

**RESTRUCTURING OF THE PORT ELIZABETH HOSPITAL COMPLEX: A  
PERSPECTIVE FROM THE PLANNED CHANGE MANAGEMENT APPROACH**

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by

**Babalwa Qwasha**

Supervisor

**Dr. Noel Pearse**

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## **DECLARATION**

I declare that this thesis, submitted to Rhodes Investec Business School in partial fulfillment of the requirements for the degree of Masters in Business Administration is my own work and has not been previously submitted for a degree except as fully acknowledged within the text.

Babalwa Qwasha

January 2009

## RESEARCH ASSISTANCE

I would like to thank the Port Elizabeth Hospital Complex for granting me the opportunity to collect data from their employees and also the Eastern Cape Department of Health for financial assistance in respect of the final year costs of this study.



**LIVINGSTONE HOSPITAL**



**DORA NGINZA HOSPITAL**



**PEHP**

(Photography by Mr. T. Mosese May 2008)

*“Don’t give up because it’s taking longer than you hoped”*

*Stormie Omartian*

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My heavenly FATHER, You are my rock and my clouds. These verses had been my pillar in this journey. “Isaiah 40:29-31; Psalm 37:3-8; Joshua 1: 6-8; Ephesians 5:15-21; Romans 8:31-39 and Hebrews 11”.

And my wonderful parents. This is for you.

## ABSTRACT

The research objectives which underpin this study were threefold. Firstly was to analyze the Port Elizabeth Hospital Complex (PEHC) restructuring process from a planned changed management perspective in particular the three stage model of Lewin (1951) which include unfreezing the current equilibrium, moving to a new position and refreezing in the new position. Secondly was to analyze how unforeseen circumstances were dealt with. Thirdly was to analyse the setting of objectives and measurements of targets to monitor progress. The study is based on the restructuring that took place in the PEHC which was called "Rationalization". The research indicates that the development and implementation of the rationalization cannot be understood from the perspective of the three stage model of Lewin (1951). The conclusion was based on the manager's perceptions of their analysis of the restructuring in the light of the theory of the three stage model of Lewin (1951).

The study has shown that:

- Rationalisation began by gathering information on the shortcomings of the structure of the three hospitals, but did not understand the degree of readiness to change.
- The timescales for achieving rationalization were not clearly defined.
- It was driven from the top with clear objectives and no timescales.
- There was no structure that prepared the employees to go through the process of rationalisation.
- There was lack of capacity of middle managers to respond to the workers in an encouraging way.

- Rationalisation sub-committees had limited time to meet with employees at the sectional level.
- External stakeholder involvement was not mobilized to its full potential.
- Rationalisation was not an open process that involved both formal and informal employees.
- Budget constraints and staff shortages were not informed by the restructuring needs.
- Workers did not feel secure about the current and future work practises.
- There was no feeling that the change will be beneficial to their wellbeing and to the organisation's goals and mission
- There was no monitoring and evaluation put in place to track progress.
- There was centralisation of even the most basic administrative functions.

The study seems to imply that the restructuring in the PEHC bears no resemblance to the Lewin (1951) planned change model and therefore cannot be understood from the perspective of this model. Given the initiative to rationalize, the PEHC management can learn from the model of Lewin (1951) planned change.

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# **CHAPTER ONE**

## **PROBLEM STATEMENT AND PURPOSE**

### **1.1 Introduction**

The research field of study is planned change management, using the restructuring of the Port Elizabeth Hospital Complex (PEHC) as a case study. Given the information available on planned changed management, it is important to note that naturally the health system is a complex organisation with many different cultures and norms arising from a number of factors including but not limited to professional autonomy of many of the health staff (Pollit,1993 and Dawson,1999). The sequential models of planned change can be valuable tools for planning and managing change in a health environment as these step-wise linear models provide managers with a guide book through which they must work to produce a successful change at any level (Callan, Latemore & Paulsem, 2004). The question being posed and the objectives that underpin this study create a roadmap to analyse the PEHC restructuring from a planned changed management perspective, in particular the three stage model of Lewin (1951) model.

### **1.2 Research Context**

Drawing on the seminal work of Lewin (1951), planned change is aimed at improving the operations and the effectiveness of the human side of the organisation through participative, group and team based programmes. The purpose of the planned approach (PA) to change is to align organisational initiatives with the organisational strategic goal (Friday & Friday, 2003). According to Coram & Burnes (2001), the purpose of this approach is to improve the effectiveness of the human side of the organisation by focusing on the performance of groups and teams (Coram & Burnes, 2001). The PA model is based on the premise that the organisational forces propelling change must

subdue the forces resisting change for highly effective change to occur (Friday & Friday, 2003). Planning for change is the method of dealing with changes that may affect the survival of the organisation (Stoner, 1982.).

The models of planned change of Lewin (1951) and Schein (1992) involve three successive stages, namely unfreezing, change and refreezing. Unfreezing is mainly directed at the present organisation culture which includes perceptions, attitudes and behaviours. According to Lewin (1951), this means that, there should be enough motivation within the organisation to want to change from its present state to the new desired state. Once the present state is unfrozen, the move that will allow the organisation's members to advance to the desired state should be put in place. Successful movement through the process requires individuals to change. Finally, in order for individuals and organisations not to revert back to their previous states, the new desired state must go through systemic, ongoing training and daily interactions at the individual level and through revised policies, procedures and systems (Lewin, 1958).

Building on the work of Lewin (1951) other writers have adopted similar approaches, Cummings & Huse (1989) developed an eight phase model and Batten (1985) developed a four phase model of planned change.

It is useful to be aware that although the focus is on the PA, change often unfolds in an unplanned way. In the late 1980's, the emergent approach (EA) arose. Coram & Burnes (2001) advocate that under this model, change is a multi-level cross-organisation process, that unfolds in an iterative and messy fashion over a period of years and comprises a series of interlocking projects. The pre-requisite characteristics for the successful implementation of this approach, is that the role of managers is not to plan or implement change per se, but to create or foster an organisational structure and climate which encourages and sustains experimentation, learning and risk taking and to develop a workforce that will take responsibility for identifying the need for change and implementing it (Coram &

Burnes, 2001). A major development of EA is an emphasis on bottom-up action rather than top-down in commencing and implementing change (Bamford & Forrester, 2003), while in the planned approach (e.g. Brooks & Bate, 1994; Clegg & Walsh, 2004 and Schein, 1992) advocates a top-down approach to change in which senior managers push change initiatives into parts of their organisation. According to Diefenbach (2007), this is a hierarchical understanding of how change is to be managed.

Central to the criticisms put by the authors advocating the EA is that PA assumes that one type of approach to change is suitable for all organisations, all situations and at all times. It is the uncertainties of the environment that make PA approach inappropriate (Bamford & Forrester, 2003). Authors argue that it is based on the assumption that everyone within the organisation agree to work in one direction with no disagreement (Bamford & Forrester, 2003). It is further argued that organisational change is seen to be less dependent on detailed plans and projections (Bamford & Forrester, 2003). In turn, the PA has been criticized because of its advocacy of refreezing organisations after they have been changed (Kanter, Stein & Jick, 1992). Callay & Arya (2005) defend PA by arguing that change in clinical systems and practice is facilitated by careful planning and preparation and by engaging clinicians in all phases of the change process and change will fail if this not achieved.

Coram & Burnes (2001, p.98) criticized the EA in that it is specifically founded on the assumption that all organisations operate in a dynamic environment which requires continuous transformation and argued that the PA is most suitable for a stable environment. The EA is, by its own definition not applicable in organisations operating in a stable environments where fine tuning is the order of the day (Coram & Burnes). According to Coram & Burnes (2001), if one examines the process of change advocated by the emergent approach, it does speak of change as a “transition” process which does have a beginning, middle and end. Therefore it can be concluded that the EA is not free from serious

criticisms and it is applicable to situations where the planned approach is not suitable.

### **1.2.1 National Department of Health and Eastern Cape Department of Health (ECDoH)**

The government's White Paper on the Transformation of Health System, published in April 1997, identified rationalization as a means of transforming South African health services. The ECDoH took a policy decision to eliminate duplication by clustering the hospitals. In line with the decentralization policy of the National Department of Health (Department of Health, 1997), the proposal of the rationalization was designed to optimize and maximize the use of capital and human resources available for the delivery of appropriate services to the general public to enable functional divisions to manage their challenging operational contexts more effectively, and to offer comprehensive secondary and tertiary health care services. Under the new dispensation the Eastern Cape Department of health did not see any need in having three hospitals running services in triplicate in the same city or area, hence rationalization of services. This was nothing else but a transformation programme to eliminate wasteful utilization of already limited resources and eliminating the racial divide, as previously, it was the policy of government to provide health services according to race groups resulting in the duplication of services in certain areas. With the advent of democracy in South Africa such policies had to be part of the past. Hence the White paper on the transformation of the health system identified rationalisation of services as a means of transforming the South African Health System.

### **1.2.2 Port Elizabeth Hospital Complex (PEHC)**

Restructuring of services took place at the PEHC between 2002 and 2004. The PEHC, a large public health organisation, is an organisation that is a product of the clustering of three hospitals, namely: Dora Nginza Hospital (DNH), Livingstone

Hospital (LVH) and Port Elizabeth Provincial Hospital (PEPH), falling directly under the Department of Health in the Eastern Cape.

The PEHC's vision is to be a centre of excellence providing comprehensive, integrated specialized health care services to the community in its catchments areas. Its clients, among others, include the complex staff, hospital board, businesses within the district and the metro, organised labour within the complex, all professional bodies, colleges including Lilitha nursing college and universities in South Africa, particularly Walter Sisulu University, Nelson Mandela University and other Further Education and Training (FET) colleges, and service providers (e.g. training providers, suppliers, victim care centres), relevant government departments (e.g. Department of Home Affairs, Department of Education, Water Affairs and South African Police Service), the community of Western District, Emergency Rescue Services, Non Governmental Organisations, and the Nelson Mandela Metropolitan Municipality (PEHC Strategic document, 2004).

### **1.2.3 The rationalization programme and its importance**

The former Chief Executive Officer, Zitumane (2003, p. 1) defined rationalization as "A process whereby health services are reviewed, re-organized and restructured so as to promote the cost-effective delivery of high quality health care and the equitable allocation of resources". The main objectives according to Zitumane (2003, p. 3) were:

- To optimize the utilization of the limited resources
- Provide accessible, affordable and quality health care services
- Promote equitable distribution of resources and provision of health care services to all racial groups.

The benefits according to Zitumane (2003, p. 4) of this concept were to:

- Prevent duplication of services;
- Address the unfair distribution of services;
- Develop the neglected and under-utilized facilities;

- Ensure optimum utilization of resources and promote the principle of BATHO PELE - People First, Bantu Kuqala being the end result of rationalization.

Livingstone Hospital, was planned to be largely a trauma hospital, Dora Nginza Hospital, a Mother and Child Centre of Excellence and Port Elizabeth Provincial Hospital, planned to focus on the tertiary services (PEHC Service delivery plan, 2002).

#### 1.2.4 Outcomes of the change/The current situation

The outcome of the rationalization had been the creation of PEHC. At a broader level the PEHC offers the following services presented in the table 1.1 below:

DORA NGINZA	LIVINGSTONE	PE PROVINCIAL	NEW PROPOSED SERVICES
MEDICINE	MEDICINE	Ear, Nose, Throat (ENT)	STEP DOWN FACILITY AT DORA
PAEDIATRICS	GENERAL SURGERY	CARDIOLOGY	
OBSTETS AND GYNAE (MOTHER AND CHILD)	NEURO SURGERY	CARDIO THORACIC SURGERY	TRAUMA UNIT AT LIVINGSTONE
BURNS UNIT	ORTHOPAEDICS	OPHTHALMOLOGY	
	RENAL UNIT	ONCOLOGY	
ANAESTHETICS	ANAESTHETICS	ANAESTHETICS	PLASTIC SURGERY AT DORA
		PLASTIC	

DORA NGINZA	LIVINGSTONE	PE PROVINCIAL	NEW PROPOSED SERVICES
		SURGERY	

**Table 1.1 – Outcome of rationalization**

**Source (Developed for this study)**

### **1.3 Research Problem**

Moving from the premise that a proposed plan was in place for the rationalization programme at the PEHC, analyzing this process from a planned approach perspective will form the basis of this research and provides the foundation to the proposed main problem: “How can the PEHC restructuring process be understood from a planned changed management perspective?”

#### **1.3.1 Objectives of the research**

The aim of the study is to analyze the PEHC restructuring process from a planned changed management perspective. In particular, the three stage model of Lewin (1951) which include refreezing, moving and refreezing. The following objectives have been identified:

- To analyse what was done from the perspective of the three-stage model of Lewin (1951).
- To analyse how unforeseen circumstances were dealt with.
- To analyse the setting of objectives and measurement of targets to monitor progress.

By presenting a case study of the restructuring process, the study seeks to understand how the PEHC restructuring process can be understood from a planned change management perspective.

#### **1.4 Justification of the study**

Given that the literature on change management is large and growing, there are reasons why the theoretical context of this research is emphasized. Firstly the PEHC is frequently involved in change management projects involving health professionals. However, according to Skinner, Roche, O'Connor, Polland & Todd (2005), it is unrealistic to expect health care professionals to be familiar with the change literature in addition to their personal professional knowledge base. Managing people in ways that result in increased productivity and innovation, ultimately arises from the management perception that human resources are valuable strategic assets rather than costs (Thompson & Strickland, 2007) that require monitoring and controlling. Given that the study is seeking to understand how the PEHC restructuring process can be understood from a planned changed management perspective, the study will draw lessons as to how future projects can be managed, so as to offer recommendation for improvement and it is hoped that the contribution would assist in shaping the regionalization and the de-complexing (disintergration of the current structure) project that is targeted in the strategic plan of the complex. Secondly although there is vast literature on change management in different disciplines, the rationalization of services particularly in hospital complexes in the Eastern Cape has been receiving little attention. With the lack of study in the area of the Eastern Cape in hospital complexes, there is a potential for this research to make a contribution in understanding the management of change in hospital complexes. Thirdly an essential element was to foster broader learning in the area of change management. It became clear that while many of the ingredients are in place to provide offerings for managing change in a hospital environment, this research has shown the researcher that change in the hospital sector needs to be approached with caution and prudence.

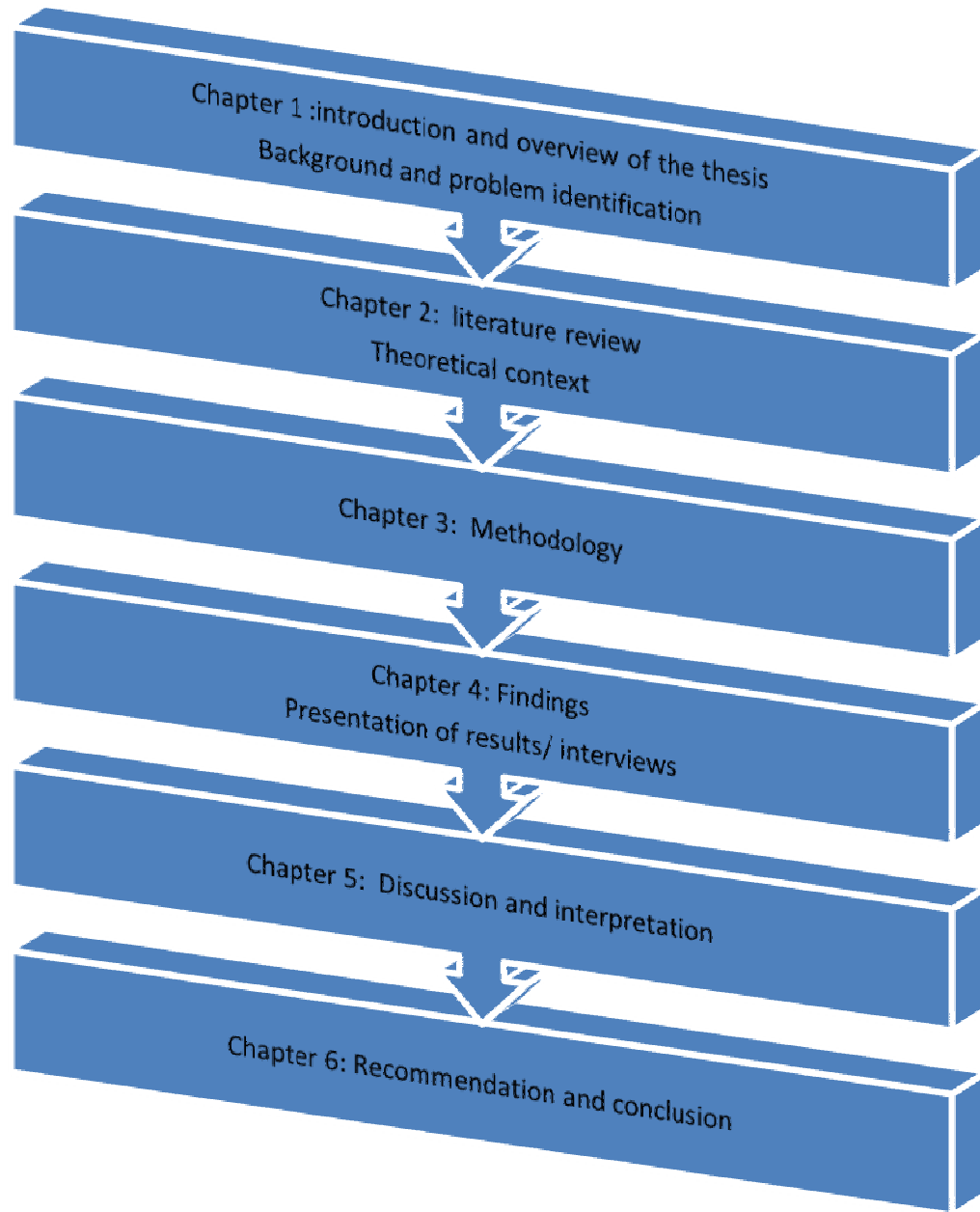
## **1.5 Limitations**

The limitation to the study was that the Chief Executive Officer could not be interviewed due to commitments. With the CEO partaking in this study this would have enriched the content of the study. Among the proposed respondents there were a few doctors who were not willing to participate, citing that they were still angry with the manner in which the rationalization was carried out.

