

# Leading Health Workforce Change: Insights from Experience

Martin Chadwick

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Primary Supervisor: Liz Smythe

## Abstract

New Zealand has unique legislation that allows for the government to plan for, and to provide for, the health and wellbeing of its population. The pressures to continue to do so are enormous. This thesis describes the work undertaken within Counties Manukau District Health Board (DHB), with an intention to align the Allied Health workforce to an organisational strategy of providing services based within localities. This first required me, in my role as the Director of Allied Health, to gain a deeper understanding of Allied Health and, in turn, to gain greater insight into the process of change. By seeking clarity on these two points and deploying an action spiral methodology, there was the ability to progressively seek to understand how change could effectively be enacted within the organisation. While this was initially within the Allied Health professions, the organisational context led to the action spiral cycles encompassing the broader workforces involved in providing services to localities.

Over time all four localities, identified within Counties Manukau DHB, progressed through the action spiral cycles in seeking to more explicitly align the healthcare workforces to their locality. As the action spiral cycles wound up, a fundamental question remained unanswered as to whether actual change had been affected. This was evaluated using an inductive thematic qualitative analysis. Seven key themes were identified: (1) Engagement, how the employed change framework engaged the staff; (2) Process, the strengths and issues of the process deployed; (3) Change, how the change framework did and did not enable change to occur; (4) Ways of working, what arose as a part of the process to challenge to facilitate changes to patterns of working; (5) Porosity of professional boundaries, how the process enabled more in the way of cross boundary working between some, but not all professions; (6) Managing change within a team, the benefits and challenges that arose; (7) Broader context, how the change framework enabled contribution to broader organisational change and/or how it potentially still remained separate.

The qualitative analysis detailed the effectiveness of the process and highlighted how ultimately it did not result in sustained change. Taking these key lessons learnt into account there has been the ability to develop a workforce change framework that considers the key theories and philosophies of change and integrates the specific lessons learnt. Potentially the greatest lesson that has come out of this process is the impact that it has had on myself as a leader of change. Understanding the non-linearity of change and the multiple tensions involved in a process of change has, I believe, placed me with a much greater understanding of change, and a responsibility to ensure I do something about it.

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## Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date:

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## Ethics Approval.

Approval for the qualitative portion of this research was obtained via the Auckland University of Technology Ethics Committee. This was obtained on the 20<sup>th</sup> May, 2015; reference number 15/85.

# Chapter 1. Introduction

## 1.1. Research question

This thesis seeks to answer the research question:

How can a workforce change framework be designed, tested, and implemented to support organisational strategy?

It is a question that is rooted in trying to gain a deeper understanding of change. The original intention was to focus on the mechanics of the framework to facilitate change. As with any research, however, in trying to answer one question, many other questions have been uncovered that required exploration. It has also required acknowledgement of my own personal contribution to the process of facilitating change, and the subsequent learning this has endeared.

This thesis is primarily a reflexive analysis. As Leader of Allied Health at Counties Manukau DHB (CMDHB) I was charged to lead a change process. I did not have direct line management over the staff involved. The change framework I adopted (Action Spirals) was informed by action research and appreciative inquiry, but in itself was not 'research'. The research component of this thesis is my reflexive analysis, telling the story of what happened and at the same time analysing effectiveness. To that ends a small research project was initiated following the action spirals. As a researcher (not in my CMDHB role) I gained informed consent from 10 participants to gain their insights on the effectiveness of the process. The outcome of this work/doctoral journey, informed by my experience and reading around the philosophies of change, was the development of a workforce change framework.

As a thesis which sits within a professional doctorate, the focus of this study is on mode two of knowledge production (Rolfe & Davies, 2009); that is, to engage in research that would directly relate to and impact my own practice, in contrast to mode one knowledge production which is more aligned to the scholarly needs of the academic community. Coughlan and Brannick (2010) defined this mode two learning as the responsibility of the action spiraler to not only 'describe, understand and explain the world but also to change it' (p. 6).

## 1.2. Reflexive statement of who I am in this thesis.

Ko Mataatua te waka

Ko Ngati Awa te Iwi

Ko Putuawki te maunga

Ko Whakatane te awa

Ko Martin Chadwick aho

This is my ancestry, what I bring with me, and what is always a part of me, and a part I continue to explore. It is important in the context of this thesis to ground who I was as this process began.

