

# Leadership and management in changing context of healthcare



## INTRODUCTION

The National Health Service (NHS) Trusts face a range of challenges arising from a national approach to the modernisation of services as laid out in the NHS Plan. (DOH, 2000) The NHS Plan recognises that the NHS is capable of providing more effective and accessible care by the rationalisation of service delivery through merged organisations. Mergers illustrate the focus on organisational restructuring as the key lever for change as indicated by the ninety nine health care provider mergers in England between 1996 and 2001. (Fulop, Protsopsaltis, King, Allen, Hutchings, and Normand, 2004) However, in many cases, mergers have unexpected consequences and drawbacks including problems in integrating staff, services, systems and working practices, clashing organisational cultures and poor leadership capacity.

This essay considers leadership and management in the context of a problematic merger of services from two hospitals onto one site. The essay focuses on the change management process within one department to highlight key leadership, team, and cultural issues that negatively affected the newly merged department. The microcosm of the department mirrors similar occurrences across the two merged hospitals. The essay concludes with a comment on the organisational consequences if a macro intervention is not implemented.

Confidentiality has been preserved by anonymising the identity of the hospitals and departments concerned.

## BACKGROUND

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This essay explores a recent change process involving the creation of a psychiatric liaison team based in a NHS hospital Accident and Emergency Department. (A & E) in January 2004.

The change occurred because of the merger of two hospitals that resulted in a number of structural changes, including the amalgamation of a traditionally split emergency service into a one site A & E department. The liaison team replaced the existing deliberate self-harm service which had operated in the one hospital for two decades.

The new liaison team consisted of eight newly appointed G-grade mental health nurses, a team leader, and a consultant psychiatrist who had both previously worked in the deliberate self-harm service. The hours of operation initially were 08: 00 to 22: 00 and there were two nurses on duty on early and late shifts.

During a four week induction period, the team participated in team building and training exercises and developed into a cohesive, effective group. The team created clear key performance indicators specific to the psychiatric liaison team, established an action plan to achieve the set objectives, and planned to carry out six-monthly reviews. The team developed a shared vision to provide high quality, person centred care to the A & E department without breaching government's four hour targets (DOH, 2001). The team leader's leadership style was democratic, and she fostered collaboration and involvement within the team (Walton, 1999). The team members considered her an expert in the field, and respected her for it.

In July 2004, the service manager attended a monthly team meeting. At the meeting she was informed that a major change was expected to the hours of operation. The service would be extended to a 24-hour service starting in September 2004. In order for the liaison team to cover a 24-hour roster there was initially be a reduction in the number of nurses on duty, however, more staff would be recruited if necessary after a six month service review. An exact date for the review was not given. The change had not been communicated as part of the strategy for the greater merger.

The Department of Health (DOH) modernisation agenda for the NHS, (DOH, 2002) sets out to modernise services in the NHS, and introduced a three star rating scale against which each NHS Trust's performance is compared against benchmark standards. Funding in turn is dependant on the star rating achieved. One such standard relates to delays in A & E departments, and stipulates that mental health patients should have 24 hour access to services, and that patients should be assessed and treated within four hours of arrival. (DOH, 2001) The underlying rationale for the change was therefore that the psychiatric liaison service had to provide a 24-hour service in order for the hospital to comply with the benchmark. Management of the merged hospitals did not consider staff shortages or how the four hour target might affect the quality of service provision, particularly when staff are under constant pressure to discharge patients before they exceed the benchmark standard. (RCP, 2004) In the service described above, reaching the necessary 98 % four hour target proved impossible, because the staff numbers did not match the requirements of the service.

The service was therefore to be expanded without additional staff, implying not only changes in hours and shifts, but also changes in work patterns. The team members reacted negatively to how the change process was introduced. Concerns were expressed about the reduction in staff numbers and questions were raised as to how the staff would be able to cope. The sense of security and continuity were put at risk. (Walton, 1999) The service manager was not available to address the concerns due to an increased scope of responsibility because of the merger that was beyond her normal remit. Lack of two way communication between the manager and the employees meant that the manager lost a valuable opportunity to resolve the negative reactions, and laid the foundation for resistance to change (Johnson, Scholes, and Whittington, 2005).