## **1.6 Delimitations**

The study is delimited in terms of the category of the interviewees. Only management was selected for interviewing. Further research can be undertaken in providing a case study from the perspective of other employees, particularly targeting professional staff.

## 1.7 Outline of the study



**Figure 1.1 – Outline of the study**

**Source (Developed for this study)**

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

In the previous chapter, a background of the research was provided which encompassed both Lewin's (1951) planned change model, and an overview of the PEHC restructuring. Given that the focus of the study is on understanding what happened during rationalization from the perspective of Lewin (1951) planned change management theory, the purpose of this chapter is to provide a descriptive account of the various theoretical perspectives and studies that have further developed Lewin's (1951) planned change management theory. Generally the purpose of the review, is to critically analyze a segment of a published body of knowledge through summary, classification and comparison of prior research studies, reviews of literature and theoretical articles. While the researcher will be paying particular attention to this, the focus will largely be on developing an understanding of Lewin's (1951) planned change management framework.

Callan, et al., 2004 argue that the vast majority of managers and leaders today adopt a planned approach to large-scale organisational change. Many managers and leaders find that in their particular circumstances, they can apply a linear, step-by-step planned process in planning and implementing major change (Callan, et al., 2004). According to them, this planned 'n-steps' approach (which varies from five, six and seven or more steps, depending upon the chosen model of change), is very popular among managers. Iles and Sutherland (2000) have recognised that practicing managers will rarely be seeking out the change management programme just because it falls within a particular school of thought. The model of planned change, a framework which incorporates three theories of changing is the Lewin's change model, the action research model, and the contemporary approaches to changing (Cummings & Worley, 2001) have

received widespread attention and serve as the primary basis for a general model of planned change.

## 2.2 N-Step Models of organisational change

There are ten models that build on the three basic stages of the Lewin model while enhancing the steps in the process by providing more planning and implementation details. These include (1) Lewin’s (1951) Change Model (Aldag & Kuzuhara, 2002; Cummings & Worley 2001; Senior 2002); through to contemporary models such as (2) Action Research Model, (Cummings & Worley, 2001); (3) Contemporary Action Research (Cummings & Worley, 2001); (4) General Model of Planned Change, (Cummings & Worley, 2001); (5) Gardner’s Action Training and Research, (Cummings & Worley, 2001); (6) Burke-Litwin Model (1992), (Burke 2002); (7) Kotter –Eight Stage Process; (Kotter, 1996); (8) Dunphy-Stace Contingency Model (Dunphy & Stace 1993); (9) Patching (Eisenhardt & Brown, 1999) and (10) Soft Systems Models for Change (Senior 2002). These models are summarized in Table 2.1 below.

**Table 2.1 N- Steps Organisational Change Models**

<p><b>1. Lewin’s Change Model</b></p>	<p>Phase 1 Unfreezing – Create high-felt need for change and minimize resistance to change</p> <p>Phase 2 Moving – Change people, tasks and structure and encourage ongoing support</p> <p>Phase 3 Re-freezing – Reinforce the outcomes and make constructive modifications (Aldag &amp; Kuzuhara, 2002; Cummings &amp; Worley 2001; Senior 2002)</p>
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<p><b>2. Action Research Model</b></p>	<p>Planned Change as a cyclical process – emphasizing research and diagnosis as the basis of action planning and implementation – eight steps:</p> <ol style="list-style-type: none"> <li>1. Problem Identification</li> <li>2. Behavioural science consultation</li> <li>3. Data gathering and diagnosis</li> <li>4. Feedback to client</li> <li>5. Joint diagnosis of problem</li> <li>6. Joint action planning</li> <li>7. Action</li> <li>8. Diagnosis after action – and return to step 4 of the cycle (Cummings &amp; Worley, 2001)</li> </ol>
<p><b>3. Contemporary Action Research</b></p>	<p>Contemporary approach to planned change increasing member involvement in the change process and building on positive aspects of the organization. Six steps:</p> <ol style="list-style-type: none"> <li>1. Choose positive subjects</li> <li>2. Collect positive stories with broad participation</li> <li>3. Examine data and develop possibilities</li> <li>4. Build a vision with broad participation</li> <li>5. Develop action plans</li> <li>6. Evaluate (return to Step 5 as required) (Cummings &amp; Worley, 2001)</li> </ol>

<p><b>4. General Model of Planned Change</b></p>	<p>General framework for change adapted from Lewin, Action Research and Contemporary Action Research - Four Steps:</p> <ol style="list-style-type: none"> <li>1. Entering and Contracting</li> <li>2. Diagnosing</li> <li>3. Planning and Implementing Change</li> <li>4. Evaluating and Institutionalizing Change (Cummings &amp; Worley, 2001)</li> </ol>
<p><b>5. Gardner's Action Training and Research</b></p>	<p>Development of the capacity for ongoing Organisational learning enables both reactive and proactive organisational change in a changing environment.</p> <p>Every member of the organization is both a trainer and a change agent.</p> <p>Two phases – strategic, decision-making research phase and change implementation action phase and based on the principle that organisations do not really change –the people in them do.</p> <p>(Bruce &amp; Wyman, 1998)</p>
<p><b>6. Burke-Litwin Model (1992)</b></p>	<p>A descriptive model, gives consideration to cause and effect, and incorporates the importance of external environment as input and individual and Organisational performance as</p>

	<p>output.</p> <p>Ten throughput dimensions are included – Mission and Strategy, Structure, Task Requirements and Skills / Abilities, Leadership, Management Practices, Work Unit Climate, Motivation, Organisational Culture, Systems and Individual Needs/Values (Burke 2002)</p>
<p><b>7. Kotter –Eight Stage Process</b></p>	<ol style="list-style-type: none"> <li>1. Establishing a Sense of Urgency</li> <li>2. Creating the Guiding Coalition</li> <li>3. Developing a Vision and Strategy</li> <li>4. Communicating the Change Vision</li> <li>5. Empowering Employees for Broad Based Action</li> <li>6. Generating Short Term Wins</li> <li>7. Consolidating Gains and Producing More Change</li> <li>8. Anchoring New Approaches in the Culture (Kotter,1996)</li> </ol>
<p><b>8. Dunphy-Stace Contingency Model</b></p>	<p>A situational model based on the premise that the most appropriate response is the one best suited to the particular environment, based on two critical dimensions:</p> <p>Scale of Change – Fine Tuning, Incremental, Modular</p> <p>Transformation or Corporate Transformation</p>

	Leadership Styles – Collaborative, Consultative, Directive or Coercive (Dunphy & Stace 1993)
<b>9. Patching</b>	The Strategic Process by which corporate executives routinely remap businesses to changing market opportunities. It can take the form of adding, splitting, transferring, exiting, or combining chunks of businesses. Patching changes are small in scale and made frequently – think evolution, not revolution. (Eisenhardt & Brown, 1999)
<b>10. Soft Systems Models for Change</b>	The Organisational Development approach to change – acknowledges the present reality of the need for continuous change without time for the ‘refreezing’ of the new reality prior to embarking on more change. Also acknowledges the importance of people and embraces the concept of learning organisations (Senior 2002).

**Source (Banham, H.C. 2005)**

Lewin was a social scientist interested in action research as a means of understanding the management of change (Cummings & Worley, 2001). His work provided the fundamental three-stage model of unfreezing, changing and refreezing, which lay the foundation for the development of many subsequent

models up until very recent times (Cummings & Worley, 2001). His work has moved from being a topic of interest to a few academics and practitioners to one that is seen as lying at the core of organisational life (Senior, 2002).

All ten models emphasize the application of behavioral science knowledge, involving organisational members in the change process to varying degrees, and recognise that any interaction between a consultant and the organisation constitute an intervention that may affect the organisation. However, Lewin's (1951) change model differs, in that it focuses on the general processes of planned change rather than on specific organisational activities (Cummings & Worley, 2001).

Lewin's (1951) model and the action research model differ from contemporary approaches in terms of the level of involvement of the participants and the focus of change. These models emphasize the role of the consultant (Cummings & Worley, 2001) with limited member involvement in the change process. Contemporary applications treat both clients and the consultant as the co-learners who are heavily involved in the change process (Cummings & Worley, 2001). Lewin's model and action research model are more concerned with fixing problems than in focusing on what the organisation does well and leveraging those strengths (Cummings & Worley, 2001).

The Lewin (1951) model also gains comparison in the work of Kotter (2005) and Kreitner, Kinicki, & Buelens (1999). According to Grove (2004), the main focus of Kotter's (1996) model is to provide a process of implementing and managing change in order to avoid major errors in the change process. Kreitner et al. (1999) state that Kotter's (2005) model emulates Lewin's (1951) model in that the first four steps assume an unfreezing process, steps five to seven correspond with the change or moving and the last step may be seen to represent the refreezing process outlined by Lewin (1951). This is supported again by Banham (2005), who notes that Kotter's Eight-Stage Process starts with the creation of a

sense of urgency, relies on creation of short term wins and ends with anchoring the new approaches into organisational culture equivalent to re-freezing in Lewin's (1951) early model.

Cummings & Worley (2001) maintain that planned change can be contrasted across situations on three key dimensions: the magnitude of organisational change, the degree to which the client system is organized and whether the setting is domestic or international. According to both Burke (2002) and Cummings & Worley (2001), although current models outline a general set of steps to be followed, considerably more information is needed to meaningfully guide how these steps should be performed in a specific situation.

### **2.3 Lewin's first stage - unfreezing**

This stage being the first stage of change refers to the recognition by the organisation of a need for change in the status quo (Iles & Sutherland, 2001). Unfreezing takes place when existing practices and behaviors are questioned and dissatisfaction with the status quo such as current management practices and organisational performance occurs (Iles & Sutherland, 2001). This dissatisfaction leads to motivation to change and forces that resist change are accordingly reduced while forces that drive change are strengthened (Iles & Sutherland, 2001).

Skinner et al. (2005) acknowledge that during this stage it can be hard to break out established routines to embrace change and innovation. Investing time at the start of the change programme to prepare and support workers is an essential step to minimise reluctance to change. Key factors that need to be addressed at the unfreezing stage include (1) Explaining why change is needed; (2) Creating readiness for change among employees by providing co-worker support, providing tools for effective communication and participation in decision making; (3) Providing organisational resources; (4) Training and development in the new

work practices and (5) Managing uncertainty associated with change. The discussion that follows will elaborate on each of the key factors.

### **2.3.1 Explaining why change is needed**

It is important to understand and acknowledge that workers have invested significant time and effort in developing and refining their current work practices (Skinner et al, 2005). According to them, it can be useful to acknowledge the pros and cons of current work practices. Key factors that need to be addressed include responding to the following types of questions:

- Whether any shortcomings have been identified;
- What is the rationale for change?;
- Is there a shared perspective that change is necessary or is change occurring anyway (i.e. in an unplanned uncoordinated manner)?;
- How does the change relate to the organisational goals and mission?;
- What is the evidence that the change will result in the desired outcomes?;
- Do the advantages of change outweigh the disadvantages, are there sufficient resources to support the change? In essence is change needed?

Skinner et al. (2005) states that, explaining why change is needed, requires investing time at the start of the change programme to prepare and support workers and this is the essential step to minimise reluctance to change.

Iles & Sutherland (2001) argue that, many people in the National Health Services (NHS) are not familiar with the thinking about change management which has come out of schools of management. Many of whom are aware of the concepts do not appreciate the context in which they were developed or the purpose to which they may be put through in the process. Important insights and guidance which the literature offers are thus not being used to maximum effect. These views are shared by Skinner et al. (2005).

The application of Soft Systems Methodology (SSM) which provides a means of articulating complex social processes in a participatory way, allowing people's viewpoints and assumptions about the world to be brought to light, challenged and tested, is viewed as the tool which has proven success in its employment during this stage (Senior, 2002). SSM comprises the following main stages as an iterative process:

- Finding out about the problem situation and its causes from the stakeholder cultural and political perspectives without attempting to impose a preconceived structure or oversimplify processes.
- Articulating root definitions of relevant systems – statements which encapsulate the main purpose, dynamics, inputs and outputs.
- Debating the situation with those involved.
- Depicting activities required to achieve the root definitions for example through processes flow charts or influence diagrams.
- Comparing models with reality by observation and discussion.
- Defining possible changes of structure, processes and attitude.
- Taking action to implement the changes.

By explaining why change is needed, helps workers to let go of current work practices and smooth the transition to new work practices, (Skinner et al., 2005).

### **2.3.2 Creating readiness for change among employees**

Skinner et al. (2005) suggest strategies that can be used to create readiness, support, guide and motivate workers during organisational change include: 1. Gaining support; 2. effective communication strategies and 3. participation in decision making.

### 2.3.2.1 Gaining Support

Support from the organisation, management, supervisors and co-workers can have a strong impact on organisational change. Encouragement and support from colleagues can also have a powerful influence on worker's motivation to change their work practice. Skinner et al. (2005) state that successful change depends on workers readiness to change. Workers have to feel secure about their current and future work situation and feel that the change will be beneficial to their well-being and to the organisation's goals and mission. The less reluctance to engage in change, the greater the likelihood of a successful change. According to them, to be ready and motivated for change, the workers must understand and accept six central messages.

- The necessity of the change, and it being driven by important factors.
- A clear discrepancy in that there is a gap between current functioning and a desired level of functioning.
- Appropriateness of the outcomes of change, that they are valid and legitimate for the organisation to strive towards, and the suggested change is the most appropriate and effective approach to achieving these outcomes.
- Capacity in the organisation, having the resources and capability to implement the desired change and achieve the desired outcome.
- Support from members in that formal and informal leadership in the organisation support the change and are committed to its application.
- Personal relevance in that there are clear benefits and advantages of the change for the organisation and the workers themselves.

### 2.3.2.2 Effective Communication Strategies

The nature of communication within an organisation going through change can affect employees responses to both their jobs and the organisation as a whole. When communication is inadequate, particularly between management and non-management, it can contribute to increased levels of strain (Grove, 2004). Effective communication strategies form the foundation for successful organisational change (Skinner et al., 2005). To be successful in organisational change initiatives, an organisation needs a structure that facilitates communication and responsiveness (Grove, 2004). Mechanisms that focus on getting people to talk, are considered to be appropriate. In other work (Grove, 2004), change management initiatives included the development and implementation of a communication strategy which consistently communicated the organisation's vision and value, the publication of an employee newsletter which announced and cheered all progress made on the planned change and implementation of a reward and recognition system for employee participation and innovation. Communication priorities at the unfreezing stage include communicating (1) Rationale for change; (2) Nature for change; (3) Process of implementing the change and (4) Seeking the workers feedback on strategies for implementing change (Skinner et al., 2005).

