

## **The Health Services Management Innovation Council**

### **Management Innovation Learning Sets**

#### **Ten learning set tools for achieving change, understanding people and problem analysis in organisations.**

The ten tools described in this document are those that have been particularly useful as part of the Management Innovation Learning Sets program, as compiled by the learning set facilitators (see below). These tools helped facilitate increased understanding, provided a framework for discussion or reminded participants of important aspects of change and innovation. It is a short list in terms of the myriad of tools available, but was developed on the basis that they address common issues raised in the sets, and provide useful as a first step. Some tools are reproduced with permission and others are adapted from a number of sources. The tools are grouped into three categories:

#### **1. Achieving change**

- 1.1 'Changing the Beliefs' Culture Change Model
- 1.2 Roadblocks to Change
- 1.3 Change Impact Statement

#### **2. Understanding people**

- 2.1 'DKRS' Enabling Empowerment Checklist
- 2.2 'DISC' Behaviour Inventory
- 2.3 'Delegation Decision Tree Model
- 2.4 Handling Difficult People

#### **3. Problem analysis**

- 3.1 Problem Solving Steps and Tools Model
- 3.2 Force Field Analysis
- 3.3 The Four Worlds of Healthcare.

A brief overview and description is provided for each tool, and templates are supplied where relevant. The document is not a detailed guide to these tools, but an introduction to how management tools can assist in the planning and implementation of innovation. References are supplied for further investigation if desired.

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***Management Innovation Learning Sets Facilitators.***

## **1. Achieving Change.**

### **1.1 “Change the beliefs” Culture Change Model**

#### ***Overview***

The Culture Change Model is an approach to understanding the foundations of organisational culture, and using that understanding to effect sustainable culture change.

#### ***Description***

Culture is often identified as being at the core of undesirable organisational behaviour that leads to poor results. Changing culture is perceived as difficult, and is often addressed by changing organisational rules in an attempt to modify group behaviour. This seldom produces the desired results and may increase staff resentment and push back.

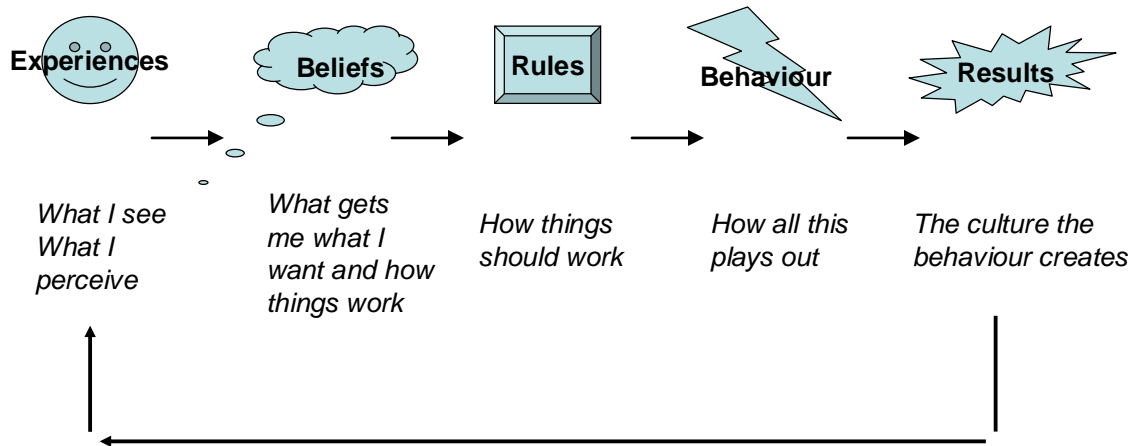
The “change the beliefs” model shows that behaviour is based on people’s experiences, which in turn create their beliefs about how the organisation/department/team should work, and which behaviours are therefore acceptable. If these behaviours are not achieving the desired results, it is important to take some time to:

- identify the behaviours of the group
- pinpoint the beliefs that are therefore appear to be creating the behaviours
- explore the experiences that may be creating those beliefs
- change those experiences to create new beliefs (see diagram).

An example of this is an organisation that has a culture of bullying. The Chief Executive consistently circulates memos and makes speeches about not tolerating bullying, but the bullying continues. Staff believe what they see – the bullying – rather than what they hear – the words of the CEO. Therefore bullying continues to be tolerated, as the belief is: ‘bullying is OK around here’ and the informal rules around ‘acceptable’ behaviour for ‘fitting in’ to the organisation are created accordingly. Changing the formal rules, but not the beliefs, is unlikely to change behaviour. Staff have to see the Chief Executive punishing bullying behaviour consistently to change the beliefs about it, and therefore the informal rules, behaviours and results emanating from that behaviour.

## Changing culture: changing experiences to change beliefs and behaviour

Culture develops from individual and collective experiences, which forms beliefs and rules about how the world works – or should work, which influences behaviour and results. To change results, start by changing what people experience.



### Reference

*Adapted from:*

Scott T, Mannion R, Davies H, Marshall M, 2003, Healthcare Performance and Organisational Culture. Radcliffe Publishing, UK.

Balestracci D, 2007, Change Management Workshop. [www.dhbarmony.com](http://www.dhbarmony.com)

Miller J, 2004, QBQ! The question behind the question. Putnam Publishing, US.

## 1.2 Roadblocks to Change

### **Overview**

The 'Roadblocks' concept is a useful tool for people to identify real and perceived roadblocks they face when:

- Dealing with change
- Implementing a new program/innovation
- Improving work performance.

### **Description:**

When reviewing the performance of people within an organisation, colleagues of Simmerman noted that the poor performers identified a larger number of roadblocks, real or perceived, that were inhibiting their performance than those people demonstrating exemplary performance.