My career is rooted in physiotherapy, graduating in 1991. It has served me well, helping me to be a problem solver in all I do. It has taken me to the United States of America for an eleven-year stint, where I met my wife. It is here that I began my management and leadership pathway, in parallel with a seemingly ongoing post-graduate pathway. I was enabled to undertake roles that sat outside of normal service delivery, and to focus on how services were delivered. It was this opportunity to be somewhat on the outside looking in that continues as a theme throughout my career and has carried over into my roles of leadership and management of teams.

What has always been a part of my professional journey is a desire to understand the 'why' as to how we did things. Similarly, there has always been a belief that things could be better. But the making of things better requires change. A seminal moment for me was watching Dr Don Berwick deliver his 'Forest Fires' address to the annual IHI conference (Berwick, 1999), which highlighted to me how much there is to do in making our systems and processes better for the people who need the services they are designed for. This has been enacted through my roles, be they in a Professional Advisory capacity, programme management, management or into Director roles. It has always been my desire to improve, and work towards a better version of today that has been a primary driver in my career.

This led me to undertaking my doctoral journey. The challenge for me became how could I separate myself, and my drivers, from the undertaking of a doctorate. Explicitly, I arrived at the conclusion that when undertaking this doctoral journey, it has not been possible for me to clearly delineate between when I was doing my job, and when I was a doctoral student. Coughlan and Brannick (2010) used the term the 'actor-director', which highlights the inability

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to be neutral; rather, as a doctoral student I was actively intervening to make things happen. My bias through the course of this thesis is that I was enacting a process of change that was a circumstance of time and my position in the organisation.

The doctoral process allowed for me to capture this process. Having led several action spirals, I recognised the need to discern both the effectiveness of the process and the ongoing impact. To this end I conducted a piece of qualitative analysis. My bias was to encourage staff to work beyond their taken-for-granted professional boundaries as a means of better aligning services to need and improving client care was with me as I enacted my role in the workplace. Further, I came with not only the bias to improve practice but also to harvest my personal insights. This had the dual benefit of working towards a DHSc qualification and developing my leadership nous. From this reflexive experience I also offer a contribution to knowledge that has been distilled into the Workforce Change Framework (WCF).

### 1.3. Background and rationale for the study

#### 1.3.1. Healthcare under constant change

The need for a workforce change framework (WCF) can be reflected in the pace of change within healthcare. Since the 1980s, it has been estimated that the New Zealand healthcare system has been subjugated to no fewer than five major reforms (Cummings, McDonald, Barr, Martin, Gerring & Daube, 2014). While the healthcare landscape has been relatively stable since the early 2000s, it has left a legacy of change being a constant.

The drivers of this constancy of change is the seemingly insatiable demand for services, and the constant requirement of service providers, the District Health Boards (DHBs) being the largest, to adapt service delivery to better meet this mandate. Such demand is twofold in nature.

The first driver of demand is the changing demographics of New Zealand. The population is growing – the older cohort is growing quickly, as is the younger cohort. Both are noted to be the highest users of the healthcare system. Thus, as the population grows, so does the demand for services (Keene, Bagshaw, Nicholls, Rosenberg, Framptom & Powell, 2016). There is also the subsequent increase in the complexity of needs for these patient groups. Chronic lifestyle influenced conditions are noted to be the largest and fastest growing components of

healthcare need in New Zealand (Keene et al., 2016). In short, the demand for healthcare services is growing, with no sign of this demand decreasing in the foreseeable future.

The second driver around the need for change in service delivery is the limited financial envelope that funds services. While this is contestable territory, Treasury has noted a 442% growth of spend on health from 1950 onwards, while GDP has only grown at 147% (Keene et al., 2016). While this figure is designed to be alarming, further analysis brings this figure into context. Comparing the percentage going towards Vote Health, there has been a relative decrease with a 6.32% proportion of GDP being allocated in 2009/10, as opposed to a 5.95% allocation of spend in 2014/15 (Keene et al., 2016). The picture that is being painted is that there is proportionally stagnation or slight decrease in the relative spend being allocated to health over time.

This context of seemingly insatiable demand for services and a relatively fixed notional spend on health from central government brings into focus the relative spend that is put towards the healthcare workforce, between 70-80% of a DHB's budget. The logic then would be that if there are gains to be made in the efficiency, or efficacy of healthcare delivery, a key place to begin would be with the healthcare workforce.

