/service user experiences as well as on clinical/service outcomes.

▶ Build good data collection practices into routine work and record keeping. Remain alert to emerging data and be prepared to review based on new evidence.

▶ Critically analyse data to distil themes, patterns and trends so as to compile evidence to support the change effort.

▶ Engage research support to assist analysis and seek independent, objective and an external perspective to validate analysis.

▶ Include measurement and analytical skills-building as an explicit element of service/quality improvement development offers [201].

1.2.8.4 Lever e-health and technology to deliver innovative solutions

▶ Realise the benefits of e-health/digital solutions as a catalyst for change (Figure 20). Target increased skills development to support people to become more digitally fluent.

▶ Use technological advancements to engage clinicians and improve client outcomes through innovative developments and leading edge advancements.

▶ Draw on improved infrastructural and ICT capacity and opportunities created through technology platforms and social media to share knowledge and accelerate information exchange.

▶ Build on developments to provide solutions that will meet future service needs – digital applications, software, e-learning, assisted support for service users, individual health records, etc.

▶ Attend to other ICT infrastructural requirements such as facilities and equipment to ensure people have the skills and resources to benefit from technological advancement.

Figure 20: Levering e-Health and Technology
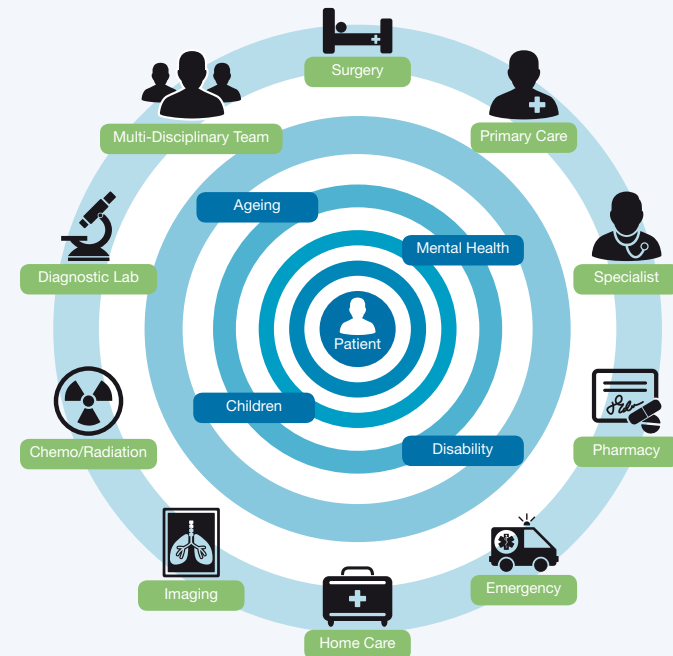
eHealth (electronic Health) involves the integration of all information and knowledge sources involved in the delivery of healthcare via information technology-based systems. This includes patients and their records, caregivers and their systems, monitoring devices and sensors, management and administrative functions. It is a fully integrated digital 'supply chain' and involves high levels of automation and information sharing.

Source: *Department of Health and HSE (2013: 5)* [88]

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1.2.9 Deliver public value and be accountable

The ultimate goal of the Change Framework is safer better healthcare for all and the delivery of staff and public value. The public health system is accountable to citizens for the robust governance of all change and service improvement activity. In line with public service responsibilities, service user and community needs must define change outcomes. Citizens working in collaboration with staff need to be at the centre of defining policy and shaping service design to meet local needs – this approach recognises the redistribution of power from health service providers to health service consumers. Performance is measured based on the delivery of outcomes that demonstrate services which (Figure 21):

- ▶ are ethical
- ▶ provide high quality in delivering best outcomes for individuals and communities
- ▶ are responsive to people's needs
- ▶ are equitable in how we treat service users
- ▶ are financially efficient and effective
- ▶ are accountable to the taxpayer
- ▶ are ecologically sustainable

Monitoring performance ensures change targets are being met and builds confidence in the health system.

Figure 21: Characteristics of Public Value

Public value describes the value that an organisation provides to society. It seeks to improve social outcomes at community level alongside meeting the needs of individuals. It requires a shared understanding of the important value that citizens, tax payers, service users and communities want to see achieved by and reflected in public service organisations. It also presents a way of improving decision-making by calling for public service leaders to engage with service users and the wider public helping to promote greater trust in public institutions.

Adapted from: O'Connor, N. (2017: 21) [296]; Moore, M. H. (2013) [274]
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ℹ **(Deliver Public Value and Be Accountable: Creating Public Value).**

Change Actions

1.2.9.1 Implement robust governance arrangements

▶ Design governance and accountability arrangements as close as possible to the point of service delivery with citizen and service user involvement and a clear connection with the frontline (Figure 22).

▶ Attend to national and corporate governance requirements and alignment, and clinical and business governance arrangements.

▶ Agree commission and mandate of the change at appropriate levels with clear accountability for decision-making and outcomes.

▶ Agree role of change management team and associated performance monitoring processes.

1.2.9.2 Empower staff to be accountable as public servants

▶ In line with the duty of care to staff, promote a governing style that is supportive and assists staff to take responsibility for change and service improvement by having clearly defined functions, roles, responsibilities and reporting relationships.

▶ Cultivate shared responsibility for outcomes, prioritising working relationships and recognising that in a complex environment 'who we work with' is often as important as 'who we report to'.

▶ Encourage and support people to try things out without the need for 'formal permission' and create conditions for innovation and freedom to improve services.

▶ Build capacity and capability of staff and teams to deliver services that are in line with national and professional standards and codes of practice, and provide added value for citizens and communities.

1.2.9.3 Enable and align regulation and oversight

▶ Support a professional regulation and oversight approach that recognises the respective roles of regulatory and oversight bodies[3] that set national standards and priorities, and the roles of service delivery units.

▶ Develop mutually supportive relationships between national/corporate functions and service delivery units through the provision of helpful interventions at local level that reflect the realities of frontline service needs.

▶ Attend to quality, safety and risk assurance processes to ensure changes are in line with legislation and regulatory frameworks.

▶ Balance 'measurement for improvement' with judgement and work with teams to ensure improvements are having the intended impact [286].

1.2.9.4 Support performance to deliver better outcomes

▶ Ensure the change process maintains a focus on the organisation's purpose and monitors accountability arrangements so that performance is measured in line with best outcomes for service users, families, citizens, communities and staff.

▶ Monitor the intended change outcomes in line with the following public value criteria – are they:

▽ valued by the public?

▽ politically and legally supported?

▽ administratively and operationally feasible? [274]

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[3] Health Information & Quality Authority (HIQA), Mental Health Commission (MHC), Medical Council, Nursing and Midwifery Board of Ireland, CORU, etc.

1.2.9.4 Support performance to deliver better outcomes (continued)

▶ Ensure alignment with agreed performance indicators as set out in the Performance and Accountability Framework[4] [154].

▶ Ensure a balanced approach to performance including the use of qualitative and quantitative measures that optimise performance at a number of levels:

  ▼ Societal benefits – population health measures

  ▼ Organisational/service targets including access to services, clinical performance, quality and safety outcomes for individuals and communities balanced with a focus on productivity and throughput

  ▼ Human resource targets

  ▼ Financial performance including value for money, return on investment

  ▼ Change/innovative performance

  ▼ Team performance

  ▼ Individual performance including performance achievement processes, continuing professional development and supervision

▶ Identify risks and put in place control-assurance processes to ensure decision-making and resource utilisation can stand up to public scrutiny and deliver public value.

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4 The HSE Performance Accountability Framework is a core part of the organisation's governance arrangements – it sets out the means by which the HSE is held to account for performance. It includes relevant performance indicators and associated measures.

Figure 22: Principles of Good Governance

Governance is the framework of rules, practice and policies by which an organisation can ensure accountability, fairness and transparency in an organisation's relationship with its stakeholders.

Source: HSE (2015c: 3) [137]

It includes oversight, regulation and accountability of all those involved in the wider system, not just those working in the health services. The key tasks of good governance are:

▶ providing vision and strategic direction to the health system as a whole

▶ exerting influence through setting, implementing and monitoring the rules which govern a system, i.e. regulation

▶ collecting and using intelligence and information to inform planning and evaluation

▶ ensuring a balance of power between users of the health service and service providers, i.e. through the provision of information to guide their decision-making and active participation

Source: HSE (2015c: 3) [137]; The Independent Commission for Good Governance in Public Services (2004: 4) [377]
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Section 2

People's Needs Defining Change

The purpose of this section is to:

▶ provide guidance and approaches to working with key people who have an interest and stake in the change, i.e. stakeholders

2.1 Working With Service Users, Families, Citizens, Communities and Staff[5]

People's Needs Defining Change – Health Services Change Guide is based on an organisation-development approach that places people's needs at the centre of change. Connecting for change through early and ongoing engagement enables people to make a real investment in the change, to develop a shared sense of purpose and to agree outcomes. Mobilising support through networking with people to strengthen relationships and deliver on the principle of co-production (Figure 23) is essential. Shared power created through interactions will stimulate different viewpoints and help people take responsibility for change. It taps into an individual's capacity and desire to participate in designing a better future.

People's Needs Defining Change

Service Users, Families, Citizens, Communities & Staff

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[5] For ease of reference we use the term 'stakeholder' to refer collectively to people who have an interest or stake in the change.

Figure 23: Six Principles of Co-production

1. Seeing people as a valuable resource: working with people's expertise and experience

2. Building on our capabilities: supporting people to put their skills to use

3. Mutual responsibilities and expectations: developing two-way relationships

4. Supporting networks and growing peer supports

5. Reduce silos: removing tightly defined boundaries to enable shared responsibility and control

6. Enabling people to achieve their own goals: facilitating self reliance and prompting action
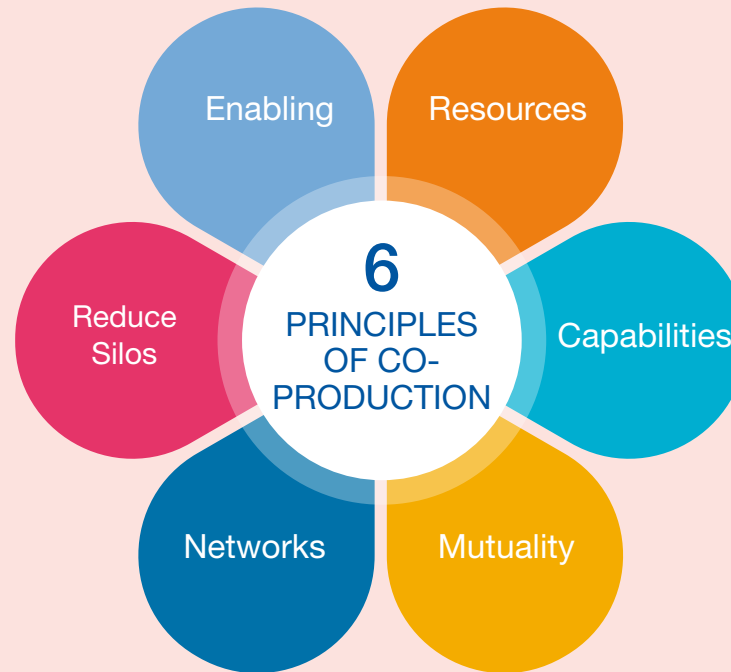
Adapted from: *Slay, J. and Penny, J. (2014: 31)* [351]

Adapted from: *Malby, B. (2014: 8)* [255]
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2.2 Develop Engagement Process

Plan for early and sustained engagement from the outset of the change process. Map and understand your network of people connections, stakeholders and influencers. Who needs to be involved? How can you secure their input and support? What groups are disconnected or 'at the edge'? Who can assist at the early stages to guide developments? A change management team to oversee and guide the process may be required – the best timing to establish this team needs to be considered and different people may take up different roles during the process (see 3.5.2: Establish Change Management Team). Early clarification on mandate is important – discuss the proposed changes with key leaders in the system and be particularly alert to the need to engage early with partner services or organisations. Information and guidance received at this early stage will help you to work with people to plan the engagement and communication needed to define, co-design and deliver change outcomes.

The strands of the engagement process (Figure 24) are:

▶ 2.2.1. Identify and map people connections

▶ 2.2.2. Understand key stakeholders

▶ 2.2.3. Tailor engagement to key groups

▶ 2.2.4. Plan and engage with a purpose

▶ 2.2.5. Develop and sustain communication and engagement

The following templates can be used to support your engagement activities, and guidance is provided in the sections below.

ℹ **See Section 6.1, Template 6.1.2: Guidance on Stakeholder Mapping and Analysis, page [105]**

ℹ **See Section 6.1, Template 6.1.3: Guidance to Develop Engagement and Communication Plan, page [107]**

Figure 24: Engagement Process
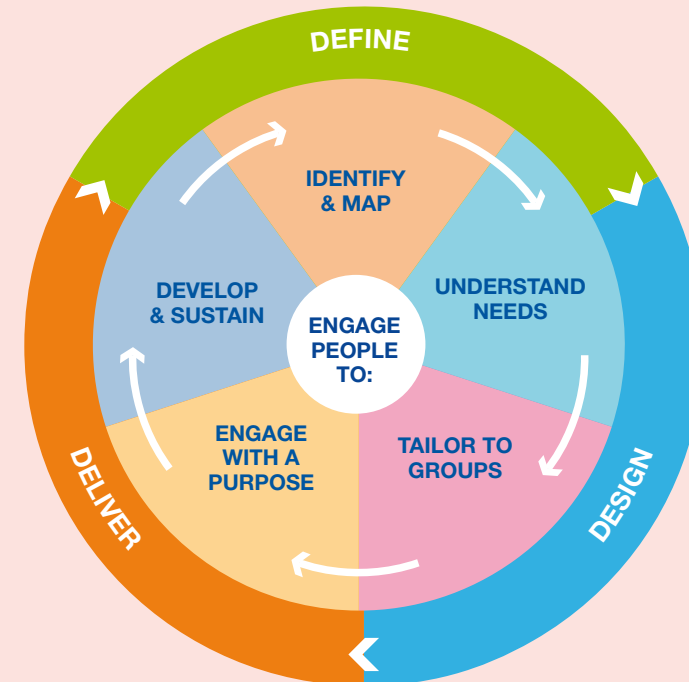
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2.2.1 Identify and map people connections

Create your network of connections by identifying and mapping all those who could be involved in designing and implementing the change process. Identify both internal and external individuals/groups. Use the prompts in Figure 25 to ensure diverse, broad and inclusive representation. Keep in mind people who can take up different roles to co-lead and support the change process.

Figure 25: Identify Key People Impacted by the Change

External Groups (examples)

▶ Service users, patients, families and carers

▶ Service user, patient or citizen groups

▶ Advocacy groups

▶ Community representatives

▶ Voluntary agencies

▶ Partner organisations and services

▶ Contracted providers e.g. GPs, Dentists and Pharmacists

▶ Trade Unions and staff associations

▶ Joint Information & Consultation Forum

▶ Representative and professional bodies – staff representative and professional associations

▶ Other statutory groups, i.e. education, local authorities, social and family affairs, etc.

▶ Regional or national health forums

▶ Local or national politicians and representatives

▶ Regulatory bodies – HIQA, Mental Health Commission (MHC), Medical Council, Nursing and Midwifery Board of Ireland, CORU

▶ Local and national media

Internal Groups (examples)

▶ Staff groups – frontline, administrative, support, clinical and social care staff

▶ Service and discipline teams

▶ People who will 'champion' and lead the change

▶ People from outside the traditional structures and hierarchical systems – the 'contrarian or rebel voices' and those who challenge traditional thinking

▶ Groups that are 'disconnected' from current services and who have a contribution to make

▶ Decision-makers, opinion leaders and commissioners of the change

▶ People with content or subject matter expertise or other levels of organisational/service intelligence or knowledge

▶ Leadership/management teams

▶ Business/functional teams, e.g. finance, human resources, HBS, ICT, estates, procurement

▶ Staff engagement forums or other user groups

▶ Consultative committees and forums

▶ Quality, service or project improvement teams

▶ Other groups at national and area levels
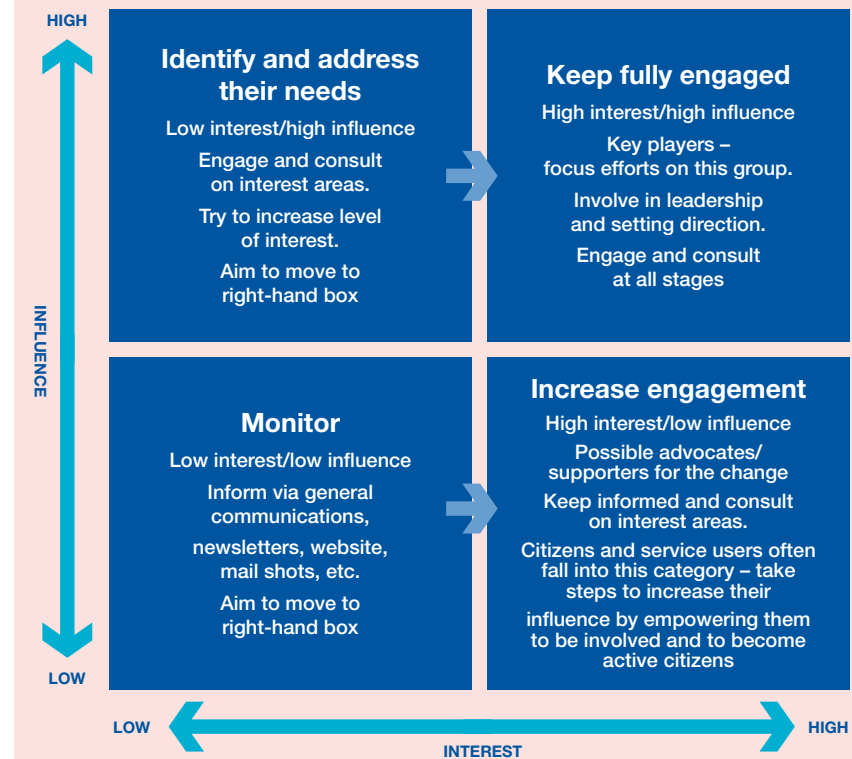
Adapted from: HSE – PHSI (2017a: 89) [188]

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2.2.2 Understand key stakeholders

Having identified your key stakeholders think about how best to understand their needs and involve them appropriately. One methodology is to group stakeholders based on level of interest and influence (Figure 26). This approach helps to prompt conversations and shape initial engagement processes. Use the high/low axis as noted in Figure 26 as guidance to consider stakeholders in terms of:

▶ their **level of interest** in the change: the extent to which individuals or groups have a vested interest in the change/their expectations of what they want the change to deliver. Based on their level of interest, plan with them how best they can be involved in the change process.

▶ their **influence**: the extent to which individuals or teams are able to influence others to change. Influence is apparent in formal and informal ways such as opinion leaders and 'go to' people as well as through position, status and access to resources. Every individual has the 'power' and personal agency to influence change and make a positive difference – this needs to be encouraged and respected. Peer-to-peer influence is also significant.

Figure 26: Influence-Interest Mapping Grid

HIGH

INFLUENCE

Identify and address their needs

Low interest/high influence

Engage and consult on interest areas.

Try to increase level of interest.

Aim to move to right-hand box

Keep fully engaged

High interest/high influence

Key players – focus efforts on this group.

Involve in leadership and setting direction.

Engage and consult at all stages

Monitor

Low interest/low influence

Inform via general communications,

newsletters, website, mail shots, etc.

Aim to move to right-hand box

Increase engagement

High interest/low influence

Possible advocates/ supporters for the change

Keep informed and consult on interest areas.

Citizens and service users often fall into this category – take steps to increase their

influence by empowering them to be involved and to become active citizens

LOW

LOW ⟵ **INTEREST** ⟶ **HIGH**

Adapted from: *Eden and Ackermann (1998: 122)* [103]*; Bryson, J. M. et al (2011)* [40]

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ⓘ **See Section 6.1, Template 6.1.1: Influence-Interest Mapping Grid, page** [103]

2.2.2.1 Engage directly with key stakeholders

Understanding key stakeholders will assist you to utilise people's time and contribution wisely by taking into account people's potential role and involvement in the change. Be open and flexible to different contributions at various stages in the process. Ask people which parts of the change process they would most like to contribute on – people may not need or want to be involved in everything. Having grouped stakeholders, a number of factors will assist with your analysis of how best individuals or groups can be involved and how they might feel about and react to the change. The best way to answer these questions is to talk to your stakeholders directly. People are usually quite open about their views – asking their opinions can be the first step in building a successful relationship. Key questions to help understand your stakeholders are outlined in Figure 27.

Figure 27: Understand Key Stakeholders

▶ **Accountability for the change:** What is their level of accountability to deliver the change? How does this translate in terms of actions?

▶ **Interest in the change:** Elaborate on personal interest in the change. What emotional, professional, clinical, business interests do individuals have in the outcome of the change? Will it enable or hinder the change?

▶ **Readiness to embrace the change:** What motivates individuals and teams most of all? What are their concerns, fears, hopes? How will you work with individuals and teams to assist them to address concerns and support the change?

▶ **Levels of interdependency:** What teams/services need to work closely together to deliver the change? How can these synergies be supported?

▶ **Assist and influence the change:** How can people assist the change to happen? What would assist them? Who influences opinion generally and how best can they be involved?

▶ **Engagement and communication:** What information do people want? How do they want to receive information? What is the best way of communicating? What is the best way to engage?

(See 2.2.3: Tailor engagement to key groups)

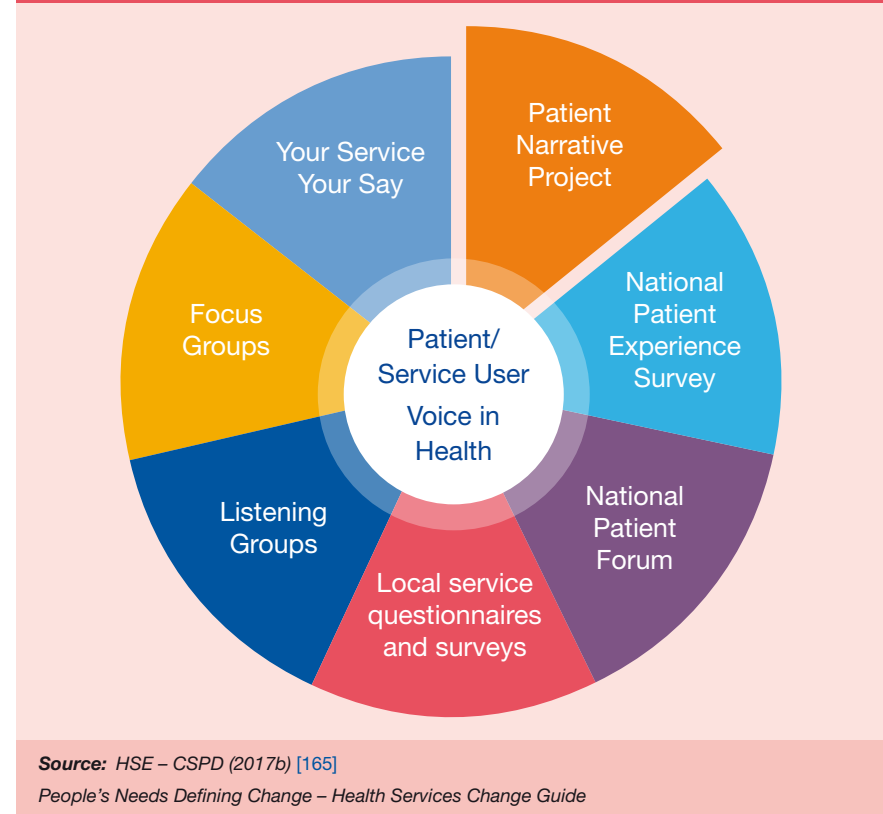*People's Needs Defining Change – Health Services Change Guide*

2.2.2.2 Revisit engagement

Revisit stakeholder engagement throughout the change process as the nature of engagement is ever evolving and needs to be constantly revised and updated as new levels of emphasis arise. Continue to include all groups over the lifetime of the change initiative. Be flexible so as to absorb emergent issues and engage with diverse groups – while this may delay progress, ultimately it will lead to better and more implementable solutions. Remain connected with the commissioners of the change to track progress and address issues as they arise.

2.2.3 Tailor engagement to key groups

Engagement processes need to meet the needs of diverse groups and individuals – multiple perspectives add richness to the thinking. While there are many groups with a stake in the change, service users, families, citizens and staff have a priority interest in the outcome (Figures 28, 29). When initiating significant change it is important to consult Trade Union representatives both nationally and locally in order that the impact on staff and staff issues can be monitored and addressed from the outset at appropriate levels. (Refer to the *Information and Consultation Agreement* between the health services and Trade Unions [206] for further guidance.) Similarly advocacy groups and service user representatives need to be engaged early in order to agree best outcomes. Developing an informed understanding of how best to progress engagement with priority groups requires focus and planning.

Figure 28: Patient/Service User Voice in Health and Social Care – Methodologies

Source: HSE – CSPD (2017b) [165]
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2.2.3.1 Service user engagement

Service user and family involvement is dependent upon the commitment of leaders and staff to fully embrace a partnership approach. It requires an investment of resources including staff time – this needs to be factored into the plan at the outset. Service user engagement challenges health and social care staff to address the balance of power and necessitates a shift in mindset and attitudes (Figure 29).

Figure 29: Service User Engagement – Key Components and Guidance

- Acknowledge patients/service users as **partners** in their own care and in the delivery of their service.
- Care for people with **compassion, dignity, respect and kindness**.
- Provide care and support that is **coordinated**.
- Support service users/patients and families to develop the **knowledge**, **skills** and **confidence** to make **informed decisions**.
- Support patients/servicer users, families and communities to participate in service design and delivery of care.
- **Create environments** where managers and clinicians can engage with patients/service users and deliver care and support that is focused on their **individual needs** and **goals**.

- Select the **method of involvement** that matches the purpose you have identified and the needs of service users (see Figure 28). In particular give consideration to the specific requirements of individuals who access services where the interactions can be complex in terms of patients/service users and their families, and the interface with staff and the service delivery system having regard to specific legislation and matters of safeguarding.
- Ensure **effective channels of communication** – they must be planned, and actively encouraged and promoted. Employ a range of different communication methods to include those for whom English is not their preferred language and for service users with communication or sensory difficulties.
- Ensure that participants, particularly those whose voices are seldom heard, are given an opportunity to participate in **inclusive and diverse ways**.

- Establish **terms of engagement** as these will set out a 'road map' and a shared purpose. They give a clear path for progression, by stating what needs to be achieved, by whom and when.
- Identify the intended outcomes of the process – this need to be in keeping with the requirements and scope set out in the terms of engagement.
- Use **feedback** to identify what is working well – recognise and promote good practice.
- Ensure a **'process evaluation'** and an **'outcome evaluation'** of the respective service user involvement process is carried out. The process evaluation will help improve involvement practices, while the outcome evaluation will help determine the degree to which engaging with service users has impacted on service delivery.

- Build ongoing opportunities for dialogue with **organisations/groups representing service users**.
- Build on processes such as the Patient Narrative Project [165], National Patient Experience Survey [130] and other **service user/patient engagement processes** across the system including those in mental health, children and youth services, disability services, older person's services etc.
- Guidance for example on appropriate service user, family and carer engagement methodologies and approaches is available through the national Mental Health Engagement Office and locally through the engagement and service user representative leads. Similar developments are taking place across the system with other client groups.

Adapted from: HSE – QID (2016b: 11) [195]

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ℹ️ **Assisted Decision-Making (Capacity) Act 2015 and Mental Health Engagement Office**
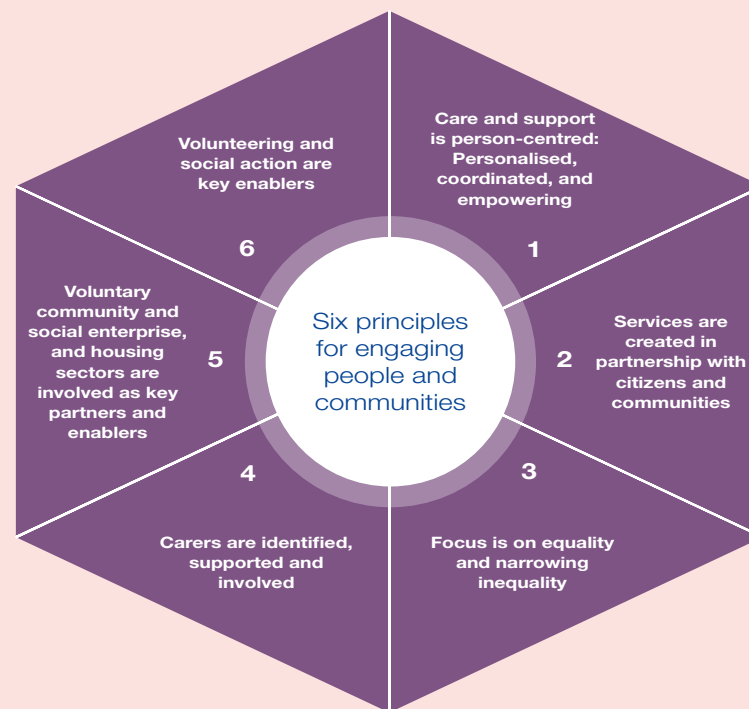
2.2.3.2 Citizen and community engagement

Citizen and community engagement builds on our commitment to public value and is a significant enabler of change. It supports service improvements guided by locally defined priorities. It requires community education and empowerment by encouraging people to learn new skills, reflect on their social and economic conditions and act in their own self interest so that they can fully participate in decision-making processes. Principles for engaging communities and key components of citizen and community engagement are presented in Figure 30.

Figure 30: Engaging Citizens and Communities

Principles for Engaging People and Communities

Citizen and community engagement – key components

▶ Provide citizens (individuals/groups) with an opportunity to influence public decisions and service design as a powerful motivator of change.

▶ Aim to work from a common platform of understanding and harness the energy generated by working with local communities to help shape services based on their experiences and needs.

▶ Engagement requires commitment and a willingness to 'share power' with the people who ultimately may be users of our services.

▶ Involve community and public representatives as agents of change – their participation brings a fresh and 'outside' perspective to service design and change.

Adapted from: Taylor, J. (2016: 7) and People and Communities Board (2016).[365]   *People's Needs Defining Change – Health Services Change Guide*

2.2.3.3 Staff engagement

Evidence shows that staff engagement results in improved performance, better patient/service user outcomes and higher staff morale. Understanding staff engagement will assist in identifying the supports required to sustain it over time. Some of the key principles that enable frontline staff's contribution are presented in Figure 31.

Figure 31: Principles to Enable Frontline Staff's Contribution to Systems Change

▶ **Model system change behaviour:** wherever you are in the organisation, take on some of the ways of being and doing described below.

▶ **Leaders must really want to engage:** be open-minded, listen to, hear and value staff feedback and acknowledge their unique contribution to fulfilling the vision of the service/organisation. Give regular feedback on how engagement is being used and the difference it is making.

▶ **Create time and space:** frontline staff need time and opportunity to think about how their system is working and how it could be improved.

▶ **Disperse power:** give explicit permission to staff to question how the system is working; don't assume that people will speak up if things are not functioning well.

▶ Encourage staff to be involved in **decision-making** and **creative problem-solving** in delivering service improvements; respect their unique knowledge of their work environment.

▶ **Nurture community:** it's very hard to make change happen alone. Help staff form peer relationships to support each other and develop effective team working.

▶ **Take down language and evidence barriers:** break down official language and jargon and accept new forms of evidence. This will level the playing field for those wanting to create change.

▶ Promote the **health and wellbeing** of staff and create a healthy workplace environment. [150]

▶ Support continuous **learning and development** through building quality improvement and change management skills and knowledge. Provide **coaching and mentoring** to staff who undertake new roles and responsibilities. Ensure staff have the necessary **skills** and **knowledge** to engage effectively.

▶ Enable and promote **lifelong learning** and **continuous professional development** as an investment in current and future competencies and qualifications of the health and social care workforce. Continuous professional development (CPD) is "a joint responsibility of the employee and the employer where employers, given their legal responsibility for good quality care delivery, should provide the required infrastructure and facilitate sufficient and adequate training possibilities." The health services as the employer should be a key 'driver' and enabler of CPD initiatives. [372]

🛈 **Invest in People and Teams: Joint Declaration on Continuing Professional Development (CPD) and Life-Long Learning (LLL) for All Health Workers in the EU**

Adapted from: HSE – QID (2016b: 13) [195]; Bevan, H. (2017a) [20]

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2.2.4 Plan and engage with a purpose

Work with key stakeholders to plan how best to engage and reach out into the system. Consider how to work with people who may be reluctant to get involved or anxious about the change. Provide opportunities for conversations to take place – understanding people's interests, requirements, expectations and capacity to influence and shape the change will help to create the energy needed for change. Focus on outcomes that matter to people and engage with a purpose. The guidance in Figure 32 will assist.

Figure 32: Engage with a Purpose

The invitation to engage must be one hundred per cent genuine and definitely not a 'tick box' exercise. People need to believe that the problem is worth their time and effort to get involved.

▶ Be clear about the **purpose and outcome of engagement**. The 'ask' needs to be clear – whether it's to inform, consult, gather data, make decisions, involve, collaborate or co-produce. What outcome do you want to achieve from engagement? How is the engagement linked to service priorities?

▶ Prioritise **face-to-face engagement**, use formal and informal systems and naturally occurring opportunities to engage and create a platform for ongoing engagement – service user/advocacy groups, staff meetings, engagement forums, staff representative and union meetings, Community Fora.

▶ **Include multiple perspectives** and consider self-nomination and peer-to-peer nomination based on interest or expertise, and aim to ensure a representative sample/cross section of stakeholders in all engagement events. Consider parallel structures, i.e. representative, or mirroring the organisation. Involve more and more people in change discussions, altering how and which people engage with each other and stimulate different perspectives to shape how people think about things.

▶ **Facilitate meaningful and challenging conversations.** Generate, filter and test ideas. Aim to be creative and think 'outside the box'. Use methods that facilitate emergent thinking and enable people to contribute to problem-solving and planning for the future – appreciative inquiry, world cafe events, future search conferences, town hall meetings, collaborative platforms and focus groups.

▶ **'Words create worlds.'** Be mindful of both verbal and nonverbal communication and avoid jargon. Use **effective framing** and the power of **stories and narratives** to maintain a sense of reality and emotional/personal connection to the experiences of citizens, service users, staff and local communities. Stories help to communicate who you are, what values are important to you – this fosters collaboration and helps to lead people to a better future.

▶ **Make ideas visible.** Use graphics and other visual methods to assist people to connect to messages and stories.

▶ **Seek feedback** and demonstrate commitment to act on the views of service users, staff and key stakeholders. Follow through on suggestions and actions agreed.

▶ Consider the option of **'hothousing change'** in a time-limited manner – intensify the efforts and accelerate change, delivering change in 30/60/90-day change cycles [286: 102-103].

▶ Where there is a **legislative** or **regulatory requirement** or **agreement** regarding the arrangements for communication/consultation this should be adhered to.

▶ Refer to the *Information and Consultation Agreement* between the health services and Trade Unions to inform engagement practices [206]

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2.2.5 Develop and sustain engagement and communication

Based on consultation develop an **Engagement and Communication Plan** that identifies how best to work with key individuals and groups. Ensure a coherent and sustained approach to listening and responding to emerging issues, keeping people up to date on what is happening, receiving and acting on feedback. Review the plan and update accordingly. Communication is the core foundation of good change management and the guidance in Figure 33 will assist.

Figure 33: Engagement and Communication Plan Guidance

▶ **Delivery channels and feedback loops** need to be effective, with a particular focus on reaching service users, staff at the 'frontline' and local citizens. Attend to the needs of people who may have communication difficulties and seek advice on how best to support their needs.

▶ Use **multiple communication platforms** to reach the widest audience on a consistent basis and have clearly identified actions at all stages of the change journey. (Use local media and social network platforms, as well as traditional approaches.)

▶ **Lever technology** to communicate, engage, co-create and learn within and outside the service involving a wider audience. Use the power of social networks/platforms as a way for diverse groups to share information and generate ideas.

▶ **Review** the effectiveness of communication and engagement efforts at regular intervals – they need to be flexible to meet changing needs and emerging issues. How can you be sure your Engagement and Communication Plan has had the intended impact? Increase communication efforts as you reach key milestones and be honest when deadlines have been missed or delayed.

▶ **Be self-aware.** Review the impact of your communication style (spoken and written) on others. An authoritative tone can do untold damage. Be realistic in terms of deadlines – remember what is important to you may not register the same way with the receiver of the message. Always ask how you could improve communication and be open to feedback. Prioritise conversations and face-to-face engagement.

▶ **Sustain communication and engagement.** Enhance the skills and knowledge of staff to sustain engagement through existing service activities in addition to supporting service user, citizen and staff engagement forums. Be alert in particular to key factors that influence positive staff engagement during change as this will impact directly on how well citizen and service user engagement is progressed.

▶ **Remember** that 'the single biggest problem in communication is the illusion that it has taken place.' George Bernard Shaw

(See Section 1.2.3: Engage and communicate)

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ℹ️ **See Section 6.1, Template 6.1.3: Guidance to Develop Engagement and Communication Plan, page** [107]

Section 3
Define Design Deliver

3

Section 3: Define

Purpose of this stage

1. Initiate change by defining the shared purpose and need.

2. Understand the current context, levels of readiness and scale of the change.

3. Agree better outcomes and future vision.

4. Design measurement plan.

5. Develop the Business Case for Change.

DELIVER ⬆

⬆ DESIGN

DEFINE ⬆
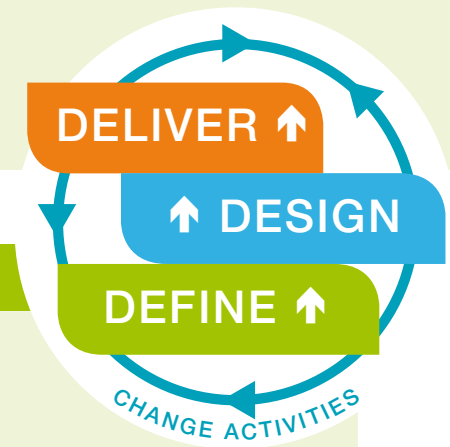
CHANGE ACTIVITIES

Define Activities

3.1 Identify Shared Purpose

   3.1.1   Identify need

   3.1.2   Examine drivers for change

3.2 Understand Current Services

   3.2.1   Describe the current situation

   3.2.2   Mobilise people and culture

   3.2.3   Understand prevailing culture and values

   3.2.4   Assess readiness and capacity for change

   3.2.5   Assess and build energy for change

   3.2.6   Identify levers for change

3.3 Agree Better Outcomes

   3.3.1   Co-design the 'vision' for the future

   3.3.2   Agree change outcomes and objectives

3.4 Measure for Success

   3.4.1   Design measurement plan

3.5 Make Case for Change

   3.5.1   Agree governance and mandate

   3.5.2   Establish change management team

   3.5.3   Identify resource requirements

   3.5.4   Communicate the Business Case

3.1 Identify Shared Purpose

Getting clarity about the **purpose of the change** is an important starting point as it assists people to understand and articulate a **'shared purpose'** – it defines and connects people with what needs to be achieved. It adds depth and breadth to the vision for change and helps to focus on a collective ambition, not just what you want to achieve but **why** it is important.

Engage with staff early and work with service users, families and individuals who interact most closely with the service to explore and develop this shared understanding of **what needs to change and why**. Engage senior managers, particularly those who have an investment in the change and those who are likely to provide the leadership and resources to support the change. Complete this early preparatory work to provide data to gain their **commitment and mandate**. Leaders need to describe a change opportunity that will appeal to people both rationally and emotionally and use this energy to generate a **sense of urgency** for the change. Agree how best to keep all key stakeholders involved and informed of progress. This is particularly important when change impacts on service users, different staff groupings, teams and services. At this early stage, consider Terms of Reference for the change. This will help keep people focused on outcomes and timescale.

3.1.1 Identify need

Describe the change issue to be addressed as a 'working definition'. Consider **framing and re-framing** the issues in terms of key themes people can understand and feel passionate about. Intellectual or rational appeal, data and analysis on their own are not sufficient. Consider prompts in Figure 34.

Figure 34: Describe the Purpose and Need for Change

▶ **What** do you think needs to be changed or improved? Is there an opportunity that could 'ignite' the hearts and minds of people to get involved? How can you quickly and urgently engage and mobilise people around this opportunity? [236]

▶ **What** aspects of the service could be delivered better or differently? What is not working well? What needs are currently not being met that require change?

▶ **Who** is most affected by the service gap or service 'problem' and at what level – individual, team, service wide? Describe the impact of the 'problem' on the service, on service users or local communities? How does it impact directly on staff? Can the impact be quantified and measured? **Who** will benefit from this change?

▶ **When** do the problems occur? Is it all year round? Does it happen at specific times of the year, or specific times throughout the year? Does it happen at a particular stage in a process or pathway? What does this information tell you in terms of service demand and capacity?

▶ **Why** is this change so important and why does it need to be done now? Why do the problems occur? What is the root cause?

▶ **What** are the outcomes if you succeed? What are the consequences of not going ahead with this change – what will happen if the situation is allowed to continue?

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Undertaking a **SWOT** analysis (Figure 35) will assist in understanding the need for change by identifying service strengths, weaknesses, opportunities and threats/challenges within a service and to lever the conversation about the need for change. This will assist to build readiness and raise people's awareness of the pressures and challenges which indicate the need to take action for change, to understand key drivers and the context for change.

Figure 35: SWOT (Strengths, Weaknesses, Opportunities and Threats/Challenges)

Strengths and weaknesses are primarily about the situation for the organisation at present and opportunities and threats are about predicting the future (external factors).

Strengths

What is the service good at doing?

Weaknesses

What is the service not good at doing and what aspects of the services are not going well?

Opportunities

Identify the events and trends that are favourable to the service.

Threats (Challenges)

Identify the trends or events that are unfavourable to the service.

