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An Organisational Development Project to Enhance Interagency Working between the Health Service Executive and Voluntary Agencies

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AN ORGANISATIONAL DEVELOPMENT PROJECT TO ENHANCE INTERAGENCY WORKING BETWEEN THE HEALTH SERVICE EXECUTIVE AND VOLUNTARY AGENCIES

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Abstract:

Worldwide there is an increasing incidence and prevalence of disability. To provide a wide range of supports to people with disability, the Health Service Executive (HSE) works in partnership with voluntary agencies to provide specialist health and social care services. The integration of this sector has led to an emphasis on joint working of an array of professionals across organisational boundaries as teams and through teamwork. In reality while the need for joint working is an important component of policy, it is something that is not delivered effectively in practice. This organisational development project aims to enhance interagency working by promoting a culture of collaboration and co-ordination of services so that effective support is provided to service users. For the first time a network analysis was introduced into the department using the HSE Change Model. A participatory approach was utilised to monitor and evaluate the project. Outcomes achieved during the project included targeted communication strategies across HSE and voluntary agencies and the identification of critical success factors for interagency working. Finally, to share the organisational learning, the project has identified and recommended further changes which can be considered across wider services with the shared vision of achieving integrated care.
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To my family and friends – thanks for your encouragement, love and concern. To my husband Don – your strength, patience and love has made this journey an easier one. Finally, my children (Danh and Mai Ly) – “mummy’s’ homework is done – we can now watch a movie".
Glossary of terms:

**Change agent:** a person who influences others and gets a job done under difficult circumstances (Etheredge & Beyer, 2011)

**Health & social care services:** a term that relates to integrated services that are available from health and social care providers. Health gain is concerned with the health status, both in terms of increase in life expectancy and in terms of quality of life through the cure or alleviation of an illness or disability or any other improvement in the health of an individual or the population at whom it is directed. Social gain is concerned with broader aspects of the quality of life (Department of Health and Children, 2001).

**Service user:** the term ‘service user’ takes account of the rich diversity of people in our society, regardless of age, colour, race, ethnicity or nationality, religion, disability, gender or sexual orientation, who may have different needs and concerns. They can include:

- people who use health and social care services as patients; carers, parents and guardians,
- organisations and communities that represent the interests of people who use health and social care services,
- members of the public and communities who are potential users of health services and social care interventions (National Healthcare Charter, DOHC & HSE, 2012).

**Voluntary agencies:** These agencies are not for profit organisations which provide specialist disability services under Section 38 or Section 39 of the Health Act 2004 (DOH, 2004, DOH, 2012a)
1. Chapter 1:

1.1 Introduction

Change involves modifying the way things are done with the goal of improving practices (Hayes, 2002). This initiative sets out to lay the foundations of an organisational development plan involving individuals across statutory and non-statutory organisations and aims to enhance interagency working. It is anticipated that if the goal is achieved this will contribute both to the valuable work of staff and needs of people who require health and social care services.

1.2 Nature of the change:

The needs of people with disability are far reaching necessitating both health and social care agencies to work in partnership to provide a range of services and supports aimed at enhancing individual’s quality of life (WHO, 2011). This project seeks to enhance interagency working by introducing a network analysis to the department and promoting the working together of staff across care settings with a view to improving care outcomes. Thus providing a more efficient and effective service. Maintaining active involvement, particularly of a large number of partners, is time-consuming; requiring significant input from staff, senior managers and leaders. Promoting a culture whereby interagency team working can adapt, thrive and succeed is substantially shaped by leaders within and across services who are confident in their ability to effect change and motivate others to follow (Kavanagh & Ashkanasy, 2006).
This project will endeavour to enhance a culture of collaboration and co-
ordination of services so that effective support is provided to service users.
With this in mind, the change agent, a Case Manager within the HSE will
provide leadership and engage with others, with the vision of achieving
integrated care. Achieving integration can make a real difference to the
quality of care received by service users (DOH, 2012). However, in reality
there is an acceptance that it is best for healthcare personnel to work
together to ensure the best outcomes for service users, in practice this poses
many challenges.

1.3 Rationale for carrying out the change

While most people with disabilities access general health and social
services, specialist services are delivered to approximately six (6) per cent of
people with physical, sensory and intellectual disabilities (National and Social
Economic Council, 2012). According to The Value for Money and Policy
review of Disability Services in Ireland (DOH, 2012a) over €1 billion revenue
funding per annum is provided from the HSE to voluntary organisations to
provide a range of specialist services.

Working with others in partnership to deliver quality outcomes is a core
requirement in delivering effective health and social care services.
Partnership organisations across the statutory and voluntary sectors of
healthcare are undergoing immense changes and facing similar challenges
(Hardy et al, 2003, DOH, 2012). Healthcare organisations need to be able to
identify emerging trends and issues and develop strategies for action. The
danger of a fragmented delivery system is that individual needs will not be met, substantially reducing service users outcomes (DOH, 2012).

To fully determine the triggers for this change initiative a PESTLE analysis (Appendix 1) was undertaken (Byars, 1991). This tool provided important information about political, economic, social, technological, legal and environmental factors which assist or hinder the progress of introducing this development. Gaining an understanding of these factors empowered the change agent to commence the project, identified ways of responding to these forces and improved the success of introducing the change (McAuliffe & Van Vaerenbergh, 2006, Kanter 1995).

Service demands:
Globally, disability affects more than a billion people. The prevalence of disability is rising due ageing populations, increases in chronic health conditions, enhanced medical and rehabilitation care (WHO, 2011). In Ireland; disability affects one in five individuals placing increased demands on the healthcare system (Department of Social Protection, 2011, Health Research Board, 2011). Despite the demand for services, there is an increased pressure on the economics of healthcare delivery with cost containment measures now focusing directly on service provision (DOH, 2012a, HSE, 2013). Consequently, quality and safety have emerged as the primary foci in the delivery of services.
National drivers:

The introduction of National Standards for Better Healthcare (HIQA, 2012) places further demands on all health care services to ensure that high quality, safe and sustainable services are provided, in line with best practices. For the first time, all statutory and voluntary service providers will be responsible for the implementation of these standards across disability health services. This can be seen as an opportunity to engage with all service providers across functional boundaries.

Furthermore, the vision of Future Health (DOH, 2012) in achieving integrated care across the health system and the establishment of The National Clinical Strategy Programmes aimed to improve and standardise patient care throughout healthcare organisations has already engaged clinical disciplines and enabled them to share innovative solutions to deliver greater benefits to service users (HSE, 2011, DOH, 2012). Initial recommendations from the National Rehabilitation Clinical Strategy confirm that the provision of quality and safe care are closely linked with the coordination of services through the development of care networks.

Service user involvement:

Within our department increasing service user involvement and participation within local interagency teams are evident. Service user involvement enables health services to anticipate problems, develop effective services and guarantees person centred services (DOH, 2008, DOHC & HSE, 2008, HIQA, 2012, NICE, 2007). This project endeavours to empower service
users by building and maintaining relationships to support their meaningful engagement within departmental interagency teams.

1.4 **Context of the change**

The specific healthcare region involved in this change project provides health care and social services for more than 280,000 people (CSO, 2011, HSE, 2013). Within the region over thirty (30) non statutory voluntary agencies are funded and monitored by the HSE, through Service level agreements to provide services to people with disabilities. All of these agencies have different philosophies, organisational cultures, visions and missions, operating procedures, human resources practices and relationships with services users. With this in mind the project aim and objectives were determined.

1.5 **Aim & Objectives**

**Aim:**

An organisational development project to enhance interagency working between the HSE and non-statutory disability service providers.

In order to achieve the aim of this project the following objectives have been identified:

**Objectives:**

1. Conduct and pilot the implementation of a network analysis within the disability department by March 2013.
2. Determine and recommend the critical success factors for successful interagency working between HSE and voluntary funded agencies by April 2013.

3. Recommend a communication strategy to senior management for sharing project outcomes between existing disability voluntary funded partnership organisations.

1.6 Summary

The aim and vision of this project is to enhance interagency working across the disability setting and improve the lives of service users. An analysis of the environment has indicated that this project is timely amidst a climate of social and economic reform, financial cutbacks, changing demographics and demands for greater efficiency of the healthcare system. The capacity of health and social care agencies to maintain and improve services relies on the ability of interagency staff to collaborate effectively with each other across different settings in the provision of services. The project lays the foundation blocks of an organisational development plan by piloting a network analysis and examines the critical success factors for successful interagency working. In approaching the project the change agent will next look at the evidence base in literature to support this change initiative.
2 Chapter 2: Literature Review

2.1 Introduction

A literature review is a description of the literature relevant to a particular field or topic. The process involves reading, analysing, evaluating and summarising scholarly material about a specific subject (Randolph, 2009). For this project, the literature was reviewed to seek new information and confirm the validity of introducing a network analysis. The chapter will firstly outline the search strategy used to obtain the literature and will discuss interagency working both nationally and internationally, giving a brief history of the voluntary sector. The chapter will examine the concept of interagency team working and collaboration within health and social care services. The review aims to provide an overview of the current literature pertaining to the benefits and challenges of partnership working, also known as cross-agency collaboration.

2.2 Search Strategy

Electronic searches were undertaken across the major academic databases via the Royal College of Surgeons in Ireland (RCSI), HSE and Irish Management Institute libraries. The literature reviewed was obtained primarily from the CINAHL, Ovid, and Emerald databases. Initially, all of the key concepts contained within the project were reviewed. Search terms were kept uniform when accessing various databases so as to ensure consistency. However, on referring to the relevant articles and the search terms employed by the author(s) of these articles, additional search terms were also used:
Keyword searches using the above search terms were also carried on a variety of inter-professional and healthcare journals using the RCSI and HSE websites.

2.3 Review Themes

There is extensive literature available in the field of interagency working and collaboration. The objective of this review was to examine literature pertaining to interagency working and the benefits of utilising a network approach to support collaboration. In analysing the search strategy a number of challenges were met by the change agent. Firstly, the search revealed the abstract nature of the term “interagency” working across national and international literature. Furthermore, gaining literature about statutory and non-statutory organisations was difficult due to the inter-changeability of terminology across countries. Within Ireland, voluntary organisations are known as non-statutory organisations, whilst internationally a variety of terms are used namely “third sector” “not for profit” agencies. Lastly, in order to narrow search results literature pertaining to information technology, private sector and social networking were eliminated.
The literature reviewed revealed four themes which will be discussed and will provide valuable information in both leading and managing this change project:

- Partnership working
- Teams
- Collaboration
- Health Care networks

2.3.1 Partnership working:

We live in a global society. It is no longer effective for healthcare organisations to work alone. Within the public and voluntary sectors the need for partnership working, often referred to as interagency working or working across boundaries, is recognised as a vital component of success (Wildridge et al, 2004). In the United Kingdom, partnership working between health and social care is a key component of the government’s agenda for the modernisation of healthcare services. This has resulted in integration of these sectors in the delivery of public services (Davies, 2011). Utilising a partnership approach creates the need to find a new way of working across organisational boundaries underpinned by a common purpose of providing the best care for service users (Plamping et al, 2000).