This relates to my place within the healthcare organisation at the time of conducting the research, which was as Director of Allied Health (DAH) at Counties Manukau DHB. Since the early 1990s, Allied Health, and the role of leadership of this, the second largest health workforce grouping after nursing, has become firmly embedded into the nomenclature and culture of the health landscape. The concept of Allied Health is discussed in Chapter 2. The DAH is a role that exists to provide leadership to this workforce grouping. Counties Manukau DHB as an organisation continues to evolve how it delivers services to meet the noted population health challenges. Hence the need to explore how the allied health workforce could be responsive to these changes. Within the context of this research, a review of how the multiple Allied Health professions worked together, and how the perceived professional boundaries could be managed so as not to be a barrier to improving service delivery, was required. It is somewhat coincidental that at the end of my research involvement with this study I also terminated my employment at Counties Manukau DHB, giving a clear 'end' to this project.



### 1.3.2. Concepts of professions and professionalism in healthcare

A key challenge when looking to improve the efficiency or efficacy of the healthcare workforce is its lack of homogeneity. Allied Health is a highly divisionalised workforce with multiple professions – some operating in harmony, and some in almost direct conflict with each other. Many of these professions exist in the healthcare landscape with a rich, identifiable and traceable history. The establishment of the Allied Health concept in New Zealand, from the 1990s onwards, has created a clinical ‘triad’ of ‘medicine, nurses and allied health’. In 2006 the Ministry of Health published the *In Good Hands* document that was the outcome of a broadly representative working group examining clinical governance in the New Zealand healthcare context (Ministerial Task Group on Clinical Leadership, 2009). The summary of this document was that good clinical governance can be identified when there is clinical input to management decisions at all levels of organisational decision making.

What this requires, however, is balanced and equitable input into these decisions; otherwise the premise of the conclusion is flawed as it will bias one leg of the clinical triad. What is highlighted is the inherent tension that exists in healthcare. It is a highly professionalised workforce, and any change needs to take into account the impact the change will have on professions and how professions interact with each other when providing services.

### 1.3.3. Concepts of Bourdieu applied to professions

To seek to understand the tension that exists between professions in the healthcare landscape, there are many models and frameworks to draw upon. One process is to use the work of sociologist Pierre Bourdieu and his *Theory of Practice* (Bourdieu, 1977). Bourdieu seeks to describe how we all exist within social fields. He termed the space we inhabit within a social field one’s ‘habitus’. Habitus is determined by collating capital which can be one of five forms (political, symbolic, cultural, social and economic). Use of Bourdieu’s writings provides a language to describe the interaction between professions, and why professions are perceived to act in the ways that they do. Potentially this can lead to a greater understanding of why things are the way they are.

#### 1.3.4. Impact and significance of allied health as a healthcare workforce

The works of Bourdieu are useful as Allied Health, by its very nature and common understanding, is not a single workforce; rather it is a conglomerate of many of the 'other' workforces that make up the health workforce. When placed within the environment of ongoing and constant change, this places Allied Health in both a position of strength and weakness.

The strength lies in that it is a grouping that has in many instances already learned how to work well together. As the march of progress and change continues, it is well placed to be able to adapt to and meet these changes. The contrary view is that it is a fragmented grouping that has little to bind it together and therefore is liable to be subjected to a divide and conquer approach from the much larger nursing workforce, and the traditional power base that lies with the medical workforce (Abbott, 1988).

History has shown that change in healthcare should be expected, and the forces that create the need for change will continue to grow stronger. The issue then lies in how this group can continue to adapt to these changes taking into account external influences.

#### 1.3.5. Practical and theoretical justification

Within the context of incessant drive for change, and using Bourdieu's theories, the nursing workforce offers strength in numbers (economic power) and its 24/7 coverage of care (cultural/political power) as detailed by Rhynas (2005). The traditional symbolic cultural and political power base of the medical workforce still holds sway within organisational hierarchy. When change is mooted, the Allied Health workforce is expected to be able to adapt to these changes, yet with minimal influence over their nursing or medical colleagues (Boyce, 2001). The question then becomes how? How can a workforce that is already a sum of many parts and does not necessarily have a traditional drive to be cohesive, be strengthened by their diversity, and bound by their ability and commitment to work more cohesively as an entity? This challenge forms the basis of the work undertaken.