Adapted from: Clarke, J. (1997: 7) [58]

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ℹ️ See Section 6.2, Template 6.2.1: SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats/Challenges), page [110]

3.1.2 Examine drivers for change

Understanding why change is needed and what is driving the need for change is critical to support early planning and initial conversations. Use the methodology in Figure 36 to assist with understanding the context for change.
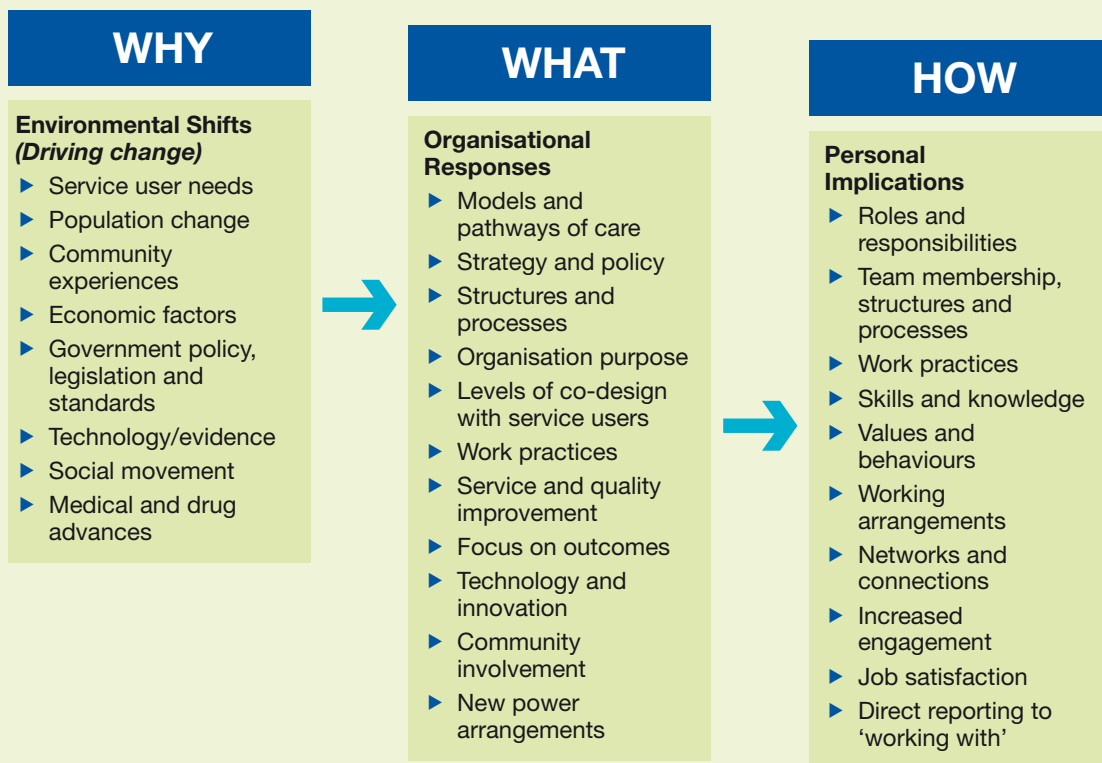
Figure 36: Context for Change – Why What How Method

The **Why What How Method** assists you to 'diagnose' the big change drivers in the external environment, identify organisational responses and anticipate the personal implications of change. This will assist you to communicate **Why** change is needed, **What** needs to change, as well as **How** it will change.

- **Why:** 'Environmental shifts' list the typical sources of external drivers of change.

- Some of the ways in which a service responds to external pressures are listed under **What**.

- Changes for individuals (service users, citizens and staff) are identified under **How**.

ℹ️ See Section 6.2, Template 6.2.2: Context for Change – Why What How Method, page [112]

ℹ️ (Define: Force Field Analysis).

WHY

Environmental Shifts *(Driving change)*
- Service user needs
- Population change
- Community experiences
- Economic factors
- Government policy, legislation and standards
- Technology/evidence
- Social movement
- Medical and drug advances

WHAT

Organisational Responses
- Models and pathways of care
- Strategy and policy
- Structures and processes
- Organisation purpose
- Levels of co-design with service users
- Work practices
- Service and quality improvement
- Focus on outcomes
- Technology and innovation
- Community involvement
- New power arrangements

HOW

Personal Implications
- Roles and responsibilities
- Team membership, structures and processes
- Work practices
- Skills and knowledge
- Values and behaviours
- Working arrangements
- Networks and connections
- Increased engagement
- Job satisfaction
- Direct reporting to 'working with'

Adapted from: *Fisher, K. et al (1995)* [108]; *McMurray, A. (2016a)* [262]

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3.2 Understand Current Services

A shared understanding of the current situation – the 'as is'/how services currently work – is essential and will assist in addressing readiness and levers for change. Understanding your service culture and subcultures will also assist in focusing on the issues that need to be addressed.

3.2.1 Describe the current situation

Developing a baseline description of current services will help you to have an identified 'starting point' against which outcomes and benefits can be measured and evaluated. Baseline data is initial measurement data collected prior to a change being implemented. Before capturing a baseline, you need to think about what outcomes you want the change to deliver and what you want to measure or assess. The value of having a baseline is that it:

▶ serves as a point of reference and demonstrates change over time

▶ helps to monitor progress and highlights areas that a change intervention aims to address

The description of the current situation will outline how services are delivered and organised, i.e. the Service Operational Model (Figure 37).

Figure 37: Service Operational Model

The Service Operational Model is shaped by the **strategic direction** for the service and by the relevant **Model of Care/Delivery Model**. The Model of Care/Delivery Model provides the theoretical foundation for the service – it is based on evidence and good practice, and it shapes the service's delivery and associated roles.

The **Service Operational Model** defines in more detail how a service is organised and delivered. It can apply to both clinical and business services. It outlines governance arrangements, referral pathways, processes for screening or assessment, diagnostic processes, types of services/interventions delivered, and evaluation and measurement processes. It attends to the following:

▶ **Governance and leadership arrangements:** clinical and business governance, decision-making processes

▶ **Organisation** of the service: high level structure and roles

▶ **Geography:** where the service is being provided

▶ **Service users/service recipients:** who the service is aimed at (service users/patients, families, staff, partner organisations, contractors for services, etc.)

▶ **Stakeholders:** who the service interacts with, individual and team members, other services, organisations, etc.

▶ **Pathways of care/service delivery processes:** referral, assessment, diagnostic, intervention pathways and processes

▶ **Business processes:** service planning, policies and procedures, financial management, communication, administrative, procurement processes, etc.

▶ **Human Resource processes:** who delivers the service, processes for workforce planning, learning and development, staff health and wellbeing, etc.

▶ **Quality, patient safety and measurement processes**

▶ **Information systems:** enabling technology and information management systems

▶ **Resourcing of the service:** funding and budgetary arrangements

▶ **Infrastructure:** accommodation, equipment required to deliver the service

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ℹ️ **See Section 6.2, Template 6.2.3: Description of the Current Situation (Service Operational Model), page** [113].

3.2.2 Mobilise people and culture

Attending to the priorities in the People and Culture Change Platform (Figure 5) in an integrated manner will help mobilise the energy required to support culture change. This joined-up approach is needed in order to reflect the dynamic and multi-faceted nature of culture change. Understanding the **current situation** and levels of **readiness** is a good starting point as this will guide relevant interventions and address issues of sustainability. Keep focused on the shared purpose and change outcome you want to deliver in order to ensure interventions are purposeful, aligned and relevant to the local context. How can you build a guiding coalition of effective people to mobilise the change? This involves working both within and outside traditional hierarchies and divisions/teams that currently work in isolation – coordinating people from across and outside the organisation or service to help drive and sustain the change. Creating networks and tapping into opportunities that connect people around a shared purpose will help build momentum.

3.2.3 Understand prevailing culture and values

Understanding the prevailing culture within your service is an essential part of facilitating change. It assists in challenging embedded practices and routines as well as enhancing opportunities for development. Culture operates at many levels and encompasses **deeply embedded values, behaviours, traditions and practices**. It represents the 'lived social reality' for people within a service and the shared meaning that evolves for a group over time. While culture is abstract, thinking of the component parts that represent culture can be helpful. These manifestations include symbols, rituals and routines, control systems, hierarchal or matrix arrangements, stories or myths and decision-making processes. It is also represented by 'internal politics' and power dynamics within the service/organisation. If a proposed change spans a number of professions, services or teams, or crosses organisational boundaries, there may be a number of different **subcultures** present. This will require particular consideration as 'one size will not fit all' in terms of possible interventions.

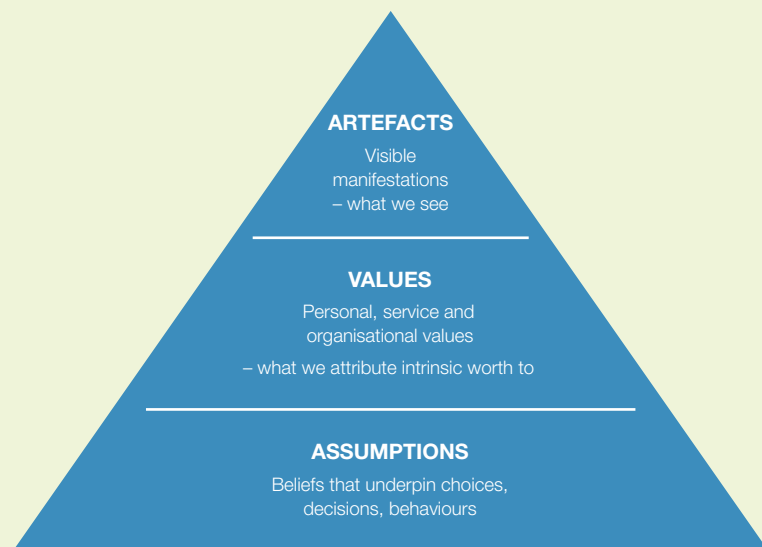### 3.2.3.1 Defining personal values

Defining personal values will help you discover what is truly important to you. Reflecting on the alignment of your personal values to the values of the team/service/organisation you work with will help you to understand the fit or otherwise between both. This level of insight will assist you in contributing in a meaningful way to addressing culture within your team or service.

3.2.3.2 Understanding service values

Engaging in a facilitated process and working with service users, team members and other key stakeholders will assist understanding of the levels of culture that operate within a service as outlined in Figure 38. Take time to describe the visible manifestations of culture (artefacts), the values (both personal and service) and to explore what shared understood assumptions are in operation and related to day-to-day decision-making. This process of exploration can best be achieved by working with people to identify 'what it is really like to work around here', considering patterns that have built up over time and assisting people to understand their working environment – their values, aspirations and feelings.

Figure 38: Levels of Culture

ARTEFACTS
Visible manifestations
– what we see

VALUES
Personal, service and organisational values
– what we attribute intrinsic worth to

ASSUMPTIONS
Beliefs that underpin choices, decisions, behaviours

Adapted from: Schein, E. H. (2014) [332]
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For culture change to be effective, it is critical to identify the right culture – what is the destination of the culture change journey, what is the outcome? The Change Framework clearly positions public and staff value as the desired outcome. The destination is shaped by defining the needs of service users, families, citizens, communities and staff – making this connection is critical to ensuring relevance, a future focus and delivering real value.

The benefit of understanding culture is that it shapes our behaviour – the role of leaders engaging with service users and staff is to clearly articulate what we want our health and social care services to be known for in the future.

This orientation towards our service users and delivering public value enables us to customise our values, beliefs and norms and translate these into a set of internal thoughts and actions. It also ensures alignment and connection between staff and service user expectations and the delivery of safer better healthcare. Clearly articulating the critical behaviours that will represent the culture and values you want to create is also a key determinant of positive cultural change. [141, 278]

The guidance outlined in Template 6.2.5 will help to generate insights. The outcome will also assist in developing the vision/future destination for the service and aligning this vision to agree values. It is important to acknowledge that accessing deeply held underlying values and assumptions is challenging and often requires more in-depth exploration.

3.2.4 Assess readiness and capacity for change

Attending to change readiness and change capacity prior to initiating change contributes to a better understanding about what approaches will help to initiate and support change effectively.

▶ **Readiness for change** is aligned to the prevailing culture and subcultures within the service (see 3.2.3) and the nature of the relationships between people, teams, services and external agencies/partners. Readiness can be assessed at individual, team, service and organisational levels.

▶ **Determine the capacity** (right number and level of people) and capability (confidence, knowledge and skills) required to support the change. Consider strategies to access the additional capacity required for your change – this may include stopping specific pieces of work, putting work on hold, slowing down other change initiatives, reallocating people's time, accessing additional staff with the right skills, outsourcing work if appropriate, and levering technology to support innovative practices.

3.2.4.1 Personal readiness

Understanding factors that impact upon readiness for change will help determine the actions to assist people to engage in the change process (Figure 39). Individuals will have different starting points and may require different levels of support.

Figure 39: Understand Personal Readiness
▶ Attend to your own personal readiness – be consciously aware of your own behaviour, your impact on others and the motivation for your choices.
▶ Attend to what motivates people to change – there is a fine balance between external factors (reward or incentives) and core intrinsic motivators such as connecting to a shared purpose and sense of meaning.
▶ Discuss the personal opportunities involved in change initiatives – new role, enhanced skills, better work arrangements, improved service user experience.
▶ Ask people who are reluctant to get involved what would make it easier for them to get involved.
▶ Try putting yourself in their shoes, and consider what the change must feel like for them. Can I see the challenges that other people have? Keep working to bring people from the 'outside' or the 'edge' to the centre, where there are opportunities to work together.
▶ What can I do as the person responsible for introducing change to address the reasons for reluctance or resistance to change?
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ℹ See Section 6.2, Template 6.2.6: Personal Readiness for Change, **page** [126]

3.2.4.2 Team readiness

Carrying out a team effectiveness assessment will create momentum and prompt conversations within teams to explore opportunities for improved performance. Data may also be available from staff surveys, exit interviews and other feedback processes. Take time to consider levels of energy in order to provide helpful guidance on possible interventions (see 3.2.5).

ℹ See Section 6.2, Template 6.2.7: Team Diagnostic, page [127]

3.2.4.3 Service readiness

Assessing service readiness in line with the People and Culture Change Platform will provide a holistic perspective on the interdependent priorities that can shape culture change. Based on this assessment of readiness key actions can be identified.

ℹ See Section 6.2, Template 6.2.8: People and Culture Change Platform – Readiness Factors, **page** [130]

3.2.5 Assess and build energy for change

Energy for change is the capacity of a team, organisation or system to act and make the difference necessary to achieve its objectives. As part of your assessment of readiness consider energy levels in line with Figure 40 – this analysis will assist you to identify ways to build and align energy for change. This approach gives voice to a different type of conversation that makes discussion on elements of personal and team energy more explicit.

Figure 40: Sources of Energy – Build Energy for Change

Energy for change is defined as the capacity and drive of a team, organisation or system to act and make the difference necessary to achieve its goals.

Energy for Change Framework

Source: Land, M. et al (2013: 16) [239]; NHS – Improving Quality (2013)
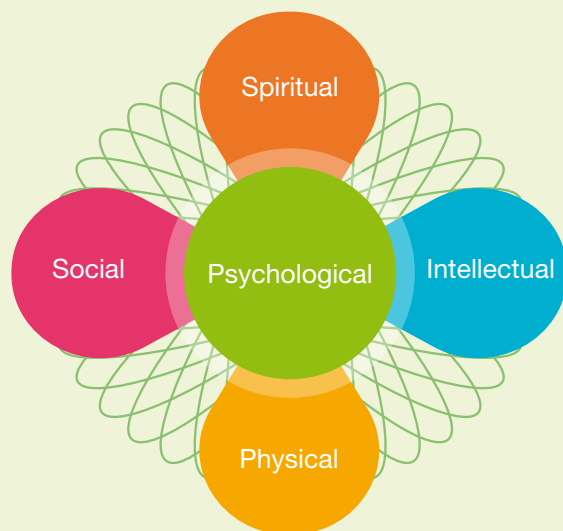
Change is most likely to happen when the following five energies are high:

▶ **Physical energy:** The energy of action, getting things done and making progress. How physically demanding will the change be?

▶ **Intellectual energy:** The energy of curiosity, analysis, thinking and cognition. How mentally demanding will the change be? Take into account the need to learn new ways of doing things, concentrate and focus attention, oversee complex processes, solve problems and deal with high levels of distraction.

▶ **Social energy:** The energy of personal engagement, relationships and connections between people. How will relationships be impacted by the change?

▶ **Spiritual energy:** The energy of commitment to a common vision for the future, driven by shared values and a higher purpose. How spiritually demanding will the change be? Take into account potential challenges to personal values and integrity, the loss of elements that are related to a personal sense of purpose or identity, and obstacles people may face in trying to do what they perceive is right or fair. Aim for greater alignment with personal values, contributing to public value and supporting personal growth.

▶ **Psychological/emotional energy:** The energy of courage, trust and feeling safe to do things differently. How emotionally demanding will the change be? Take into account different feelings people are likely to experience. Increased self-awareness and strong working relationships will all help to boost energy.

Other sources of 'energy demand' may include lack of control or involvement in planning, a sense of being treated unfairly, a history of unsuccessful change or other factors that are likely to cause the change to be particularly demanding.

Positive energy can be increased by high levels of engagement and contributing in a meaningful way to deliver positive service user/service outcomes.

Adapted from: Hoopes, L. (2017) [216]
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3.2.6 Identify levers for change

Leverage actions are small focused actions that produce ripple effects, act as catalysts and build energy for change. Examples of levers that can prompt enabling actions are included in Figure 41.

Figure 41: Levers for Change

▶ Existing good relationships, strong alliances and partnerships (internal and external) – building on interdependency between services, teams and people

▶ Service user/citizen feedback including stories and narratives about people's experiences.

▶ Exit or arrival of leaders and influencers

▶ Staff surveys, interviews, feedback and engagement processes

▶ Regulation, standards and policy direction

▶ Quality, service improvement, culture development initiatives, i.e. *Framework for Improving Quality in our Health Service* [195]; *Person-Centred Practice Framework* [258], *Values in Action* [141], etc.

▶ New or enhanced partnerships with citizens, voluntary bodies or other sectors

▶ Shared services, business process improvements, communities of expertise, centres of excellence

▶ Performance and measurement data, complaints/compliments/comments, service reviews, investigations, service accreditation, research findings, improvement notices

▶ Learning from continuing professional development

▶ Infrastructure such as ICT systems, accommodation, equipment or new technology

▶ Accelerated digital delivery and social media platforms

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3.3 Agree Better Outcomes

A core component of a change process is being clear on what outcomes you want to achieve rather than on what you have to do – outcomes describe from the perspective of the key people involved what can be reliably demonstrated or measured at the end of a change initiative. Outcomes relate to the visible results that take you towards your ultimate goal or vision for the service. Outcomes must be clear, agreed and owned by all key stakeholders and capable of being measured. Agreeing better outcomes is part of the process of describing the future vision for the service.

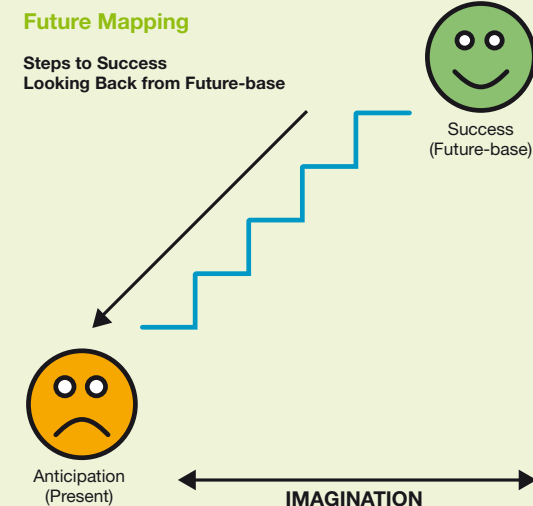### 3.3.1 Co-design the 'vision' for the future

Describing outcomes and the vision for the service provides all stakeholders with an opportunity to shape the future and engage in a co-design process. Agreeing a shared purpose and core values for the service will act as a solid foundation for this work (see 3.1/3.2.3). Accessing evidence will also prompt thinking to describe a better future. Work towards describing and articulating what the future could look like (Figure 42) with all the key people who have a stake and interest in the change.

Figure 42: Developing a Vision for the Future

An effective vision seizes a 'big' opportunity – it is bold and inspiring. The better people can envision where they are going, the more they can focus on specific initiatives that will make the vision a reality.

Developing a person-centred vision

▶ Describe the future vision of the service from the perspective of all key stakeholders – prioritising service users and frontline staff – if their needs were addressed and all the 'problems' as outlined in the 'current state' were resolved.

▶ This involves looking back from a future position of success with an understanding of what is important in terms of people's personal experiences and outcomes.

▶ Provide opportunities for service users, families, community groups, partnering services and staff to be actively involved in describing the future as they would like to experience it.

Future Mapping

Steps to Success
Looking Back from Future-base

Success
(Future-base)

Anticipation
(Present)

IMAGINATION

Source: McMurray, A. (2015: 9) [261]

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3.3.1.1 Use evidence to inform the vision

▶ Examine emerging patterns of data and evidence from multiple sources to inform the process of describing what a better future could look like. Sources of data could include patient/service user and staff narratives, literature, research, policies, standards, pilot studies, practice wisdom, case studies, etc.

▶ Translate national strategic direction into a local vision that is meaningful for service users and staff. If the local plan for the future is not aligned, is there a compelling case to proceed?

▶ Scan what is going on elsewhere in the organisation to indicate strategic initiatives and service improvement projects that are relevant for the change and to ensure alignment and fit.

▶ Seek information on service models, clinical care pathways used by recognised leading edge practitioners and other providers. [164]

▶ Explore possibilities enabled by advanced technologies to improve practices (clinical, surgical, operational, business practices, etc.)

3.3.1.2 Create a compelling narrative

▶ Use the data gathered to describe in vivid detail what the service will look like to achieve the outcomes and experiences that are valued by service users and staff.

▶ The vision provides the guide for the 'future direction of travel' for the service acknowledging that people may be starting from different places and their experiences may be different – however, a shared destination is important.

▶ Engage in creating a **compelling narrative** that will draw people into the future. Frame issues and what the future will look like in ways that engage and mobilise the imagination, energy and will of diverse individuals and groups.

▶ Agree a 'working draft statement' of the vision which can be communicated to all key stakeholders and decision-makers and towards which change activities can be directed.

▶ In crafting the vision consider the following:

▼ **Rational appeal:** why the change is important, why now, why us?

▼ **Emotionally compelling:** an authentic appeal to what really matters to people

▼ **Memorable:** clear, short and no jargon [236]

People will invest in change that they believe in and that connects with them at both a rational and emotional level. It is the process of involvement and the capacity to connect to what really matters to people that will determine how effective the vision statement is in reality.

ℹ **See Section 6.2, Template 6.2.9: Developing a Vision for the Future, page** [134]

3.3.2 Agree change outcomes and objectives

Set out the change outcomes that will deliver on your vision for the future and the ultimate goal of safer better healthcare and staff and public value. These will form the anchor for the Action Plan (developed in more detail in Design – see 4.4). Outcomes focus on what you intend to achieve, and objectives describe the actions that will be taken to bring about the desired outcomes – they are specific and focused.

Aim to create clear outcomes and objectives and use these to proof decision-making and as part of the Action Plan (see 4.4) and associated communication process (see 4.5). Consider the following criteria (Figure 43) and aim to develop outcomes and objectives that are challenging to deliver in terms of their positive intent and overall direction.

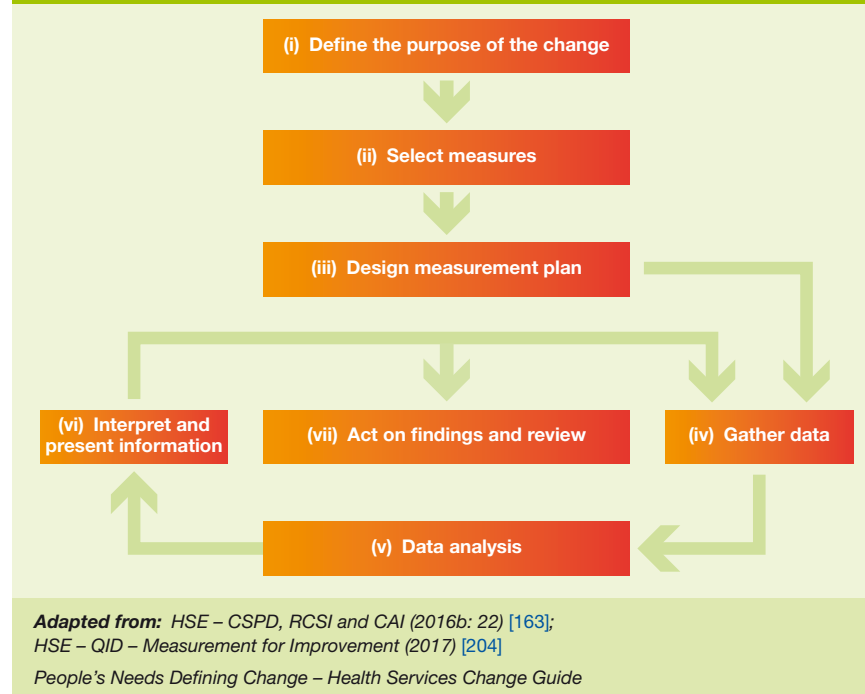#### Figure 43: Criteria to Guide Setting Objectives and Outcomes

▶ **Person-centred:** Address outcomes that service users, local communities and staff place value on.

▶ **Forward looking:** Take a long-term view, forecast possible future trends or likely changes. Show a clear direction and alignment with relevant national, organisational or service policies/strategies, legislation, regulatory frameworks or standards.

▶ **Outward focused and evidence informed:** Take into account changes in client profile, improvements in intervention or emerging evidence and experiences.

▶ **Innovative:** Willing to question established ways of doing things and encourage new and creative ideas. Provides 'stretch' and challenges those involved to envision the best service and experience for service users and staff.

▶ **Financially viable:** Delivered within budget or has a realistic opportunity to receive or generate funding. Provides 'added public value' for service users, citizens, staff and the tax payer.

▶ **Address infrastructure:** Has the required physical and ICT/therapeutic/clinical infrastructure to deliver what is required.

▶ **Focus on outcomes:** Focus on what you want to achieve rather than on what you have to do. Can the action/intervention be measured and demonstrated in line with the specified and intended outcome?

▶ **Socially responsible:** Takes into account the welfare/needs of the wider society, e.g. situations where the wider 'society benefit' outweighs the 'downside for the service'.

▶ **Add value:** Expenditure or resource allocation has the potential for improved outcomes that are measurable in terms of quality of life, i.e. recovery orientation in mental health services.

▶ **Joined-up:** Take a holistic, whole system perspective, looking beyond service or organisational boundaries and connected to service needs. Ensure appropriate activities are linked and use this connection to make the case for change and lever opportunities.

Adapted from: Drucker, P. (2012) [102]*; NEHB – OD Unit (2004: 8)* [294]

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3.4 Measure for Success

Planning for measurement at an early stage in a change process is key to demonstrating progress and the delivery of better outcomes. Measurement shapes behaviour and is a lever for change – 'what gets measured gets done'. Figure 44 presents a **Measurement for Improvement Process** and the steps involved. Think about "how much did we do?"; "how well did we do it?" and "what was the impact or result for service users?".

Figure 44: Measurement for Improvement Process

(i) Define the purpose of the change

(ii) Select measures

(iii) Design measurement plan

(vi) Interpret and present information

(vii) Act on findings and review

(iv) Gather data

(v) Data analysis

Adapted from: HSE – CSPD, RCSI and CAI (2016b: 22) [163];
HSE – QID – Measurement for Improvement (2017) [204]
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3.4.1 Design measurement plan

The Measurement for Improvement Process will assist you to design the measurement plan and provide the evidence needed to support your case for change and to monitor progress.

(i) **Define the purpose of the change:** At this stage you will have an early indication of what needs to change and conversations with key stakeholders will assist in confirming the purpose of the change and/or where improvement is required (see 3.1).

(ii) **Select measures:** Performance measures must be aligned to the desired outcomes for a service, otherwise they will not influence behaviour in the desired way. Identify measures and the most appropriate data sources to ensure that a baseline can be created of the current situation and so that the impact of change activities on intended outcomes can be measured. Measure only what matters and use existing measures where possible such as key performance indicators (KPIs) aligned to the Performance and Accountability Framework [154] and the Balanced Scorecard. Measures that gather evidence in relation to compliance with standards are essential and need to be complemented with more diverse forms of measurement that address wider service learning and user experiences. A mixed method approach will provide a more balanced and complementary perspective using qualitative and quantitative measures.

(iii) **Design measurement plan:** Choose the data collection methods for each measure. Be clear on the client group or aspect of the service that is being measured. Determine the frequency and duration of data collection. Consider what analytical tools will be used. Plan how measurement will be reported. Ensure the measurement plan is ethical.

(iv) **Gather data:** Agree how relevant data will be collected to form the baseline. Factual 'hard' data once agreed can be gathered through a number of different approaches. Gathering 'soft data' will require face-to-face interactions and conversations in small or larger groups, surveys or online feedback processes. Guidance on data gathering is outlined in Figure 45.

See Section 6.2, Template 6.2.10: Clarifying Measures, page [136]

Figure 45: Guidance on Gathering Data

▶ Determine **what data** is needed to fully understand the current situation from the perspective of all relevant stakeholders and to explore the possibilities for change.

▶ Gather both **hard and soft data** to understand the change issue, i.e. the service/business challenge that needs to be addressed. Remain alert to new data that emerges and use it to inform your thinking.

▶ Consider **types of data** to be gathered:

  ▼ Community profile, demographic data, determinants of health status, assessment of need information

  ▼ Service user information such as client profile, referral rates, types of presentations

  ▼ Consultation data based on service user feedback, patient narratives, surveys

  ▼ Profile of staff groups or core human resource information (i.e. workforce data including staff numbers, skill mix)

  ▼ Workload distribution or caseload mix

  ▼ Service throughput and performance data, key performance indicators

  ▼ Financial data

  ▼ Data from quality improvement, risk assessment processes, accreditation, case studies, inspections, site visits

▶ Determine **data sources** and gather **comparative data** from other services in addition to service user, family, staff and community based feedback. Distil data from people's experiences and narratives in order to present a balanced perspective.

▶ Give consideration to the easiest, most effective **ways to gather, process and share reliable data**. Seek support in accessing existing data to avoid duplication and 're-inventing the wheel'.

▶ Be pragmatic and **minimise the measurement burden on staff** by collecting data only on what really matters and record data accurately. Consider if there are gaps in the data being collected and decide on appropriate action.

▶ Access data in relation to **transitions between services** in order to understand patient flow – consider integrated pathways and how well they are working.

▶ Consider information in relation to the effectiveness of **business processes** as well as **clinical processes**.

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(v) **Data analysis:** Following data collection consider how this information will be analysed in order to develop an informed understanding of the current situation, to measure changes and to provide evidence to support your efforts.

▶ Use the baseline data gathered to engage stakeholders in the early analysis. Examine emerging trends, patterns and themes, variations and identify core learning. Benchmark and agree how to compare with similar services (comparative analysis).

▶ Supplement data on the current situation with evidence from good practice – this will help people understand problems, issues and underlying causes.

▶ Seek help to build capability to measure and analyse information including access to information technology and supports in quality and patient safety, human resources, finance, performance management, health and wellbeing, population health, integrated care programmes, clinical programmes, business intelligence units, programme management offices, etc.

(vi) **Interpret and present information:** Consider what supports are needed to assist you to interpret both the quantitative and qualitative data gathered. Where possible involve people with subject expertise. Look at ways of combining data to give an overall picture. Ensure service users and other relevant people and teams are involved in this part of the process. Consider how the data gathered and analysed can be presented and applied to your service to inform improvements. Share information and use visual/graphic tools to assist people to understand the data being presented and build the case for change.

(vii) **Act on findings and review:** Use the measurement results to inform the next steps of the service improvement or Action Plan. Share this information with key people and plan how to measure progress and strengthen the process of using evidence to inform decision-making.

3.5 Make Case for Change

At this point the scale and ambition of the change is scoped. Frame the data gathered to date into a **Business Case for Change** to get 'buy in' and to mobilise support. A formal Business Case may not be needed for every change initiative – however, it is good governance practice. It will act as a solid reference point for your change initiative and assist with tracking progress.

3.5.1 Agree governance and mandate

Governance arrangements are essential to setting the change agenda, establishing a sense of urgency and accountability for action and getting the 'investment' required (time, energy, funding). Ensuring a clear mandate for the change gives authority to the process, compels alignment and commitment from key stakeholders and supports the process of securing resources for the change. Guidance is provided in Figure 46.

Figure 46: Guidance on Governance and Accountability Arrangements

Agree governance and accountability arrangements that:

▶ are robust and 'lean' with **access to key decision-makers** and a connection to frontline staff, patient/service users, citizens

▶ enable staff to do their jobs effectively and reaffirm the **public accountability mandate** of all staff to continuously improve through ongoing professional development activity and to improve how they fulfil their role

▶ foster **collective leadership** – build accountability into change efforts by developing a shared purpose and objectives, and working with team members to keep each other mutually accountable

▶ ensure leaders maintain **oversight** of key processes so that an **integrated approach** is adopted and all related processes mutually reinforce the change

▶ ensure continuous **monitoring of progress**, to raise and mitigate risks, to present proposals for decision-making and an escalation route for any issues that need to be resolved

▶ build in processes to **review learning** and ensure that experiences are shared and used to improve future initiatives

▶ consider factors that will **sustain the change**, mark progress and recognise achievement. This may include attending to succession planning so that the change is not dependent on any one individual or group to maintain it over time.

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3.5.2 Establish change management team

A change management team (Figure 47) will oversee and guide the change process. It needs to be flexible and reflect the stage of development of the change process. For example, a change sponsor may emerge early on in the process and the stakeholder analysis may result in the establishment of various reference groups. In establishing a **change management team**, clarify the roles and responsibilities of all involved. Consider how the change management team is formed and agree appropriate selection criteria in line with your service values and design criteria. Pay particular attention to the best ways to involve service users, citizens and other service providers as part of the change team, as well as ensuring a representative number of staff across the service. Revisit the Terms of Reference to ensure continued relevance.

Figure 47: Change Management Team Members

Address the following when developing your change team:

Clear mandate: Action-orientated group accountable for the successful delivery of change.

Complement skills and perspectives: Ensure a diverse and complementary set of views and capabilities are represented on the team.

Enabling structure: Consider using subgroups to balance inclusivity and manageability as well as to ensure all members are fully involved. Ensure connectivity and communication between all groups.

Role	Purpose
Change sponsor	Provides the mandate and initiates change with service leaders
Steering group	Strategic accountability and guidance (guiding coalition)
Service user/staff reference and representative groups	Co-design, consultation, development and quality assurance, impact assessment, implementation, review and monitoring
Lead/project manager	Responsible for delivery and accountable to steering group. Integrates change activities and monitors progress
Change implementation team	This is the change 'engine room' where the energy and focus is on delivering the change outcomes. Ensure strong leadership, clear mandate, the right blend of skills and knowledge and the business supports to deliver on the work
Content reference group/design team	Design, clinical, technical, content advice or expertise
Communities of expertise	Communities of practice, quality and service improvement, clinical care programmes, population health, human resources, organisational development and design, change management, project management, academic/research partners or other relevant groupings of expertise

Adapted from: Hackman, R. (2002) [122]*; Hirsch, W (2017)* [215]
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3.5.3 Identify resource requirements

An outline funding proposal will address the type and extent of resources required to support the change process. This will include staff, project team, skills and infrastructural requirements, accommodation, equipment, ICT needs, data systems, administrative supports, specific expertise, coaching and supervision; when you will need supports and where they can be sourced. Take into account existing resources and the sourcing of appropriate support, guidance and expertise from within the system and externally if needed. Aim to build internal capacity as far as possible and align resources so that they are mutually supportive.

> **(Define: Programme for Health Service Improvement (2017a) – Costs and Resources).**

3.5.4 Communicate the Business Case

Consider how best to communicate the Business Case (Figure 48) and test it with leaders and stakeholders to progress discussion on mandate and to continue to mobilise support. Consider how to communicate with citizens and communities, to 'bring society with you' as a key lever for change. Utilise local and national media, public representatives and other community and communication platforms to help increase understanding of the change and to widen your support network. Consider how best to continually refresh the change 'story' to attract new, and active supporters. Remember the importance of connecting with people at an emotional as well as a rational level – the communication aligned to the Business Case proposal will need to be complemented by a more human-centred approach in order to bring people with you. The Business Case can be developed further to become the detailed Action Plan at the end of the Design Stage.

> See Section 6.3, Template 6.3.4: Action Plan, page [172]

> See Section 6.1, Template 6.1.3: Guidance to Develop Engagement and Communication Plan, page [107]

Figure 48: Business Case for Change

Provides an early outline description of the following and can be included in a Project Initiation Document:

▶ Rationale and need for the change

▶ Context including drivers for the change and leverage points

▶ Scope, scale and parameters of the change project

▶ Governance, authority and mandate

▶ Interdependencies, alignment and fit

▶ Key stakeholders, influencers and leaders

▶ Current baseline measures

▶ Vision and outcomes (initial considerations)

▶ Change objectives and indicators/measures (initial considerations)

▶ Dependencies and risks (early analysis)

▶ Estimate of time frames

▶ Resource requirements (early analysis)

▶ Overview of sustainability factors

▶ Communication and engagement plan

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> See Section 6.2, Template 6.2.11: Project Initiation Document, page [138]
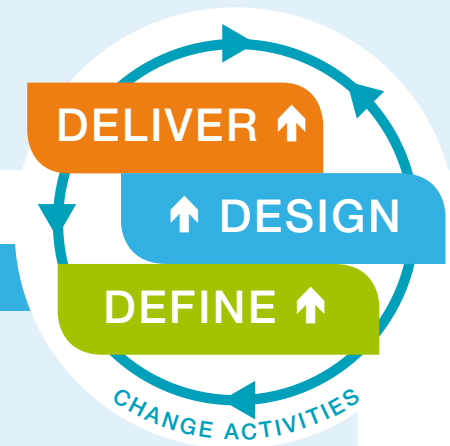
Section 4
Define **Design** Deliver

Section 4: Design

Purpose of this stage

1. Progress co-design with key stakeholders.

2. Determine the detailed design of the Service Operational Model.

3. Test and refine the model for feasibility.

4. Agree Action Plan including required resources.

5. Communicate Action Plan.

DELIVER ⬆

⬆ DESIGN

DEFINE ⬆

CHANGE ACTIVITIES

Design Activities

4.1 Agree to Co-design

    4.1.1 Agree service design principles

    4.1.2 Address enablers of co-design

4.2 Design Service Operational Model

    4.2.1 Confirm user need

    4.2.2 Design service choices and options

    4.2.3 Determine the detail of the Service Operational Model

4.3 Test and Refine

    4.3.1 Test change in practice

    4.3.2 Undertake gap analysis

    4.3.3 Assess impact and interdependency

4.4 Agree Action Plan

    4.4.1 Consolidate key change actions and measures

    4.4.2 Identify risks and dependencies

    4.4.3 Identify enabling and sustaining actions

    4.4.4 Identify impact for resources

    4.4.5 Clarify responsibility for action and timeframes

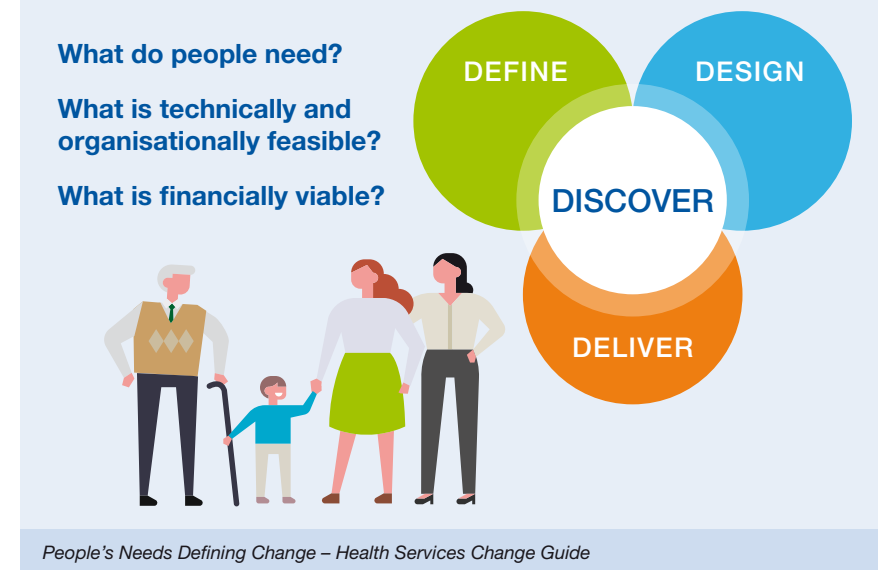**4.5 Communicate Action Plan**

4.1 Agree to Co-Design

Organisations operate in an environment of constant change – the challenge is not to design a response to a current issue, but to design a means of continually responding, adapting and innovating to meet future needs. Co-design is a more open and collective design activity where multiple stakeholders, particularly service users, families, frontline staff and people from diverse fields, are included as equal partners in the design process. The Design stage describes how the service will be organised and delivered to achieve better outcomes. It involves testing the Service Operational Model (or the aspect of the service that is being redesigned) to see how well it will work in practice (see 3.2.1 – Figure 37). Organisations need to embrace changing delivery models and organisation designs to reflect the need for networked teams and more flexible approaches to deliver integrated services.

4.1.1 Agree service design principles

Human-centred design practice is an enabling and collaborative methodology involving active citizenship and community empowerment. It starts with people's needs, redistributes power and puts people at the centre of decision-making. It signals a shift from designing from the inside out to designing from the **outside in** – bringing the needs of citizens in balance with the requirements of the organisation. **It enables service user and citizen experiences to drive organisational change working in partnership with staff.** Human-centred design begins with a **discovery** process that involves various types of activities in which we learn from our service users about what their experiences are. Developing this level of insight requires us to **empathise** with service users so that we have a deep understanding of their needs. This enables us to **define** the problem we need to solve or address. Through a **design** process we can then consider options and put in place ways to test and refine possibilities.

