HS Paper 25/17

BOARD MEETING: 29 September 2017

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EVALUATION OF THE FUNCTIONAL REALIGNMENT

Recommendation/action required:

The Board is asked to note the conclusions of this final report on the functional realignment of Health Scotland's directorates and functions and endorse the recommendations for future change projects, based on lessons learned.

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September 2017

EVALUATION OF THE FUNCTIONAL REALIGNMENT

Purpose

1. This paper describes to the Board the outcomes of the functional realignment and its impact on the organisation. It asks the Board to note the conclusions and endorse the recommendations for future change projects, especially in the light of public health reform.

Introduction

3. Our structure is now more aligned to our strategic priorities than it was in 2013. We have clearer leadership structures throughout the organisation. More of our people understand how their role fits with the aims of the organisation. We are more flexible because we have fewer niche job descriptions. Most people in NHS Health Scotland feel involved in decisions that affect them.

4. The functional realignment has helped achieve all of these improvements.

5. Over and above that, through this period of change levels of employee engagement have been maintained and employee turnover has fallen. There are also strong indications that organisational performance on delivery has improved over the same period.

6. Because this paper is the last formal part of the realignment, we want to acknowledge the contribution of everyone involved. People in NHS Health Scotland worked extremely hard to make it happen, going above and beyond what was required of them.

7. We also want to acknowledge that while the realignment achieved everything we wanted it to, there is still valuable learning for how we manage large scale change processes.In the particular, the process taking much longer to complete than originally envisaged, meant more uncertainty for longer for some people.

8. This paper starts with the background to the functional realignment: its aims and the process. Then it reports on outcomes achieved. Following that, it looks at the wider impact of the realignment process on NHS Health Scotland. It concludes by presenting our recommendations for how we should prepare for change and transition in the new public health landscape.

Background

9. In April 2014 the Director of Equality, People and Performance(later the Director of Strategy) wrote of the purpose of the functional realignment:

> "[Functional realignment] aims to ensure that NHS Health Scotland's functions are aligned in a way that ensures delivery of A Fairer Healthier Scotland (AFHS), given the anticipated retirement of the Director of Resource Management, completion of

our Estates Strategy and the impact of staff leavers through the Voluntary Redundancy Scheme.

By 31 March 2015:

- Directorates will have been realigned to better support achievement of AFHS
- Associated teams will have been re-structured
- Staff feedback will show an improvement on how they feel the organisation has involved them in the changes that affect them
- The above feedback will be reported to the Partnership Forum."

10. These were the primary aims of the programme as set out at the start. The paper went on to outline a number of other parameters, including the ambition for the revised structure to put no added pressure on the existing staff budget and the intent to meet the Scottish Government's requirement to reduce the number of staff in the Senior Management Pay Cohort.

11. The realignment was led by the Change Advisory Group (CAG), chaired by the Director of Equality, People and Performance and with representatives of senior management, staff side and HR.

12. The first phase of the realignment was to integrate the teams and functions from the Resources Management directorate into the remaining directorates. The Information Governance, Risk, and Health, Safety and Facilities team moved into the Strategy directorate. The Information Technology team and Business Improvement Programme moved into the Health Equity directorate. The Finance team joined the Chief Executive's office. The Procurement function was transferred to the Scottish Ambulance Service (SAS) in a shared services arrangement with the SAS and Healthcare Improvement Scotland. This phase was completed by April 2014.

13. The second phase was to fully integrate these teams into their new directorates and align the structures of these directorates to our strategy, A Fairer Healthier Scotland. This took place one directorate at a time starting with Strategy, then Chief Executive's, finally Health Equity. Public Health Science did review its job descriptions immediately after the realignment but neither took in any of Resource Management teams nor changed its structure in any significant way.

14. The functional realignment concluded in December 2016.

Outcomes of the Functional Realignment

15. This section looks at the extent to which the functional realignment delivered what it set out to.

16. We have successfully **reformed and realigned NHS Health Scotland's leadership**. Before the realignment there was inconsistency on the grading, terms and conditions of leaders, tiers of leadership and management and number of people reporting to.