Analysis showed that the performance difference was related to the employee's perceptions about his or her own power to remove the roadblocks so as to higher level performance.

The analogy was found to be relevant in areas other than staff performance. Roadblocks fall into four categories that can be applied to any situation. The categories are:

### **Category 1 - THE BRICK WALL**

The immovable and real roadblock which may inhibit performance and is unlikely to be changed by the individual or organisation. For example, government policy, the funding models, the organisational structure, etc. These are all factors which affect employee performance but are well beyond individual or collective control.

### **Category 2 - THE PARTITION**

The second category of roadblocks are those that can be managed with effort, time, money and/or additional personnel, or other resources. The individual might make some progress in overcoming this roadblock. However, a small team can make even more progress and this type of roadblock can be managed with the support and assistance of managers. This type of roadblock is characterized as a partition, since a partition, if pushed from the bottom, might move slightly, but if pushed from a higher level will often topple. These are real roadblocks which the employees require assistance to remove.

### **Category 3 - THE PAPER WALL**

The paper wall looks like it can't be broken but when people test this perception they find they can get through. There are many workplace examples, such as the belief that the manager will not approve the new process, that it won't be supported by another department, that it is "policy" or the way things have always been done, etc.

Staff discover that these beliefs aren't true when they test these perceptions. For example, other departments have done things differently and are doing things differently.

## **Category 4 - THE MINDSET**

This type of roadblock is the hardest for managers to address as it represents the untested beliefs and perceptions. The Mindset roadblock is the most common of all the different types and the ones that block the below average performers from improvement.

In the workplace, top performers are willing to test the roadblocks to see which are which and are quick to refer the Category 1 and 2 roadblocks to management whereas they push through the 3s and 4s. Average performers may try to move the Category 1's, even with out the power to do so, and spend a lot of time on the 2s as individuals rather than tackling it as a team. Poor performers generate long lists of roadblocks that get in the way of getting things done.

### ***Using the tool***

The model is simple, requires little preparation and therefore can be used in a planned or spontaneous fashion.

- Ask people to identify the 'roadblocks' to getting things done. This could be done as a group or individually.
- Brainstorming the ideas and writing them up on a flip chart/white board is useful.
- When the list is complete, describe the 'Roadblock' concept, describing the categories and the general frameworks of each.
- Go back to the list and categorise the roadblocks.

Expect to find that 80% of the roadblocks will be 3s and 4s and that the top performers will often offer everyone suggestions as to how to manage the 2s more effectively. The Category 1 roadblocks are those that you should escalate to senior management and some of the 2s might be addressed by a team.

Celebrate any ideas for improvement and attempts to address specific problems.

An example of a worksheet which could also be used is provided over the page.



### **Overview**

A Change Impact Statement is a tool that is used to identify and assess the anticipated or actual impacts of a change.

### **Description**

The Change Impact Statement is a useful tool when planning to implement change or for review of a change after implementation to provide information for improving the design of future changes.

The Change Impact Statement provides a structured approach for identifying and assesses the impact of the change in a number of areas. The tool can be used in a number of settings: for managers planning change; for use with groups of staff within one service/department/unit; or through a multidisciplinary approach.

### **Using the Tool**

The Change Impact Statement covers eight major areas:

- Brief Description of Change Proposal
- Current Situation
- Proposed Situation
- Benefits and Cost Savings of Proposed Changes
- Effects of Change Proposal on Staff
- Changes of Terms and Conditions of Employment
- Effects of Proposal on Services/staff in other Departments
- Consultative Mechanisms planned or undertaken

Each of these sections is completed by the appropriate staff. The issues may be brainstormed or gathered in other ways.

The Change Impact Statement is endorsed by the appropriate manager/s and can be used to communicate the impact of a proposed change.

An example of a Change Impact Statement is provided below.

### **Reference**

Carlopio J, Andrewartha G, Armstrong H 2001, Developing Management Skills. Prentice Hall, Australia.

**EXAMPLE**

**CHANGE IMPACT STATEMENT**

<b>ORGANISATION:</b>	
<b>DEPARTMENT: (if applicable)</b>	<b>Ambulatory Services / Primary Care</b>
<b>PROGRAM: (if applicable)</b>	<b>Ambulatory Services / Primary Care</b>

**1. Brief Description of Change Proposal**

- Establishment of a different model of managerial support for Primary Care and the creation of a new managerial structure for Primary Care and Quality Management
- Establishment of a different model of managerial support for a range of nursing programs
- Rearrangement of internal duty allocation as necessary
- Timing – as soon as practicable

**2. Current Situation**

- Existing Medical Ward NUM workload has been assessed as excessive
- Existing positioning of the Community Nursing Service under the control and guidance of the Primary Care Manager has been reported and assessed as inappropriate
- Review of existing organization structure has supported the need for an alternative management structure to be instituted

**3. Proposed Situation**

- Create a new position – “Ambulatory Services NUM” to manage nursing services including – HITH, Palliative Care, Cancer Support and Community Nursing
- Transfer the Community Nursing Service from control of the Primary Care Manager to the Nursing Division
- Create a new position – “Director of Primary Care and Quality Management” to manage and lead Allied Health and Primary Care activities and provide direction to quality activities

**4. Benefits and Cost Savings of Proposed Change (if appropriate)**

- Improved service delivery and output
- Improved monitoring of Departmental performance to ensure effectiveness and efficiency
- More direct involvement of Community Nursing in Nursing Division operations – communication / reporting linkages simplified
- Elevation of Primary Care and Allied Health level of accountability to the Executive