This process of testing enables us to come up with a preferred option for **delivery**. Part of the process of human-centred design also requires us to consider how feasible our options are from a public value perspective – whether they are technically and organisationally feasible and financially viable (Figure 49a).

Figure 49a: Human-Centred Design

What do people need?

What is technically and organisationally feasible?

What is financially viable?

DEFINE   DESIGN

DISCOVER

DELIVER

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The service design principles outlined in Figure 49b reflect our public value commitment and human-centred design practice – they act as an anchor and reference point to guide decision-making regarding design.

Figure 49b: Key Service Design Principles

Co-design new service. Build relationships. Create staff and public value.

1. Practice human-centred design

▶ *Co-design* with service users, families, citizens and staff acknowledges that people who receive and deliver services are **best positioned to provide the relevant insights**. The service user concept also applies to staff who are internal users of human resources, finance and other business support/shared services.

▶ Start from a deep understanding of the people involved – put yourself in the place of those you want to serve. **Empathy** for the service user must underpin the design and sustainability of service models.

▶ Use service user need as your **compass**. Design with the person at the centre and follow the person's journey or pathway of care/service.

2. Co-create public value through collaboration in design

▶ Value the input of service users who have a unique and highly relevant perspective – their input into designing services can be invaluable as they have an **experience** that staff cannot access. Aim to gain **service user perspectives** both 'before and after' to check improvements have worked.

▶ Engage with those **closest to local communities** to seek feedback on the way services can work and how they can be improved. Use the learning from broader citizen input to inform service design so that a more holistic population perspective can be achieved. **Citizen engagement** will also strengthen the governance arrangements required within public service organisations.

▶ Maximise the involvement of staff from the outset and ensure that the experiences and voice of **clinical and frontline staff** are involved in all service design activities.

3. Use evidence to inform design

▶ Use evidence from **multiple sources** to ensure design activity is robust.

▶ **Test concepts** so that solutions designed are visualised and simulated early and often.

▶ Ensure design is informed by the organisational **context, policy and standards, regulatory frameworks**, etc. – this will ensure that options under consideration are feasible, evidence informed, financially viable and joined-up.

4. Test for agility and feasibility

▶ Services should be **prototyped** before being developed in full – design a viable service model and then aim to improve it to add additional value based on service user feedback.

▶ Start small, test early and learn quickly from both successes and failures. **Test and validate** with stakeholders throughout the process.

Figure 49b: Key Service Design Principles [continued]

Co-design new service. Build relationships. Create staff and public value.

5. Unify and join-up design activities

▶ Take into account **whole system requirements**, interdependency and design in a connected manner rather than based on component parts. Enable maximum connectivity and alignment and attend to interface between services and transition arrangements when service users are transferring between services.

6. Design for integrated pathways of care

▶ Prioritise developments to improve **'patient flow'** and joined-up working between teams and services that improve outcomes of care as well as service efficiency.

▶ Enable cross service teams and agencies to work together to provide **flexible networks of care** that are responsive to the needs of service users, families and communities and improve experiences.

▶ Support the development of **'centres of excellence/communities of expertise'** based on evidence and economies of scale. Aim to make processes 'as lean' as possible and monitor the need to balance generalist and specialist interventions along the continuum of care for service users.

7. Form follows function

▶ Design services in line with a clear **model of care**. 'Form follows function.' The service purpose or model of care (function of the service) must be clear including service objectives and outcomes in order to define the structure (form of the service). Changes in structures must support the delivery of the service (function).

▶ Design services based on genuine comprehension of the **purpose of the service**, the demand for the service and the ability of the service provider to deliver that service.

▶ **Locate authority** at the most appropriate level. Ensure that staff who are working close to the frontline have the authority to make decisions appropriate to their service or team.

8. Utilise resources to deliver best outcomes

▶ Create **value for service users** and be as efficient as possible. Streamline processes, standardise appropriately, build on synergies and avoid duplication and waste. In addressing increased efficiencies, continue to attend to quality standards and provide more holistic and person-centred approaches that meet individual's health and wellbeing needs.

▶ Design based on an understanding that **special events** (those that cause variation in general processes) will be treated as common events (and processes designed to accommodate them).

ⓘ **(Design: Principles of Service Design Thinking, and People and Culture Change Platform: Person-Centred Practice Framework).**

Adapted from: Interaction Design Organisation (2017) [223]; Pirinen, A. (2016) [311]
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4.1.2 Address enablers of co-design

Delivering on the commitment to co-design requires a significant level of organisational and leadership support. The key enablers are set out in Figure 50.

Figure 50: Enablers of Co-Design

▶ **Collaboration – finding a common ground:** Taking account of the local context, culture and subcultures, and fostering collaboration with service users, families, citizens, communities and staff.

▶ **Creating organisation-level commitment:** Ensuring that human-centred design is core to organisational policy, embedded into work practices and actively supported in terms of time and resources.

▶ **Integrated, connected and joined-up processes:** Co-design embedded into core business processes/service needs and enabled by other processes such as human resources, finance, HBS, ICT, procurement, etc.

▶ **Implementation that adds value and meaning:** People supported to practice human-centred co-design, building on networks and supporting behaviour change.

▶ **Building co-design practice and capability:** Integrating co-design methods into existing service improvement methodologies and enabling dedicated skills development.

▶ **e-Health and technology:** Used to maximise human-centred design through sharing information, connecting activity, innovating clinical practice, increasing digital fluency and driving behaviour change.

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ℹ **(Design: Enablers of Co-Design in Organisations and Services).**

4.2 Design Service Operational Model

The stages involved in designing the Service Operational Model mirror those presented in the Change Framework – **Define, Design and Deliver**. Change is an 'iterative process' and involves cycles within cycles, therefore revisit earlier actions and build upon thinking and work completed to date.

4.2.1 Confirm user need

4.2.1.1 Revisit commission and scope

Continue to engage key stakeholders in defining and confirming the need for change, and in co-creating the design. The key tasks include:

▶ Agree and revisit the **commission** for service design with key service managers and stakeholders.

▶ Address **resource issues** so that the planning process can be based on a realistic estimate of what is feasible and realistic.

▶ Clarify the **scope of the service design**, i.e. client group, pathway of care for chronic disease, access to children's services, redesign of a service such as diagnostic services, establishment of a primary care team, clinical care pathway for older persons, human resources or finance process, shared services process, etc.

4.2.1.2 Understand the current design

Complete work on mapping the current services (see 3.2.1) – existing pathways, processes, etc. Identify best practice, assess needs of service users and service providers, and identify unmet needs to assist you to understand the current design and service user need.

4.2.1.3 Problem redefinition

Revisit your earlier definition and analysis of the 'need for change' or for service design (see 3.1) and re-define if necessary. This will involve increased engagement with the people who will be impacted by the change. Seek to affirm with colleagues what the problem is you are trying to resolve and why – at this point you can develop a more informed understanding. The most helpful approaches to problem redefinition include:

▶ **Increase your focus** on understanding the service user experience related to the problem you are trying to solve. Develop a deeper understanding of the different stakeholders involved in delivering and receiving your services to help bring further clarity to the issue.

▶ **Gather additional insights** by being present where services are delivered. Observe actions and interactions keeping your purpose in mind. Visit locations where services are delivered. Understand and empathise with unmet needs.

▶ Look for and **capture patterns and repetitions**. What is missing? Aim to define the real problem. Based on insights gathered, explore different ways of viewing the problem. Can you look at it from different perspectives? This exercise may lead you to 'reframe' the problem you initially addressed.

▶ **Agree a service design brief.** Create a design brief that defines your challenge area, sets the course and frames the opportunities available. Describe the brief from a user point of view – 'how might we design this service to deliver better outcomes and experiences for our service users?'

4.2.2 Design service choices and options

Place the vision, change outcomes and associated change objectives (see 3.3.1, 3.3.2) at the centre of designing the 'new' or 'improved' Service Operational Model for your service. In some instances you may be re-designing an element of your service – maintain a focus on how these changes will impact on other parts of your service and other services that you interact with.

4.2.2.1 Design services based on Model of Care/Delivery Model

Align the Service Operational Model to an agreed Model of Care/Delivery Model (see 3.2.1 – Figure 37) which describes the philosophy, best practice and the services or responses within a system for a population, client group or service users as they progress through the different stages of need. The model shapes how the service is organised and delivered and how people take up their roles. Models of Care include medical, social care or psychosocial models, etc. Business models include the human resources delivery model, models for finance, shared services, other business practices, etc.

Design the service around personal experiences and narratives, deliberations and information flows, and episodes of care and not around specific roles or jobs. This translates in practice as the **pathway of care or service** which reflects the patient/service user journey and delivers on the ambition of person-centred care (Figure 51). This approach aims to ensure that people get the right care or service, at the right time, by the right team and in the right place. It supports improved patient/service user experiences, improved clinician/staff experiences, better outcomes and more efficient use of resources. This approach is in line with the Key Service Design Principles (Figure 49b) and the establishment of Integrated Care Pathways.

ℹ **(Design: 10 Step Integrated Care Framework – National Clinical and Integrated Care Programme).**

Figure 51: Person-Centred Services

Defined from a service user perspective: Person-centred coordinated care provides me with access to and continuity in the services I need when and where I need them. It is underpinned by a complete assessment of my life and my world combined with the information and support I need. It respects my choices, builds care around me and those involved in my care.

Source: HSE – CSPD (2017a)

Defined from a staff perspective: Person-centred coordinated services means I have access to a range of human resource supports when I need them – from the time I apply for a job, through induction to my new role and team, ongoing support, supervision and personal development planning, feedback on how well I am doing at work, support when I feel stressed and opportunities to develop to my full potential. I also want to feel my contribution matters and that I can make a difference.

Source: Staff member (2018)
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4.2.2.2 Generate options for service design

Aim to generate creative and solution-focused options when designing the Service Operational Model. Explore novel ways in which you can 'imagine a better future', i.e. scoping out different scenarios and creating solutions to meet service user needs (Figure 52). The temptation may be to manage expectations and set boundaries – however, the option-generation phase needs to encourage 'out of the box' thinking and thinking from the 'edge'.

▶ Map out all the key elements that will form part of the 'pathway of care' (or service) against which the new service solution will be designed.

▶ What are the **essential requirements** for your service design?

▶ Consider appropriate **benchmarks** in other services. Use **comparative data** in addition to evidence of good practice and standards to assist you with this process.

Enable a **collaborative and interactive approach**. Consider individual as well as group based methodologies for engagement as some people may have a preference. Actively seek out those who have been identified as having a contribution to make and who may not have engaged in the process to date. Pay particular attention to the people who interact most closely with service users as they will have the greatest insights. Continue to revisit stakeholder analysis to ensure people are informed and involved in supporting progress.

Figure 52: Service Design – Imagine Possible Scenarios

Open up the solution space to increase the likelihood that your service will be better and more innovative. Create new concepts and seek novel solutions. Explore possibilities and refine ideas. Use methodologies such as Lean Six-Sigma to support process improvements.

Work with key stakeholders including service users and staff to explore the following:

Patient/service flow

▶ Try to imagine what the different stages of the service user interaction with services will look like – pathways of care at different stages of need, different 'touch points', times when key deliberations/decisions occur and different stages across the life span.

▶ Explore experiences for different presentations or different 'personas' – this will help to create a number of critical scenarios.

▶ Map how service users/patients navigate the system, who should be involved in their care and what services need to work together to ensure improved service user/patient flow?

▶ Create support systems (diagnostic, pharmacy, clinical and therapeutic services, home support services, etc.) and imagine how a seamless transfer or transition would be achieved.

Information flow

▶ Consider how information needs to flow in the service.

▶ How could technology or digital solutions help information flow?

▶ What structures and supports are necessary so that the right information is available at the right time and to the right people?

▶ Who needs to be involved in these deliberations and information flows and what are their roles and responsibilities in relation to the decision-making process? How do roles need to be structured?

Processes and technology

▶ Monitor changes in technology and how these changes impact on how people work.

▶ What new processes are needed?

▶ What are the infrastructural changes?

▶ How can efficiencies be increased without compromising service quality and duplication or waste be reduced?

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See Section 6.3, Template 6.3.1: Service Design – Option Generation and Appraisal, page [146]

4.2.2.3 Option appraisal of the service design

Having generated options consider how to appraise the options in order to **refine your ideas** and present possibilities for action, i.e. **preferred option**. Consider 'third party endorsement' such as review by service users, referral sources, recognised independent individuals or teams. Appraisal will require 'criteria' against which the options can be assessed. Criteria will include:

▶ Compatibility with **design principles** for the service improvement/change (Figure 49b)

▶ Delivery of **change objectives** and **outcomes**

▶ **Ease of implementation** of the options (people impact, process and system impact, budget impact, time to implement, cost to implement)

🛈 **Assess the options against agreed criteria. Criteria are presented in Section 6.3, Template 6.3.1: Service Design – Option Generation and Appraisal, page** [146].

Keep engagement processes active during this phase. Balance the need for solutions with the flexibility to adapt to local needs to increase ownership. At the end of this process of appraisal put forward your preferred option.

4.2.2.4 Agree the preferred option

Agree a process to **'sign off'** on the **preferred service design option** – consider if some changes can be implemented and other changes tested or trialled to see how well they work in practice. In 'signing off' on option(s), leaders may need to be supported to take measured and appropriate risks and to accept variation in design to meet local needs.

4.2.3 Determine the detail of the Service Operational Model

Once you have agreed on the preferred option, work out the detail of the design under key service and process headings (see 3.2.1 – Figure 37: Service Operational Model), i.e. what needs to be in place to ensure delivery of the service (e.g. processes, organisational arrangements, workforce plan, systems resources that will make it work in practice). Continue to support cross functional team collaboration and stakeholder input on the service design – integrated service planning requires all the relevant services to work together on the design.

🛈 **See Section 6.3, Template 6.3.2: Detailed Design of the Service Operational Model, page** [151].

4.3 Test and Refine

Consider tangible ways to examine feasibility and viability of the preferred option. This may require **prototyping/testing** – putting a new organisational arrangement in place even though it is not perfect and then learning from that experience and continually making adjustments. Given the nature of health and social care change, it is important to recognise the need for emergent planning and design based on monitoring progress and adapting as you go.

4.3.1 Test change in practice

Plan-Do-Study-Act (PDSA) [182] is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the method adapted for action-orientated learning. This approach empowers staff to run small scale test cycles, to share their ideas regularly, to determine if the change is a better way of doing things and to see first hand if additional improvements could be recommended.

It may be appropriate to **trial an option** or a component of a service design so that it can be tested to see how well it works in practice. A time-limited trial period can be agreed. Determine what you want to test and how. Select the test method that most closely matches the test setting or context while maximising the possibility to test the desired outcomes.

▶ **Create a prototype for testing:** Work with stakeholders to agree the prototype. The process of working on tangible elements of the future solution can make it more real for people. Prototyping is not the finished 'product' but has enough detail to allow you to test it and receive feedback from service users on how well it works in practice.

▶ **The outcomes of the testing phase** can indicate patterns, comparisons and findings to support implementation. This phase also provides service users and staff with an opportunity to test out new ways of working, knowing that their experiences can shape future plans for implementation. Learning from previous attempts to implement change is also valid and should inform the thinking.

▶ **Gather the learning from the testing phase and refine the design:** Elements of the design may need to be changed or streamlined. Pay particular attention to elements of the design that impact on other teams or services. Review the design based on the principles agreed, as these will keep the process focused.

▶ **Disseminate new concepts and processes:** Review the 'test cycle' and respond to feedback. Gather the learning from testing with service users, staff and providers. See what works and what doesn't before rolling out or scaling-up. Go for depth rather than breadth – aim to gain deep insights by observing a small number of service users/providers.

4.3.2 Undertake gap analysis

Gap analysis involves an assessment of the impact of the future design in order to identify key actions needed to bring about the change.

▶ Compare the future/preferred Service Operational Model with the current situation to determine what needs to change, be discontinued, developed or initiated.

▶ Identify the gaps between where you are and where you want to be.

▶ Determine how the gap could be filled, i.e. what actions need to be taken to transition to the future service vision. This analysis highlights the detail and the scale of the change. These actions will form the basis of the Action Plan.

ℹ️ **See Section 6.3, Template 6.3.3: Service Design – Gap and Impact Analysis, page** [161]

4.3.3 Assess impact and interdependency

The potential impact of changes requires particular consideration and adds a further layer of analysis to the gap analysis – sometimes impact can be expected or unexpected and both need to be monitored. Types of impact include:

People Impact: Consider the **personal impact** of the proposed changes on service users, families, individual staff and teams. This insight will allow you to clarify the people and cultural factors that need to be addressed and to engage in dedicated discussion with staff, managers, staff representative bodies and Trade Unions to agree the critical actions and timeframes. It is important to assess the impact on staff in terms of working arrangements and Terms and Conditions and engage appropriately and at the required levels in the system. Refer to the *Information and Consultation Agreement* between the health services and Trade Unions to inform engagement practices. [206]

Policy impact: Changes at strategic and policy levels, changes in how services are designed, increased service user and community engagement, changes in models of care or delivery based on standards, regulation, etc.

Systems impact: Changes in how services are coordinated, development of new services, partnership arrangements, development of pathways of care, etc. Pay particular attention to impact in terms of interdependency and interface with other teams, services, community and voluntary sector. **Co-design for services** is intended to enable **integration** – working across organisational, service, sectoral, network and team boundaries and a focus on diverse bases of expertise. It involves understanding existing and future **relationships**, particularly at the interface where service encounters take place between users/communities and the service. This level of impact requires particular consideration.

Resource impact: Funding arrangements, investment requirements, workforce planning including skills mix, increase in levels of activity and capacity, infrastructural needs including accommodation and equipment, technological requirements, administrative supports, cost benefit analysis, cost effectiveness, etc.

> **ⓘ** See Section 6.3, Template 6.3.3: Service Design – Gap and Impact Analysis, page [161]

4.4 Agree Action Plan

The gap analysis and impact assessment will help bring clarity to key actions to deliver the change.

4.4.1 Consolidate key change actions and measures

Consolidate the main actions to get from the 'current situation' to the agreed 'future vision' using the data gathered to date and outline these in the **Action Plan**. The actions will have to be **sequenced** and **prioritised** particularly the 'spread or unlocking actions' that can lever other changes. Consider 'all at once', phasing in a stepped approach, or incremental change keeping in mind the ongoing requirements of the service – balancing day-to-day running of the service with change. The scale of the gap between the current situation and the future vision may prompt reconsideration of critical aspects of the design and associated resourcing. Identify **key performance indicators** (see 3.4: Measure for Success) that will measure agreed outcomes – a small select number of metrics is more realistic than being over ambitious.

> **ⓘ** See Section 6.3, Template 6.3.4: Action Plan, page [172]

4.4.2 Identify risks and dependencies

Prior to completing the Action Plan consider the **risks** to the delivery of the plan or key **dependencies** and how these can be addressed. The Action Plan may need to be adjusted and/or additional supports secured to address identified risks. The risk assessment process includes the steps set out in Figure 53.

Figure 53: Identify and Manage Risks and Dependencies

Risk management *is the process of identifying possible risks, assessing their potential consequences, and then developing and implementing plans for minimising any negative effects.*

Dependencies *are events or work that are either dependent on the outcome of the change initiative or that the initiative will depend on now or in the future. Dependencies may be internal or external to your service.*

Steps involved:

▶ **Identify risks and dependencies.** Determine which aspects of your Action Plan or environment may change and/or pose a potential risk to the delivery of the Action Plan (e.g. staffing levels, skill mix, staff released to participate in change initiatives, learning and development, leadership, resources, change management capacity, design skills, ICT, infrastructure). Consider what dependencies need to be addressed to enable the change to be delivered.

▶ **Analyse and evaluate the potential effects of those risks on your Action Plan.** Consider what can happen if those aspects don't work out the way you envision.

▶ **Develop plans to mitigate the effects of the risk.** Decide how you can protect your service from the consequences of risks and put in place contingency plans if needed.

▶ **Inform key stakeholders of all risks and dependencies involved with your change plan.** Explain the status and potential effect of all change risks and identify clearly all dependencies.

▶ **Monitor the status and track progress of your Action Plan's risks and dependencies.** Determine whether existing risks are still present, whether the likelihood of these risks is increasing or decreasing, and whether new risks are arising. Determine how well dependencies are being addressed.

Adapted from: HSE – PHSI (2017a: 103-108) [188]

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4.4.3 Identify enabling and sustaining actions

Enablers are elements that support the achievement of change objectives and assist in delivering outcomes. **Sustaining actions** help the change to be continued over the longer term.

Some of the change actions will require discussion with the commissioners of the change/senior leaders in order to secure their support for key **enabling and sustaining actions**, and to accelerate delivery of the change. Record the enabling actions in the Action Plan, taking into account that significant change initiatives will require the following:

▶ **Human resources:** Securing sufficient human resource capacity and support is critical to the success of change initiatives – including workforce planning, skills mix, role re-definition, succession planning, changes to work schedules, work distribution, work practices. These changes may require employee relations support, access to employee assistance, learning and development supports, leadership development, coaching, active Trade Union engagement, partnering with staff associations.

▶ **ICT investment:** e-Health developments, digital technologies, clinical and diagnostic, surgical and therapeutic technologies.

▶ Negotiating changes in **service arrangements** with other agencies or services to facilitate improvements, i.e. changes in service level agreements such as client groups, referral criteria, service thresholds, quality assurance processes, and shared care arrangements between services, agencies or teams.

▶ **Organisation development, change management, project management** support and assistance at local level, assistance from staff with expertise in the use of **quality improvement and measurement methodologies and tools**, and other technical assistance such as demographic analysis, research, learning and development supports, etc.

▶ Possible transfer of a service to a new service provider. This process will require a **due diligence** exercise – informed assessment/information sharing carried out prior to changes in a service in order to inform decision-making, assure governance and guide implementation.

▶ **Possible decommissioning** of an existing service (or aspect of a service) – taking a planned process to stop, remove, reduce or replace a service.

ⓘ **(Design: Due Diligence).**

ⓘ **(Design: General Principles and Checklist for Decommissioning).**

4.4.4 Identify impact for resources

An outline of resource requirements for the change was presented in . A more detailed analysis is now possible for inclusion in the Action Plan. Identify budget impact and the requirement for additional or redirected resources. Change initiatives will require cost analysis, including once-off (capital investment, ICT and other equipment) and ongoing costs (pay and non-pay including salaries, training and development, etc.). This brings a sense of reality to the plans – prompting discussion on current use of resources, increased cost consciousness of all involved, examination of areas of duplication or waste and discussion on possible efficiencies. Consider also how 'social resources' in the system can be levered through active engagement with key stakeholders, building relationships, personal investment and commitment to the change.

4.4.5 Clarify responsibility for action and timeframes

The process of agreeing who takes responsibility for action in the **Action Plan** is an important part of good change governance. Be specific and reach agreement on roles and responsibilities. Direct 'hands-on' involvement of the support business services such as human resources, finance, estates, quality and risk, and ICT is paramount to the successful delivery and sustainability of change. Leadership roles are critical at this stage – continue to attend collectively to the priorities identified in the People and Culture Change Platform.

Complete and review the timeframe for actions to be delivered. Monitor achievement of timeframes as implementation unfolds. Acknowledge milestones and work with the team to agree ways to keep the plan on track. Service user involvement in this element of the Action Plan can assist to maintain momentum.

4.5 Communicate Action Plan

The **Action Plan** will need to be signed off by the change sponsor, relevant managers in the system, Trade Unions and other key stakeholders. The Action Plan becomes the key reference point for monitoring and tracking the actions agreed. It is a live, dynamic plan – remain open to emerging issues as implementation progresses and attend to challenges and opportunities that arise. Revisit the Action Plan at appropriate intervals so that action can be taken to prevent drift. Allow for re-negotiation, adaptation and re-mandating if required.

▶ Agree how best to communicate the Action Plan to relevant stakeholders using multiple approaches and as part of an ongoing process (not a once-off event).

▶ Provide opportunities for team members and service users to be involved – think creatively and visually about how the change can be communicated. Use personal stories and narratives as a means of making the change real and connecting with people on a more personal level.

▶ Agree how feedback on the Action Plan will be managed. Acknowledge feedback and act on the data that emerges and reprioritise or adjust actions if needed.

▶ Consider external communication requirements, i.e. media, local politicians and advocacy groups. Keep all relevant parties briefed on progress and challenges as they emerge and work with them to sustain the change process.

(See Section 6.1, Template 6.1.3: Guidance to Develop Engagement and Communication Plan, page [107])
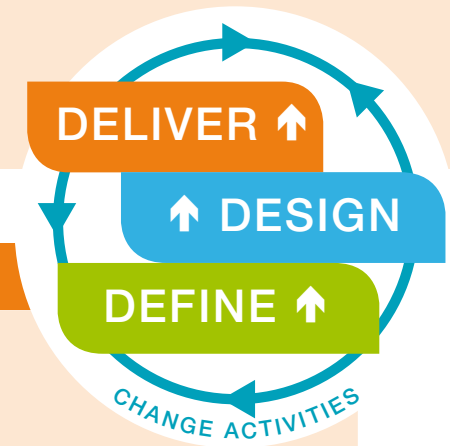
Section 5

Define Design **Deliver**

Section 5: Deliver

Purpose of this stage

1   Implement actions and go live with the change.

2   Support all involved with implementation.

3   Measure progress in line with agreed outcomes.

4   Celebrate success.

5   Sustain improvements and share learning.

DELIVER ↑

↑ DESIGN

DEFINE ↑

CHANGE ACTIVITIES

Delivery Activities

5.1   Implement Actions

    5.1.1   Energise collective leadership and governance

    5.1.2   Scale-up engagement and communication

5.2   Support Implementation

    5.2.1   Intensify individual and team supports

    5.2.2   Support inter-team/service and inter-agency working

    5.2.3   Sustain engagement with service users, citizens and other key partners

5.3   Measure Progress

    5.3.1   Adapt to emerging needs and take corrective action

5.4   Celebrate Success

    5.4.1   Acknowledge increased change capacity

    5.4.2   Mark key milestones

5.5   Sustain Improvement

    5.5.1   Evaluate and share learning

    5.5.2   Scale-up innovations

5.1 Implement Actions

Implementation is an intensive and interactive stage. It is the culmination of all the work to date – it tests the effectiveness of the design and the capacity to deliver. People need to be supported to transition to new ways of delivering services. Leaders and change practice staff need to work with all involved to support the personal behaviour change effort. Performance is monitored to ensure that the change activities are achieving the intended outcomes and corrective action is taken if necessary.

Implementing the Action Plan requires a twin track approach: managers must continue to deliver services in the 'here and now' while at the same time embed new ways of working. A critical mass of people is needed to support implementation and share responsibility for delivery of the change outcomes. It takes time and an ongoing supportive environment for all involved. Credibility at the implementation phase is critical, i.e. achieving better outcomes that add value and meaning for people. The **People and Cultural Change Platform** outlined in the **Change Framework** enables sustainability and requires continuous monitoring and focus throughout.

> ℹ **See Section 6.4, Template 6.4.1: Factors to Monitor During Implementation, page** [175]

5.1.1 Energise collective leadership and governance

Ensure leaders and decision-makers are available to provide oversight and support and to champion the change (Figure 54). Continue to prioritise clinical and social care leadership and frontline practitioner involvement – their leadership and influence is central to the success of change initiatives. Support and connect with all frontline managers and delivery staff who are managing busy caseloads/workloads and delivering service improvements. Continue to seek their advice and involvement as implementation progresses.

Figure 54: Leadership Actions to Deliver and Sustain Change

Sustainability is:

▶ the continuous process of keeping service users, families and staff informed and engaged

▶ providing innovative ways for them to become proficient in new tasks quickly

▶ measuring changes in critical outcomes

▶ striving to sustain that level of performance long-term

Actions to sustain change are closely aligned to the People and Culture Change Platform in the Change Framework.

Practice collective leadership: Model shared values

▶ Monitor **governance arrangements** and ensure a dynamic connection with frontline managers, staff, service users and citizens. Keep decision-making processes transparent.

▶ Be visible, engage with staff and service users, actively **model the changes** required and be available to support staff in addressing issues as they arise.

▶ Ensure the principles of **human-centred design** remain core to organisational policy, embedded into work practices and actively supported in terms of time and resources.

▶ Revisit the **agreed vision and alignment** with core values in order to continue to motivate and sustain staff – is the change still **compelling** and are **leaders living the values**? Are staff confident to challenge behaviour that is contrary to agreed values?

▶ Revisit **core messages** to ensure that the intended outcome for the change has been widely communicated, reinforce that the change fits with the organisation's strategic aims for improvement, and through collective leadership demonstrate a 'can do' attitude to deliver the changes.

▶ Continue to be alert to **subcultural issues** as they arise and continue to reinforce actions that progress cross service, inter-team working.

▶ Revisit **resource requirements** in line with the pace and scale of the change.

Be accountable for performance and outcomes

▶ Ensure **organisation-level supports** are in place, i.e. human resources, quality improvement, finance, organisation development, change management, project management.

▶ **Prioritise facilities, appropriate accommodation and equipment** required to sustain new ways of working.

▶ **Assist staff to adapt improved processes.** Integrate and embed changes into key business processes such as business/service planning, decision-making processes and performance processes (KPIs) at individual, team and service level. Revise and update policies and procedures. [196]

Figure 54: Leadership Actions to Deliver and Sustain Change [continued]

Engage and communicate: Invest in people and teams

▶ Continue to **engage** and **collaborate** with staff, service users and key stakeholders prioritising those involved in direct service delivery. Sustain the focus on two-way communication, conversations and listening to personal narratives.

▶ Continue to work with staff and their **Trade Unions** to monitor impact and to work together to progress implementation in line with the *Information and Consultation Agreement between the health services and Trade Unions*. [206]

▶ Maintain the emphasis on **building capacity and continuous improvement** in line with changing needs of service users, local communities and staff. Ensure effective supports are in place for people and teams impacted by and leading the change (i.e. coaching and mentoring).

▶ Integrate **co-design methods** into existing service improvement methodologies and enable dedicated skills development.

▶ Progress strategies to **release additional capacity** – this may include stopping specific pieces of work, putting work on hold, slowing down other change initiatives, reallocating people's time, accessing additional staff with the right skills, outsourcing work if appropriate and levering technology to support innovative practices.

▶ Clarify processes for **'trouble shooting'** issues as early as possible and act on feedback as it arises.

Network and partner

▶ Continue to focus on strengthening **relationships** and building **commitment** in the wider system with key services providers, referral sources, other statutory bodies, local communities, public representatives and media.

▶ Put in place ways to proactively address **integration** and **cross service** issues at the appropriate level to support implementation.

Use evidence and lever technology

▶ Clearly articulate **outcomes and benefits**. Are they still credible for service users, families, staff and local communities? Is there feedback on improved performance through the use of evidence and 'before and after' measures?

▶ Ensure that **measurement and tracking of progress** is active and clearly communicated. Take corrective action if needed and be clear on what success looks like.

▶ **Acknowledge progress** and milestones – visit services locally and reinforce change practices and behaviour.

▶ Dedicate support to enabling staff to use e-health, digital transformation or other **technology based innovations**. Discontinue old ways of operating – decommission if required.

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5.1.2 Scale-up engagement and communication

Monitor the effectiveness of **engagement and communication plans** (Figure 55). As implementation progresses people will be more tuned into the information that is important to themselves, their role and their service. Service users and staff need to be offered opportunities to express their ideas and concerns and share in the process of finding solutions to implementation challenges. Service users are experiencing change and staff will be dealing with their reactions. Be available to assist service users and staff, acknowledging that change takes time and a significant level of personal investment.

Figure 55: Scale-up Engagement and Communication

▶ Actively **scale-up communications and engagement** to help service users and staff deal with changes. Revisit the stakeholder mapping and analysis. As the change progresses it is likely that the focus will shift and you will need to target a different group of service users, staff, key stakeholders. What information do they need? When do they need it? How do they continue to engage with the change plans?

▶ Revisit **service user and staff consultation** and increase communication to keep people up to date, involved in monitoring impact and supporting progress.

▶ In line with the *Information and Consultation Agreement* between the health services and Trade Unions continue to provide opportunities for staff and their representatives to contribute ideas, views and solutions adding value, improving the quality of decision making and outcomes. [206]

▶ Monitor **communication style** and communication processes to increase spread and to deepen understanding and trust.

▶ Ensure that the **methods of communication** used are reaching all those who need to be engaged in different ways. Top down approaches alone will not work and need to be supplemented with other ways of communicating. Focus in particular on feedback loops so that feedback can be acted upon.

▶ Strengthen the **power of connectivity and social networking** as a way of supporting change. Use social platforms to share experiences, stories and narratives and to build connections. Continue to have two-way conversations and prioritise face-to-face contact.

▶ Check **access to information** and **clarity on key actions and commencement dates**. Ensure feedback processes are working and attend to new information that emerges. Consider how this new information is being handled.

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5.2 Support Implementation

During implementation people will be realising the full impact of the change – this will involve letting go of 'old ways' and practices, taking on new roles, changes in work practices, etc. The sense of stability in 'knowing what to do' will be less certain as individuals and teams adopt new practices. Their level of commitment to the change and tolerance for ambiguity will be tested. Revisit the shared purpose and keep conversations ongoing. Because this part of the process can be unpredictable, be prepared to give additional support.

(See 1.2.4: Understand personal experiences and 1.2.5: Support behaviour change)

5.2.1 Intensify individual and team supports

Be particularly alert to the personal impact of change and listen to people's experiences – uncertainty associated with change can increase levels of anxiety and worry for staff. Leaders have to understand these reactions and support people appropriately (Figure 56).

ℹ️ **See Section 6.4, Template 6.4.2: Personal Checklist for Change, page [181]**

ℹ️ **See Section 6.4, Template 6.4.3: Working with Emotional Reactions to Change, page [182]**

ℹ️ **See Section 6.4, Template 6.4.4: People Indicators to Support Behaviour Change, page [186]**

ℹ️ **Understand Personal Experiences: Finding the Reason Behind the Resistance – Framing Questions**

Figure 56: Intensify Individual and Team Supports

▶ **Be present and demonstrate active leadership** in order to embed and reinforce new practices and behaviours into day-to-day activities. Scan to ensure that the old ways of working are phased out sensitively and support the new behaviours required to operate in the changed environment.

▶ Ensure **personal supports** are in place for staff who are finding the transition challenging. Encourage staff to **express their ideas** regularly and take on board their feedback. Work closely with staff and their Trade Unions to monitor the impact of the changes.

▶ Ensure easy access to **coaching, employee assistance/staff health and wellbeing programmes** and other developments that can assist people at this time (see page 210).

▶ Continue to involve staff in **identifying any skills** gaps and to access training and development so that they are confident and competent in the new ways of working.

▶ Ensure that learning and development plans are **targeted at identified needs. Scale-up education, training and development efforts** to target key knowledge and skills needed to deliver and sustain the change effort.

▶ Support staff in **implementing new skills and behaviours** required for the change and offer 'hands-on' support on site for challenges that may arise including supervision, personal development planning and coaching. **Customise supports** to the local context and to the needs of individuals and teams.

▶ Empower staff to run **small scale test cycles** (Plan-Do-Study-Act or PDSA) [182] based on their ideas to see if additional improvements could be recommended.

▶ Monitor data emerging from **staff meetings, staff surveys, key performance indicators** and other sources of evidence to monitor requirements for personal and team supports.

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5.2.2 Prioritise inter-team/service and inter-agency working

Working-relationship issues within teams or between teams may emerge during the implementation stage. Support will be needed to address factors such as changes in roles and responsibilities, reporting relationships, changes in service boundaries, work practices, changes in working conditions that impact directly on teams, and inter-team working. Early engagement during the change process should assist in highlighting these issues. However, some issues may not emerge until implementation is advanced. Finding solutions through joint problem-solving and respectful involvement of all team members will assist. Seek the assistance of HR staff to provide support and guidance. Work with Trade Unions to monitor impact and seek solutions to issues that emerge. Interface with other organisations and services in particular will require ongoing leadership attention to address cross service issues, strengthen relationships and sustain progress. Differences in work processes and practices between agencies, e.g. where increased partnership working is being progressed, will require dedicated focus.

5.2.3 Sustain engagement with service users, citizens and other key partners

The initial motivation and energy to involve service users, families, citizens and other key partners needs to be sustained – learning from their experiences in implementation is important. Revisit how engagement processes are delivering and be prepared to reinvest energy in these relationships, connections and networks. Build on the energy of positive feedback and address issues that emerge.

5.3 Measure Progress

Measuring and tracking progress to ensure the intended outcomes are being delivered is essential, in addition to providing feedback to all relevant stakeholders. Review measurement metrics to see if they are being consistently achieved or missed, and seek patterns of performance that can inform ongoing delivery of the change. Seek 'real-time' data so that improvements in performance can be addressed in a timely manner. Monitor risks that have been identified and put in place controls to manage risks or to escalate them to the appropriate level of management. Attend to the measures and outcomes as detailed in Figure 57.

Figure 57: Measure Progress to Support Sustainability

Understand and improve measures

▶ Assist people to **understand the measures** and to know what to look for to signal progress.

▶ Monitor the **effectiveness of measures**. Consider if additional or different monitoring systems are needed to identify and measure improvements, i.e. feedback systems to reinforce benefits and progress.

▶ Continue to **monitor progress** beyond the formal life of the change initiative. Integrate into existing performance measurement systems.

Credibility of the outcomes

▶ Challenge the **outcomes from a service user perspective** – are service users offered opportunities to provide feedback? Gather and listen to stories/narratives that demonstrate progress (or lack of) towards the new culture and a better future – follow up as required. What patterns and trends are emerging?

▶ How **credible are the benefits/outcomes**? Are the benefits to service users, staff and the service visible? Are they immediately obvious, supported by evidence and believed by stakeholders?

▶ What is the **added value of the change**? Are there benefits beyond improvements for service users? Examples may include creating efficiency, reducing waste and making people's jobs more satisfying/meaningful. Broader societal and public value benefits also need to be considered.

Communicate outcomes

▶ How well have you **communicated the outcomes** of the change? Are staff able to fully describe a wide range of intended benefits for this initiative? If not, what action is needed?

▶ Is there a need to **intensify communication** within the service and to service users and communities and to provide feedback on progress? What systems are in place to do this in a timely manner?

▶ Take opportunities to **celebrate** and **recognise** milestones and best practices, and to affirm new behaviours and success.

Adapted from: NHS - Improving Quality (2014). [279]
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5.3.1 Adapt to emerging needs and take corrective action

Leaders need to balance the predictable aspects of managing the change process, meeting targets and keeping it on track with the ability to deal with emerging challenges. They also need to adapt to local needs while maintaining the overall integrity of the Action Plan. Leaders should allow the implementation to evolve naturally as far as is reasonable, learning from what occurs and influencing appropriately. They will also need to be receptive to any new regulatory and environmental changes in the wider system and adapt accordingly.

Based on the monitoring data and observations, it should be possible to determine if corrective action is needed to deliver the change outcomes. Make sure to look for things that are on track as well as things that require adjustment (Figure 58).

Figure 58: Adapt to Emerging Issues and Take Action

▶ Attend to **governance arrangements** as the change progresses – monitor the effectiveness of decision-making processes and associated follow-up.

▶ Consider if issues or concerns in **sustaining** the ongoing day-to-day business and the change effort are emerging.

▶ Seek **additional resources** at the earliest opportunity if needed in terms of manpower, education/training, ICT and accommodation.

▶ Revisit **inter-agency or inter-team working arrangements** at regular intervals to address issues as they emerge.

▶ Consider if further **service redesign** is required. In such cases re-engage with the commissioners of the change as redesign may impact on individuals, teams and services.

▶ Revisit **due diligence** plans to see if actions have been attended to. Address governance issues that emerge when services are transferring to new 'owners' and put in place transition arrangements as required.

▶ Attend in particular to ongoing challenges in the provision of **administrative or other support services** – new service developments will place additional demands on the system and improvements in support services will need to be addressed as a priority.

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5.4 Celebrate Success

Signs of success are important motivators in the change process. They show people that change is possible, and build confidence in their ability to make further progress. Take stock of progress and celebrate success – you may never actually reach the 'end' of the journey, as new changes and demands will be emerging. Generating and celebrating success or 'wins' along the way is important to sustain people's interest and energy for the change. Consider how best to recognise team members, clinicians and managers in order to sustain the motivation to continue to improve. Remember to explicitly acknowledge people for the personal effort and investment that change takes.

5.4.1 Acknowledge increased change capacity

Reflect on your **definition of success** and in addition to the accomplishment of the change objectives and outcomes include the following:

▶ **Individual development** – evidence of learning, growth and improved capacity to change and connect with others around change. Evidence of behavioural change, change in mindset or culture and improved resilience.

▶ **Improved capacity**, strength or confidence in the team, service or local community.

▶ **Improved working relationships** within teams and between services, partner organisations and local communities.

▶ **Organisational learning** and spread of good practice, evidence shared and used to inform further improvements and scaling-up of services.

▶ **Societal benefits and public value** – evidence of improved partnership working and broader benefits for local communities, society, population health indices and progress in line with *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2015*. [82]

5.4.2 Mark key milestones

Acknowledge success when key milestones are reached or when there is evidence of improved performance. Consider ways that are meaningful to staff and service users. Use stories and narratives to communicate success – stories matter because they add the heart, the emotion and the motivation to the 'head' (the more formal evidence of outcomes delivered). They provide the opportunity to connect emotionally to what matters to people. Track success using creative, visual and graphic material that is accessible and easily communicated. Support teams to showcase their work when opportunities arise, e.g. service achievement/excellence awards, quality improvement projects, submissions to journals or other publications, presentation at conferences or in peer-support groups, sharing case studies, etc. (Change Hub at www.hseland.ie)

5.5 Sustain Improvement

When change is done well, it is more likely to be sustained. Identify early the core conditions necessary for the change or improvement to be ongoing, focusing in particular on the People and Culture Change Platform. See how these conditions can be supported. People who are engaged in developing or adapting improvements, and people who believe that the 'new way' delivers better results for service users and for themselves, are generally more motivated to sustain the improvement. Embedding new practices needs consistent communication and feedback, tapping into individual's belief that services can be improved, and reinforcing the link between individual behaviours and improved outcomes for service users.