Within a month of the announcement, the team leader had resigned. A new team leader was appointed and was tasked to lead the team through the change. The team started gradually becoming fragmented, staff sickness rates soared, and morale plummeted. The situation reached a crisis point by December 2005, by which time two more staff members had resigned. The majority of staff had taken sick leave, and the psychiatric liaison service was left uncovered for several days. A number of mental health patients in A & E waited for hours, sometimes all night, to be seen by a mental health professional. The A & E department laid a formal complaint about the liaison team's performance.

In March 2005, following discussion with a union representative, the team took out a grievance against the team leader. The key issues of concern were the way the change process had been introduced, lack of two-way  
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communication and the team leader's unsuitable task-oriented, directive leadership style. The team leader was suspended and the Trust commenced a lengthy investigation into the change process. The investigation continues to date.

## ANALYSIS

Cameron and Green (2004) suggest McKinsey's 7S model as a diagnostic tool to identify interconnected and related aspects of organisational change. The model is problem rather than solution focussed, and hence useful for pointing out retrospectively why change did not work. The weakness of the model is that it does not explicitly identify drivers from the external environment and accordingly key forces have been described by way of explanation. According to Burke and Litwin (1992), the external environment is any outside condition or situation that influences the performance of the organisation.

### Systems, Staff and Strategy

Systems refer to standardised policies and mechanisms that facilitate work, primarily manifested in the organisation's reward systems, management information systems, and in such control systems as performance appraisal, goal and budget development, and human resource allocation. (Burke and Litwin, 1992) Systems are the mechanisms through which strategy is achieved. Strategy is how the organisation intends to achieve a purpose over an extended time scale. Johnson, Scholes, and Whittington (2005) link it directly to environment (industry structure), organisational structure, and corporate culture. Leaders are the executives and managers providing

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overall organisational direction and serving as behavioural role models for all employees. (Burke and Litwin, 1992)

The systems that the service had in place to support the staff prior to the merger had functioned efficiently. The psychiatric liaison team had monthly team meetings, weekly ward rounds and supervision, and twice daily handovers to ensure high quality service.

Teams in this context mean “ a group who share a common health goal and common objectives, determined by community needs, to the achievement of which each member of the team contributes, in accordance with his or her competencies and skill and in co-ordination with the functions of others.” (WHO, 1984) Under the previous team leader’s management, the team had achieved a mature and productive level of performance that fell within Tuckman’s model of team development of a performing team. (Mullins, 2002) The leader demonstrated characteristics of an effective team leader (e. g. good communication) and ensured that the team members’ views were passed on to the management. (Marquis and Huston, 2003)

The team also developed team specific performance indicators to fit the Trust’s strategy, such as the goal to provide high quality care within four hours of service users presenting to the A & E department. However, the new management of the merged hospitals did not take into account that the reduction in staff numbers would make it difficult for staff to find time to attend ward rounds and to supervise care. Lack of supervision had a negative impact on the quality of care provided, and staff shortages meant that the team did not reach the four-hour targets in A & E department. The

change process indicated a lack of sincere stakeholder consultation which would have alleviated the crisis in the department. (Iles and Sutherland, 2001)

### Structure and Style

Structure is the arrangement of functions and people into specific areas and levels of responsibility, decision-making authority, communication, and relationships to assure effective implementation of the organisation's mission and strategy. (Burke and Litwin, 1992) The NHS Leadership Qualities Framework (DOH, 2002, p34) suggests “ leading change through people” with “ effective and strategic influencing” is essential in a merger environment. This is supported by Johnson, Scholes and Whittington (2005) who suggest that strategic, transformational leadership is a key element within an organisation staffed by professionals and that a collaborative style is required to achieve transformational, lasting change. However, the new team leader's leadership style was autocratic and the team members were no longer consulted about matters concerning it, which was inappropriate in team nursing approach associated with collaborative patient centric care.