17. We did this by creating a single head of service tier that reports to directors. Previously reports to directors had ranged from grades 7 to executive grades, with 23 direct reports in total. Now all heads of service are graded 8c, with the necessary provisions for staff with medical, dental or public health consultant contracts who are occupying these roles. This creates a consistency in the pay, terms and conditions that is more **transparent, fairer and equitable**. It has also allowed us to create a more cohesive leadership cohort at this level and have a much more consistent leadership ask of the staff in this cohort. Heads of service are now working together much better to make strategic and operational planning and resource decisions, evidenced, for example, through the planning improvements delivered through the Commissioning Group and process.

18. The **reduced number of people reporting to** directors and greater consistency in grade, competency and responsibilities of direct reports has allowed directors to delegate more consistently and focus more on strategic issues than was always possible in the past. (See: Table 1 in Appendix 1 for the change in the number of people reporting to directors; Chart 1 in Appendix 1 for a comparison of the number of whole time equivalent (WTE) by grade before and after the realignment.)

19. We used this change in leadership to **integrate linked functions**. For example, now our work to support others with learning is in the same team as our externally-focused support on improvement. Another example is how we have brought together our work on physical activity and place: two areas which are intimately linked but were structurally distinct before. Internally, IT and web services are now in the same team and work more closely than they did before, as do risk and planning. Our decision to bring together HR, Facilities and OD into one People and Workplace team has supported a reduction in heads of service, emphasises the importance of staff experience and is a model that has been replicated since in at least one other national board. (Figures 1 and 2 in Appendix 1 illustrate the differences in our organisational Charts before and after.)

20. The 2017 Chart also shows far closer match between team names and functions with the strategic priorities of the organisation with a significant move away from, for example, individual health topic teams towards teams aimed at improving health and reducing inequalities in integrated and upstream ways.

21. We are also designed to be **more flexible** than we were in 2013. One way of showing potential flexibility is in the number of job descriptions in the organisation. Exploratory work at the start of the realignment showed that there were 257 individual 'live' job descriptions with considerable variation in style, substance and status of review. In April 2017 there were 174. Fewer job descriptions means that we are more able to move people to match the changing needs of the people we work with, and make the most of unexpected opportunities to influence public policy.

22. We have explored whether people in the organisation feel more aligned to organisational aims in two ways. Immediately after the realignment, the proportion of people who felt that the change supported our strategic aims was low (see Chart 2 in Appendix 1). We wondered whether people might still be working through the change process and whether it was too early to make a proper assessment of the impact of the change. We therefore resurveyed staff in late summer. They told us that they felt the structure was better aligned than it was in 2013 (although many didn't know either way) and that the structure of the organisation generally delivers outcomes and prioritises effectively (see Charts 3 and 4).

23. Another way to see whether people feel more aligned is to look at the proportion of people who understand how their role fits with the aims of the organisation. In 2013 78% of people said their role fitted with the aims of the organisation. This varied a lot by directorate, with a low of 59% for the Resource Management directorate before its functions were integrated. After the realignment, **86% of the organisation agreed their role fitted** and there was very little variation between directorates.

24. In summary, by December 2016, NHS Health Scotland's directorates were realigned to better support the achievement of AFHS and the associated teams were restructured. As a result, leadership is more consistent, transparent and cooperative, linked functions are better integrated, the organisation is more flexible and more people see how they fit with the organisation's aims.

The Impact of Functional Realignment on the Organisation

25. This section examines how the process of functional realignment impacted on the organisation and also how it shaped other changes.

26. When we started functional realignment, we were aiming to use the results of a recent audit on staff engagement to improve how we communicate with and engage staff during change. The evidence is that we are **doing change communication better** now than we did in the past. Throughout the realignment, the Change Advisory Group (CAG) emailed all staff every week immediately after its short catch up meeting. After the alignment, people said they felt better informed about this change than they have in the past (see Chart 5). This fits with staff survey results (Chart 6) which shows that there has been a marked improvement in the level to which people felt well informed.

27. However, although we kept staff better informed, results show that we could have kept the vision and aims of the realignment clearer in people's minds. When we surveyed staff we found that a lot of people were **not that clear on the purpose** of the changes (Chart 7). Change is easier and more likely to be successful when people know why they are changing and what the goal is. It is important to reflect on this and how we could improve this. For example, this may not necessarily be about the organisation providing even more information on a corporate basis. It may be more about continuing to develop leaders and managers so that responsibility is taken across the organisation to convey information and check and reinforce understanding at a team and individual level.