What cannot be underestimated, and is reflected throughout these writings, is the impact that the process has had on myself as the researcher and the driver for change within an organisation. This reinforces the benefit of choosing action spiral as the research paradigm, as

it allows for explicit acknowledgement of myself as the researcher influencing the research itself. The ability to use the concept of reflexivity, as used within action spiral to explicitly examine the impact the research has had within a cycle, lead to the design of the next research cycle.

## 1.4. Focus and approach to the study

### 1.4.1. Methodology

The approach which informed my actions as leader in the project/s discussed in this thesis was the development of a series of action spirals (Cardiff, McCormack & McCance, 2018). Choosing this methodology (while acknowledging it was conducted as 'leading-change' rather than 'research') has allowed for explicit acknowledgement that the desired future state of the work undertaken was unknown. It was only by undertaking cycles of change that clarity was gained as to what process was to be employed on an ongoing basis. Furthermore, action spiral allowed for explicit acknowledgement of my role as the 'actor-director' influencing the work undertaken. Appreciative inquiry was employed to provide the framework by which the action spiral cycles were shaped and in turn deployed. The specific research component embedded within this thesis to evaluate the effectiveness and impact of the change process was qualitative and employed the methodology of inductive thematic analysis (Braun & Clarke, 2006).

### 1.4.2. Thesis structure

This thesis is structured to best reflect the journey that I have been on as a researcher. To understand the context of the research setting, time is taken in Chapter 2 to explore the specifics of Counties Manukau DHB where I was employed during the period of the research itself. The challenges that this DHB faced during the period of the research were being addressed in a specific way. There was a desire to drive services via a focus on specific localities and the populations contained within, and in turn to align services to the needs of

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these resident populations. In essence, to move from a system of discipline specific responses with multiple health practitioners, to a greater sharing of professional intervention. This is best described in the analogy of moving from multiple cars in a patient driveway, to one car and one health professional fulfilling many tasks.

A key component of this drive for change was a renewed focus on the workforce, of which Allied Health is a significant component. However, in order to better understand the role Allied Health could have in any changes, I first took time to explore the construct that is Allied Health; how the term came about, how the term has been used internationally, and in turn how this has translated to the New Zealand setting. This background allowed for a more explicit understanding of how alignment to the locality could be achieved by this workforce.

The word change is used frequently and liberally throughout the thesis. As such Chapter 3 has a focus on the theories behind change, and how they can be applied to the context of Counties Manukau DHB, where the research occurred. The specific theories and philosophies that underpin change are given space for exploration. The uniqueness of change in healthcare is addressed by examining the concept of professionalism as it relates to change and how, in turn, this can be tied back to the writings of Pierre Bourdieu. In this context, other relevant literature that has undertaken a similar path is noted.

Chapter 4 describes the approach taken. The rationale for choosing action spirals as an approach is explored, as well as the associated philosophies. Specifics are given around the study design, including the site and how the field work was undertaken. The process of evaluating the effectiveness of the change process via a qualitative approach is also detailed. The rigour of the qualitative research process is addressed.

Chapter 5 details the specific action spiral cycles that were undertaken. A total of five cycles were completed, and each followed the format of observe (research and data collection), reflect (critical reflexivity), plan (strategic action plan), and act (implement). This is a format noted within the literature and allows for consistency of reporting on each cycle and captures the development of each cycle integrating the learnings from the previous cycle.

As the research progressed, it became self-evident that the data derived from the action spirals did not tell the story of 'what happened next'. Chapter 6 details the evaluative process that was undertaken in conducting a piece of qualitative analysis using an inductive thematic analysis. The rationale behind this approach is given, as well as the data gathered, and the themes that were generated.

Chapter 7 pulls together chapters 5 and 6 for appropriate analysis and discussion. Within this chapter, the theoretical implications of the research are debated, as well as the implications of viewing the research through the works of Pierre Bourdieu. Space is devoted to look at each action spiral in turn, what can be taken forward out of the study, as well as the limitations of the study.

As this research is grounded in the workplace, there is significant benefit in using the lessons learned, and in turn developing a change framework that integrates the work to date. This is the focus of Chapter 8. The rationale behind what is presented is given as well as detail of a reusable change process that can be uplifted from the work undertaken and applied in other contexts.