**5. Effects of Change Proposal On Staff In Your Department (include aspects such as EFT numbers, shift/penalty rate changes, location changes, etc. If available, list staff who may be impacted)**

- Position of existing full-time permanent post of Primary Care Manager no longer required within Organisation
- Net reduction in EFT – NIL
- Adjustment to reporting relationship of Community Nursing and other services within the Nursing Division

**6. Will Staff Have To Be Retrained to Achieve Proposal?**

- Opportunities for redeployment or retraining of impacted staff will be explored
- Changes reflect a realignment of activities / reporting relationships and will require minimal training

**7. Measures to Mitigate Effects on Staff**

- Incumbent Primary Care Manager to be offered opportunity to apply for other roles commensurate with experience available within Organisation
- If necessary offer redundancy as per Public Sector Package Guidelines for a “Targeted Separation”
- Offer of counselling / outplacement assistance
- Discussions (when appropriate) with all staff to advise of changes
- Communication with whole Organisation to clarify on-going reporting relationships / work flows

**8. Effects of Proposal On Services / Staff In Other Departments**

- Minimal impact
- See #7 re communication with whole of Organisation

**9. Timeframe and Dates For Proposed Change**

- Advise Primary Care Manager during w/c 30 May 2005
- Newly created roles to be advertised on or about June 10
- Finalisation of change when recruitment / selection / appointment activities are completed.

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**Chief Executive Officer**

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**Divisional Director**

## CHANGE IMPACT STATEMENT

Campus:

**Change Title:**

**1. Brief Description of Change Proposal**

Broad description of the nature and rationale for the change:

**2. Current Situation**

**3. Proposed Situation**

**4. Benefits and Cost Savings of Proposed Changes**

**5. Effects of Change Proposal on Staff**

Areas Involved

Staff affected

Unions Involved

**6. Changes of terms and Conditions of Employment**

Relocation of staff

Changes to existing shift patterns

Changes to existing rostering patterns

Changes to existing classification

Other relevant issues

Options considered reducing the negative impacts on staff

[Re}training required

**7. Effects of Proposal on Services/staff in other Departments**

**8. Consultative Mechanisms**

Meetings to date

**Author**

**Date**

## 2. Understanding people

### 2.1 DKRS: Enabling empowerment checklist

#### **Overview**

DKRS stands for 'Direction, Knowledge, Resources and Support'. The checklist has been developed as a guide to empowering staff to own and manage change and improvements. The content is derived from a number of sources (see References) and provides an overview of the key elements of empowerment. The key to the model is that each element is required to be present for true empowerment to occur.

#### **Description**

Much of the research on empowering staff in organisations to take ownership of change reports that staff require leaders to provide four key enablers: Direction; Knowledge; Resources; and Support (DKRS: see Diagram).

**Direction:** Staff need to be clear about the objectives of any change and their role in it. The more specific this can be, the easier it is to enact. This includes the overall rationale and objectives of the project, the expectations of the team or individual in terms of their contribution to the overall objectives, how this will be tracked and measured, and their scope and boundaries. Clarity around what is in scope and what is not, and the decisions that staff in various planning and implementation roles are free to make, enhances confidence and creativity and minimises the risk of unexpected or unhelpful actions that interfere with project progress. A collaborative approach to agreeing these elements of empowerment with the people involved sets a strong foundation for staff ownership and sustainability.

**Knowledge and Skills:** One of the barriers to staff participation in change is a real or perceived lack of ability to enact the changes, particularly if this involves learning a new technical skill, data collection and analysis, or even a different interaction with colleagues, such as running a meeting, or facilitating a brainstorming session. Ensuring roles in change are clear, helps define the skills require to enact that role, and empowerment requires staff to be confident in their ability to fulfill that role through relevant training. Similarly, empowering staff to own a change may require new information to be shared with them, so that they can make good decisions within the role boundaries agreed.

**Resources:** It is unlikely that staff will be able to drive systems change as an add-on to their substantive role. To achieve ownership of significant and sustained change, staff need to feel that their contribution is valued through the provision of resources such as administrative and data support and backfill to take them off line, even for short periods. The right tools for the job are also essential, and these can range from access to computers and software, to data analysis, presentation and change tools. New tools require staff access to training. Resources can also involve funding catering, whiteboards and room hire to facilitate stakeholder meetings.

**Support:** This may be the most obvious component of empowerment, but effective support for ownership of change requires a planned and consistent effort. Regular time is required for coaching and feedback, recognising that change in complex environments such as health services is likely to require many course corrections as unexpected barriers and resistance are encountered. Recognition is a powerful tool – not only of positive results, but of effort, constructive process and learning from mistakes.

***DKRS: Empowering people to own and drive change and improvement:  
 Checklist***

<p><b>Direction</b></p> <ul style="list-style-type: none"> <li>•key result areas</li> <li>•goals</li> <li>•measurements</li> <li>•role responsibility and boundaries</li> <li>•scope</li> </ul>	<p><b>Knowledge and skills</b></p> <ul style="list-style-type: none"> <li>•job, team and organisational information</li> <li>• job and technical skills</li> <li>•interpersonal, conflict and decision-making skills</li> </ul>
<p><b>Resources</b></p> <ul style="list-style-type: none"> <li>•tools</li> <li>•materials</li> <li>•facilities</li> <li>•time</li> <li>•money</li> </ul>	<p><b>Support</b></p> <ul style="list-style-type: none"> <li>•approval</li> <li>•coaching</li> <li>•feedback</li> <li>•encouragement</li> <li>•reinforcement</li> <li>•recognition</li> </ul>

The bottom line: *Each of these components must be present to enable people to take ownership of change.*

**References**

*Developed and adapted by Qualityworks P/L from:*

Balding C 2005, Strengthening clinical governance through cultivating the line management role. AHR, vol. 29, no.3.