(2002) and Wilson et al (1997) both agree that there is no universally accepted definition of partnership. However, Lowndes (2001) sees partnership as a variety of arrangements with different purposes, time-scales, structures, membership and operating procedures. Common to the definitions of partnership are approaches between organisations, groups, agencies or disciplines (Gray 1989, Wilson 1997), with shared aims or vision, goals or interests (Audit Commission, 1998, Gray 1989, Glendinning, 2002). Clark (2002) views the commonalities of partnerships encompassing joint rights, resources and responsibilities. From an Irish perspective, perhaps the simplest way to understand partnership is viewing it as a process of participations through which people, groups and organisations work together to achieve desired results (IPA, 2001).

Within healthcare, the partnerships between public and voluntary organisations are associated with improved and enhanced access to services for users and carers (Whittington, 1999, Grone, & Garcia-Barbeo 2001). Conversely Macmillian (2010) in an extensive study, over a six year period questions whether new commissioning processes within the United Kingdom are leading to service improvement, and fundamentally what difference partnership services make to service users. This study highlights that most of the research has focused on Third Sector Organisations views and much more needs to be known about service users views; only then can improvements be made across services. Wildridge, et al (2004) emphasise that partnership working does provide significant benefits to service users.
and staff. Fundamentally, the act of working together is a benefit in its own right, alongside any anticipated outcomes in service delivery.

2.3.2 Defining voluntary agencies

In Ireland, voluntary disability and community organisations have had a major role in creating and providing a wide range of services for people with disabilities (NESC, 2012). Davies (2011) uses a relatively narrow definition emphasising the voluntary sector as organisations that are formally constituted; non-profit distributing, constitutionally independent from the state and benefiting from voluntarism. Perhaps some of the most important attributes of this sector that were considered absent from the public sector such as closeness to the service user, their capacity for innovation, flexibility and democratic engagement through an advocacy role.

The integration of statutory and voluntary services within the disability sector has led to an emphasis on joint working of an array of professionals across organisational boundaries as teams and through teamwork. However, according to Dickinson & Neal (2011) while the need for joint working is an important component of policy, it is something that is not delivered effectively in practice.

2.3.3 Concept of team and teamwork

It is no longer possible for one person or one discipline to have all of the knowledge and experience to solve the complexity of issues involved in delivering healthcare services to an individual (NHS, 2009). The concept of
teams and teamwork as the most effective way of delivering healthcare recognises that this way of working offers the assurance of more progress than can be achieved by individual efforts (Borrill et al 2003, Ancona, 2007).

In a literature review by McCallins (2001), which studied the development of inter-disciplinary practice the concept of “team” and “teamwork” showed a discrepancy stating that teams are a specific functioning unit in the organisation that facilitates how teamwork is achieved. Mickan & Rodger (2005) recognise teamwork as the on-going process of communication between the team members as they work together to achieve their primary objective. The core aspects of teamwork are seen as agreed objectives, defined roles, shared responsibilities, defined boundaries, mutual resources and shared opportunities for learning (Mickan & Rodger 2005). For teams to be truly effective there must be congruence between individual team members and the organisations core structures and processes.

2.3.4 Teams: 
Oandassan & Reeves (2005) refers to an array of terms which are used by health care organisations to describe team working, many of which are used interchangeably. The prefixes such as “professional” vs. “disciplinary” are used randomly throughout the literature reviewed. According to McCallin (2001) when transferred into the healthcare setting these terms can appear unclear and misleading. Oandassan & Reeves (2005) draw an important distinction between discipline and profession, noting that discipline is defined
as a “field of study, which is usually taught” whereas profession is described as “requiring specialised knowledge through academic preparation.

The prefixes of “multi”, “inter”, “trans”, “cross” are also often used interchangeably with the suffixes above (Oandassan & Reeves, 2005). “Multi” is referred to partners who work independently towards a purpose whereas “inter” implies a partnership of members from different domains of work who work collaboratively towards a common goal. Sorrell-Jones (1997) describes inter-disciplinary team working as a collaboration in which processes such as evaluation is done jointly, with professionals from different disciplines pooling their knowledge together in an independent manner. Using this approach; disciplines share common goals, are committed to communicating and working through planned interaction, client involvement and enhanced co-ordination of tasks (HSE 2010).

Bruder (1994) identifies a “trans” partnership approach to teamwork as an ideal design for the delivery of services particularly for young people with disabilities. This approach involves collaboration as a process of problem solving by all team members each of whom equally contributes their knowledge and skills. The primary purpose of this type of team is to pool and integrate the expertise of its members so that more efficient and comprehensive service delivery can occur. Connolly (1995) sees trans-disciplinary teams as inter-disciplinary teams that are functioning with high levels of inter-professional synergy. Hall & Weaver (2001) expand on this and sees the engagement of trans-disciplinary teams involving role blurring.
and where professionals undertake tasks outside their normal professional roles.

Perhaps, what is more important; is the way in which various healthcare staff interacts and integrate with each other. According to Leathard, (1994) what is truly important for today’s medicine, nursing and allied health professionals is to provide integrated care in an inter-professional or trans-professional context which supports specialisation, justification, maximization and avoids duplication of services. Within health and social care few would dispute that partnership organisations should move from the traditional “silo” approach with single providers to a seamless, well integrated care approach that brings together expertise from various disciplines to provide quality of care (DOH, 2012).

2.3.5 Collaboration
A prerequisite for effective partnership working identified throughout the literature is collaboration. Collaboration is identified as form of collective action, involving multiple agencies working together in response to mutually dependent needs and complex problems (Clairbourne & Lawons, 2005). Agencies come together to collaborate because no one alone can achieve its missions and goals, improve results and attain desired benefits without the contribution of others. Himmelman (2001) furthers this view and sees it as an exchange of information for mutual benefit, co-operating, sharing resources and working to build capacity of others.
Pressures to identify and address priorities have prompted collaboration among organisations in public settings (Kurland & Zeder, 2001). The literature cites benefits of collaboration include improved service delivery, (Provan & Milward, 2001), improved quality and efficiency of care (Gittell, 2000), stakeholder empowerment (Bond, et al 1993), exchange of knowledge and enhanced relationships between partner organisations (Provan & Milward, 2001). According to Burke (2002) and Gittell et al, (2006) when organisations respond to adversity by sustaining or strengthening their working relationships, they improve their collective capacity to respond.

While many have noted the benefits of collaboration, challenges to achieving it are also evident. These include limited resources, conflicting beliefs or confidentiality concerns (Florin, et al 2000). Issues of territoriality, conflicting goals, lack of trust and perceptions about status are also factors to inhibit collaboration of partners (Dickson & Neal, 2011, Gittell & Weiss 2004, Lopes & Calapez, 2011). To achieve inter-organisational and interagency collaboration, health structures and processes must develop mutually beneficial relationships through the exchange and sharing of information and implementation of services.

Lawson (2004) in examining the concept of collaboration highlights that it is the correct mix of stakeholders which is important. Stakeholders who have a history of successful collaboration and staff who possess the necessary competencies to collaborate are more likely to succeed that those stakeholders who may not have the fundamentals of collaboration or ability.
From an international perspective, it is not uncommon for funders or governments to mandate collaboration with little understanding of the challenges that practitioners face in the provision of healthcare services (Wolff, 2001b).

Many of these challenges often focus on relational issues. According to Bond & Hoffer Gittell (2010) successful collaboration appears to require establishing interconnected and supportive relationships in which trust enables joint problem solving and conflict resolution in the quest of shared vision and goals. The quality of human relationships can either support open and honest communication or undermine it. Communication is seen to be an essential ingredient of partnership working and critical for achieving collaboration outcomes (Gittell & Weiss, 2004, Smith et al, 1995). In providing effective and efficient services staff across all statutory and voluntary agencies must overcome these challenges to share resources and information for person centred outcomes.

2.3.6 Health care networking

Globally, within healthcare services clinical networks have been increasingly used as a mechanism for managing, organising, improving the quality of care and implementing change across complex organisational and professional boundaries (Cunningham, et al, 2010, Goodwin, et al, 2004, Curry & Ham, 2010). Clinical or health networks are viewed as a social-professional structure made up of medical, nursing and allied health staff tied through
inter-dependencies such as collegiality, friendships, referrals, function or common interests (Goodwin, et al, 2004).

Network “type” is an important theme in the literature review (Braithwaithe et al, 2009). Ranging from purposefully, designed or imposed networks by governments to natural networks, composed of emergent relationships amongst clinicians through professional interests, supports, referrals and communications. From a United Kingdom and Irish perspective, healthcare networks, at a policy level, are to be engaged and strengthened in the reform of the National Health System (DOH, 2012, Mc Lean, 2011). According to Curry, & Ham (2010) for “mandated” networks to succeed there must be an alignment of mandated structures with pre-existing professional arrangements, so that there is the appropriate combination of top-down and bottom-up influences. The study emphasises the importance of achieving not only organisational integration but the integration of services and networks across all layers of the organisation.

According to Goodwin, et al (2004) in a comprehensive review across public and private sectors securing linkages both within and between agencies are essential to meet the needs of service users. Effective networks enable healthcare professionals to work together constructively with some individuals acting as a “boundary spanner” in a network, playing an important role in exchanging information, developing and improving relationships across agencies (Boyer, et al 2008, Goodwin, et al, 2004). Conversely, the literature cites poor outcomes associated with networks particularly if
networks are not supported. Clear goals, a willingness to collaborate, trust and effective leadership are essential ingredients which are required across healthcare agencies (Proven, et al 2001, Goodwin, et al 2004).

2.4 Implications for change project:
The literature reveals that interagency working is critical within the provision of healthcare services. The process requires nurturing and support across all layers of organisations. This includes a dynamic process which involves staff and service users across multiple agencies. The studies reviewed demonstrate how networks can be used as a mechanism to develop and support the relationships between groups. Success of this project however, will require interagency staff and service users to play an active role by taking ownership and responsibility for ensuring effective communication and collaboration across all interfaces of care.