As this change process is based on action spirals, it is written throughout in the first person as is detailed by Coughlan and Brannick (2010) and McNiff and Whitehead (2011). My role as the actor/director of the change project is explicit, along with the inability to separate myself from the process itself. This endears intensive reflection of my role within the research and, as the literature details, there is often the unintended impact on the person writing in the first person, namely myself. My process is captured in Chapter 9, which provides the opportunity to detail the reflection that occurred as the research unfolded over time. I see my role in an ongoing sense as the actor/director within the context of the workplace. While my place of work has changed since leading this change process at Counties Manukau DHB, my new appointment is to a similar role within another DHB.

Chapter 10, as the final chapter, is used to weave together outstanding threads. It reviews how this work can be synthesised and supports previous theoretical work. It reviews its correlation with similar research, and the implications for ongoing practice, education, and potential for further research.

### 1.4.3. Parameters of the study

This research took place entirely within the confines of a DHB, specifically Counties Manukau DHB, within New Zealand. While the research itself was informed by international examples, the actual application was within this single setting.

## Chapter 2. Context and Issue Identification

### 2.1. Chapter introduction

This thesis came about to address a specific need. This work is based within a New Zealand DHB that at the time was facing increasing pressures around service delivery while operating within financial constraints. These pressures are examined in a level of detail within this chapter to provide a rationale as to why the research was undertaken. Specifically, the intention of redesigning service delivery to be more aligned to specific geographic and population centric localities is explored. Central to this re-alignment is the workforce, of which allied health represent a large component.

To understand Allied Health in this context, the genesis of the term, and how as a concept it has developed internationally, is critiqued. I further explore the application of allied health in a New Zealand context, and then more specifically within the context of Counties Manukau DHB.

### 2.2. Counties Manukau Health as a District Health Board

Counties Manukau DHB, the entity whereas the researcher I was employed, formally came into existence in 2001 as a result of the Health and Disability Act which was passed into legislation in 2000 (New Zealand Public Health and Disability Act, 2000). This ended a period of relative upheaval in the New Zealand health sector (1980-90s) where it was estimated there were no fewer than five separate changes in how healthcare in New Zealand was structured and provided (Cumming et al., 2014). The legislation is unique internationally in that it specifically sets out that the DHB is responsible for the health and wellbeing of the resident population within its catchment area (New Zealand Public Health and Disability Act 2000, s22). The uniqueness is that the DHB is responsible for providing health services and has a responsibility for the wellbeing of the community.

The catchment area of a DHB is defined geographically. Counties Manukau DHB is defined geographically as the southern portion of Auckland city, in the North Island of New Zealand. It takes into account the urban areas of what was previously defined as Manukau City, the eastern portions of Howick and Botany, and the more southern urban areas of Papakura and Pukekohe. It also encompasses the rural areas in the east of Maraetai and Kawakawa Bay, and south to the Bombay hills. To the west it captures the rural areas surrounding Pukekohe and

the Awhitu peninsula (see Figure 1). In 2016 the land area contained a resident population of 534,750 (Counties Manukau Health, 2017).



**Figure 1: CMDHB Boundaries (Counties Manukau Health, 2017)**

Under the Health and Disability legislation, the DHB is governed by a board comprising of 12 members; seven elected within the local body election cycle and five appointed by the Minister of Health. The chair of the board is one of these appointed members. The board has ultimate responsibility under the legislation for overseeing the budget which in 2015 was 1.5 billion dollars. This is delegated operationally to the chief executive and the executive leadership team who oversee the facilities and human resource capacity of the DHB.

### 2.3. Challenges facing Counties Manukau DHB

The resident population of Counties Manukau DHB is one of the more challenging in New Zealand from the perspective of demographics and service need. It is one of the largest from a population perspective and has one of the fastest growing and largest older populations in the country. It has a significant and growing younger cohort. The population itself is ethnically diverse, with New Zealand European being in the minority in some areas of the DHB. It also has large pockets of socioeconomic deprivation. All are noted to be factors that can adversely

affect the health status of a population (Wilkinson & Pickett, 2010). This is borne out in health status statistics where there is a 10-year gap in life expectancy for the resident Maaori<sup>1</sup> and Pacifica population as opposed to the New Zealand European population of the DHB. Both ethnicities are noted to be overly represented in the statistics for long term conditions, as are those living with a disability.

While this snap shot of the population highlights significant challenges for the DHB in the provision of healthcare services, as well as maintaining the wellbeing of the resident population, it is further exacerbated by the ongoing and continual growth of the resident population. While the population has been growing, the relative proportionality of the associated challenges has kept pace. In essence, the DHB is faced with a basic scenario of needing to provide more of more, with no tangible change on the horizon.