Byham WC, Cox J, 1998, Zapp! The lightning of empowerment. Random House Publishing Group, New York.

Byham WC, Nelson, GD, 1994, Using employee empowerment to make quality work in health care. Quality Management in Health Care, 2(3):5-14.

Murrell K, Meredith M, 2000, Empowering Employees. McGraw-Hill.

NHS, 2008, Quality Improvement: Theory and Practice in Healthcare, National Health Service, UK.

## 2.2 The DISC Behavioural Inventory

### **Overview**

DISC is a group of psychological inventories developed by John Geier and based on the work of psychologist William Moulton Marston undertaken in 1928. It is a four quadrant behavioural model which looks at an individual's behavioural style and behavioural preferences. The purpose of personality and temperament type models, such as DISC, is to help people enhance communication, understanding, and improve personal relationships by:

- thinking about how you come across to other people.
- thinking about the styles of those you work with.

### **Description**

The assessment classifies four aspects of behaviour by testing a person's preferences in word associations. DISC is an acronym for the four elements:

- **Dominance** - relating to control, power and assertiveness
- **Influence** - relating to social situations and communication
- **Steadiness** - relating to patience, persistence and thoughtfulness
- **Conscientiousness (or Compliance)** - relating to structure and organisation.

### **Specific characteristics for each element are:**

- **Dominance:** People who score high in the intensity of the 'D' styles factor are very active in dealing with problems and challenges, while low D scores are people who want to do more research before committing to a decision. High "D" people are described as demanding, forceful, egocentric, strong willed, driving, determined, ambitious, aggressive, and pioneering. *(8% of the population)*

Low D scores describe those who are conservative, low keyed, cooperative, calculating, undemanding, cautious, mild, agreeable, modest and peaceful.

- **Influence:** People with High I scores influence others through talking and activity and tend to be emotional. They are described as convincing, magnetic, political, enthusiastic, persuasive, warm, demonstrative, trusting, and optimistic. *(12% of the population)*

Those with Low I scores influence more by data and facts, and not with feelings. They are described as reflective, factual, calculating, skeptical, logical, suspicious, matter of fact, pessimistic, and critical.

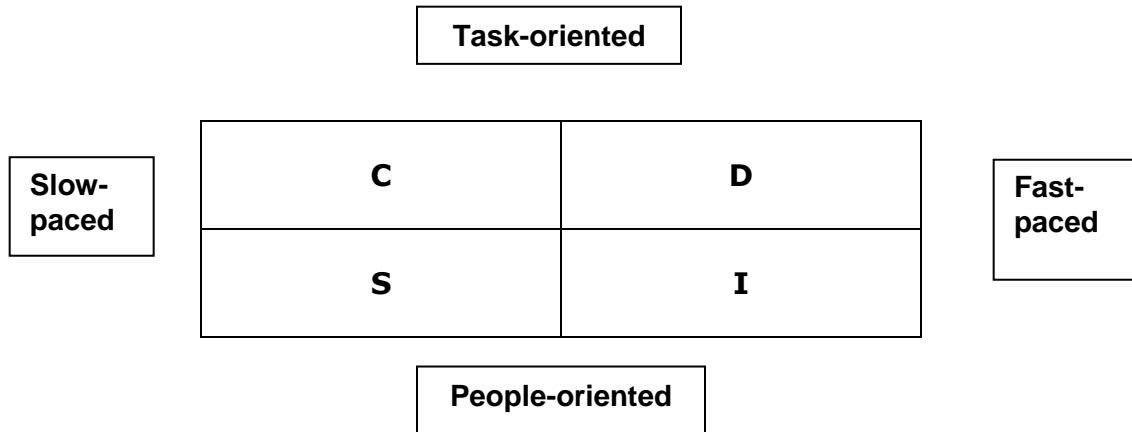
- **Steadiness:** People with High S styles scores want a steady pace, security, and don't like sudden change. Low S intensity scores are those who like change and variety. High S persons are calm, relaxed, patient, possessive, predictable, deliberate, stable, consistent, and tend to be unemotional and poker faced. *(68% of the population)*

People with Low S scores are described as restless, demonstrative, impatient, eager, or even impulsive.

- **Conscientious:** Persons with High C styles adhere to rules, regulations, and structure. They like to do quality work and do it right the first time. High C people are careful, cautious, exacting, neat, systematic, diplomatic, accurate, and tactful. (*12% of the population*)

Those with Low C scores challenge the rules and want independence and are described as self-willed, stubborn, opinionated, unsystematic, arbitrary, and careless with details.

**These four dimensions can be grouped in a grid as follows:**



Communication and behavioural styles vary in *pace and priorities*. People may be fast or slow paced and may be task-oriented or people-oriented.

**Fast-paced** individuals are active; assertive; competitive; leading; outgoing; risk-taking and taking charge (D and I preferences).

**Slow-paced** people are: cautious; listening; not risk-taking; quiet; reserved; security seeking and shy (C and S preferences).

**Task-oriented** people are more comfortable with "doing things". They make decisions based on the facts. (C and D preferences)

**People-oriented** individuals enjoy "being with people". They are seen as warm, caring, sensitive, feeling, and compassionate. (S and I preferences)

***To use the tool:***

1. Provide minimal background on the tool.
2. Read through the Behavioural Style Questionnaire (see attached).
3. Tick those points that relate to you.
4. Add the ticks up in each quadrant. The quadrant with the most ticks is your preference. (The quadrant descriptions fit with the order shown in the grid above. An example is given below. In this example, the individual's preference is 'I'.)
5. After completing the tool, describe the DISC methodology.