Marquis and Huston (2003) suggest that a democratic leadership style works best with a mature experienced team with shared responsibility and accountability. The change in leadership style meant that the team felt disempowered and uninvolved in decision making which did not allow ownership of the change process to emerge. Furthermore, the flow of information to the team slowed down and the team's concerns about the



change did not reach top management implying that communication channels in the new organisational structure were not functioning efficiently.

Management style equally affects culture. Johnson, Scholes and Whittington (2005) state that culture is the “ taken for granted” assumptions that are accepted by an organisation or team. These work routines are not explicit, but are essential for effective performance. Ignoring these as the new team leader did, reduces motivation and performance, and stiffens resistance to change.

### Skills

Skills are the distinctive capabilities of key people. (Cameron and Green, 2003) The nature of the team membership implied a range of key skills interdependent on the other for effective performance. A problem area in the skills portfolio was information technology skills. The Trust managing the merged hospitals had introduced a Trust wide electronic patient record system in accordance with NHS requirements. (DOH, 2003) This was implemented simultaneously with the decision to extend the working hours. The change aimed to improve the service user experience by allowing staff a 24-hour access to service user’s care and crisis plans. (DOH, 2003) The staff shortage meant that team members did not receive appropriate training on the system and the use of the electronic patient record system became a source of frustration and confusion. Lack of computer skills contributed to staff’s frustration and negative attitudes with the change process.

### Superordinate goals

Superordinate goals are the longer term vision of the organisation and the shared values and guiding principles that that shape the future of the organisation and motivation achievement of strategy. (Cameron and Green, 2003) The team's superordinate goals were initially created during the four-week team building period and aligned with those of the larger organisation. The team's vision was to provide high quality, service user centred care. The team also considered change as a natural part of organisational development. However, the team became increasingly resistant to change when it felt that the organisation did not really care about its employees, their concerns, and the ultimate reason for the organisation's purpose, being the patient.

#### DISCUSSION OF CHANGE PROCESS

Change management is art of influencing people and organisations in a desired direction to achieve an agreed future state to the benefit of that organisation and its stakeholders. (Cameron and Green, 2003)

A number of models can be used to model a change management process. A popular model is Kurt Lewin's forcefield analysis. A forcefield analysis is a useful tool to understand the driving and resisting forces in a change situation as a basis for change management. This technique identifies forces that might work for the change process, and forces that are against the change. Lewin's model suggests that once these conflicting forces are identified, it becomes easier to build on forces that work for the change and reduce forces that are against the change (Cameron and Green, 2003). The difficulty is the assessment of strength or duration of a force, particularly

when the human dimension is considered. The key resisting force in the change process was a lack of staff and poor leadership.

The change process under discussion was largely motivated by external factors. However, due to poor project planning, Trust management failed to consider the internal factors that had a major impact on the change. In particular, the management failed to involve the necessary stakeholders at a local level to increase ownership of the change thus failed to consider the human dimension (Walton, 1999 and DOH, 2004). The new team leader's autocratic leadership style did not fit the requirements of the task, or the culture of the team and thus sowed the seeds of resistance to change. (Hogg and Vaughan, 2002). The poorly managed change process became costly to the Trust due to the loss of human resources, reduced staff morale and lowered the credibility of the management. The change left the psychiatric liaison team feeling betrayed, and individual team members traumatised.

As the change process progressed, it became evident that a thorough analysis of current resources and various dimensions of organisational change had not been carried out (Johnson, Scholes and Whittington, 2005). The management had not prepared a clear plan for launching and executing the change at a local level.

The NHS Modernisation Agency Improvement Leaders' Guide (DOH, 2004) stresses the importance of taking into consideration the human aspect when planning a change project. Similarly, Walton (1999) argues that change initiatives should be thought through and planned as far as possible taking

into account the psychological bonds that staff form with their work groups and their organisation as a whole.