These challenges need to be compared against the funding that is allocated to the DHB for the current and ongoing provision of services. As noted earlier, the current budget allocated to the DHB is in the order of 1.5 billion dollars. The funding for health services in New Zealand has been fortunate insofar as there were not cuts to health spending during the global financial crisis, rather there was continued growth. Such growth, however, is noted to not be in step with the growth for services, a situation further exacerbated by the 2011 Christchurch earthquake which essentially diverted the majority of allocated capital funding nationally to the city to enable it to rebuild its infrastructure and health services that were significantly impacted during the earthquake. This then has not allowed for any ongoing funding for new facilities within the Counties Manukau DHB to provide for the growth in services.

Simply put, Counties Manukau DHB is in an unenviable position of a challenging population for which to provide health services. It is a high needs population which is also growing. In parallel, the funding which has been allocated to the DHB to provide these services has also been growing, but not at a rate to match the growth of the growing complexity of the populations and the healthcare services required to meet the obligations under the legislation. The stark reality is that maintaining the status quo is untenable. There is a clear call for something to change.

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<sup>1</sup>The spelling of Maaori uses a double 'a' which reflects the convention of the Tainui as the local iwi as opposed to the more common presentation of Maaori spelt with a macron i.e. Māori.



## 2.4. Localities as a strategy to address the challenges facing Counties Manukau DHB

The existence of good longitudinal data has highlighted the issues that Counties Manukau DHB does, and will face; issues not lost on the board or the CEO and the senior leadership team. In the early 2000s planning was undertaken to examine how to best address the problem the DHB faced. What emerged was the concept of seeking to align services more directly to communities, and acknowledging the differing communities that existed within the DHB bounds.

In 2009 a series of workshops were undertaken to explore the concept of 'Takiwaa Ora', or locality planning. An internal document summarised the process and the intended direction of travel around the concept of localities and gained official sign-off by the board within the 2009/10 District Annual Plan (Counties Manukau DHB, 2009). The approach was echoed within neighbouring DHBs as an intended direction of travel. Due to change in government however, enacting the strategy at this time was not achieved. The new government had a strong focus on 'Better Sooner More Convenient' (BSMC) care delivery. While this was not a governmental policy in its own right, it gave direction to the DHB, along with direction around greater regional working, culminating in 2010 with the establishment of the Greater Auckland Integrated Health Network (GAIHN) which stated three main aims:

1. Identification of individuals at high risk of unplanned admission, and provision of enhanced care for these individuals through their primary care practice
  2. Better responses to acute events in the community
  3. Enablers of better individual care, including clinical pathways for priority conditions.
- (Martin, 2012)

The focus on BSMC and GAIHN consumed considerable DHB time and resources, and substantively diverted attention away from the Takiwaa Ora/locality strategy. While the intended aims of GAIHN were well founded, it did not achieve its intended goals and was gradually wound up over 2014/5, with regional clinical guidelines being one of the few substantive achievements that survived. While the intended outcomes were not achieved, it allowed Counties Manukau DHB to refocus energies locally.

What followed was a series of centrally funded, locally focused initiatives to clarify the needs of specific communities within the DHB that allowed for two things to occur. Firstly, it provided an in-depth analysis of the health needs of the resident population, and it allowed for further questioning as to what communities existed within the Counties Manukau DHB. This bought

the ability to group the residential communities logically. What emerged was a picture that was similar, but different from, Takiwaa Ora. It was similar insofar as there was a level of agreement that four main communities could be identified within the DHB bounds, but the make-up of these communities was somewhat different. The four localities that were identified were, and still remain, Franklin, Manukau, Eastern, and Otara/Mangere. The stated purpose of the establishment of the locality approach was the first step in integration of care and services across the DHB (Counties Manukau DHB, 2016).