28. **The realignment overran** its original timescales. This was the biggest issue for staff (see Chart 8) and certainly meant that those who found the process stressful and distracting were in that place for longer.

29. One might expect dips in employee engagement and organisational performance during episodes of largescale change, and a spike in employee turnover. However there is no evidence of this:
    - Employee engagement was maintained. NHS Health Scotland continued to have strong scores in iMatter and its predecessor, the Staff Survey.
    - While it is difficult to tell whether and how organisational delivery performance has changed, the only like-for-like measure of performance we have (our rating against the EFQM excellence model) improved.
    - Our data around employee turnover shows no non-random increase in turnover (see Chart 9). The only non-random change was a **downward shift in turnover** that matched Health Equity going through the slotting in/recruitment period of the realignment process.

30. A very positive result on employee experience is that it is now much more consistent (much less variation across directorates) across the organisation than it was at the start of the realignment (see Chart 10).

31. In summary, we are better at communicating in change although we could have kept communicating the purpose better, and while the realignment took longer than planned, we sustained levels of employee engagement, improved organisational performance and reduced turnover.

What This Means for Public Health Reform

32. NHS Health Scotland is not driving public health reform. However we are major part of it and what we have learned is valuable for informing the reform process and for how we manage the transition of our own organisation into the new public health body for Scotland. This section considers what functional realignment would lead us to recommend in terms of public health reform.

33. **The hard work we undertook for functional realignment is good preparatory work.** The task of integrating NHS Health Scotland into a new public health body will be easier thanks to the improvements in the consistency of leadership roles, job descriptions, grading, and terms and conditions. Our structure now makes much more sense than it did in 2013. While the leadership of the new body may still wish to make structural changes, the work of the realignment provides a much clearer starting point.

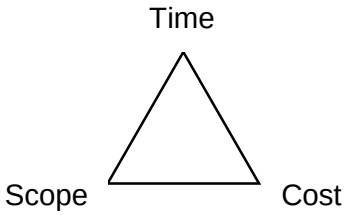
34. **What we have learned about communications stand us in good stead.** We have established ways of communicating with people through change. We also know that our weakness was in the vision and purpose of the change being reiterated. We should aim to do this better in the next change, but also use other feedback to determine how to do this. For example, early feedback from current EFQM staff workshops indicates that staff are likely to look for a lot of direct and visible leadership in the future context – possibly a different mix from some of the

team-led and ‘empowered’ communication we sought to foster with functional realignment.

35. **Having a clear vision is invaluable**. Leading change without a vision for what we want to see or where that vision is not shared is hard. While people talk a lot about communication, often what they are looking for is connection: to hear regularly from a leader who they feel is on their side, even if that means being asked to do some things they do not want to do. Having a clear vision that everyone can relates to is fundamental for change leadership. However, we also have to be prepared for a new context where the vision for change is not at the behest of this organisation alone to determine (as it was with functional realignment). There are therefore likely to be both uncertainties and frustrations with vision that the leadership of this organisation, including the Board, will need to manage.

36. **We will have to make compromise – and we may face harder choices than we did in the realignment.** The realignment took longer than anticipated. A helpful way of exploring why is to consider the below ‘project triangle’ of scope, time and cost. The concept is that decisions in a project are dictated by the tension between what you are trying to achieve (the scope), how long you have to achieve it (the time) and how much you pay for it (the cost or resource).

Figure 3: The project triangle



37. In part, we had not fully appreciated the extent of the work required on job descriptions or how important this was. There were also more delays than anticipated to follow through on our intent of optimum staff engagement (e.g. delaying some meetings until all staff were available to attend). That meant we were faced with a choice of compromising on one or more of the aims (i.e. the scope), how much resource achieving the aims would take, or how long it would take to achieve them.

38. We chose to neither compromise on the original aims of the realignment nor increase the amount of resource available to deliver the realignment more quickly, e.g. by employing a dedicated fixed term project team. Therefore, the realignment had to take longer than we originally planned.

39. This option will not be open to us in public health reform. The Scottish Government has publically committed to establishing a new public health body by 2019. The reality is that we will need to be clear on our choices of compromising either on the scope of the work we want to do in preparation or the costs of preparing for transition.

