Mutual trust is essential for successful change: lessons from implementing NHS reforms

It is often said that trust enables change — but the opposite isn’t true. In fact, the very essence of change — that uncomfortable move from the known to the unknown — often creates fears that actively erode trust.

It is this tense relationship between trust and change that Andrew Day and Guy Lubitsh, of Ashridge Consulting, explore within the complex reforms proposed for the UK’s National Health Service.
Introduction

The NHS is experiencing the most dramatic transformation in its history. We believe that the scale, depth and pervasiveness of the changes facing the NHS offer significant learning to managers in all sectors as to how to support organisational change.

This article summarises our research and work over the past two years with NHS leaders who are leading complex organisational change and development projects. Over this period, we have been interested in how senior managers and change agents in the NHS can effectively introduce organisational changes. Our central finding is the pivotal role that mutual trust plays in forming the conditions that encourage people to collaborate across organisational, professional and political boundaries to change structures and improve services.

The political and economic context

The Coalition Government in July 2010, soon after coming to power, launched its White Paper, Liberating the NHS, which set out an ambitious programme of reform for the NHS. These reforms are intended to bring about a radical change in how public healthcare is delivered in England. In January 2011 the Health and Social Care Bill was published. This proposes a number of key changes to the NHS in England, including:

• Providing greater choice to patients
• Abolishing Primary Care Trusts and giving groups of GP practices and other professionals — clinical commissioning groups — responsibility and budgets to buy care on behalf of their local communities
• Increasing competition between providers by inviting the private sector and third sector to offer services to NHS patients
• Moving responsibilities located in the Department of Health to a politically independent NHS Commissioning Board
• The creation of a health specific economic regulator with a mandate to guard against ‘anti-competitive’ practices

• Moving all NHS trusts to foundation trust status.

The Government has argued that the reforms are necessary to enable the NHS to find £20 billion in productivity improvements and to effectively meet the health needs of society. They represent “the biggest shake-up of the NHS since its inception and will be implemented against the backdrop of the biggest financial challenge in its history”\(^1\). Comprehensive and complex organisational changes on this scale can be considered to be ‘frame breaking’ or discontinuous change involving sharp and simultaneous shifts in strategy, power relations, structures and control mechanisms\(^2\). They are pervasive, affecting the whole system; deep, requiring a paradigm shift; and large scale, covering the entire country and the entire workforce of the NHS and its partner organisations\(^3\). The reform of the NHS is therefore an enormous change project and challenge, particularly given that, historically, administrative reforms in the UK public sector have frequently failed to meet publicly-declared objectives\(^4\).
Overview of our research

From October 2010 to October 2011 we studied how senior managers in the NHS have been leading the transformation of services in their organisations. We explored two questions:

- How are senior managers responding to and dealing with the changes to the NHS that they are experiencing in their roles?
- How are they engaging different stakeholders to facilitate the process of change in their institutions?

Our research involved:

1. In-depth interviews with 18 senior managers in a variety of health settings including: Acute, Primary Care, Strategic Health Authorities and Mental Health. These interviews explored how individuals are leading the transformation of services in the NHS.

2. Observations from our consulting work with ten senior managers in the NHS over a period of eight months to support them in leading change in their organisations.

3. Our observations from two NHS Trusts with whom we consulted over the period of the study to help them to transform their structures and services.

What do the reforms require leaders to do?

Translating policy into local practice

Senior managers and clinicians are grappling with translating the macro policy guidelines set by central Government into workable and viable local practices. This involves changing and re-configuring services to identify cost savings and making efficiency improvements. It requires action to turn the abstract principles into tangible changes which account for the realities of service provision and the local pressures and tensions confronting their institution. It also requires negotiation with external bodies and stakeholders to ensure multiple interests and agendas are represented.

To achieve this task, managers have to exercise judgement and considerable creativity. Many of the decisions that need to be made are emotionally demanding — for instance making staff redundant, transferring services to other organisations or scaling back or closing down services. This has particularly been the experience of managers in Primary Care Trusts whose experience over the past two years has involved preparing for the closure of their organisations and the transfer of services to other parts of the NHS.

