

**AUCKLAND REGION DISTRICT HEALTH
BOARDS (DHBS)**

**REVIEW OF TRANSITION TO NEW
COMMUNITY LABORATORY SERVICES
PROVIDER**

Graeme Milne and Jens Mueller

30 September 2010

“Nothing endures but change”

-Heraclitus

TABLE OF CONTENT

	Page No
1. PURPOSE OF THIS REVIEW AND APPROACH	2
2. EXECUTIVE SUMMARY	3
3. HISTORY IN A NUTSHELL	5
4. CHANGE IN ORGANIZATINS	7
5. STEPS TO SUCCESSFUL CHANGE	11
6. SUMMARY OF RECOMMENDATIONS	33
7. CONCLUSIONS	34
8. REFERENCES	36

1. PURPOSE OF THIS REVIEW & APPROACH

The Hon Tony Ryall, Minister of Health, has directed Graeme Milne and Jens Mueller, the “Reviewers”, to review the transition process of the Auckland region laboratory services with a view to recommend learnings generated from this transition.

The Reviewers have solicited submissions to this topic through a web portal and have interviewed key stakeholders and participants in that transition. All submitters were assured anonymity, and all original submissions have been destroyed to assure that anonymity.

More than 80 submissions/interviews have been considered and are reflected in the findings and recommendations of this report. The Reviewers have no direct or indirect interest in laboratory services in the Auckland region, or the operation of any of the stakeholders of that process.

The Terms of Reference for this review have been attached as Appendix (A). We thank the Governance and Crown Entities Team at the Ministry of Health for their support to arrange interview scheduling and to provide the secretariat for this review. We thank the Waikato Management School MBM students Rinu Vimal Kumar, Balaji Mandey Govardhanan and Wenjia Liu for their contribution of background material. We thank the submitters and interviewees for their time and effort to add facts and commentary.

2. EXECUTIVE SUMMARY

The initiation of a review process to reduce community laboratory service spending was completely appropriate for the DHBs to undertake and entirely within the purview of organizations accountable to the NZ tax payer for their utilization of funds.

The execution, starting with the decision to examine procurement of the community laboratory service and ending with the transition to the new service, was inadequate and raises questions about the appropriate oversight of the critical steps of the process.

The tender documents were created without sufficient input from experts and described a set of services quite different from what was being supplied by the incumbent. The resulting discrepancy of what the new provider LTA believed they were to deliver, and what clinicians had come to expect, contributed significantly to the dissatisfaction and confusion of clinicians.

The resulting contract lacked sufficient opportunity for appropriate DHB oversight and intervention and allowed the new provider, LTA, to plan for and begin operations with a limited set of accountabilities, including not being required to be accredited until one year after start-up.

The assumption by the DHBs that there would be cooperation from the outgoing provider DML was not well founded. The good faith provisions in the old contract requiring cooperation with the DHBs were simply ignored by DML.

The award of a 10% share of the contract back to the unsuccessful tenderer, DML, may have made short-term sense to relieve pressure for LTA but

undermined the original intention of maintaining economies of scale. It also aggravated the problem LTA had and has to recruit staff. It reduced the savings the DHBs would generate from this contract change by several millions. We understand that this 'temporary' award has now been extended to a 4-year contract which reduces the long-term savings targeted by this transition. It is inconsistent with DHB representations that the incoming LTA provider could handle all of the tasks they had committed to undertake.

Throughout the transition communication with stakeholders was not as effective as desired, even though considerable efforts had been expended on consultations. There was a fundamental lack of understanding of the strong clinician backing of the outgoing provider DML. This was due to a variety of reasons including business/financial relationships, and it contributed significantly to the ability of DML to wage an unprecedented interference campaign which drained DHB resources during the transition and caused confusion among patients and clinicians.

The single most significant deficiency in this transition was the lack of early stage senior DHB management strategic and clinical oversight into the process to change the provider landscape in the Auckland region with its resultant impact on many providers and consumers. Although it is absolutely appropriate for DHBs to determine that another laboratory provider is preferred for reasons of cost savings or other efficiencies, the initial delegation of the implementation process to an insufficiently supported procurement team allowed the previously mentioned operational deficiencies to compound to a point where it produced a perception of inferior performance. CEO-level involvement should have begun much sooner in the process than it did. Using historic contract templates for a far-reaching future contract was inappropriate.

We are concerned that the decision to seek a more economical community laboratory service was not anchored strongly into a long-range strategy of the DHBs for provision of services in this sector. It is clear from the statements offered by many interviewees that such a long-term strategy was not fully developed prior to the original tender process and is in fact only now being formulated. We believe that a fully-fledged procurement strategy, well developed, communicated and agreed between the DHBs involved would have been an essential pre-requisite for such a major tender process.

3. HISTORY IN A NUTSHELL

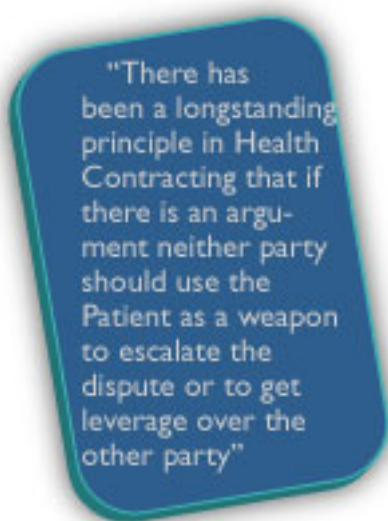
Three District Health Boards in the Auckland region (Counties Manukau, Auckland and Waitemata, the “DHBs”) had approached their current provider of laboratory services to reduce annual expenditures, which were forecasted to continue to rise at a rate of 5% per annum, which was unacceptable to the DHBs. Those discussions did not yield a result and, prompted in part by a previous Commerce Commission decision, they decided to conduct a competitive process for selecting a laboratory provider. This resulted in a tender process for community laboratory services in the region. The tender documents were based on the prior laboratory services contract and included new cost-saving features such as a reduced number of collection centers and electronic reporting of all results.

The incumbent laboratory service provider, Diagnostic MedLab (“DML”), was not awarded the new contract and began lengthy litigation, ultimately

resolved by the Supreme Court of New Zealand declining to hear its last appeal. Significant media coverage continued throughout the litigation, with a resulting public polarization of attitudes among stakeholders in the region.