2.5 Summary
Within healthcare systems teamwork and collaboration occurs at varies levels. This may be a fundamental part of a service providers work, or undertaken informally through the numerous linkages and networks of relationships between agencies to support the care needs of service users (Calciolari & Ilinca, 2011). Mechanisms to share information across statutory and voluntary agencies are the basic ingredient that enables professionals to coordinate supports for service users. A key challenge facing all these leaders and managers is their ability to ensure services are dynamic and adaptable to fully meet the needs of service users.
Chapter 3  Change Process

3.1  Introduction

Change is a constant feature of health and social care delivery. The on-going change within healthcare services impacts on the way we work, the way in which we relate to each other, how services are planned and delivered for the benefit of those requiring healthcare (HSE, 2008). Change is a continuous and adaptive process in which all of the elements are interrelated and can influence each other. Making changes in any organisation is dependent upon changing people. It is for this reason that change cannot be predicted easily and emerges over time (HSE, 2008).

This chapter will outline the process of leading and managing the changes involved in this project. Successfully managing organisational change can be a difficult task, even for the most skilful of leaders (Reardon, et al 1998). A critical review of the approaches to leading this change will be discussed. The majority of change efforts fail (Beer & Nohria, 2000, Sirkin et al, 2005). To increase the likelihood of successful implementation of this project, a change model will be used to help understand and undertake the process of leading this project (Brady 2010, Carney, 2000). Many models of change exist - however the HSE Change (2008) model was chosen as the most applicable for this project. A rationale for the selection of the change model will be discussed. The main body of this chapter is concerned with the development of this project by utilising the selected model which consists of four phases namely: Initiation, Planning, Implementation and Mainstreaming
(HSE, 2008). Finally, the chapter will highlight the strengths and limitations of the project.

3.2 Critical review of the approaches to change

Today’s health services are facing two major conflicting challenges firstly control of healthcare costs and secondly the provision of quality care to all service users. Ultimately these factors are altering the healthcare delivery system and so impact on the ability to lead effectively during periods of change. In approaching this project the change agent has considered the internal and external environment of her organisation using a commonly used PESTLE analysis business tool (Byars, 1991) (Appendix 1).

**Internal Environmental Analysis:** In examining the internal environment of her workplace it is evident that anxieties are placed on staff with the recent merger between the disability and the primary care healthcare settings. Additionally, demands are mounting within each sector for the provision of health services by service users. **External Environmental Analysis:** The external challenges of imminent regulation by the Health Information Quality Authority (H.I.Q.A., 2012), an increasing focus on for value for money initiatives and a national drive to integrate all healthcare partners has created the urgency for this change management project (DOH, 2012).

According to McAuliffe & Van Vaerenberg (2006) the way in which change is approached is to a large extent related to the organisations underlying belief about the nature of change. The strategic objectives of the change agents
workplace, involves the utilisation of the core competencies of staff across organisational boundaries; to ensure that they are meeting the needs of the service users. Key drivers include ensuring highly efficient and effective services are provided in line with national strategies and policy directives. Fundamentally this strategy is interdependent of the people, structures, technology and objectives of the organisation itself. As a result the change agent utilised an organisational development approach to the project. Using this approach to change involves a planned long term effort, led and supported by top management, to improve an organisations visioning, empowerment, learning and problem-solving processes, through on going, collaborative management of organisational culture (French and Bell, 1999).

Dawson (1994) and Wilson (1992) both challenge the appropriateness of using a planned model of change in an environment that is increasingly dynamic and uncertain. They argue that by relying on an approach of organisational change which is achieved through a pre-planned and centrally focused process does not address crucial issues of the change environment such as the continuous need for staff flexibility and organisational adaptation. McAuliffe & Van Vaerenberg (2006) suggest that an emergent approach of change would be useful in this environment as change is viewed as a process which unravels through the interplay of multiple factors including the context, culture, political processes within any organisation.

Predominantly, it is the change agent’s view that the successful engagement and collaboration of multiple stakeholders will underpin the success of this
project. In utilising an organisational development approach key stakeholders can pay close attention to ensure both the process of change and content of change to ensure they are carefully managed. Additionally an organisational development approach can encourage stakeholder participation in problem solving and implementing solutions.

Beer & Norhria (2000) emphasise while an organisational development approach has the benefits of improving stakeholder values, it can viewed as an indirect approach to change which takes too long to achieve organisational goals, especially when the need for change is urgent. Nevertheless, using this highly participative approach has the ability to implement this planned change while at the same time, monitor emergent changes through collaboration, meaningful engagement, and active listening to stakeholders. This can facilitate top-down and bottom up influences within and across partner organisations (McAuliffe & Van Vaerenberg, 2006). In proceeding with the implementation of the project, the change agent was politically astute of her work place environment so that if necessary a contingent approach to the projects steps may have needed to accommodate and balance any emergent factors.

3.3 Rationale for the change model selected

A number of models were considered for this project and included Kotter’s (1995) eight step model as outlined in Figure 1.
This model offers a common sense framework for approaching organisational change based on simple beliefs of create and communicate and get the organisation onside. In examining the model it is evident Kotter’s work is largely based on his own experience within private industry and the model is not well tested within a healthcare context (Noble et al, 2011).

The model is easy to follow and is structured so that each step is followed in sequence (Fernadnez and Rainey 2006). Although, Kotter (1996) himself suggests that this is not entirely the case. Key to successful outcomes of using this model is ensuing that each step is carefully followed by change agents ensuring that no steps are missed in an attempt to speed up the process. The change agent was concerned that the linear approach to leading this change would be too restrictive due to the unpredictability of a wide range of stakeholder’s views during project implementation. Kotter’s model (1995) has been criticised whereby small changes are celebrated early in the process of change (Cameron & Green 2004). Unless skilfully
managed, there is a danger that stakeholders claim victory too early by celebrating short term wins, hence ignoring the other steps in order to ensure a lasting change within the organisation.

Another change model considered for the change project was Action Research as outlined in Figure 2.

![Figure: 2 Action Research Change model (Coghlan & Brannick, 2005)]

This model based on the seminal work of Lewin (1947) involves iterative cycles of diagnosing an issue, planning the action/intervention, implementing the plan and evaluating the outcomes (Coghlan & Brannick, 2005, Coghlan & Casey, 2001). As the process develops the change has been introduced and embedded within the organisation. Using an Action Research approach would be of benefit for the change agent and participants of this project as it enables them to become co-researches based on real time events within their workplace (Coghlan & McAuliffe, 2003). However, the change agent in recognising both her personal strengths and areas for professional development she decided on reflection she would be vulnerable in initiating
this change project solely using an action research approach (Belbin, 1993, Krebs-Hirsh, et al 2000).

3.4 HSE Change Model (2008)

After consideration of the previously mentioned models of change, the HSE Change Model (HSE, 2008) was chosen as the most appropriate model as it is an all-inclusive organisational model for approaching change. This model (HSE, 2008) outlined in Figure 3, provides a detailed structure of approaching change within an organisation is provided with a comprehensive toolkit to guide individuals. The model was selected due to its continuous cyclical nature. Adapted from the extensive work of others, this model has been specifically developed to meet the needs of multiple stakeholders (Kolb & Frohman, 1970, Huse, 1980, Neumann, 1989, Kotter, 1995, Ackerman Anderson, & Anderson, 2001).

Staff involvement and buy-in are important to the success of any program of change. (Huber, 2006). Another advantage of using this model is that the change agent, who works within the HSE, can access the expertise of colleagues who are familiar with the model itself. Furthermore, as the project reaches the mainstreaming phase information could be disseminated to other areas of the HSE, perhaps with more ease.
3.4.1 Initiation: Preparing to lead the change:

*Identification of what is driving the need for change and determining the degree of urgency:* The purpose of the initiation phase is to build a platform or foundation for effective change to take place. According to Kotter (1996) the real job of leaders is to prepare organisations for change and help them cope as they struggle through changes. Providing clarity about the purpose of the change and an understanding of how the change was identified enables others to become committed to the change process (HSE, 2008). During this phase it is critical to identify what are the driving forces behind the change and understand the factors which may cause resistance to the process (Figure 4).
Figure 4: Drivers & Resisters to Change

Drivers to Change
- Strong Support from Senior Management
- Interdisciplinary Teams Engagement
- Reduce Fragmentation of Services
- Service Users Demands
- Finite Resources
- Legislative – New Monitoring HIQA
- Merging Primary Care & Disability Sector

Resisters to Change
- Low trust
- Mixed organisational cultures
- Poor Communication
- Low Resources – Human and Financial
- Disengagement / Low Morale
- Fear of change
- Regional Disability Services Staff Relocation
As stated earlier, the implementation of new statutory regulation by the Health Quality and Information Authority (H.I.Q.A., 2012) to monitor both the HSE and voluntary organisations for their standards of care for has placed significant urgency and pressures on all organisations to collaborate through existing partnerships. Initially the HSE and voluntary funded organisations will be expected to carry out self-assessments of where they are currently, in relation to the compliance with all the National Standards and then demonstrate progressive implementation plans to address any gaps (Figure 5). The real challenge for the HSE and voluntary organisations is to mitigate the impact on providing front line services to people with disabilities to the greatest extent by re-examining or changing the way in which we work with each other (DOH, 2012).

Figure 5: National Standards, Better Safer Healthcare, HIQA (2012)
Networking by staff provides a platform for examining and changing the way we work. To determine why some members of interagency teams networked with each other, the change agent held informal discussions with a number of team members. Informal discussions can enable ideas to be explored in an iterative fashion whereby detailed information can be obtained in an inexpensive way (NICE, 2007). A number of reasons for informal networking were identified by team members such as “I find it useful to talk with my peers as we are all trying to provide support services with less money”, “It’s useful to examine problems with another pair of eyes”, “I’m trying to figure out what they are doing differently”, “I’m getting a name of someone who can provide information about entitlements for this family”.

The literature cites partnerships that have a history of working together and support both formal and informal networks are more likely to succeed in their vision and mission (Provan, et al, 2001, IPA, 2001). Although holding informal meetings was a useful approach for the change agent to use, there are some disadvantages as it relies on key individuals, responses can be biased and additional corroboration may be needed (NICE, 2007).

Despite a willingness of some staff to network other colleague’s preferred not to, which could lead to resistance. It is crucial that the change agent assesses and recognises the reasons for staff resisting the process of change (Patton & Mc Callam, 2008). To identify the threats of the project and to access the capacity for change, the change agent brainstormed with her peers (Appendix 2, SWOT analysis, Appendix, 3 Readiness & Capacity
Brainstorming is a way of creating solutions to problems and helps engage people in the change process (NICE, 2007). It was recognised during this session that misunderstandings of the project could be perceived by some stakeholders, due to a lack of trust in the HSE as it continued to inflict budgetary cuts. Additionally staff could have different views from those initiating the change which could give rise to resistance during this change process.