**Behavioural Style Questionnaire**

**EXAMPLE**

Gives priority to detail and organisation	✓	Gives priority to achieving results	...✓....
Sets exacting standards	.....	Seeks challenges	.....
Approaches tasks and people with steadiness	.....	Approaches tasks and people with clear goals	.....
Enjoys research and analysis	...✓....	Is willing to conform	.....
Prefers operating within guidelines	.....	Makes decisions easily	...✓....
Completes tasks thoroughly	.....	Is keen to progress	.....
Focuses attention on immediate task	.....	Feels a sense of urgency	.....
Likes accuracy	.....	Acts with authority	...✓....
Makes decisions on thorough basis	.....	Likes to take the lead	.....
Values standard procedures highly	.....	Enjoys solving problems	...✓....
Approaches work systematically	.....	Questions the status quo	.....
Likes to plan	...✓....	Takes action to bring about change	...✓....
	<b>C</b> ...3....		<b>D</b> ...5....
Gives priority to supporting others	...✓....	Gives priority to creating a friendly environment	...✓....
Enjoys assisting others	.....	Likes an informal style	...✓....
Approaches people & tasks with quiet and caution	.....	Approaches people & tasks with energy	...✓....
Has difficulty saying no	...✓....	Emphasises enjoying oneself	...✓....
Values cooperation over competition	...✓....	Rates creativity highly	...✓....
Eager to get on with others	.....	Prefers broad approach to details	...✓....
Willing to show loyalty	...✓....	Likes participating in groups	...✓....
Calms excited people	.....	Create a motivational environment	.....
Listens well / attentively	.....	Acts on impulse	.....
Prefers others to take the lead	.....	Willing to express feeling	.....
Gives priority to secure relationships	...✓....	Enjoys discussing possibilities	...✓....

and arrangements

Prefers steady not sudden change ..... Keen to promote change .....

**S** ...5... **I** ...8...

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### Behavioural Style Questionnaire

Gives priority to detail and organisation	.....	Gives priority to achieving results	.....
Sets exacting standards	.....	Seeks challenges	.....
Approaches tasks and people with steadiness	.....	Approaches tasks and people with clear goals	.....
Enjoys research and analysis	.....	Is willing to conform	.....
Prefers operating within guidelines	.....	Makes decisions easily	.....
Completes tasks thoroughly	.....	Is keen to progress	.....
Focuses attention on immediate task	.....	Feels a sense of urgency	.....
Likes accuracy	.....	Acts with authority	.....
Makes decisions on thorough basis	.....	Likes to take the lead	.....
Values standard procedures highly	.....	Enjoys solving problems	.....
Approaches work systematically	.....	Questions the status quo	.....
Likes to plan	.....	Takes action to bring about change	.....
	.....		.....
Gives priority to supporting others	.....	Gives priority to creating a friendly environment	.....
Enjoys assisting others	.....	Likes an informal style	.....
Approaches people & tasks with quiet and caution	.....	Approaches people & tasks with energy	.....
Has difficulty saying no	.....	Emphasises enjoying oneself	.....
Values cooperation over competition	.....	Rates creativity highly	.....
Eager to get on with others	.....	Prefers broad approach to details	.....
Willing to show loyalty	.....	Likes participating in groups	.....
Calms excited people	.....	Create a motivational environment	.....
Listens well / attentively	.....	Acts on impulse	.....
Prefers others to take the lead	.....	Willing to express feeling	.....
Gives priority to secure relationships	.....	Enjoys discussing possibilities	.....

and arrangements

Prefers steady not sudden change ..... Keen to promote change .....  
.....

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## 2.3 Delegation Decision Tree Model

### **Overview**

Asking people to participate in decision making teams may lead to better participation and empowerment, but when teams are unnecessary they can result in decreased motivation and be costly for an organisation. The attached Delegation Decision Tree is a useful model to determine whether team decision making is appropriate (see diagram).

### **Description**

The model requires the manager/supervisor to consider five questions to determine when team decision making is appropriate:

1. Do I have sufficient information to make the decision?
2. Can I identify a group of people within the organisation that possess the information and expertise necessary to make the decision?
3. Can these people work together with a set of common values?
4. Is it important for the people who will have to implement the decision to be committed to the decision?
5. Will the capabilities and interests of the people participating in the team decision process be enhanced by this delegation?
6. Is there sufficient time for the team to go through the group processes to make the decision?