Finance and Resource Implications

40. There was no planned nor realised reduction in costs as a result of functional realignment. Our salary costs in 2013/14, were £11,678,000. In 2016/17 were £11,875,000. These costs include the standard incremental rises and so that took place over the period of functional realignment.

41. In terms of staff time, a considerable time from HR, staff side, and managers went into the realignment although because we only started staff time recording in the latter stages of the realignment, we cannot quantify this.

Staff Partnership

42. The intention to undertake functional realignment was approved by the Partnership Forum and it was conducted in partnership, with staff side representatives formally sitting on the Change Advisory Group and also providing a great deal of informal support through joining many team meetings (for all staff, not just union members) and individual support of staff.

Communication and engagement

43. There are no plans to formally communicate the contents of this paper externally. We have already indicated to staff via the Corporate Cascade that this final report is going to the Board to this meeting and we will share the paper with all staff through the next Corporate Cascade.

Corporate Risk

44. In 2016/17 CMT identified the impact of the functional realignment's overrun as a corporate risk: As a result of not properly concluding the functional realignment there is a risk that we don't see the improvements we expect from it as quickly as we need.

45. This paper captures the improvements that resulted from the functional realignment and provides an analysis of why the project missed it's planned timescales. It does also, however, provide some reassurance that negative impacts on the organisation as a result of the process taking longer than planned were not as significant as perhaps feared.

Promoting Fairness

46. Our strategy is to promote fairness. This paper captures the extent to which the functional realignment helps us deliver this better. It shows that we are better aligned to our strategy than we were in 2013.

47. Internally, this paper shows that we have improved the consistency of leadership positions and transparency of and consistency of expectations on all job grades, including their grading and terms and conditions. This promotes fairness because differences in grading and terms and conditions are risk factors for unfair pay

practices. It is also worth noting that HR and staff side worked closely and well together on the allocation of roles and the implementation of new job descriptions. While it is inevitable that these processes invoked issues with some people, none of this has given rise to any formal complaints of unfairness or inconsistency.

Sustainability and Environmental Management

48. The carbon impact of the functional realignment has not been assessed.

Action/ Recommendations

49. Board is asked to note the conclusions and endorse the recommendations for future change projects, especially in the light of public health reform.