Skinner et al. (2005) suggest that strategies that can be used to increase worker's knowledge and awareness during change include:

- Persuasive communication from managers, supervisors and change agents . These may be in the form of speeches, articles in newsletter and posters
- Face to face meeting including questions and answer forums.
- Active participation by workers e.g. consultative committees.
- Sysmbolic activities such as ceremonies and awards.

Skinner et al. (2005) recommend that, for change related communication strategies to be effective, they need to be conducted via multiple channnels e.g

faces-to-face communication, written documents and over repeated occasions. As such Skinner et al. (2005), maintain that workers who are kept informed and up-to-date in the change process are more likely to (1) Maintain high levels of performance; (2) Be committed to the change process; (3) Be less resistant to the change process; (4) Have more confidence in the change process; (5) Maintain regular attendance and (6) Experience high levels of psychological well-being and job satisfaction.

The suggestion here is that effective communication strategies will produce better and more sustained outcomes.

### **2.3.2.3 Participation in decision making**

Providing opportunities for participation in decision making is particularly important during a change situation Skinner et al. (2005). Naturally hierarchical, bureaucratic organisational structures are characterised by poor communication and exclusion of employees from the decision-making process (Grove, 2004). According to Skinner et al. (2005), opportunities for participation should be provided to (1) Frontline workers; (2) Workers in supervisory and managerial roles; (3) Representatives from external bodies such as the unions (4) Representatives from different professional groups within the organisation e.g administration and clinicians. Strategies that can be employed to engage workers to participate include two-way communication about the change and workers participating in the planning.

Organisational structures associated with increased opportunities to participate in decisions are associated with higher levels of job satisfaction and commitment to the organisation and increased sense of well-being (Cartwright, Cooper & Murphy, 1996). According to Skinner et al. (2005), common strategies that can be employed to encourage participation include: (1) Formal meetings; (2) Informal

discussion including brainstorming, (3) Inputs into the outcomes of change and (4) Inputs into the collection of information.

Participation is likely to increase (1) Perceptions that the change is fair and just; (2) Understanding of the need for change and its benefits; (3) Confidence in capacity for change; (4) Commitment to the change process; (5) Ownership of the change process and (6) Acceptance of change.

Senge (1990) talks of the difference between commitment, enrolment, and compliance suggesting that while it is more pleasant to have considerable commitment it is not necessary for everyone to be as fully signed up as this. There exists a number of positions along a continuum, along which players may position themselves in response to proposed action and change. Senge (1990) suggests an analysis of what level of support is required from each of the players and directing energy to achieve that, rather than trying to persuade everybody to commit.

The most consistent message throughout the change plan is that workers must actively be involved in a change initiative for it to be successful and result in sustained and long term practise change. The suggestion here is that change is most likely to be successful when it is conducted in collaboration with workers characterised by open dialogue between workers and management.

### **2.3.3 Providing organisational resources**

Organisational change is most likely to be successful when it is supported by sufficient organisational resources through development and promotion of a policy outlining work practice change; sufficient number and quality of staff; provision of training and professional development opportunities to support required change and appropriate office and other physical work space (Skinner et al., 2005). This requires that change agents have the power, the influence or the authority to

allocate resources, combined with the appropriate information and skill (Tosi & Neal, 2003). Ensuring workers are confident in the organisation's capacity to achieve change is an important consideration in the unfreezing stage and awareness of a need for change without confidence that it can be achieved, can lead to reluctance to change, defensiveness and withdrawal from the change process (Skinner et al.,2005).

#### **2.3.4 Training and development in the new work practicesc**

Providing training and development to support the capacity of workers and conduct new procedures, is likely to improve uptake and long term sustainability of work practice change. Skinner et al. (2005) suggest the use of peers and colleagues to conduct the professional development to encourage and motivate workers to adopt the desired change. Professional development can benefit the organisation by building workers' confidence in their abilities to perform new work practices; increasing the workers understanding of the advantages and benefits of the desired change and demonstrating organisational support for the change. Training and development opportunities include identifying programme needs analysis, individual training needs analysis and individual motivation for professional growth. Providing the required education, training and professional development is a key strategy to support workers' capacity to change their work practice (Skinner et al., 2005).

#### **2.3.5 Managing uncertainty associated with change**

Organisational change can be a period of great uncertainty for workers. According to Skinner et al. (2005) negative consequences of uncertainty include (1) Breakdown in communication; (2) Withdrawal from participation; (3) Formation of destabilising cliqués; (4) Sabotage of change initiatives; (5) Increased stress and (6) Lower job satisfaction and commitment to remaining with the organisation and (7) Unhealthy work dynamics. Skinner et al. (2005) suggest strategies to

reduce feelings of uncertainty to include effective communication and involvement of workers in all aspects of planning and decision-making resembling some of the strategies mentioned earlier. Stroh (2005) states that traditional, studies and models of change management have either ignored the importance of strategic communication as a contribution to successfully changing or saw communication as only a tool in the first stages of transformation. Stroh (2005) states that communication leaders can connect groups, teams and workgroups by driving communication and building trust, resulting in uncertainty being minimised. Involving staff in change management decision-making creates opportunities for innovation. According to Stroh (2005), this can be done by addressing the following questions before driving change:

- Who is driving the change, what is the rationale for change. Is it legitimate?
- Is there a shared perspective that change is necessary?
- Is change occurring anyway (i.e. in an unplanned uncoordinated way)?
- How does the change relate to the organisational goals and mission?
- What is the evidence that the change will result in the desired outcome?
- Do the advantages of change outweigh the disadvantages?
- Are there sufficient resources to successfully implement the change?

The first stage calls for human-focused elements which include communication, participation, consultation and training. The section that follows will focus on the second stage of Lewin (1951) model which is moving.

## **2.4 Lewin's second stage – moving**

Moving or changing refers to the second stage of change in Lewin's (1951) model and this stage has to do with moving to a new position. This is often achieved through cognitive restructuring. This frequently occurs through identifying with a new role model or mentor. Paulsen et al. (2004), shows that what managers do at this stage is critical to promoting employee adjustment and commitment to the

whole process. According to Skinner et al. (2005), during this stage employees learn new behaviours, and new policies and practices are implemented.

During this stage, various organisational practices and processes are changed or transformed. According to Iles & Sutherland (2001), strategies to assist the transition from old to new work practices include: (1) Conducting trial changes (2) Engaging in ongoing monitoring and evaluation and (3) Supporting workers to change their behaviour. Iles & Sutherland (2001), advocate that; changes that can be tested and evaluated on a trial basis are more likely to be accepted by workers. However Skinner et al. (2005), warns that a slow change process may not be appropriate for all initiatives and it is important to ensure that participating in the change trials does not become a source of stress and frustration in itself. Furthermore, Iles & Sutherland (2000), state that introducing a change in small steps allows workers to develop new or complex skills gradually, build confidence in performing new work practices and minimizes feelings of stress associated with new behaviour. Skinner et al. (2005) also advise that it is reasonable and realistic to expect that workers will require time to explore and rehearse the required change in work practice. They advocate that investing time and effort on trial changes can have long term benefits in that benefits of change and potential barriers can be identified. According to them, these trials can also be used to demonstrate to workers that the organisation has the capacity to implement the change.

The aspect of engaging in ongoing and monitoring at the changing stage is discussed later in this chapter. As stated in the first stage the aspect of supporting workers to change their behaviour is another strategy that can be employed in the changing stage.

Communication priorities at the changing stage include managers responding to questions of specific information regarding how the change will influence workers' job roles and responsibilities being the essence of this stage.

## **2.5 Lewin's third stage – refreezing**

### **2.5.1 Embedding in systems and procedures**

Refreezing or confirmation is the final stage in Lewin's (1951) model of change. During this stage all changes in the transformation stage are made permanent and a new equilibrium results (Cummings & Worley, 2001). New points of view are integrated into significant relationships (Iles & Sutherland, 2001). Employees' newly learned behaviours with regard to the recently implemented practices and processes are embedded by way of coaching, training and appropriate reward systems (Iles & Sutherland, 2001).

### **2.5.2 Aligning new approaches into organisational culture**

The extent to which an organisation's culture, policies, practises and behavioural expectations are aligned, support, guide and encourage workers to respond to organisational change issues is an important aspect during any change process (Iles and Sutherland, 2001). In essence this stage involves confirming and supporting by anchoring the new approaches into organisational culture. Strategies that help to ensure that new behaviours become standard work practices include (1) Continuing to offer support for the new work practices, (2) Continuing with monitoring and evaluation of change, including making required modifications to the new work practices (Skinner et al., 2005).

Each of the stages of Lewin (1951) model demonstrate an element of communication. Communication priorities at the refreezing stage include (1) Celebrating successes, (2) Continue to clarify changes to roles, (3) Regular support and communication with supervisors and (4) Continued expressions of support from senior management.

In essence this stage is calling for managers to respond on whether (1) A plan has been developed to provide ongoing support to workers for example plans for future check up meetings or group discussions and (2) Results of the evaluation process discussed with workers.

Each of the stages of Lewin (1951) model demonstrates the role of monitoring and evaluation. The section that follows focuses on monitoring and evaluation at each stage of the Lewin (1951) model.

## **2.6 Monitoring and evaluation**

Monitoring and evaluation of work practices are essential to track the progress of change over time and to determine if the change programme has been successful or not. An element of monitoring and evaluation is evaluated at all the three stages of Lewin (1951). The “benefits”, “what”, “who” and “when” of monitoring and evaluation are discussed below.

The benefits of monitoring and evaluation which can be located in the work of Bordia, Hunt, Paulsen, Tourish & DiFonzo (2004) where they found that managers who provide timely and accurate information during large-scale change, can provide higher levels of support for their employees, as this information allows employees to confront potentially threatening issues in a more active way. What managers do during change is critical to promoting employee adjustment and commitment to the whole process of change (Bordia et al., 2004). It is during the time of change that the majority of employees feel low levels of personal control and high levels of job uncertainty, and supervisors need to demonstrate high levels of hardiness and tolerance for ambiguity (Bordia et al., 2004).

According to Skinner et al. (2005), the specific outcomes that are evaluated will depend to a large extent on the original goals of the change. A comprehensive

evaluation will address the process, impact and outcomes of a change programme.

Iles and Sutherland (2001) recommend that monitoring and evaluation of change should involve all stakeholders (i.e. managers , supervisors, frontline workers and clients. They emphasize that involving workers in the monitoring and evaluation of a change process is likely to increase the credibility of information. They point out that poorly managed evaluation can generate resistance and resentment. They suggest that active collaboration will produce better and more sustained outcomes than organisational scrutiny.

Looking at when the information should be collected, Iles & Sutherland (2001) point out that there are no hard and fast rules about how often information should be collected to monitor and evaluate a change programme. However, information should be collected during each of the three stages of change – unfreezing, changing and refreezing.

### **2.6.1 Monitoring and Evaluation at the unfreezing stage**

At the unfreezing stage, monitoring and evaluation address workers' perceptions of the quality of change-related communication. These include: openness to change and confidence in their ability to change (Skinner et al. 2005). For example monitoring and evaluation of workers' readiness to change at the unfreezing stage may indicate a low level of readiness to change. This indicates that it may be beneficial to do further work at the unfreezing stage (e.g. further communication regarding benefits of change) in line with the recommendations of Iles and Sutherland (2001).

### **2.6.2 Monitoring and Evaluation at the changing stage**

At the changing stage, monitoring and evaluation may address adoption of the new behaviour/work practises or procedure; factors that hindered or helped change (e.g. availability of support) and the availability of opportunities to participate in the change process (Skinner et al., 2005). Common strategies for participation include formal meetings, representation of organisational change committees, Callan et al. (2004) argue that there can unfortunately be a lack of quality dialogue at the top during change – executives often push their own agendas and create a lack of cohesion

### **2.6.3 Monitoring and Evaluation at the refreezing stage**

According to Skinner et al. (2005), monitoring and evaluation at the confirmation stage may address sustainability of change (i.e. maintenance of change in the longer term) and also the impact of the change on client outcome (i.e. client satisfaction).

In summary, monitoring and evaluation can provide useful information regarding the pace of change particularly the pace of moving through the three stages of change.

## **2.7 The emergent approach**

During change there are sometimes considerable periods of uncertainty, confusion and ambivalence, especially when a manager is creating “deep change” (Quinn, 1996). Deep change is change that is a major discontinuity with the past, and where there is no way back to the status quo (Quinn, 1996). Different people involved in the change programme will have different views of the underlying causes of the problem and of the desirable outcome and will measure them differently (Iles and Sutherland, 2001). They argue that in practise

organisation change is chaotic, often involving shifting goals, discontinuing activities and unexpected combination of activities (Dawson, 1999). Stroh (2005) points out that change cannot solely be based on plans and projections but rather on understanding the complexities of situations and weighing the different options available. According to Stroh (2005), the best-laid plans will not adequately prepare one for the emergent realities of the future. Many authors advocate that change programmes must allow for emergence and surprise as organisations are systems and also political. Callan et al. (2004) are of the view that while recognising the demonstrated value of the step-wise models of change, the complex and difficult nature of leading change should not be understated. Accurate accounts of change need to fill in the many gaps, showing its messiness. For example, it lacks manageability at times, the politics of change means a resultant lack of co-operation can occur, managers may have to make decisions with incomplete information, mistakes may happen, plans do change and that is the fundamental nature of large-scale change.

In addition there are also external factors such as the economy, competitor's behaviour or internal features such as uncertainty influence the change in directions outside the manager's control. Iles & Sutherland (2001) argue that even the most carefully planned and executed change programmes will have some emergent impact.

Managers must therefore develop the capabilities needed to ensure their organisations and employees can capitalize on opportunities for innovation and business development that these events create. It is clear that change can be planned, but plans need to recognise the often chaotic quality of any change implementation process that often involve shifting goals, unforeseen consequences and accompanying messiness (Callan et al., 2004).

## **2.8 Empirical evidence**

In their findings, Callan et al. (2004) recommended a planned approach to change. Like Lewin (1951) and other advocates of planned change, they see that change sometimes requires years of effort. Their findings revealed that a change management plan is very important to change processes and that the rationale and motivation for change is just as important. The role of the Chief Executive Officer is to build the case for change and to engage people so that they become committed to the change. These findings share similar views to those of Lewin's first stage – unfreezing - and a core idea of Kotter's (1996) important first step – “build a sense of urgency.” Banham (2005) draws on the approach employed by Jack Welch in General Electric and asserts that, it closely follows the unfreezing, moving and refreezing stages of Lewin's (1951) model.

## **2.9 Critical perspective**

Lewin's (1951) model in particular has received a number of criticisms in that with the increasingly turbulent business and economic environment, there is just no time for the 'refreezing' stage of the Lewin Model (Senior, 2002) and its current validity is therefore questionable. The linearity inherent in the Lewin Model is challenged further because all three activities are said to be occurring at the same time and there may be no time for refreezing before the requirement for another change arises (Styhre 2002). Organisations of today are unable to keep a level of stability for very long (Zeffane, 1996). Burke (2002) acknowledges that the sequential models can be valuable tools for planning and managing a change effort but have their limitations because their linearity is not matched to the complex reality of organisational change. Burke (2002) further argues that, these linear models focus more on a planned approach to change, which is less likely to be appropriate to small and medium enterprises due to their unique characteristics including limited management resources.

It should be noted, that while Lewin (1951) model has been criticised for its linearity, the work has also recently been defended as contextual and incorporating situational reaction through feedback to inform subsequent action (Rosch, 2002) and therefore should not be disregarded as irrelevant to organisational change today. Step-wise linear models of change do offer very useful insights and guidelines (Callan, et al., 2004). According to them, these step-wise linear models provide managers with a guide book that they know helps many managers to construct a more sophisticated understanding of the challenges through which they must work to produce successful change at any level.

An important message of recent change management literature, is that organisational-level change is not fixed or linear in nature, but contains an important emergent element (Iles and Sutherland, 2001) which makes the planned change more chaotic, often involving shifting goals. To survive, the change leader needs to develop a contingency view of leading change that recognizes the unexpected.