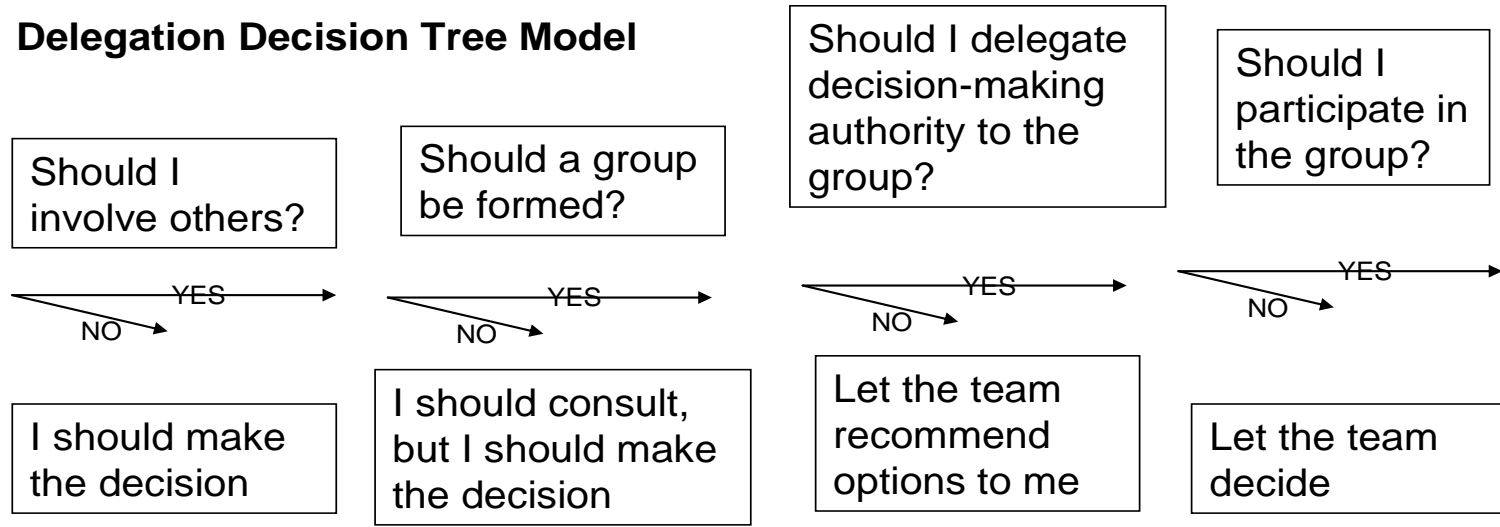
Using the answers to these questions you can work through the attached Delegation Decision Tree, which will guide you to one of four possible outcomes:

1. You should make the decision yourself
2. You should consult with the identified group of people, but you should still make the decision yourself
3. You should design the team decision making process so that the teams do not make the decision, but recommend options to you for your consideration
4. You can let the team make the decision on your behalf.
5. You can let the team make the decision, but you need to participate in the team.

### **Reference**

Carlopio J, Andrewartha G, Armstrong H 2001, *Developing Management Skills*. Prentice Hall, Australia.

## Delegation Decision Tree Model



### Involve others when:

- They possess relevant information or skills
- Their acceptance and understanding are important
- Personal development can result
- Time is not a crucial factor

### Form a team when:

- Interaction will clarify or structure a problem
- Interaction will increase motivation
- Disagreements may lead to better solutions
- Dysfunction conflicts won't arise
- Time is not a crucial factor

### Delegate to the team when:

- The team will perform competently and your time will be saved
- Motivation among team members will increase
- Sufficient information and talent exist among team members
- You can live with all likely solutions

### Participate in the team when:

- No one else can provide the leadership
- The team needs information only you have
- Your presence will not disrupt the free flow of ideas, information or feelings
- Your time would be spent productively in the team

Adapted from: Carlopio, J, Andrewartha, G & Armstrong, H (2001)  
 Developing Management Skills. Frenches Forest: Prentice Hall

## 2.4 Handling Difficult Group and Team Members

### Overview

Dealing effectively with difficult and uncooperative group and team members in a meeting situation is one of the most challenging management roles. The Table below identifies some of the common disruptive behaviours and tips for addressing them to maximise a constructive meeting process.

### Description

<b>MEMBERS WHO ARE:</b>	<b>MAY DISPLAY BEHAVIOURS SUCH AS:</b>	<b>THE TEAM LEADER CAN RESPOND WITH:</b>
Hostile	'It'll never work' 'That's a typical medical viewpoint'	'How do others here feel about this?' 'You may be right, but let's review the facts and evidence.' 'It seems we have a different perspective on the details, but we agree on the principles.'
Know-it-all	'I have worked on this project more than anyone else in the room...' 'I have a PhD in Economics and ....'	'Let's review the facts.' (avoid theory or speculation) Another noted authority on this subject has said...
Loudmouth	Constantly blurts out ideas or questions. Tries to dominate meeting.	Interrupt: 'Can you summarise your main point/question for us?' 'We appreciate your comments, but we should also hear from others.' 'Interesting point. Help us understand how it relates to our subject.' 'There is something I would like to say about that when you are finished.'
Interrupter	Starts talking before others are finished.	'Wait a minute, Jim; let's let Jane finish what she was saying.'
Interpreter	Interprets the points of others: 'What John is really trying to say is...' 'John would respond to the question by saying...'	'Let's let John speak for himself. Go ahead John, finish what you were saying.' 'John, how would you respond?' 'John, do you think Jim correctly understood how you would respond.'
Gossiper	'Isn't there a regulation that you can't ...' 'I thought I heard the General Manager say ...'	'Can anyone here verify this?' 'Let's not take up the time of the group with this until we can verify the accuracy of this information.'
Whisperer	Initiating side conversations	Walking up closely to the guilty parties and making eye contact

<b>MEMBERS WHO ARE:</b>	<b>MAY DISPLAY BEHAVIOURS SUCH AS:</b>	<b>THE TEAM LEADER CAN RESPOND WITH:</b>
		<p>Stop talking and look at the offender; keep the silence until the whisperer stops</p> <p>Politely ask the whisperers to wait until the meeting is over to finish their conversation.</p>
Silent distracter	Reads, rolls their eyes, shakes head, and fidgets.	Ask questions to determine their level of interest, support and expertise. Try to build an alliance by drawing them into the discussion. If that doesn't work discuss concerns with them privately.
Busy-busy	Ducks in and out of meeting repeatedly, taking messages, dealing with crises.	Preventive measures include scheduling meetings away from the office, checking with common offenders before the meeting to ask if the planned timeframe is okay for minimum interruptions. Get team to hold each other accountable, such as agreeing the group values, establishing a meeting interruption fine or other penalty, refusing to review material/decisions where the offender was not present.
Latecomer	Comes late and interrupts the meeting.	Announce an odd time (8:46) for the meeting to emphasise the necessity for promptness. Make it inconvenient for latecomers to find a seat and stop talking until they do. Establish a latecomer fine or other penalty.
Early leaver	Announces, with regrets, that they must leave for another important activity.	Before starting, announce the ending time and ask if anyone has scheduling conflicts.
Reluctant participants	Reluctant to speak.	Ask them to directly contribute to the meeting. Use structured techniques, such as smaller groups, brainstorming, or anonymous contributions.