The DHBs were subsequently ordered by the Court of Appeals to get on with the implementation of their new laboratory services contract with their new provider, Labtests Auckland (“LTA”). LTA was a newly formed entity for the purposes of this specific contract and represented to the DHBs that it was ready to perform. Both LTA and DML are owned by Australian parent entities that compete vigorously and publicly against each other in other markets.

The DHBs rejected the suggestion to switch over the laboratory services for all three districts at the same start time, and LTA reluctantly agreed to a ramp-up schedule that would begin at Counties Manukau and then add the Auckland DHB two weeks later and the Waitemata DHB after a further two weeks.



Initial teething issues occurred immediately upon switch-over, but the operational problems multiplied when the Auckland region was added, due in part to the transiency of many Auckland GPs and the resulting challenge to provide patient reports to them in a timely manner and the novelty of electronic results reporting. By the time the Waitemata region was added, a full-fledged media circus had ensued, providing near-daily news coverage of the operation of the new laboratory service, fuelled in part by DML operating its own video ‘reporting’ of patient dissatisfaction.

Many complaints were made by patients, clinicians, provider groups and others, including over 160 directly to the Health and Disability Commissioner, describing poor performance by the new laboratory service. The DHBs had constituted a team of specialists, QSTAT, to advise and later direct LTA as to corrective action. The performance improved within a few months. Meanwhile, DML was awarded the contract to provide histology laboratory services for specialists in the region on a short-term basis, and that contract has now been extended to a four-year term. This sharing arrangement appeared to relieve the pressure on LTA to develop its internal systems and represents about 10% of the total laboratory contract.

The laboratory performance in the region is now reported as uneventful, and is described by some as better than before. LTA is now an accredited laboratory and no current issues of significance appear to exist. The DHBs report they have achieved multi-million dollar cost savings over the length of the 7-year contract and have secured a contractual right to acquire the laboratory equipment at the end of the term at its depreciated value.

4. CHANGE IN ORGANISATIONS

District Health Boards are large and complex organizations in New Zealand, receiving considerable funds from the public purse to provide quality health services in their regions. DHBs operate under a directive to manage within a budget based on a population-based funding regime. Given increasing health care costs, increasing demand for services and increased accountability for

their spending, the three DHBs in the Auckland region identified laboratory services as an area where costs could be reduced, through a number of changes including a reduction in collection centres, a switch to 100% reporting of electronic results and re-negotiations of fees, with their community laboratory services provider. This initiative sits perfectly well within the authority of DHBs, and the same DHBs would likely have been chastised for not embarking on an aggressive approach to save costs, had they not reviewed their annual spending for laboratory services.

The issue then arises as to how organizations manage a process of change. “Change Management” as a discipline within corporate management is well established. Change Management has three basic definitions in literature:

- *The task of change management, which refers to the task of managing change in a planned and managed fashion.*
- *An area of professional practice where many consultants internationally, profess to specialise in managing change on behalf of clients.*
- *A body of knowledge, which consists of models, methods and techniques, tools, skills and other forms of knowledge that go into making up a practice.*

(Nickols, 2000)

Change management as it is understood today is a convergence of two predominant fields of thought:

- An engineer’s approach to improving business performance
- A psychologist’s approach to managing the human side of change

While systems and organizational structures can be meticulously designed and implemented by managers and technicians, it is the human reaction to

change that often proves the most challenging aspect of the process. In this case, the large group of stakeholders in the region with diverging interests made this specific change process one of significant complexity.

DML had established relationships throughout the region and was by all accounts a provider of superb, albeit expensive, laboratory services. During the years of its operation, strong relationships were established between DML and clinicians, in some cases through financial arrangements for the sharing of resources and space. To many of the stakeholders, including DML and their staff, it appeared inconceivable that the DHBs would not continue with the same provider arrangement as before. As it became clear that this change would indeed occur, the reaction of many became emotional. Additionally the subsequent intensely emotive public debate had clearly not been expected by the DHBs and caused them to invest substantial resources and time.

There is a difference between change and transition. (McKee, 1998) states that many changes are successfully made by organisations, but they fail when it comes to the actual transition from a current state to a future state. While change is physical, like moving from point A to point B, transition is a psychological process that people go through to come to terms with a new situation. Unless the transition is managed with equal or greater intensity than the change planning process, the change will likely fail for lack of stakeholder acceptance.

Given the definitions of change management, research with hundreds of project teams, however, has shown that a one-size-fits-all approach to change management is not appropriate. To be effective at leading change, organisations will need to customise and scale their change management

efforts, based on the unique characteristics of the change and the attributes of the impacted organisation (Prosci, 2004). In this case, the DHBs believed they had engaged in considerable consultation through the region, a contention vehemently denied by several stakeholders. We must note that the interruption of the implementation by several years of legal wrangling, and the “hurry up and wait” effect this had on the DHBs implementation plans, clearly degraded a smooth transition plan. While the DHBs believed they would succeed in their defense against DML’s court action, many in the community did not share those views and thus did not accept the reality that a new laboratory service provider would begin work. When this event then arrived, the frustration and anxiety that had been built-up during this period of uncertainty likely made any further consultations ineffective.

While it theoretically would have been possible for the DHBs to step back from an implementation after the Appeals Court ordered them to proceed with their initial tender outcome, it would bely the realities of the situation at the time to do so. With DML initiating a relentless media campaign to interfere with the transition, with a 6-month time until transition ordered by the Appeals Court, and with all eyes on every move the DHBs would now make, it is not realistic to assume there was any other choice available for the DHBs than to proceed towards a rapid implementation.

Changes can be incremental or transform rapidly according to their outcomes. Incremental changes are usually concerned with improving methods, skills and standards that could not be considered as the need of the future. Incremental changes involve small and medium alteration to the existing business strategy, structures and management process rather than fundamentally changing the present system (Senior, 2002). In

transformational changes, organisations shift in strategy and culture where old paradigm and business models are replaced by new systems that move the entity towards a new direction (Nutt and Backoff, 1997, Senior, 2002). DHBs that look at major changes, including those that disrupted existing relationships, in order to become more efficient in the provision of services, are pursuing a transformational change that brings with it all of the issues that were seen in this specific case. It is therefore important to test whether the DHBs anticipated and planned for the effects of such a change, including performance issues during ramp-up, stakeholder reaction, quality control and remedial action.