According to Kotter & Schlesigner (1979) people mainly resist change when they think it will impact on them personally by affecting their ways of working or undermine or enhance their own power and status within their organisation. At this stage people, not the plans and practices, were the paramount factors as ultimately, they were the ones who will make or break the change effort. To be effective, stakeholders must feel that their efforts count. At this stage, the change leader adapted her skills by providing logical explanations, managed expectations and at the same time supported and energised those involved (Ford & Ford, 2009, Reardon et al, 1998).

**Clarification of leadership roles**: Gaining efficient organisational support from top management is critical to the successful implementation of any change (Garde, 2010, HSE, 2008, RCN, 2007). The change agent engaged with her line managers in November 2012 to propose this project as a mechanism to enhance interagency working and discuss a Project Impact Statement (Appendix 2). Secondly the change agent needed to clarify her own level of authority for implementing the change. By clarifying her level of authority at an early stage, the change agent was then able to make the necessary
decisions and implement strategies to introduce changes within her workplace (Tannenbaum & Schmidt 1973, Fiedler 1996, Vroom & Yetton 1973).

It was during this stage that senior management recognised that this project would have the potential to provide an opportunity to support the development of a growing number of interagency teams and assist in sustaining local partnerships across the disability sector. A communication strategy was agreed with senior management to provide monthly updates of the project during internal staff meetings and permission was obtained to engage with members of interagency teams. A commitment was also received from senior management to engage for the first time in a network analysis for their sector. Senior management also understood that stakeholders were demonstrating their own leadership by being proactive in bringing about changes in service provision (NHS, 2011). Taking into consideration the aforementioned factors a DICE framework was used to predict project outcomes: a score of 10 was calculated, indicating the project was likely to succeed (Sirkin, et al, 2005).

Identify the key influencers and stakeholders: Critical to managing any initiatives is effective leadership, beginning with the leader’s sensitivity in understanding themselves and their power in influencing their followers (NHS 2011, Peadler, et al 2007). In reality this means not only self-awareness but more importantly, awareness of others (Reardon, et al 1998). Understanding who could be affected by this change is key to successful outcomes. A
stakeholder is anyone who is likely to be affected, directly or indirectly by an organisational change (Huczynski & Buchanan, 2001). This view is extended by Freeman (1984) identifying a stakeholder as any individual or group who can affect or is affected by the achievement of organisational objectives. This definition perhaps may be too broad for some as it includes interested parties as well as affected parties. For this project the change agent prefers the later definition (of stakeholders) as, this includes the service users who work in partnership with the HSE and those who are in receipt of specialised disability services.

An analysis of stakeholders was undertaken during a staff meeting using the professional judgement of her colleagues. Stakeholders were then grouped in relation to their level of interest and influence for the project (Figure 6). This in turn enabled the change leader and her colleagues to communicate, develop, build momentum for, and monitor changes as the change project was implemented. Furthermore, this analysis enabled interventions to be planned in leading and managing the project.
Figure 6: Stake holder analysis Grundy (1998)

An analysis of stakeholder power was particularly useful as it assisted in decision-making situations where various stakeholders had competing interests, provided opportunities in communicating that resources were finite, and determined how to balance the particular needs of stakeholders. As a starting point; the change agent and her line manager, who was now actively engaged in driving this initiative, agreed how best to communicate project objectives within established forums of their workplace. This provided an opportunity for stakeholders to receive information and created a number of forums for receiving their feedback. Goleman (2000) emphasises the importance of individual’s using their emotional intelligence so that they have an ability to manage themselves and their relationships effectively. Interestingly, it was during this phase of the project; the change agent was
conscious that she was actively using her self-awareness, self-management, social awareness and social skills to understand others viewpoints and at the same time seeking ways and opportunities to get them on board with implementing the project outcomes (Peadler, et al 2007).

Although an initial stakeholder analysis was undertaken in this phase of the project on-going reviews of the stakeholders were undertaken at various intervals for the duration of the project. Hayes (2012) emphasis that is vital that change leaders review their assessment of stakeholders as the change project unfolds and circumstances change as the identity of key stakeholders may also change.

*Assess readiness and capacity for change & attend to organisational politics:* The management of change is a complex and continuous process (Coghlan & McAuliffe, 2003). Organisational culture appears to be a crucial factor in understanding the ability of any organisation to perform, adapt and compete (Davies *et al*, 2000). A simplified explanation of culture as the way we do things around here, resonates across the literature (McAuliffe & Van Vaerenberg, 2006, Handy, 1976). This view is expanded by Deal and Kennedy (1982) emphasising culture is seen as the way things are done in an organisation and is closely aligned to the values, assumptions and judgements made within an organisation. Muldrow, *et al* (2002) supports this view suggesting the employees’ behaviours and attitudes towards the organisational values will contribute to the success or failure of any change process no matter how well planned. Due to the diversity of stakeholders
involved in this project an understanding of the organisational culture was crucial at an early phase of the project.

An analysis of the culture of change agents’ workplace was undertaken using Harrison’s (1972) “Organisational Culture Questionnaire”. This questionnaire describes four types of organisational culture namely: power, role, person and task. The change agent perceives the existing culture of her workplace has a combination of task and power cultures. This represents an environment which is adaptive, flexible, solutions are provided using a team approach and normally the environment responds quickly to changes (Handy, 1976, Harrison, 1972). An understanding of her workplace’s culture was reassuring for the change agent in proceeding; however she was mindful to monitor for changes, particularly during a time when resources were finite and there was sustained pressures on staff due to on-going reduction in numbers.

Identifying leverage points and opportunities for change: An effective leader will actively scan their environment to consider and influence situations which will support their vision of change (HSE, 2008). It was identified at a collaborative meeting that a number of interagency teams had been recently formed and some other teams had been established for a number of years. Any team, who come together, will go through a number of stages of development, before becoming efficient (Truckman, 1965). Team building is a process which requires its own pace (Borrill, et al, 2003, RCN, 2007). It
was recognised this would be an ideal opportunity to provide information about the project, to other stakeholders and build commitment for the project.

This was a critical stage as some colleagues collectively agreed to communicate the vision of this project to each interagency team that they were directly involved in. This gained momentum for the project by creating open communication channels. At this point, supporters for the project were showing their own leadership qualities by discussing and communicating our project goal. Colleagues were actively communicating their vision of the project which was aimed at enhancing the quality of care and quality of life, service user satisfaction and system efficiency for people with disabilities through collaboration and networking across multiple services providers.

*Perform an initial assessment of the impact of the change & outline the initial objectives and outcomes for the change:* In preparation of the planning phase an initial impact analysis was carried out in consultation with her line manager (Appendix 5). To receive feedback, the information was disseminated during staff meetings. At this point, it became evident that we needed to reiterate the project objectives to a number of stakeholders as they began to suspect that the project had expanded to conducting a network analysis for each interagency team and across voluntary agencies.

During a staff meeting the change agent provided an update and reiterated the project objectives, with a particular emphasis on the process of conducting a network analysis which was confined to one pilot site. As
discussed in Chapter 2, a network analysis can be described as method of examining the relationships between staff working in partnership with each other (Provan et al, 2007). Providing additional information at this time, alleviated some of concerns of colleagues as they realised that they would be involved in the process and they were not expected to carry out the network analysis themselves. At this point a collective decision was made to proceed with implementing a network analysis prior to the next staff meeting.

Although the initiation phase was a lengthy process it established the foundations for the remaining phase of the project. With the successful commitment of senior management, colleagues and the interest demonstrated by some members of interagency teams, it was possible to advance to the planning stage.

3.4.2 Planning phase:

Building commitment: The purpose of the planning stage is to provide an opportunity to increase commitment for and communicate the change across multiple stakeholders (HSE, 2008). Communication plays a vital role in the change process. It is an essential prerequisite for recognising the need for change, and it enables change managers to create a shared sense of direction, agree priorities and reduce uncertainty (Hayes, 2012).

At this point, a mandate had been agreed and momentum was gathering with some members of established interagency teams. These teams viewed the project as providing them with an opportunity to take stock of their own
practices by exploring and developing ways in which they informally and formally networked with other agencies. Encouraging these linkages both within and between service providers are essential to meet the needs of the service users and improve service delivery (National Federation of Voluntary Bodies, 2010).

However, feedback was received at a department meeting that there was growing suspicion from a newly developed interagency team about the reasons behind the implementation of the project. Clampitt, et al (2000) suggests that change managers often give insufficient attention to the role of communication and the way in which they communicate. In recognising that this was a newly established team where trust and relationships may still have to develop between team members the change agent facilitated a team discussion regarding the vision of the project (Truckman, 1965, Borrill, et al 2003).

As previously discussed, partnership working between organisations is difficult and creating a truly shared purpose is paramount (Plamping et al, 2000). Using a communication strategy of “underscore and explore” the change agent focused discussions on service users’ needs and how enhanced collaboration could meet their needs in a more timely manner thus increase the quality of their service provision (Clampitt, et al 2000, Cunningham, et al 2012). Utilising this communication strategy assisted in creating a vision of a shared currency between stakeholders and enabled the team to provide feedback.
Developing the implementation plan: Democratic leaders build consensus through participation (Goleman, 2000). At this point, taking into consideration the mixed level of engagement and resistance of some team members, the project impact statement and stakeholder power influence grid were reassessed. Analysing this data provided valuable information to the now established project team, as it clarified the next steps to be taken:

1: To understand the concept and process of healthcare networks, staff needed to engage and be involved in conducting a network analysis of their own workplace. A meeting was arranged in February 2013.

2: In recognising the learning needs of others, group and individual discussions were arranged to provide an opportunity for feedback about the network analysis. It was agreed, the change agent would facilitate these meetings. Kolb (1984) identifies a cycle in which learners have natural preferences to approach learning situations. This depends on the way in which an individual thinks; acts or behaves. Where there is alignment of individual preferences and activities, learning is more likely to occur (Cassidy 2004, Honey & Mumford, 1986, Kolb 1984).

3: Due to the mixed level of engagement and diverse cultures of stakeholders across agencies, the change leader recognised that she needed to pilot the introduction of a network analysis firstly within her own workplace before the process could be rolled out. This process of piloting testing is in line with an action learning approach. Action learning is based on
the idea that taking action and learning are interdependent (TOHM, 2003, Revans, 1983). The benefit of utilising this approach for the implementation phase would combine peer assisted learning and problem solving for the project.

4: The change agent arranged to meet with her senior management team to provide an update and ensure their support was sustained.

3.4.3 Implementation phase:

Introducing a network analysis: This stage of the change involved applying and monitoring the project plan. During this phase leaders must actively attend to what is actually happening, as their organisation is changing (HSE, 2008). Effective communication which considers both the content and way information is received is critical during this phase.