Sustainability also requires focus, energy and a capacity to reframe or reinvent components of the service as needed. Try to remain 'faithful' to the new service design as drift can set in. It is a fine balance as aspects of the design may need to be adapted to local contexts and this flexibility is important. Balance is also essential in sustaining improvement – how do you counterweigh the tendency to over-manage? Where are the opportunities for people across the organisation or service to behave more like collective leaders? [235, 236]

Support teams to implement methodologies that focus on continuous quality improvement, i.e. *Framework for Improving Quality in our Health Service* [195]. Flexibility and openness to continuous improvement is essential for services to remain relevant and responsive to the needs of service users and staff and to support sustainability. Consider the guidance in Figure 59.

Figure 59: Sustain Improvement

▶ Explicitly **reinforce responsibility** for ongoing leadership, monitoring and reporting.

▶ Remain alert to **changing contexts** and emerging data that require you to agree 'course correction' to keep the change on track. Remain connected to frontline service delivery to be in tune with implementation challenges and new drivers for change.

▶ Build in **'review/learning points'** during implementation or when scaling-up, where key partners can review the roles and resources needed at different phases, and consider changes.

▶ Monitor how well the changes have been **integrated and embedded** into the broader continuum of services or practices within the service. Are key leaders reinforcing this alignment – if not, what action is needed?

▶ Clear and consistent means of **monitoring** need to be incorporated into the delivery process, with agreed outcome measures and indicators.

▶ Support the use of **new skills and practices** into everyday activities to enable real behaviour change.

▶ Use **feedback loops** to inform what is needed (e.g. people, infrastructure) for sustainability, and proactively address these factors.

▶ Consider if improvements are dependent on individuals or groups, on technology or finance. Could it keep going if these were removed? **Succession planning** may need to be reviewed so that the change is not dependent on any one individual or group of individuals.

▶ Scan for any remaining dual systems and **decommission** appropriately.

▶ Attend to the **end stage of projects**. When a dedicated change project is finished, steering groups or other governance arrangements may need to be 'stood down', contracts ended, etc. Where project leads are in place, these posts may need to be discontinued or redesigned to integrate into existing services. Documentation may need to be archived or stored, learning documented and organisational 'intelligence' shared.

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5.5.1 Evaluate and share learning

Put in place ways to evaluate and learn from the change process itself. This will help to increase readiness to engage in further change and to continuously improve.

▶ Take time to capture the learning and good practice from the change process and the experiences of all those involved or impacted by the change.

▶ Gather the stories and narratives of people involved and make them available to assist learning.

▶ Develop case studies and use this data to inform future planning for change. (Change Hub at www.hseland.ie)

▶ Gather details on useful tools or materials and seek to share these with others.

▶ Seek opportunities to share learning, i.e. study days, conferences, workshops, peer-to-peer action learning, etc.

▶ 'Close out' on this phase of the change process and record the learning as you move into the next phase of change and development.

5.5.2 Scale-up innovations

Evidence of innovation and change initiatives across the health services that has demonstrated good outcomes can inform further improvements and identify opportunity for scaling-up innovations. A key enabler is the early identification of possible improvement sites and the involvement of 'change champions'. Seek evidence of 'what works' in scaling-up innovations to assist in making decisions that improve the prospect for better outcomes. The outcomes from PDSA sites, pilot testing and other rapid cycle tests will help identify opportunities for spread. Spread can also be incentivised through recognition schemes such as the achievement and excellence awards, ring-fenced development funds, etc. The promotion of a learning culture with opportunities to share practice through the Change Hub [147] and other such sites can also promote the dissemination of case studies and good practice with view to scaling-up innovation across the system. The guidance in Figure 60 will assist.

Change as a continuum – a new beginning

The need for a Health Services Change Framework was driven by the realisation that change is changing, and good change practice needs to become the norm and embedded rather than an event, an initiative or a project. This Change Guide is intended to provide practical help for those undertaking change or service improvement and to focus on people and culture as core determinants of good change outcomes.

In reaching the 'end' of the Change Guide you are in fact moving back to the beginning as the multiple cycles of change activity re-emerge and patterns repeat and evolve. New possibilities become more evident, and the people and cultural platform that has been created becomes the spring board for new energy to deliver our shared purpose – safer better healthcare and staff and public value.

Figure 60: Scaling-Up – Key Messages from the Evidence

Scaling-up innovations and encouraging change

Consider the following key messages in relation to scaling-up innovations:

▶ Size and complexity matter in scaling-up innovations.

▶ While planning and strategy are critical, the non-linear nature of spread means that not all dynamics and consequences of an innovation can be planned for in advance.

▶ Collaboration and networking are crucial.

▶ Facilitating information exchange, collaboration and using existing knowledge is critical for scale-up and spread.

▶ Scaling innovations and transformation change can take an emotional, mental and physical toll on people.

▶ Any innovation being scaled-up requires adequate infrastructure.

▶ The innovation narrative is very important.

▶ Influence and drivers from multiple sources are most effective.

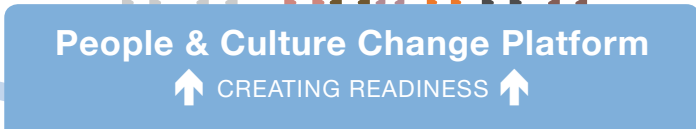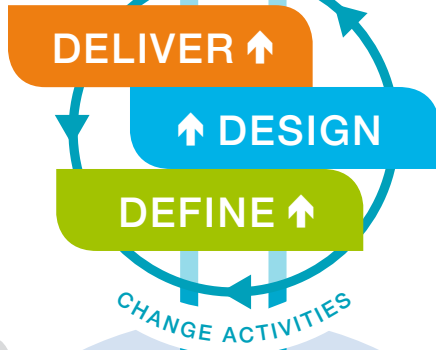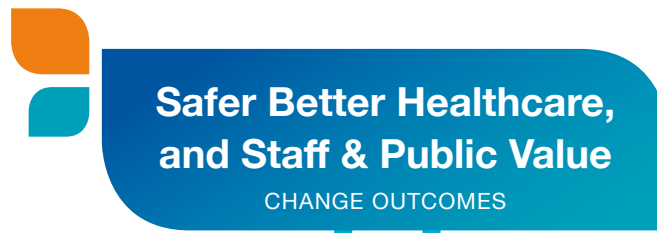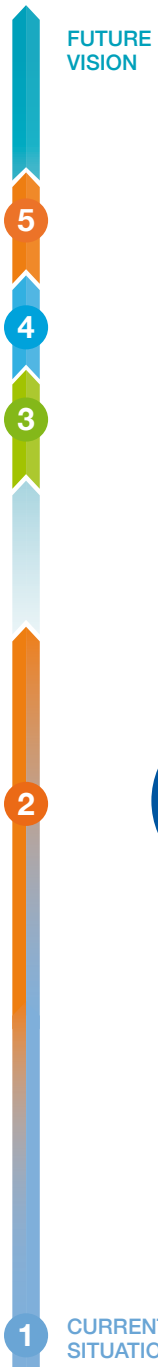▶ Leadership in spreading innovations is most effective if distributed and collective.

Key questions to consider

▶ What are some of the first steps in scaling-up an innovation?

▶ How can you prepare people before the change process, and provide appropriate ongoing support while recognising that support needs may change?

▶ If you were to look back at the scaling process two years on from the implementation of the innovation, what difference would you like to say it made?

Adapted from: Shiell-Davis, K. et al (2015) [350]

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ⓘ **(Deliver: Scaling-up Innovations – Evidence of What Works).**

Health Services Change Framework

www.hse.ie/changeguide

Click diagram to navigate

FUTURE VISION

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4
3
2
1

CURRENT SITUATION

Safer Better Healthcare, and Staff & Public Value

CHANGE OUTCOMES

DELIVER ↑

↑ DESIGN

DEFINE ↑

CHANGE ACTIVITIES

Practice Collective Leadership

Understand Personal Experiences

Support Behaviour Change

Invest in People & Teams

People's Needs Defining Change

Service Users, Families, Citizens, Communities & Staff

Engage & Communicate

Model Shared Values

Use Evidence & Lever Technology

Be Accountable for Performance

Network & Partner

People & Culture Change Platform

↑ CREATING READINESS ↑

Human Resources
Leaders in People Services

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Visit us online
www.hse.ie/changeguide

Access all of the **Essential Templates** and **Additional Resources**, in two formats:

1 Stand-alone Templates/Handouts which you can download, complete, save, print

2 Part of the full online Change Guide document

The Change Guide online is **interactive!**

Go to **page 7** and click on any element of the Change Framework OR navigate from the Contents section (pages i-v).

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Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES

Health Services Change Framework
www.hse.ie/changeguide
Click diagram to navigate

FUTURE VISION

DELIVER
DESIGN
DEFINE

CHANGE ACTIVITIES

Practice Collective Leadership

Understand Personal Experiences

People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff

Support Behaviour Change

Invest in People & Teams

Engage & Communicate

Model Shared Values

Use Evidence & Lever Technology

Be Accountable for Performance

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Section 6
Essential Templates

* *Visit us online:* **www.hse.ie/changeguide**

6

Contents

6.1 Essential Templates – Working with Service Users, Families, Citizens, Communities and Staff

Download Templates: Each of the Templates in this section can be downloaded

Template 6.1.1: Influence-Interest Mapping Grid

Template 6.1.2: Guidance on Stakeholder Mapping and Analysis

Template 6.1.3: Guidance to Develop Engagement and Communication Plan

Purpose

This template assists you to understand your stakeholders in terms of their level of interest in the change and their level of influence. This data will support you in distilling core groups and shaping how best to involve stakeholders in the change process.
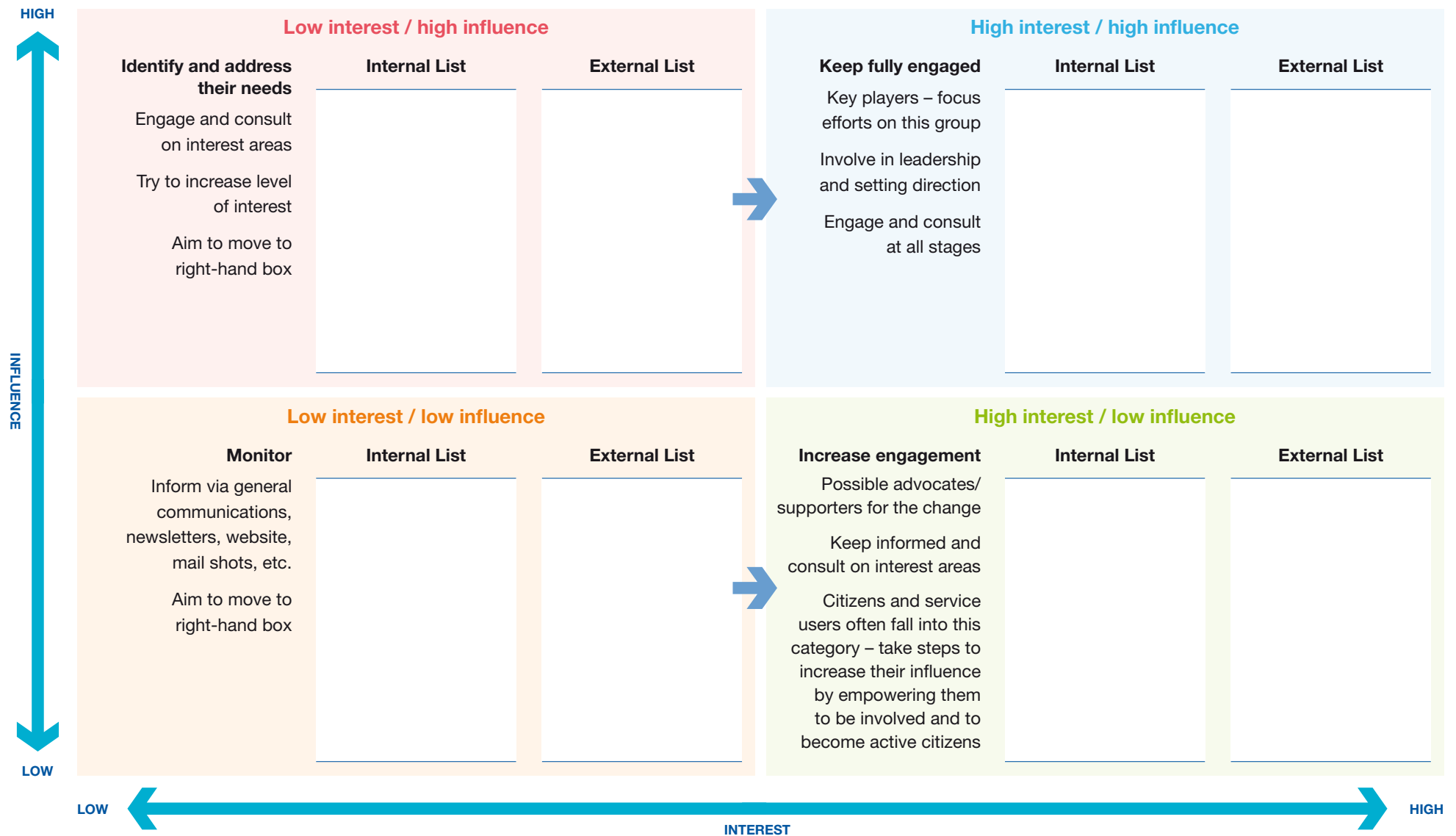
How to use it?

Use the high/low axis as guidance to list both internal and external stakeholders in the relevant quadrants in terms of:

▶ their **level of interest** in the change – the extent to which individuals or groups have a vested interest in the change/their expectations of what they want the change to deliver

▶ the **influence** – extent to which individuals or teams are able to influence others to change. Influence is apparent in formal and informal ways such as opinion leaders and 'go to' people, as well as through position, status and access to resources

Having grouped stakeholders, engage directly with them to consider how they might feel about and react to the change. Consult the individuals and groups on how they would like to be involved and what approaches would work best. Use the guidance to inform your planning, i.e. individuals/groups whom you need to keep fully engaged and those for whom you wish to increase engagement.

Colour coding – optional

To assist you to transfer this data to other templates, you may consider colour coding each grouping in line with the four quadrants and group internal and external stakeholders separately for ease of reference.

HIGH

INFLUENCE

Low interest / high influence

Identify and address their needs

Engage and consult on interest areas

Try to increase level of interest

Aim to move to right-hand box

Internal List	External List

High interest / high influence

Keep fully engaged

Key players – focus efforts on this group

Involve in leadership and setting direction

Engage and consult at all stages

Internal List	External List

Low interest / low influence

Monitor

Inform via general communications, newsletters, website, mail shots, etc.

Aim to move to right-hand box

Internal List	External List

High interest / low influence

Increase engagement

Possible advocates/ supporters for the change

Keep informed and consult on interest areas

Citizens and service users often fall into this category – take steps to increase their influence by empowering them to be involved and to become active citizens

Internal List	External List

LOW

LOW ← → **HIGH**

INTEREST

Adapted from: Eden and Ackermann (1998: 122) [103]; *Bryson, J. M. et al (2011)* [40].

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Template 6.1.2: Guidance on Stakeholder Mapping and Analysis

Purpose

The Stakeholder Mapping and Analysis Template:

▶ lists the key stakeholders

▶ identifies their level of accountability for the change

▶ considers levels of readiness to embrace the change

▶ considers levels of interdependency

▶ explores how stakeholders can assist and influence the change

▶ identifies how best engagement and communication can be progressed

How to use it?

▶ Having identified and grouped individuals and groups in line with the **Influence-Interest Mapping Grid**, complete this template in respect of key individuals/groups initially, i.e. those whom you need to keep fully engaged and those for whom you wish to increase engagement.

▶ Complete the template for internal groups and external groups separately. Use the colour coding system (optional) in the Influence-Interest Mapping Grid to transfer the names of individuals and groups based on the classification used in the grid, i.e. grouping all those in the high influence/high interest together, etc.

▶ Revisit this template throughout the change process as the nature of stakeholder engagement is ever evolving and needs to be constantly revised and updated as new levels of emphasis arise.

Stakeholder name	Accountability for the change	Personal/team interests and readiness	Interdependency	Assist and influence the change	Engagement and communication
(individual/group)	What key actions are you responsible for individually or as part of a team?	Identify people's interest in the change.	Consider services that need to work together to achieve the change required.	Identify ways individuals or groups could assist and support the change process.	Consult with people on how best to engage and communicate with them.
		Identify hopes and concerns regarding the change at personal or team level.	How might a change in one service/team impact upon other services/teams (ripple effect)?	Who influences them most? Who do they influence?	Outline engagement processes.
		What factors would make it difficult for individuals or groups to 'get on board'?	What changes are required in other parts of the organisation or service to enable this particular service to change/operate effectively?		Outline communication processes.
		What would help?			Agree, review and update at agreed intervals.

TITLE OF PROJECT: DATE: VERSION: LOCATION:

Stakeholder name	Accountability for the change	Personal or team readiness	Interdependency	Assist and influence the change	Engagement and communication

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Purpose

The Engagement and Communication Plan outlines who you are communicating and engaging with, the purpose and focus of the communication/engagement, the methods to be used, the frequency, and responsibility for communicating and engaging.

How to use it?

Guidance is provided below to assist you to complete the columns. Continually review your communication and engagement efforts, including feedback loops, to ensure your engagement and communication efforts are effective.

Who? Audience	Why? Purpose/change outcomes	What? Content and focus	How? Method and impact[6]	When? Frequency/timeline	Who? Responsibility
(see stakeholder mapping and analysis) **Identify who you are communicating and engaging with** ▶ Individuals ▶ Groups ▶ Evolving networks and coalitions for change. *(Note: The identification of the different individuals and groups you are communicating with, i.e. your target audience, will influence your decisions regarding each of the questions in the columns to the right.)* See Section 2: People's Needs Defining Change	Clarify the purpose of engagement and communication, i.e. to inform, consult, involve, collaborate or co-produce? Identify the 'purpose of the change' and associated 'outcomes': why is the 'change outcome' a reason for me to get involved? Is there a compelling vision for change? How will the change outcome inspire people to engage? *(Note: The purpose of communication/engagement will determine the content and focus – see column to the right.)*	Consider what will assist you to connect with people and help them to engage – how will you frame your message? Take into account what your 'audience' already knows. What do people need to know? What key focus/messages do you want to give? What issues are people already dealing with that will impact on their capacity to engage?	Consider how individuals or groups are currently engaged – what is working well? Utilise existing opportunities to communicate and engage. Identify the most appropriate method or means of communication, or engagement. Be clear on how people can get involved or get more information. Use the potential of social media to reach wider audiences and diverse groups. Address challenges to communication and engagement – tailor your message/language to meet the needs of particular groups. Consider accessibility issues for people with particular communication needs. Consider access including venue location and facilities for engagement events.	Consider the best time to share information and engage. Are there other competing issues that you need to be aware of? Be clear on frequency of communication. In setting timelines for a response be specific and open to feedback on what is realistic. How will ongoing communication and engagement be managed so that it is not a 'once-off' event?	Clarify and assign responsibility for communication – this may be an individual or group. Who is best placed to deliver the message? How can these individuals be supported in their role? Encourage personal responsibility for sharing information through networks and different media. Recognise that 'we all have the power to be change agents.' Clarify responsibility for engagement. How can this be shared? How can service users/citizens be involved?

6 Link with local communications unit for guidance in relation to communication protocols/ management of events

TITLE OF PROJECT: DATE: VERSION: LOCATION:

Who? Audience	Why? Purpose/change outcomes	What? Content and focus	How? Method and impact	When? Frequency/timeline	Who? Responsibility

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6.2 Essential Templates – Define

Download Templates: Each of the Templates in this section can be downloaded

Template 6.2.1: SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats/Challenges)

Template 6.2.2: Context for Change – Why What How Method

Template 6.2.3: Description of the Current Situation (Service Operational Model)

Template 6.2.4: Guidance on Defining your Personal Values

Template 6.2.5: Cultural Web Exercise

Template 6.2.6: Personal Readiness for Change

Template 6.2.7: Team Diagnostic

Template 6.2.8: People and Culture Change Platform – Readiness Factors

Template 6.2.9: Developing a Vision for the Future

Template 6.2.10: Clarifying Measures

Template 6.2.11: Project Initiation Document (PID)

Template 6.2.1: SWOT Analysis
(Strengths, Weaknesses, Opportunities and Threats/Challenges)

Purpose

SWOT is an acronym for examining an organisation's or service's strengths, weaknesses, opportunities and threats, and using the result to identify priorities for action. The main principle underlying SWOT is that internal and external factors must be considered simultaneously when identifying aspects of an organisation that need to be changed. Strengths and weaknesses are internal to the organisation, while opportunities and threats are external. An analysis of the organisation and the external environment will enable the organisation/service to plan more effectively for the future, while taking into account opportunities and potential threats. A SWOT analysis assists in understanding why we need to change.

How to use it?

▶ Evaluate your service by identifying and considering its current strengths and weaknesses and the threats and opportunities facing it in the future.

▶ Strengths and weaknesses are primarily about the organisation's present situation, and opportunities and threats are about predicting its future (external factors).

▶ Based on the data, how can you build on the strengths and lever the opportunities?

▶ How can you deal with weaknesses and minimise threats/challenges?

STRENGTHS
What the service is good at doing?

WEAKNESSES
What the service is not good at doing and aspects of the services that are not going well?

OPPORTUNITIES
Identify the events and trends that are favourable to the service.

THREATS (CHALLENGES)
Identify the trends or events that are unfavourable to the service.

Conducting a swot analysis – additional guidance

A strategic analysis of the organisation and the external environment will enable the organisation to plan more effectively for the future, while taking into account opportunities and potential threats. The following key questions provide a basis for this analysis.

What are your organisation's/service's strengths and weaknesses?

For example
▶ What strengths are in the organisation that can lever/enable the change?
▶ What are its main achievements over the last three years?
▶ How successful has it been in achieving its strategic objectives?
▶ Has it met or exceeded its targets?
▶ Do current services meet users' requirements?
▶ How effective are its links with other key organisations/agencies in its area or sector?
▶ How secure is your organisation's financial position?
▶ Does it have the staffing/volunteer levels and expertise necessary to meet its objectives?
▶ How is your organisation/service regarded externally? Does it have a good reputation?
▶ Is it able to build effective relationships with those it wishes to influence?
▶ Where are there strong alliances/relationships/partnerships which could assist in levering change both internal and external to the organisation?
▶ Is your organisation/service effective at communicating with internal teams and external groups?
▶ How effective are its management systems and processes? Is your organisation/service well-structured and efficient or overly bureaucratic?
▶ Does its governance arrangements have the capacity/expertise to meet the demands of the organisation/service?
▶ What areas of good practice or innovation are relevant to the change that can be repeated across the system? Examples may include Quality Initiatives (PDSAs). Are there opportunities to build on area/local level initiatives?

What are the key opportunities and threats facing your organisation?

▶ Trends in its area of work/services
▶ Audit of local situation
▶ User needs
▶ Demographics
▶ Competition from other or similar organisations in its area
▶ Facilities
▶ Barriers to your organisation's development
▶ Deprivation of its catchment area
▶ Consultation findings, e.g. community audit, needs assessment
▶ Opportunities for developing new areas of work
▶ Opportunities for extending services to new client groups
▶ Partnerships/collaborative working opportunities
▶ Local authority policies and plans in its area
▶ Policy documents relevant to your organisation's work or location
▶ Funding opportunities for your organisation/service

Additional analysis

Ask further questions about each of the factors listed under the four headings.
For **strengths** and **weaknesses** the questions asked are:
1. What are the consequences of this? Do they help or hinder your service/organisation in achieving its core purpose?
2. What are the causes of this strength (or weakness)?

For **opportunities** and **threats** the questions are slightly different:
1. What impact is this likely to have on your service/organisation? Will it help or hinder it in achieving its core purpose?
2. What must it do to respond to this opportunity or threat?

Reflect on the core purpose of the service and on all four components. Pay particular attention to the causes of the strengths and weaknesses, and to the responses required to the opportunities and threats. Link together common threads into a set of priorities for the team to address.

Adapted from: www.diycommitteeguide.org [96]; Iles, V. and Sutherland, K. (2001: 40-41) [220]; Clarke, J. (1997: 7) [58]
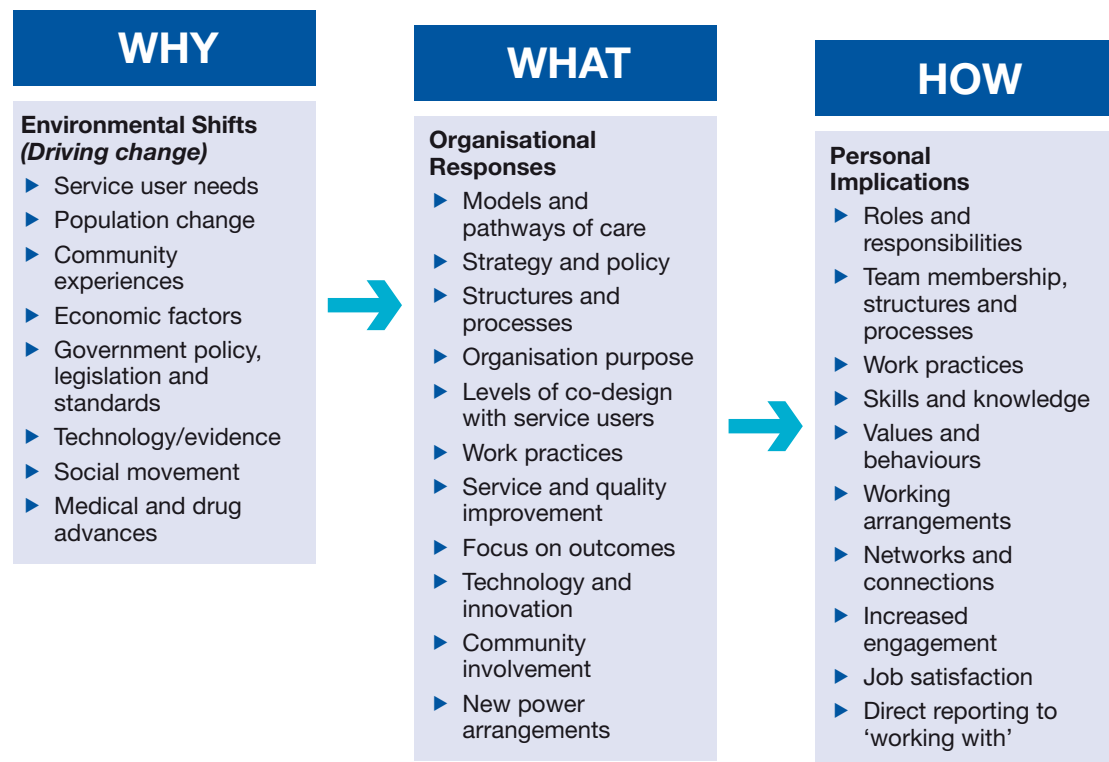*People's Needs Defining Change – Health Services Change Guide*

Purpose

The **Why What How Method** assists you to 'diagnose' the big change drivers in the external environment, identify organisational responses and anticipate the personal implications of change. This will assist you to communicate **Why** change is needed, **What** needs to change, as well as **How** it will change.

How to use it?

Use the prompts with your team on a flip chart to:

▶ list 'environmental shifts' – the typical sources of external drivers of change – under **Why**

▶ list ways in which a service responds to external pressures under **What**

▶ identify changes for individuals (service users, citizens and staff) under **How**

▶ discuss the implications of the data gathered to increase your understanding of the context for change

WHY	WHAT	HOW
Environmental Shifts *(Driving change)*	**Organisational Responses**	**Personal Implications**
▶ Service user needs	▶ Models and pathways of care	▶ Roles and responsibilities
▶ Population change	▶ Strategy and policy	▶ Team membership, structures and processes
▶ Community experiences	▶ Structures and processes	▶ Work practices
▶ Economic factors	▶ Organisation purpose	▶ Skills and knowledge
▶ Government policy, legislation and standards	▶ Levels of co-design with service users	▶ Values and behaviours
▶ Technology/evidence	▶ Work practices	▶ Working arrangements
▶ Social movement	▶ Service and quality improvement	▶ Networks and connections
▶ Medical and drug advances	▶ Focus on outcomes	▶ Increased engagement
	▶ Technology and innovation	▶ Job satisfaction
	▶ Community involvement	▶ Direct reporting to 'working with'
	▶ New power arrangements	

Adapted from: Fisher, K. et al (1995) [108]; McMurray, A. (2016a) [262]
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Purpose

This template assists you to define and describe your current Service Operational Model, to outline the current baseline and to describe the measures that are in place. It acts as a foundation to guide change activities.

How to use it?

Describe the current situation/baseline of your service in Column 2 based on the prompts outlined in Column 1. Indicate measures that are in place or agreed in Column 3.

Service:		Date:
Current Service Operational Model	**Baseline of the service – describe the current situation**	**Measures – outline what is in place**
Model of Care or Service Provision		**Model of Care or Service Provision**
▶ Overall philosophy of care (medical, psychosocial, therapeutic, holistic, etc.)		
▶ Who will use the service?		
▶ Who will deliver the service?		
▶ Who will the service interact with most, i.e. referral sources, other teams or agencies, etc.?		

Service: **Date:**

Current Service Operational Model	Baseline of the service – describe the current situation	Measures – outline what is in place
▶ Eligibility and access criteria		
▶ Service delivery arrangements – location, time, opening hours, etc.		
Governance and Leadership Arrangements		**Governance and Leadership Arrangements**
▶ Service team purpose, structure and reporting relationships		
▶ Leadership and decision-making arrangements (including governing groups and legal or regulatory requirements)		
▶ Clinical governance arrangements: Supervision practice Monitoring of professional standards, policies and procedures		

Service:		Date:
Current Service Operational Model	**Baseline of the service – describe the current situation**	**Measures – outline what is in place**
▶ Business governance including finance, human resources, etc.		
▶ Service level agreements, memorandums of agreements or other inter-agency agreements		
Key activities required to deliver the service:		**Key activities required to deliver the service:**
Pathways and Processes of Care		**Pathways and Processes of Care**
▶ Referral, assessment, diagnostic, intervention pathway		
▶ Shared care arrangements or protocols		
▶ Transfer or discharge pathway		

Service:		Date:
Current Service Operational Model	**Baseline of the service – describe the current situation**	**Measures – outline what is in place**
▶ Supporting process, i.e. booking arrangements, pharmacy systems, notification to other services, etc.		
Business Processes		**Business Processes**
▶ Service planning		
▶ Policies, procedures, protocols and guidelines (PPPG)		
▶ Budget and financial processes, procurement arrangements		
▶ Costing model for the service (income generation, etc.)		

Template 6.2.3: Description of the Current Situation (Service Operational Model) (continued)

Service:		Date:
Current Service Operational Model	**Baseline of the service – describe the current situation**	**Measures – outline what is in place**
▶ Information and data management processes (data bases, etc.)		
▶ e-Health and ICT requirements		
▶ Communication and information sharing processes (internal and external)		
▶ Administrative support processes and services		
▶ Procurement Processes		

6.2.3, 6.3.2,
6.3.3, 6.3.4

Service: | **Date:**

Current Service Operational Model	Baseline of the service – describe the current situation	Measures – outline what is in place
Human Resources		**Human Resources**
▶ Workforce planning, talent management succession planning		
▶ Roles and responsibilities		
▶ Individual and team performance		
▶ Work practices and methods		
▶ Work distribution, caseload management		
▶ Learning and development requirements – knowledge, competencies and skills		

Service: **Date:**

Current Service Operational Model	Baseline of the service – describe the current situation	Measures – outline what is in place
▶ Human Resources business processes – time and attendance, performance systems, etc.		
▶ Staff engagement processes		
▶ Scheduling, rostering and work flow		
▶ Staff health and wellbeing		
▶ Health and safety arrangements		

Service: | **Date:**

Current Service Operational Model	Baseline of the service – describe the current situation	Measures – outline what is in place
Quality, Patient Safety and Measurement		**Quality, Patient Safety and Measurement**
▶ Quality, standards and measurement processes (including compliance arrangements, dealing with service feedback/ complaints, etc.)		
▶ Indicators – performance measurement (quantitative and qualitative)		
▶ Key performance indicators		
▶ Risk management processes		

Service: | **Date:**

Current Service Operational Model	Baseline of the service – describe the current situation	Measures – outline what is in place
Infrastructure		**Infrastructure**
▶ Utilisation of space/facilities, location of service delivery, service settings (capital expenditure plans, etc.)		
▶ Environmental changes		
▶ Equipment (assessment, diagnostic and intervention requirements)		
▶ ICT infrastructure		

Resources

Comment on the overall situation with regard to current resources for the service. Identify any anomalies or funding issues that need to be addressed:

People's Needs Defining Change – Health Services Change Guide

Purpose

Defining your personal values – process of inquiry

When you define your personal values, you discover what's truly important to you. A good way of starting to do this is to look back on your life to identify when you felt really good and really confident that you were making good choices. Reflecting on the alignment of your personal values to the values of the team/service/organisation you work with will help you to understand the fit or otherwise between both.

How to use it?

Engage in personal reflection with regard to the following:

Step 1: Identify the times when you were happiest

Find examples from both your career and personal life. This will ensure some balance in your answers.
- ▶ What were you doing?
- ▶ Were you with other people? Who?
- ▶ What other factors contributed to your happiness?

Step 2: Identify the times when you were most proud

Use examples from your career and personal life.
- ▶ Why were you proud?
- ▶ Did other people share your pride? Who?
- ▶ What other factors contributed to your feelings of pride?

Adapted from: Mind Tools (2017) [271]

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Step 3: Identify the times when you were most fulfilled and satisfied

Again, use both work and personal examples.
- ▶ What need or desire was fulfilled?
- ▶ How and why did the experience give your life meaning?
- ▶ What other factors contributed to your feelings of fulfilment?

Step 4: Determine your top values, based on your experiences of happiness, pride and fulfilment

Why is each experience truly important and memorable?

Step 5: Prioritise your top values

This step is probably the most difficult because you'll have to look deep inside yourself. It's also the most important step because, when making a decision, you'll have to choose between solutions that may satisfy different values. This is when you must decide which value is more important to you.
- ▶ Write down your top values, in no particular order.
- ▶ Look at the first two values and ask yourself, 'If I could satisfy only one of these, which would I choose?' It might help to visualise a situation in which you would have to make that choice. For example, if you compare the values of service and stability, imagine that you must decide whether to sell your house and move to another country to do valuable foreign aid work, or keep your house and volunteer to do charity work closer to home.
- ▶ Keep working through the list by comparing each value with the other values, until your list is in the correct order.

Step 6: Reaffirm your values

Check your top-priority values, and make sure they fit with your life and your vision for yourself.
- ▶ Do these values make you feel good about yourself?
- ▶ Are you proud of your top three values?
- ▶ Would you be comfortable and proud to tell your values to people you respect and admire?
- ▶ Do these values represent things you would support, even if your choice isn't popular, and it puts you in the minority?

When you consider your values in decision-making, you can be sure to keep your sense of integrity and what you know is right, and approach decisions with confidence and clarity. You'll also know that what you're doing is best for your current and future happiness and satisfaction. You also need to consider the alignment between your personal values and your workplace values. Does this alignment assist you to live your values in your personal and work life?

Making value-based choices may not always be easy. However, making a choice that you know is right is a lot less difficult in the long run.

Key points

Identifying and understanding your values is a challenging and important exercise. Your personal values are a central part of who you are – and who you want to be. By becoming more aware of these important factors in your life, you can use them as a guide to make the best choice in any situation. Some of life's decisions are really about determining what you value most. When many options seem reasonable, it's helpful and comforting to rely on your values – and use them as a strong guiding force to point you in the right direction.

Purpose

To develop an understanding of your service culture in order to increase readiness for change. This exercise will assist in mapping and analysing key cultural factors. It contains six inter-related elements that represent the artefacts (what we see), values (what we attribute intrinsic worth to) and assumptions (beliefs) about your service. This knowledge can be used to design and monitor ongoing developments, and to plan how to work with concerns and resistance in the system.

How to use it?

Baseline measure: Identify through an engagement process the prevailing culture of the team or service and subcultures – see Columns 1 and 2 below. Understanding culture requires 'being present', listening to the lived experiences of staff and service users and observing how the service actually operates in practice.

Repeat the exercise to describe the 'desired culture' – see Columns 3 and 4 as part of the Visioning Exercise (see 3.3, 3.3.1). This will provide you with a focus for intervention and assist in describing the vision for your service.

The Cultural Web diagram above identifies six interrelated elements that help to make up what Johnson, G (2017) calls the 'paradigm' – the pattern or model – of the work environment. By analysing the factors in each, you can begin to see the bigger picture of your culture: what is working, what isn't working, and what needs to be changed.

Source: *Johnson, G. (2017)* [228]

1 Cultural web elements	2 Prevailing culture Baseline	3 Cultural web elements	4 Future 'desired' culture Future
Listen and gather **stories** that reflect what it is like to work in the service.		**What would service users, staff, other services be saying about our service (desired future culture)?**	
Observe **rituals and routines** that signal acceptable behaviour – what organisational habits/routines are at play?		**What rituals would we have?** **Describe behaviours that would be evident.**	
Examine **symbols** that visually represent what the service stands for – what are the physical environment cues telling you?		**What symbols would be visible?**	

1 Cultural web elements	2 Prevailing culture Baseline	3 Cultural web elements	4 Future 'desired' culture Future
Determine **power structures** – who has the greatest influence on decisions, direction and day-to-day operations?		**Who would influence decisions?** **How would power and influence be distributed?**	
Consider the organisational **structure**, both the formal and informal lines of power and influence – whose contributions are most valued?		**How would new working relationships be reflected in the structure/service?** **How would the structure support organisational networks as well as traditional hierarchies?**	
Assess **control measures** including performance indicators, budget management, rewards, etc. and their impact on people		**How would we manage accountability and performance for delivering better outcomes, quality standards, financial targets etc.?**	

People's Needs Defining Change – Health Services Change Guide

Template 6.2.6: Personal Readiness for Change

Purpose

This template assists you to understand levels of personal readiness for change and to assist conversations with individuals and teams to address readiness factors.

How to use it?

Individuals can complete this readiness table. A composite score for the team can also be compiled. Rate 1-5, where 1 = Low and 5 = High. High scores indicate positive levels of readiness.

Identify actions: Based on the outcome of the above, what key actions are needed to increase personal readiness for change? How can concerns highlighted be addressed? What actions require personal follow-up? What actions require attention at team or service level?

People in the service:	LOW 1	2	3	4	HIGH 5
Understand the external forces that are driving the change and the perceived value of the change	☐	☐	☐	☐	☐
Have been afforded an opportunity to have their say and get involved, have identified what is important to them	☐	☐	☐	☐	☐
Are willing to let go of the status quo and open to a new future	☐	☐	☐	☐	☐
Have resolved emotional issues from past changes and recovered from any personal toll these changes created	☐	☐	☐	☐	☐
Have confidence that decisions regarding the change will be made fairly and justly	☐	☐	☐	☐	☐
Feel they have a degree of influence over making this change	☐	☐	☐	☐	☐
Are confident they will get support, access to necessary organisational resources and be equipped with new skills	☐	☐	☐	☐	☐
Have confidence in the leader's credibility and capacity to manage the change in a collective manner	☐	☐	☐	☐	☐
Feel they have the ability to make the change a success and fulfil its requirements	☐	☐	☐	☐	☐
Express a level of urgency about the change, and their ability to respond effectively	☐	☐	☐	☐	☐
Believe they will be empowered as a result of the change	☐	☐	☐	☐	☐
Are comfortable with uncertainty and can live with some ambiguity as things unfold	☐	☐	☐	☐	☐

Adapted from: *Ackerman Anderson, L. and Anderson, D. (2010: 81)* [3]

People's Needs Defining Change – Health Services Change Guide

Purpose

The Team Diagnostic is a questionnaire based on the *HSE Improving Team Working Guidance Document* which is designed to identify areas within a team that are working well and also areas that require improvement.

The questionnaire explores a number of key areas of team working such as:

▶ Purpose

▶ Goals and objectives

▶ Values

▶ Roles and responsibilities

▶ Distribution of work

▶ Policies and procedures

▶ Team meetings

▶ Communication

▶ Continuous improvement

▶ Decision-making

▶ Feedback

▶ Change

▶ Conflict

▶ Motivation

▶ Team development

▶ Morale

How to use it?

This particular Team Diagnostic works well with a team of ten or more members. It can also be used as a checklist to prompt discussion within a team. Please note that team diagnostics are best used as part of a team development process.