5. STEPS TO SUCCESSFUL CHANGE

Over a period of ten years, Harvard Professor John Kotter observed more than 100 companies trying to make themselves into significantly better entities. His review included giants like Ford, General Motors, British Airways and many smaller firms. In every case, the basic goal was to make fundamental changes to how business is conducted



In Kotter's words, "A few of these corporate change efforts have been very successful. A few have been utter failures. Most fall somewhere in between, with a distinct tilt toward the lower end of the scale." (Kotter, 1995)

The most general lesson to be learned from the more successful cases is that the change process goes through a series of phases that, in total, usually

require a considerable length of time (Kotter, 1995). He warns that skipping steps would create an illusion of speed, but would never produce a satisfying result. He noted that critical mistakes in any of the phases can have a devastating impact, slowing momentum and negating hard-won gains.

In 1996, John P Kotter published a book, *Leading Change* which discusses rapid, significant changes that organizations had to undergo in order keep pace with their competitors in the last quarter-century. He points out that, while these changes are inevitable, they can be challenging and painful to many involved. However, he believes that most of the challenges associated with change can be avoided by following certain guidelines. Kotter points out a list of the eight most common problems that occur in transforming businesses. He further describes an eight stage process that is designed to void or mitigate those problems that occur from major change initiatives. These eight stages were (Kotter, 1996);

1. Establishing a sense of urgency
2. Creating the guiding coalition
3. Developing a vision and strategy
4. Communicating the change vision
5. Empowering employees for broad-based action
6. Generating short-term wins
7. Consolidating gains and generating more change
8. Anchoring new approaches in the culture

We will apply this stepwise process to review the effectiveness of the laboratory services transition.

Throughout these eight stages, Kotter insists that for any successful change the quality of leadership is critical. Leaders and managers continually make

efforts to accomplish successful and significant change, and we thus test how the leadership of the various stakeholders in the transition has performed. The first three steps create a climate for change, and set the foundation of the change process. By the next three steps, the organization is enabled and empowered to make the change. And the last two steps deal with how to make the change sustainable.

Kotter says in his 1995 Harvard Business Review article, *Leading Change – Why Transformational Efforts Fail*: “There are still more mistakes that people make, but these eight are the big ones. I realize that in a short article everything is made to sound a bit too simplistic. In reality, even successful change efforts are messy and full of surprises. But just as a relatively simple vision is needed to guide people through a major change, so a vision of the change process can reduce the error rate. And fewer errors can spell the difference between success and failure.”

“Kotters Eight Steps of Change”



© Kotter, John P. and Cohen, Dan S. *The Heart of Change*. Boston: Harvard Business School Press

1. Creating a sense of urgency - Change in an organisation does not happen in a vacuum. If nothing happened to disturb organisational life, change would be very slow and perhaps, merely accidental (Senior, 1997). Establishing a sense of urgency is crucial to gaining the needed co-operation to bring about change. Participants at all levels within the organisation and among its external stakeholders need to be aware of the forces driving change, and need to be motivated to undertake change that will impact on their personal and working environment (Peters, 2006). Kotter suggests that for change to be successful, 75% of a company's management needs to "buy into" the change (Kotter, 2007).

In this case, the sense of urgency was widely communicated as a desire to create significant laboratory services savings which could be used to improve health services in other areas, coupled, eventually, with a court order to proceed forthwith. It is of consequence but unavoidable, that this sense of urgency would not be shared by all parties. Clearly, those with an interest to maintain the status quo would deny the existence of urgency, and those pursuing the change would find themselves pushed along by it. It is not possible for DHBs to arrange their activities to please all stakeholders equally and yet to operate within a system of tight accountability for their budgets.

We are satisfied that a genuine urgency existed to proceed with a change in laboratory services arrangements in order to realize substantial savings for the DHBs.

There are questions whether this urgency had been extensively communicated throughout the stakeholder community. While some refer to

“consultation fatigue” and did not reply to DHB requests to participate in consultations about this change, others argue they had not been given sufficient opportunity to express their views, or that their views had not been considered with the same weight as was intended. Several interviewees suggested that most of the affected stakeholders did not take the tender process seriously and expected it to be merely a vehicle to force DML into concessions, and that it was a foregone conclusion that DML would retain the contract.

It appears clear that especially GP physicians in the area were not sufficiently informed about the mechanics of the change, i.e. different methods of reporting test results, in some cases different scales used to report test values, pick-up routines (including such mundane matters as the colour and printing of labels and envelopes), and other technical details. Many of the problem reports after the beginning of the changeover related to minor technical matters that were compounded into a perception of unreliability and poor performance. We must state unreservedly that it was univervally reported that the LTA transition and start-up team was less-than-forthcoming when prompted by the DHBs to share their specific plans and resources for the start-up of the new service. Whether there were attitudinal differences between local stakeholders and LTA’s Australian staff or simply a desire to not disclose any possible defects, the interaction between LAT and the QSTAT team and then the DHBs was strained.

It is notable that the agreement between LTA and the DHBs did not provide for effective oversight by the DHBs during the transition period, and thus there was little the DHBs could do other than to intensify their own contribution to the transition process.

We believe much better stakeholder buy-in could have been achieved if the DHBs had built the tender process into a long-range strategy for services in this sector. The single-provider model, which both laboratory service providers agree is the only economically viable method given the small size of the Auckland catchment area, raises long-term questions of dependency. For a contract so significant in cost and clinical relationships, the DHBs would have been better off to develop a long-range strategy and then logically embed this into the tender process to demonstrate the ultimate stakeholder benefits. Although there may very well have been issues of commercial sensitivity that would preclude a disclosure of specific future intents, it appears that a tender process for the community laboratory services would have been better understood and possibly more easily accepted, had it been presented as part of a well-defined long-range plan by the DHBs to provide efficient services.

We note that there is a considerable difference of view from senior members of the DHBs as to whether there was a long term plan conceived at the time the services were tendered. Some aspects of the awarded contract, for example the right to acquire the laboratory equipment at the end of the contract period, support the argument that a long range strategy did exist, but if it did it was certainly not well documented or well communicated between the DHBs at the time they agreed to tender the service together. The reviewers believe that at the time there was more of a “momentum” for change than a “plan” for change.