As previously identified in Chapter 2, linkages both within and between health agencies are essential to meet the needs of service users. Networks can be used as a mechanism of streamlining service user’s care and fostering the flow of knowledge between the many different professions involved in health and social care (Addicott & Ferlie, 2007). In March 2013, the change agent facilitated a peer staff meeting to introduce and conduct a network analysis of their workplace. At this juncture sustaining the participation, encouragement and commitment of senior management was crucial. McAuliffe and Van Vaerenberg (2006) suggest without the implicit support of senior management, it is likely the project will end in failure.
However, Beddoes-Jones (2012) highlight that staff may not be to express their true feelings about the change if they do not respect or trust their leaders and managers. As the change agent was conscious of the culture of her workplace she was satisfied that staff would view the engagement of senior management as normal practice and staff would not be compromised by their involvement in the network analysis.

Nadler (1993) suggests one of the ways of motivating people to change is to involve them in the collection, analysis and presentation of information. Data that people collect for themselves is more believable than information presented to them by advocates of change. Using a participation and involvement strategy of change management; individuals were invited to firstly identify each entity of their network, otherwise known as “nodes” (Kotter & Schlesigner, 1979). These “nodes” are seen as actors or players within networks (Wasserman & Faust (1994).

Consideration was then given as to the “tie” or connection of each node to the centrality of their work. Balkundi & Harrison (2006) refers to these ties or connections between different groups as conduits for the flow of interpersonal resources. Thirdly, staff identified the direction and strength of network connections. Using a traffic light methodology (Kneebone, et al, 2007) staff identified the effectiveness of communication of each network connection (Figure 7).
During the session, staff plotted the healthcare network using a sociogram (a visual representation of relationships in a social group) shown in Figure 8. This enabled staff to objectively assess and discuss network nodes and connections. The next step involved asking staff to combine the findings of their network analysis and specific problems which they were experiencing within their caseloads.

Finally, staff agreed priorities and formulated an action plan which prioritised developing network ties with a large voluntary service provider and three acute hospitals within the region. Cunningham et al (2012) suggests that change implementation takes time, however with the alignment of a networks agenda and service priorities are combined, greater results can be achieved in the delivery of healthcare services. An evaluation and further discussion of the outcomes of the network analysis will be provided in Chapter 5.
Sustain momentum & opportunities for feedback: Regular and effective communication provides immense benefits to the change process (McAuliffe & Van Vaerenberg 2006). At the same time leaders need to actively involved and seek opportunities to receive feedback from staff. Strong leaders can hear and learn from their critics. According to Forde & Ford (2009) people who are outspoken about their objections to a change are often those who are genuinely care about getting things right. Resistance can be defined as criticism or not buying into the change process and it should be used as a
welcome resource during the change process (Ford & Forde, 2009). Ensuring there were sufficient opportunities to provide timely feedback to managing stakeholder’s apprehension, fear and resistance levels was critical in sustaining momentum for the project. To provide staff with opportunities to give their feedback members of the project team informally networked with colleagues to gain an understanding of their needs. This enabled staff depending on their own personality type to voice their concerns individually or as part of a group (Krebs-Hirsh, et al, 2000).

Although there were mixed feelings about examining their workplace network, some staff did confide and made suggestions for the next meeting when the network would be discussed again. This was recognised as a small but important step for the project, as staff were already talking about examining the network again, indicating their support. According to Hayes (2012) this can be identified as an evolutionary approach to change which involves taking tentative incremental steps in what is hoped is, the right direction.

3.4.4 Mainstreaming phase:

Making it the way we work: the purpose of this phase is to focus attention on the success of the change effort and find ways to integrate the new ways of working and behaving across the organisation (HSE, 2008). Essential this involved holding on to gains, making the change stick and spreading these gains to other parts of the organisation. To ensure progress and raise the awareness of the benefits of collaboration through examining their
operational network, weekly meetings were held within the unit and status reports were provided from peers who were involved in interagency teams.

Additionally work was progressing by the staff who undertook to establish stronger ties with the acute hospital services. Initial contact had been made by staff to the discharge planners of the regional hospitals and a meeting was imminent with the view of establishing a joint procedural guideline for the discharge planning of service users. In recognising that there has been proactive engagement of the disability sector with acute hospitals in the region has indicated to the project team that staff will continue to examine their professional networks through open discussions and collaboration of staff across their work boundaries. This will enhance the quality of patient care through greater co-ordination of services particularly for those clients (HSE, 2008, HSE, 2011, HIQA, 2012).

Simultaneously, relentless communication was on-going by the project team to improve the network ties with a large voluntary organisation. Initial improvements were made with direction of communication between agencies. However the project team were aware that extra commitment and Support was required to ensure a lasting change. The senior management team were updated resulting in the engagement of middle managers across organisations to implement strategies for improving communication and strengthening the connection ties between organisations. Middle managers can become change agents and are in a pivotal position to form key links between groups (Cunningham, et al 2010). Through their engagement
middle managers can unite and transmit the shared vision of these projects objectives.

3.4.5 Evaluation phase: A project evaluation will be provided in Chapter, 4

3.5 Strengths and limitations of the project: Figure 9

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; time for a network analysis to be undertaken. Alignment of network with service priorities.</td>
<td>Project evaluation focused on qualitative methods of data collection.</td>
</tr>
<tr>
<td>With time and shared leadership the examination of our professional network can become embedded within our sector.</td>
<td>A pilot of a network analysis has only been conducted for 1 department. However, it was important to spend time introducing this to staff so that they themselves become change champions and influence members of other interagency teams.</td>
</tr>
<tr>
<td>Staff have demonstrated commitment &amp; engagement despite the immense pressures they are facing.</td>
<td>Cultural change is an aspect of change that requires huge energy and it can take some time before any changes are apparent. (McAuliffe &amp; Van Vaerenberg, 2006).</td>
</tr>
<tr>
<td>The foundations of an organisational development project have been laid. As we move forward into yet more challenging times, with fewer resources and ever higher expectations of health services, it is important to understand how we can</td>
<td>The change agent anticipates that she will need to continue to support and champion others so additional progress can be made.</td>
</tr>
<tr>
<td></td>
<td>Without the continued support of staff &amp; mandate from senior management</td>
</tr>
</tbody>
</table>
Implementing organisational change requires a clear plan, commitment and the participation of stakeholders. This project focused on the introduction of a network analysis to a disability department utilising the HSE Change Model (2008). The model enabled a structured approach to be undertaken, involving a wide range of stakeholders. Ensuring the participation of staff throughout the project has led to their engagement, empowerment, commitment and not merely compliance (Kotter & Schlesinger, 1979, NHS, 2011). It is however important to evaluate the project outcomes so that adjustments can be made.
4.0 Chapter 4: Evaluation

4.1 Introduction

Evaluation is a way of measuring the extent to which a set of actions achieves its objectives (Lazenbatt, 2002). The evaluation of this project provided practical information to help decide if the introduction of a network analysis should be rolled out to interagency teams within the disability sector or not. Secondly, the evaluation provided crucial information of understanding the critical success factors for effective interagency working. From a health and social care perspective, the evaluation was vital to ensure that service users were included in decisions and ensured that the support provided delivered good outcomes (HIQA, 2012, DOH, 2012).

4.2 Evaluation methods & tools

For this project the change agent considered the distinctive features between two approaches of data collection and analysis namely: qualitative and quantitative (Gilbert, 2001). Deciding between the applications of these two approaches and selecting of one over the other can be challenging. Parahoo (1997) defines qualitative research as “Collecting data from respondents often in their natural environments taking into account how cultural social and other factors influence their experiences and behaviour” (p. 59). Equally, qualitative research can be difficult to define clearly as it has no theory or paradigm that is distinctively its own (Denzin & Lincoln, 1998).

A qualitative participatory approach was the method deemed most suitable for this project because the change agent recognised the benefit of going
straight to stakeholders to gain an understanding of their unique perspectives. This partnership approach enabled stakeholders to actively engage in developing the evaluation, discuss the findings and conclusions then make project recommendations (Bradley Cousins, et al. 1992). Although this approach required a significant amount of time, it provided an opportunity for monitoring the project, empowering participants, building capacity and developing leaders within our department.

Oermann & Gaberson (2006) believe that evaluation needs to be viewed as a continuous process and more perhaps more importantly used as a tool to develop organisational efficiencies. During the initiation phase, the committee identified the stakeholder typology for the project (figure 5) and a small working group created. Collectively this group defined the priorities for evaluation and agreed to monitor and participate in the process by combining collaborative and appreciative enquiry methods during all project meetings.

Based on the work of Lewin (1946) a collaborative enquiry method involves monitoring peer discussions and reflections of staff. As the project evolved, stakeholders’ views were obtained using an appreciative enquiry process. This method of inquiry is a process that involves exploring the best of what is and amplifying this best practice (Bushe, 1999, Cooperrider, 1990). It seeks to emphasise the positive rather than eliminate the negative, and focuses attention on what is good and working rather on what is wrong and not working.
In total eight meeting of the working group were held. Although initially slow, once project objectives were agreed and staff began to understand the process, they began to share their feelings about piloting a network analysis within their department and discuss the benefits and challenges associated with interagency working. Gradually recurring themes began to emerge from participants reflections which in turn were identified as the critical success factors for effective interagency working. This achieved objective 2 of the project and will be discussed later.

Finally, the participatory approach provided a mechanism for developing a common understanding of the results and an action plan for the senior management team was developed. This achieved our last objective and provided valuable information for the next stage of this organisational development plan which will continue beyond the scope of this project. A discussion of project recommendations and action plan for the senior management team will provided in Chapter 5.

4.3 Evaluation results and discussion of findings

4.3.1 Objective 1: Introduction of a network analysis

A network analysis was completed to identify the extent of collaboration between the disability department and voluntary agencies. An initial examination of the network was undertaken in March 2013, with the involvement of senior management and staff within the department.
Using their professional judgement each entity of the network was firstly identified and the strength and direction of communication ties between agencies were examined. Professional judgement can be defined as a process used to reach a well-reasoned conclusion that is based on the relevant facts and circumstances available at that time of the conclusion (Coles, 2002). A fundamental part of this process was the involvement of staff within the department who had both knowledge and experience of the disability sector. An initial examination of the network revealed the extent of stakeholders that interact with the department in the provision of health services. In total forty-seven “nodes” or agencies of the network were identified and grouped (Figure 10).

![Disability Department Network](image)

**Figure 10: Disability Department Network**

**Outcomes:**

a.) **Departmental Governance**: Examination of the operational network revealed our department had strong connections and relationships
established with the majority of voluntary agencies. Feedback from collaborative meetings confirmed this was due to trusting relationships, effective communication, effective strategic leadership and management within the department. It is critically important for the executive leader to ensure a well-governed service is accomplished, by directing and managing activities using good business practices, objectivity, accountability and integrity. Consolidating this was distributed leadership where staff had role clarity and effective transparent governance procedures were operating within the department (DOHa, 2012). Distributed leadership is viewed as an activity that is shared or distributed among members of the team and where leadership is not restricted to people who hold designated leadership roles (NHS et al, 2009).