Vertical and horizontal integration of services

NHS managers and clinicians are trying to protect and improve the quality of services by finding synergies and efficiency savings through the integration services across geographical and institutional boundaries. In effect this is a strategy of vertical and horizontal integration. It involves merging organisations and departments, forming alliances across different service providers, setting up GP Consortia, creating integrated care pathways and forming partnerships across Providers.

Creating new organisations

Many managers and Heads of Clinical Services reported that they are involved in creating new forms of organisations. Metaphorically, some managers are building new organisations, others are knocking them down and others are renovating them. This requires them to make decisions around what form of organisation is required to deliver the required level of service; how to re-design services and processes and how to develop business cases to inform re-structuring of organisations. Many, particularly those from a clinical background, felt under-skilled for this work, having limited knowledge and expertise in designing organisation structures and forms.

Maintaining morale

During the process of change, managers are working hard to maintain morale and to help employees’ understanding and accept the changes that were happening in their part of the system. For many senior managers this task is being made extremely difficult, either because they personally do not agree with their perception of the ideology behind the NHS reform or because they are themselves adversely impacted by the reforms.

A senior manager in a PCT observed she fundamentally disagreed with the principles behind the reforms and the political process by which the Health and Social Care Bill was introduced, and she was aware she was very likely to lose her job. She felt it was very difficult for her to respond constructively to staff who were angry about the changes or were anxious about their future because of her own anger and anxiety about the changes.

In her organisation, she was aware that her colleagues held similar views — however their Executive had made it clear that they did not want people to express their resistance and opposition to the reforms.
What can be learnt about organisation change from the NHS reforms?

On the basis of our research, we have outlined below a number of observations about how leaders are establishing the conditions that support complex organisation change.

The need to make decisions that have consequences

In implementing the reforms, senior managers and clinicians have had to make complex decisions which have consequences for many stakeholders and are not easily reversible. For these decisions to realise a meaningful impact they require the support of multiple stakeholders. The process of decision making therefore is critical to whether local changes are supported or not. Decisions around how the reforms are implemented are also setting the tone and climate of the relationships between staff and the NHS for years to come.

Complex and demanding decisions have personal consequences for those making them. In many cases, the decision that is in the interests of the reforms is experienced to contradict with those of their institutions, their professional body or their personal interests. These contradictions give rise to dilemmas, tensions, anxieties and doubts, including:

- How to transform services whilst simultaneously meeting operational and quality targets?
- How to motivate people when you are shutting down services and feel insecure about your own future?
- How to balance patient care and quality with financial constraints?
- How to protect one’s own interests when they conflict with what one is being asked to do?
- How to ensure people support critical decisions whilst making them within limited time constraints?
- How to communicate the rationale for a decision when it is based on sensitive and confidential information?

In parts of the system, psychological insecurity is evoking survival anxieties and defensive behaviour

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Survival behaviour

In such a context, the leadership task of engaging people in change and encouraging collaboration on the task of change becomes extremely challenging

Figure 1. The role of mutual trust as a core condition for organisational change
Survival anxiety works against change

The speed, size, uncertainty and ambiguity of the changes have left many staff feeling powerless, out of control and helpless. Clinicians and managers are worried that transforming services, whilst simultaneously cutting back on expenditure, could lead to mistakes, falls in the quality of services and potentially harm to patients. This is provoking considerable anxiety and strong emotions, such as anger, guilt and fear.

We observed in some NHS institutions what we have termed ‘survival’ behaviour (see Figure 1). This is characterised by individuals attempting to protect themselves by looking after their own interests, avoiding or denying threats or difficult issues, or attacking others who may be perceived as a threat. These behaviours can be understood as a fight/flight response as individuals attempt to manage their anxiety in the face of perceived threats and risks. Real or imagined threats include professional risks, such as putting patients at increased risk or being blamed for mistakes in practice; personal losses such as losing one’s job or hard won career prospects; the anger and hostility of employees’ reactions and anger about the changes; and feeling threatened and overwhelmed by the magnitude and scale of the transformation agenda.

Managers’ accounts indicated that when survival behaviour was present it is very hard to engage staff constructively in the process of change. In these contexts, staff viewed service reforms to be a threat that was outside of their control. It represented a disruption to their working environment which they wanted to prevent or deny, rather than engage with and enable.