2. Building a Strong Guiding Coalition

Because major change is so difficult to accomplish, a powerful force is required to sustain the process (Kotter, 2007). A strong guiding coalition is always needed - one with the right composition, level of trust and shared objectives. The kind of leadership that needs to be present with major change efforts is transformational leadership (Peters, 2006). In addition to this, Kotter highlights a sharp distinction between managers and leaders; he states that only good leadership can slice through negative corporate inertia to motivate people towards change. According to Kotter, leaders should clear obstacles and provide necessary support for frontline managers and staffs. He argues that, leadership and management differ in terms of their primary function. The first is to produce useful change and the second is to create orderly results that keep things working efficiently. Kotter sees leaders as needing to be inspiring while it is sufficient for managers to be organized, efficient controllers. He suggested that, for any changes to be effective at least 75% of the general management teams should believe that change is necessary. It is required that internal motivation for change grows from the clear knowledge of the present threatening condition or anticipation of future gains (Deetz, Tracy et. al. 2000). Having a powerful force behind the change involves having a senior management team, which supports and drives the change. The implementation of change needs constant and effective communication. It should be based on a formal communications plan, which motivates employees to undertake the change and which is repeated to enforce the need for change in the minds of employees. The communications plan needs to build a foundation for change (Peters, 2006).

In this case, the leadership of the DHBs, throughout the management team and up to the boards and Chairs, became deeply involved in the transition process. Although there were robust discussions within the DHB group, the DHBs were unified in their response to the challenges, and significant leadership time was invested to front up to the public during the initial weeks of the transition.

It is notable that several key stakeholders in health provisioning in the Auckland region argue that their leadership was not invited to participate and assist the DHBs during the transition phase. As several of these proponents for a more inclusive leadership discussion had publicly voiced their opposition to the change in laboratory providers, we conclude that some of these arguments appear disingenuous. The DHBs were put into a situation where they needed to deal with operational issues at the laboratory, communicate with patients and families, clinicians, clinician groups, the Ministry of Health and its Minister, the Health and Disability Commissioner and the media, and manage the day-to-day business of large and complex organisations. Under these circumstances we conclude that there was sufficient leadership involvement to signal to all stakeholders the importance of proceeding to improve the laboratory services performance.

Stakeholder theory proposes that the firm's success is dependent on the effective management of all the relationships the firm may have with its stakeholders. Stanford research institute defines stakeholders as "those groups without whose support the organization would cease to exist" (Freeman, 1983, p.33). As the whole entity is perceived to be a nexus of explicit and implicit contracts between the firm and its stakeholders (Jensen and Meckling, 1976), the inclusion of stakeholders in major change projects is essential.

Stakeholder participation in organizational transformation is an effective tool in developing their trust, information and communication needs and clarifying their roles and responsibilities. Stakeholder involvement in transformation has the tendency of identifying elapsed barriers and also has the potential to increase the listening ability or willingness of others involved. Transparency towards stakeholders has an empowering effect on stakeholders by providing them with a feeling of being valued. (Bovee et.al, 2000). Hence, when introducing new change in systems and strategies, it is necessary to communicate these changes to the stakeholders of the organization. It is also necessary to analyze how these changes may impact the stakeholders' interests within the entity. A common technique for effectively managing change includes encouraging participation from as many stakeholders as possible, addressing their concerns in the proposed change, or ensuring that leaders act as role model during changes (Heracleous, 2002).

We therefore need to review how well the DHBs had connected with their stakeholders during this transition process, and how effectively the stakeholder reactions had been factored into the work plan of the transition.

There is extensive commentary from stakeholders that points towards frustration at not having been involved more in the specific planning issues of the transition. While it is reasonable to presume that the attitudes of some stakeholders had hardened during the extensive legal battle between DML and the DHBs, we believe more effort could have been expended by the DHBs in the period between the final court order and the transition of services. It appears that the DHBs were fully occupied in dealing with the mechanics of the transition and a recalcitrant outgoing laboratory services provider and thus had dedicated less resource to a continued and indeed invigorated

campaign to connect with local clinicians and other stakeholders. It is likely that the venomous DML media campaign would have had considerably less effect and thus would have required less time and energy to deal with, if the DHBs had spent more time and ensured that the incoming provider spent more time to develop alliances with local clinicians.

Part of the test for the existence of a guiding coalition is to probe for inclusiveness of the required expertise.

In this case, the root cause for many of the transition problems rests with the specifications within the tender document, where it appears that laboratory expertise was thin at best.

The evidence is persuasive that what the DHBs wanted to achieve, which was similar lab services as before but cheaper and with fewer collection locations, was not what they asked for in the tender document. The services DML had provided under the prior contract included a myriad of services that DML had added on their own volition during the many years of performance. Those services were tailored to the needs of the clinicians and communities and were largely unknown to the DHBs. In addition, DML had developed many work-arounds to the processes originally specified in their contract, which were significant in that they were indistinguishable by the clinicians from the 'basic' services.

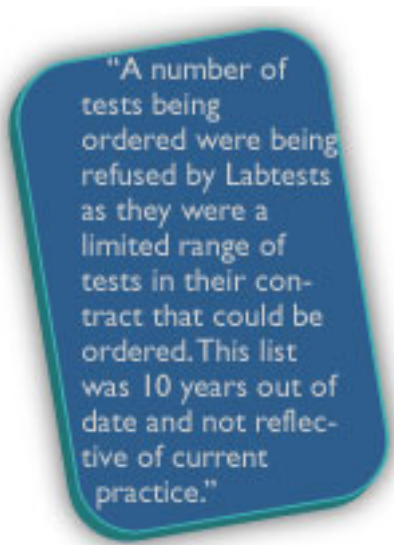
The result of this lack of knowledge at the DHB level was that the tender document asked for 'plain vanilla' services, without detailing the specific enhancements currently experienced by the local clinicians. Those basic service levels were what both LTA and DML tendered for, and it thus came as a surprise to LTA that the services demanded by clinicians differed from those they had planned to provide. Without doubt, the unexpected demand for a

variation of service provisioning affected LTA's ability to perform to community expectations.

While it could have been expected that DML would point out the contract omissions to the DHBs, it was certainly part of their strategy to not be transparent about factors that might aid a competitor to better understand the market. We understand that the DHBs have now embarked on an IT strategy to develop a knowledge-based system in-house that no longer relies on the voluntary contribution by suppliers but allows the capture of key data, i.e. clinician contact details, for the benefit of the whole network and not allow this information in future to be uniquely held by only one provider. Had such a system existed before, the information DML labeled as proprietary and did not share, would then have been accessible to LTA.