In addition to service level agreements with voluntary agencies, the committee recognised that quality of services are monitored and maintained through individual service providers undertaking their own approach to quality assurances. Leaders in voluntary organisations have achieved high standards through the use of accredited quality assurance systems (DOH, 2012, NESC, 2012).

b.) Governance of interagency teams: the project committee recognised that a shared approach to team governance could be developed across four interagency teams within the department. As highlighted in Chapter 3, some teams had been recently been formed and other teams had been established for a number of years.
Outcome: this was raised with members of staff who were involved within interagency teams. Collective feedback is still awaited from all interagency teams however service managers have agreed to monitor the collective feedback with the view of establishing a working committee to progress the issue. This item of discussion has been added to the agenda of our Regional Disability Governance committee meeting for further progression. The meeting is scheduled for June 2013.

c) Service user involvement: An analysis of operational network revealed that service users are involved in the majority of nodes and teams across the region. Recent developments and changes within the disability sector are now focused on measuring the quality of services by delivering person-centered supports, greater involvement of service users and a more inclusive approach to providing supports to individuals (DOH, 2008, DOH, 2012a, HIQA, 2012). This in turn empowers service users to remain a part of their own communities with the ability to make choices and receive personal supports to enhance their independence and quality of life (NESC, 2012, HSE, 2011). For people with disabilities; receiving these quality services should mean they receive the right type of supports and they are included in the decision making process to make informed choices about their lives and services.

Outcomes: Discussions at collaborative meetings acknowledged the importance of monitoring the level of service user involvement across the disability network. Due to the large number of agencies providing services
across the region, there is a risk that standards can vary. In order to accurately measure quality of services, data must be available (Powell, et al 2008) and accurate data collection is the prerequisite for quality improvement (WHO, 2007). A proposal has been made to the Regional Disability Governance committee requesting that an audit of service user participation is carried out by the last quarter of 2013. To achieve this goal will require effective distributive leadership from interagency teams so they can work across services with the specific focus of identifying and improving ways of engaging service users (NHS, 2011).

d.) Communication & collaboration difficulties: examination of the network identified weak communication and poor collaboration with the acute hospitals within the region. It was recognised that proactive discharge planning with hospital staff was ad hoc across the region. Ultimately, this affects system efficiency and the quality of services provided to service users as they require timely information, support and coordinated care packages to be agreed between services before returning to their communities (HSE, 2011, HSE, 2008). Effective integrated discharge planning relies on knowledge of available healthcare services, partnerships between organisations and a clear understanding of respective roles (HSE, 2008). As evident in Chapter 2, achieving the integration of services remains a challenging agenda for health and social services. The increased emphasis on a whole systems approach challenges all staff to coordinate services across organisational boundaries in order to deliver seamless and appropriate services for patients.
Outcomes:
A working committee was established to develop a discharge planning policy and care pathway for the discharge of complex disability cases. Additionally, extensive communication with the National Rehabilitation clinical care programme network was established to obtain information on best practice guidelines which would lead to more effective discharge planning (HSE, 2011). At this point, the working committee have identified stakeholders, draft terms of reference have been developed and a meeting is imminent with the relevant hospital personnel. This committee will report directly to an appointed member of the senior management team so that their progress can be monitored.

e.) Communication difficulties: Ineffective communication with a large voluntary organisation was identified by exploring our department’s network analysis. The stakeholder typology of the voluntary organisation indicated this was a key player within the disability service provision as such effective co-ordination and communication was vital to ensure quality service provision.

Outcomes:
Feedback from the collaborative committee meetings identified that operational staff had already deployed a number of communications strategies with this agency, however no progress had been made. A retrospective review of departmental minutes revealed a number of outstanding issues and actions. Once the project team updated the Senior
Management Team, the issues were raised to a macro level between organisations for their direct intervention. As evidenced in Chapter 2, although the principles of collaboration are simple, it is often difficult to achieve in practice (Dickson & Neal, 2011). Partnering organisations are often unwilling to surrender autonomy, communicate frequently and effectively leading to poor integration of services and poor services for service users (Evans & Baker, 2012).

Following the intervention of the Senior Management Team a review meeting with the senior personnel of the voluntary agency was held to align communication and collaboration within and between organisations. An action plan was drawn up resulting in more frequent reviews and monitoring arrangements with the agency. The individual issues associated with each case were allocated to a named member of staff who was responsible for updating and reporting directly to Senior Management.

4.3.2 Objectives 2 & 3:

- Determine & recommend the critical success factors for successful interagency team
- Recommend a communication strategy for sharing project outcomes.

As evident in Chapter 2, successful partnership working is difficult to achieve and can be effective at different layers and to varying degrees within organisations (Atkinson & Maxwell, 2007). As part of an organisational development plan staff involved in the project identified the critical success
factors of interagency working. Critical success factors can be described as are the essential areas of activity that must be performed well if we are to achieve the mission, objectives or goals of an organisation (Forster & Rockart, 1989). These are recognised as the basic ingredients which must be present at all levels of partnership organisations and are enablers of effective interagency work. During collaborative meetings two items of discussion were added to the agenda:

➢ “What are the factors that promote interagency working?”
➢ “Why should we roll out a network analysis to interagency teams?”

Over the course of enquires and discussions with staff a number of themes emerged which have been determined as the critical success factors for interagency working within our department (Figure: 11).

![Diagram showing critical success factors for interagency working]

**Figure: 11 Critical success factors for interagency working**
Outcomes:

As previously discussed in Chapter 3, a SWOT analysis at project initiation identified sustained economic difficulties and a lack of vision by staff to embrace a new approach to enhance interagency working were identified as major threats to the project. With sustained pressures and finite resources both financial and human resource, the project team recognised that the culture of the department could be in danger of developing a role culture (Handy, 1976). This would lead to a hierarchical environment, limited communication between staff and individuals acting only within the parameters of their work role and job description. Using an appreciative enquiry for the project assisted in maintaining a positive culture and providing a vision that our department still had the capacity to enrich and enhance the quality of life for all the stakeholders (Elliot, 1999).

Using this approach empowered staff to identify the unique qualities and strengths of their department. Ultimately, this approach engaged staff and enabled them to consider what areas the department was doing well in; rather on the problems of the organisation. Employee engagement approaches can help organisations deal with the recession and its challenges by establishing trust. It can unlock knowledge and commitment of individual employees in developing ways of performing tasks more effectively and efficiently (MacLeod & Clarke, 2009). Future Health (DOH, 2012) highlights that enhanced methods of delivering services needs to be found and recognises the importance of engagement, the need to involve all
stakeholders in the reform and that collaborative working and leadership are required to implementing this reform.

Finally, it is important to assess the expected outcomes (Appendix 4) and consider the financial impact of this project. Although progress was slow, at this early stage, this project has improved communication by enhancing collaborative efforts, leading to increased trust between stakeholders. Additionally, there has been an increase in the discretionary effort of staff leading to increased productivity within the department. There is a growing awareness and ownership by staff to build and support relationships across our network of service providers. Through their continued cooperation, information can be shared across agencies resulting in less duplication and perhaps a leaner approach to quality improvement efforts across services. According to Covey (2006) greater efficiencies across systems are achieved when relationships are developed and built on mutual trust beginning with individuals, teams and rippling throughout the services of an organisation. To ensure coordination of the project outcomes and avoid duplication of processes, a communication strategy has been determined for consideration of the Senior Management Team (Appendix 6). Ultimately, this project has demonstrated how a co-ordinated effort of reaching out to stakeholders has provided an opportunity to enhance dialogue aimed at providing integrated care to service users.
4.4 Summary

This project evaluation combined both collaborative and appreciative enquiry methods to capture data about the project. This enabled stakeholders who were most directly affected to participate in the design process and allow them to provide feedback about the local impacts of the project. As the project evolved, it built knowledge, trust, rapport and an understanding between stakeholders. Although the project is in its infancy, it has the potential to develop, strengthen relationships and build capacity between HSE and voluntary agencies.
5.0 Discussion & conclusion

5.1 Introduction

The evaluation has demonstrated that introducing a network analysis in the change agents department has already enhanced interagency working. In order to sustain and develop a number of recommendations are put forward so that the leaders and managers across organisations both locally and nationally can consider future improvements across their own services.

5.2 Implications of the change for management:

In the immediate future:

1. Management within the disability department should put in place mechanisms, which facilitate the empowerment of interagency teams. Consideration should be given to the establishment of a dedicated project team to develop a standardised governance framework to support collaborative practice. Other interventions to include the introduction of team assessments for interagency teams to firstly determine their baselines utilising the Performance & Development Team Effectiveness questionnaire (HSE, 2010). Acquiring this information will enable teams to share leadership roles, collaborate, understand key issues facing them and uncover areas for team improvements, leading to greater efficiencies across services.

2. Greater utilisation of the leadership competencies of middle managers within services, who can act as boundary spanners across organisations. Consideration should be given to these staff facilitating
the roll out of a network analysis across interagency teams, making connections and building relationships with others.

3. To embed the department’s network analysis, continued monitoring and reviewing should be undertaken during staff meetings, with a formal review at the year end. This will empower staff and enable planned actions to support collaboration and teamwork across the region.

4. Led by the Senior Management Team, leaders and managers across services should take every opportunity to promote networking as a mechanism to support interagency working. Consideration should be given to sharing critical success factors of interagency working during induction training of staff. An online directory of services to be developed and disseminated across the region to promote collaboration of staff across agencies.

5. A review of the departments' strategic plan to include the Critical Success Factors of interagency working. Utilisation of these factors should help build working relationships on foundations of mutual trust and respect and assist in achieving our strategic mission and objectives.

6. Continued service user involvement should be encouraged to ensure their meaningful engagement across disability services. An audit of service user participation across the region to be undertaken by the year end 2013 to establish a baseline and monitor quality improvements.
In the Intermediate Future:

1. Regional managers across the sector should put in place mechanisms, which facilitate the assessment of strategic partnership organisations utilising a Partnership Assessment Tool (Hardy et al, 2003). The purpose of this tool is to provide a simple, quick and cost effective way of assessing the effectiveness of partnership working between agencies. It enables a rapid appraisal which clearly identifies problem areas so that remedial action can be taken. In utilising this tool both the HSE and voluntary agencies may find ways of supporting their work and find solutions to the challenges that lie ahead.