## **2.10 Summary**

Throughout the literature review process, as the unique characteristics of Lewin's planned change model became more clearly apparent and the models for planned change continually receiving critiques, it is evident that one plans for major change, but also plans for uncertainty. Steps in planned change may be implemented in a variety of ways, depending on the client's needs and goals. Thus planned change can vary enormously from one situation to another (Cummings & Worely, 2001).

Large-scale change is a process and it can be viewed as a series of events that can be managed. Adopting a linear step-by-step view about change allows managers to plan and to attend to important challenges that will arise in most

change processes. On the other hand, large-scale organisational change does not always occur as planned and probably not in an orderly, predictable and linear manner. Managers need to develop capabilities in themselves and in their employees that allow them to cope with the uncertainty and complexity that is an integral part of any major change process, irrespective of how well it is managed led. It is this capacity that will allow organisations and people to respond to emergent opportunities. This chapter examined the theoretical background of the Lewin (1951) model of change. The following chapter will describe the research methodology used to meet the research objectives.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

The aim of this chapter is to describe the research design and the steps taken to conduct the study. Firstly, details of the research objectives and the related research objectives have been described. Secondly a description is provided of the qualitative methodology used for the data-gathering phases including research paradigm and design; a description of who the participants were; how these participants were obtained, and their characteristics. The data analysis, and the steps taken for all phases of data-collection will then be described including the manner in which the issue of confidentiality and ethics was dealt with.

#### **3.2 Research Aim and Objectives**

Moving from the premise that a plan was in place for the rationalization programme at the PEHC, the aim of the study was to analyze the PEHC restructuring process from Lewin's (1951) planned changed management perspective. This provided the answer to the research question and provides the foundation to the main problem: "How the PEHC restructuring process can be understood from a planned changed management perspective?" In order to promote a logical solution of the stated problem, the aim was further broken down into the following research objectives.

RO1: To analyse what was done from the perspective of the three-stage model of change.

RO2: To analyse how unforeseen circumstances were dealt with.

RO3: To analyse the setting of objectives and measurement of targets to monitor progress.

### **3.3 Research design**

This section details the research paradigm and its applicability to the overall research objective and the research design.

#### **3.3.1 Research paradigm**

For the purposes of clarity, the research paradigm is defined by Guba & Lincoln (1994) as the basic belief system or world view that guides the researcher, not only in choices of method, but in ontologically and epistemologically fundamental ways. The research was conducted within the scope of the interpretivist paradigm (Cohen, Morrison & Marion, 2000; Guba & Lincoln, 1994) which is also referred to as constructivist paradigm. This paradigm provided the researcher with an opportunity to create an understanding through words of what happened (Yin, 2004).

Key features of the interpretivist paradigm is the focus on understanding the subjective experience of individuals. It is concerned about the meaning that people make of the phenomena (Pearse, 2006). This is also supported by (Babbie, Mouton & Prozesky, 2006), in that the meaning of human creation, words, actions and experiences can only be ascertained in relation to the context in which they occur. Babbie et al. (2006) further note that an interpretive orientation more easily allows the researcher to identify patterns of meaning which emerge. The qualitative aspect of the interpretive paradigm is appropriate for this research because it seeks to interpret a social phenomenon in a natural setting in which peoples' experiences, views, behaviours, actions and knowledge are gathered from interviews and documents (Merriam, 2001)

In this case the opportunity existed allowing the researcher to uncover and understand the rationalization project from the management perspective (Cohen, et al., 2000).

### **3.3.2 Research method**

Based on the principle and method of research advocated by Yin (1994), constructing a qualitative case study was deemed fit because this approach is preferred when “how” and “why” questions are being asked. It is recommended for research purposes when examining a single instance of a phenomenon of interest (Yin, 2004). Case studies can provide a rich understanding of the organisation. Yin (2004) defines a case study as an empirical inquiry that “investigates a contemporary phenomenon within its real-life context.....” especially when the boundaries between phenomenon and context are not clearly evident.

Yin (1994) identifies the following characteristics of case study research:

- The research aims not only to explore certain phenomenon but to understand them within a particular context;
- The research does not commence with a set of questions and notions about the limits within which the study will take place and
- The researcher uses multiple methods for collecting data which may be both qualitative and quantitative.

Qualitative methods such as case studies commonly follow realistic modes of enquiry where the main objective is to discover new relationships of realities and build up an understanding of the meanings of experiences rather than verify predetermined hypothesis (Riege, 2003).

### **3.3.3 Methods of data collection**

#### **3.3.3.1 In-depth interviews**

Data was mainly collected through semi-structured one-on-one interviews with open-ended questions (Babbie et al., 2006) with ten managers. Notes of the

interviews were recorded using a pen and paper with no audio recording done. Protecting anonymity and confidentiality of respondents can be a challenge in small organisations (Skinner et al., 2005). The pen and paper recording encouraged more open and honest responses and ensured that participation in the interview did not have repercussions for respondent's relationship with their immediate superior.

This approach was used as an attempt to gather information about the restructuring process. An interview guide, which served as a general plan of enquiry (Babbie et al., 2006) was used in accordance with the advice of Patton (2002) to ensure that each interview followed the same basic lines yet could accommodate flexibility to explore issues as they were discussed. Prior to scheduling appointments, the general plan of enquiry was sent to the supervisor of the researcher for review, advice and insight. The general plan of enquiry was sent to the participants prior to the interview. The interview guide approach allowed participants to prepare themselves in advance which also afforded them the opportunity to look for information relating to the rationalization which could be of assistance to the researcher. The interview covered the three distinctive stages of the Lewin (1951) model, the unfreezing, moving and refreezing. The interview guide which was included in a letter to the participants before the interviews, is provided in Appendix A. As recommended by Paton (2002), the interviews were conversational and situational. The interview guide was particularly important for research objective one and two. The questions are listed in Appendix B.

### **3.3.3.2 Other data gathering methods**

In addition to this, a large amount of written material produced by the hospital complex was used, namely:

- Minutes of the meetings,
- Service delivery plan comments,

- Rationalization proposals, and
- Presentations

This documentation was made available to the researcher and was used as a supplement to the interview information already gained. As advocated by Yin (1994), the advantage of documentation is that it is stable and can be repeatedly reviewed. It is also unobstructive in that the data was not created as a result of the case study. The data is exact as it contains precise details of names, positions and events.

### **3.3.3.3 Participant Selection**

Interviews were conducted with ten managers. Purposive sampling was employed by selecting ten middle and senior managers to interview (Cohen et al., 2000). A list of the proposed interviewees was formulated by the researcher based on the managers who were part of the rationalization when it started. Before rationalisation there was a compliment of twelve managers. The sample was viewed as being representative of the management team in place during the time of rationalization. The participants were mainly black and coloured female managers, with one white female, and one coloured male. The respondents reflected the following professional categories, namely professional doctors, a pharmacist, finance officials, a human resources official, and clinical support staff. The interviews with the managers sought to establish their views regarding the restructuring process. The choice of interviews in the research design provided richer detail than would have been possible if questionnaires had been used (Gable, 1994).

### **3.3.4 Data analysis**

The thematic code for understanding the restructuring was built on framework of Lewin's (1951) three stage model of managing change. Three themes in line with the theory were used. Both pattern-matching and explanation-building as

advocated by Yin (1994) was used with a focus on relying on theoretical propositions. This was done by following the theoretical propositions of the Lewin (1951) model as the original objectives of the case study were based on the proposition of the Lewin (1951) model. The analytical strategy used, which is a special type of pattern-matching, was explanation-building (Yin, 1994). In order for the researcher not to drift away from the original topic, the data was read and areas that were related to the question posed or the area under investigation, including specific quotations that struck the researcher as being very descriptive or rich were highlighted. Common themes emerged and thematic connections were made (Yin, 1994).

With reference to the theoretical concepts on the three stage model of Lewin (1951) the researcher formulated the signals of evidence that would support the theory. The elements of the code are derived from the elements of the theory (Boyatzis, 1998). The wording of the themes emerged from the theorists construction of the meaning and style of communication. Miller & Crabtree (1992) in Boyatzis, (1998) shows a situation where the researcher uses someone else's framework to process or analyse the information. Lewin's (1951) framework was used to generate a code and the framework was used to analyse the information. As supported by Boyatzis (1998), the goal of the research is to obtain insights and to create frameworks with which to understand the world around us.

### **3.4 Research procedure followed**

This section deals with the tests applicable to the research method employed (Yin, 1994) and their application to this research. Initially there had been skepticism about being interviewed because never before had any study undertaken sought management views on work related issues. The respondents were made aware of what the study involved, their role and how the information from the study would be disseminated. The respondents were assured of the confidentiality of their contribution and they were informed that they are free to

withdraw. For the purposes of this study, the researcher focused on the tests designs developed for qualitative research which include credibility, transferability, dependability, and confirmability

### **3.4.1 Confirmability**

As advocated by Riege (2003), confirmability assesses whether the interpretation of data is drawn in a logical and unprejudiced manner. The design test assesses the extent to which the conclusions are the most reasonable one obtainable from the data. The researcher employed confirmability as suggested by Riege (2003) as it establishes correct operational measures for the concepts being studied. This technique which corresponds to construct validity design tests in quantitative research, ensures that the researcher does not use subjective perceptions and judgements on which to base the findings by failing to identify the process events being investigated (Riege, 2003). To meet the requirement of confirmability the researcher has outlined the research question and the research objectives being investigated and the findings will be evaluated in order to reflect relevant and accurate outcomes. The researcher as suggested by Riege (2003), made efforts to refrain from subjective judgements during the data collection.

The researcher attempted to “encapsulate complex meanings into a finite report but to describe the case in sufficient descriptive narrative so that readers can vicariously experience these happenings” (Winegarder, 2004). This will allow the reader to identify with the situation (Winegarder, 2004).

The purpose of the research is to create a “thick understanding” (Winegarder, 2004:6) of the rationalization project from the management perspective. A thick understanding requires that various sources of evidence are used to set the scene of the “phenomenal situation” (Winegarder, 2004). To enhance confirmability as suggested by Riege (2003) use of triangulation techniques such as multiple sources of evidence were employed and these have been retained

and available for reanalysis by others.

### **3.4.2 Credibility**

To enhance the credibility of the study, following the write up of the content, the respondents were asked to review it for accuracy, which they did. As the research progressed, formal and informal feedback was provided as suggested by Riege (2003) to foster subsequent credibility. For the purposes of getting participant feedback, participants had an opportunity to identify areas in the written notes of the interview that they felt were inaccurate or unfair (Yin, 2004). In this way, as suggested by Riege (2003) credibility was achieved during the research design. Credibility was also achieved through the researcher's self monitoring by carrying out the inquiry in such a way that ensured credibility.

### **3.4.3 Transferability**

Transferability is parallel to the function of generalisation in quantitative research (Riege, 2003). This test is achieved when the researcher shows similar or different findings of a phenomenon amongst similar or different respondents (Riege, 2003). The findings included enough thick descriptions to enable the readers to assess the transferability appropriateness for their own settings and this was done by putting into words, the meaning of the experience for the participants. The researcher has also established connections among the experiences of management. Siedman (1991) is of the opinion that the links among the people whose individual lives are quite different but who are affected by common structural and social forces can help the reader see patterns in the experience. Transferability will be upheld by ensuring that the researcher declares and clearly describes the research context.

#### **3.4.4 Dependability**

Dependability is parallel to reliability in quantitative research. The purpose of this test is to show indications of stability and consistency in the process of inquiry.

A number of researchers note that research results derived from interviews are very subject to the level of skill (Zikmund, 2000) and ability of the interviewer. In that light, more effort was taken on the interpretation of the results to ensure that bias was negated. Care was taken not to evaluate comments but to be an active listener confirming understanding and following up on areas of interest. Generally, the interview approach may result in the true motivation remaining hidden from the interviewer resulting in information not being divulged in the interview. This makes it difficult for the interviewer to assess the extent of deliberate or unintentional bias.

Reasonable care was taken by comparing the way in which the PEHC undertook its rationalization in relation to the identified themes that emerged from the Lewin's model of planned change (Cooper and Schindler, 2006). Analysis of data in this manner provided an understanding of how the PEHC executed its rationalization project. The data enhancement role that is expected from the qualitative research was therefore able to be met.

Strauss and Corbin (1998) maintain that supporting theories should be traceable to the data that gave rise to them and thus it is incumbent upon the researcher to leave a trail of evidence for any interested reader to follow up. In this regard an audit trail was kept.

#### **3.5 Ethical considerations**

Researchers have an ethical obligation to participants in a research study. (Babbie et al., 2006). The researcher obtained approval of the research proposal

by the Higher Degrees Committee of Rhodes University. Permission to undertake the research was secured with the former chief executive officer of the PEHC now currently the Chief Operating Officer of the Eastern Cape Department of Health. The general plan of enquiry provided for informed consent of the participants. The general plan of enquiry indicated to the participants that their contribution was voluntary and that they were free to withdraw at anytime. Confidentiality was been preserved by the researcher in accordance with the ethical guidelines of the researcher. It was made clear to the participants that the individual data would be kept anonymous and that a general discussion of the results from an organisational level would only be reported in total and summary form without disclosing any individual participant. Contact details of the researcher were provided in the general plan of enquiry.

### **3.6 Summary**

This chapter covered the research aim and objectives, and the related research questions. A case study approach was used within an interpretive research paradigm. The procedure followed to address the research question was described. The way in which the researcher attempted to meet the appropriate quality criteria for the study was discussed and potential limitations were identified. Matters relating to conducting the research ethically were considered. The next chapter presents in detail the research findings as gathered in the interviews and documentary data.

## **CHAPTER FOUR**

### **RESEARCH FINDINGS**

“It is much different when you go through it than when you look at it from some academic ivory tower.”

Stephen Covey

#### **4.1 Introduction**

The purpose of this chapter is to put together the findings as revealed in the interviews and documentary data in order to address the research question and the research objectives established in the preceding chapters. Firstly the researcher starts by giving an overview of the restructuring (rationalisation). This is followed by presenting findings in respect of the first objective, that of analyzing the PEHC restructuring from the perspective of the three stage model of Lewin (1951). Three key themes were created namely (1) unfreezing (2) changing and (3) refreezing. The first and the third themes were further developed to contain sub themes. Thirdly, the findings on monitoring and evaluation are presented in order to establish how it was carried out during the restructuring. Fourthly, the findings in respect of how unforeseen circumstances were dealt with are also presented and lastly, presentation of findings as to the measurement of targets and setting of objectives are outlined.

#### **4.2 Overview**

The case study describes the rationalization process undertaken over three years by the PEHC. The PEHC is an organisation that is a product of the clustering of three hospitals, namely Dora Nginza Hospital Livingstone Hospital and Port Elizabeth Provincial Hospital falling directly under the Department of Health in the Eastern Cape. The original development of the three hospitals were based on policies of the previous Government rather than need.

This restructuring emerged as a result of government policy to rationalize the provision of services with a clear view of eliminating duplication of services. DNH was previously serving the African community and is located adjacent to townships. LVH was previously serving predominantly the Coloured community and is also located close to the Coloured community residential areas. The PEPH was previously serving predominantly the white community and is located in the city centre. The management structures and workforce of these institutions resembled the same racial lines. All these hospitals are located within close proximity of one another and the furthest distance between them is 10km. As the Chief Executive Officer in his presentation on the service delivery plan said:

“It is against this background and the purpose for which they were established (now outlawed) that encouraged the provincial government to cluster them and establish structures that will co-ordinate its activities. Under the new dispensation the Department of Health did not see any need in having three hospitals running services in triplicate in the same city or area, hence rationalization of services.” (Zitumane, 2003)

The rationalisation was driven by eight key factors, namely:

- Providing accessible, affordable and quality health care services;
- Promoting equitable distribution of resources and provision of health care services to all racial groups;
- Preventing duplication of services;
- Addressing the unfair distribution of services;
- Developing the neglected and under-utilized facilities;
- Ensuring optimum utilization of resources;
- Promoting the principle of BATHO PELE, People First, Abantu Kuqala and
- Promoting race relations

The rationalisation focused on changing the service delivery system of the three hospitals running services in triplicate as depicted in Table 4.1 below. It represented a large scale programme that eliminated duplication of services.