**Reference**

*Adapted from:*

Carlopio, J, Andrewartha, G & Armstrong, H (2001) Developing Management Skills. Prentice Hall, Australia.

### **3. Problem Analysis**

#### **3.1 Problem Solving Steps and Tools Model**

##### ***Overview***

The Problem solving steps and tools model was developed to support a systematic approach to problem solution via a process of problem identification, analysis, solution and implementation with corresponding tools and methods. The model is adapted from a number of sources (see References), with a key objective to prevent early judgement on problem causes, leading to premature and inappropriate solutions.

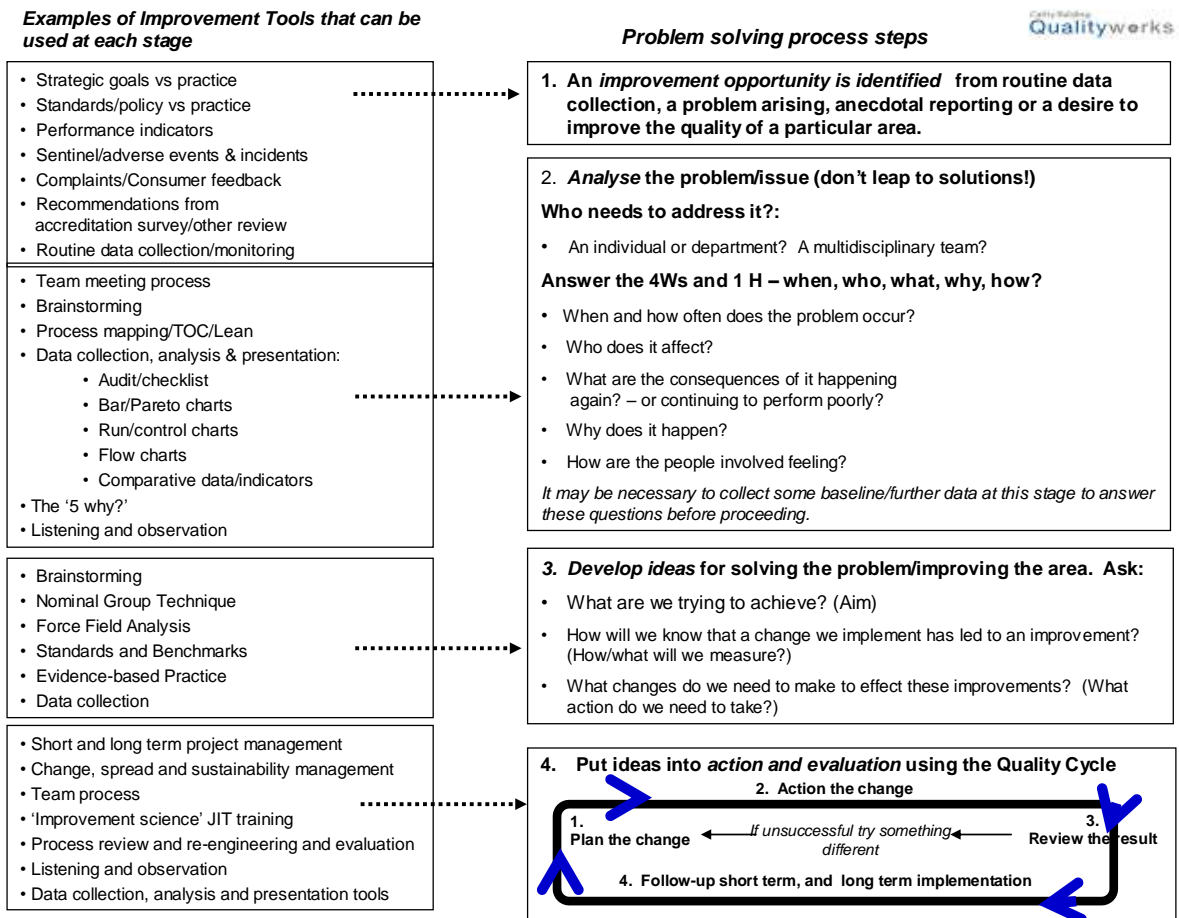
##### ***Description***

The tool is divided in four steps (see diagram for further detail):

- Problem identification
- Problem diagnosis
- Solution generation
- Implementation and review.

The model follows the quality improvement cycle, and adds a number of question prompts at each stage to assist facilitators and leaders to generate a thorough discussion of the issues. Tools to assist with answering these questions are suggested for each of the four stages. The tools are not described individually, but references for sources that describe the tools in detail are supplied.

## The Problem Solving Steps and Tools Model



### References

Developed and adapted by Qualityworks P/L from:

Associates in Process Improvement, 2008, The Model for Improvement.  
[www.apweb.org](http://www.apweb.org)

Australian Commission on Safety and Quality in Healthcare 2005. The Measurement for Improvement Toolkit. [www.safetyandquality.org](http://www.safetyandquality.org)

Cleary BA, 1995, Supporting empowerment with Deming's PDSA cycle. Empowerment in Organisations, vol 3, issue 2.

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. 1996. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey Bass, USA.