5.3 Recommendations for future improvements

In the long-term:

1. The organisational learning of this project is transferrable both internally within the HSE and externally to voluntary organisations. The change agent intends to utilise the national structures of the National Nursing Midwifery Planning Development Unit, Communications Directorate, HSE Libraries and the Quality and Patient Safety Directorate of the HSE to disseminate this learning internally within the HSE.

2. Regional managers have agreed to provide external dissemination of this organisational learning through the current governance structure and processes operating within the HSE for all voluntary funded agencies.
3. To develop a culture of learning across agencies, consideration should be given to the continued professional development of staff. This has the potential of raising individuals self-awareness, empowering teams and allow a wider dissemination of standards of care across the disability sector.

5.4 Conclusion
This project has demonstrated that a planned approach to managing change has been effective in enhancing interagency working. Nurturing and sustaining effective interagency working and developing relational networks requires leadership (NHS, 2011). To ensure the success of this project into the future, leadership must be shared and distributed throughout interagency staff and across organisations. Empowering interagency teams across boundaries contributes to the establishment of positive working relationships based on mutual trust and respect and in turn enhances quality and safety of healthcare services (Hardacre, et al, 2011).

Simultaneously leaders can adopt a holistic approach for health and social care services and consider how the interrelationships between statutory and voluntary organisations and synergistic effects of related practices can affect performances across the disability sector. Through effective distributive leadership; interagency staff can be empowered to work across services with the specific focus of identifying and eliminating areas where waste and duplications occurs (Powell, 2008, NHS, 2011).
Interagency working involves differences in status, priorities, resources, power and culture. Unless these differences are made explicit and time is given to reaching common understandings, effective working across boundaries is unlikely. Mutual trust of partnership organisations has to be earned and it certainly does not come with policy directives. Partnership organisations must continue to invest in shared goals that could make a difference to service users’ lives. To achieve this vision, individual leaders across agencies will need to work, through others to achieve their objectives, motivating and engaging followers (The Kingsfund, 2012). This has the potential to engage service users and individuals working across organisations and systems to deliver transformational improvements on which the health care system of the future depends.
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Appendix: 1 PESTLE Analysis  (Byars, 1991)

The following is a summary of the applied pestle diagnostic tool to ascertain the factors influencing this change initiative and provide rationale and urgency of this change within the current climate.

<table>
<thead>
<tr>
<th>PESTLE Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Factors</strong></td>
</tr>
<tr>
<td><strong>Political:</strong> 30 non statutory voluntary agencies funded to provide services to people with disabilities within HSE area.</td>
</tr>
<tr>
<td><strong>Economic:</strong> Implementation of cost containment &amp; measures &amp; reduced funding across HSE &amp; voluntary services. (DOH 2012)</td>
</tr>
<tr>
<td><strong>Sociological:</strong>  - Increasing number of people within requiring additional supports (HRB 2011).  - Increasing service user involvement &amp; participation within local interagency committees</td>
</tr>
<tr>
<td><strong>Technology:</strong> No integrated Information Technology system across HSE &amp; voluntary organisations.</td>
</tr>
<tr>
<td><strong>Environmental:</strong>  - Variety of local organisational cultures across statutory and non-statutory care settings.</td>
</tr>
</tbody>
</table>
### Appendix 2: Project Impact Statement (HSE, 2008)

<table>
<thead>
<tr>
<th>Describe here how things are now in relation to the issue</th>
<th>Describe here how things should (ideally) be when the issue has been addressed</th>
</tr>
</thead>
</table>
| **Behavioural:** *describe current patterns of behaviour/ attitudes of the key people involved with the issue* | **Behavioural:** *what sort of behaviours would (ideally) be evident when the issue has been addressed?*
| Staff unconscious of benefits of networking | Conscious networking |
| Unidentified network | Formal network analysis aligned to departmental strategy |
| Varying degrees of informal/formal networking of staff | Planned interventions based on examination of network |
| Ad hoc collaboration | Shared & enhanced collaboration |
| **Structural:** *describe the way roles and responsibilities are currently organised* | **Structural:** *describe how roles/responsibilities would be organised once this issue has been addressed* |
| Ad hoc development of interagency teams | Established rationale for clear governance structure & roles of team members |
| Varying team agendas | Alignment of teams own network agendas with service priorities and capabilities |
| **Personal:** *describe how you participate in and contribute to the current reality* | **Personal:** *describe how you will participate in and contribute to the new reality* |
| Lack of awareness of benefits & challenges of interagency working | A shared vision & approach |
| “too busy” | “let's do it together” |
| Silo approach | Team approach |
**Appendix 3: SWOT ANALYSIS** (Ansoff, 1965)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weakness</th>
<th>Opportunities</th>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong connection to local HSE services &amp; voluntary agencies.</td>
<td>Diverse organisational cultures.</td>
<td>Build relationships between voluntary agencies &amp; enhance communication.</td>
<td>Sustained national and international economic difficulties.</td>
</tr>
<tr>
<td>Engaged interagency teams across local disability services.</td>
<td>Silo approach to service provision.</td>
<td>Investment in the future development &amp; sustainability of existing partnerships.</td>
<td>1st time to pilot network analysis.</td>
</tr>
<tr>
<td>Existing relationships with HSE Disability services through regular monitoring review process of Service Level agreements.</td>
<td>Existing capacity is limited by current service level agreements with HSE</td>
<td>Unique opportunity for HSE to engage with voluntary service providers to find sustainable solutions and tangible benefits for service users.</td>
<td>Lack of vision and ability to embrace new initiative.</td>
</tr>
<tr>
<td>Growing service user involvement within local structures &amp; processes.</td>
<td>Strained public finances.</td>
<td>Facilitates national policy of interagency collaboration &amp; enhance problem solving abilities.</td>
<td>Lack of trust and influence by HSE.</td>
</tr>
<tr>
<td>Involvement of voluntary agencies in existing networks through local Consultative committee forum.</td>
<td>Introducing organisational change is difficult particularly dealing with the soft aspects of change.</td>
<td>Expand innovation, capacity and increase efficiencies while providing a broader range of individualised services.</td>
<td>Lack of leadership to drive process.</td>
</tr>
<tr>
<td>Rich staff skill base across HSE &amp; Voluntary agencies.</td>
<td></td>
<td>Create a culture of mutual understanding of shared knowledge and goals.</td>
<td>Existing partnerships may have become entrenched.</td>
</tr>
<tr>
<td>Strong voluntary ethos &amp; support.</td>
<td></td>
<td>Unique opportunity to create a pilot for application in other national locations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promotes &amp; explores value for money initiatives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opportunity to evaluate, redefine and review existing and new partnerships.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 4: Readiness and capacity for change grid (HSE, 2008)

**Preparing to lead the change**

#### 1.3 Assess readiness and capacity for change

To determine the potential for effective change and to work with resistance we must consider how ready people are to undertake what is required. The *activities for change* outlined in the left hand column are the key factors in assessing readiness and capability for change. This information will assist in planning how to provide support in order to increase readiness and confidence to lead and deliver change.

**Organisational, team or stakeholder group:**

Using the prompts below, rate the stakeholder group from the perspective of readiness and capacity for change.

<table>
<thead>
<tr>
<th>Readiness</th>
<th>How would you rate readiness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity</td>
<td>How would you rate capacity?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities for change</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall readiness and capacity of the leaders to bring about effective change</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of responsiveness to the urgency for the change</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The level of shared understanding for the vision for change</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The level of focus on service users, communities and the local population</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The effectiveness of communication processes both internally and externally</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The orientation towards team working and working across boundaries</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The levels of engagement and partnership working based on experiences to date</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The culture of continuous learning and evaluation</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The level of resources available to support the change. Consider factors such as people, financial, ICT, infrastructure</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The capacity to balance stability and change</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Note: This template can be adapted to meet specific requirements. Groups can use it to self-assess. Other key dimensions can be included depending on the nature of the change and the specific requirements of the service.*

*Adapted from: Beckhard and Harris, Readiness-Capacity Assessment Chart (1987: 63)*

*Improving Our Services – A Guide to Managing Change in the HSE*
### Impact Assessment Template: Internal Organisation: Disability Department (HSE, 2008)

<table>
<thead>
<tr>
<th>Description of the current situation</th>
<th>Transition from current to future</th>
<th>Description of the future vision</th>
</tr>
</thead>
</table>
| **Unconscious awareness about value of networking** | The department will be facilitated to assist in the review and discussion around Networking, collaboration and Interagency working.  
  - Networking will be defined clearly  
  - Benefits of Networking outlined  
  - Methods, barriers and challenges identified  
  - Awareness of Skills and competencies identified and acknowledged  
  - Risks of failure to network | Conscious networking - planned & informal |
| **No network analysis of department** |  
  - Review and identify stakeholders  
  - Define the strengths and gaps in networks  
  - Align network with departmental strategies | Monitoring & review of departments network during staff meetings – agenda item |
| **Varying levels of communication between agencies** |  
  - Identify the varying levels and strengths of communication between agencies  
  - Review on an on-going basis  
  - Develop communication strategy | Enhanced communication & networking between agencies |
| **Unconscious awareness of critical success factors of interagency working** |  
  - Clearly outlined and define CSF of interagency working in consultation with the stakeholders  
  - Develop an action plan to assist in the implementation and reinforcement of these CSF’s | Determined & Implement critical success factors of Interagency working |
### Appendix 5: Impact assessment template (HSE, 2008)

<table>
<thead>
<tr>
<th>Description of the current situation</th>
<th>Transition from current to future</th>
<th>Description of the future vision</th>
</tr>
</thead>
</table>
| Ad hoc interagency team development - Non standardised governance structures across region | • Identify the current status and team functioning through the administration of the Team Effectiveness Questionnaire (TEQ)  
• Analyse results and prioritise teams based on outcomes  
• Review governance structures based on best practice | Standardised approach to interagency team development  
Clear governance structures |
| Developing interagency teams | • Implement tailored team interventions based on the TEQ in line with enhancing strengths of networks | Enhanced trust and clear roles of team members and move to interagency team working |
| Leadership – mixed approach | • Identify individual and team requirements for leadership and implement a strategy to achieve dispersed leadership | Dispersed leadership and shared ownership |
| Service user involvement | • Identify the need and strengths of SUI  
• Develop a plan to recruit SU from within the service  
• Support SU’s becoming core members of governance structures and decision making forums | Embedded, continuous but varied participation approaches which engage service users as partners in decision making for influencing change |
| Varying levels of Communication | • Conduct network, stakeholder analysis and develop a robust communications strategy with all  
• Adapt SMART goals and objectives towards this communication strategy | Supported, timely, open and respectful communication |
| Multiple diverse disability voluntary agencies with mixed organisational cultures | • Identify the strengths in diversity, with effective networking principles and practices  
• Develop shared goals and a vision for future service collaboration  
• Shared vision and goals in quality outcomes for service users | Shared goals & vision towards future of Disability Services therefore increasing and enhancing inter agency working |
### Appendix 6: Communication matrix for Senior Management Team