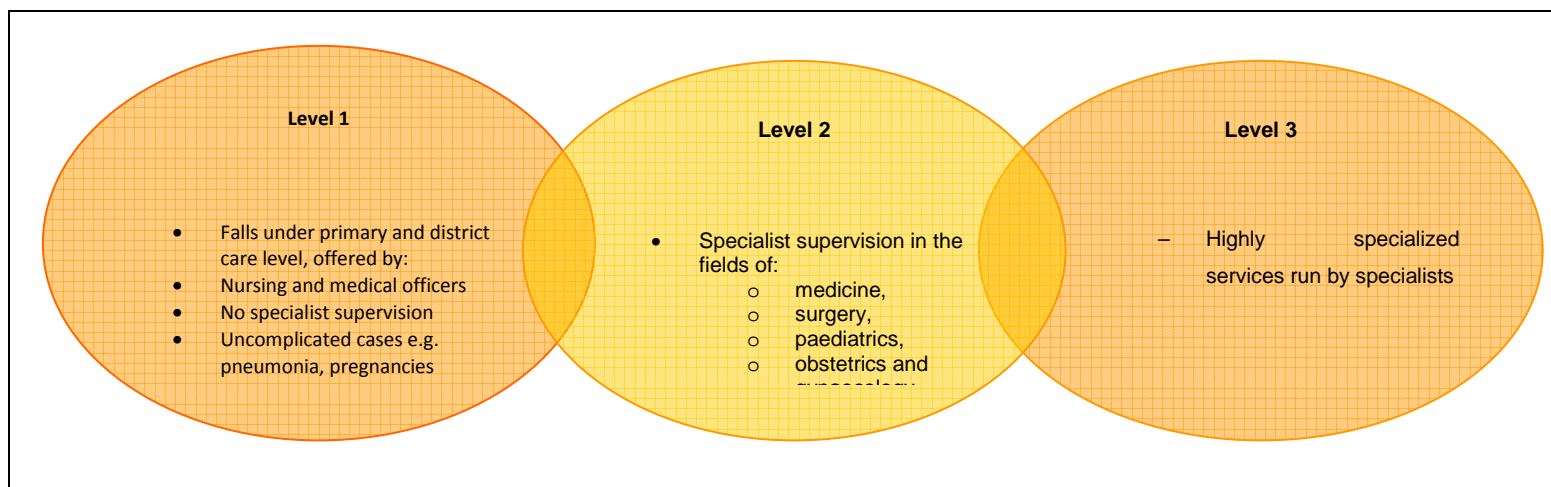
	LVH	DNH	PEPH
Level 1	Level 1 services	Level 1 services	Level 1 services
Level 2	Level 2 services	Level 2 services	Level 2 services
Level 3	None	None	Level 3 services

**Table 4.1 Situational analysis before rationalization**

**Source: Developed for this study**

Level one and two services were offered at all the three institutions resulting in duplication of resources. Level 3 services were mainly offered at PEPH.

There was a need for the researcher to define services that were offered by level one, level two and level three services.



**Figure 4.1 Services offered per category**

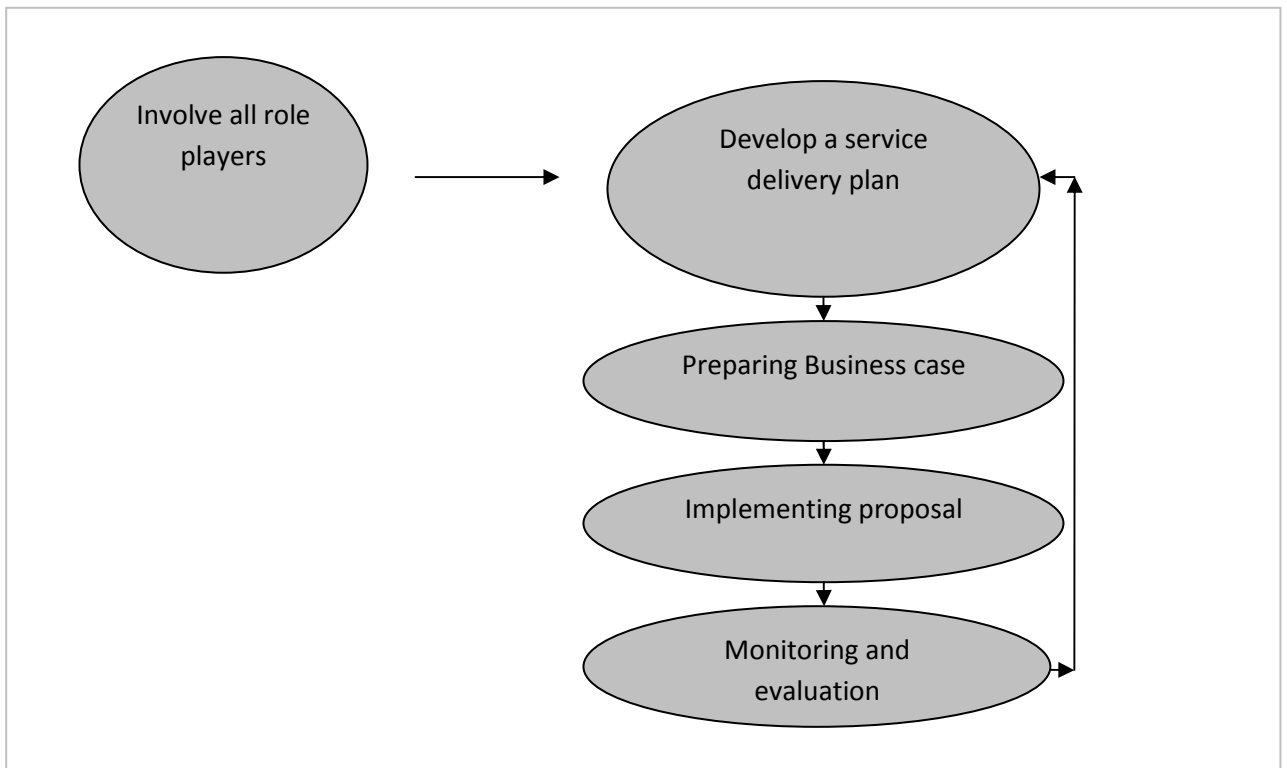
**Source (Figure developed for this research)**

Level 1 falls under primary and district care level and these services are offered by nursing personnel and medical officers. No speciality supervision is needed. Level 2 are special services with specialist supervision only in the fields of medicine, surgery, paediatrics, obstetrics, gynaecology, psychiatry and casualty.

Level 3 services are highly specialized services run by specialists and these are listed in table 4.2 – proposal one below.

#### 4.2.1 Planning

The initial enthusiasm for change was reflected after the recruitment of the transforming Chief Executive Officer in 2002. In his first year, the newly appointed Chief Executive Officer undertook an extensive review of the service delivery system, as a result of which he commenced implementation of the change management programme entitled “Rationalization of Services”. The Provincial Office (Head Office) was approached by the Chief Executive Officer to assist in developing a service delivery plan that would guide in planning for the rationalization and utilization of resources. In response to this, a framework was drawn up as indicated in figure 4.2 below, followed by the proposals as to the envisaged structure of proposed services in the PEHC.



**Figure 4.2 Framework for rationalization**

**Source – Service Delivery plan document (2001)**

The planning was organised on the basis of three proposals which were drawn up by the provincial office with no consultation with the PEHC stakeholders. The first proposal is depicted in table 4.2 below.

- **Proposal i**

<b>Level of service</b>	<b>LVH</b>	<b>DNH</b>	<b>PEPH</b>
Level 1	Level 1 Services	Level 1 Services	Level 1 Services
Level 2	Level 2 Services	Level 2 Services	
Level 3	Trauma,	Mother and Child Centre	Maxilla Facial
	Orthopaedic,	Burns Unit,	Ophthalmology
	Renal	Plastic Surgery	Cardiac
			Urology,
			Neurology,
			ENT
			ICU

**Table 4.2 Proposal 1**

**Source (Developed for this study)**

- **Proposal ii**

The service delivery plan document outlined that level 1 services be handed over to District Health or primary health care which is mainly the clinics. This would be done either by erecting a new hospital or utilizing available space at DNH. It was also proposed that Level 3 services be moved to DNH.

- **Proposal iii**

This proposal sought to look at the possibility of utilizing only two hospitals to maximize both equity and efficiency. Alternatively close down PEPH and outsource it as a public private partnership (PPP) or operate it as a military hospital.

Neither of the proposals were accepted. Proposal two and three fell out of the picture. Proposal one contained elements of duplication of services that was sought to be eliminated and was discussed and debated to eliminate duplication of services and resulted in the rendering of services as depicted in table 1.1.

In order to address the first research objective as “To analyse what was done from the perspective of the three-stage model of change”, the data was thematically presented from the perspective of the three stages of Lewin (1951).

### **4.3 Unfreezing**

The first theme being unfreezing was further developed into the following sub themes:

#### **4.3.1 Explaining why change is needed**

It is worthwhile to ensure that stakeholders understand the essence of the change and its likely benefits as this is likely to assist to gain stakeholder support and increase the likelihood that the organisation will be able to manage and sustain change.

The interviews revealed that the Chief Executive Officer addressed stakeholders on the objectives and benefits of rationalisation in various workshops. Meetings included:

- Listening to a presentation made by the CEO on the rationalisation.
- Addressing shortcomings of the current service delivery

- Addressing the rationale for change as highlighted in the preceding chapters
- Half day and full day workshops were spent with the stakeholders discussing how best proposal one could be implemented
- Stakeholders included management, clinicians, hospital board and unions.

The clinicians identified a set of specific strategies for carrying the service delivery system to overcome duplication of services some of which were common ideas and others were new approaches.

The interviews revealed that there was not enough time that was invested at the start of the rationalisation to acknowledge the pros and cons of current work practices. The process did not allow all stakeholder's viewpoints and assumptions about the rationalisation brought to light. The interviews further revealed that staff were informed of the pros and cons before rationalisation and highlighted the effect of the movement but in terms of the system there was no structure that prepared employees to go through this process.

As Skinner et al. (2005) emphasizes the importance to understand that workers have invested significant time and effort in developing and refining their current work practices, it became apparent from the interviews that no time was invested at the start of the rationalisation and no support was given to workers. The respondent's view was that people were told that management was going to restructure and explanations to all stakeholders including non-clinicians was not done appropriately.

#### **4.3.2 Creating readiness for change among employees.**

##### **4.3.2.1 Gaining support**

To promote management, supervisors and co-worker support in the change

process it is important to ensure that they understand the goal of change in order to feel secure about future work situations and feel that the change would be beneficial to their wellbeing Skinner et al. (2005),.

The interviews revealed that, while the Chief Executive Officer addressed the rationale for change, there was uncertainty at the level of administrative personnel and other clinical domains as to how the rationalisation would be used to address the current work practices. There was no implementation committee with an implementation plan that was tasked to translate the planned changes into work practices and there were also no evaluation committee created to monitor and assess the implementation of the changes. Consequently there were no estimates of time and commitment provided to staff. As indicated in the preceding chapters that hierarchical organisations are characterised by poor communication and exclusion of employees in decision making, invitation of inputs from administrative personnel and feedback were not invited. It was difficult as staff from PEPH had worked in PEPH all their years. It was a huge culture shock with white people having to be located in DNH which was previously catering for black people only. On the other hand this meant that personnel from LVH previously catering for the coloured community had to travel to DNH which was previously catering for African population. As a result of these uncertainties and exclusion of certain administrative sections full co-worker support especially at the administrative level was not gained.

As a result of this, people resigned, others booked themselves off sick on long sick leave with stress after they reported from PEPH to DNH. At DNH, a majority of personnel welcomed the change. A majority of clinicians in DNH were happy about the rationalization. The interviews revealed a positive perspective with regard to DNH in that the majority of staff embraced the change and realized it was a good thing to do.

It is apparent that investing time at the start of the change programme to prepare and support workers is an essential step to minimise reluctance to change. The respondents acknowledged lack of support affected workers' readiness to

change. As a result of this, even preparing DNH to receive all the extra patients was and still is a problem today even though rationalization was welcomed in this hospital.

In terms of readiness it became apparent from the interviews that staff members were not ready, and this was evident in the number of people who took long sick leave. One participant commented that “It was only a consultative process and that was a weakness, no care of psycho-social needs of staff was carried out”.

#### **4.3.2.2 Effective Communication Strategies**

A successful change is one that obtains open and honest input from people within the organisation. Communication about change should demonstrate how the change would make a difference to current work practices through a structure that facilitates communication and responsiveness in a number of ways (Grove, 2004). The interviews revealed that no communication plan was in place. Neither was there a communication policy. Decisions that were taken were not filtered in the operational activities. Over 80% felt that there was insufficient contact between management and staff. Face-to-face meetings including questions and answer forums were not mobilised throughout the organisation particularly at the level below management.

To inform the residents at large in Port Elizabeth an advert in *The Herald* newspaper was sent out, informing them of the rationalization plan.

It was clear that, there were inadequate opportunities for upward feedback. As a result, personnel did not want to move to where they were allocated and wanted to locate themselves to where they wanted to go.

#### **4.3.2.3 Participation in decision making**

According to Skinner et al. (2005) a successful change process is one that encourages extensive participation with opportunities provided to all employee groups: frontline workers; workers in supervisory and management roles; representatives from external bodies such as the unions; and representatives from different professional groups within the organisation (e.g administration and clinicians)

The interviews revealed that a rationalization subcommittee was formed to oversee the operational structure. Membership on this committee consisted of management and labour. This committee was responsible for driving the process at departmental level. Due to time constraints this committee did not have enough time to meet with the staff, listen to their views and give feedback at the departmental levels.

The respondents reported that clinicians from each hospital formed working groups to discuss the service delivery plan. These consultative forums in the form of working groups only involved clinicians. Each department in the clinical domain, for example, maternity, paediatrics in each hospital formed a working group. Every occupation within the clinical domain in each hospital was represented in these working groups. Examples of such representation included: medical heads of departments, doctors and nurses. The clinicians performed a situational analysis of their departments, developed a service plan proposal, and reviewed resource requirements for implementation. They looked at matters of moving services to other institutions, debating whether there were enough resources to cater for the services proposed to be moved to other institutions and making recommendations where necessary.

It became apparent that not all stakeholders were actively involved in the rationalisation initiative. As indicated earlier, inputs from administrative staff were

not invited. Only clinicians, management and unions participated in the planning process. There were no informal meetings conducted where frontline and administrative staff participated. It became apparent that there was no open dialogue between management and workers.

### **4.3.3 Providing organisational resources**

It can be easy to underestimate the resources required in a change process. It is important to ensure that sufficient resources i.e. sufficient number and quality of staff, provision of training and professional development opportunities, budget to support the required change and physical work space be made available for the entire cycle of the change and even after the change in order to sustain the new vision (Skinner et al.,2005). A priority is to provide accurate estimates to management of the resources required for the entire duration.

The interviews revealed that there was capacity to a limited extent, not in all areas, in the sense that, facilities were there. The process did not require facilities to be built. Finances to drive the processes were made available but not enough. Human resources, clinical resources for the levels introduced were not provided. There was also no overseer to play an oversight role in the form of monitoring and evaluation, now that the three institutions were in the process of operating under the complex structure. One participant commented that:

I don't think there was capacity to drive the change, there was just the CEO for the complex. The CEO was operating with few hospital managers, the same managers that had to drive the change"

The interview revealed that the processes started by forming the Complex, thereafter officials were appointed later to oversee the process. The appointments were phased in and the new officials were never presented with the plan as to where the Complex was heading in the system. Officials had to find

their own way of running their sections. People who were supposed to drive the process were the newly appointed officials but no plan was presented to them.

Resource requirement and availability in terms of human and financial was a constraint. It became apparent that disparities existed between the required resources and the available resources resulting in the operating capacity falling far below the actual potential capacity of the hospitals. This resulted in reducing the quality of service that the complex planned to provide.

#### **4.3.4 Training and development in the new work practises**

A successful change process is one that is characterised by providing training and development to support the capacity of workers and conduct new procedures of work practice change (Skinner et al. 2005)

The interviews revealed that training and development was available through workplace skills development but the pace was not fast enough due to staff shortages which made it difficult for people to go on training courses. The funds were there, but staff shortages made it impossible for employees to be released to go on training. Consequently there were no policies and procedures that were developed to enable a smooth flow in the process.

