

Challenging Perspectives on Organizational Change in Health Care

Louise Fitzgerald and Aoife M McDermott

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CHANGE IN THE RIGHT WAY

Innovation (as disruptive as possible) and change (radical, transformational, breakthrough) are the buzzwords of the decade. You want better health care? Then make something new and different happen. If you work in the NHS you will know that it funds a mushrooming industry of change agents, change programmes, change frameworks, and whole-system change events hosted by indefatigably smiling change facilitators. An embarrassing amount of money is passed to management consultants in the process.

Some of us make a living studying the successes and failures (of which the latter probably outnumber the former) of this transformational change industry. The statistics are apocryphal but perhaps not wildly out: it is said that around 60% of all healthcare change efforts, and 80% of those involving a new IT system, fail (with or without the input of said consultancies). Why? If I can make over my living room, why can't I introduce a new, evidence-based, and NICE-endorsed care pathway in the clinical specialty of which I am the designated lead — even when my entire team knows it is going to be performance-managed against the change and the patients and staff are already on side?

The answer, according to a new book by management academics Louise Fitzgerald and Aoife McDermott, is that achieving the kind of top-down 'transformational' change envisaged by policymakers (and promised by fast-talking consultants) is nigh-on impossible, for two main reasons. For one thing, this kind of change is inherently impossible in complex public-sector organisations (in such settings, there are mathematical and ecological reasons why incremental and adaptive change has a far

better chance of succeeding). For another, the health system lacks the capacity (in terms of what Pettigrew long ago called the 'receptive context for change':¹ the necessary resources, knowledge, leadership, relationships, and vision within healthcare organisations and the supportive political and economic environment beyond them) to implement major transformational changes. It was ever thus, but, because of the progressive downward squeeze on budgets and the triple pressures of technological progress, rising patient expectations, and demographic shifts, it's all getting worse.

Take, for example, the repeated restructuring of healthcare commissioning in recent years (a topic dear to the hearts of the *BJGP*'s readers). Describing commissioning as 'a prime example of a complex subject where knowledge and skilled change implementation are crucial', Fitzgerald presents empirical evidence that a succession of governments in recent years have mandated the 'transformation' of commissioning with a view to improving efficiency, value, the patient experience, etcetera, etcetera (you can fill in the blanks). But study after study has shown that the policy vision of smooth, focused service transformation never seems to materialise — and, what is more, policymakers fail to learn from their mistakes. As Fitzgerald sums up in Chapter 5:

'Restructuring is frequently based on simplistic notions of organizational change, which do not incorporate the effects of dynamic contexts, individual responses and agency. It is therefore unlikely to produce system transformation. Empirical research on mandated change and restructuring has indicated that effective, radical organizational change requires high levels of knowledge, skill and commitment throughout the organization [...] The disruptive, negative effects of restructuring appear to have been dismissed by policymakers or become lost through government changes. The role of civil servants in preserving institutional memory and learning is important. Restructuring distracts attention from ongoing priorities and delays improvements in patient care. It also causes dislocation of relationships and the loss of organizational memory and potentially some workforce skills with each restructuring. However, the history of restructuring featured here indicates limited

learning from experience and significant re-making of errors.'

Perhaps it's heartening to hear from an international expert in public-sector management that the treacle you felt you were wading through the last time you tried to help solve a local commissioning restructuring problem had a robust theoretical explanation. And the same goes for disruptive innovations more generally.

Those who know the way critical management scholars' brains work will not expect simple or universal solutions to such deep-seated problems. But the authors do offer some important recommendations (Chapter 10). First, those who trumpet the need for 'transformational' and 'disruptive' change should familiarise themselves with the substantial evidence base against this approach and learn the advantages of what they call 'accumulative change processes' — humbler, less radical efforts that aim not to disrupt or destroy the complex infrastructure that forms the fabric of our healthcare organisations.

Second, policymakers who seek change should put substantially more effort into supporting healthcare organisations to build the capacity for change, including the ability of individual staff to seek out new knowledge and apply it adaptively to changing situations (something Sarah Fraser and I argued for 16 years ago).² Third, accumulative change is more likely when there is space and support for interprofessional dialogue, sensemaking, and collaborative problem-solving. And, finally, more attention needs to be paid to 'the relationship between actors and contexts' (which is academic speak for 'I'd love to have politician X shadow me for a day').

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