## 2.5. Allied health as a key workforce within the locality strategy

The locality webpage on the Counties Manukau DHB website highlights that the intent is for 'hospital and primary care staff to work together to support patients in the community'. Inherent within this statement is a strong focus on staff enabling the Locality Strategy. Staff can be grouped into three main clinical workforces; nursing, allied health, and medicine. Allied health is a term used to describe the second largest workforce, after nursing, that is involved in providing clinical patient care. Roughly there are three groupings that fall under this term, providing services throughout the whole system:

- Therapies (e.g. physiotherapy)
- Scientific (e.g. laboratory scientists)
- Technical (e.g. medical radiation technologists)

Allied health accounts for over 1000 Full Time Equivalent (FTE) within Counties Manukau DHB and has been steadily increasing in line with the other clinical professional groups. From a budgetary standpoint, in the 2014/15 financial year this equated to 9.5% of provider cost as a percentage of revenue. This percentage has essentially been unchanged over the last four years.

## 2.6. Understanding allied health as a concept

Allied health as a title is well established in Counties Manukau DHB; yet allied health is a generic term. To better understand the impact this workforce can have in providing clinical services, there is benefit in understanding the term, and then placing it into a local context.

### 2.6.1. Genesis of the term allied health

As with many words and terms, the origin allied health could have been lost to the mists of time. Thankfully in the *Allied Health Workforce and Services: Workshop Summary for the National Academy of Sciences* (Institute of Medicine, 2011), Steve Olsen writes specifically of the genesis of the term allied health:

In 1966 the deans of 13 university-based schools of health professions met in Washington, DC, to discuss possible federal actions to bolster the health care workforce. According to David Gale, Dean of the College of Health Sciences at Eastern Kentucky University, a persistent story that has emerged from the meeting is that a secretary at the meeting suggested using the term allied health to refer to the professions and occupations other than medicine, dentistry, and nursing that are essential to health services—and the name stuck. (p. 11)

The report goes on to detail the use of the term from this genesis and resultant legislation that specifically uses the term allied health. From this point of inception of the term in the United States (US), it has been a term grounded in legislation.

### 2.6.2. Understanding allied health internationally

Allied health is a term well used internationally, but not uniformly. While the term allied health has its origins in the US, its subsequent use internationally is both simple and complex. At its very simplest, a definition of allied health is one which encompasses the health workforce that is not medical doctors and nurses. The intention in this section is to examine the term allied health and how it has been used over time within the US, Scotland as a country of the United Kingdom, Australia, and New Zealand.

#### 2.6.2.1. Allied health in the United States of America

The text *Allied health: Practice issues and trends in the new millennium* (Lecca, Valentine, & Lyons, 2003) provides a historical overview of the application and associated difficulty with the use of the term allied health within a US context. Lecca et al (2003) traced the attempts to define allied health from a Federal Government standpoint. One of the earliest attempts of defining allied health he notes was in 1980 when the National Commission on Allied Health

Education defined the grouping as, "... all health personnel working towards the common goal of providing the best possible service in patient care and health promotion" (p. 34).

Being non-definitive, it was criticised in the 1989 Institute of Medicine report for not providing the guidance as to who is 'in or out'. A rather more lengthy definition was derived from the 1995 *Report of the National Commission on Allied Health* and referenced the Health Professions Education Extension Amendment of 1992, section 799 of the Public Health Service Act, defining allied health as:

A health professional (other than a registered nurse or physician assistant) who has received a certificate, and associate's degree, a bachelor's degree, a master's degree, a doctoral degree, or post baccalaureate training in a science related to healthcare, who shares in the responsibility for the delivery of healthcare services or related services, including (1) services relating to the identification, evaluation and prevention of disease and disorder, (2) dietary and nutrition services, (3) health promotion services, (4) rehabilitation services, or (5) health systems management services, and who has not received a degree of doctor of medicine, a degree of doctor of osteopathy, a degree of doctor of veterinary medicine or equivalent degree, a graduate degree in public health or equivalent degree, a degree of doctor of chiropractic or equivalent degree, a doctoral degree in clinical psychology or equivalent degree or a degree in social work or equivalent degree. (Health Professions Education Extension Amendment s799(5)A-C, 1992)

This definition provides some broad points in that an allied health professional must come from some form of formalised training (a certificate and associate's degree, a bachelor's degree, a master's degree, a doctoral degree, or post baccalaureate training in a science related to healthcare), and it clarifies who cannot fall under the term (doctor of osteopathy for example). This legislation tried to define broadly what allied health is and, more specifically, what it is not. A summation of the legislative perspective within the US could then be that a tight definition remains problematic, other than defining that formal training is required, and there are professions that are defined as not being a part of allied health.