It follows then that no precautions had been taken to address resistance to change. Johnson, Scholes and Whittington, (2005) state that there should be a clear communication plan to state how information about the change project will be communicated inside and outside the organisation. The team members were not given an opportunity to challenge and test the change proposal, or clarify what aspects of the change they could or could not influence. (Walton, 1995)

Fulop, Protsopsaltis et al, (2004) suggest that change project should be presented as an opportunity to improve the quality of performance and that clinicians should be involved on a consultative basis. Team members were aware of the consequences of extending the hours of operation without increasing the resources, however, there were no systems in place to communicate these views to the Trust management, a key aspect of the change process. The lack of key stakeholder involvement in the change meant that the management did not have access to the psychiatric liaison team's valuable experience on the immediate and wider implications of cutting down resources. (Henderson, 2002)

The team members felt that their concerns about the lack of resources had not been taken seriously, and this inevitably led to a feeling that the Trust did not care about its employees or their views. Strong emotions such as anger and frustration were expressed by the team members. The lack of formal communication channels, meant that the team members took them

out on each other. Johnson, Scholes and Whittington, (2005) confirm that at times of change, rumours, gossip and storytelling increases in importance and that team members engage in countercommunication, thus unconsciously spreading distrust, suspicion and negativity which leads to lowered staff morale and job satisfaction.

Although the rationale for change was clear to everyone, the change was executed at such short notice that the team members did not have time to develop strategies to deal with it. The NHS Improvement Leaders Guide to Managing the Human Dimension of Change (DOH, 2004) suggests that clinicians go through phases of shock, denial, anger, betrayal, conformance and understanding before they finally develop commitment to the change. The team members were left in a state of shock after the service manager's initial announcement of the impending change in July 2004 and then moved into a state of denial. The general opinion was that the management would sooner or later realise that the change could not be executed without increasing the resources and accordingly delayed the change process until more staff would be employed. When there was no indication of this in the weeks that followed, the team members became demotivated. The team failed to move on to the next stages in their reactions to change, and commitment to the change process did not develop.

The team leader's task-oriented leadership style did not suit the context of the change process, and partly contributed to its failing. Cameron and Green (2003) suggest that leadership will be most effective when the leader's leadership style, the subordinates' preferred leadership style and the requirements of the task fit together. A directive leadership style

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therefore is ineffective if the subordinates' preferred leadership style is democratic, even though the task is well defined within tight parameters. In addition, Hogg and Vaughan (2002) argued that the most effective leaders are those who are able to combine task and socio-emotional leadership styles, and organise team members to work towards achieving goals at the same time promoting harmonious relationships. The new team leader paid no attention to the team culture and failed to communicate to management about the impending issue.

Johnson, Scholes and Whittington (2005) suggest that power is a key element in a change process. Power is the ability of individuals to persuade or coerce others into following a course of action. The new team leader's source of power was based on his hierarchal position in the Trust rather than on expertise or knowledge as shown by the previous team leader. The team members did not consider that the new team leader possessed appropriate expertise or personal characteristics. The team leader exercised coercion which was met with resistance by the team and for this reason the team members lacked respect for him. He was seen as an executor of decisions made by the management.

The new team leader appeared to be more concerned about a successful completion of the change, was target driven and lacked sensitivity to employees feelings and concerns. The team leader used his positional power in a negative way, filtered information and gave the management a distorted view of how the staff were coping with the change process.

The relationship between the team leader and the staff members eventually deteriorated to a point where communication broke down. Two staff members went on a long term sick leave, and two other staff members resigned. Following a meeting with a union representative in March 2005 the team members, including those who had resigned, made a decision to take grievance out against the teamleader. The key issues brought up in the meeting were the way the change had been introduced, poor project management and the team leader's autocratic management style (Walton, 1999).

## CONCLUSION

In conclusion, lack of stakeholder involvement, poor project planning and the teamleader's unsuitable leadership style lead to the psychiatric liaison team becoming fragmented, and resistant to change. No systems were put in place to ensure two-way communication with the employees. Lack of communication reduced the staff's commitment to, and ownership of the change, and lead to a lower quality service provision and increased long waits in A & E. The poorly managed change process became costly to the Trust due to loss of trained human resources, staff morale and credibility of the management. Similar incidents occurred in other areas of the hospital indicating that the change processes associated with the merger had created organisational wide problems that were indicative of failure at a top management and strategic level.

Strategic leadership is a key element of the change process. A successful merger will only be achieved with consistent communication and the

establishment of a vision that percolates throughout an organisation as a basis for effective change to realise the stated benefits of all stakeholders.

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