Tim Andrew
Organisational Lead for Improvement
September 2017

Appendix 1: Supporting Charts, Figures and Tables

Figure 1: NHS Health Scotland's Structure in March 2014

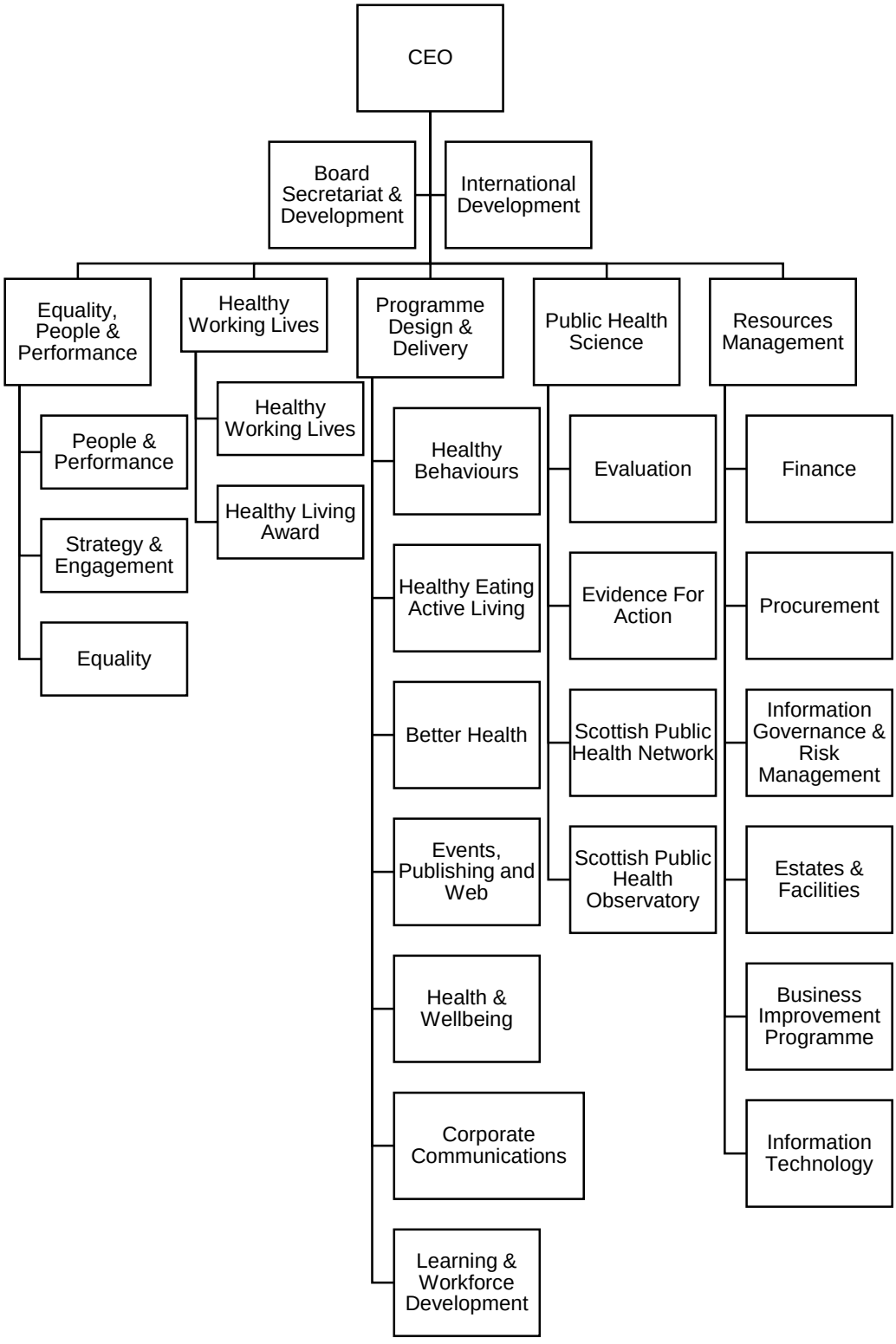


Figure 2: NHS Health Scotland's Structure in 2017

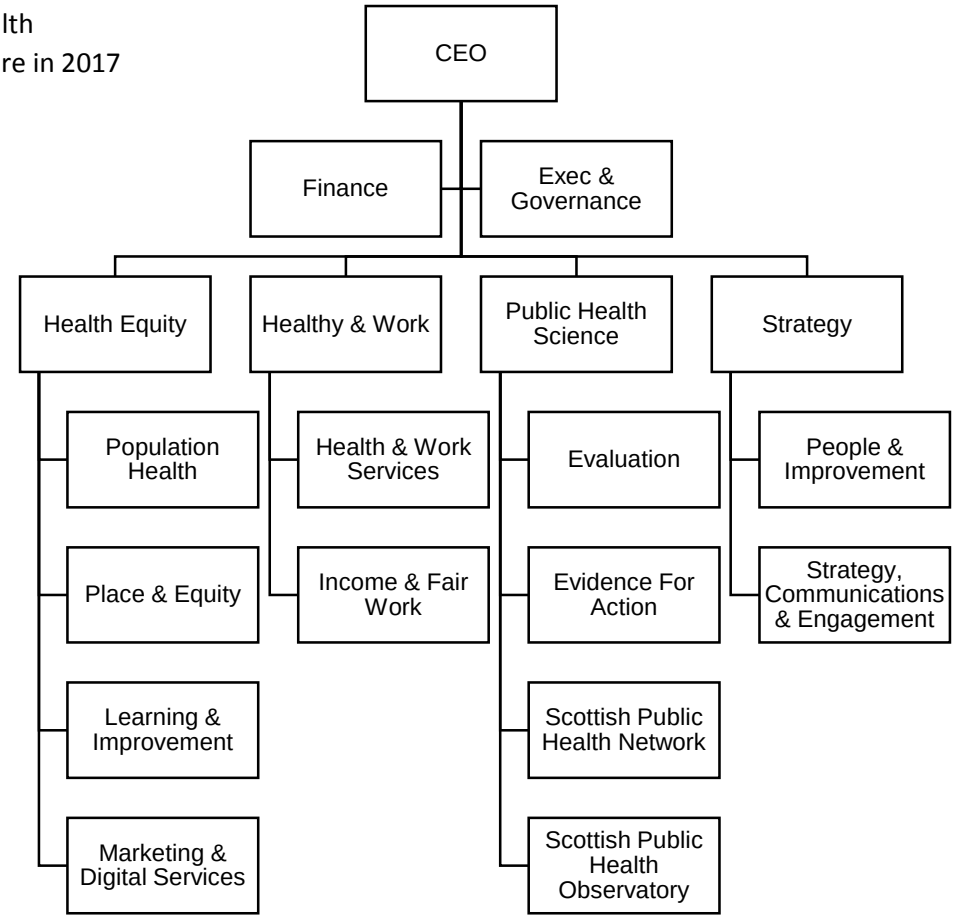


Chart 1: Change in the profile of workforce by grade (WTE)

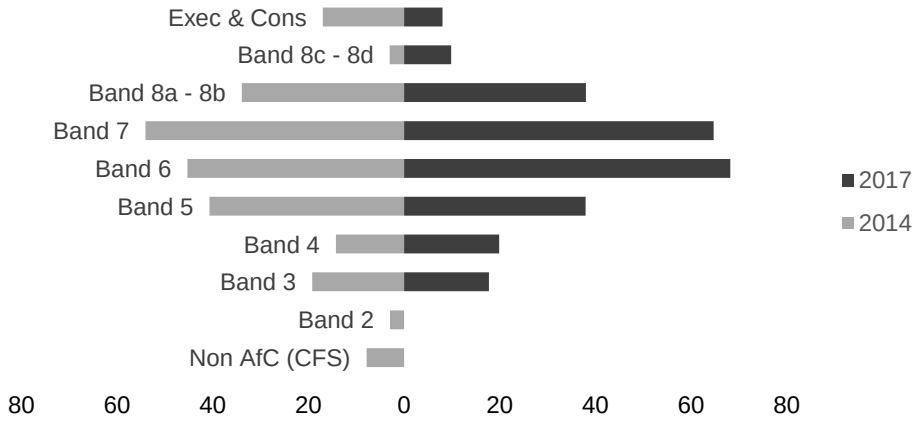