We therefore must identify as a fundamental shortcoming in the DHB tender process the lack of understanding of the laboratory services market in the region. This is clearly a business in which the professional component of highly qualified staff adds greatly to the ability to perform, and the DHBs' expectation that the DML staff would simply switch allegiances and join LTA borders on fantasy. It has been pointed out to us that DML used techniques at its disposal to make it harder for staff to switch to LTA and for LTA to take over collection centres it would need, but those tactics should have been anticipated and thus addressed as elements of the new contract. The assumption that there would be sufficient skilled resources available in the market to fully service the out-going provider until the last day of their contract and then to seamlessly switch over to join the new in-coming provider was flawed. Given the strong emotional attachment of some of the (few) qualified staff in this field, this assumption by the incoming provider should have been tested by the DHBs and would then have been found lacking.

Patient complaints resulted from new and inexperienced staff at collection centres, many of which were qualified but did not have not much work experience.



We suggest that in future re-arrangements of clinical services, the DHBs acquaint themselves thoroughly with the market and industry background before assessing factors on which they base their decisions. At a minimum, a stronger presence of laboratory specialists in the planning team would have been helpful, and we acknowledge that there would have been few such specialists in New Zealand who are not conflicted by having affiliations with either DML or LTA. It might well have been necessary to contract for such talent from outside of New Zealand, incurring additional costs. The approach to tender for laboratory services on the basis of it being a “commodity” that was poorly understood in terms of content and complexity adversely impacted on the success of this transition.

3. Formulating a Vision and Strategy

According to (Nickols, 1990), the change problem lies at the heart of change management. That is, for some future state to be realised, some current state needs to be left behind and some structured, organised process for getting from one to the other needs to exist. It is clear that the accomplishment of change-savvy organisations is to minimize the period of transition and to move quickly from the prior state to the new state. In this case it was not “the King is dead – Long live the King”, but “The King is dead – Is the new King ready?”, which compounded the operational difficulties by adding significant

uncertainties among the stakeholders that then quickly turned into frustration and aggression.

Change (as per Lewin's Change Model), has three distinct stages:



Illustration of the three stages of change (Source: Balogan, J., Hailey, V.H. (1999): *Exploring Strategic Change*, Prentice-Hall: London).

The vision is the bridge between the current and future states and is the force behind transformations. The vision should include the rationale, benefits and personnel ramifications of the suggested change.

John Kotter mentions three steps to be included in this phase. First, there should be a clear guiding vision for the change. People should be able to see what the future will look like, after the change. Next, that vision should be communicated to all stakeholders using multiple channels, so that they have a clear understanding of what the change is all about, and why it is important. Finally, there should be a clear strategy to remove the obstacles to change (Kotter, 1996).

In this case, the DHBs had championed this change mainly on a platform of cost-savings. As legitimate as that argument is given the accountability duties

of DHB leaders, it resonated poorly with the external stakeholders. It is not the DHBs role to please every stakeholder and thus it is part of its daily challenge to mitigate between competing interests, often resulting in dissatisfaction. It is, however, evident that the argument of cost-savings did not achieve the traction the DHBs had hoped for. The many millions of dollars of savings from this transition will undoubtedly flow into other services currently constrained by a lack of funding, and a perhaps more coherent argument could have been made to better explain the effects of this change in terms of better service provisioning in other parts of the service spectrum.

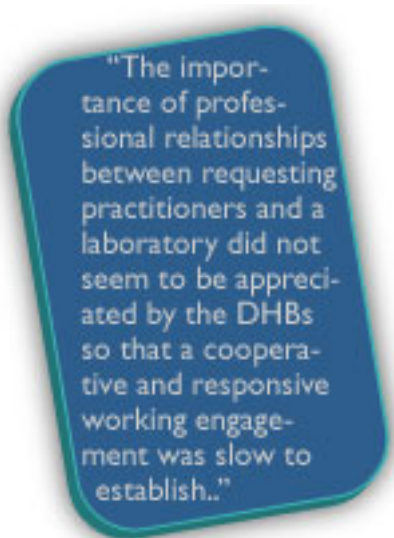
4. Communicating the Change Vision

Communication plays a crucial role in effective implementation of organizational change (DiFonzo and Bordia, 1998; Lewis and Seibold, 1998; Schweiger and Denisi, 1991). The general importance of communication during planned change has been empirically demonstrated and generally agreed among practitioners (Lewis, 1999). Inadequately managed change communication may result in rumors and resistance to change, exaggerating the negative impact of those changes (DiFonzo et al., 1994; Smelzer and Zener, 1992). The empirical picture that is slowly emerging indicates that communication process and organizational change implementation are inextricably linked processes (Lewis and Seibold, 1998).

Managers must be clear in their communications and a formal communications plan is very helpful during a change initiative. Communication competes with “share of mind” with many other communications. Weak communications exist, when senior and middle

managers do not confer with supervisors or employees about the intended changes.

Communication needs to be assessed by looking at the why, what, how, and when of communicating during the planning and implementation phases of change. Many change interventions fail because companies fail to plan and manage communications, which means that the change programme doesn't gain the awareness, support, involvement and commitment needed to succeed (Peters, 2006).



"The importance of professional relationships between requesting practitioners and a laboratory did not seem to be appreciated by the DHBs so that a cooperative and responsive working engagement was slow to establish.."

This transition project must surely be one of the most talked-about change projects in New Zealand in recent history. The willingness of many to participate in this debate, whether publicly or through direct approaches to the DHBs assured that communication of the transition and any failures that occurred became a central issue of managing this process. We are of the opinion that the communication from the DHBs was not as effective as it could have been and that the

absolutely needed focus on the LTA performance overshadowed the need to communicate well throughout this process. Although most of the interviewees stated they were surprised by the unexpected activity of DML, it could hardly have come as a complete surprise to the DHBs that the incumbent would not only have no desire to aid an orderly transition of providers but would vent its frustrations through a deliberate campaign to destabilize the transition process. Given the historic animosity between the parent organisations of DML and LTA, the DML loss in multiple law courts, the emotional investment

by the DML staff and management in the many years of laboratory service provisioning in the Auckland region, it would have been prudent for the DHBs to anticipate significant interference. We note that, supported by several interviewees, the contract under which the DHBs purchased laboratory services from DML did not include an easily enforceable provision that mandated a 'good faith' cooperation during any future transition. Technically, the DHBs had no ability to force reasonable DML conduct during this transition other than to seek, again, recourse in court. Such an application would surely have been seen as litigious by the public, had limited appeal as courts rarely wish to order 'good behaviour' in the future and would have diverted more resources away from managing the transition.