In our consulting work, we have discovered the importance of providing space for individuals and groups to meet and make sense together of the growing commercial and financial pressures on the NHS. Survival anxiety works against constructive change.

Mutual trust is essential for successful change

We noted that the levels of trust in a given social system vary, depending on the history of relationships and events in the past; the extent to which the different parties understood the motives and interests of others; the extent to which individuals or groups were perceived to act consistently and possess credibility; and the level of risk and uncertainty that was present (see Figure 2). Low trust environments were characterised by historical mistrust between organisations and professional groups, the experience of hierarchical pressure to conform to policy changes, opposition to the ideology behind the reforms, and ‘unspoken’ emotions of fear and anger.

In contexts of low trust, anxiety and fear associated with organisation change was amplified. Different stakeholders perceived other actors in the system as possible threats whose motives may lead them to act in a manner that is in opposition to their interests. These conditions are likely to lead to survival behaviour which, as we have argued above, acts against constructive change.

In low trust environments, managers reported the presence of the following range of responses by staff:

- Criticism and suspicion of other organisations and professional groups. For instance, senior clinicians would continuously question and challenge managers’ intentions behind decisions and oppose their proposals for change.
- Opposing changes based on a cynical interpretation of the motives of those proposing them or because they perceived the changes to be imposed upon them. For instance, one clinician stated: “We must accept it even though we do not believe in it.”
- Passive opposition to changes, such as failing to complete tasks on time, not responding to requests for information or general apathy and low commitment to changes.

Trust therefore appears to be a necessary condition for change where there is uncertainty and a level of risk.
A senior manager in a PCT told us how she is trying to lead the transition of services from her PCT to newly established GP Consortia, whilst her organisation is in the process of being dissolved. She commented that: “At times it feels like it is payback time for the GPs”. She found that despite her best intentions the GPs did not trust her advice or dismissed her suggestions. At the same time, she was suppressing her feelings and emotions around the closure of her organisation as she felt she was “expected to toe the party line”.

A Medical Director in an acute hospital described how she felt trapped between the board of her institution and the clinical consultants who distrusted ‘management’. She was trying to work with other hospitals in the region to share specialist staff between them and make significant financial savings. She was experiencing much opposition despite the strong financial case to work together, because it would mean clinical staff being dependent on colleagues in other hospitals whom they did not trust.

A case of how participation and involvement develops mutual trust

In one Mental Health NHS Trust where we worked for nearly 12 months, the Executive Board has established a group of 50 internal change agents who are working across the Trust to engage staff in the process of change. They are taking a highly participative approach in which employees are encouraged to gather stories of effective performance that represent the Trust at its best. Employees are being encouraged to identify small actions and interventions that will amplify the behaviours and values they perceive to represent effective practice. This process is enabling individuals to express themselves and it implicitly communicates to staff that the senior management trusts them to act in the interests of the Trust. We have observed that as trust develops through this process, managers and staff are more willing to work together on a shared agenda of service improvement and to take risk in their relationships.

Political dynamics are amplified in contexts of mistrust

Heightened anxiety and distrust also amplify covert political dynamics as individuals seek to protect their interests by forming coalitions and hiding feelings or opinions that are not considered to be expressible in public. We interpreted political behaviour to both support change and learning, and operate to block or act against change. Individuals view the comprehensive organisational changes through the filter of their own emotional and political concerns.

Political acts included: presenting a public view which contradicted one’s own views on the changes — forming coalitions to protect one’s position, spreading gossip and misinformation to undermine the agendas of others, making deals behind the scenes with other stakeholders and manipulating statistics to present information in a favourable manner. Much of this behaviour can be understood as a response to real or imagined fears about how individuals in positions of authority or other groups will judge them. For instance, in one NHS Trust, senior managers expressed concerns about a programme of service transformation that was being demanded by the Board of the Trust. Most of the management team felt it was unsafe to express their views in public, because when they had in the past they were attacked or criticised by members of the Board. This led them to express their resistance through a lack of commitment to specific changes or to express their complaints and concerns about the changes to colleagues with whom they felt safe.