Chart 2: Staff perception of how the change supported AFHS varied with a negative skew

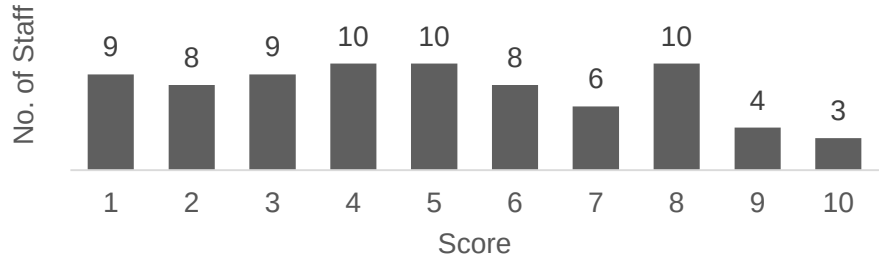


Chart 3: Staff are not sure whether NHS Health Scotland's structure is more aligned to its strategic aims than in 2013

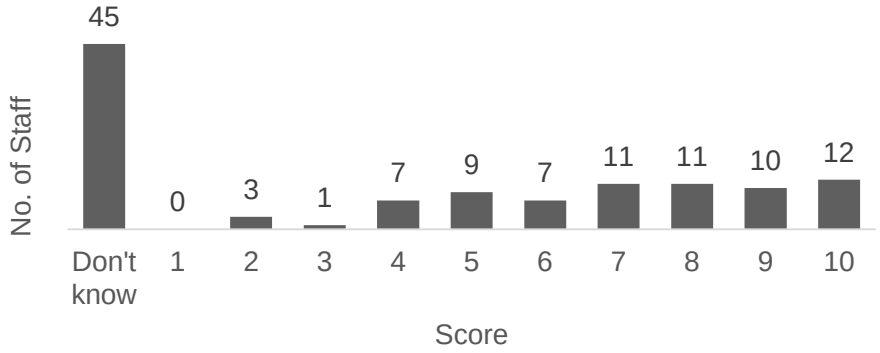


Chart 4: Staff perception of how well our structure delivers outcomes and prioritises activity effectively and effieciently has a positive skew