Access to Team Diagnostic / Team Development Services

To access Team Diagnostic / Development Services, please contact **Leadership, Education & Talent Development** at the following numbers for further information and support:

▶ HSE Offices, Ardee, Co Louth: 041 6857816

▶ HSE Offices, Tullamore, Co Offaly: 057 9370611

▶ HSE Offices, Letterkenny, Co Donegal: 074 9109131

▶ HSE Offices, Cork City, Co Cork: 021 4921213

Scoring: On a scale of 1-5, where 1 = Strongly disagree and 5 = Strongly agree, indicate your level of agreement with the following statements. Record your score for each statement in the 'Score' column. Scores of 3 or below indicate areas for improvement.	Strongly disagree 1	Disagree 2	Undecided 3	Agree 4	Strongly agree 5	Score
1. I am part of a results-orientated team	☐	☐	☐	☐	☐	
2. I am clear about the vision and purpose of my team	☐	☐	☐	☐	☐	
3. My team has clear goals and objectives for the year ahead	☐	☐	☐	☐	☐	
4. My team has clearly defined key performance indicators (KPIs)	☐	☐	☐	☐	☐	
5. My team has a shared set of values that guide the way we operate	☐	☐	☐	☐	☐	
6. I understand my role and responsibility within my team	☐	☐	☐	☐	☐	
7. I am clear about the role and responsibility of others within my team	☐	☐	☐	☐	☐	
8. I have a clear reporting relationship with my team leader	☐	☐	☐	☐	☐	
9. I have a good working relationship with my team leader	☐	☐	☐	☐	☐	
10. There is equal distribution of workload on this team	☐	☐	☐	☐	☐	
11. There are clearly defined policies and procedures governing my team	☐	☐	☐	☐	☐	
12. My team has regular team meetings where everyone contributes	☐	☐	☐	☐	☐	
13. As a team we communicate well with each other and others	☐	☐	☐	☐	☐	
14. My team has an ethos of continuous process improvement	☐	☐	☐	☐	☐	
15. I feel involved in decision-making that directly impacts my team	☐	☐	☐	☐	☐	
16. My team proactively identifies future challenges and opportunities	☐	☐	☐	☐	☐	
17. We are open to giving and receiving feedback on my team	☐	☐	☐	☐	☐	
18. A spirit of teamwork and cooperation exists in my team	☐	☐	☐	☐	☐	
19. My team responds well to change	☐	☐	☐	☐	☐	

Scoring: On a scale of 1-5, where 1 = Strongly disagree and 5 = Strongly agree, indicate your level of agreement with the following statements. Record your score for each statement in the 'Score' column. Scores of 3 or below indicate areas for improvement.	Strongly disagree 1	Disagree 2	Undecided 3	Agree 4	Strongly agree 5	Score
20. Conflict is resolved effectively within my team	☐	☐	☐	☐	☐	
21. There is high morale within my team	☐	☐	☐	☐	☐	
22. I feel valued as a team member	☐	☐	☐	☐	☐	
23. People on my team treat each other with respect	☐	☐	☐	☐	☐	
24. I feel motivated in my job	☐	☐	☐	☐	☐	
25. I have a personal/professional development plan	☐	☐	☐	☐	☐	
26. I have regular performance and development discussions with my team leader	☐	☐	☐	☐	☐	
27. As a team we acknowledge and celebrate success	☐	☐	☐	☐	☐	
28. I am proud to be associated with my team	☐	☐	☐	☐	☐	
29. My team is highly client/customer focused	☐	☐	☐	☐	☐	
30. My team promotes diversity and inclusiveness	☐	☐	☐	☐	☐	

Any additional comments you would like to make?

Date

Source: *This Team Diagnostic is informed by: Team Working Policy and Guidelines; 2004 and associated Team Working Diagnostic; 2004 (Heslin, C., Kinch, C. and Malone, J., 2004). It was further developed in HSE Improving Team Working: A Guidance Document; 2010 (Heslin, C. and Ryan, A.) and adapted by Hanlon, V., Pentony T. et al (2016)* [211, 212] *for use as an online Team Diagnostic Instrument.*

People's Needs Defining Change – Health Services Change Guide

Purpose

This template assists in identifying readiness in relation to the People and Culture Change Platform outlined in the Change Framework. The findings will guide as to where focused attention is required to address cultural elements in an integrated manner.

How to use it?

Carry out this exercise as a team-based activity. Use the key activities below to generate a rating for each of the people and cultural priorities outlined below. Identify actions to increase readiness based on the findings – actions can be prioritised as follows:

High: to maintain focus and do more of
Medium: to improve
Low: to target in a dedicated way

People and cultural factors - for more detailed explanation refer to 1.2.1 to 1.2.9	Readiness How would you rate readiness?			
	High	**Medium**	**Low**	**Action**
Practice collective leadership 1. Be self-aware 2. Role model the change 3. Communicate with integrity and purpose 4. Nurture collective leadership activity 5. Build relationships and create networks	☐	☐	☐	
Model shared values 1. Understand personal values 2. Connect on a noble goal – add public value 3. Translate values into action 4. Monitor performance in line with values	☐	☐	☐	

Engage and communicate				
1. Involve service users, families, citizens, communities and staff				
2. Address core needs to enable engagement				
3. Tap into clinical and other frontline experiences				
4. Mobilise widespread involvement				
5. Develop a plan to engage and communicate				
Understand personal experiences				
1. Facilitate transitions				
2. Understand personal responses				
3. Create the safety and space to support personal change				
4. Understand and work with resistance and personal readiness				
Support behaviour change				
1. Understand behavioural change				
2. Focus on emotional connections				
3. Support and affirm mindset and behaviour change				
4. Challenge unacceptable behaviours				

Invest in people and teams

1. Support personal learning

2. Prioritise effective team working

3. Support a learning culture

4. Resource the change

Network and partner

1. Develop capacity for co-production

2. Lever partnerships to influence health and social gain

3. Value connections and use social networking

4. Commission and partner for public value

Use evidence and lever technology

1. Use evidence to lever change and demonstrate outcomes

2. Gather data and knowledge from multiple sources

3. Engage in robust measurement and analysis

4. Lever e-health and technology to deliver innovative solutions

Deliver public value and be accountable

1. Implement robust governance arrangements

2. Empower staff to be accountable as public servants

3. Enable and align regulation and oversight

4. Support performance to deliver better outcomes

People's Needs Defining Change – Health Services Change Guide

Purpose

This template outlines a session plan to assist you to develop a vision for the future. An effective vision fits the organisation's purpose, values and culture, and it provides a bridge from the present to the future. It should be motivating, inspiring enthusiasm and commitment and move people to action. The future is never certain, and unless we imagine possibilities to aim for, we stay stuck in the routine of yesterday's thinking. Having a vision helps an organisation to be proactive rather than reactive.

How to use it?

Process of developing a vision

The first step in this process is to engage the leaders to focus on the future. It is the job of leadership to create the vision – and to do so in line with the commitment to collective leadership. This requires a more holistic and inclusive process to defining leaders and to also engaging service users and citizens in the process. People need time and space to think and talk together about what the future would look like if the organisation were to be successful in living up to its core values and delivering on its purpose. Developing a vision involves everyone focusing on the future and drawing out the answers to the following questions:

Future focus

▶ What will our service users and key stakeholders need in 5-10 years?

▶ What are the most influential trends in health and social care and how will we adopt or adapt to them?

▶ How well have we prepared for future developments in healthcare? What needs to be in place?

▶ What kind of relationship do we want with service users, communities and staff?

▶ How will we create public value?

▶ What aspects of our organisation will empower people?

▶ How will we be organised to deliver effectively?

Reflection on what we do well

▶ How well are we performing?

▶ What is unique about what we offer?

▶ How do we handle the good times and the bad times?

▶ Why is this organisation/service a great place to work?

▶ How well do we measure progress?

There are no right or wrong answers to any of these questions. Everyone's view is valid. The session is designed to provide time out for busy people to express and share their ideas, as a way of developing a shared picture of the future.

'If you don't know where you're going, any road will do.'

Future Mapping

Steps to Success
Looking Back from Future-base

Success
(Future-base)

Anticipation
(Present)

IMAGINATION
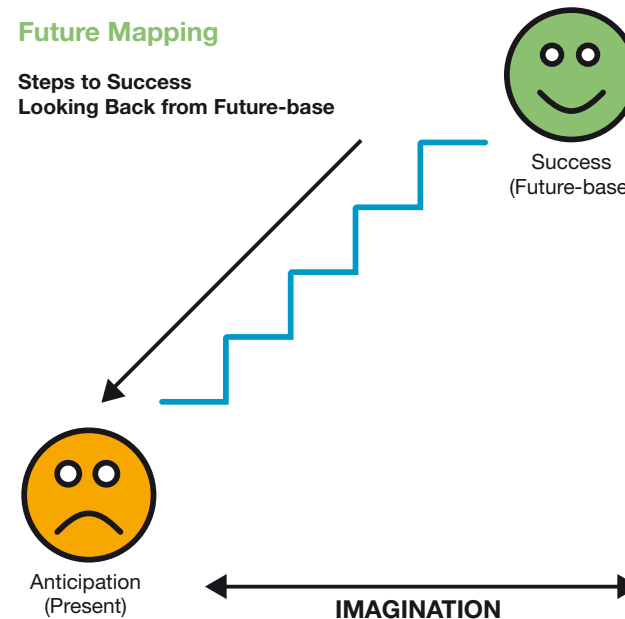
▶ Describe the future vision of the service from the **perspective of all key stakeholders** – if their needs were addressed and all the problems as outlined in the 'current state' were resolved. This involves looking back from a future position of success with an understanding of what is important in terms of experiences and outcomes.

▶ **Describe the vision in terms of valued experiences.** Ask people to describe their ideal experience, as this will tap into the cultural elements that are sometimes hard to measure and are less tangible. Ask people what a 'good day' would look like for a service user or a staff member, i.e. older person living in a residential unit, family member bringing a loved one to Accident and Emergency, a teenager attending Child and Adolescent Mental Health Services (CAMHS).

Additional prompt questions

▶ What would the service 'look like' if it was working well?

▶ What would service users be experiencing?

▶ What would families and carers be experiencing?

▶ What would staff/team members be experiencing?

▶ What would other teams/services be experiencing?

▶ What would the senior leadership be attending to?

Adapted from: McMurray, A. (2015: 9 and 2017) [261, 264]

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Template 6.2.10: Clarifying Measures

Purpose

This template provides guidance to assist you to identify the metrics currently in use in your service, as well as agreeing what the measures will do and how they are calculated. This template will also assist you to design the process for the collection of metrics.

How to use it?

Use the prompts below to assist you to explore each of the areas identified in Column 1. Based on the outcome of this analysis, consider what steps and assistance you need to take to improve your Measurement for Improvement Plan.

Title	Summarise **what** is being measured
Purpose	Consider the purpose of measuring this aspect of performance. If there is no good reason, do you really need to measure it?
Relates to	Which service outcomes does the measure relate to? Design measures to support their achievement. By completing this section you ensure the link is made between measures and outcomes.
Target	Which performance targets should you set and by when? This communicates precisely what you are trying to achieve.
Formula	How do you calculate the performance measure? Be precise: the formula must include exactly what you are measuring to avoid any confusion. Measures should be: ▶ Relevant ▶ Accurate and reliable ▶ Comparable and coherent ▶ Accessible and clear ▶ Timely
Types of measures	**Structural:** Measures the organisation's capacity and the conditions in which care is provided by looking at factors such as an organisation's staff facilities or health IT systems. **Process:** Measures how services are provided, i.e. whether an activity is proven to benefit patients or service users, such as writing a prescription or administering a drug. **Outcome:** Measures the results of health and social care. This could include whether the patient's/service users' health improved or whether the person was satisfied with the service received. Outcomes include clinical outcomes and patient/service user outcomes. [119] **Observable measures:** What will people be doing and saying about the service? These are subjective assessments of whether outcomes are being realised. They provide valuable insights and can be based on 'formalising' anecdotal benefits. **Measurable outcomes:** Measures and indicators identified to determine whether outcomes have been delivered. These are agreed measures that are used to track the delivery of outcomes. **Quantifiable outcomes:** Agreed numerical measures identified to quantify outcomes. This may include analysis of trends and patterns over a period of time. **Qualitative outcomes:** Descriptive measures used to determine outcomes. Some qualitative outcomes can be turned into measurable outcomes, e.g. level of satisfaction in a survey.

Frequency	Decide how often you will measure and how often you will review the measure itself.
Who measures?	Identify the persons responsible for the measure.
Source of data	Specify the source of data so you can use the measure consistently. This way you can compare performance between periods accurately.
Who takes action?	Who is responsible for taking action in the measure?
What do they do?	Specify the types of action people should take to improve the performance of the measure.

Adapted from: *NHS – Institute for Innovation and Improvement (2010a: 152)* [282] *and HSE – National Clinical & Integrated Care Programmes (2017)* [178]

People's Needs Defining Change – Health Services Change Guide

Purpose

The Project Initiation Document, also known as a PID, is the agreed document in use in the HSE to assist people undertaking projects. Available at: http://www.hseland.ie/lcdnn/Portals/0/Files/2%20PID%20Template.docx. The purpose of the PID is to outline key information regarding a defined project. The document is designed to be a vehicle for communication to all key stakeholders and can be updated throughout the project.

How to use it?

Assistance in completing the PID is available from the Programme for Health Service Improvement (PHSI) team: http://www.hse.ie/eng/about/Who/healthserviceimprovement/

See also *Programme for Health Services Improvement Handbook – Resources Area on Change Hub* at: http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx

Support is also available from locally based **Programme Management Offices** in each of the Community Healthcare Organisations. Hospital Groups have also designated service improvement/transformation teams that provide programme and project management supports.

HSE Programme for Health Service Improvement

Project Initiation Document

Division:	
Project Name:	
Document Prepared By:	
Date Submitted:	
Date Approved:	
Document Version:	

Document Purpose

The purpose of this Project Initiation Document is to outline the key information regarding the:

[INSERT PROJECT NAME].

This document is designed to be a vehicle for communication to all interested parties and will be updated throughout the project.

Please note: for all projects under the governance of the Programme for Health Service Improvement, the Project Initiation Document should be prepared and submitted for approval using this template. Once approved, it should be transferred to the ProjectVision project management software tool and updated there throughout the project lifecycle.

Executive Summary

Describe the high level purpose for the project.

Context

Describe the circumstances that have led to this project, i.e. define the current business need or problem that the project aims to understand and solve. Describe any other organisational factors that relate to the project.

Objectives

Detail the project objectives – specific, measurable, action-oriented, realistic, and time-based statements that describe what you want to achieve to address the defined business need or problem.

▶	
▶	
▶	
▶	
▶	

Strategic Alignment

Detail how the project supports the achievement of the HSE's Corporate Goals:

1. Promote health and wellbeing as part of everything we do so that people will be healthier.

2. Provide fair, equitable and timely access to quality, safe health services that people need.

3. Foster a culture that is honest, compassionate, transparent and accountable.

4. Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them.

5. Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money.

Scope

Detail what work will be carried out as part of the project, and what work will be excluded. Describe any constraints that may affect the project, i.e. existing conditions that the project team is powerless to change, e.g. external standards and regulation.

In Scope:

Out of Scope:

Constraints:

Benefits

List the benefits of undertaking the project, i.e. the positive outcomes from the change(s) that the project delivers. (Recommended maximum of 10)

Benefit	
Measure	
Target	
Baseline	
Stakeholder	

Benefit	
Measure	
Target	
Baseline	
Stakeholder	

Benefit	
Measure	
Target	
Baseline	
Stakeholder	

Deliverables

List the outputs that a project must deliver in order to achieve its objectives.	
▶	
▶	
▶	
▶	
▶	

Dependencies

List the external dependencies for the project, i.e. projects, events or work outside of control of the project that affect or are affected by the project's work or outcomes.

In particular, what other HSE projects are required to support or be aware of this project.

Dependency	
External Dependency Owner	
Impact	
Assumptions	
Rating	

Dependency	
External Dependency Owner	
Impact	
Assumptions	
Rating	

Dependency	
External Dependency Owner	
Impact	
Assumptions	
Rating	

Risks

List any relevant risks of which you are aware, i.e. something that may arise in the future which has the potential to negatively impact the project.
▶
▶
▶
▶
▶
▶

Resourcing

Outline expected people costs associated with the project.

Governance

List the key governance roles for the project.

Governance Role	
Name	

Governance Role	
Name	

Governance Role	
Name	

Project Initiation Document (PID)

This is the mandated template for developing a PID for any project or programme under the governance of the Programme for Health Service Improvement, HSE.

6.3 Essential Templates – Design

Template 6.3.1: Service Design – Option Generation and Appraisal

Template 6.3.2: Detailed Design of the Service Operational Model

Template 6.3.3: Service Design – Gap and Impact Analysis

Template 6.3.4: Action Plan

Template 6.3.1: Service Design – Option Generation and Appraisal

Purpose

This template enables you to present options in relation to the design or re-design of your **Service Operational Model** (see Template 6.2.3 which outlines the current description of your service). The components of the model are outlined in this template. The advantages and disadvantages of possible options are explored. They are then assessed in line with agreed design principles, alignment with the change objectives and in relation to ease of implementation. Based on this analysis a preferred option can be presented for consideration by the team and key stakeholders. In some instances you may be re-designing **an element of your service**, in which case you can decide what part(s) of the template are most relevant. Remember, however, to maintain a focus on how these changes will impact on other parts of your service and other services that you interact with.

How to use it?

Use one Template per option under consideration (label as A, B or C, etc.)

1. Describe the operational model option in broad details – use the components of the Service Operational Model in the template below as prompts.

2. Outline the advantages and disadvantages of this option.

3. Assess the option in terms of alignment with the design principles identified (rate 1-4).

4. Rate the option in terms of alignment to your change objectives (rate 1-4).

5. Rate the option in terms of ease of implementation (rate 1-4).

6. Summarise your findings and compare with other options in order to reach a position on your preferred option.

Option A or B or C, etc.

Step 1: Generate option description. Broad description of the option – see prompts below re. components of the Service Operational Model.

Components of the Service Operational Model

Model of care or service provision	Human resources
Governance and leadership arrangements	Quality, patient safety and measurement
Pathways and processes of care	Infrastructure (including e-health and ICT)
Business processes	Resource requirements

Step 2: Option appraisal – advantages and disadvantages	
Advantages	Disadvantages

Step 3: Alignment to design principles (higher score signals greater alignment to design principles)				
Criteria	Design option does not align with any of the design principles	Design option aligns with less than half of the design principles	Design option aligns with more than half of the design principles	Design option fully aligns with all of the design principles
Score	1	2	3	4
Tick one score	☐	☐	☐	☐

Step 4: Achievement of change objectives (higher scope signals greater alignment to change objectives)				
Score	1	2	3	4
Tick one score	☐	☐	☐	☐

Step 5: Ease of implementation (higher scope signals 'easier to implement') (See detailed explanation below for scores 1-4)				
Score	1	2	3	4
People impact	☐	☐	☐	☐
Process and system impact	☐	☐	☐	☐
Budget impact	☐	☐	☐	☐
Time to implement	☐	☐	☐	☐
Cost to implement	☐	☐	☐	☐
	Step 5: Total the scores and divide by 5, and use the average score to plot on the axis at Step 6 below.			

Adapted from: *HSE – Office of the Director General of the Health Service (2017) – Developed by PwC and HSE* [184]

Ease of implementation (Guidance to assist you to rate ease of implementation)

	1	2	3	4
People impact	Will **fundamentally change** the roles and responsibilities of those involved in the provision of this particular service	Will have a **significant impact** on the roles and responsibilities of those involved in the provision of this particular service	Will have **some impact** on the roles and responsibilities of those involved in the provision of this particular service	Will have **no impact** on the roles and responsibilities of those involved in the provision of this particular service
Process and system impact	**Fundamental changes** to the way this particular service is managed	**Significant changes** to the way this particular service is managed	**Some changes** to the way this particular service is managed	**No change** to the way this particular service is managed
Budget impact	Implementation of the new operating model will **significantly increase the cost** to the health system of providing this service	Implementation of the new operating model will **increase the cost** to the health system of providing this service	Implementation of the new operating model will **have no impact on the cost** to the health system of providing this service	Implementation of the new operating model **will reduce the cost** to the health system of providing this service
Time to implement	Transition will **take greater than 3 years**	Transition will take between **2 years and 3 years**	Transition will take between **1 year and 2 years**	Transition will take **less than 1 year**
Cost to implement	Costs associated with implementation are estimated to be **high**	Costs associated with implementation are estimated to be **moderate**	Costs associated with implementation are estimated to be **low**	Costs associated with implementation are estimated to be **negligible**

Source: HSE – Office of the Director General of the Health Service (2017) – Developed by PwC and HSE [184]

Step 6: Evaluation Criteria – Overview

The preferred option emerges from plotting on the matrix below (Achievement of Objectives and Ease of Implementation) combined with alignment with design principles.

Outcome – preferred option:

Alignment to design principles (see Step 3):

(Note the number score and associated explanation)

Adapted from: HSE – Office of the Director General of the Health Service (2017) – Developed by PwC and HSE [184]

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ACHIEVEMENT OF OBJECTIVES
(plotting the single score ticked – see Step 4)

4

**Higher benefit,
more difficult to implement**

**Higher benefit,
easier to implement**

3

2

**Lower benefit,
more difficult to implement**

**Lower benefit,
easier to implement**

1

0

0   1   2   3   4

**EASE OF IMPLEMENTATION
(plotting the average score – see Step 5)**

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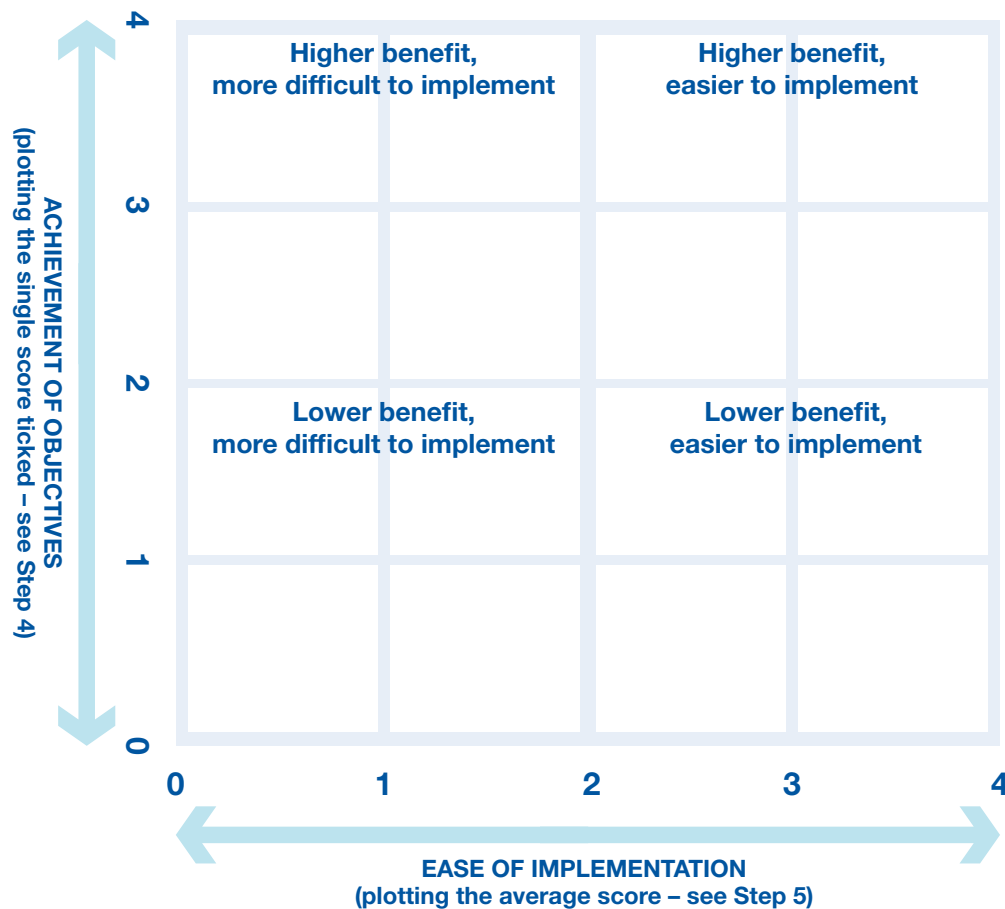
Purpose

This template enables you to describe the detail of your preferred Service Operational Model, i.e. how the future service will be organised and delivered. You can also use the template to focus on an element of your service.

How to use it?

Complete this template for the preferred option

Describe the detail – how the service will be organised and delivered (future vision/design for the service). Use the prompts to guide you. Complete for all parts of the service that are changing and/or note if no change is planned.

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
Model of care or service provision	
▶ Overall philosophy of care (medical, psychosocial, therapeutic, holistic, etc.)	
▶ Who will use the service?	
▶ Who will deliver the service?	
▶ Who will the service interact with most, i.e. referral sources, other teams or agencies, etc.?	

Template 6.3.2: Detailed Design of the Service Operational Model (continued)

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
▶ Eligibility and access criteria	
▶ Service delivery arrangements – location, time, opening hours, etc.	
Governance and leadership arrangements	
▶ Service team purpose, structure and reporting relationships	
▶ Leadership and decision-making arrangements (including governing groups; legal or regulatory requirements)	
▶ Clinical governance arrangements: Supervision practice Monitoring of professional standards, policies and procedures	

Template 6.3.2: Detailed Design of the Service Operational Model (continued)

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
▶ Business governance including finance, human resources, etc.	
▶ Service level agreements, memorandums of agreements or other inter-agency agreements	

Key activities required to deliver the service:

Pathways and processes of care

▶ Referral, assessment, diagnostic, intervention pathway	
▶ Shared care arrangements or protocols	
▶ Transfer or discharge pathway	

6.2.3, 6.3.2,
6.3.3, 6.3.4

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
▶ Supporting process, i.e. booking arrangements, pharmacy systems, notification to other services, etc.	

Business processes

▶ Service planning	
▶ Policies, procedures, protocols and guidelines (PPPG)	
▶ Budget and financial processes, procurement arrangements	
▶ Costing model for the service (income generation, etc.)	

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
▶ Information and data management processes (data bases, etc.)	
▶ e-health and ICT requirements	
▶ Communication and information sharing processes (internal and external)	
▶ Administrative support processes and services	
▶ Procurement processes	

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
Human resources (people strategy)	
▶ Workforce planning, talent management (skill mix), succession planning	
▶ Roles, responsibilities	
▶ Individual and team performance	
▶ Work practices and methods	
▶ Work distribution, caseload management	

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
▶ Learning and development requirements – knowledge, competencies and skills	
▶ Human resources business processes – time and attendance, performance systems, etc.	
▶ Staff engagement processes	
▶ Scheduling, rostering and work flow	
▶ Staff health and wellbeing	
▶ Health and safety arrangements	

Template 6.3.2: Detailed Design of the Service Operational Model (continued)

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
Quality, patient safety and measurement	
▶ Quality, standards and measurement processes (including compliance arrangements, dealing with service feedback/complaints, etc.)	
▶ Indicators – performance measurement (quantitative and qualitative)	
▶ Key performance indicators	
▶ Risk management processes	

Template 6.3.2: Detailed Design of the Service Operational Model (continued)

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**
Infrastructure	
▶ Utilisation of space/facilities, location of service delivery, service settings (capital expenditure plans, etc.)	
▶ Environmental changes	
▶ Equipment (assessment, diagnostic and intervention requirements)	
▶ ICT infrastructure	

Service:	Date:
Component of the Service Operational Model	**Describe the detail of the Service Operational Model, i.e. how the future service is organised and delivered**

Overall resource requirements

Based on describing how the future service is organised and delivered, how will the resources required to implement these changes be assessed?

Who could assist in providing this costing analysis to deliver on the preferred option?

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Template 6.3.3: Service Design – Gap and Impact Analysis

Purpose

This template assists you to identify the gap between your current service and the future Service Operational Model so that actions can be identified to assist you to get from the current situation to a better future.

How to use it?

▶ Transfer the data from Template 6.2.3: Description of the Current Situation (baseline data) into the left-side column (prompts can be deleted once detail is completed).

▶ Transfer the detailed data from Template 6.3.2: Detailed Design of the Service Operational Model into the right-hand column below (Future Service Operational Model design).

▶ Identify the gaps and complete the middle column. This column will contain the actions required to get from the current state to the future design. It will also outline key actions required to address the impact of the changes and the enabling actions.

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
Model of care or service provision		**Model of care or service provision**
▶ Overall philosophy of care (medical, psychosocial, therapeutic, holistic, etc.)		
▶ Who will use the service?		

Service: | **Date:**

Current Service Operational Model (baseline)	Actions based on gap and impact analysis	Future Service Operational Model design
	Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	
▶ Who will deliver the service?		
▶ Who will the service interact with most, i.e. referral sources, other teams or agencies, etc.?		
▶ Eligibility and access criteria		
▶ Service delivery arrangements – location, time, opening hours, etc.		

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
Governance and leadership arrangements		**Governance and leadership arrangements**
▶ Service team purpose, structure and reporting relationships		
▶ Leadership and decision-making arrangements (including governing groups; legal or regulatory requirements)		
▶ Clinical governance arrangements: Supervision practice Monitoring of professional standards, policies and procedures		
▶ Business governance including finance, human resources, etc.		

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
▶ Service level agreements, memorandums of agreements or other inter-agency agreements		
Key activities required to deliver the service:		**Key activities required to deliver the service:**
Pathways and processes of care		**Pathways and processes of care**
▶ Referral, assessment, diagnostic, intervention pathway		
▶ Shared care arrangements or protocols		
▶ Transfer or discharge pathway		

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
▶ Supporting process, i.e. booking arrangements, pharmacy systems, notification to other services, etc.		
Business processes		**Business processes**
▶ Service planning		
▶ Policies, procedures, protocols and guidelines (PPPG)		
▶ Budget and financial processes, procurement arrangements		

Service: **Date:**

Current Service Operational Model (baseline)	Actions based on gap and impact analysis	Future Service Operational Model design
	Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**.	
	Based on an assessment of the impact of the future design on individuals, teams and the service, what actions are needed to address these factors?	
▶ Costing model for the service (income generation, etc.)		
▶ Information and data management processes (data bases, etc.)		
▶ e-Health and ICT requirements		
▶ Communication and information sharing processes (internal and external)		
▶ Administrative support processes and services		

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
Human resources		**Human resources**
▶ Workforce planning, talent management succession planning		
▶ Roles and responsibilities		
▶ Individual and team performance		
▶ Work practices and methods		
▶ Work distribution, caseload management		

Service: **Date:**

Current Service Operational Model (baseline)	Actions based on gap and impact analysis	Future Service Operational Model design
	Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	
▶ Learning and development requirements – knowledge, competencies and skills		
▶ Human resources business processes – time and attendance, performance systems, etc.		
▶ Staff engagement processes		
▶ Scheduling, rostering and work flow		
▶ Staff health and wellbeing		
▶ Health and safety arrangements		

6.2.3, 6.3.2,
6.3.3, 6.3.4

Service:		Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
Quality, patient safety and measurement		**Quality, patient safety and measurement**
▶ Quality, standards and measurement processes (including compliance arrangements, dealing with service feedback/ complaints, etc.)		
▶ Indicators – performance measurement (quantitative and qualitative)		
▶ Key performance indicators		
▶ Risk management processes		

Service:		Date:

Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?	**Future Service Operational Model design**
Infrastructure		**Infrastructure**
▶ Utilisation of space/facilities, location of service delivery, service settings (capital expenditure plans, etc.)		
▶ Environmental changes		
▶ Equipment (assessment, diagnostic and intervention requirements)		
▶ ICT infrastructure		

Service:			Date:
Current Service Operational Model (baseline)	**Actions based on gap and impact analysis** Based on an assessment of the gap between the 'current state' and the 'future state', identify the **actions needed to deliver on the future Service Operational Model**. **Based on an assessment of the impact** of the future design on individuals, teams and the service, what actions are needed to address these factors?		**Future Service Operational Model design**

Overall resource requirements to deliver the change

Based on describing how the future service is organised and delivered, how will the overall resources required to implement these changes be determined?

Who could assist in providing this costing analysis?

What action is required to complete a full assessment of the resource requirements to support the Action Plan?

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Purpose

This template is the Action Plan that will guide the change process. It outlines the outcomes you want to achieve, the actions required to deliver on the outcomes, resources required, persons responsible and timeframes. It is based on the culmination of all your work on defining the need for change and designing a better future. In addition to identifying key actions to get from the current situation to the future, key enabling and sustaining actions also need to be included.

How to use it?

1. Summarise the key outcomes agreed for the change in Column 1 to anchor the Action Plan.

2. Transfer the actions agreed in **Template 6.3.3: Service Design – Gap and Impact Analysis** into Column 2 and align to the outcomes.

3. Identify the **key performance indicators** that will be used to track and measure progress on change actions.

4. Identify **dependencies** and specify the **resources** required to implement the change.

5. Identify **key people responsible** for actions.

6. Identify realistic **timeframe** for delivery of actions.

Service: **Date:**

Outcome*	Actions	Key performance indicators**	Dependencies and resources	Person(s) responsible for action	Timeframe
	Include detailed **actions** Also actions to **address risks, to support enablers of the change and address any dependencies**				

Service: **Date:**

Outcome*	Actions	Key performance indicators**	Dependencies and resources	Person(s) responsible for action	Timeframe

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* **Outcomes:** What is the expected result or benefit of the change? Use a specific change term to assist measurement and analysis, i.e. increased efficiency …, reduced number of …, faster delivery of …, increased satisfaction with …, reduced waiting times …, etc. ('improved' or 'better' are not specific enough).

** **Key performance indicators:** Measures used to track delivery of the outcomes.

6.4 Essential Templates – Deliver

Download Templates:
Each of the Templates
in this section can
be downloaded
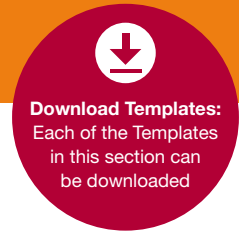
Template 6.4.1: Factors to Monitor During Implementation

Template 6.4.2: Personal Checklist for Change

Template 6.4.3: Working with Emotional Reactions to Change

Template 6.4.4: People Indicators to Support Behaviour Change

Template 6.4.1: Factors to Monitor During Implementation

Purpose

This template identifies key areas that require focus during implementation to maintain momentum and to sustain changes.

How to use it?

Leaders can use the prompts below as a 'checklist' to monitor how well key enablers of change are being attended to and to identify areas where targeted interventions may be required.

No.	Key considerations	Actions needed
1	**Values:** How well have the values of **care**, **compassion**, **trust** and **learning** translated into leadership behaviours and decision-making? Are values evident to citizens and service users as well as to staff?	
2	Are behaviours that do not reflect values challenged and addressed?	
3	**Vision:** Does the vision need to be re-stated and alignment with strategic direction and the delivery of public value re-affirmed?	
4	**Leadership and governance:** Are governance and accountability arrangements robust, contextually relevant and responsive to the needs of the implementation phase?	
5	Are senior leaders and decision-makers available to support and champion the change?	

No.	Key considerations	Actions needed
6	How are **integration, whole system and 'cross service'** issues being addressed? Are appropriate links in place?	
7	How well are human-centred design principles understood and being applied in practice?	
8	How effective and transparent are decision-making processes and follow-up?	
9	Are risks being attended to and control measures in place?	
10	**Resources:** Are the resource requirements in place and tailored to ensure that the pace and scale of the plan can be delivered?	
11	Are additional resources needed in terms of workforce, education/training, ICT, accommodation?	

No.	Key considerations	Actions needed
12	Are practice-based and development supports in place at local level to enable staff to deliver on the change?	
13	**Stakeholders:** Are all stakeholders clear regarding their responsibility for successful implementation of the change, including all of the content, people and process elements?	
14	**Communication and engagement:** Is the communication and engagement plan in place and intensified to target those involved in the rollout of the change?	
15	Are the staff, service user, familiy and citizen **engagement strategies** effective? Is there ongoing focus on developing and sustaining relationships and enabling others to act?	
16	Are communication and information delivery channels and feedback loops effective? Is there clarity on key actions, commencement and milestone dates?	
17	Are feedback processes working – is new information being generated and how is new information and feedback being handled?	

No.	Key considerations	Actions needed
18	**Personal and team impact:** Has there been sustained effort to address **people and cultural** priorities at individual and team levels: ▶ Ongoing communication with staff and service users, ways of resolving issues, acting on feedback as it arises? ▶ Working with staff and their Trade Unions to monitor the impact of the changes? ▶ Supporting staff in implementing new skills required for the change and offering 'hands-on' support on site for challenges? ▶ Continuously scanning to ensure that the old ways of working are phased out sensitively and supporting the new behaviours required to operate in the changed environment? ▶ Monitoring the overall environment for staff – is it supportive? Is there an acknowledgement that change takes time? ▶ Are staff health and wellbeing services available?	
19	**Learning and development supports** to build capacity at individual and team levels. ▶ New skills and learning needed to undertake revised processes and practices ▶ Behaviour change needed to support changing culture over time ▶ Supports in place for those leading the change	
20	**Outcomes and measurement:** Are adequate monitoring and tracking mechanisms established?	
21	Are the outcomes and benefits for service users clearly described and widely communicated?	
22	Are the benefits of the change credible – do staff and service users believe in them? If not, what action is needed?	

No.	Key considerations	Actions needed
23	Are measurement metrics being consistently achieved or are they being missed?	
24	Are stories/narratives that effectively demonstrate progress towards the new culture and a better future being gathered and listened to?	
25	**Trouble shooting and corrective action:** Are clear processes for 'trouble shooting' emerging issues in place?	
26	Are issues or concerns in sustaining the ongoing day-to-day business and the change effort emerging? How are they being addressed?	
27	Are systems in place to recognise the need to take corrective action and have we the means to do it?	
28	How are emerging issues being addressed? Are mechanisms in place to communicate necessary adjustments to the change process?	

No.	Key considerations	Actions needed
29	Are the temporary support structures, systems, policies and technologies still in place and needed?	
30	**Celebrating success:** Does everyone know what to look for in terms of outcomes to recognise and acknowledge success?	
31	Are we taking opportunities to celebrate and recognise milestones, best practices, and affirm new behaviours?	
32	Recognising that change is cyclical and takes time, is there a focus on continuous improvement?	

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Template 6.4.2: Personal Checklist for Change

Purpose

This checklist identifies some of the factors that are important at an individual level in relation to a person's commitment to engage in a change process.

How to use it?

Staff may wish to complete this checklist and use the findings as a basis for discussion and action planning at team level.

These are the factors that I need to believe in to support the change	Yes / No	
I am clear about the reasons for change.	☐	☐
I agree change is necessary.	☐	☐
I am clear on the outcomes of the change for service users.	☐	☐
I have access to regular information.	☐	☐
I have access to information relevant to my role and the role of my team.	☐	☐
I have worked out the personal impact of the change.	☐	☐
My concerns have been listened to.	☐	☐
My concerns have been responded to.	☐	☐
I have had an opportunity to influence decisions.	☐	☐
I have had an opportunity to be involved.	☐	☐
I believe the change is well planned.	☐	☐
I am clear on the change implementation Action Plan.	☐	☐
Milestones are being acknowledged and celebrated.	☐	☐
We are meeting change objectives.	☐	☐
I am feeling positive about the future.	☐	☐

Adapted from: The Workplace Change Project (2016) [381]

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Template 6.4.3: Working with Emotional Reactions to Change

Purpose

This template outlines possible emotional reactions to change that may be evident at individual and team levels. It assists reflection and conversations that can prompt action.

How to use it?

Consider the questions below and use them to prompt conversations within the team – agree actions that will address issues that arise.

No.	Key considerations	Actions
1.	Do the change leaders need support to understand people's emotional reactions during change? Do people feel supported by the organisation leadership? Is a support plan in place?	
2.	Are there legacy issues from past change efforts that need to be considered? Has the pace of recent changes had a significant personal impact?	
3.	Do people fully understand the need for the change – what is driving it?	
4.	Consider the potential 'negative' impacts on people in the current change plan? How can these be worked through and minimised?	

No.	Key considerations	Actions
5.	Are people willing to let go of the status quo or their past successes in order to commit to a new future?	
6.	What degree of influence do people feel they have over making this change, as opposed to feeling that the change is being done to them?	
7.	What support can the change leaders initiate to help people manage their reactions during the change process and work through their emotions in a way that assists them to engage with the change? This will include listening to concerns, acknowledging progress, affirming good practice, coaching, shadowing, job rotation, further education, etc.	
8.	People need support to embed the changes into their everyday activities and behaviours. How are people encouraged to discontinue 'old systems and ways' and integrate changed practices?	
9.	Do people feel they have the competencies and skills to be able to succeed in making the change a success?	

No.	Key considerations	Actions
10.	Are people worried about failing at either their operational duties or the changed practices?	
11.	Are there concerns that the organisation has adequate resources, knowledge and skills to succeed?	
12.	How do people feel about the level of urgency communicated, and their ability to respond effectively in the given timetable?	
13.	What new behaviours and ways of doing things are being demonstrated and encouraged? Can people relate to these in a meaningful way? Do they resonate with the values of care, compassion, trust and learning?	
14.	Do people feel that decisions regarding the change will be made fairly and justly?	

No.	Key considerations	Actions
15.	Do people feel they will lose power and autonomy as a result of the change?	
16.	What resources already exist in the organisation for employee assistance? How can these be levered to support staff?	
17.	How do we acknowledge people's level of comfort with chaos – their need for order and knowing how things will unfold?	
18.	Does the culture of the organisation support people to be open about reactions to change and seek support? Is there a need to enhance communication in this regard?	

Adapted from: *Ackerman Anderson, L. and Anderson, D. (2010: 81)* [3]

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Template 6.4.4: People Indicators to Support Behaviour Change

Purpose

This template includes key people and cultural indicators that are important to monitor during change implementation. They will assist you to be in tune with what mindset and behaviours are emerging in the 'informal system'.

How to use it?

Use the prompts as a reflection exercise at individual and team level. Based on the reflection consider how best to use the data to support helpful conversations and prompt action.

No.	Key considerations	Action needed
1.	What are you observing in the team and at individual level regarding people's reactions and how they are being dealt with?	
2.	Mindset and behaviour changes – what change are we recognising? Are these changes in line with agreed values and being reinforced?	
3.	Are people participating in training/development and coaching?	
4.	Are sustained, meaningful conversations taking place? [115]	

No.	Key considerations	Action needed
5.	What are staff and managers saying regarding team effectiveness drop in/surge in energy levels, targets achieved/missed, tension, etc.?	
6.	Are you observing cultural norms that need to be changed and values that are not being respected?	
7.	Is commitment to the change from the leaders or key stakeholders evident?	
8.	Are people balancing stability and change in terms of capacity to engage in the change as well as performing their ongoing responsibilities?	
9.	Are people coping with the pace and scale of change?	

No.	Key considerations	Action needed
10.	Are there unforeseen relationship issues – tension within the team or between individuals?	
11.	Are you observing political/organisational and personal dynamics/relationships that support or hinder progress?	
12.	How are change leaders coping and demonstrating the ability to 'walk the talk' and model a new better future?	

Adapted from: *Anderson, D. and Ackerman Anderson, L. (2010)* [3]

People's Needs Defining Change – Health Services Change Guide

Additional Resources

and other Appendices

www.hse.ie/changeguide

Contents

Appendix A: Additional Resources

This appendix signposts users of the Change Guide to other helpful supports in the system. It is intended to supplement the information in the Change Guide and is not an exhaustive list. It will be updated periodically. Handouts/templates included in Additional Resources can be downloaded.