*\*\*The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study."*

NHS Modernisation Agency, 2005, Improvement Knowledge and Skills – General Improvement Skills. NHS, UK.

Tague N R, 2004, The Quality Toolbox, Second Edition, ASQ Quality Press.

## **3.2 Force Field Analysis**

### ***Overview***

Force field analysis is a useful technique for identifying and analysing the forces for and against a plan of action. It helps weigh up the importance of these factors and decide whether a plan is worth implementing.

Force field analysis can also be used to assist enhancement of a plan that is already underway.

### ***Description***

Force field analysis is a management technique developed by German psychologist, Kurt Lewin, for diagnosing situations. Lewin, who was one of the first researchers to study group dynamics and organisational development, assumed that in any situation there are both driving and restraining forces that influence any change that may occur.

### ***Driving Forces***

Driving forces are those forces affecting a situation that are pushing in a particular direction; they tend to initiate a change and keep it going. For example, in terms of implementing a new work process, support from senior management, additional funding and changes to legislation may be examples of driving forces.

### ***Restraining Forces***

Restraining forces are forces acting to restrain or decrease the driving forces. Apathy, hostility, and poor adherence to work processes may be examples of restraining forces against a new work process.

### ***Using the tool***

To carry out a force field analysis, use a worksheet or whiteboard and:

- Describe the plan or proposal for change in the middle.
- List all driving forces for change in one column, and all restraining forces against change in another column.
- When complete the lists are reviewed for 'groupings' of similar themes.
- Assign a score to each force, from 1 (weak) to 5 (strong).
- Add the scores for each side.

For a change to be successful the score of the driving forces needs to be equal to, or greater than, the forces restraining it. If it is not, then staff/managers need to consider what can be done:



- To reduce the strength of the forces opposing (restraining) the project, or
- To increase the forces pushing a project (driving).

An action plan can then be developed and implemented.

## Force field analysis

### Worksheet

In considering the ( ..... *insert issue* ..... ) you are asked to consider the factors working for you (driving forces) and against you (restraining forces) in your task. Write them below.

<b>Driving forces</b> 	<b>Restraining forces</b> 

### **Reference**

*Adapted from:*

Kurt Lewin's Force Field Analysis: [www.valuesbased management.net](http://www.valuesbasedmanagement.net)

### 3.3 The Four Worlds of Health Care

#### **Overview**

In 2001 Sholom Glouberman and Henry Mintzberg presented a model to help us understand why communication and shared decision making may be difficult in health care organisations. They suggested that there are four different worlds that are represented within the health care system as well as within most of our health care organisations. These four worlds are outlined below.

#### **Description**

In the **cure world** the doctors focus on curing patients, usually with short bursts of interventions. In contrast to the cure world, in the **care world** the nursing staff (and sometimes allied health staff) provide care on a more continuous basis. It is suggested that doctors and nurses can be seen to form clinical coalitions within the system that exclude the community and managers.

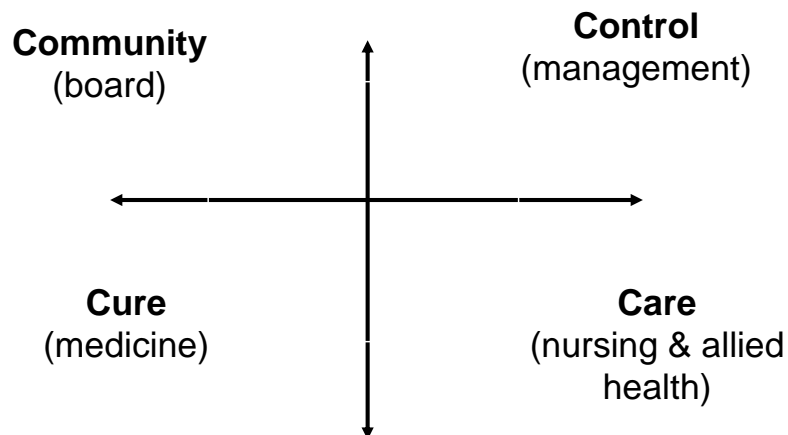
Administrators were first introduced into hospitals to assist the chief doctor. Over time the administrators have become managers with a specific role in exerting control – largely control of the resources – within health service organisations and within the system overall. The managers' perspective is represented in the **control world**. The **community world** is usually represented by a governing board that has a role in representing community interests.

The Four Worlds Model suggests that each of the worlds often have different goals for the health care service or health care system. A stronger focus on cure, on care, on control and on community interest would result in different goals and objectives, with different expectations for expected outcomes for the health care organisations, and the health care system overall. The members of each of the worlds may have a particular language or jargon associated with their world, and each of the worlds tends to have its own operating approaches. Glouberman and Mintzberg suggested that this leads to strong barriers or cleavages among the four worlds. Effective managers need to consider ways to bridge these cleavages within their organisation and within the health care system as a whole.

The Four Worlds Model can be used by health professionals and managers to consider the competing values, perspectives and desired outcomes that the worlds bring to system and organisational issues. Use of the model can assist in the planning of strategies to ensure a coordinated and collaborative approach is structured to identify and respond to health care issues. This can be achieved by considering how each of the four worlds would describe an issue, how they would analyse the impact of the issue and which solutions each of the worlds would favour. A strategy can then be designed that focuses on bringing these four worlds closer together in issue analysis and

development of shared solutions. Coordinated and collaborative strategies must address the values and perspectives of each of the four worlds.

## The 4 worlds of health care



### **Reference**

Glouberman S. and Mintzberg H. 2001 Managing the care of health and the cure of disease – Part I: Differentiation. *Health Care Management Review* Winter pp56-69.