Chart 5: Most staff felt better informed about this change compared to previous changes

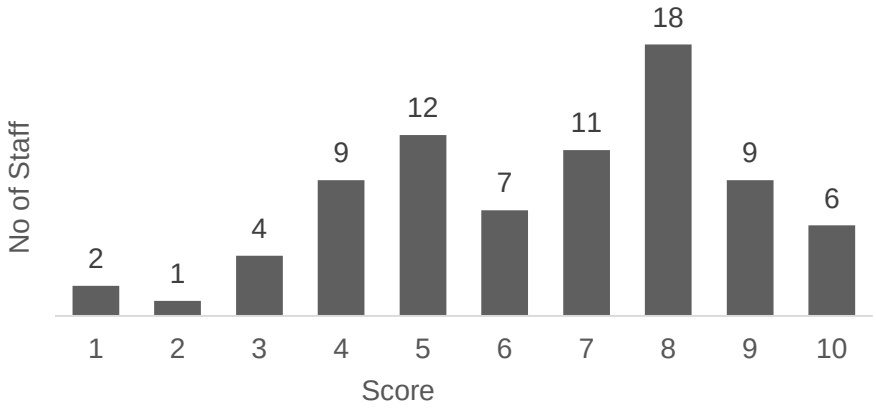


Chart 6: Percentage of staff who agree that staff are consulted on changes that affect them