#### **4.3.5 Managing uncertainty associated with change**

Most change initiatives are characterised by periods of great uncertainty for workers due to breakdown in communication, withdrawal from participation, formation of destabilising cliques to mention a few.

While most of the staff were uncertain about rationalization, it created great disparities in that there was loss of labour force. Management could not provide opportunities for participation in decision making for frontline and administrative

personnel. As indicated earlier, not all stakeholders were actively involved. Management fell short in encouraging workers to participate. As previously stated there was uncertainty as to how the rationalisation would be used to address the duplication of services. The initiative fell short of demonstrating through a communication plan how the change would make a difference to current work practices in the form of a structure that demonstrated communication and responsiveness. As a result of these uncertainties there was loss of labour force.

#### **4.4 Moving**

This stage has to do with moving to a new position. Various organisational practices and processes are changed and this is done through conducting trial changes. According to Skinner et al. (2005) it is reasonable and realistic to expect that workers will require time to explore and rehearse the required work practice change and for that reason trial periods can be very useful. Engaging in ongoing monitoring and evaluation and supporting worker to change their behaviour are important aspects to be considered during this stage (Skinner et al. 2005).

The interviews revealed that the rationalisation package with its focus on providing accessibility, affordable and quality health care services and promoting equitable distribution of resources included:

- Appointment of new managers
- Movement of services to different hospitals
- Creation of the Corporate Services Centre
- Creation of three divisions led by three senior managers reporting to the CEO
- Development of policies and procedures
- Budget which was not informed by the needs

In an attempt to move to the desired direction the rationalisation started by having the institution led by people who had management and leadership training and

experience hence the appointment of new managers. To ensure optimum utilisation of resources services were moved per department over a period of a year. Table .4.3 depicts the movement of services between hospitals.

## Movement of services between hospitals

HOSPITAL	DEPARTMENT	CURRENT BEDS	MOVED TO /FROM	REMAINED
<b>I. Livingstone</b>	a) Medicine	180		R
	b) Surgery	153	FROM DORA & PEPH	R
* Includes:	c) Paediatric	138	DNH	
– Neuro Surg	d) Orthopaedics	134	FROM PEPH	R
– Facio Maxilla PE	e) Obstetric & Gynaeno	127	DNH	
– Paediatric. Surg.	f) Neonatal	55	DNH	
	g) ICU (+ Neonatal)	24	DNH	
	h) Psychiatry	0	DNH	
	i) Cardiothoracic	26	TO PEPH	
	j) Urology	50	TO PEPH	
	k) Paediatric. Surgery	11	TO PEPH	

R = Remained

HOSPITAL	DEPARTMENT	CURRENT BEDS	MOVED TO /FROM	REMAINED
<b>II Dora Nginza</b>	a) Medicine	30	FROM PEHP	
	b) Surgery	52	TO LIV	
* Includes:	c) Paediatric	57	FROM LIV & PEPH	
		0		
	e) Obstetrics & Gynaecology	49	FROM LIV AND PEPH	
	f) Neonatal	13	FROM LIV & PEPH	
	g) ICU (+ Neonatal)	6	FROM LIV	
	h) Psychiatry	20	FROM LIV & PEPH	

R = Remained

HOSPITAL	DEPARTMENT	CURRENT BEDS	MOVED TO	REMAINED	
III P.E. Provincial	a) Medicine	75	TO DORA		
	b) Surgery	*55	TO LIV		
	c) Paediatric	12	TO DORA		
	* Includes	d) Orthopaedics	34	TO LIV	
	– Facio Maxilla	e) Obstetric & Gynaeno	59	DORA	
	– Neuro Surg	f) Neonatal	8	DORA	
		g) ICU	12		R
		h) Psychiatry	16	DORA	
		i) ENT	15		R
		j) Cardiothoracic Sx	26	FROM LIV	
		k) Ophthalmology	18		R
		l) Plastic Surgery	10		R
		m) Urology	50	FROM LIV	
		n) Oncology	47		R
		o) Paediatric. Surgery	11	FROM LIV	

R = Remained

Table 4.3 – Movement of services between hospitals

**Source ( Developed for this research)**

The approach necessitated pulling the already limited resources together and utilizing them optimally. This process also led to the creation of a corporate services centre to focus on the administration matters of the three hospitals.

The movement also led to the creation of the structure with three senior managers reporting to the CEO. The three components led by the three senior managers included the corporate services centre, the clinical governance and the facilities

component. The corporate services centre was mainly focusing on ensuring that support services were rendered mainly in the areas of Information Technology, Supply chain, Financial Management, Human resources and general administration. The clinical head was mainly responsible to mentor clinical staff and ensure that clinical service deliverables were achieved. The facilities section was mainly responsible for the maintenance of facilities.

Policies were developed for support systems in the areas of supply chain, financial management, general administration, human resources and information technology. Budget was provided for the implementation of rationalisation but it was not adequate.

The interviews revealed that there was a great disparity in the utilization of facilities at the three hospitals and services were duplicated/triplicated resulting in facilities being under utilized in some hospitals, particularly DNH. Facilities at DNH were not developed despite this hospital serving the vast majority of the Port Elizabeth population. As depicted in table 4.3 the implementation on the other side resulted in most of the services moving away from PEPH resulting in most of the buildings being left empty.

The interviews further revealed that what did not happen was the analysis of the impact of the step-wise implementation (e.g. when one department has changed, to hold on and take the stock of what was done). The emphasis was to make sure departments were moved but whether that was according to the plan was not taken into account.

The aspect of monitoring and evaluation will be addressed later in this chapter.

This stage also calls for management to support workers to change their behaviour. As indicated earlier in the findings that the management styles employed resulted in increased level of strain as it fell short in breaking free of the

normal constraints imposed by the organisation and engaging in genuine enquiry with the employees.

The movement of services created an opportunity in that the opening of level two beds in DNH and availability of specialist services created a great opportunity. DNH is at the doorstep for people from the township.. Before rationalization patients who required specialist's services had to be transferred to PEPH or LVH. One participant commented that:

“Before rationalization DNH was a white elephant, nice building but it was never fully utilized. It had long tiring passages which is still the case and at that time HIV was not a prominent disease”.

It was also revealed that the rationalization created an opportunity for most administrative staff to be promoted though it was implemented later in 2006. It became apparent that the restructuring created an opportunity as it happened during the time the HIV epidemic started showing complications in most patients.

The interviews further revealed that the threat that derailed the process was the centralization of even the most basic administrative function. The situation continued to frustrate as the glaring staff shortages could not be addressed speedily. This included general assistants who were responsible for the general upkeep of the facilities. The situation even got worse as the transport system was outsourced and it was promising a nightmare.

It became apparent that, disparities existed between the required resources and the available resources resulting in the operating capacity falling far below the actual potential capacity of the hospitals. This resulted in reducing the quality of service that the complex planned to provide.

In terms of readiness it became apparent from the interviews that staff were not ready for the rationalisation as this was evidenced by people who took long sick leave. One participant commented that “it was only a consultative process and

that was a weakness, no care of psycho social needs of staff was carried out". The respondents acknowledged lack of supporting workers' readiness to change.

## **4.5 Refreezing**

Refreezing or confirmation is the final stage in Lewin's (1951) model of change. During this stage all changes in the transformation stage are made permanent and a new equilibrium results. New points of view are integrated into significant relationships (Iles and Sutherland, 2001).

### **4.5.1 Embedding in systems policies and procedures**

During this stage all changes in the transformation stage are made permanent and a new equilibrium results, employees' newly learned behaviours with regard to the recently implemented practices and processes are embedded by way of coaching, training and appropriate reward system. The interviews revealed that there was no system that facilitated coaching, training and appropriate reward for small wins. Consultants were eventually appointed to assist and provide the necessary training to the administrative staff after the change. The process did not provide an opportunity for employees to learn new behaviours with regard to the recently implemented policies and procedures.

There were no systems put in place to ensure that new behaviours became standard work practices and continuing to offer support for the new work practices. Consequently there was no celebration of successes or continuity in clarifying changes to roles.

### **4.5.2 Aligning new approaches into organisational culture**

An important aspect is the alignment of an organisation's culture, policies, practises and behavioural expectations to encourage workers to respond to

organisational change issues. The interviews revealed that there were no formal processes or protocols followed to ensure sustainability and maintenance. What was happening was operating reactively, waiting for something bad to happen. Consequently, the system was not sustained and now there are plans to undo the process. The department thought it would save money after rationalization which was not the case.

As a result of this people resigned and others booked themselves off sick on long sick leave with stress after they reported from PEPH to DNH. At DNH, majority of personnel welcomed the change. A majority of clinicians in DNH were happy about the rationalization.

Services are now closer to the people in the communities. The question is whether there were enough resources to cater for the new model. Without the rationalization DNH would have stayed as small as it was and would not have developed.

The aspect of monitoring and evaluation will be dealt later in the chapter. In essence this stage involves confirming and supporting by anchoring the new approaches into organisational culture which was not done.

Each of the stages of Lewin (1951) model demonstrates the role of monitoring and evaluation. The section that follows focuses on monitoring and evaluation at each stage of the Lewin (1951) model.

#### **4.6 Monitoring and Evaluation at the unfreezing, changing and refreezing**

It became apparent that no monitoring and evaluation was being conducted and at no stage was one aware whether they were still on the right track in terms of the plan. A designated individual was only appointed three years later to perform monitoring and evaluation for the complex and not for the restructuring.

The findings that follow seek to address the second research objective as to “How unforeseen circumstances were dealt with”.

#### **4.7 Unforeseen circumstances**

A strong message was becoming clear from the documentary data (minutes of the meeting and presentations) that the rationalization process appeared not to be very popular within the circles of some complex employees. This counter-transformation behaviour seemed to enjoy some degree of comfort, as some elements within management were not totally committed to the rationalization process. The interviews revealed that there were disagreements and employees resigned due to them not wanting to be allocated in DNH, this matter was not accommodated. The interviews further revealed that surgery even today did not move to DNH because of the doctors resisting and that the department was not ready and did not have the resources to refer full services to DNH. The respondents further commented that an unintended consequence for example DNH was meant to be a centre of excellence and only complicated cases be referred to DNH and normal deliveries be done at the Medical Obstetric Unit (MOU), however, the community did not want to go where there was no doctor which resulted in DNH having a heavy influx of patients which was not the intended purpose.

The message that was emerging was that human resources related queries, were not being accommodated, but for those queries that were service related, an arrangement was made to accommodate those services. Employees had to adapt to the situation.

The interviews further revealed a shortage of personnel. This situation differed from one hospital to the other. The situation at DNH was critical. There were critical shortages of staff in the following areas: nurses, doctors, administrative

staff (finance, human resources, and supply chain), general assistants, and technical staff (engineering services). Over and above this, there appeared to be a lack of capacity and skill with the administrative personnel in all hospitals. The process of matching all the existing personnel of the complex against posts provided for by the new establishment was supposed to have been finalized by October 2004, that never happened.

On the other side it became apparent that there were huge frustrations with regard to inadequate budget which was not informed by complex needs. Due to the serious financial position of the province, the complex was asked to return funds back to the province, this exacerbated the situation. As a result, functions which could be implemented were not done.

#### **4.8 Setting of objectives and measurement of targets**

In order to address the last research objective as to “The setting of objectives and measurement of targets to monitor progress. The interviews revealed the following as depicted in the following table:

Objectives pursued	Achievement of objectives
1) Improved Labour Productivity	No
2) Improved Business Processes	No
3) Improved Decision Making	No
4) Improved Internal Communications	No
5) Increased Employee Commitment	No

Objectives pursued	Achievement of objectives
6) Lower Absenteeism	No
7) Eliminate duplication of services	Yes
8) Address the unfair distribution of services	No
9) Develop the neglected and under-utilized facilities	Yes but resulted in PEPH being neglected
10) Ensure optimum utilization of resources	No
11) Promote the principle of BATHO PELE, People First, Abantu Kuqala	No
12) Promote race relations	Yes

**Table 4.4 Setting of objectives and measurement of targets**

**Source: (developed for this study)**

As already indicated earlier, there was no monitoring and evaluation in place during the process of rationalization.

#### **4.9 Conclusion**

This chapter reported on the results of the in-depth interviews conducted with ten participants at the level of management, together on results obtained from documentary data on the restructuring of the PEHC in the light of the research problem and objectives. It is important to note that there are important aspects in

Lewin's planned change management which the PEHC management can learn from after having undertaken its initiative of rationalisation and given that :

- Rationalisation began by gathering information on the shortcomings of the structure of the three hospitals, but did not weigh the degree of readiness to change.
- The timescales for achieving rationalisation were not clearly defined.
- It was driven from the top with clear objectives but no timescale
- There was no structure prepared the employees to go through the process of rationalisation
- There was lack of capacity of middle managers to respond to the workers in an encouraging way.
- Rationalisation sub-committees had limited time to meet with employees at the sectional level.
- External stakeholder involvement not mobilized to its full potential.
- Rationalisation was not an open process that involved both formal and informal employees.
- Budget constraints and staff shortages were not informed by the restructuring needs.
- Workers did not feel secure about the current and future work practises.
- No feeling that the change would be beneficial to their well-being and to the organisation's goals and mission
- No Monitoring and Evaluation put in place.
- Centralisation of even the most basic administrative functions.

In the next chapter the findings will be discussed in view of the theoretical framework and research findings discussed in the preceding chapter.

## **CHAPTER FIVE**

### **DISCUSSION AND INTERPRETATION**

#### **5.1 Introduction**

In this chapter the findings of the study are discussed in the light of the research problems and the research objectives. The final objective of the study to understand how the restructuring process in the PEHC could be understood from a planned change management perspective, particularly the Lewin (1951) model of change which incorporates unfreezing, changing and refreezing. This section answers the research question and weaves together literature and findings. Utilizing Lewin's (1951) framework, a discussion of the restructuring will be undertaken. Three key themes become apparent, namely unfreezing, changing and refreezing. The focus will be on how the researcher managed to answer the research objective. It was therefore deemed necessary to analyse what was done from the perspective of the three-stage model of change. This was followed by a discussion of how unforeseen circumstances were dealt with and finally to analyse the setting of objectives and measurement of targets to monitor progress. It is the purpose of this chapter to reveal the extent to which the PEHC's restructuring can be understood from the three stage model of Lewin (1951).

#### **5.2 The value of the planned change model for restructuring**

It became apparent that there was limited academic theory on introduction of rationalization of services in hospital complexes in the Eastern Cape. This suggested the need to pay particular attention to analysing the restructuring of the PEHC and understanding what was done from the perspective of the three-stage model of change. The study contributes to a theoretical point of departure for describing rationalization in the hospital complexes in the Eastern Cape. Burke

(2002) acknowledges that the sequential models can be valuable tools for planning and managing a change effort. Step-wise linear models of change offer very useful insights and guidelines (Callan, et al., 2004). According to them, these step-wise linear models provide managers with a guide book that they know help many managers to construct a more sophisticated understanding of the challenges through which they must work to produce successful change at any level.

### **5.3 Unfreezing**

The unfreezing stage being the first stage in the Lewin (1951) calls on five aspects that are critical during this stage namely: (1) Explaining why change is needed. (2) Creating readiness for change among employees by providing co-worker support, providing tools for effective communication and participation in decision making; (3) Providing organisational resources; (4) Training and development in the new work practices and (5) Managing uncertainty associated with change.

Looking at the aspect of explaining why change is needed, rationalization began by identifying options and choosing the preferred options, Iles and Sutherland (2001). As Skinner et al. (2005) shows, it is important to invest time at the start of the change programme to prepare and support workers. While the PEHC believed that the three hospitals required to be restructured for services being rendered, the details of the rationalization and the timescale for achieving it were not clearly defined. Yes, it was driven from the top with clear objectives but no timescales. The interviews revealed that staff were informed of the discrepancy in the gap between current functioning and the desired level of functions (Skinner et al (2005), before rationalisation and highlighted the effect of the movement but in terms of the system there were no structures that prepared employees to go through this process. A potential barrier to realizing the full benefits of the initiative was the capacity of middle managers to respond to the workers in an

encouraging way. Since staff were informed of the pros and cons before rationalization, it follows then that Skinner et al. (2005), views were completely supported.