<table>
<thead>
<tr>
<th>Stakeholder Name</th>
<th>Communications Approach (from Power/Interest Grid)1</th>
<th>Key Interests and Issues</th>
<th>Current Status 2</th>
<th>Desired Support 3</th>
<th>Desired Project Role (if any)</th>
<th>Actions Desired (if any)</th>
<th>Messages Needed</th>
<th>Action and Communication</th>
</tr>
</thead>
</table>
| Interagency Teams | Manage closely | - Quality outcomes for service users  
- Transparency & prioritisation of resources | Advocates & supporters & blockers | High | Engagement & development of shared team governance policy, procedures & guidelines | Await feedback from all interagency teams | Increase team efficiency & effectiveness  
Improve outcomes for service users | Discussion & further feedback at June 2013 Regional Disability Governance Group |
| Regional Disability Governance group | Manage closely | - HIQA monitoring | Advocates & supporters | High | Identification of audit team members & establish terms of reference | Agree mandate at Regional Disability Governance Group | Engagement of service users | Agenda item for June 2013 |
| Working committee for Discharge planning | Manage closely | - Proactive discharge planning for complex Disability cases | Advocates | High | Await confirmation of meeting with Acute hospitals stakeholders | Increase collaboration & develop standardised procedure in line with National Rehabilitation Clinical Care programmes | Links established with Lead for National Clinical Rehabilitation Programme & informal/formal communication with stakeholders from each hospital site |

1. Manage closely/Keep satisfied/Keep informed/Monitor.  
3. High/Medium/Low.
<table>
<thead>
<tr>
<th>Stakeholder Name</th>
<th>Communications Approach (from Power/Interest Grid) 1</th>
<th>Key Interests and Issues</th>
<th>Current Status 2</th>
<th>Desired Support 3</th>
<th>Desired Project Role (if any)</th>
<th>Actions Desired (if any)</th>
<th>Messages Needed</th>
<th>Action and Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Voluntary agency</td>
<td>Manage closely</td>
<td>• Service user outcomes</td>
<td>Supporters</td>
<td>High</td>
<td>Individual assignment of relevant case to a named staff member</td>
<td>Senior Management Team - &amp; Department Manager</td>
<td>Align communications &amp; collaboration within/between organisations, fulfilment of Service Level Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• value for money initiatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary agencies in general</td>
<td>Manage closely</td>
<td>• Service user outcomes &amp; Value for money</td>
<td>Supporters &amp; advocates</td>
<td>High</td>
<td>Shared Responsibilities &amp; leadership</td>
<td></td>
<td>Implementation of HIQA Standards &amp; development of monitoring/assessment tool</td>
<td></td>
</tr>
<tr>
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</tr>
</tbody>
</table>

1. Manage closely/Keep satisfied/Keep informed/Monitor.
3. High/Medium/Low.
Appendix 7: Group/Team Effectiveness Questionnaire (HSE, 2010) (HSE HR Performance & Development Unit, 2010)

Instructions: Please circle or highlight the number you wish to choose – choices must be one number or the other, e.g. you cannot put the x at 3.5. Also please return either by email or anonymously by fax/post, stating the Group/Team you are part of, to avoid confusion of the questionnaire with those submitted from other Group/Teams.

1. Group/Team Goals and Objectives

   a. Clarity around Goals and Objectives

   (1) I am not clear at all about our Group/Team goals
   (2) (3) (4) (5) I am crystal clear about our Group/Team goals

   b. Investment in Goals and Objectives

   (1) I don't agree with our Group/Team goals and they are not really important to me
   (2) (3) (4) (5) I fully agree with our group/team goals and they are extremely important to me

2. Roles and Responsibilities

   a. Clarity around own role

   (1) I am unclear about my role responsibilities
   (2) (3) (4) (5) I am crystal clear about my role and responsibilities
### b. Clarity around others’ roles

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>I am unclear about</td>
<td>I am crystal clear about everyone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other people on my Group/Team's</td>
<td>else on my Group/Team's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>roles and responsibilities</td>
<td>roles and responsibilities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Group Procedures or Work Processes

#### a. Decision-Making

##### a.i. Efficiency of Decision Making

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
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<td>Decisions which are</td>
<td>Decisions within the power of the</td>
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<td>within the power of the</td>
<td>Group/Team to make are made</td>
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<td>Group/Team to make are delayed</td>
<td>quickly</td>
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##### a.ii. Involvement in Decision Making

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<td>(1)</td>
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<tr>
<td>I feel completely</td>
<td>I feel involved in decision making</td>
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<td>uninvolved in making decisions</td>
<td>when I have relevant information</td>
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<td>even when I have relevant</td>
<td>or strong feelings about the</td>
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<td>information or strong feelings about</td>
<td>decision</td>
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<td>the decision</td>
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### b. Communication

#### b.i. Interpersonal Communication
4. Interpersonal Relationships

a. *Degree of mutual trust*

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<tr>
<td>Members distrust one another</td>
<td>Members really trust one another</td>
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b. *Degree of Openness within the Group/Team*

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<tr>
<td>Members are afraid to criticise or to be criticised</td>
<td>Members feel they can freely express negative reactions without fearing reprisal, as long as they are respectful</td>
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c. *Degree of mutual support*

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<tr>
<td>Every person is out for himself</td>
<td>There is genuine concern for each other; and willingness to give support to others on the Group/Team</td>
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d. Interpersonal Relationships: Listening

I rarely feel listened to
I always feel listened to

(e. Interpersonal Relationships: Understanding

I do not feel understood by my colleagues
I feel completely understood by my colleagues

f. Interpersonal Relationships: Openness

The Group/Team displays careful, cautious conversation
The Group/Team can openly discuss all topics, especially difficult areas

g. Handling Conflicts Within Group/Team

The Group/Team is unwilling to deal with conflict
The Group/Team accepts conflict as a natural part of Group/Team working as long as it is done respectfully

5. Group leadership Needs

a. Leadership from the Line Manager

Line Manager does not meet the Group/Team’s needs
Line Manager meets the Group/Team’s needs for
b. Leadership within the Group/Team

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The Group/Team depends too much on one or two persons for Leadership. Many members of the Group/Team provide Leadership.

6. Utilization of Member Resources

(i) General

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One or two Group/Team members contribute Group resources are encouraged and fully used.

(ii) Encouragement to Contribute

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I am never encouraged to Fully utilise the range of skills I have. I am always encouraged to use the range of skills I have.

7. Organisational Environment

a. Pressure for Conformity

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There is a pressure for conformity in the Group/Team. There is a supportive respect for differences in the Group/Team.
b. Energy within the Group/Team

(1) (2) (3) (4) (5)
The Group/Team lacks vital energy

The Group/Team is engaged and interested in its work

c. Innovation within the Group/Team

(1) (2) (3) (4) (5)
Most of the work of the Group/Team is done in a routine manner

The Group/Team seeks new and better ways of doing things

d. Flexibility within the Group/Team

(1) (2) (3) (4) (5)
Group/Team members are stereotyped and rigid in their roles

Group roles are flexible and open to learning
Abstract

Worldwide there is an increasing incidence and prevalence of disability. To provide a wide range of supports to people with disability, the Health Service Executive (HSE) works in partnership with voluntary agencies to provide specialist health and social care services. The integration of this sector has led to an emphasis on joint working of an array of professionals across organisational boundaries as teams and through teamwork. In reality while the need for joint working is an important component of policy, it is something that is not delivered effectively in practice. An analysis of the change environment using quality management improvement tools such as SWOT, PESTLE analysis confirmed the need for change.

This organisational development project aims to enhance interagency working by promoting a culture of collaboration and co-ordination of services so that effective support is provided to service users. For the first time a network analysis was introduced into the department using the HSE Change Model. A participatory approach was utilised to monitor and evaluate the project. Outcomes achieved during the project included targeted communication strategies across HSE and voluntary agencies and the identification of critical success factors for interagency working. Finally, to share the organisational learning, the project has identified and recommended further changes which can be considered across wider services with the shared vision of achieving integrated care.
Enhancing Interagency Working

Student ID: 1116706
MSc in Healthcare Management, 2012-2013,
Institute of Leadership, Royal College of Surgeons in Ireland

Introduction & Background
The needs of people with disability are far reaching necessitating both health and social care agencies to work in partnership to provide a range of services and supports aimed at enhancing individuals quality of life. An analysis of the internal and external environment has indicated that this participatory project is timely amidst a climate of social and economic reform, financial outbacks, changing demographics and demands for greater efficiency in healthcare.

Promoting a culture whereby interagency working can adapt, thrive and succeed is substantially shaped by leaders who are confident in their ability to effect change and motivate others to follow. To engage stakeholders and monitor emergent changes an Organisational Development (OD) Approach was used for the project.

Aim & Objectives
The project seeks to enhance interagency working between the HSE & 30 Voluntary agencies.

> Conduct & pilot the implementation of a network analysis (connection strength).
> Determine Critical Success Factors (CSF’s) for interagency working.
> Provide a communication strategy for Senior Mgt Team to share outcomes.

Change Process

![HSE Change Model](image)

Figure 1: HSE Change Model

Initiation:
- Collaboration & identification of stakeholders to gain support & provide information about project drivers – implementation of National Standards for Safer Better Healthcare, efficiencies & creating opportunities for networking.
- SWOT, PESTLE analysis to validate the need for change.
- Assess readiness & capacity for change – departmental culture identified as adaptive, flexible & solution focused environment which utilised team approaches.

Planning:
- Build commitment & networking across interagency teams.
- Relentless communication of project aim & objectives, implement strategies for resistance & feedback to stakeholders.

Implementation:
- Conduct a network analysis i.e. weak links = weak communication.
- Examine service priorities & align with network.

Mainstreaming: reported views -
"its easier to view the whole system"
"together we can achieve more"
"we can learn from each other"

Evaluation

A participatory approach was used combining collaborative & appreciative enquiry methods.

Outcomes:
- Targeted communication with hospitals & voluntary agencies.
- Determined CSF’s – trust, shared values, ownership, respect.
- Has created an urgency to standardise interagency team governance & assess team baselines.
- Commencing audit of service user engagement.

Organisational Impact

Strengths: Alignment of Network with service priorities. Identification of CSF’s of interagency working & further strategies to support interagency teams. Limitations: 1 pilot site, early stage of network analysis – needs champions to nurture process.

Conclusion

Change affects all parts of the service. The outcomes of this OD project have filtered across voluntary agencies and other HSE departments. Some work done – a lot more to do, with a key driver - enhancing service user outcomes.

References