It seems reasonable for DHBs to include such a binding provision in future contracts for any services, so that the reasonable unwillingness of an outgoing service provider does not extend into deliberate acts to undermine the outcome of any contract change.

5. Empowering Action

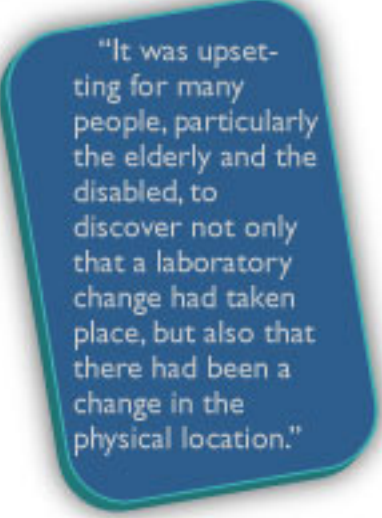
Successful transformations begin to involve large numbers of people as the process progresses. Participants in the change process are emboldened to try new approaches, to develop new ideas, and to assume leadership roles. The only constraint is that the actions fit within the broad parameters of the overall vision. The more people involved, the better the outcome.

In this case, empowerment was significantly hampered by the contractual constraints under which LTA were to perform its services. The evidence is overwhelming and clear that the LTA approach was one of obfuscation rather than transparency. As a result, many of the DHB staff sent to assist LTA prior to start-up of the lab and during the transition phase were ineffective as they were not sufficiently empowered to force action they believed was needed. Only after a nearly complete management change at the LTA leadership level did LTA take on board suggestions by DHB staff and began to address the many deficiencies in its approach to providing community laboratory services in the Auckland region.

It would have been more reasonable to specifically address the transition co-operation and the various authorities flowing from the transition plan in the contract between the parties, so that remedies could have been built-in if there was non-performance. We note that the contract used for this new relationship was modelled after the prior contract for laboratory services and thus had not been drafted originally to include such provisions. The pervasive notion throughout this contract document appears to have been the expectation that health care providers and the DHBs work well and closely together, and such a premise had been taken for granted by the DHBs.

Rather than shying away from similarly complex service changes in the future, DHBs should be encouraged to create new contract language that reflects the competitive and sometimes combative realities of health care in the commercial arena today. More specific authorities for the DHB to seek information and disclosures, to intervene early if such disclosures signal inadequacies and to impose a punitive regime if remedial actions were not forthcoming, would likely have assisted with a much earlier identification of issues – and their resolution.

6. Generating Short-Term Wins



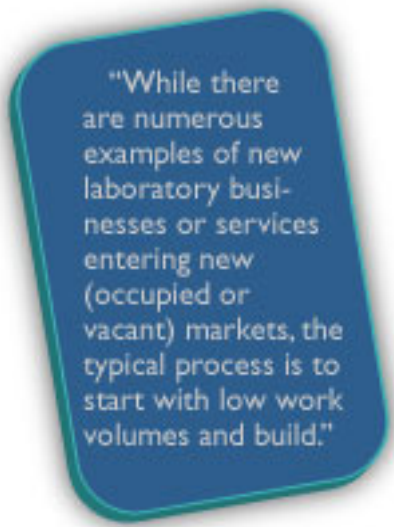
"It was upsetting for many people, particularly the elderly and the disabled, to discover not only that a laboratory change had taken place, but also that there had been a change in the physical location."

Kotter talks about how creating short term wins is very important during the initial stages of implementation. The small wins will motivate the change agents and stakeholders, and silence critics, building a strong platform for the change initiative to proceed. Once a series of short-term wins has been achieved, the change managers should build on those successes, and achieve yet more change. And finally, these changes should become second nature to the organisation, and

become a part of day to day activities (Kotter, 1996). There exists some practical first steps that make the change more "real" to employees (Peters, 2006).

In this case, the elephant was not eaten in many bites but was proposed to fit into one large gulp. Not only was this a transition from an established provider to a new one, but the DHBs had also asked for a change of service content (i.e. reducing the number of collection centres and converting all reporting to a new electronic format). Stacking these three major changes on

top of each other in one single swoop appears to have contributed greatly to the difficulties during the transition.



Although it would have diminished some of the projected cost-savings during the first year by delaying some phases of the transition until the initial steps were stabilized, this would have been a more prudent course of action. A compounding factor was the short ramp-up period given to transition each of the three DHBs to the new provider. A 2-week period between the phasing in of the new service at three different DHBs, with different service characteristics and different patient mix and needs appears to be a much larger step than would have been reasonably manageable.

To break this transition into smaller success stories, the reduction of collection centres could have been delayed, and the phasing-in of the second and then third DHB could have been spaced months apart rather than weeks.

We are mindful that such a deviation from the originally agreed contract would have required a renegotiation of key parameters, and to which LTA might have objected, and in some cases did. We refer again to the lack of contractually secured powers for the DHBs to not proceed with a roll-out of services if they believed it would not be achievable. We also take great pains to point out that such a delay in implementation would have required the goodwill and cooperation of DML, which likely would have been withheld or only granted at prohibitive expense, given the combative attitude. Therefore, we concede that these suggestions might not have been operationally feasible

in the pre-transition phase but they reinforce the importance of earlier comments about the shortcomings of the contract itself in not having researched these issues. Several of those interviewed stated that they knew of no other “cold start” medical laboratory in the world, where the new lab was expected to process approximately 29000 tests per day within a few days of start up. The representations by LTA, by successive management teams sent to assist with their start-up, that they were ready to perform, were at best overly enthusiastic and at worst misleading.

7. Consolidating Gains and Generate More Change:

Kotter emphasizes the dangers of declaring victory too early. Changes should sink deeply into the organizations culture, before the change initiative can be labeled a success in its whole.

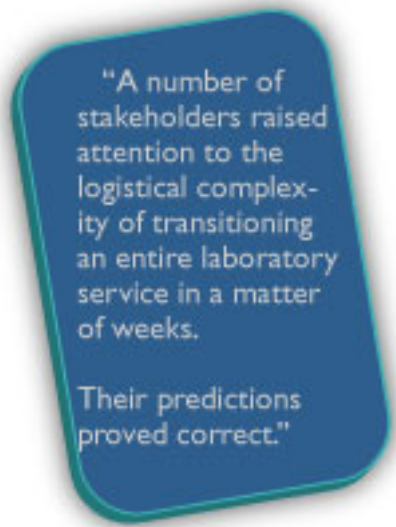
Each success provides an opportunity to build on what went right and identify what you can improve.