The findings highlight the role the Chief Executive officer played in addressing the objectives and benefits of rationalisation in various meetings Skinner et al. (2005). The findings also highlight the role of the clinicians in identifying a set of specific strategies for carrying the service delivery system. The findings are silent as to the involvement of other stakeholders in identifying strategies to carry the service delivery plan. Given that the theory recommends the application of SSM in explaining why change was needed, which provides a means of articulating complex social processes in a participatory way, allowing people's viewpoints not only limited to and assumptions about the rationalisation to be brought to light is an aspect which the PEHC management could employ in other change projects that the complex plans to embark in. The SSM application can be very useful in giving the insight and guidance to those involved in the change.

Looking on the aspect of creating readiness to change three key aspects became apparent namely gaining support from management, supervisors and co-workers; effective communication and participation in decision making. As might be expected, the rationalization did not emerge without much discussion and debate, though the implementation of rationalization was not without difficulties, it was implemented remarkably quickly and with relatively little consultation with its internal and external stakeholders. As Senior (2002) puts it, creating readiness involves debating the situation with those involved. Skinner et al. (2005), also contends that both informal and formal people in the organisation must be committed to the application of change. Indeed there was a form of participatory forums that were formed but these did not involve staff at the administrative level. There was significant number of staff that were unhappy about the situation.

The findings highlighted a gap in support from supervisors and co-workers. This was very critical at administrative level and other clinical domains, as there were no committees formed to respond to questions on how the rationalisation would be used to address the current work practises. As Skinner et al. (2005) suggest, workers must understand and accept six central questions. A gap was also highlighted in that there was no implementation committee with an implementation plan that was tasked to translate the planned change into work practices. There was also no evaluation committee to monitor and assess the implementation of the change. Consequently there were no estimates of time and commitment that was provided to staff. Given that the theory calls for gaining support from all stakeholders, the PEHC management can learn by employing the six central questions as suggested by Skinner et al. (2005).

Looking on the aspect of communication strategies employed, the findings highlight that there was no communication plan that was in place and there was insufficient contact between management and staff. To be successful rationalisation needs a structure that facilitates communication and responsiveness being a mechanism that focus on people to talk as suggested by Grove (2004). Face-to-face meeting, persuasive communication from management, active participation and symbolic activities such as ceremonies and awards are some elements that the PEHC could learn from which fell short based on the findings.

Looking at the aspect of participation in decision making, the findings highlight that a rationalisation subcommittee was formed to oversee the operational structure. A potential barrier to realizing the full benefits of the participation initiatives was the time constraints and the capacity of middle managers to respond to the workers in an encouraging way. Much of the outcome of the direct participants did not show a clear polarization. It is clear from the evidence that not all stakeholders were allowed an opportunity to be involved. The findings support the views of Senge (1990) when suggesting that, while it is more pleasant

to have a considerable commitment it is not necessary for everyone to be as fully signed up in the change programme. According to Senge (1990) an analysis of what level of support is required from each of the players is required and directing energy to achieve that, rather than trying to persuade everybody to commit. The restructuring was not an open process that involved a great number of people.

The PEHC management can learn from the initiative of rationalisation as suggested by Skinner et al. (2005) by providing opportunities for participation to frontline workers, workers in supervisory and managerial roles, representatives from external bodies such as the unions, representatives from different professional groups within the organisation e.g. (administration and clinicians). The benefits of these, as advocated by Cartwright, Cooper and Murphy (1996), suggests that organisational structures associated with increased opportunities to participate in decisions. are associated with higher levels of job satisfaction and commitment to the organisation and increased sense of well-being.

Looking at the aspect of providing organisational resources the literature highlighted that it can be easy to underestimate the resources required in a change process. The findings revealed that there was capacity to a limited extent, not in all areas, in that, facilities were there and ready. The process did not require facilities to be built. Finances to drive the processes were made available but not enough. Findings reported concerns with regard to budget constraints where the level of services introduced could not be sufficiently accommodated in the allocated budget. Another potential barrier to realizing the full benefits of rationalization had been shortages of staff and an overseer to play an oversight role in the form of monitoring and evaluation, now that the three institutions were in the process of operating under the complex structure. As Tosi and Neal (2003) show that capability is determined by whether the change agents had the authority to allocate resources. The findings highlighted that there were inadequate resources for the level introduced. Resource requirement and availability in terms of human and financial was a constraint. As Skinner et al.

(2005) suggests, organisational change is most likely to be successful when it is supported by sufficient organisational resources through development and implementation of a policy outlining work practice change, sufficient number and quality of staff, provision of training and professional development opportunities to support required change and appropriate office and other physical work space important aspects which the PEHC management can learn by employing these in their future change programs.

Looking at the aspect of training and development, it is mentioned that providing training and development to support the capacity of workers and conduct new procedures is likely to improve the uptake and long term sustainability of work practice change. The findings were not consistent with the literature studied. As Skinner et al. (2005), suggests, the use of peers and colleagues to conduct the professional development to encourage and motivate workers to adapt to the desired change is an important aspect during this stage. It became apparent in the findings, that while funds were made available due to shortages of staff, it became difficult to release the limited personnel to attend professional development courses. The findings highlighted the availability of workplace skills development (Skinner et al. 2005) but the pace was not fast enough due to staff shortages which made it difficult for people to go on training courses.

Looking at the last aspect at the unfreezing stage, that of managing uncertainty associated with change, managers at the sectional level lacked clarity of rationalization and this created a lot of uncertainty. Stakeholder commitment was not mobilized through joint diagnosis of the hospital problems in the form of tapping on employee's talents, subsequent discussion and planned action by internal stakeholders and management. Strides have been made in terms of fostering employees to comply. As Skinner et al. (2005), puts the less reluctance to engage in change, the greater the likelihood of a successful change. The process used did not bear resemblance to Lewin's (1951) model description of unfreezing.

The literature indicated that organisational change could be a period of great uncertainty for workers due to breakdown in communication, withdrawal from participation, formation of destabilising cliques, increased stress and lower job satisfaction. The findings highlighted that management could not provide opportunities for participation in decision-making for all stakeholders which was contrary to the recommendation made by Skinner et al. (2005). Management fell short in encouraging workers to participate and there was no structure that demonstrated communication and responsiveness which resulted in uncertainty.

Given the initiative of rationalisation, the PEHC management can learn from their mistakes. As the researcher looks at the theory it becomes apparent that workers have to feel secure about their current and future work situations and feel that the change would be beneficial to their wellbeing and to the organisation's goals and mission.

#### **5.4 Changing**

The second stage began to initiate the moving stage, Skinner et al. (2005). This was done by identifying options and choosing the preferred options. As shown by Iles and Sutherland (2005). moving to a new position occurs through identifying with a new role and scanning the environment for new relevant information. The rationalisation package included the appointment of new managers, movement of services to different hospitals, creation of the corporate services centre, creation of three divisions led by three senior managers reporting to the CEO, development of policies and procedures and Budget that was not informed by the needs. More emphasis was put on moving services without state of readiness being accessed. The findings highlighted the appointment of managers as was planned.

The Lewin (1951) model demonstrates the contribution that the pilot projects can make to the management of change (Skinner et al., 2005). It was widely acknowledged in the findings that services were moved per department and not everything at the same time, consistent with the theoretical aspects as advised by (Skinner et al., 2005) and also in support of Iles and Sutherland (2000) who contend that changes that can be tested and evaluated on a trial basis are more likely to be accepted by workers. The findings also revealed the creation of corporate services centre which resulted in centralisation of even the most basic administrative functions.

The findings further revealed that, what did not happen was the development of policies and procedures for the core business (i.e. clinical services). There was also no analysis undertaken of the impact of the step-wise implementation e.g. when one department has changed, to hold on and take the stock of what was done. The emphasis was to make sure departments were moved but whether that was according to the plan was not much of a concern. The process did not bear resemblance to the views of Iles and Sutherland (2000) of engaging on monitoring and evaluation during this stage as one of the strategies that assist the transition from old to new work practices.

Paulsen et al, (2004) show that what managers do at this stage is critical to promoting employee adjustment and commitment to the whole process. A potential barrier in the rationalization was the capacity of rationalisation sub-committee to respond to the workers in an encouraging way as shown by Paulsen et al., (2004). The parameters of the management role as shown by Paulsen et al., (2004) and the associated management style, were not clearly defined. It became apparent in the findings that employees felt a low level of personnel control and high levels of uncertainty. A key thrust of the restructuring in this stage has been to move the departments in small scales. The finding highlighted the potential in the contribution made, by not moving all services at the same time.

Consistent with Stroh (2005) of whether change is legitimate, the opening of level two beds in DNH and availability of specialist services created a great opportunity. Secondly, DNH is at the doorstep for people from the township. It created an opportunity for most administrative staff to be promoted .

Participants reported concerns with regard to centralization of even the most basic administrative function. This finding did not completely support the question as to whether the advantages of rationalization outweigh the disadvantages as shown by Stroh (2005). The centralization meant that the support needed by the level introduced was not there as the demands from the doctors and nurses were very high.

While this stage could not be considered to have operated in accordance with the best practice of Lewin's (1951) second stage, it can be said that the PEHC management could learn from some of the gaps which among others was developing policies not only for the support services but also for clinical services.

## **5.5 Refreezing**

As shown by Cummings and Worley (2001), this stage is characterised by making permanent the changes and a new equilibrium results. The findings revealed that there were no formal processes or protocols followed to ensure sustainability and maintenance through coaching, training and appropriate reward system as suggested by Iles and Sutherland (2000). As indicated in the findings, the process did not provide an opportunity for employees to learn new behaviours with regard to the recently implemented policies and procedures. Consequently the findings were silent on the aspect of alignment of organisation's culture, policies, practices, and behavioural expectations to encourage workers to respond to organisational change issues.

While the findings did not resemble the above aspects, there are important aspects that are highlighted in the theory which are more important during this stage through which the PEHC management could learn, namely that of celebrating successes, continue to clarify changes to roles, regular support and communication with supervisors and continued expression of support from senior management

## **5.6 Monitoring and Evaluation**

As Skinner et al., (2005) shows implementing change that will ultimately transform an organisation is a long term process and Kotter (1996) emphasizes the importance of short term wins, both as a motivator and as a mechanism for tracking progress towards longer term goals. While the PEHC believed that the three hospitals required restructuring for services being rendered, the details of the rationalization and the timescale for achieving it were not clearly defined. Neither there was an overseer to monitor and track progress. Yes, it is argued that it was a planned approach as it was driven from the top with clear objectives but no timescales.

Monitoring and evaluation of work practices are essential to track the progress of change and to determine if the change programme has been successful. The absence of monitoring and evaluation during this process did not give the researcher an opportunity to determine to what extent the rationalization conformed to the principles as outlined by Lewin (1951) and the principles proposed by his predecessors. This is another important aspect that the PEHC management could learn from.

## **5.7 Unforeseen circumstances**

The second research objective was to understand how unforeseen circumstances were dealt with. Accordingly the study produced an early identification that

change cannot solely be based on plans and projections but rather on understanding the complexities of situations and weighing different options available, as shown by Stroh (2005). As might be expected and highlighted earlier, the rationalization did not emerge without much discussion and debate, it became apparent in the findings that there were significant amounts of personnel who were not happy about rationalization. There were disagreements and as a result:

- Employees resigned due to unwillingness to locate to DNH.
- Surgery department did not move to DNH because of doctors claiming that the department was not ready and did not have the necessary resources to refer full services to DNH.
- Another unintended consequence, DNH was meant to be a centre of excellence and only complex cases be referred to DNH and the normal deliveries be done at the MOU's but the community did not want to go to where there was no doctor and that resulted in DNH with heavy influx of patients and that was not the intended purpose.
- No Intensive Care Unit in DNH as was originally planned
- The interviews revealed that a shortage of personnel in all hospitals.
- A lack of capacity and skill with the administrative personnel in all hospitals.
- Huge frustration with regard to inadequate budgets which was not informed by complex needs.

Managers did not develop capabilities needed to ensure that the PEHC and its employees could capitalize on opportunities for innovation and business development as shown by Stroh (2005). As Stroh (2005) says, the best laid plans will not adequately prepare one for the emergent realities of the future.

The best approach was first to overcome significant structural constraints within the three hospitals. It is argued that structural change needs to be relatively quick and requires an approach which is capable of involving people and winning over

the majority of the internal stakeholders especially those who are in the position to block the change.

## **5.8 Setting of objectives and measurement of targets**

In order to address the last research objective as to “The setting of objectives and measurement of targets to monitor progress. Table 4.4 was used to gather information as to the objectives pursued and measurement of those set targets. The outcome of the rationalization as depicted in table 4,4 presented the PEHC with major challenges. A potential barrier to realizing the full benefits of rationalization had been the absence of the person to conduct monitoring and evaluation during the restructuring. This was directly linked to shortages of staff, lack of funding and the capacity of the change agents to foster implementation. At a broader level no monitoring and evaluation was being conducted and at no stage one was aware whether they were still on the right track in terms of the plan. A designated individual was only appointed three years later to perform monitoring and evaluation for the complex and not for the restructuring. It became apparent in the findings that among the objectives pursued as illustrated in the findings, only the prevention of duplication of services was confirmed to have been successfully achieved and developing DNH which was previously neglected and promoting race relations.

## **5.9 Conclusion**

The next chapter concludes the study, highlighting the main findings and making recommendations for future research.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATIONS**

#### **6.1 Summary of Findings**

The study has reported on the restructuring of the PEHC from the perspective of the planned management perspective. The proposed main problem was “How can the PEHC restructuring process be understood from a planned changed management perspective? The aim of the study was to analyze the PEHC restructuring process from a planned changed management perspective in particular the three stage model of Lewin (1951) which include unfreezing, moving and refreezing. The aim was broken down into three objectives. The first objective was to analyse what was done from the perspective of the three-stage model of change. The second objective was to analyse how unforeseen circumstances were dealt with and finally to analyse the setting of objectives and measurement of targets to monitor progress. The development and implementation of the rationalization cannot be understood from the perspective of the three stage model of Lewin (1951).

The outcome of the rationalization had been the creation of PEHC. Evidence presented here suggests that the restructuring that took place in the PEHC did not accord to the planned changed management perspective in particular the three stage of Lewin's (1951) framework. The pattern of change involved in the rationalization and the way in which it had been managed did not meet the conditions for change outlined by Lewin (1951). Hence the rationalization cannot be understood from the perspective of the Lewin (1951) model.

The parameters of the management role and the associated management style were not clearly defined. The restructuring was not an open process that involved a great number of people. There were many uncertainties in the process. Stakeholder commitment was not mobilized through joint diagnosis of the hospital problems in the form of tapping on employee's talents, subsequent discussion and planned action by all internal stakeholders and management. A potential barrier to realizing the full benefits of the participation initiatives was the capacity of middle managers to respond to the workers in an encouraging way. Much of the outcome of the direct participants did not show a clear polarization. Strides have been made in terms of fostering employees to comply. The process used did not bear resemblance to Lewin's (1951) model description of change. It is clear from the evidence that stakeholders did not welcome the opportunity for the restructuring and the lack of participation to address problems.

Given the theory on planned change in particular the Lewin (1951) model there are important aspects which the PEHC management can learn from the initiative of rationalisation. Implementing change that will ultimately transform an organisation is a long term process and Kotter (1996) emphasizes the importance of short term wins, both as a motivator and as a mechanism for tracking progress towards longer term goals.

One should not underestimate the difficulties in implementing restructuring and indeed the requirements of training and development as these were totally not part of the plan during the restructuring.

It became apparent in the findings that the basic configuration of the hospital changed and there was a gradual development of internal consistency especially in DNH. However, this study has shown that the outcome of the rationalization presented the PEHC with major challenges. A potential barrier to realizing the full benefits of rationalization had been the absence of the person to conduct monitoring and evaluation during the restructuring. At a broader level, no

monitoring and evaluation was being conducted and at no stage was one aware whether they were still on the right track in terms of the plan.

As might be expected the rationalization did not emerge without much discussion debate and disagreements resulting in some of the personnel resigning, surgery department as was original planned to move to DNH did not move to DNH due to doctors claiming that the department was not ready and did not have the necessary resources to refer full services to DNH. Among other disagreements DNH was meant to be a centre of excellence and only complicated cases be referred to DNH and the normal deliveries be done at the MOU's but the community did not want to go to where there was no doctor and that resulted in DNH with a heavy influx of patients and that was not the intended consequence. Managers did not develop capabilities needed to ensure that the PEHC and its employees to capitalize on opportunities for innovation and business development as shown by Stroh (2005). As Stroh (2005) says the best laid plans will not adequately prepare one for the emergent realities of the future.