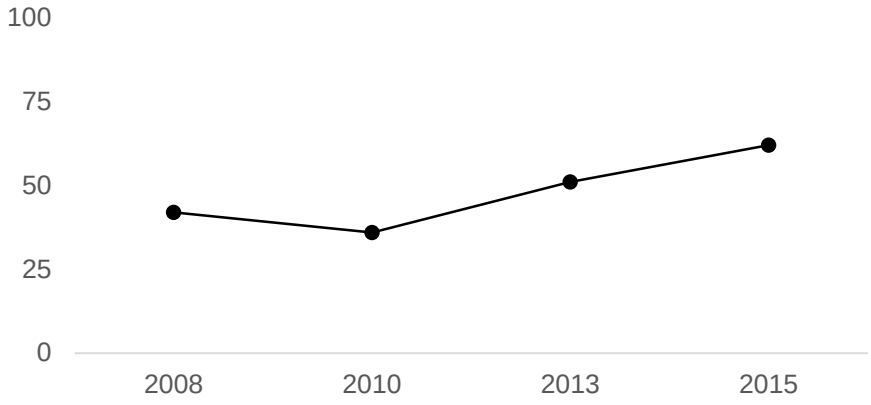


Chart 7: Staff felt somewhat clear on the purpose of the proposed changes

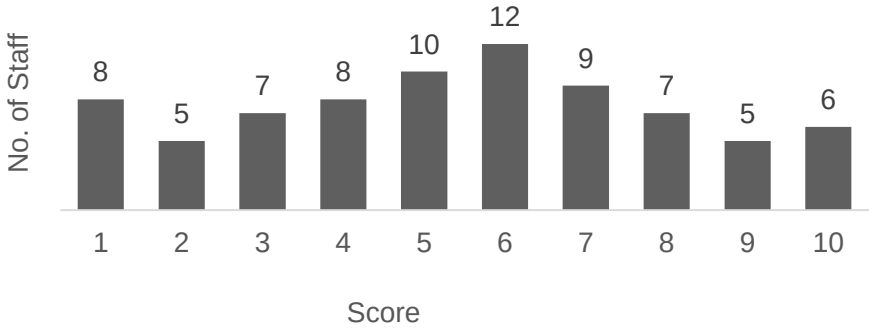


Chart 8: Top five most common areas staff said we could do better in the future

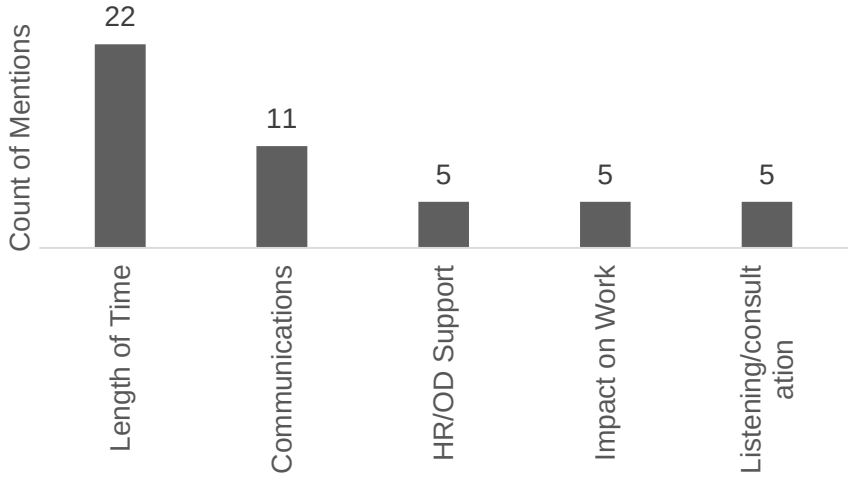
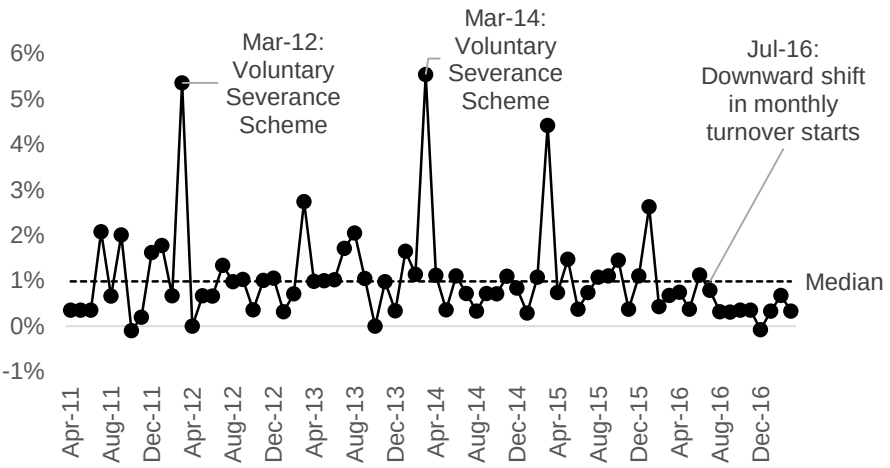


Chart 9: % Monthly Turnover from April 2011 to March 2017



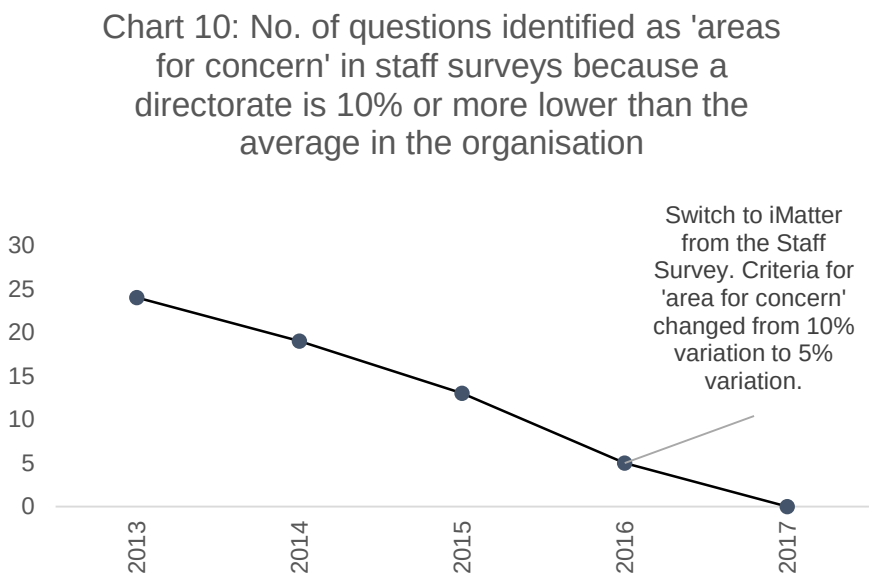


Table 1: No. of People Line Managed by a Director

Year	No. of People Line Managed by a Director
2014	32
2017	20