Introduction and Context

Literature Review/Conceptual Framework

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The Scottish Government (2015). **Quality, Efficiency & Support Team (QuEST): Applying Quality Improvement Science to Performance Challenges** [online]. http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/Supporting-Improvement

Person-centredness

Person-Centred Principles

Source: Health Service Executive – Quality Improvement Division (2016a). *Draft Pillars and Principles of Person Centred Practice*. Dublin, Ireland: Health Service Executive. (See end of this section)

Person-Centred Practice Framework

Source: McCormack, B. and McCance, T., eds. (2017). *Person-centred Practice in Nursing and Health Care: Theory and Practice, 2nd Ed.* Oxford, United Kingdom: Wiley Blackwell. (See end of this section)

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(See also Section 3: Define)

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Organisation development and change

Organisation Development Approach

Adapted from:

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- ▶ Taylor-Pitt, P. and OD Bootstrappers (2018). *A new architecture of Organisational Development: Developing a blueprint for OD practice in the NHS* [online]. https://odbootstrappers.wordpress.com/downloadables/

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French, W. L., Bell, C. H. and Zawacki, R. A. (2005). ***Organization Development and Transformation: Managing Effective Change***, *6th Ed.* New York, USA: McGraw-Hill/Irwin.

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Person-Centred Principles

Principle 1	Being person-centred means affording people dignity, respect and compassion, whether service user or provider.
Principle 2	Being person-centred means the person is a partner in their own health care, and the health and wellbeing of the person is the focus of care, not their illness or conditions.
Principle 3	Being person-centred means offering co-ordinated care, support or treatment across multiple episodes of treatment, care and therapy over time and acoss services.
Principle 4	Being person-centred means offering personalised health and social care, support or treatment, for example by incorporation the person's family knowledge, values, beliefs and cultural backgrounds into the planning and delivery of care
Principle 5	Being person-centred means being enabling where systems and services are oriented towards supporting persons to recognise and build upon their own strengths, preferences and goals, to achieve their full potential.
Principle 6	A person-centred health and social care system supports the person to make informed decisions about, and successfully manage, their own health and social care at the level they choose, including choices about when to let others act on their behalf.
Principle 7	Being person-centred means collaboration between the person, their family and staff to influence policy and service design and development, and be partners in evaluation.
Principle 8	Achieving a person-centred culture requires a change in behaviour and mindset supported by a system that puts the person at its heart.
Principle 9	Being person-centred means a whole system approach to health and social care that values people, innovation, learning and teamwork throughout the organisation and demonstrates appreciation and respect for the unique contribution that people make regardless of position or status.

Source: HSE – QID (2016a)

People's Needs Defining Change – Health Services Change Guide

Person-Centred Practice Framework
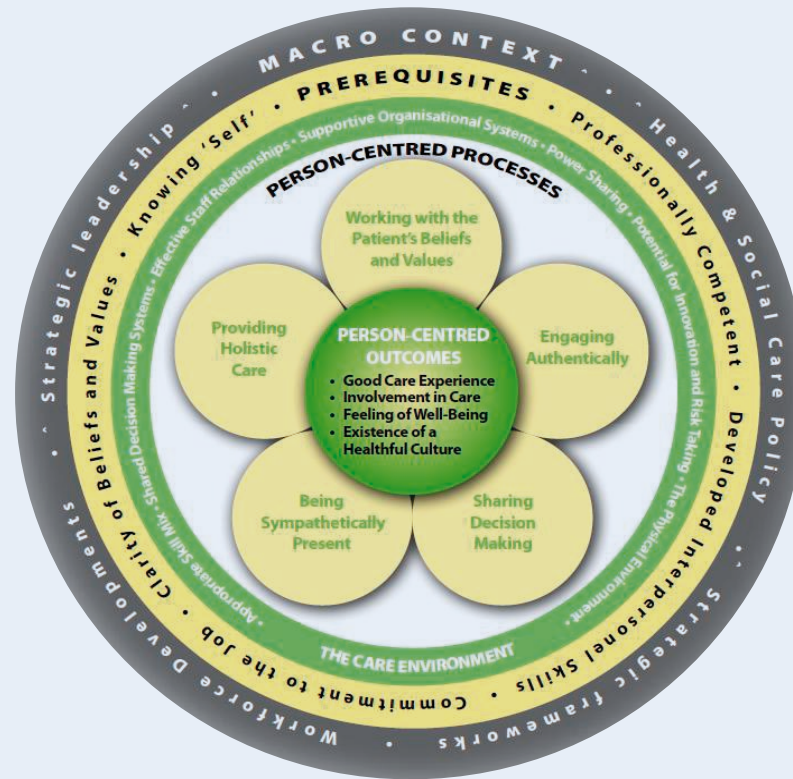
Source: McCormack, B. and McCance, T.V. (in press) (2017)
People's Needs Defining Change – Health Services Change Guide

People's Needs Defining Change – Health Services Change Guide is based on an organisation development (OD) approach that prioritises the people and cultural factors that impact on personal experiences and behaviour and ultimately shape the delivery of safer better healthcare. The Change Framework (contained in the Guide) is founded on the belief that community, citizen, service user and staff engagement strengthens our public accountability commitment, and improves personal experiences and health outcomes. The following key characteristics of an OD approach have been integrated into the guidance provided:

▶ Grounded in **behavioural science and builds from the perspective of people** impacted by change.

▶ **Values driven** – it seeks to understand values, supporting people to translate values into behaviour and action.

▶ Focuses on the **'big picture'** and the **'whole system'**, recognising the **interdependencies** between all of the parts.

▶ Committed to the **transfer** and **sharing of knowledge** and **skills** and to creating **learning organisations** that support innovation and improvement.

▶ Develops the organisation's ability to **adapt to emerging challenges**. This approach is dynamic and attends to real time needs.

▶ **Data driven** and promotes an **action research** approach.

▶ **Collaborative** involving all stakeholders in discovering and finding solutions to their own issues.

▶ Acknowledges the co-existence of **hierarchical** and more **networked, bottom-up approaches** and recognises the value of both.

Adapted from: Coghlan, D. and McAuliffe, E. (2003)

Human-centred design is core to OD and is based on principles of **co-production**, with service users, citizens and staff acknowledging that people who receive and deliver services are best positioned to guide change. It involves 'co creating' solutions and testing options for delivery with the service user in mind. Key stakeholders frame problems together, make sense of the current situation and explore possibilities and solutions that can improve the experiences of all. This human-centred design lens sharpens the focus on the people side of change practices.

A new architecture for OD

The following diagram (Taylor-Pitt, P. and OD Bootstrappers (2018: 16)) highlights the evolving nature of organisation development from diagnostic to dialogic to a more contemporary dynamic approach. The latter encompasses the need for improvisation, the importance of relationships and the focus on collaboration and integration (i.e. focus on the spaces between). It also reflects the wider contextual need to focus on the present – what is happening now given the changing nature of change itself and the requirement for flexibility and emergence.

Diagnostic   **Dialogic**   **Dynamic**
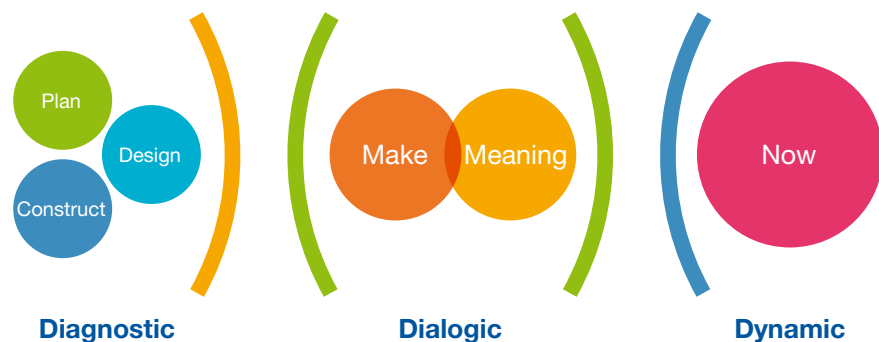
	Diagnostic OD	Dialogic OD	Dynamic OD
Approach	Planned	Structured	Improvised
Instrument	Tools and techniques	Conditions and climate	Curiosity and courage
Role	Change agent	Host	Collaborator
Focus	Tool	Container	Spaces between
Enabler of change	Insight	Meaning	Acceptance
Distance	Future	Conversation and beyond	Moment to moment
Territory	Steps	Language	Self
Success depends on	Scaffolding	Approach	Relationship
State	Solid	Liquid	Gas

Source: *Taylor-Pitt, P. and OD Bootstrappers (2018)*

Data in handout adapted from: *Coghlan, D. and McAuliffe, E. (2003); Oswick, C. (2017); Taylor-Pitt, P. and OD Bootstrappers (2018)*

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Practice Collective Leadership

Leadership development

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Goleman, D. (2000). *Working with Emotional Intelligence.* New York, USA: Bantam.

Practice Collective Leadership

PMI Southwest Ohio Chapter (2011). **The Emotional Competence Framework**. *PMI Southwest Ohio Chapter* [online]. http://pmiswohio.org/images/downloads/2017_Mega_Event_Speaker_Decks/sigler_emerson_handout__the_emotional_competence_framework_golemandaniel.pdf

How to Become a Game-Changing Leader

Adapted from: Ready, D. and Mulally, A. (2017: 5 and 10–11). *How to Become a Game-Changing Leader. MIT Sloan Management Review* [online]. Fall 2017 issue. http://sloanreview.mit.edu/article/how-to-become-a-game-changing-leader/

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10 Ways to Build Change Agency: The Power to Make a Positive Difference
Source: School for Change Agents (2018b: 19). *Module 2 Slides: The power to make a difference* [SlideShare presentation online]. https://www.slideshare.net/HorizonsCIC/school-for-change-agents-module-2-the-power-to-make-a-difference-88708717

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Practice Collective Leadership

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http://www.margaretwheatley.com/articles/Leadership-in-Age-of-Complexity.pdf

Narratives and storytelling

Public Narratives: Ethical Framing and Storytelling

Adapted from:

▶ Ofri, D. (2017). *8 Key Components of Storytelling* (Facebook) 18 August 2017. https://www.facebook.com/DanielleOfriMD/photos/pb.78285974468.-2207520000.1503311138./10155614619874469/;

▶ Taylor, J. R. A. and Singfield, A. (2014: 22). *The little book of Large Scale Change*. London, United Kingdom: National Health Service Improving Quality.
http://www.hseland.ie/lcdnn/Portals/0/GERALDINE/The%20little%20book%20of%20Large%20Scale%20Change%20PDF,%20NoV.pdf

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Bevan, H., Plsek, P. and Winstanley, L. (2011: 70–71). *Part 1 –* **Leading large scale change: A practical guide** *(What the NHS Academy for Large Scale Change learnt and how you can apply these principles within your own health and healthcare setting)* [SlideShare presentation online]. United Kingdom: National Health Service – Institute for Innovation and Improvement. http://www.slideshare.net/NHSIQ/leading-large-scale-change-part-1

Skills and mindsets transformation leaders need

To guide their organisations through periods of major change, senior executives must combine traditional leadership skills with five mindsets that help them balance a series of tensions inherent in leading organisations through complexity.

Skills		Mindsets
Crafting compelling stories	1	Urgency and patience
Building collective leadership	2	Collective leadership and individual accountability
Driving innovation and growth	3	Developmental coach and relentless performance driver
Aligning metrics and rewards	4	Perpetual student and inspiring teacher
Creating a talent pool	5	Humble servant and bold change catalyst

Are you a game-changing leader?

It's not easy to be the kind of executive who can successfully lead an organisation through major changes. Reflect on the 10 questions below to see if you are on your way to becoming that kind of game-changing leader.

1 Have you crafted and articulated your organisation's story, emphasising the importance of it being purpose-driven, performance-focused, and principles-led?

2 Have you engaged your entire organisation to the point where there is a powerful sense of mutual accountability and mutual investment?

3 Have you put in place rigorous and disciplined processes to ensure that your organisation's strategic and operational priorities are identified and implemented?

4 Have you put in place metrics, milestones and rewards that accurately and transparently align with your messaging about the organisation's top priorities?

5 Have you created talent-management processes that ensure that you will have the necessary pipeline of leaders to accomplish your strategy and vision?

6 How well are you balancing the need to express a sense of urgency about driving change with the patience it will take to do things well and right?

7 While you are building a sense of collective leadership accountability, are you also emphasising the importance of each individual delivering excellence?

8 How well are you balancing your role as a developmental coach for key members of your team with the role you must play as the driver of exceptional performance?

9 How well are you balancing your role as a perpetual student who asks important questions with your role as an important teacher of your organisation's purpose, vision, strategy and values?

10 How well do you balance acting as a humble servant and steward of your organisation's reputation and legacy with being a bold catalyst for change?

Adapted from: Ready, D. and Mulally, A. (2017: 5 and 10–11)

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Public narratives

Public narratives use real stories and contain three parts. In one you tell the story of 'me', exposing your values and why you are driven to deliver your transformational change. In another version you create the story of 'us', finding common ground that links us together. Finally, it includes a story of 'now', the change that is imperative, its threat to our shared values and the request for support or action. A public narrative revolves around choice points that illustrate a decision and its consequences, and these choice points reveal our values. It also uses the richness of storytelling with vivid characters and scenes, drawing us into it in the way all good stories do.

Source: *Taylor, J. R. A. and Singfield, A. (2014: 22).*

Ethical framing and storytelling

How can you **frame your message** about change in a way that will win others to your cause and call them to action? If you want people to join you in your change attempts, you will need to engage them. This may include storytelling – the foundation of a story is an emotional foundation. Think intentionally about your stories. Practise them. Turn your experience into a resource that helps you deal with uncertainty, and inspire, connect and organise with others. Here are some guidelines*:*

▶ Tell a story

▶ Make it personal

▶ Be authentic

▶ Create a sense of us (and be clear who 'us' is)

▶ Build in a call for **urgent action**

8 key components of storytelling

▶ Who is my audience?

▶ What is the central problem/conflict? How does it get played out?

▶ What is my goal/message for sharing this story?

▶ What do I want my audience to feel, think or do?

▶ What parts of my story can create that feeling and message?

▶ How does this story relate to other people's experiences?

▶ How did this story change me?

▶ How does this story reflect my journey?

Adapted from: *Ofri, D. (2017); Taylor, J. R. A. and Singfield, A. (2014: 22); School for Change Agents (2017d: 5–7)*

People's Needs Defining Change – Health Services Change Guide

Model Shared Values

Health Service Executive (2016d). *Values in Action.* Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/about/valuesinaction/

Health Service Executive (2017o). *Values in Action Behaviours* [video online]. https://www.youtube.com/watch?v=-sLUefXoV-Y&feature=youtu.be

Ganz, M. (2011b). *Public Narrative Participant Guide*. (Connecting Values to Action).
https://www.ndi.org/sites/default/files/Public%20Narrative%20Participant%20Guide.pdf

Leandro Herrero (2017). *Organizations as social movements* [video online]. https://leandroherrero.com/dr-leandro-herreros-latest-talk/

Engage and Communicate

Engagement

(See also Additional Resources: Section 2)

HSE Staff Engagement Website
https://www.hse.ie/eng/staff/staff-engagement/

Health Service Executive (2016d). *Staff Engagement: What is it and why does it matter?* Dublin, Ireland: Health Service Executive.
http://www.hse.ie/eng/about/Who/QID/Staff-Engagement/
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Top Tips for an Engaged Workforce
https://www.hse.ie/eng/about/Who/QID/Staff-Engagement/

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http://www.hse.ie/eng/staff/staffsurvey/

Health Services National Partnership Forum (2006: 12)*. Information and Consultation Agreement between the health services and trade unions, working under the auspices of the Health Services National Partnership Forum.* Dublin, Ireland: Health Services National Partnership Forum.
https://www.hse.ie/eng/staff/Resources/HR_Agreements/Health%20Service%20Information%20and%20Consultation%20Agreement%202006.pdf

Engage and Communicate

Communication

Health Service Executive – Organisation Development and Design (2008: 13 – **Levels of Communication & Engagement**). *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive.* Kells, Co Meath, Ireland: Health Service Executive.

Health Service Executive – Programme for Health Service Improvement (2017a: 15–19: **Change Communications and Culture Framework** and 96–101: **Communications**). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive.
http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

Health Service Executive – Communications Division (2018). *Guidelines for Communicating Clearly using plain English with our Patients and Service Users: A resource to improve the quality and consistency of our communications.* Dublin, Ireland: Health Service Executive.
https://www.hse.ie/eng/about/who/communications/communicatingclearly/guidelines-for-communicating-clearly-using-plain-english.pdf

Principles for Communicating Change – Change and Communication Culture Framework
O'Sullivan, J. (2016: 12). Presentation given at the Joint Information and Consultation Forum on National Centre Transformation Programme in Dublin on 20th October 2016. Dublin, Ireland: Health Service Executive.

Shared Objectives for Communicating Change and Improvement
Health Service Executive (2017j: 14). *National Centre Transformation Programme: Change and Communications Plan (V0.3 Draft).* Dublin, Ireland: Health Service Executive.

Understand Personal Experiences

Kübler-Ross Change Curve

Adapted from:

▶ Kübler-Ross, E. (1997). *On Death and Dying* (classic edition). New York City, USA: Scribner

▶ McMurray, A. (2016b). *The Kübler-Ross Change Curve*. Belfast, Northern Ireland: Anne McMurray Development Ltd

(See end of this section)

Stepping out of your comfort zone

Source: Teach Thought (2016). *What Happens When You Start Stepping Out Of Your Comfort Zone* [online]. https://www.teachthought.com/pedagogy/happens-start-stepping-comfort-zone/

Understanding core human needs

Adapted from: Anderson, D. and Ackerman Anderson, L. (2010: 140–141). *Beyond Change Management: How to achieve breakthrough results through conscious change leadership*, *2nd Ed.* San Francisco, California, USA: Pfeiffer.

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Finding the Reason Behind the Resistance – Framing Questions

Adapted from: Moulton, T. (2017). Finding the Reason Behind the Resistance. *Change Management Review* [online].
http://www.changemanagementreview.com/finding-the-reason-behind-the-resistance/

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Understand Personal Experiences

National Health Service – Institute for Innovation and Improvement (2010a). **The Handbook of Quality and Service Improvement Tools**. Coventry, United Kingdom: National Health Service. http://www.miltonkeynesccg.nhs.uk/resources/uploads/files/NHS%20III%20Handbook%20serviceimprove.pdf

▶   Pages 304–308: **Resistance – addressing uncertainty**

▶   Pages 309–310: **Resistance – understanding it**

▶   Pages 311–314: **Resistance – working with it**

Being Resilient and Dealing with Resistance to Change
Source: School for Change Agents (2018c). *Module 3:* **Dealing with resistance to change and being resilient** [online]. http://theedge.nhsiq.nhs.uk/school/2018-resources/module-3-being-resilient-and-dealing-with-resistance-to-change/

National Health Service – Institute for Innovation and Improvement (2005). **Improvement Leaders' Guide: Managing the human dimensions of change (personal and organisational development)**. Coventry, United Kingdom: National Health. http://www.qihub.scot.nhs.uk/media/162203/human_dimensions_of_change.pdf

Bridges, W. with Bridges, S. (2017). **Managing Transitions: Making the Most of Change**, *4th Ed.* Boston, Massachusetts, USA: Da Capo Lifelong Books.

Bridges, W. (2013). **"Managing Transitions"** – *Brief summary of key points (presentation)* [online]. http://www.moravian.org/wp-content/uploads/2013/06/Bridges_Transition_Model.pdf

Wheatley, M. (2014). **The Order on the Other Side of Chaos**. *Awakin.org* [online]. 23rd June 2014. http://www.awakin.org/read/view.php?tid=996

Health Service Executive – **National Human Resources Coaching Service** available at: http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Staff_Development/ and http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Training_and_Accreditation/

Understand Personal Experiences

Coaching

Health Service Executive – Human Resources Division (2015a). *Guide to Coaching for Potential Coaches and for Potential Coaching Clients*.
Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/staff/leadership-education-development/guidetocoaching-2015.pdf

Health Service Executive – *National Human Resources Coaching Service* available at: http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Staff_Development/ and http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Training_and_Accreditation/

Mediation

Health Service Executive (2017h). *HSE Mediation Service* [online]. http://www.hse.ie/eng/staff/benefitsservices/Mediation_Service/

Workplace health and wellbeing

Health Service Executive (2017i). *HSE Workplace Health and Wellbeing Unit* [online]. http://www.workwell.ie

Kübler-Ross Change Curve

The Kübler-Ross Change Curve is helpful in understanding reactions and feelings in relation to change. It assists people in plotting their individual reactions and to engage in discussion to assist them to address their concerns and maximise their contribution.

ENERGY MORE INTERNALLY FOCUSED → **ENERGY MORE EXTERNALLY FOCUSED** →

Shock – losing focus

Turbulent time

Euphoria

Coping

Denial

Minimising

Pining

Numbness daze

Blame

Self

Others

Feelings of – panic, dread, helplessness, apathy.

Testing/experimenting

Discovery and learning

Integration and new meaning

Feelings of satisfaction

Feelings of optimism, hope, renewed energy

HOLDING ON   **LETTING GO**   **MOVING ON**

FIGHTING DISINTEGRATION   **REINTEGRATION**

Managerial/leadership tasks at each stage

Minimise shock Give full and early communication of intentions, possibilities and overall direction	Be patient Discuss implications of change with individuals Notice and pay attention to people's small signals	Listen, empathise, offer support Do not suppress conflict and expression of difficult views/emotions Help individuals weather the storm Recognise how the change can trigger off 'past' experience in individuals Try not to take others' reactions personally	Help others complete, e.g. rituals Allow others to take responsibility Encourage Create goals Coach	Encourage risk-taking Exchange feedback Set up development opportunities	Discuss meaning and learning Reflection Overview of experience Celebrate success	Prepare to move on

Adapted from: Kübler-Ross, E. (1997); McMurray, A. (2016b)

People's Needs Defining Change – Health Services Change Guide

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Anderson, D. and Ackerman Anderson, L. (2010: 140–141) present helpful guidance in understanding core human needs. They refer to six primary care needs, all of which can be triggered by events in transformational change. They suggest that we all have six needs to some degree, but one or two are always dominant and drive the majority of our behaviour – these one or two are where we live internally most often. They represent as these authors outline our 'hot buttons', our most sensitive issues as human beings. When our core needs are threatened, we react to protect ourselves. When we are emotionally hurt or upset – or resistant – it is usually because one or more of these core needs have been triggered by events around us.

Core human needs

▶ Security

▶ Inclusion and connection

▶ Power

▶ Order and control

▶ Competence

▶ Justice and fairness

Definition of core needs

▶ **Security** – needing to feel secure and physically and emotionally safe, cared about.
   'I need to know things will be okay. I need to feel physically and emotionally safe, without threat.'

▶ **Inclusion and connection** – needing to be invited to join the group, be part of what is happening and in relationship with others.
   'Will I be on the team that is doing this work or overlooked as a result of this change? Will I keep my relationships intact? Will I be selected?'

▶ **Power** – needing to have direct influence over the outcome and process of the change, needing things to go as I want, needing to maintain power or influence as a result of the change.
   'Will I lose power through this change, or will I gain it? Will I be able to influence things to go the way I want?'

▶ **Order and control** – needing to know what is going on at all times and have things be predictable, structured and planned; needing logic and order in the change, with minimal surprises.
   'I need a clear plan so we know what is happening and can minimise disruptions and chaos.'

▶ **Competence** – needing to feel capable, effective, skilled and right.
   'Will I be able to perform and succeed in the new organisation and be seen as competent and 'in the know'? Will I get adequate training before I am held accountable to produce?'

▶ **Justice and fairness** – needing things to be fair and equitable.
   'Will the decisions of this change and their implications for me be just and equitable? Will politics or nepotism rule over fairness and equality?'

These six core needs (First Tier) are ego needs – the ego's way of feeling okay and that all is good. In transformation, when our ego perceives that these core needs will be met, then it judges the change as good. When our ego perceives they are at risk, then we believe that we have a problem.

Please refer to the authors noted below for further helpful guidance on this topic.

Adapted from: Anderson, D. and Ackerman Anderson, L. (2010: 140–141)
People's Needs Defining Change – Health Services Change Guide

Engaging with stakeholders using a framework of five question types to explore complex ideas, reveal issues and problems, uncover assumptions, increase understanding and develop relevant, practical solutions can help to truly understand what people really think about a change initiative.

- ▶ **Clarification** questions are designed to create a detailed understanding of what people think.

- ▶ **Assumption** questions go one level deeper to uncover why people have these ideas.

- ▶ **Reason and evidence** questions help us to focus colleagues on facts rather than perceptions.

- ▶ **Implication and consequence** questions generate an exploration of probabilities and possibilities, allowing us to embrace solutions.

- ▶ **Viewpoint and perspective** questions help us to walk in other people's shoes, bringing richness to the whole discussion and helping us to create solutions that can work for the majority.

Question type	Example
Clarification	▶ What do you mean by …? ▶ What do you think is the main issue? ▶ Could you give me an example of how this will impact? ▶ Can you expand on … further? ▶ Why is this question about this issue important? ▶ Why do you think that? ▶ Does this question about this issue lead to other important issues and questions?

Question type	Example
Assumption	▶ What assumptions are you making about this issue/this change? ▶ What would lead someone to make this assumption ▶ What are we assuming here? ▶ What could we assume instead? ▶ You seem to be assuming …; do I understand that correctly?
Reason and evidence	▶ What would be an example of this impact/concern/issue? ▶ Why do you think that this is true? ▶ What other information do we need to analyse this impact/concern/issue? ▶ Could you explain your reasoning to me? ▶ How did you come to this conclusion? ▶ Is there reason to doubt that evidence? ▶ What led you to that belief? ▶ Is this your idea or did you hear it elsewhere? ▶ Have you always felt this way? ▶ What, in particular, has influenced your opinion on this?
Implication and consequence	▶ What effect would that have? ▶ On a scale of 1–10 how likely is that to really happen? ▶ What alternative is there? ▶ How would you mitigate that effect? ▶ If that happened what else might happen as a result?
Viewpoint and perspective	▶ How would others respond to this question/concern/issue? ▶ How could you answer the objection that … would make? ▶ What might someone who believed … to be true think? ▶ What alternatives are there? ▶ How else could you look at this issue/concern? ▶ What would you need to know to be able to do that?

Adapted from: Moulton, T. (2017)
People's Needs Defining Change – Health Services Change Guide

Support Behaviour Change

Health Service Executive (2016d). *Values in Action.* Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/about/valuesinaction/

Prochaska, J. O., DiClemente, C. C. and Norcross, J. C. (1992). *In search of how people change: Applications to addictive behaviours*. *American Psychologist,* 47(9), 1102–1114.

Wilbers Integral Model – Integrated Development for Organisational Effectiveness
Source: Wilber, K. (2000). *A Theory of Everything: An Integral Vision for Business, Politics, Science and Spirituality*. Adapted by: Bermingham, M. (2016).
Wilbers Integral Model: Integrated development for organisational effectiveness. Cork, Ireland: Health Service Executive. (*To access this paper, please email:
Michele.Bermingham1@hse.ie.*)

Winning Hearts and Minds in the 21st Century

Adapted from: Basford, T. and Schaninger, B. (2016b). Winning hearts and minds in the 21st century. *McKinsey Quarterly* [online] April 2016.
https://www.mckinsey.com/business-functions/organization/our-insights/winning-hearts-and-minds-in-the-21st-century

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Health Service Executive – Programme for Health Service Improvement (2017a: 47–48*: Behavioural Change*). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive. http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/ Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

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Aiken C. and Keller S. (2009). *The Irrational Side of Change Management*. *McKinsey Quarterly* [online]. April 2009. https://www.mckinsey.com/business-functions/ organization/our-insights/the-irrational-side-of-change-management

Michie, S., van Stralen, M. M. and West, R. (2011). *The Behaviour Change Wheel: a new method for characterising and designing behaviour change interventions. Implementation Science* (2011) 6:42 [online]. https://implementationscience.biomedcentral.com/articles/10.1186/1748–5908–6–42

Winning Hearts and Minds in the 21st Century – Influence Model

Organisations can now influence people in new ways. The workforce is increasingly made up of younger generation millennials who are hyper connected to digital platforms that increasingly influence their motivation to engage with change. Leaders must therefore consider new ways to influence mindset and behaviour change. The following diagram (Influence Model) identifies four key areas that need to work together to provide tangible proof that will influence people's mindset and behaviour change. Leaders must also take account of 'What's changed' in the wider context as noted in the diagram.

Millennials: a person reaching young adulthood in the early twenty-first century.

WHAT'S CHANGED
Social Networks allow companies to gauge the opinions of the group – but employees can also be easily swayed by the collective voice.

WHAT'S CHANGED
Technological advances and new channels facilitate more frequent and increasingly personalised communication.

ROLE MODELLING
"I see my leaders, colleagues and staff behaving differently."

FOSTERING UNDERSTANDING AND CONVICTION
"I understand what is being asked of me and it makes sense."

"I will change my mind-set and behaviour if…"

DEVELOPING TALENT AND SKILLS
"I have the skills and opportunities to behave in the new way."

REINFORCING WITH FORMAL MECHANISMS
"I see that our structures, processes and systems support the changes I am being asked to make."

WHAT'S CHANGED
Digital platforms provide an opportunity for organisations to highlight – and celebrate – those who have acquired new knowledge and skills.

WHAT'S CHANGED
The things that motivate millennials probably differ from what motivates more tenured employees – organisations may need to be more creative with rewards

Source: Basford, T. and Schaninger, B. (2016b)
People's Needs Defining Change – Health Services Change Guide

Invest in People and Teams

8 Steps to Become More Resilient

Source: Center for Creative Leadership (2016). 8 Steps to Resiliency. *Center for Creative Leadership* [online]. 6th April 2016. https://www.ccl.org/blog/8-steps-to-resiliency-and-how-they-led-ccl-to-re-launch-this-blog/

10 Ways to Build Your Resilience

Source: School for Change Agents (2018d: 32). *Module 3 Slides: Dealing with resistance to change and being resilient* [SlideShare presentation online]. https://www.slideshare.net/HorizonsCIC/school-for-change-agents-2018-module-3-being-resilient-and-dealing-with-resistance-to-change-89278504

10 Things Fab Teams Do!

Source: Bevan, H. (2017c). *Here's what fabulous teams do! Sketchnote created for session B2 at #Quality 2017 "How to build a high performance, high energy team": 10 Things Fab Teams Do!* [Twitter] 24th August 2017. https://twitter.com/helenbevan/status/900875363286474753

Competencies for Change and Improvement Practitioners

Adapted from: Lewis, H. (2017b). How to build an effective change team*. Halo Psychology* [online]. https://halopsychology.com/2017/09/07/how-to-build-an-effective-change-team/

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The European Hospital and Healthcare Employers' Association-European Public Sector Union (HOSPEEM-EPSU) (2016). ***Joint Declaration on Continuing Professional Development (CPD) and Life-Long Learning (LLL) for All Health Workers in the EU*** [online]. https://www.epsu.org/sites/default/files/article/files/Final-Joint-Declaration-CPD&LLL-08.11.2016-EN.pdf

Community Healthcare Organisation Team Establishment and Development Checklist

Source: Keoghan, D. (2017). *Community Healthcare Organisation Team Establishment and Development Checklist.* Tullamore, Co Offaly, Ireland: Health Service Executive.

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Invest in People and Teams

HSE and other supports

Please contact HSE Leadership, Education and Talent Development team for more information and for details of services/supports available:

Health Service Executive – Human Resources Division (2017). *HSE Leadership, Education and Talent Development* [online]. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/Who/hr/Departments.html

Online HSE resources

Health Service Executive (2017f). *HSeLanD and Change Hub Resources* [online]. www.hseland.ie and http://www.hseland.ie/lcdnn/Welcome/tabid/396/Default.aspx

HSE Coaching and Mentoring Service

Health Service Executive – *National Human Resources Coaching Service* available at: http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Staff_Development/ and http://hsenet.hse.ie/Human_Resources/Workplace_Relations_Unit/Training_and_Accreditation/

Health Service Executive – Human Resources Division (2015a). *Guide to Coaching for Potential Coaches and for Potential Coaching Clients*. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/staff/leadership-education-development/guidetocoaching-2015.pdf

Health Service Executive – Human Resources Division (2018a). *HSE Women in Leadership Mentoring Programme: A Guide for Mentees*. Dublin, Ireland: Health Service Executive. https://preview.hse.ie/eng/staff/benefitsservices/hse-women-in-leadership-mentoring-programme-guide-for-mentees.pdf

Health Service Executive – Human Resources Division (2018b). *HSE Women in Leadership Mentoring Programme: A Guide for Mentors*. Dublin, Ireland: Health Service Executive. https://preview.hse.ie/eng/staff/benefitsservices/hse-women-in-leadership-mentoring-programme-guide-for-mentors.pdf

Health Service Executive – Human Resources Division (2018c). *Mentoring Programme: Women in Leadership*. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/staff/benefitsservices/mentoring-programme-women-in-leadership.pdf

Invest in People and Teams

Workplace Relations Unit, National Human Resources Division

Health Service Executive – National Human Resources, Quality Assurance & Verification Division and the IMD Co-Design Group (2017). *Making Decisions about Appropriate Pathways for Investigations and Reviews*. https://www.hse.ie/eng/about/qavd/protected-disclosures/incident-management-framework/making-desisions-about-appropriate-pathways-for-investigation-and-reviews-guidance.pdf

Team working

Hanlon, V. (2016). *HSE Team Diagnostic Instrument* based on Heslin, C., Kinch, C. and Malone, J. (2004). *Team Working Policy and Guidelines* and *Team Working Diagnostic*. Kells, Co Meath, Ireland: North Eastern Health Board.

Aston Team Performance Inventory

Aston Team OD. *Aston Team Performance Inventory* [online]. http://www.astonod.com/team-tools/aston-team-performance-inventory-diagnostic-tool/

Heslin, C. and Ryan, A. (2010). *Improving Team Working: A Guidance Document*. Kells, Co Meath, Ireland: Health Service Executive.
http://www.hse.ie/eng/staff/Resources/cmr/itw.pdf

Mindshift: Activities for Teams, Innovators and Change Agents

BC Patient Safety and Quality Council – *Working Together Accelerating Improvement* (2016). *Mindshift: Activities for Teams, Innovators and Change Agents*. Vancouver, British Columbia, Canada: BC Patient Safety and Quality Council. http://mindshift.bcpsqc.ca/wp-content/uploads/2016/05/0Full_MindShift.pdf

Whittle, S., Colgan, A. and Rafferty, S. (2011). *Capacity Building: What the literature tells us*. Dublin, Ireland: Centre for Effective Services.
http://www.effectiveservices.org/downloads/Capacity_Building_What_the_Literature_tells_us_v1_4.11.13.pdf

Developing change agents

Horizons Team – The Edge NHS: **Supporting frontline staff to do their jobs better**. http://www.theedge.nhsiq.nhs.uk/about/horizons-team/

School for Change Agents – *The Edge NHS.* http://theedge.nhsiq.nhs.uk/school/

Competencies for Change and Improvement Practitioners

The following are the main competencies needed to support service improvements and manage change effectively. When working with change teams, it is having all these competencies (or the lack of) across the team that makes the difference.

- **Analytical thinking** – the ability to understand and comfortably use employee, quality standards, financial, performance and any other service/clinical data that is relevant.
- **Business thinking** – the ability to understand the wider health and social care context within which the organisation is operating and the opportunities that change presents.
- **Communication** – the ability to speak and write in ways that are straightforward, easy to understand and compelling.
- **Handling ambiguity** – the ability to make sense of (and help others make sense of) what is going on when there is uncertainty and absence of a clear pathway.
- **Handling complexity** – the ability to understand and work with various organisational systems, particularly where other services/organisations might be affected by the change.
- **Influence, persuasion and negotiation** – the ability to get the majority of people on board, adopting a 'win-win' approach.
- **Managing relationships** – the ability to build and maintain relationships with a wide range of people from all levels and parts of the organisation through effective engagement / co-production approaches and methodologies.

- **Addressing conflict** – the ability to work with teams/services to openly address conflict, find common ground/interests, explore solutions and seek resolutions.
- **Planning and organising** – the ability to ensure you and whoever else you're working with to deliver the change get the right things done at the right time.
- **Resilience** – the ability to handle whatever is thrown at you (but not be a pushover), bounce back and not take things personally.
- **Strategic thinking** – the ability to keep the 'big picture' in mind and focus on the outcome to be achieved.
- **Consultancy skills** – the ability to analyse problems, guide and support managers and teams to address complex issues and find workable solutions.
- **Human centred design** – the ability to use human centred design thinking/ practices to influence and shape how services are improved or developed, co-creating solutions and testing options for delivery with the service user in mind.
- **Knowledge of improvement/change methods** – the ability to use improvement/ change methodologies based on assessment of need, enabling others to become self sufficient and build capacity for change and improvement across the system.

Adapted from: Lewis, H. (2017b)
People's Needs Defining Change – Health Services Change Guide

CHO Team Establishment and Development Checklist

Please use this checklist to identify areas that may require your attention in the initial stages of establishing a team or a working group. There are resources available on www.hseland.ie and through your local Leadership, Education and Development (LED) group should you need guidance and/or facilitation around each of these points.				Priority & Timeline: Use the timeline and RAG (Red, Amber, Green) system to prioritise your actions.				

Governance and functioning checklist	Yes / No / N/A	Action required	By Whom	When	0–3 mths	3–6 mths	6–12 mths	12 mths+	Priority RAG
1: What is the vision for the service/division/team/group?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
2: Has the mission statement of the team/group been discussed and agreed?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
3: Is the purpose of the group defined? Are people clear what you are – a group or a team?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
4: Are the team/group goals and objectives clear to all? What are their short, medium, long-term objectives?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐

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	Yes / No / N/A	Action required	By Whom	When	0–3 mths	3–6 mths	6–12 mths	12 mths+	Priority RAG
5: Are the objectives consistent with the vision and objectives of the team/group/service?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
6: Are the team/group values and guiding principles clear and known to all?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
Terms of reference/ housekeeping	**Yes / No / N/A**	**Action required**	**By Whom**	**When**	**0–3 mths**	**3–6 mths**	**6–12 mths**	**12 mths+**	**Priority RAG**
7: Are the team/group arrangements/terms of reference agreed and documented (chairperson appointment, duration of office, chair rotation, voting rights, quorum, note-takers)? Templates available from LED	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
8: Are the meeting procedures or housekeeping arrangements for the team/group agreed and documented (for example, frequency of meetings, notice of meetings, quorum required, who takes minutes, timing for agenda items, approval of agenda, timing for dispatch of minutes, timing for sign-off of minutes)?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐

	Yes / No / N/A	Action required	By Whom	When	0–3 mths	3–6 mths	6–12 mths	12 mths+	Priority RAG
9: Is the team/group co-located or a virtual team/group? Have you discussed how this will impact on the dynamics of the team/group? What strategies have you identified that will negate the issues identified?									Red Amber Green
10: Is the management structure of the service/team members known to all?									Red Amber Green
11: Is there a communication strategy identified for all stakeholders?									Red Amber Green
Roles and responsibilities	**Yes / No / N/A**	**Action required**	**By Whom**	**When**	**0–3 mths**	**3–6 mths**	**6–12 mths**	**12 mths+**	**Priority RAG**
12: Is the composition of the team/group agreed? Do service users/patients/unions need to be involved – refer to your stakeholder analysis?									Red Amber Green

13: Are the roles and responsibilities of the team/group agreed and documented? Does the team/group have an agreed role definitions and a process for allocation for key work areas?												Red Amber Green
14: Are all members clear on each other's roles, how they overlap and will interact and collaborate?												Red Amber Green
15: Are each person's skills and abilities used to the full potential?												Red Amber Green
16: Is there a plan to utilise these skills and abilities?												Red Amber Green
17: Is the team/group clear on how decisions will be made and by whom? Is the team/group clear on their level of involvement in decision-making within the group (implicit, unanimous, consensus, etc.)?												Red Amber Green

18: How are conflicts managed within the team/group? Is there a conflict management resolution policy?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
19: Is there an identified service manager who is accountable and responsible for the overall team/group/service in the area?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
20: Is there an identified manager for each unit/team/group who has a clear reporting relationship to the service manager and to the main senior management team/group?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
21: Do all team/group members have appropriate supervision/clinical supervision if required?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
22: Have performance achievement sessions been held with each member of staff? Refer to local LED lead for support and advice.	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐

Business processes	Yes / No / N/A	Action required	By Whom	When	0–3 mths	3–6 mths	6–12 mths	12 mths+	Priority RAG
23: Is there a framework agreed for compliance with standards and performance targets?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
24: Are the KPIs and monthly/ annual monitoring and evaluation reporting mechanisms of the team/group known to all?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
25: Is each team/group member clear on their responsibility to attend to these KPIs/monitoring and evaluation reporting mechanisms?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
26: Has a quality assurance system been identified that best fits the mission statement and purpose?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐
27: Have continuous quality improvement initiatives been identified? How will they be identified and measured?	☐ ☐ ☐				☐	☐	☐	☐	Red ☐ Amber ☐ Green ☐

28: Have you considered a mechanism agreed for service planning?	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐
29: How can service users/key stakeholders' views be heard concerning service planning?	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐
30: Where interagency partnership/consultancy arrangements applies, are there service arrangements and legal frameworks in place?	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐
31: Are there risk management processes in place? Who manages the risks? And how will they be managed by the team/group? Refer to Risk Management PPPGs.	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐
32: Are there stress management processes in place? Refer to Work Positive initiative.	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐

	Yes / No / N/A	Action required	By Whom	When	0–3 mths	3–6 mths	6–12 mths	12 mths+	Priority RAG
33: Is there a policy on confidentiality in place?	▢ ▢ ▢				▢	▢	▢	▢	**Red** ▢ **Amber** ▢ **Green** ▢
34: Have you considered a procedure for receiving and responding to formal complaints?	▢ ▢ ▢				▢	▢	▢	▢	**Red** ▢ **Amber** ▢ **Green** ▢
35: Are there policies and procedures for records maintenance, management and security?	▢ ▢ ▢				▢	▢	▢	▢	**Red** ▢ **Amber** ▢ **Green** ▢
Team/group development	**Yes / No / N/A**	**Action required**	**By Whom**	**When**	**0–3 mths**	**3–6 mths**	**6–12 mths**	**12 mths+**	**Priority RAG**
36: Is there a formal mandatory induction programme for all team/group members?	▢ ▢ ▢				▢	▢	▢	▢	**Red** ▢ **Amber** ▢ **Green** ▢

37: Have team/group members identified the skills and training needs of the team/group? For support and templates on a Training Needs Analysis which covers Statutory and Mandatory Training, please refer to your local LED department. Has each manager completed the following training?: ▶ People Management Legal Framework ▶ Trust in Care ▶ Dignity at Work	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐
38: Do you have regular team/group reflexivity meetings to reflect on and adapt the working methods and functioning of the team? Refer to LED for support and facilitation on PESTELI (checklist for analysing the environment of an organisation or service) and when considering pending changes that will impact on the team/group.	☐ ☐ ☐				☐	☐	☐	☐	**Red** ☐ **Amber** ☐ **Green** ☐

39: Have you had a facilitated session on the vision, mission, purpose, function and values of the team/group? Do you have agreement on what behaviours are acceptable and what behaviours mean you are not living the values of the team/group and how to measure same?												**Red** **Amber** **Green**	
40: Does the team/group have opportunities to meet and bond outside of the structured work environment?												**Red** **Amber** **Green**	
41: Are projects/work streams identified that utilise a mix of team/group members and their skills and abilities from across the area?												**Red** **Amber** **Green**	
42: Are you aware of your team/ groups current perception of the team/group effectiveness? Refer to LED for support, tools and templates. Have you considered doing pre and post evaluation with your team?												**Red** **Amber** **Green**	

43: Do you have a plan to continuously improve the service provided by the team/group which includes all of the key stakeholders?											Red	
											Amber	
											Green	

Source: Keoghan, D. (2017)

Contact details: Denise Keoghan, HSE HR Leadership, Education & Training Development Specialist/Lead for Coaching & Change Management, Tullamore, Co Offaly (denise.keoghan@hse.ie)

People's Needs Defining Change – Health Services Change Guide

Our ✓**alues**
Care Compassion Trust Learning

Network and Partner

An Assessment of Community Involvement: individual and organisational
Pillinger, J. (2010: 18). *Formative Evaluation of the Joint Community Participation in Primary Care Initiative (Final Report).* Dublin, Ireland: Health Service Executive.
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Methods used to promote, develop and sustain community participation
Pillinger, J. (2010: 24). *Formative Evaluation of the Joint Community Participation in Primary Care Initiative (Final Report).* Dublin, Ireland: Health Service Executive.
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Use Evidence and Lever Technology

Department of Health and Health Service Executive (2013**). eHealth Strategy for Ireland.** Dublin, Ireland: Department of Health.
http://www.ehealthireland.ie/Knowledge-Information-Plan/eHealth-Strategy-for-Ireland.pdf

Health Service Executive (2018). **eHealth Ireland** [online]. http://www.ehealthireland.ie/

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http://www.hse.ie/eng/about/Who/QID/MeasurementQuality/measurementimprovement/Measurement-for-Improvement-Curriculum-Ver1.pdf

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and leadership development in NHS-funded services. United Kingdom: National Improvement and Leadership Development Board.
https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf

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Centre for Effective Services (2011b). **Introduction to Logic Modelling**. Dublin, Ireland: Centre for Effective Services.
http://most.ie/webreports/MOST%20Reports%20March11/New%20Folder/Workbook%20One%2028.2.11%20v5.pdf

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HSE Library Services

Health Service Executive (2017g). **HSE Library Services** [online]. http://hselibrary.ie/

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Strategy and Implementation Plan for the National Health Library and Knowledge Service: Turning Knowledge into Action – Enabling Care; Improving
Health 2018 – 2023. Dublin, Ireland: Health Service Executive. http://hselibrary.ie/wp-content/uploads/2018/04/Turning-Knowledge-into-Action-Enabling-Care-
Improving-Health-2018-2023.pdf

Deliver Public Value and Be Accountable

Public value

Creating public value

Adapted from:

▶ Moore, M. H. (2013). *Recognizing Public Value*. Cambridge, Massachusetts, USA: Harvard University Press.