Each component neither conformed to the framework of the three stage model of Lewin (1951) nor the principles proposed by his predecessors. Hence the restructuring could not be considered to have operated in accordance with the best practice of the three step model of Lewin (1951). The development and implementation of the rationalization could not be understood from the perspective of the three stage model of Lewin (1951). The stages do not seem very much alike to Lewin's (1951) three stage models.

## **6.2 Recommendations for managers**

Pollitt (1993) and Dawson (1999) suggest that the health sector is characterized by three defining features:

- Range and diversity of stakeholders
- Complex ownership and resources

- Professional autonomy of many of its staff.

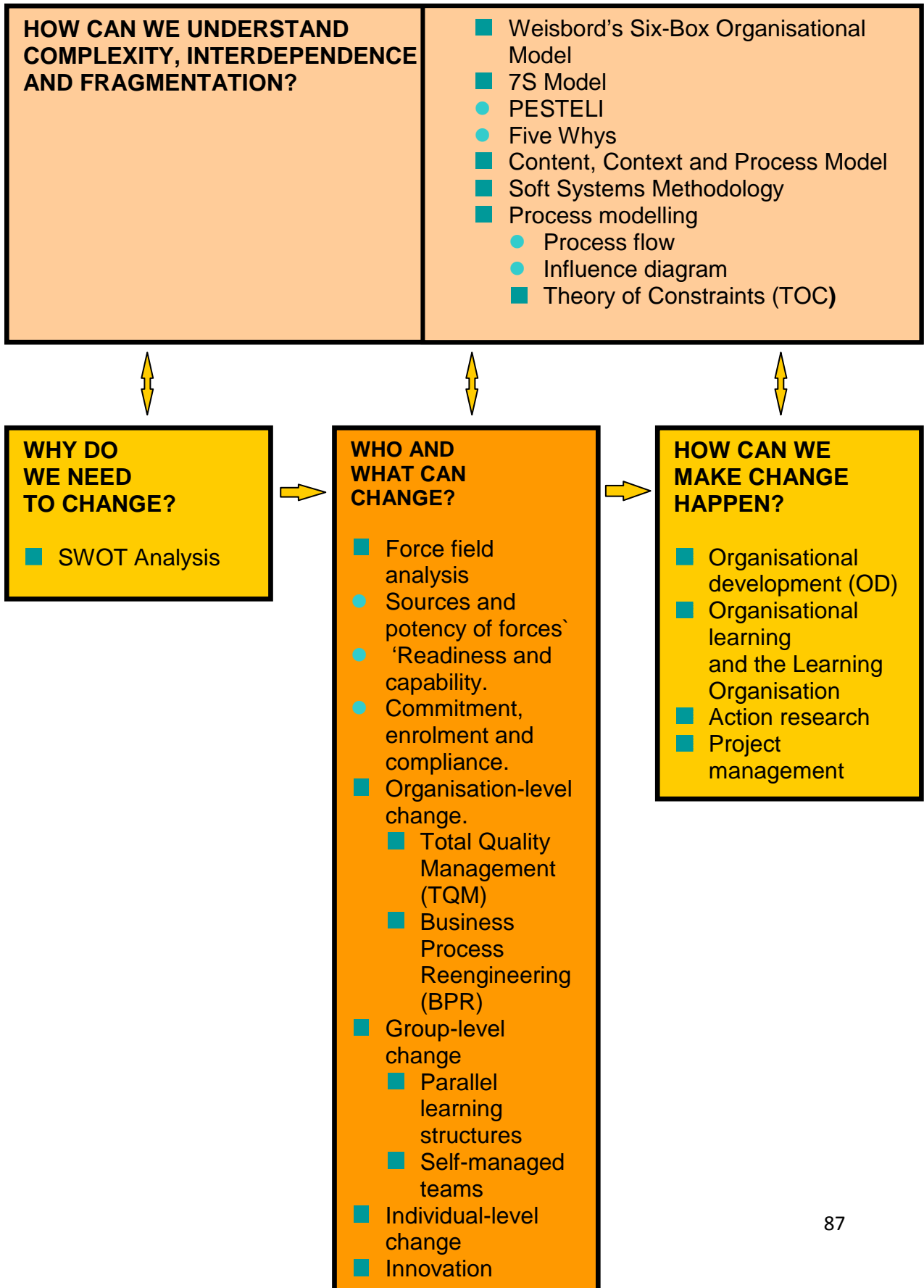
The biggest challenge in a health sector organisation is that teams are interdependent, that is, they can only achieve their objectives by relying on other people, seeking to achieve different objectives. For all these reasons change in the health sector is never likely to be straightforward and linear. Proposed change needs to offer benefits of interest to frontline staff and the approach need to be iterative (Ywye & McClenahan, 2000). In making recommendations the researcher has decided to employ the model designed by Iles and Sutherland (2002). The model is clustered around key questions. It is suggested that the questions and the clusters are not the only ways to organize the model. Neither are they intended to be a prescription for managing the process of change. Rather they act as a guide to those planning to manage a process of change. The key questions are:

- How can one understand complexity, interdependence and fragmentation?
  - It needs to be borne in mind that the system is complex and dynamic
  - This means that one cannot plan everything that will happen.
  - Need to take into account that any intervention one makes may spark off unplanned consequences.
  - Then in the light of that what framework what framework can help one to think constructively about living with this kind of complexity.
- Why do we need change?
  - What frameworks can help one to share an understanding of why change is needed?
- Who and what can change?
  - Many different processes and people have to be involved if change is to happen effectively.
  - What frameworks can help one to identify the key areas for the agent of change attention?

- How can we make change happen?
  - Those involved understand the situation. They know why change is needed. They see who and what needs to change.

To create a change initiative that will deliver the results that are needed the change agent can be assisted by the following framework:

## Change management tools, models and approaches



## KEY TO MODELS

- Subject to literature search
- Not subject to literature search

### Figure 6.1 - Tools, models, and approaches: A selective review

**Source: Managing change in the NHS – Organisations Change, A review for health care managers: Iles and Sutherland (2001).**

Generally, organisations need to understand their current situation and constraints. According to Obrien (2002) this does not refer to environmental stability but to the preparedness of a major change of its internal stakeholders. In the same way organisations must decide on their preferred management style, Do they want to be centralizing or devolving facilitators, meaning are managers happy taking all the responsibility for change or would they prefer to push that further down the organisation?

There is strong need to develop an effective communication strategy as that will go a long way in building relationships internally and externally. Effective communication is the backbone of any form of a relationship.

Large-scale change is a process and it can be viewed as a series of events that can be managed. Adopting a linear step-by-step view about change allows managers to plan and to attend to important challenges that will arise in most change processes. Large-scale organisational change does not always occur as planned and probably not in an orderly, predictable and linear manner. Managers need to develop capabilities in themselves and in their employees that allow them to cope with the uncertainty and complexity that is an integral part of any major change process, irrespective of how well it is managed or led. It is this capacity that will allow organizations and people to respond to emergent opportunities.

Change in organizations is experienced not only at the personal level, but also at an intergroup level. The mutual dependence or interdependence between people and organisational groups is a natural setting for conflict, rivalry, distinctions about winners and losers during change, and in building important new identities. Supervisors and managers need to use multiple channels of communication to reflect the complexity of any change situation. Where it is possible, face-to-face communication should be the first choice in explaining the vision, purpose and timing of the change. During change processes, the leaders of change should brief and encourage their first-line supervisors to be the most visible communicators with employees. People trust communication from their immediate supervisors, before they will believe any communication from higher up. The leaders of major transformation processes ignore the impact of change upon human resources at their danger. The change agents need to focus on the humanity of change not just on the systems and structures for change. When leaders communicate, they need to speak with one voice. At the very time when the organization needs to harness the best and most creative of its people, it is advisable to take a risk and be creative.

Change agents need to tolerate ambiguity and allow messiness. Leaders of change should be a little more spontaneous and less predictable. Give more permission to your intuitive self and tolerate a few mistakes and wrong turns and errors of judgment among your people. Critics have suggested several problems with the way the change is carried out. Their concerns are not with the planned change model itself but with how change takes place. Although Lewin (1951) proposed this theory of organisational change as early as the 1950's, it still continues to influence thinking on organisational change today (Tosi and Neal, 2003).

Depending on the answers to the above questions, organisations must decide on their preferred style or the most appropriate approach to change or whether to realign their management style to the changing environment. The rationalization

experience has helped to identify many of the ingredients. In this way this would assist in designing the initiatives in ways that make it easier for all stakeholders to contribute their knowledge and skill. The restructuring has been a learning experience, a system for learning about the change in a hospital environment. Managers realized that they have failed in effectively tap on the talents of those that exists amongst lower level staff. As Kanter (1982, p101) shows that it is easier for managers to whip up excitement over a vision at the start up than to keep the goal in people's minds. If the project is to maintain momentum, managers must sustain the enthusiasm of all by being persistent (O'Brien, 2002).

### **6.3 Recommendations for further research**

An important limitation in this research was the unavailability of the former Chief Executive Officer who was heading the PEHC during rationalization. With the CEO partaking in this study, this would have enriched the content of the study. The data collected rests upon data collected through conducting interviews with management and use of documentary data. Given its delimitations to management and the findings has opened a gap to advance a research agenda paying particular attention to the staff at the administrative level or front line employees.

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## **Appendix A**

Office of:

The Finance Manager

Port Elizabeth Hospital Complex

Telephone: 083 378 0918

Email: Babalwa.qwasha@impilo.ecprov.gov.za

### **NOTICE TO PARTICIPANTS – RESEARCH INTERVIEWS**

My name is Babalwa Qwasha and I am the Finance Manager in the Port Elizabeth Hospital Complex (PEHC). I am currently involved in research relating to the rationalization process that took place in the Port Elizabeth Hospital complex. The focus of the research is on understanding what happened during rationalization from the perspective of the theory on planned change management.

This research is in partial completion of the requirements for the Master in Business Administration programme at Rhodes Investec Business School, and a copy of the report will be made available to the top management of the PEHC so as to contribute to the continual improvement of management practice. This research is important for the ECDoH as there are many change programmes that are being implemented that may benefit from the lessons learnt in previous programmes. The findings from this research therefore have the potential to assist the organization to cope with the never-ending requirements for change that characterize today's business environment.

You have been selected to participate in this research because of your involvement and participation and more importantly as a recipient of this change.

Basically the research is seeking to understand

- What was done from the perspective of the three stage model of planned change
- How unforeseen circumstances were dealt with
- The setting of objectives and measurement of targets to monitor progress
- How participation in team based changes were encouraged

The questions for the interview are attached to help you prepare for the interview. The interview will be conducted in a more open ended way, with the questions being used as a guide to the conversation rather than as a prescribed structure.

If you have a question or concern regarding the research, you are welcome to contact The Secretary, Rhodes Investec Business School by telephone at 046 603 8617 to speak to the Director of the School or my supervisor, Dr Noel Pearse.

In accordance with the Ethical Guidelines for Research of the Rhodes University, I would just like to restate that your participation is entirely voluntary. The findings will be reported in aggregate. A summary of the findings will be made available to each of the participants.

If you would like any additional information, please feel free to call me at 084 250 3270, or contact me by email at [babalwa.qwasha@impilo.ecprov.gov.za](mailto:babalwa.qwasha@impilo.ecprov.gov.za). Thank you for your valuable contribution to this research effort. While your participation is entirely voluntary, it is sincerely appreciated.

Babalwa Qwasha

Finance Manager – Port Elizabeth Hospital Complex and

Final year MBA student – Rhodes Investec Business School

## Appendix B - Interview Guide

The primary purpose of the interview is to address the following research question.

How can the PEHC restructuring process be understood from a change management perspective?

This research question was further subdivided into the following four sub-research questions

- RO1 To analyse what was done from the perspective of the three-stage model of change.
- RO2 To analyse how unforeseen circumstances were dealt with.
- RO3 To analyse how the objectives were set and how the targets were monitored and measured

1. The planned management approach is an interactive process involving diagnosis, action and evaluation

- a. Take me through this process and explain how the clinicians were involved
- b. How was other staff involved?
- c. How were the unions involved?
- d. What were the driving forces of this change?

2. The models of planned change involve 3 successive stages namely unfreezing, moving and refreezing. Unfreezing is mainly directed at preparing

the present organisational culture for change. This includes perceptions, attitudes and behaviours.

What kind of actions and initiatives were taken, if any, to begin to prepare the organisation to change from its former state to the desired state represented by rationalization?

3. At the unfreezing stage certain matters have to be addressed

- 1) It can be hard to break out established routines to embrace change. Can you comment on this statement with reference to your experience during this process
- 2) Would you say enough time was invested at the start of the project to prepare and support workers? If so how was this exercise done?
- 3) It is important to understand and acknowledge that workers have invested significant time and effort in developing and refining their current work practises. Would you say staff were aware of the pros and cons of the pre rationalisation work practises and if so what were they and how was this communicated
- 4) Successful change depends on the workers readiness for change. How were workers supported in terms of readiness for change
- 5) It is said that the organization must have capacity to implement the desired change and achieve the desired outcomes. Would you say that there was capacity to drive the change if so please elaborate on this.
- 6) It is said that planning for change is a method of dealing with changes that may affect the survival of the organization. In the context of the

restructuring of the PEHC what would you regard as factors that - if not changed - were to affect the survival of the organization

7. Gurus of change say there should be a sense of urgency to ensure that change happens and that the plans for change must be widely communicated.

(1) What motivated the change?

(2) In your opinion would you say the plan was widely communicated if yes or no please explain?

8 What event created the greatest opportunity during this process

9. What event created the most serious threat to the process

### Stage 2 Changing

Strategies to assist the transition from old to new work practises include conducting trial of change, engaging in ongoing monitoring and evaluation and supporting workers to change their behaviour.

Comment on the pace of change and the size of change implemented at each stage

6. Monitoring and evaluation of work practises are essential to track the progress of change over time and to determine if change programme has been successful

1) Was there a designated individual to monitor progress

2) If yes how was it performed? And if no what was done instead

3) What was found to be the factors that hindered or helped change?

4) How was sustainability of change addressed?

5) And what was the impact of change on clients?

### Stage 3 Refreezing

Stage 3 involve confirming and supporting and strategies to ensure new behaviours become standard work practices meaning continuing to offer workplace support for the new work practises and continuing with monitoring and evaluation including making required modifications to the new work practises.

7. How would you say the rationalization process was maintained and sustained?

8. Successful movement through the process requires individual to change. Can you say that individuals did change? If so why do you say that, or what characterized this behaviour?

9. In order for individuals not to revert back to their previous state, the new desired state must go through systematic ongoing training and daily interactions at the individual level and through revised policies, procedures and systems. Can you say this process was adopted and if so how was it implemented IRO

- i. Ongoing training
- ii. Daily interaction at the individual level
- iii. Revised policies , procedures and systems

### Participation, monitoring and adjusting

10. How was participation in the rationalization process encouraged?

11. Underpinning planned change is the emphasis on improving organizational effectiveness.

- What were the areas targeted for improvement and
- How were those areas measured?

12. It is said that change normally unfolds in an unplanned way and more especially that any change programme must allow for emergence and surprise, since organizations are systems and are also political.

- 1) Did everyone agree to work in the same direction or were there disagreements? If so, how did this process unfold?
- 2) How were any unforeseen circumstances dealt with?
- 3) Managers make a number of decisions unrelated to the change that emerges. The change is therefore not planned. Were there any such matters and how were these incorporated into the plan?

14. Has the PEH Complex achieved its goals set out when planning for rationalisation and what is the evidence to support this conclusion?

Has the PEH complex altered its practices to achieve the goals and objectives in the change plan?

15. Which of the following objectives were pursued during that process?

–

13) Improved Labour Productivity

14) Improved Business Processes

15) Improved Decision Making

16) Improved Internal Communications

17) Increased Employee Commitment

18) Lower Absenteeism

16. To what extent were these objectives achieved?

17. What affect these factors had on implementing the project?

- 1) Availability of Budget
- 2) Inflexibility in the Work Force

That covers the questions that I wanted to ask, can you think of anything that I should have asked you about the rationalization programme but haven't?

Is there anything else you would like to tell me about the PEHC rationalization programme?

Thank you very much for your participation