Kotter speaks about how the renewal process takes years, and not months: “...in one of the most successful transformations that I have ever seen, we quantified the amount of change that occurred each year over a seven-year period. On a scale of one (low) to ten (high), year one received a two, year two a four, year three a three, year four a seven, year five an eight, year six a four, and year seven a two. The peak came in year five, fully 36

months after the first set of visible wins.”(Kotter, 2007)

Without doubt, this change in providers has now turned out to be a successful exercise where in a competitive environment DHBs have been able to generate savings. It is equally evident that this success has come at a price of stakeholder-scarring with some stakeholders still unhappy about the change as a whole and about some specific experiences.



We suggest that it would be helpful for DHBs to engage in regular post-battle discussions with the local stakeholders to better understand their ongoing needs and reactions to the change. This process should not be structured to allow the flare-up of issues long disposed of, but be concerned with creating a stronger relationship exploiting experiences and knowledge that can guide future tweakings of the laboratory service provisioning to assure that it adapts seamlessly to the ongoing needs of the community.

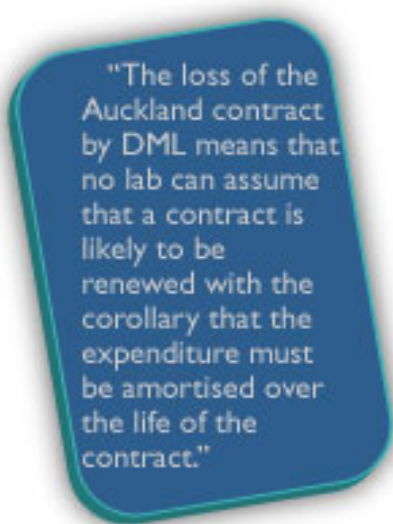
8. Anchoring New Approaches in the Culture

There are two factors which are particularly important in institutionalizing change into corporate culture:

1. A conscious attempt to show people how the new approaches, behaviors, and attitudes have helped improve performance
2. Taking sufficient time to make sure that the next generation of top management really does personify the new approach.

Kotter points out: “In at least three instances I have seen, the champion for change was the retiring executive, and although his successor was not a resistor, he was not a change champion. Because the boards did not understand the transformations in any detail, they could not see that their choices were not good fits.”.

DHBs experience turnover like any other organization with the added spice of tri-annual board elections through which elected DHB board members rotate in and out of the entity.



We wish to discourage DHB board members and senior management from looking mainly at the publicly debated disaster stories when they reflect on this laboratory services transition. If this transition were to reduce the willingness of DHBs to constantly look out for opportunities to sharpen their game and to improve their services, it would constitute a much higher price than the cost and inconvenience of the transition itself. It is essential that DHBs and their leaders consider this specific activity as a stepping stone of learning and continue their work towards a better and more efficient healthcare system in New Zealand. At the end of the day, this transition has resulted in a competitive market price for laboratory services at considerable savings for the NZ tax payer. Learnings were achieved and should now flow through the respective organizations to lay the groundwork for more and faster change in the future.

6. SUMMARY OF RECOMMENDATIONS

A. Contracting decisions with far-reaching impacts, either financially or in terms of stakeholder relationships, require senior management leadership and must be based on extensive factual knowledge of the subject matter. If that expertise is not available in-house, it must be secured externally. This should not deter DHBs from making complex changes to their operations, but safeguard it against failures during implementation.

B. Provider contracts can no longer be based on 'expected good faith' behavior of any party but must include effective and enforceable provisions under which the DHBs can hold parties accountable for their performance, or lack thereof. This must include specifics of end-of-contract/transition behavior for any outgoing provider.

C. Changes in service provisioning that affect a wide group of stakeholders must be anchored in a coherent and well-communicated long-term strategy and not solely rely on short-term financial parameters.

7. CONCLUSIONS

This transition failed largely because of compounding factors set in motion by flawed contracting contributed to by a lack of early stage senior management strategic and clinical leadership and oversight. Most of the downstream events resulting in the poor transition performance were thereafter predictable and to some extent inevitable. Some of the difficulties could have been avoided if the transition had have been spread over a longer period but there were many reasons why this was difficult to achieve after the initial contract had been awarded.

This community laboratory services transition was initiated by well-intentioned people who used a narrow platform of short-term/mid-term financial considerations to embark on a complex change of relationships. This niche-view approach created a “we don’t know what we don’t know” myopia as to foreseeable consequences that arose too late to be effectively addressed. For complex large organizations with extensive resources, such as DHBs, this is a poor outcome.

The DHBs should have had the contractual ability or the political willpower to delay the phased implementation of the new service until the new provider demonstrated competence and to prevent the interference by the outgoing provider.

As a result, damage has been done to the value of clinical relationships and to the public perception of the DHBs involved., The potential financial gain through savings has also been reduced. The original savings were estimated to be \$15 million per year initially and \$120 million over the life of the contract. Due primarily to the letting back of 10% of the work to DML the savings will be likely some \$4 – 5 million per year less than originally contracted. This will still amount to an appreciable sum over the original contract period and thus one of the major objectives for this transition has been achieved. Additionally it must be acknowledged that the service provided now is considered by most to be efficient and reliable and by some to be superior.

30 September 2010

Graeme Milne and Jens Mueller

8. REFERENCES

- Balogan, J., Hailey, V.H. (1999): *Exploring Strategic Change*, Prentice-Hall: London
- Bovee, L. and Thill, J. (2000) *Business Communication Today*, Prentice Hall, London.
- Branson, C. (2008). Achieving organisational change through values alignment. *Journal of Educational Administration*, 46(3).
- DiFonzo, N. and Bordia, P. (1998), "A tale of two corporations: managing uncertainty during organisational change", *Human Resource Management*, Vol. 37 No. 3, pp. 295-303.
- Fjeldsoe, K., Aimer, M., Meehan, T., Howard, F. C., & Kidd, J. (2009). *A Time For Change - Evaluation of Health Waikato Adult Mental Health and Addictions Service*. Hamilton.
- Freeman, R. (1983) 'Strategic Management: A Stakeholder Approach' *Advances in Strategic Management*, I, pp. 31-60.
- Heracleous, L. (2002), "The contribution of a discursive view in understanding and managing organizational change", *Strategic Change*, Vol. 11 No. 5, pp. 253-62.
- Jensen, M. C., and Meckling, W. H. (1976) 'Theory of the Firm: Managerial Behaviour, Agency Costs and Ownership Structure', *Journal of Financial Economics*, Vol. 19, pp. 127-168.