▶ O'Connor, N. (2016: 3). *Public Value Creation (Academic Submission to the Disability Federation of Ireland Seminar 4th February 2016)*.
http://www.per.gov.ie/wp-content/uploads/Nat-OConnor-Universtity-of-Ulster-Academic-Submission-Appendix.pdf

▶ O'Connor, N. (2017: 21). *Making an Impact: The Public Value of Citizens Information Services in Ireland*. Ireland: Citizens Information Service.
http://www.citizensinformationboard.ie/downloads/social_policy/CIS_Making_an_Impact_2017.pdf

▶ Standards in Public Office Commission (2008). *Civil Service Code of Standards and Behaviour*. Dublin, Ireland: Standards in Public Office Commission.
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▶ Health Service Executive (2009: 4–5). Health Service Executive – *Code of Standards and Behaviour (Framework for the Corporate and Financial Governance of the Health Service Executive – Document 2.1)*. Dublin, Ireland: Health Service Executive.
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Performance accountability

Health Service Executive (2017m). **Performance and Accountability Framework 2017**. Dublin, Ireland: Health Service Executive.
http://www.hse.ie/eng/services/publications/corporate/Performance-and-Accountability-Framework-2017-Mar.pdf

Health Service Executive – National Human Resources (2016: 14). **Performance Achievement Framework** *(HSE HR Performance Achievement – Presentation: Connecting with our People – through Quality Conversations)*. Dublin, Ireland: Health Service Executive.
http://www.hse.ie/eng/staff/benefitsservices/Performance_Achievement/performance_achievement.html

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Deliver Public Value and Be Accountable

Governance

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London, United Kingdom: Office for Public Management Ltd and The Chartered Institute of Public Finance and Accountancy.
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Standards and regulation

Health Information and Quality Authority (2012). *A Guide to the National Standards for Safer Better Healthcare*. Dublin, Ireland: Health Information and Quality Authority. https://www.hiqa.ie/sites/default/files/2017–01/Safer-Better-Healthcare-Guide.pdf

Mental Health Commission (2018). *Judgement Support Framework*. Dublin, Ireland: Mental Health Commission. http://www.mhcirl.ie/File/JSFversion5.pdf

Citizens at the centre of defining policy, service design and delivery

Public value describes the value that an organisation provides to society. It seeks to improve social outcomes at community level alongside meeting the needs of individuals. It requires a shared understanding of the important values that citizens, tax payers, service users and communities want to see achieved by and reflected in public service organisations. It also presents a way of improving decision-making by calling for public service leaders to engage with service users and the wider public, thereby promoting greater trust in public institutions.

In creating public value leaders must answer three questions:

1. Is the purpose valued by the public?
2. Will it be politically and legally supported?
3. Is it administratively and operationally feasible?

Adapted from: *Moore, M. H. (2013)*

Adding value to society

'Societal value' is created not just in the output of public services but also in the processes and ethos involved in service provision. All organisations – public, private and voluntary – create 'public value' whenever they generate economic, social or environmental benefits as part of, or alongside, their core activity. Organisations create public value by adhering to the qualities of good public services.

Good public services are **ethical**, provide high **quality** service, are financially **efficient** and **effective**, are **responsive** to people's needs, are **accountable** to the taxpayer, are **equitable** in how they treat anyone seeking a service, and are ecologically **sustainable**.

Adapted from: *O'Connor, N. (2016: 3 and 2017: 21)*

Ethical dimension of public value creation

The Irish Civil Service Code of Standards and Behaviour identifies the following principles:

- ▶ Integrity
- ▶ Impartiality
- ▶ Effectiveness
- ▶ Equity
- ▶ Accountability

Source: *Standards in Public Office Commission (2008)*

Supporting a Culture of Safety, Quality and Kindness
A Code of Conduct for Health and Social Service Providers (May 2018)

Introduction

The Department of Health has developed a unified Code of Conduct that "applies to all service providers and individuals acting on behalf of those service providers that come into contact with a user of health or social services."

The purpose of the Code of Conduct is:

1. To **ensure the safety of those that access our services**, simultaneously striving to ensure that the **quality of these services is always improving** and establishing that the **primary obligation** of anyone working in health or social services is to proactively advocate within their organisation in the best interests of service users, treat them as they would a family member and challenge others to do the same.

2. To implement a set of responsibilities:

   ▶ That **clearly set out the standards expected of service providers** in relation to promoting and achieving an optimal safety culture, corporate and clinical governance and performance in the organisation.

   ▶ The ongoing adherence of which should be monitored by:

   ▼ Service providers as part of internal corporate and clinical governance arrangements and audit.

   ▼ HIQA in the context of the Health Act 2007 and the licensing of all providers of health and social services.

   ▼ Mental Health Commission in accordance with the Mental Health Act 2001 and its Quality Framework for Mental Health Services in Ireland.

   ▶ That **complement and build** upon existing health and social service provider corporate and clinical governance systems, policies and performance frameworks as well as professional regulation and associated codes of professional conduct.

▶ That **articulate a framework** against which service providers, board members, executives and employees can be assessed and held to account should they be found to be in breach of the Code.

The **guiding principles** are:

▶ Patient-Centredness/Putting people first

▶ Kindness, Dignity and Respect

▶ Openness and transparency, honest communication, learning and accountability

▶ Excellence, effectiveness and efficiency

▶ Working together/team work and patient/family involvement

Implementation of the Code of Conduct

The implementation of the Code is considered a key element of achieving an improved patient safety culture throughout health and social care services.

Please consult the full text of the Code of Conduct: https://health.gov.ie/wp-content/uploads/2018/07/Code-of-Conduct-15062018.pdf

Source: *Department of Health and Health Service Executive (2018:2–16)*

Other relevant policies:

• Policy on Good Faith Reporting: https://www.hse.ie/eng/staff/resources/hrppg/good-faith-reporting-policy-2011.pdf

• Policy on Fraud: https://www.hse.ie/eng/staff/resources/hrppg/framework%20for%20the%20corporate%20and%20financial%20governance%20of%20the%20health%20service%20executive.pdf

Working with service users, families, citizens, communities and staff

See also Engage and Communicate, and Network and Partner

WHO makes change happen? List A and List B

Source: Bevan, H. (2016a: 6–7). ***Rocking The Boat and Staying in it: How to be a Great Change Agent*** [SlideShare presentation online]*.*
http://www.slideshare.net/HelenBevan/how-to-be-a-great-change-agent

Service user, patient and family engagement

Guidance on Service User Involvement in Change – Checklist:

Health Service Executive – Advocacy Unit (2010: 32–33). *Service User Involvement Methods – A Guidance Document.* Naas, Co Kildare, Ireland:
Health Service Executive. https://hse.ie/eng/services/yourhealthservice/Documentation/MethodsResource2010.pdf

Health Service Executive (2017o). ***The Mental Health Engagement Office*** [online]. https://www.hse.ie/eng/services/list/4/mental-health-services/
mentalhealthengagement/apply/

Government of Ireland. ***Assisted Decision-Making (Capacity) Act 2015***. Dublin, Ireland: Stationery Office. http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/pdf

10 Guiding Principles for Working Together (Community Participation):

Health Service Executive – Advocacy Unit (2010: 34). *Service User Involvement Methods – A Guidance Document.* Naas, Co Kildare, Ireland: Health Service
Executive. https://hse.ie/eng/services/yourhealthservice/Documentation/MethodsResource2010.pdf

Health Service Executive – Quality Improvement Division (2017b). ***Guidance for Setting up and Engaging Patients and Family Members on Patient Councils***.
Dublin, Ireland: Health Service Executive.
http://www.hse.ie/eng/about/Who/QID/Person-Family-Engagement/ResourcesQID/Guidance-for-Setting-Up-Patient-and-Family-Councils-V1.pdf
http://www.hse.ie/eng/about/Who/QID/Person-Family-Engagement/ResourcesQID/

Health Service Executive – Clinical Strategy and Programmes Division (2017c). ***Your Voice Matters: Stories to Build a Better Health Service*** [online].
https://www.hse.ie/eng/about/Who/cspd/patient-narrative/your-voice-matters/

Working with service users, families, citizens, communities and staff

Health Information and Quality Authority, Health Service Executive and Department of Health (2018). ***The National Patient Experience Survey: Findings of the 2017 inpatient survey***. Dublin, Ireland: Health Information and Quality Authority. https://www.patientexperience.ie/app/uploads/2017/12/NPES_National-Report_2017_Web.pdf

Health Service Executive (2017p). ***Listening, Responding and Improving: The HSE response to the findings of the National Patient Experience Survey***. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/services/publications/hospitals/national-patient-experience-survey-2017.pdf

Health Service Executive – ***Clinical Strategy and Programmes Division*** (2017a). ***Clinical Strategy and Programmes Division*** [online]. https://www.hse.ie/eng/about/Who/cspd/

Health Service Executive – Quality Improvement Division (2016d)*. **National Patient Forum***. Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/about/Who/QID/Person-Family-Engagement/National-Patient-Forum/

Department of Health (2018a). ***Framework for Public Involvement in Clinical Effectiveness Processes***. Dublin, Ireland: Department of Health. http://health.gov.ie/wp-content/uploads/2018/03/Final-WEB-COPY_PI-Framework-Feb-2018–1.pdf

Framing engagement with service users

Institute for Healthcare Improvement. ***"What Matters": A Vision for "What Matters to You?"*** [online]. http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx/

Royal College of Physicians of Ireland and Health Service Executive (2017: 38–39: ***Case Studies of putting the 'What Matters to Me' initiative into practice in Irish Healthcare Settings)***. *National Quality Improvement Programme: Diploma in Leadership and Quality in Healthcare 2011 –2016 (Book of Abstracts).* Dublin, Ireland: Royal College of Physicians of Ireland. https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2017/03/Book-of-Abstracts-2011–2015-FINAL-V5.pdf

Health Service Executive – Quality Assurance and Verification Division (2017c). ***Your Service Your Say: Guidance Resource***. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/QAVD/Complaints/ysysguidance/ysysguidancefulltext.html

Health Service Executive – Quality Assurance and Verification Division (2017d). ***Your Service Your Say: The Management of Service User Feedback for Comments, Compliments and Complaints***. Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/services/yourhealthservice/feedback/Complaints/Policy/complaintspolicy.pdf

Working with service users, families, citizens, communities and staff

Engagement methodologies

HSE Staff Engagement Website

https://www.hse.ie/eng/staff/staff-engagement/

Health Service Executive – National Staff Engagement Forum and Quality Improvement Division (in press). *Leadership Skills for Staff Engagement in Improving Quality – A practical toolkit*. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/who/qid/staff-engagement/developingengagementskills/

HSE Liberating Structures User Group

Email: liberatingstructures@gmail.com

Liberating Structures (2017). *Principles to Guide Engagement Practice* [online]. http://www.liberatingstructures.com/principles

Leandro Herrero (2017). *Organizations as social movements* [video online]. https://leandroherrero.com/dr-leandro-herreros-latest-talk/

Health Service Executive – Quality Improvement Division (2017e). *Schwartz Rounds* [online]. https://www.hse.ie/eng/about/who/qid/staff-engagement/schwartzrounds/

Health Service Executive – Quality Improvement Division (2017d). *Quality Improvement Talktime* [online]. https://www.hse.ie/eng/about/who/qid/resourcespublications/qitalktime.html

The World Café (2017). *World Cáfe Method and Design Principles* [online]. http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/ http://www.theworldcafe.com/key-concepts-resources/design-principles/

Working with service users, families, citizens, communities and staff

Supporting meaningful conversations/conversational intelligence

Communication Style

Source: Health Service Executive – Organisation Development and Design (2008:12). *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive.* Kells, Co Meath, Ireland: Health Service Executive.

(See end of this section)

Glaser, J. E. (2013). **Conversational Intelligence**. *HuffPost* [online]. 17th August 2013. https://www.huffingtonpost.com/judith-e-glaser/conversational-intelligen_b_3773875.html

Glaser, J. E. (2016b). **Conversational Intelligence: How Great Leaders Build Trust and Get Extraordinary Results**. New York, USA: Routledge.

Wheatley, M. J. (2002: 29). **Turning to one another: simple conversations to restore hope to the future**. California, USA: Berrett-Koehler Publishers, Inc.

Stanfield, B., ed. (2000). **The Art of Focused Conversation: 100 Ways to Access Group Wisdom in the Workplace**. Canada: New Society Publishers/ The Canadian Institute for Cultural Affairs.

Appreciative inquiry

Cooperrider, D., Whitney, D. D., Stavros, J. M. (2008). **The Appreciative Inquiry Handbook: For Leaders of Change**, *2nd Ed.* Oakland, California, USA: Berrett-Koehler Publishers.

The Center for Appreciative Inquiry (2017). **Generic Processes of Appreciative Inquiry** [online]. https://www.centerforappreciativeinquiry.net/more-on-ai/the-generic-processes-of-appreciative-inquiry/

Communication style has a significant impact on how we engage with people, develop effective working relationships and support people through a change process. A respectful communication style requires that we:

▶ listen with an open mind

▶ think about the impact of our communication

▶ be aware of our tone and language in both spoken and written communication

▶ prioritise face-to-face communication

▶ take responsibility for giving and receiving feedback

▶ communicate honestly and sensitively

▶ readily share information that allows others to do their work better

▶ think about the potential and impact of social media – pause before you post

▶ communicate in a way which is meaningful for the people with whom we are communicating

▶ promote an open and inclusive style of communication

▶ be honest about the negative as well as the positive aspects of change

▶ discuss with people how the changes will impact on them, listen to what people are saying and be prepared to act based on this knowledge

Source: HSE – OD&D (2008: 12)

People's Needs Defining Change – Health Services Change Guide

Figure 11b: Levels of Communication and Engagement
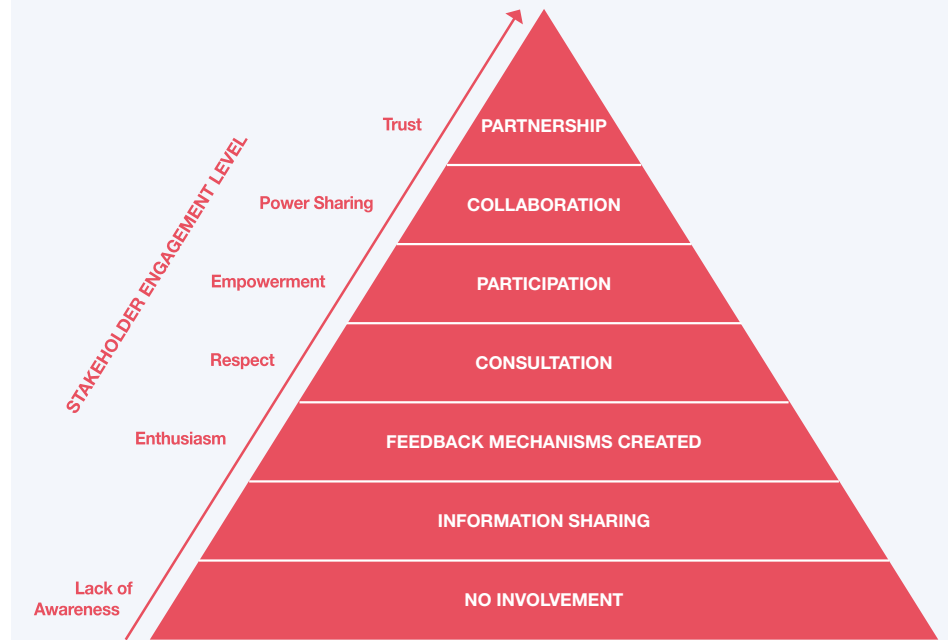
Source: HSE-PHSI (2018: 102) [415] and HSE-OD&D (2008: 13) [186]

People's Needs Defining Change – Health Services Change Guide

Define

Context for Change

Force Field Analysis
Adapted from:

▶ Cummings, T. G. and Worley, C. G. (2005: 126). *Organisation Development and Change, 8th Ed.* Ohio, USA: South-Western College Publishing

▶ Iles, V. and Sutherland, K. (2001). *Managing Change in the National Health Service – Organisational Change: A Review for Health Care Managers, Professionals and Researchers*. London, United Kingdom: National Co-ordinating Centre for NHS Service Delivery and Organisation R&D

(See end of this section)

Culture

10 Principles for Mobilising Your Organisational Culture.

Source: Katzenbach, J., Oelschlegel, C. and Thomas, J. (2016). 10 Principles of Organizational Culture. *Strategy & Business* [online]. 15th February 2016/Spring 2016/ Issue 82. https://www.strategy-business.com/feature/10-Principles-of-Organizational-Culture?gko=3e299

Alex Lyon (2017). *Organizational Culture by Edgar Schein* [video online]. https://www.youtube.com/watch?v=wd1bsxWeM6Q

Jeff DeGraff (2012). *Competing Values Framework Introduction* [video online]. https://www.youtube.com/watch?v=45veR-Se-rI&feature=youtu.be

Cameron, K. S. and Quinn, R. E. (2011). *Diagnosing and Changing Organizational Culture: Based on the Competing Values Framework, 3rd Ed.* San Francisco, California, USA: Jossey-Bass.

Cameron, K. S. and Quinn, R. E. (2018a). *Organizational Culture Type*. *OCAI* [online]. https://www.ocai-online.com/about-the-Organizational-Culture-Assessment-Instrument-OCAI/Organizational-Culture-Types

Cameron, K. S. and Quinn, R. E. (2018b). *The Four Types of Organizational Culture*. *POPin* [online]. https://popinnow.com/four-types-organizational-culture/

Burke-Litwin – Understanding Drivers for Change.
http://www.exeter.ac.uk/media/universityofexeter/humanresources/documents/learningdevelopment/understanding_drivers_for_change.pdf

Aston Team OD. *Aston Team Performance Inventory* [online]. http://www.astonod.com/team-tools/aston-team-performance-inventory-diagnostic-tool/

Define

Measurement

Health Service Executive – Quality Improvement Division – Measurement for Improvement (2017: 9). ***HSE Measurement for Improvement Curriculum: A reference document to support consistent Measurement for Improvement training in Irish healthcare***. Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/about/Who/QID/MeasurementQuality/measurementimprovement/Measurement-for-Improvement-Curriculum-Ver1.pdf

Integrated care

Health Service Executive – National Clinical & Integrated Care Programmes (2017: 46–50). ***Making a start in Integrated Care for Older Persons: A practical guide to the local implementation of Integrated Care Programmes for Older Persons***. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/A-practical-guide-to-the-local-implementation-of-Integrated-Care-Programmes-for-Older-Persons.pdf

Performance measurement

Health Service Executive (2017m). ***Performance and Accountability Framework 2017***. Dublin, Ireland: Health Service Executive. http://www.hse.ie/eng/services/publications/corporate/Performance-and-Accountability-Framework-2017-Mar.pdf

Health Service Executive – National Service Plan 2017 ***Balanced Scorecard and Performance Indicator Suites*** https://www.hse.ie/eng/services/publications/Non_Statutory_Sector/National-Service-Plan-2017-Balanced-Score-Card-PI-Suites.html – check updates annually on www.hse.ie.

Plan-Do-Study-Act (PDSA)

Health Service Executive – National Quality Improvement Programme (2016). ***Model for Improvement (including Driver Diagrams and PDSA Cycles): Guidance note on key concepts.*** Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/Who/QID/nationalsafetyprogrammes/pressureulcerszero/Model_for_Improvement_Guidance_Document.pdf

National Health Service – Institute for Innovation and Improvement (2010a: 145–150: ***The model for improvement and plan, do, study, act (PDSA)***. *The Handbook of Quality and Service Improvement Tools*. Coventry, United Kingdom: National Health Service. http://www.miltonkeynesccg.nhs.uk/resources/uploads/files/NHS%20III%20Handbook%20serviceimprove.pdf

Define

Guidance on governance for Boards

Health Service Executive – Quality Improvement Division (2017a). ***A Board's Role in Improving Quality and Safety: Guidance and Resources***. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/Who/QID/governancequality/Board-role-Improving-Quality-and-Safety/A-Board-s-Role-in-improving-quality-and-safety-Guide-Final.pdf

Programme for Health Service Improvement

HSE Project Initiation Document: Health Service Executive – Programme for Health Service Improvement (2017a: 55–56: **Project Initiation Document**). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive.
http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

Change Management Team: Health Service Executive – Programme for Health Service Improvement (2017a: 114–122: **Team**). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive. http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

Resource Requirements: Health Service Executive – Programme for Health Service Improvement (2017a: 109–113: **Costs and Resources**). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive.
http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

Framing outcomes

National Health Service – Sustainable Improvement Team and the Horizons Team (2017: 82). ***Leading Large Scale Change: A practical guide***. Leeds, United Kingdom: National Health Service. https://www.england.nhs.uk/wp-content/uploads/2017/09/practical-guide-large-scale-change-april-2018-smll.pdf

Force Field Analysis

Positive forces for change		Forces for maintaining status quo
New technology		How we do things currently
Demographic demands	**Present state or desired state**	Fear of change and uncertainty
Service user experience		Complacency/low morale
Competition for talent		Well-learned skills

Purpose

This methodology will assist in identifying and understanding the factors that will impact upon change implementation. Force Field Analysis is based on Kurt Lewin's work and is a systems approach to analyse the factors that:

▶ **Support the change**, i.e. exert a push force towards the change, such as national standards, service user advocacy and feedback, political pressures, technology

▶ **Resist the change**, i.e. exert a pull force away from the change, such as lack of necessary skills, recruitment/retention challenges, resources, ICT enablers, infrastructure

How to use it?

Use Force Field Analysis to organise data and assist analysis in relation to forces for and against change. Assess the relative strength of the forces to provoke thinking about how to increase the 'push forces' or decrease the 'pull forces' as part of the change plan.

Session outline

▶ Develop a list of all the forces for change and all the forces for staying the same.

▶ Based on discussion determine the most influential forces for and against the change. Use the length of the arrows to indicate the strength of influence.

▶ Work with the group/individuals to agree the key drivers for change and why.

▶ Engage in a process to work with the group/individuals who wish to maintain the current situation to fully understand their perspective. Seek other views including those of service users to open the discussion to different perspectives.

▶ Work with people to understand why maintaining the status quo is not sustainable. Put in place supports to address concerns and support people to embrace the change.

Adapted from: *Cummings, T. G. and Worley, C. G. (2005: 126) and Iles, V. and Sutherland, K. (2001) People's Needs Defining Change – Health Services Change Guide*

Design

Enablers of Co-Design in Organisations and Services

Adapted from: Pirinen, A. (2016). The Barriers and Enablers of Co-design for Services*. International Journal of Design* [online]. 10(3).
http://www.ijdesign.org/ojs/index.php/IJDesign/article/view/2575/750

(See end of the section)

Principles of Service Design Thinking (Process, Organisational, Information and Technology Design Principles)

Adapted from: Interaction Design Organisation (2017). The Principles of Service Design Thinking – Building Better Service. *Interaction Design Organisation* [online]. 26th September 2017. https://www.interaction-design.org/literature/article/the-principles-of-service-design-thinking-building-better-services

(See end of this section)

General Principles and Checklist for Decommissioning

Adapted from: Institute of Public Care, Oxford Brookes University (2010: 4, 18, 19). *Yorkshire and Humber Joint Improvement Partnership: Decommissioning and reconfiguring services: a good practice guide for commissioners of adult social care*. Bath, United Kingdom: Institute of Public Care, Oxford Brookes University.
http://ipc.brookes.ac.uk/publications/pdf/Decommissioning_and_reconfiguring_services.pdf

(See end of this section)

Due Diligence

This template is based on Due Diligence documentation developed by Leo Kinsella, HSE manager and adapted for use by Caitríona Heslin and Anne Ryan, OD&D, Health Service Executive (February 2014).

(See end of this section)

Lean Methodologies

Request support from Quality Improvement/Project Management re: Learn Six-Sigma.

Design

Service design – integrated pathways of care

Health Service Executive – Clinical Strategy and Programmes Division (2016a:9). *CSPD reform and the establishment of Integrated Care Programmes Charter*. Dublin, Ireland: Health Service Executive. http://hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/CSPD-reform-and-the-establishment-of-Integrated-Care-Programmes-Charter.pdf

Health Service Executive – National Clinical & Integrated Care Programmes (2017: 8 – *10-Step Integrated Care Framework for Older Persons*) *Making a start in Integrated Care for Older Persons: A practical guide to the local implementation of Integrated Care Programmes for Older Persons*. Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/A-practical-guide-to-the-local-implementation-of-Integrated-Care-Programmes-for-Older-Persons.pdf

Health Service Executive – Clinical Strategy and Programmes Division *(see model for promoting integrated pathways of care)*. http://www.hse.ie/eng/about/Who/clinical/

Person-centredness

Person-Centred Principles

Source: Health Service Executive – Quality Improvement Division (2016a)**.** *Draft Pillars and Principles of Person Centred Practice*. Dublin, Ireland: Health Service Executive.

Person-Centred Practice Framework

Source: McCormack, B. and McCance, T., eds. (2017). *Person-centred Practice in Nursing and Health Care: Theory and Practice, 2nd Ed.* Oxford, United Kingdom: Wiley Blackwell.

National Health Service – Institute for Innovation and Improvement (2010a: 79–86: *Patient perspectives to assist service design*). *The Handbook of Quality and Service Improvement Tools*. Coventry, United Kingdom: National Health Service. http://www.miltonkeynesccg.nhs.uk/resources/uploads/files/NHS%20III%20Handbook%20serviceimprove.pdf

Design

Service design testing

Plan-Do-Study-Act (PDSA)
Health Service Executive – National Quality Improvement Programme (2016). **Model for Improvement** *(including Driver Diagrams and PDSA Cycles): Guidance note on key concepts.* Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/Who/QID/nationalsafetyprogrammes/pressureulcerszero/Model_for_Improvement_Guidance_Document.pdf

Identifying and managing risks

Health Service Executive – Programme for Health Service Improvement (2017a: 103–108: **Risks and Issues**). *Programme for Health Service Improvement Handbook: Building a Better Health Service (V1.0).* Dublin, Ireland: Health Service Executive. http://www.hseland.ie/lcdnn/Welcome/Resources/tabid/398/cid/57/Programme-for-Health-Services-Improvement-Handbook.aspx
http://www.hse.ie/eng/about/Who/healthserviceimprovement/

Quality Assurance and Verification

Health Service Executive – Quality Assurance and Verification Division (2017a). **HSE Integrated Risk Management Policy**: *Incorporating an overview of the Risk Management process*. Dublin, Ireland: Health Service Executive.
http://hse.ie/eng/about/QAVD/riskmanagement/risk-management-documentation/HSE%20Integrated%20Risk%20Management%20Policy%202017.pdf

Health Service Executive – **Quality Assurance and Verification Division** (2017b). *Quality Assurance and Verification Division* [online].
https://www.hse.ie/eng/about/QAVD/riskmanagement/risk-management-documentation/

Policies, Procedures, Protocols and Guidelines (PPPGs)

Health Service Executive – Quality Improvement Division and Clinical Strategy and Programmes Division (2016c). **HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs).** Dublin, Ireland: Health Service Executive. https://www.hse.ie/eng/about/Who/QID/Use-of-Improvement-Methods/nationalframeworkdevelopingpolicies/National-Framework-for-developing-Policies-Procedures-Protocols-and-Guidelines-PPPG-.html

Collaboration: finding a common ground

▶ Building trust, finding a common ground, working and creating solutions together.

▶ Credible and responsive communication (common vocabulary); know the **context** (system) and the 'audience'.

▶ Shared purpose and agenda that people see as adding value to the service and to individual practices; being clear on the problem you want to address; define and redefine the brief.

▶ In-depth understanding of the nature and culture/subcultures within the service or organisation.

▶ Safe environment for different perspectives to come together as equals – service users, citizens, multiple disciplines, groups.

▶ Taking responsibility to lead the co-design process; clarity on responsibilities of all parties involved; every participant has a personal interest at stake.

Organisation: creating commitment

▶ **Human-centred design** core to organisational policy – the way we do things. Support from management, connection to the overall strategic goals of the organisation and connection to people's everyday work and practices.

▶ Allocation of time, resources and funding for co-design.

▶ Meaningful personal role in co-design and benefit/relevance to one's own work (clinical, practice).

Processes: integrated, connected and joined up

▶ Finding where co-design truly adds value; using it to realise ideas, support innovation and design beyond traditional solutions.

▶ Integration and embed with the core business/service needs and other initiatives and developments; needs to be enabled by other organisational processes (ICT, procurement, e-health).

▶ Coordination and timing of co-design.

▶ Continuity beyond single projects; development support that is sustained over time.

▶ **E-health and technology**: used to maximise human-centred design through sharing information, connecting activity, innovating clinical practice and driving behaviour change.

Implementation: making an impact

▶ Translating the outcomes to add value and meaning.

▶ Building capacity (and not dependency) for co-design, to sustain the process and add credibility; build service design as a core competency for people in development roles; develop methods and practices for facilitating actual collaboration between stakeholders. Access design support – process mapping expertise, design and measurement skills and seek external assistance to assure the process.

▶ Building on good practice, existing networks, test sites, pilots or prototyping.

▶ Focus on changing behaviours and address issues with a more holistic perspective.

Methods: building co-design practice and capability

▶ Integration and connection of co-design methods into existing work flows or service improvement/quality projects.

▶ Effective, well-focused and well-prepared design methods, facilitation and reporting (shift from talking to doing); employing participatory design techniques.

▶ Open and flexible methods, scalable to different situations.

▶ Transfer of skills and facilitator training; use of portable toolkits and methodologies.

Adapted from: Pirinen, A. (2016)
People's Needs Defining Change – Health Services Change Guide

Principles of Service Design Thinking

Process design principles

▶ Work activity that fails to add value should be eliminated or minimised.

▶ Work is structured around processes and not around internal constructs such as functions, geography, etc.

▶ Work should not be fragmented unless absolutely necessary. It encourages creativity, innovation and ownership of work.

▶ Processes should be as simple as possible. Focus on reducing process steps, handovers, rules and controls. The owner of the process should have control over how it is delivered.

▶ Processes should reflect user needs and many versions of a process are acceptable if users have different needs.

▶ Process variation should be kept to a minimum.

▶ Process dependencies should be kept to a minimum.

▶ Processes should be internalised rather than overly decomposed (training is better than work instructions).

▶ Process delays and breaks should be kept to a minimum.

▶ Reconciliation, controls and inspection processes must be kept to a minimum.

▶ KPIs for processes will only measure things that matter.

Organisation design principles

▶ Work groups organised so that they match the processes and competencies required.

▶ Individual staff given sufficient autonomy to make useful decisions.

▶ Work will take place in a location where it is done with the most efficiency.

Information design principles

▶ Data should be normalised between the organisation and its service users and within the organisation itself.

▶ Data should be easy to transfer and be reusable within the organisation and with partner organisations.

▶ Data entry will be avoided and be replaced by data lookup, selection and confirmation utilities instead.

Technology design principles

▶ Technology should always be used to enable a service; it should never be the driver of a service.

▶ Technology should be pulled into a service design rather than pushed into it.

▶ Technology design is to be flexible enough and agile enough to allow fast modification in the face of changing service user requirements.

Adapted from: Interaction Design Organisation (2017)
People's Needs Defining Change – Health Services Change Guide

The following is a set of principles on which to base any decision to decommission. Many decisions will be significantly influenced by financial constraints but the interests of service users, staff and partners must be taken into account and prioritised during any decommissioning process.

▶ **Transparency and fairness** – there should be transparency in the decision-making process, with fairness in the approach to all stakeholders. It should be absolutely clear why a decision has been taken to decommission a particular service, and this needs to be understood and shared by all stakeholders. Equally, there should be fairness in the way stakeholders are treated, whether this is between different providers or different service users.

▶ **Users** – safeguarding the welfare of service users must be a key priority throughout any decommissioning process. Decommissioning a service should not remove essential or important provision from any existing user. The interests of service users should be protected throughout the decommissioning process, to ensure that ongoing support and care needs are addressed appropriately.

▶ **Staff** – providers have a responsibility to ensure that the decommissioning process is transparent and that the welfare of staff involved in providing the service is protected through proper consultation between the service provider and the commission authority.

▶ **Value for money** – the purpose of decommissioning services will be to ensure that health and social care and other services most effectively meet the needs of vulnerable people, are of the best quality and offer value for money.

▶ **Risk management** – there should be clarity about the risks involved in the process and the approach being taken to manage these risks.

▶ **Partnership** – relevant agencies/services to work with all stakeholders to achieve a smooth transition, with particular regard for service users and staff.

▶ **Communication** – a sound communications strategy will help to ensure that the process of decommissioning is ultimately successful through the full engagement of users, staff, elected members, providers and the media where appropriate

Decommissioning Checklist

A	Prepare	Yes	No
1	Is there a decommissioning policy and/or guidelines for decommissioning in your organisation?	☐	☐
2	Is this policy/guideline recent, and does it have both corporate and political support?	☐	☐
3	Does it include: ▶ decision-making processes? ▶ risk assessment and management? ▶ appropriate project management? ▶ communication plans? ▶ adequate resources?	☐	☐
4	Do service contracts allow for potential decommissioning situations?	☐	☐
5	Is there regular engagement with providers, which includes the discussion of the decommissioning policy?	☐	☐
6	Is there ongoing performance management of contracts with proactive approaches to reviewing and improving services?	☐	☐
7	Are there well-publicised communication mechanisms and consultation structures in place? Are these accessible for all stakeholder groups?	☐	☐
8	Is there an approved approach to risk assessment and management, and to carrying out impact assessments?	☐	☐

B	Decide	Yes	No
1	Is it clear what the issues are with the service that is being reviewed?	☐	☐
2	Is there a good understanding of the needs and aspirations of current and potential service users?	☐	☐
3	Has there been a thorough consideration of all of the options for the service? Have all of the potential service models been researched and considered? Is it clear how this service fits with local and national policy drivers?	☐	☐
4	Is it clear what resources are available to meet this need, and whether any resources released through decommissioning can be recycled into any reconfigured services?	☐	☐
5	Have all of the key stakeholders been identified and is it clear what their role will be in the decision process? When will they be involved, and how will they be involved?	☐	☐
6	Has the contract for the service been reviewed, and does it create any particular issues for potential decommissioning?	☐	☐

C	"Do"	Yes	No
1	Is there a project plan which clearly describes the scope of the project? Would it be more deliverable if it were broken down into smaller projects?		
2	Has a lead officer or project manager been identified who has access to support as needed?		
3	Does the project plan include clear milestones which fit with stakeholder decision-making structures, and does it allow time for effective communication? Is there scope for some flexibility within it?		
4	Is it clear what the legal requirements for the process are, and how they will impact on timescales in particular?		
5	Is there a clear communication plan which includes all stakeholders? Are messages tailored for particular audiences?		
6	Is there ownership of the project plan, both corporately and politically?		
7	Does the project plan allow for an impact assessment and a risk assessment (if not already completed)?		
8	Are there clear transitional arrangements for service users which have been agreed with the provider, and which minimise impact on service users? Do these include proposed timescales, ongoing communication arrangements and an agreed approach to the sharing of information?		

D	Review	Yes	No
1	Is there an agreed approach to the evaluation of the decommissioning process?		
2	Does this evaluation process include other stakeholders?		
3	Is there a mechanism for sharing any learning from this evaluation process?		

Adapted from: *Institute of Public Care – Oxford Brookes University (2010: 4, 18, 19)*

People's Needs Defining Change – Health Services Change Guide

Due Diligence handover documentation

(To be used when services are in transition/transferring between areas.)

Guidance notes

▶ This template contains a list of questions/prompts that are designed to ensure all salient issues are raised as part of the Due Diligence handover. It is not an exhaustive list and can be added to.

▶ The Due Diligence should be completed by the transferring service to assist the managers in the receiving service to undertake an impact assessment and to jointly plan appropriately for the transfer.

▶ It is suggested that once the initial decision based on early scoping is made to progress the transfer, the Due Diligence process is completed as it will assist in determining the detail of the change. It should be revisited and updated prior to the final transfer taking place.

▶ The information should as appropriate be crosschecked and signed in consultation with Finance, Quality & Patient Safety, HR, ICT, Estates, Communication and any other shared/relevant services. It is important that this part of the process is carefully attended to in order to minimise risk of key information not being formally handed over.

▶ A date should be agreed from which relevant activity and resource data is used for the purpose of this Due Diligence exercise.

▶ High level information only is required initially; however, on matters which currently or may in the future require more significant management focus, greater detail should be provided. This may be referenced and attached in the form of additional supplementary information (reports and spreadsheets).

▶ In the event that Due Diligence is undertaken in respect of a service transfer from one geographic area to another, boundary/geographic analysis will be required from a population-impact perspective.

▶ Evidence must be provided of input into the Due Diligence process from senior management.

▶ Evidence must be provided of input into the Due Diligence process from relevant specialists/clinical leads as appropriate to the service. Specialists/clinical leads for example can give an overview of key issues for the client group to the lead manager.

▶ Each template must be signed off by the relevant managers at the appropriate levels.

Area:
Service Area:

Section 1: Background information Please provide the following information:		
1.1	Date of establishment of service	
1.2	Purpose of the service	
1.3	Service/client profile	
1.4	Referral/access eligibility criteria	
1.5	Key service dependencies and relationships relevant to the client group, i.e. access to respite services, day hospital services, preschool services, etc.	
1.6	Identify shared care arrangements/protocols if in place	

Section 1: Background information Please provide the following information:		
1.7	Identify the boundaries of the transferring service and assess for population and geographic impact for service delivery	

Section 2: Responsibilities		
2.1	Name of manager	
2.2	Position held	
	Contact details	
	Address	
	Email	
	Phone	
2.4	Currently reports to	

Section 3: Budget/financial information	
3.1 What is the current overall budget and planned budget for next year for the service?	
3.2 Specify suballocations	
3.3 Is overall budget on target?	
3.4 Specify any cost containment measures	
3.5 Specify any major risk issues with cost containment implications	

Section 4: Human Resources		
Staffing and whole time equivalent information		
4.1 Staff ceiling	Confirm approved staff ceiling for the service (provide relevant breakdown per discipline, etc.)	