How leaders are developing mutual trust

To establish trust is paradoxical. To develop trust requires both parties to be willing to make themselves vulnerable to others, which individuals tend to be reluctant to do when they mistrust the other. Trust develops slowly and requires both parties
to progressively take greater risks with each other in order to demonstrate that they trust the other party. When trust is low, leaders need to take the risk to explore the quality of the relationship and the underlying dynamics of mistrust if there is going to be an opportunity for trust to develop. This is best done by each party taking small risks with each other rather than taking giant leaps of faith. The paradoxical dynamic of trust building, based on the work of Vangen & Huxham⁹, is illustrated in Figure 3 below.

Our research indicated that managers facilitate the development of mutual trust by:

- Helping staff to make sense of what is changing in their part of the organisation and why
- By openly and transparently sharing information with staff and other stakeholders, even when the information is unlikely to be received favourably. This requires managers to be explicit about what they know and what they do not know: for instance, some timescales will be known and others will remain undecided or open to negotiation.
- Listening to employees’ concerns and opinions. Research revealed that being listened to and treated with dignity and respect increases employees’ trust¹⁰.
- Reframing changes to help staff understand how they can take control and influence the changes in their part of the system. For instance, one leader had engaged her staff by saying to them: “We have a choice of how it is done rather than letting it be done to us”. This intervention gave staff permission to take control and responsibility for transforming their services.
- Working politically across organisation boundaries to build connections, dispel rumours, develop shared agendas and looking for opportunities for integrating services.
- Supporting stakeholders to make sense of what is changing and how. This includes helping staff to understand how and why they are experiencing specific reactions to changes in their organisations and helping them to prioritise activities.

The interaction between line managers and those they manage is important in relation to the generation of perceptions of fairness about organisation change. In our work with managers we observed how much of this work goes on behind the scenes and is not visible or cannot be measured. Managers experienced it as difficult and emotionally demanding. It requires a strong sense of personal conviction that people can be trusted. Fundamentally, it requires leaders to exercise compassion for others and demonstrate empathy for the pressures and anxieties they experience in their work. We can only empathise with others if we take responsibility for our own feelings and emotions and we have the emotional reserves to meet others in their distress or anxiety. We believe therefore that it is important that leaders have sufficient support from others to be able to help their teams work through the process of change.

Conclusion

Our research indicates that mutual trust is a core condition for supporting effective decision making and enabling organisation and behaviour change. If leaders are to successfully introduce complex change then they need to pay attention to the quality of relationships and particularly to the levels of mutual trust that are present in the organisation system. This requires an active focus on developing the quality of relationships across groups and with individuals.
How Ashridge is supporting change in the NHS

NHS London teamed up with the King’s Fund and Ashridge on Action Learning for Senior Leaders, a highly successful development process which enables both Non-Executive Directors (NEDs) and Executives to work in a more effective manner. Over the course of a year, small diverse groups tackled important organisational issues, with members of the group taking turns to share in confidence with the rest of the group.

The owner of the issue explored options, identified ways forward and was challenged, encouraged and supported to take effective action. With the help of a facilitator, all members reflected and learned from each other. Members of these Action Learning sets also built a network with other senior leaders that they have been able to continue to utilise.

The process worked towards good listening and skilful questioning, in particular how to question, as well as soft skills of when to show empathy and when to be sharp and assertive. It provided a safe environment for Executives to ask questions, to check their assumptions and to take action to introduce changes in their organisations.

The end result has been a series of positive responses from both NEDs and Executives.

“Provided an opportunity to have support. I certainly personally don’t have access to anything like this!” – Executive

“I have been able to prioritise issues and understand the value of my contribution, which has increased my confidence. This is particularly important if your background is non-NHS.” – Non-Executive

Ashridge and the NHS

Ashridge Consulting has been working in the NHS for many years with clients such as the National Institute of Health Research, the Health Foundation, the NHS Leadership Academy, NHS London, NHS Midlands and a number of NHS Trusts.

“I always used to jump in with both feet, now I think ‘what do you want to get out of this and who am I seeking to influence’, before I act.” – Non-Executive

“...not just that you start to question more, but that you develop a methodology of HOW to question and challenge and have a safe space in which to trial those skills.” – Non-Executive

References

1. The King’s Fund (2011) www.kingsfund.org.uk

Further reading