Kotter, J. (2007). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review*, 85(1).

Lewis, L.K. and Seibold, D.R. (1998), "Reconceptualizing organisational change implementation as a communication problem: a review of literature and research agenda", in Roloff, M.E. (Ed.), *Communication Yearbook 21*, Sage, Beverly Hills, CA, pp. 93-151.

McKee, T. W. (1998). It Isn't Change That Does You In, It's the Transitions. from <http://www.managerwise.com/cgi-bin/frames.cgi?page=kbank//kb42.html>

McShane, S. L., & Von Glinow, M. A. (2000). *Organizational Behaviour : Emerging realities for the workplace revolution* United States: Mc Graw-Hill.

Nickols, F. (1990). *Change Management 101: A Primer*.

Nutt, P and R.W. Backoff (1997), "Facilitating Transformational change" *Journal of Applied Behavior Science*, 33(4), pp.490-508.

O'Brien, G., & Doube, B. (2010). *A Time For Change Mental Health Addictions Service*.

Peters, A. H. (2006). Understanding and Managing Change. from http://www.projectperfect.com.au/info_change_mgmt.php

PMG. (2005). *Governance in Programme and Project Management*.

Prosci. (1996). "ADKAR" - a model for change management. *Change Management Tutorial Series*, from <http://www.change-management.com/tutorial-adkar-overview.htm>

Prosci. (2004). *Change Management: The People Side of Change*.

Smelzer, L.R. and Zener, M.F. (1992), "Development of a model for announcing major layoffs", *Group and Organisation Management: An International Journal*, Vol. 17 No. 4, pp. 446-72.

Schweiger, D. and Denisi, A. (1991), "Communication with employees following a merger: a longitudinal experiment", *Academy of Management Journal*, Vol. 34 No. 1, pp. 110-35.

Senior, B. (1997). *Organizational Change*. Great Britain Pitman Publishing

Stable, R. L. (1999). *Managing Organisational Change: 'How To' Guide*.

Sustainability, governance and organisational change. (2003). from <http://www.greenleaf-publishing.com/content/pdfs/lcch5.pdf>

UNDP. (2008). Programme Management. *Programme and Operations Policies and Procedures*, from <http://content.undp.org/go/userguide/results/ppm-overview/management-structure/>

APPENDIX A

TERMS OF REFERENCE: AUCKLAND REGION DISTRICT HEALTH BOARDS (DHBs) – REVIEW OF TRANSITION TO NEW COMMUNITY LABORATORY SERVICES PROVIDER

This document sets out terms of reference for a review of the transition processes relating to the Lab Tests Auckland Ltd (LabTests) contract for community laboratory services in the Auckland region.

Background

The Minister of Health wishes to enable the health service, including DHBs, to learn from the experiences during the Auckland Region laboratory contract transition, to assist their own decision-making processes in the future.

As DHBs continue to seek out opportunities to provide services more efficiently and with high regard for cost-containment, lessons should be available for the future from this specific contracting and implementation process.

The Minister considers it important to know which factors contributed to the less-than-satisfactory implementation of the laboratory contract. He also wants to know if contractual arrangements with LabTests supported or hindered the transition and the recovery work needed to meet LabTest's obligations. The Minister, most importantly, wants to know how the transition process and arrangements could have been organised better to have caused less disruption and maintained patient and clinical confidence.

The outcome of this review should be the learnings from this experience that the health service, including DHBs, should consider when making significant decisions that affect transfer of the provision of major services, involve multiple stakeholders, or are complex in nature.

The review is commissioned by the Minister of Health and will be conducted by a Committee comprising two independent reviewers (the Committee), in collaboration with such other parties as the reviewers deem necessary.

The review is not intended to probe the content of the decision made to tender community laboratory services or to award the contract to LabTests. While this review is about the

processes followed to secure a safe transition, the Reviewer should consider any relevant matters that may have contributed to the transition problems

Purpose

Through conducting the review, the Minister aims to:

- identify factors that significantly contributed to the poor implementation and transition outcomes.
- determine what factors, if any, were overlooked, not sufficiently considered, insufficiently communicated or erroneously interpreted
- provide the learnings from this experience that the health service, including DHBs, should consider when making decisions of this kind, and provide recommendations on how these factors can be appropriately taken into account in the future.

Scope

The review is focused on:

- factors that contributed to the poor transition from Diagnostic Medlabs Limited (DML) to LabTests Auckland Limited (LabTests)
- whether or not risks were appropriately identified and understood
- whether contractual arrangements with LabTests supported or hindered the transition and the recovery work needed to meet LabTests' obligations
- impacts and effectiveness of the regional governance, implementation and project management of the transition
- how the transition process and arrangements could have been organised so that there was less disruption to health services
- how patient and clinical confidence could have been maintained
- impacts and effectiveness of interventions by DHBs post-implementation
- what factors, if any, were overlooked, not sufficiently considered, insufficiently communicated or erroneously interpreted
- possible learnings from the experience for DHBs making similar decisions; and
- any other matters the Committee considers necessary.

The Committee

The review will be conducted by a Committee comprising two independent reviewers, one of whom will have change/risk management and external governance experience and the other expert in DHB governance.

The Committee will be supported by the Governance and Crown Entities team (Regulation and Governance Directorate of MoH), and legal and other resources of the MoH as may be required. However it is not expected that significant support will be needed.

Approach

The reviewers will conduct an in-depth study, through interviews, document reviews and consideration of relevant literature, to accomplish their objective.

The Committee may request information from any person they deem to have a perspective relevant to the substance of the review. The ARDHBs are requested by the Minister to facilitate access to all relevant personnel as needed.

The Committee may seek comments and submissions from selected parties such as the ARDHBs, professional groups and the Quality & Safety Turnaround Assurance Team.

Deliverable and process/timing

Deliverable

The Committee will produce a report on the matters set out in the Purpose section above

Process/timing

The final report shall be delivered by 30 September 2010. Editorial control of the report is the responsibility of the Committee.