Section 4: Human Resources		
4.2	Recruitment/business cases	List any priority posts for recruitment List any posts currently in process of recruitment
4.3	Employee relations	Outline any major or potentially major staff relations issues/disputes Are there any staff on administrative leave or suspended from duty? If so provide details
4.4	Attendance management Include current level of sick leave and measures taken to address high absenteeism if relevant	

Section 4: Human Resources		
4.5	Education and training Provide information regarding skill capacity, management and staff development, including clinical skills development	
4.6	Administrative/clerical supports Outline current level of administrative support to the service/team and any deficits in this regard	

Section 5: Service issues
Service activity

Section 5: Service issues		
5.1	Service activity Please list for all relevant parts of the service including caseload numbers, waiting lists, activity data, etc. Provide relevant Comp Stat or other similar returns	Reference Service Activity as per Service Plan or relevant Comp Stat returns.
5.2	Eligibility Describe current eligibility criteria for the service and plans to address any eligibility issues that will arise in the receiving service	
5.3	Service level agreements (SLAs) in place with the non-statutory sector or other agencies Include any element of service provision/care provision provided by contract to another external agency/organisation, i.e. respite services, home help services Outline SLAs and their status (signed/outstanding) and indicate performance monitoring arrangements	

Section 5: Service issues		
5.4	Interdependencies with other services i.e. clinical care pathways relevant to the client group (e.g. interface with preschools, schools, other service teams, CAMHS, day hospital services, respite services)	
5.5	Current status of service planning process or service development proposals i.e. business cases	
5.6	Specific service issues of concern i.e. requiring review or investigation	

Section 6: Governance		
6.1	Organisational structure Provide details of staff, grade and reporting line. It is important to also include/identify staff who input into the service as part of their job/role – this will apply to specialists/clinical leads, staff from education sector, etc.	
6.2	Decision-making process Describe management processes, team and membership, meetings, frequency, etc.	
6.3	Identify clinical governance issues, if any, that need to be addressed	
6.4	Performance management/supervision processes (Provide details and how these operate, frequency, etc., e.g. Comp Stat, Performance Management meetings, clinical supervision/ clinical governance)	

Section 6: Governance	
6.5 Identify core skills and competencies required to deliver the service	
6.6 Number and name of committees in place (Please provide backup information re: membership, terms of reference)	

Section 7: Quality, standards and risk	
7.1 HIQA, Mental Health Commission or other List any ongoing reviews in the service or any other relevant information	
7.2 Health & Safety (H&S) (Is there an up-to-date H&S statement, nominated H&S representative, date of last H&S audit, etc.)	

Section 7: Quality, standards and risk		
7.3	Risk Register Is there an up-to-date Risk Register, nominated person, etc.?	
7.4	Incident management including serious incident reports/alerts List any ongoing serious incident reviews (Risk Register to be submitted as supporting document)	
7.5	Service developments or reviews which are ongoing including any impact assessments List any other service initiatives or reviews such as service/demand capacity reviews, etc.	
7.6	Log of recent service reviews commissioned and completed in the area	
7.7	'Customer'/service user compliments or complaints Similar information required as with incidents above	

Section 7: Quality, standards and risk		
7.8	Quality improvement initiatives List ongoing initiatives including service user/advocacy involvement in service developments	
7.9	Standard Operating Procedures/PPPGs List all relevant service policies and procedures or where to source same	

Section 8: Information management and communication		
8.1	Describe information management plans including systems interface issues, processes for transfer of confidential information and arrangements for sharing information Note any data protection issues that need to be addressed	

Section 8: Information management and communication		
8.2	Media Detail any positive/negative local publicity in past year	
8.3	Detail communication plans and details of how legacy issues will be dealt with	
8.4	Status of any relevant FOI requests	

Section 9: Legal matters		
9.1	Provide copy and back-up information relating to all delegated functions under relevant legislation to your office/service	

Section 9: Legal matters		
9.2	List of all current or pending litigation including parties involved, nature of legal action and remedies sought	
9.3	Any previous judgements which have resulted in ongoing financial obligations Compliance with legislation, e.g. Children's First, disability legislation	
9.4	Outline plans for transfer of warrants, indemnity issues, etc.	

Section 10: Technology	
10.1 List all IT systems in place (including email, financial & HR reporting, systems used for data collection, etc.)	
10.2 Specify any risk issues in relation to current IT systems, deficits or supports	

Section 11: Capital/accommodation	
11.1 Capital plans Ongoing or planned initiatives completed	
11.2 Minor capital plans Ongoing or planned initiatives completed	

Section 11: Capital/accommodation		
11.3	Other accommodation priorities Infrastructural works not listed above which require attention	
11.4	List deficits in core service equipment/aids and appliances	
11.5	Any ongoing procurement issues Specify ownership of contracts shared with other sites, etc.	
11.6	Outline current accommodation arrangements including both clinical and office space – identify any concerns/deficits in this regard	

Section 12: Service arrangements in place with non-statutory sector or other agencies	
12.1	Include any element of service/care provision provided by contract to another external agency/ organisation (see also 5.3 above)	

Section 13: Transfer arrangements	
13.1	Identify transfer arrangements planned or agreed including negotiated timeframes	
13.2	Outline arrangements for existing clients/service users and for new clients/service users	

Section 14: Other information/areas of responsibility	
This template is intended as a guide. Please ensure that any relevant information which does not fit into the headings above is included in an appended sheet. Please ensure that any other critical documents, reports or known information relevant to internal enquiries, service reviews/audits, etc. are also provided.	
14.1	Contact details of relevant manager
14.2	Confirm relevant managers have been involved in contributing to the Due Diligence process
14.3	Outline the key issues at local/area level, proposed plans and next steps to address/escalate
14.4	Any other high level issues

Section 15: Due Diligence sign off process	
Prepared by:	Date:
Manager of service	
Approved by:	Date:
Manager (oversight responsibility)	

This template was based on Due Diligence documentation developed by Leo Kinsella, HSE and adapted for use by Caitríona Heslin and Anne Ryan, HSE (February 2014).

People's Needs Defining Change – Health Services Change Guide

Deliver

Scaling-Up

Scaling-Up Innovations – Evidence of what works

Adapted from: Shiell-Davis, K., Wright, A., Seditas, K., Morton, S. and Bland, N. (2015). *What Works Scotland Evidence Review:* **Scaling-Up Innovations**. Scotland, United Kingdom: What Works Scotland. http://whatworksscotland.ac.uk/wp-content/uploads/2015/06/WWS-EB-evidence-review-Scaling-Up-Innovations-June-2015.pdf

(See end of this section)

Sustainability

National Health Service – Improving Quality (2014). **Sustainability Model.** United Kingdom: National Health Service. Link for the 2010 version: http://webarchive.nationalarchives.gov.uk/20160805122935/http://www.nhsiq.nhs.uk/media/2757778/nhs_sustainability_model_-_february_2010_1_.pdf

National Health Service – Institute for Innovation and Improvement (2007). *Improvement Leaders' Guide:* **Sustainability and its relationship with spread and adoption (general improvement skills)**. Coventry, United Kingdom: National Health Service. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.7-Sustainability-and-its-Relationship-with-Spread-and-Adoption.pdf

https://curve.coventry.ac.uk/cu/file/77a593a1–5b18–9aaa-77b3-ea5818dd453b/1/P-Sustainability.pdf

Implementation

Burke, K., Morris, K. and McGarrigle, L. (2012). **An Introductory Guide to Implementation: Terms, Concepts and Frameworks**. Dublin, Ireland: Centre for Effective Services. http://www.effectiveservices.org/downloads/Guide_to_implementation_concepts_and_frameworks_Final.pdf

Hayes, C. (2016). **Implementation Science** (Presentation given at the Department of Health, Clinical Effectiveness Unit – Implementation Workshop on 7th April 2017). http://health.gov.ie/wp-content/uploads/2016/06/Implementation-Science.-Prof-C-Hayes.pdf

Celebrating success

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Email: excellenceawards@hse.ie

Scaling-Up Innovations – Evidence of What Works

The data below is distilled from *Scaling-Up Innovations- Evidence Review (2015)* produced by What Works Scotland. The review draws together broad findings and theory from across multiple fields and sectors. It draws together common themes and learning points on scaling-up innovations.

Key findings

What is scaled-up and when

▶ Innovation and research are inextricably linked, so innovations with robust evidence-bases are best for scaling-up, ideally from several field tests or piloting sites.

▶ An innovation doesn't necessarily need to be subject to a randomised control trial (RCT) to be evidence-based; the type of evidence should be appropriate for the innovation with a focus on sufficient, good quality data that supports effective implementation and delivery.

▶ Innovations that explicitly address an identified problem, an under-served population, or emerging issues are more likely to be scaled-up.

▶ The financial and human resources required for scaling-up an innovation means an innovation should 'fit well' with intended sites/settings.

▶ Wider social and political forces play a role in determining what types of innovations get scaled-up and when, so keeping up to date on external issues and events can help with the process.

Talking points

▶ What is the intended purpose of the innovation – e.g. to meet a need or to address a gap – and is there a clear sense of how it will do so?

▶ Is there robust and clear evidence supporting the effectiveness of the innovation?

▶ What do you mean by 'evidence'? Is the type of evidence appropriate for the type of innovation?

▶ Is there available funding for the innovation, and does the innovation fit with any funding criteria?

▶ Have the external factors – wider, social and political forces – been identified and have their impact on and links with the scaling process been considered?

Enabling and success factors for scaling-up

▶ Pairing the innovation and original sites to the settings in terms of compatible goals, objectives, values and population characteristics is critical.

▶ Scaling-up an innovation needs large amounts of time and commitment.

▶ Communication needs to be as clear and direct as possible, and happen frequently between all partners and stakeholders.

▶ People's expectations and perceptions help to shape the scaling-up process.

▶ Involving as many groups of stakeholders as possible from a very early stage in the scaling-up process helps with buy-in and influence.

Talking points

▶ Has a realistic and comprehensive assessment of available resources – financial, human and contextual – been carried out and communicated to colleagues and partners?

▶ Have the ways in which the new setting(s) differ from the originating context been mapped out, understood and planned for?

▶ Are there multiple means and ways of communicating within the organisation and across partnerships?

▶ What types and means of communication might help to get all stakeholders involved and sharing?

Barriers to scaling-up

▶ Scaling-up an innovation is complex, with many 'moving parts' that need managing and attention.

▶ A lack of understanding due to different perspectives and visions is problematic.

▶ Resources and stakeholders' energy need to be taken into account.

▶ Reluctant partnership working can be detrimental to scaling-up an innovation.

Talking points

▶ Have the likely differences in working styles and contexts between partners been identified, understood and incorporated into the scaling strategy?

▶ Is there a consensus across all partners on the expectations, aims and goals of scaling an innovation?

▶ Are those in leadership positions encouraging cross-boundary knowledge and experience sharing? How?

▶ Have adequate technical assistance and support been factored in across the whole of the scaling process?

Sustainability mechanisms

Key findings: mechanisms for sustainability

▶ Good practices and strategies that facilitated an innovation to be scaled-up in the first place need to be continued into the long term.

▶ Determining the balance between fidelity and adaptation is difficult but necessary, as too much rigidity can result in incompatibility, but too many changes can reduce the innovation's effectiveness.

▶ A careful and informed approach is needed to determine whether an innovation can be adapted, and if so, how much and at what points.

▶ Monitoring and evaluation are not used only for pilots or field tests – this process needs to be ongoing throughout the scaling-up process.

Talking points

▶ Can you link with the innovation designer or originating site to identify the core components necessary for effectiveness?

▶ Are there planned 'review points' across the scaling where key partners can review the roles and resources needed at different phases, and consider changes in strategy?

▶ Has the scaling-up of the innovation been situated within a broader continuum of services or practices of the setting(s), with key leaders reinforcing this alignment?

▶ Have clear and consistent means of monitoring and assessment been incorporated into the scaling process, with agreed outcome measures and indicators?

▶ How can you use feedback loops and monitoring data to inform what is needed (e.g. people, infrastructure) for sustainability?

Adapted from: *Shiell-Davis, K., Wright, A., Seditas, K., Morton, S. and Bland, N. (2015)*
People's Needs Defining Change – Health Services Change Guide

Miscellaneous

Internal Resource Documents

Internal resource documents developed by Organisation Development & Design Consultancy Service, HSE, Kells, Co Meath.

Health Service Executive – Dublin North East – Organisation Development and Design (2005). *An exploration of culture in one Irish health service organisation: key messages and survey results*. Kells, Co Meath, Ireland: Health Service Executive. http://www.lenus.ie/hse/bitstream/10147/45313/1/7127.pdf

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Heslin, C., Kinch, C. and Malone, J. (2004). *Team Working Policy and Guidelines* and *Team Working Diagnostic*. Kells, Co Meath, Ireland: North Eastern Health Board.

Heslin, C. and Ryan, A. (2010). *Improving Team Working: A Guidance Document.* Kells, Co Meath, Ireland: Health Service Executive. http://www.hse.ie/eng/staff/Resources/cmr/itw.pdf

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North Eastern Health Board – Organisation Development Unit (2004). *Guidelines for Policy Making: Promoting good governance in policy development*. Kells, Co Meath, Ireland: North Eastern Health Board. http://www.lenus.ie/hse/bitstream/10147/43611/1/3830.pdf

Appendix B: Development Process

People's Needs Defining Change – Health Services Change Guide was developed over a two year period through a collaborative process and informed by the applied experiences, learning and practice of many individuals, groups and organisations. It was informed by learning from the application of the 2008 Change Model (incorporated in *Improving Our Services – A Users' Guide to Managing Change in the Health Service Executive, 2008*) and associated online resources on the Change Hub (www.hseland.ie). Caitríona Heslin and Anne Ryan, Organisation Development and Design, Kells, Co Meath, led the development process.

Commissioning and Governance

The HSE Leadership Team commissioned this work through Rosarii Mannion, National Director of Human Resources. The revision of the Change Model (2008) was seen as opportune to reflect best current thinking on change and to inform wider system reform within health and social care services. Governance arrangements were put in place to provide oversight including guidance by the Joint Information and Consultation Forum, the Programme for Health Service Improvement, Centre Transformation Programme and the HSE HR Leadership Team.

Stakeholder Engagement

A comprehensive stakeholder engagement process was designed and implemented over a two year period. This included the establishment of reference groups to:

▶ provide assistance in relation to the early development phase

▶ inform the detailed design phase

▶ support testing and refinement of the Change Framework, Change Guide and associated templates

The reference groups were made up of a representative cross section of staff from different work settings with a blend of expertise and knowledge. Engagement processes also included a significant number of individual and group consultation sessions and workshops with content 'experts' in relation to key elements of the Change Framework. Survey methods were used to obtain feedback on the Change Framework at different stages of development. Members of the HSE National Staff Engagement Forum based on their own personal experiences of change contributed to the process and helped shape communication processes. Engagement with service users also informed the process – this was achieved through practice-based sessions and other feedback methodologies conducted during 2016 and 2017.

Research and Evidence

A literature review was commissioned from the Centre for Health Policy and Management, Trinity College Dublin, and an extensive review of the grey literature was also carried out by the authors to inform the development process. This level of review ensured the Change Framework was informed by best current thinking on change and up to date evidence. Submissions were sought from a wide number of people and organisations throughout the system, reflecting change/thought leaders, practitioners and academic contributors across a range of behavioural and human science fields. Submissions were also sought from all parts of the HSE – this included targeted consultation with service teams. An organisation-wide broadcast issued to all HSE staff was conducted in October 2016 yielding very insightful submissions from staff and teams throughout the system.

Testing, Refinement and Document Drafting

The development process prioritised testing the Change Framework in order to ensure the guidance and templates were accessible, user friendly and could be applied within different local contexts. This included data gathering, analysis and significant redrafting of documentation. The Health Services Change Guide was shared at different stages in its development and based on extensive feedback it continued to be refined until final sign-off.

Sign-Off and Implementation

The final sign-off of the *Health Services Change Guide* took place in April 2018 with endorsement by the HSE Leadership Team and the membership of the Joint Information and Consultation Forum. The implementation phase was initiated across the system including a dedicated focus on communication using a wide range of methodologies and digital platforms. The implementation phase will continue to target building capacity for change, education, curriculum and resource development, evaluation and refinement of the offering to the system to ensure accessibility and continued relevance.

Acknowledgements

Please see Acknowledgements in main Change Guide.

Appendix C: Stakeholder Engagement

Organisation-Wide Engagement

All HSE staff members (through organisation-wide broadcast)

National Staff Engagement Forum: individual and group submissions, forum leads

All Change Hub Users – HSeLanD – testimonials and feedback

HSE Leadership Team members and colleagues

HSE HR Leadership Team members and colleagues

Joint Information and Consultation Forum

Community Healthcare Organisations: chief officers

Hospital Groups: chief executive officers

Quality Improvement Division: national director, leads, project managers

Programme for Health Service Improvement: head of programme and colleagues

National Centre Transformation Programme: programme director and colleagues

Organisation Development & Design colleagues, HSE

Leadership, Education & Talent Development colleagues, HSE

Consultation Sessions

The lists below include all those invited to participate in consultation sessions; some individuals participated in reference groups in 2016 and again in 2017. People also contributed by providing feedback if they were unable to attend the sessions. Every effort was made to record accurate data – titles and locations are noted at time of consultation sessions.

May, June 2016

Professor Joe Barry, Chair of Health Population Medicine, TCD Centre for Health Policy & Management

Colum Bracken, Programme Manager, Mental Health Division/Centre for Effective Services

Dr Mary Browne, Directorate Lead/Specialist in Public Health Medicine, Quality Improvement Division, HSE

Thora Burgess, Project Manager, Clinical Governance Development, Quality Improvement Division, HSE

Nicola Byrne, HSE Mental Health Division/Centre for Effective Services

Sibéal Carolan, RCSI Institute of Leadership

Dr Philip Crowley, National Director, Quality Improvement Division, HSE

Maureen Flynn, Director of Nursing & Midwifery, Quality Improvement Division – Lead Governance & Staff Engagement for Quality, HSE; Adjunct Associate Professor UCD

Joan Gallagher, Policy Analyst, Office of the Director General, HSE

Jennifer Garry, HSE HR Leadership, Education & Talent Development, Specialist/Lead for Team Development & Leadership

Cathal Hand, Monaghan Primary Care Network Manager, HSE

Dr Catherine Hayes, Associate Professor/Specialist in Public Health, Trinity College Dublin

Jenny Hogan, National Lead for Performance Improvement, Scheduled Care, Special Delivery Unit, Acute Hospitals Corporate Division, HSE

Caralyn Horne, Quality Standards & Compliance Officer, National Social Care Division, HSE

Vera Kelly, Organisation Design & Development Consultant, National OD&D Lead for CHO Development, HSE

John Kenny, Division Programme Manager, Quality Improvement Division, HSE

Denise Keoghan, HSE HR Leadership, Education & Training Development, Specialist/Lead for Coaching & Change Management

Anne-Marie Keown, National Programme Manager, Irish Hospital Redesign Programme, Special Delivery Unit, HSE

Libby Kinneen, Area Head of Organisation Development & Design, HSE West; National HR Lead for Staff Engagement

Patrick Lynch, National Director, Quality Assurance & Verification Division, HSE

Clare O'Connor, Primary Care Development Manager, HSE North Dublin

Evelyn O'Shea, Systems Reform Group, HSE

Steve Pitman, Programme Director & Lecturer, RCSI Institute of Leadership

Martina Ralph, Development Officer/Network Manager, HSE Louth

Siobhan Regan, HSE HR Leadership, Education & Development Manager

Siobhan Reynolds, Quality Facilitator: Governance for Quality & Safety, Quality Improvement Division, HSE

Joe Ryan, Head of Programme for Health Service Improvement, HSE

Mary Rose Smith, Cavan Primary Care Network Manager, HSE

Camille Staunton, System Reform Group, HSE

Victoria Taylor, Programme Executive, National Quality Improvement Programme (HSE/Royal College of Physicians of Ireland)

Seamus Treanor, HR Programme Manager, HSE

Dr Mark White, Programme Manager – System Reform Group, HSE

June, October 2017

Dr Sarah Barry, Associate Professor of Health Services Management/Course Director, MSc in Health Services Management, Centre for Health Policy & Management, Trinity College Dublin

Colum Bracken, Program Manager, Mental Health Division/Centre for Effective Services

Grainne Clarke, Head of Programme Management Office, Mental Health Division/Centre for Effective Services

Louise Collins, Director of Clinical Services, Connolly Hospital Blanchardstown

Ann Coyle, General Manager, Health & Wellbeing, CHO8, HSE

Dervila Eyres, General Manager, Mental Health Services, CHO8, HSE

Evelyn Flavin, Physiotherapy Manager, HSE Dublin South East

Denise Keoghan, HSE HR Leadership, Education & Training Development, Specialist/Lead for Coaching & Change Management

Dr Feargal Leonard, Executive Clinical Director, Cavan Monaghan Area Mental Health Service, HSE

Sheila Marshall, General Manager, Social Care Division – Disability Services, CHO DNCC, HSE

Mairead McGahon, Office of Nursing & Midwifery Planning & Development, HSE

Andrew McKeon, Deputy Support Services Manager, Midland Regional Hospital, Mullingar

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Martina Ralph, Development Officer/Network Manager, HSE Louth

Mandy Reilly, Support Services Manager, Midland Regional Hospital, Mullingar

Ciara Scott, Orthodontic Surgeon, Regional Orthodontic Unit, Loughlinstown Hospital

Emma Wall, Speech & Language Therapist, Connolly Hospital Blanchardstown

Orla Walsh, Project Manager, Health & Wellbeing, HSE

Vicki Willetts, HSE HR Leadership, Education & Talent Development

Individuals and Groups Consulted

This list below includes people consulted individually or in groups and/or who provided feedback and support.

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Nuala Doherty, Director, Centre of Effective Services and colleagues

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Eileen Lawrence, Staff Side Secretary, National Joint Council

Diane Lynch, Integrated Workforce Planning, National HR Division, HSE

Paul Marley, Quality Improvement Project Manager, Quality Improvement Division, HSE

Dr Jennifer Martin, Lead on Measurement for Improvement, Quality Improvement Division, HSE

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Dr Eilish McAuliffe and colleagues, Professor of Health Systems, University College Dublin, Co-Lead Project

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Anne McMenamin, Communications & Service Improvement Liaison, CSPD & HR Divisions, HSE

Mary Morrissey, Psychology Lead, Health Intelligence, Knowledge Management, Health & Wellbeing Directorate, HSE

Des Mulligan, Service Improvement Manager – Integrated Care Programme for Older Persons, Clinical Strategy & Programmes Division, HSE

Deirdre Munro, Innovation and Communication Specialist, National HR Division, HSE

Seosamh Ó Maolalaí, Facilitator and Mediator, HSE National Mediation Service, Employee Relations Advisory Services, HR Division

Marie O'Sullivan, Office of the National Director Human Resources, HSE

Lorna Peelo-Kilroe, HSE Programme Lead Facilitator, Quality Improvement Division and Office of Nursing & Midwifery Services Director

Thelma Pentony, Training Specialist/Facilitator and Coach, HSE HR Leadership, Education and Talent Development, Ardee

Caroline Smith, Office of the National Director Human Resources, HSE

Thank you also to **HSE graduate interns** who supported the development process and in particular the communication aspects.

Development Groups

Membership of development groups noted below from 2016 to March 2018 – some membership changed during this period.

Membership of HSE Leadership Team (2016 – March 2018)

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Dr Áine Carroll, National Director, Clinical Strategy & Programmes

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John Connaghan, Deputy Director General, Chief Operations Officer

Paul Connors, National Director, Communications

Richard Corbridge, Chief Information Officer

Philip Crowley, National Director, Quality Improvement

Pat Healy, National Director, Community Strategy & Planning

John Hennessy, National Director, Acute Strategy & Planning

Patrick Lynch, National Director, Quality Assurance & Verification

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Stephen Mulvany, Chief Financial Officer & Interim Deputy Director General

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Professor Frank Murray, Director – National Doctors Training & Planning (From March 2018)

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Frank O'Leary, Assistant National Director, HR – Workforce Planning, Analytics & Informatics

Siobhan Patten, Assistant National Director HR – Transformation Portfolio Manager

Jackie Reed, National Health & Social Care Professions Lead

Francis Rogers, Assistant National Director, HR – Hospitals Lead

Dr Lynda Sisson, National Clinical Lead in Workplace Health & Wellbeing

Seamus Treanor, HR Programme Manager

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Submissions Received

Every effort was made to record accurate data – titles and locations were recorded at time of submission, 2016-2017.

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Tim Hanly, Protection of Vulnerable Persons, HSE

Fiona Hanrahan, Assistant Director of Nursing/Midwifery, Rotunda Hospital

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Geraldine McLoughlin, Counsellor/Therapist, Regional Counselling Service, HSE

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Glossary of Terms and Definitions

Abbreviations

Glossary of Terms and Definitions

Note: This glossary has been developed within the context of how terms relate to the Health Services Change Guide.

Term	Definition
Accountability	The ability to demonstrate to key stakeholders that a change innovation works and that it uses resources effectively to achieve and sustain projected goals and outcomes.
Accreditation	Self-assessment and external peer review process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system.
Action research	Action research is a cyclical approach to change in which researchers and decision-makers work together to initiate change. They adapt and adjust the change process based on lessons learned through a disciplined process of planning, initiating, implementing and reflecting on the change process.
Action learning	An approach to management development that is based on managers addressing real management issues or concerns in the company of a group, usually of about eight of their peers. It is designed to encourage resolution of on-the-job challenges and is based on learning from experience – your own experience and that of the other members of the group.
Agile	A system is agile when it anticipates change from the external environment and allows for flexible responses to situations and information that emerge. It can adapt more speedily and nimbly to resolve problems that arise, often engaging in rapid testing of innovative solutions to complex problems.
Balanced scorecard	This approach guides an organisation to achieve results under a balance of related management perspectives. It addresses priorities which will ensure accountability for the four dimensions: 1. Access to services 2. Quality and safety of those services 3. Using only the financial resources available 4. Effectively optimising the efforts of staff (Human Resources) This approach supports a balanced perspective and enables a more whole system approach.

Term	Definition
Business case for change	Presents the case for change and captures key information about the potential change project. It provides a structured format for gathering all the key information required to define, design and deliver a project on a sound basis. It provides a reference point throughout the change process and can be used to continually proof and track progress of the change project as it unfolds.
Capability for change	Confidence, knowledge and skills to lead change.
Capacity for change	Having the right number and level of people who are actively engaged and able to take action.
Care Plan	A plan formulated in consultation with individual patients/service users, their families and appropriate health and social care professionals that describes what kind of services and care a person should receive.
Change agency	The power, individually and collectively, to make a positive difference. It is about pushing the boundaries of what is possible, mobilising others and making change happen more quickly.
Clinical governance	A framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical care pathways	A method used in healthcare to organise, evaluate and promote consistency in patient care. This method integrates the components of the care plan into one which addresses the needs and services provided to deliver a holistic response. A multidisciplinary care plan outlines the main clinical interventions that are carried out by different healthcare practitioners for service users with a specific condition or set of symptoms. They are usually locally agreed, evidence-based plans that can incorporate local and national guidelines into everyday practice.
Co-design **Co-production**	Co-designing a service involves sharing decision-making power with people. This means that people's voices must be heard, valued, debated and then most importantly – acted upon. Co-production goes one step further by enabling people to play roles in delivering the services that they have designed.
Commissioning cycle	Commissioning is the process of planning, agreeing and monitoring services. It includes population needs assessment, strategic planning and prioritisation, service design, service planning, contracting, and performance and accountability arrangements. The Evidence Informed Commissioning Cycle (under development in the HSE) places patients and service users at the centre of the cycle, enabling a culture of quality and service improvement informed by information and evidence. For further information email centreprogramme@hse.ie.

Term	Definition
Communities of expertise/ practice	Communities of expertise/practice are defined as a group of people who share a common interest or concern, a set of problems or a passion about a topic, and who deepen their knowledge and expertise on the area by interacting on an ongoing basis.
Comparative analysis	An analytical approach that rigorously researches different approaches to service delivery or interventions. Quantitative and qualitative approaches are used to assist comparison. Qualitative approaches include case studies.
Complex adaptive system	A complex adaptive system is a system in which a perfect understanding of the individual parts (individual, team, organisation) does not automatically result in a perfect understanding of the whole system behaviour. It consists of many diverse and autonomous parts which are interdependent and linked through may interconnections and relationships. It is characterised by distributed, not centralised control and is able to change in response to feedback or stimulus from its environment. It adapts to emergent challenges and opportunities to make sense of disruption and chaos and to survive and thrive in new situations.
Complexity science	As an emerging approach to research, complexity science is the study of a system. It is concerned with complex systems and problems that are dynamic, unpredictable and multidimensional, consisting of a collection of interconnected relationships and parts. Unlike traditional 'cause and effect' or linear thinking, complexity science is characterised by non-linearity. It is not based on a single theory but on a collection of theories and conceptual tools from a range of disciplines including natural science (i.e. mathematics) and social sciences (i.e. ecology). Complexity science is increasingly referenced in healthcare literature.
CORU	CORU is the regulator for health and social care professionals. Its role is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professionals. It was set up under the Health and Social Care Professionals Act 2005.
Deliverables	Deliverables are the tangible elements of the project that have to be produced in order to achieve its objectives. When describing deliverables, it is important to describe them from the perspective of the service user, and their acceptance criteria (i.e. the criteria the deliverables must meet in order to be fit-for-purpose and acceptable to the service user).
Dependencies	Dependencies are events or work that are either dependent on the outcome of the change initiative or that the initiative will depend on now or in the future. Dependencies may be internal or external to your service.

Term	Definition
Determinants of health	Determinants of health are defined as the range of behavioural, biological, socio-economic and environmental factors that influence the health status of individuals or populations.
	Determinants of health fall under several broad categories: policymaking, social factors, health services, individual behaviour, biology and genetics. It is the inter-relationships among these factors that determine individual and population health. Because of this, interventions that target multiple determinants of health are most likely to be effective. Determinants of health reach beyond the boundaries of traditional healthcare and public health sectors; sectors such as education, housing, transportation, agriculture and environment can be important allies in improving population health.
Diversity	The concept of diversity relies on accepting the value of each individual, whatever their race, ethnicity, gender, sexual orientation, socio-economic status, age, physical or mental abilities, religious beliefs or political stance. It is about recognising, valuing, harnessing and managing difference.
Due diligence	A comprehensive appraisal of a service that is undertaken when a handover/transfer/merger of responsibility is planned. The actions outlined are considered reasonable for people to take in order to ensure an orderly transfer of responsibilities, assets, risks, etc.
E-health (electronic health)	E-health involves the integration of all information and knowledge sources involved in the delivery of healthcare via information technology-based systems. This includes patients and their records, caregivers and their systems, monitoring devices and sensors, and management and administrative functions. It is a fully integrated digital 'supply chain' and involves high levels of automation and information sharing.
Empowerment	Refers to measures designed to increase the degree of autonomy and self determination in people and in communities in order to enable them to represent their interests in a responsible and self-determined way, acting on their own authority. Empowerment as action refers both to the process of self-empowerment and to professional support of people, which enables them to overcome their sense of powerlessness and lack of influence, and to recognise and use their resources.
Epidemiological	Information about variabilities in human situations which may have an influence on the occurrence of disease within populations.
Force field analysis	Identifies the driving and resisting forces associated with any change, and to achieve success, ensures that driving forces outweigh resisting forces.

Term	Definition
Framing	The process by which leaders and agents of change construct, articulate and convey their message in a powerful and compelling way in order to 'win' people to their cause and call them to action. Framing requires a strong awareness of ethics and values.
Goals	Goals are the broad general statements of what the organisation hopes to achieve. The goals set the priorities for the organisation.
Governance	The framework of rules, practice and policies by which an organisation can ensure accountability, fairness and transparency in an organisation's relationship with its stakeholders. It includes oversight, regulation and accountability of all those involved in the wider system, not just those working in the health services.
Holistic	A holistic approach is characterised by the belief that the parts of something are intimately interconnected and explicable only by reference to the whole. In health and social care it is characterised by the treatment of the whole person, taking into account psychological and social factors, rather than just the symptoms of a disease.
Human Resources (HR) early warning systems	Gathering of HR and people-related data from multiple sources and use of HR indices to indicate patterns. This data can be used to prevent or mitigate risks to service users and staff. Data is collected, collated, analysed and responded to. Patterns are analysed. Corrective action or appropriate performance developments can be put in place to bring about system improvements.
Human-centred design	This is based on principles of co-production with service users, citizens and staff acknowledging that people who receive and deliver services are best positioned to provide relevant insights into service design. It involves 'co-creating' solutions and testing options for delivery with the service user in mind. Key stakeholders frame problems together, make sense of the current situation and explore possibilities and solutions that can improve the experiences of all. This human-centred design lens sharpens the focus on the people side of change practices to ensure that operational models and team structures are capable of being implemented.
Impact assessment	Impact assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on individuals, teams, organisations or communities. This also applies when changes are made to arrangements and practices that impact on people's lives.

Term	Definition
Interdependency	Interdependence is the mutual reliance between two or more groups or parts of a system such as service teams or units in an organisation. It is particularly relevant in organisations where change in one part of the system can have a knock-on effect on other parts.
Inter-sectoral	The term used to describe policy issues that involve more than one department or agency and which may require a coordinated approach.
Key performance indicators (KPIs)	Key performance indicators (KPIs) are measurable indicators that demonstrate progress towards a specified target. They enable decision-makers to assess progress towards the achievement of an outcome, objective or goal within an agreed timeframe.
LEAN	LEAN is a methodology for a total redesign of clinical health systems. Lean thinking bridges together several strands of process improvement. The core idea is to maximise customer value while minimising waste. A lean organisation understands customer value and focuses its key processes to continuously increase it.
Measurement for improvement	The analysis and presentation of qualitative and quantitative data in a format that allows us to identify opportunities for improvement.
Mission	General expression of the overall purpose of the organisation, which ideally is in line with the values and expectations of major stakeholders. Statements of mission are often summarised by the question 'Why do we exist?'
Model of Care	Model of Care is a multifaceted concept, which broadly defines the way health services are delivered. It outlines best practice patient/service user care delivery through the application of a set of service principles across identified streams and patient flow continuums. The broad objective of developing a Model of Care is to ensure people get the right care, at the right time, by the right team and in the right place.
Narratives (public)	Narratives are stories. Public narrative is a leadership practice of translating values into action. It is based on the fact that values are experienced emotionally and as such are a source of motivation to take action. Narratives or stories are the means we use to access values and that give us the courage to make choices when things are uncertain. A public narrative or story revolves around choice points that illustrate a decision and its consequences and these choice points reveal our values. It also uses the richness of storytelling with vivid characters and scenes, drawing us into it in the way all good stories do.

Term	Definition
Objectives	Brief, clear statements that describe the actions that will be taken to bring about the vision and desired outcomes; they are specific and focused so that you know what is intended to be achieved.
Option appraisal	Option appraisal is a systematic evaluation based on agreed criteria of the relative pros and cons of alternative options in meeting specific health or organisation objectives before resources are committed to one or more programmes.
Organisational alignment	Enables higher performance by optimising the contributions of people, processes and inputs into the realisation of measurable outcomes. It minimises waste and misdirection of effort and resources to unintended or unspecified purposes.
Outputs	Outputs are a quantitative summary of an activity and relate to 'what we do'. For example, the number of sessions delivered or the number of people attending a service. An output tells you an activity has taken place, but it does not tell you what changes as a result.
Person-centred	A person-centred health system: • identifies and responds to the needs of individuals • is planned and delivered in a coordinated way • helps individuals participate in decision-making to improve their health and wellbeing.
Performance management	This refers to a supportive process where performance is monitored and evaluated through the identification of agreed targets, competencies and learning needs within pre-determined timescales.
Personal development planning	A planned and structured process that allows employees to identify, discuss and agree training and development needs that support the individual and the organisation.
Plan-Do-Study-Act (PDSA)	The Plan-Do-Study-Act Cycle is a framework for an efficient trial-and-learning methodology used as part of the Model for Improvement. The cycle begins with a plan and ends with action taken based on the learning gained from each phase of the cycle. The four steps consist of: • planning the details of the test and making predictions about the outcomes (Plan) • conducting the plan and collecting data (Do) • comparing predictions to the data collected (Study) • taking action based on the new knowledge (Act).

Term	Definition
Process mapping	Process mapping is an explicit process that allows the service provider to see and understand the service user's/patient's experience by separating the management of a specific condition or treatment into a series of consecutive events or steps.
Project Initiation Document (PID)	The Project Initiation Document is a record of key information needed to start and run a project on a sound basis.
Project management	Project management is the application of knowledge, skills, tools and techniques to project activities to meet project requirements and deliver the necessary outputs.
Public value	Public value describes the value that an organisation provides to society. It seeks to improve social outcomes at community level alongside meeting the needs of individuals. It requires a shared understanding of the important values that citizens, taxpayers, service users and communities want to see achieved by and reflected in public service organisations. It also presents a way of improving decision-making by calling for public service leaders to engage with service users and the wider public, thereby promoting greater trust in public institutions.
Quality assurance	The process of evaluating overall performance on a regular basis to provide confidence that the service will satisfy relevant quality standards.
Regulatory framework	A system of regulations and the means to enforce them, usually established by a government to regulate a specific activity.
Risk management process	The systematic application of management policies, procedures and practices to the activities of communicating, consulting, establishing the context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.
Root cause analysis	Root cause analysis is a useful tool to help a team deepen their understanding of a problem. Skilfully facilitated, this allows all members of the team to voice their understanding of why a problem occurs.
Scope	Scope is the entirety of work that must be completed in order to satisfy a project's objectives. It outlines what the project will and will not deliver.
Service Operational Model	Defines how a service is organised and delivered. It can apply to both clinical and business services. It outlines referral pathways, processes for screening or assessment, diagnostic processes, types of services/interventions delivered, and evaluation and measurement processes. It also describes how a service is governed.

Term	Definition
Service user	People who use health and social care services as patients, clients or service users.
	For the purpose of this Change Guide, the term 'service user' also takes account of the rich diversity of people in our society irrespective of age, colour, race, ethnicity or nationality, religion, disability, gender or sexual orientation, and people who may have different needs and concerns. We use the term 'service user' in general, but occasionally use the term 'patient' where it is more appropriate.
Service Level Agreement	A contract drawn up between a service commissioner and service provider, which outlines the timescale of the contract, the level of funding available, any agreed targets, monitoring arrangements and performance indicators. It also clarifies expectations concerning adherence to relevant legislation, guidance and procedures, and the provision of necessary documentation pertaining to the organisation requested by the commissioning organisation.
Silos of care	In the world of health and social care, silos refer to systems, processes, departments, etc. that operate in isolation. This tends to be a traditional way of working and can make it difficult to bring about change across organisations.
Social movement	A social movement is a group action that comprises large informal groupings of individuals or organisations that focus bpolitical or social issues. They provide a bottom-up approach to support social change. Modern movements utilise technology and the internet to mobilise people nationally and globally.
Social networking	An online platform that is used by people to build social networks or social relations with other people who share similar personal or career interests, activities, backgrounds or real-life connections. It includes media sites such as Facebook, Twitter, LinkedIn and Google.
Social prescribing	Social prescribing refers to the process of accessing non-medical interventions; it is a mechanism for linking people with non-medical sources of support within the community to improve physical, emotional and mental wellbeing. Social prescribing adopts a broader holistic framework, with an emphasis on personal experiences, relationships and social conditions.
Stakeholders	Stakeholders are individuals or groups of individuals who: • are (or might be) affected by change • have a direct interest in or investment in an innovation or change • whose actions could affect the change.

Term	Definition
Stewardship	Stewardship is the careful and responsible management of the wellbeing of the population and is viewed as the essence bgovernance. Components of stewardship are: • health policy formulation – defining the vision and direction for the health system • regulation – setting fair rules of engagement with a level playing field • intelligence – assessing performance and sharing information. Stewardship is the overarching function that determines the success or failure of all other functions of the health system.
Sustainability	Sustainability can be described as when new ways of working and improved outcomes become the norm. Not only have the processes and outcomes changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed as well. The change has become an integrated or mainstream way of working rather than something 'added on'. As a result, when you look at the process or outcome one year from now or longer, you can see that at a minimum it has not reverted to the old way of working, or old level of performance.
Terms of engagement	The 'rules' that people or organisations must follow when they engage and interact with each other.
Value for money (VFM)	This refers to examinations carried out to establish whether resources have been acquired, used or disposed of economically and efficiently. Examinations can also investigate whether public bodies have appropriate systems, practices and procedures for evaluating the effectiveness of their activities.
Values	Values represent the goals to which individuals attribute intrinsic worth. They are what you believe are important in the way you live and work. They have a major influence on a person's behaviour and attitude and serve as broad guidelines in all situations.
Vision	A relatively short description of the desired/better future state of the organisation or service.
Whole system approach	Reflects strategic action which is taken and is aimed at having an impact on all the constituent element of a system as opposed to dealing with one service or part of the system in isolation. This approach recognises the interrelatedness of different parts of the system and their interdependence.

Abbreviations

CHO	Community Healthcare Organisation
CIPD	Chartered Institute of Personnel and Development
CPD	Continuing professional development
CSPD	Clinical and Strategy Programme Division
DoH	Department of Health
DPER	Department of Public Expenditure and Reform
E-health	Electronic health
FOI	Freedom of information
HBS	Health Business Services
HIQA	Health Information and Quality Authority
HR	Human Resources
HSCP	Health and Social Care Professionals
HSE	Health Service Executive
HSeLanD	Health Services e-Learning and Development Service
ICT	Information and communication technology
JICF	Joint Information and Consultation Forum
KPIs	Key performance indicators
LED	Leadership, Education and Development
NAS	National Ambulance Service
OD&D	Organisation Development & Design
QID	Quality Improvement Division

PID	Project Initiation Document
PDP	Personal Development Plan
PDSA	Plan-Do-Study-Act
PPPGs	Policies, Procedures, Protocols and Guidelines
PHSI	Programme for Health Service Improvement
SLA	Service Level Agreement
SWOT	Strengths, weaknesses, opportunities and threats (challenges)
VFM	Value for money

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