Lecca et al. (2003) went on to explore the relationship between the American Medical Association (AMA) and the allied health professions where from the 1930s to 1993 the AMA provided accreditation of the allied health education programmes. Their position statement details their stance:

The AMA recognizes that it has great responsibility and that it must be acutely aware of, and related to, all the allied fields for one extremely important reason: that all the allied health workers find their focus, indeed their reason for existence, in the care of the patient; and where the care of the patient is concerned, the physician ultimately has legal, moral and ethical responsibility. As the major professional organisation for

physicians, the AMA feels this responsibility keenly and believes that it must increasingly be involved in the coordination, guidance and direction of the multiple, increasingly fragmented components of the healthcare team, through which the care of the patient is provided. (Cited in Lecca et al., 2003, p. 16)

This overtly paternalistic stance did not last, with the oversight function ending in 1993, and a defined accreditation body being established for the allied health professions.

Donini-Lenhoiff (2008) supported many of the views offered by Douglas, specifically with regards to the education oversight that has been offered or imposed by the AMA. In his article, he traced the use of the term allied health as it pertains to the oversight of the education of the professions which fall under this umbrella. He drew an interesting conclusion that as professions have matured and sought to stand on their own merits, they have chosen to move away from being grouped under the allied health umbrella. He noted that while this has reinforced individual professions' autonomy it has come at the cost of the broader representative power that is afforded with many professional groups choosing to be identified as a collaborative versus smaller individual professions.

#### 2.6.2.2. Allied health in Australia

To date, in Australia, a definitive text such as Lecca et al. (2003) for the US has not been published. However, there have been several active authors who have detailed the progression of the allied health construct in the Australian setting from the 1990s onwards. As one of the earliest allied health focused authors, Astley (2000) described the process that the Women's and Children's Hospital Adelaide undertook in reforming their Division of Allied Health. She noted the formation of the division in 1992, and the challenge offered in 1995 to "officially review its service delivery models and organisational structure in order that it might better meet the vision and values of the Women's and Children's Hospital Adelaide, and the needs of Allied Health consumers" (Astley, 2000, p. 160). She described the process of gaining consumer input and ensuring that there was a clear strategy before structure was designed. The result was one whereby the Division was reformed along the lines of 'programmes' with a management role established to facilitate services being delivered within these programmes.

Boyce (2001) provided a 10-year review (1990-2000) of the development of allied health within Australia. She highlighted the predominance of five organisational structures for allied health:

- Traditional (classical) medical model: individual profession-managed departments reporting to a medical director
- Allied Health Divisional Model: representative/rotating chair of Allied Health located within a larger medical division consisting of individual profession-managed Allied Health departments
- Allied Health Divisional Model: appointed Director Allied Health located within a medical division consisting of individual profession-managed Allied Health departments
- Allied Health Divisional Model: appointed Director Allied Health in a freestanding division reporting to a Chief Executive Officer or Clinical Services Manager position, consisting of individual profession managed Allied Health departments
- Unit Dispersement Model: individual professionals are dispersed amongst clinical units. Profession management is eliminated although notional professional leadership positions acting in an advisory capacity may be maintained. (Boyce, 2001, p. 24)

Boyce noted a transition over time from the traditional (classical) medical model, to the Unit Dispersement model. At the time of writing in 2000/1, the allied health divisional model, in its three forms, dominated. Boyce also noted the waves of re-structuring that occurred in the late 1980s to mid-1990s, with a second wave in the mid to late 1990s. The second wave was as a result of the funding moving towards case mix funding which provided for a greater level of scrutiny of the services offered by allied health professions.

This work was further built upon by Law and Boyce (2003) who noted that while allied health was not the target of reforms in Australia, they were nevertheless pulled along by these same reforms. Interestingly, Law and Boyce make the point that structural changes in allied health need to align to two main domains: resource management and service delivery. The argument being made that allied health needs to be better managed through re-organisation in order to achieve better utilisation of allied health as a resource, and in turn improved service delivery.

In order to manage allied health as a resource, there has been the requirement to define what actually is allied health. Boyce (2013) has argued that it is fruitless to define allied health, noting that it is not: “about who is in or out, rather it is more about who is out and wants in”.

The management of resources most frequently relates to the ability to control budgets. Hence the fear of professions has been that by being ‘out’ of the allied health construct, they risk being ‘out’ of the ability to control budget and, in turn, the ability to control the resources

pertaining to individual groups. This then provides the motivation for individual groups to lobby for inclusion 'in' the allied health grouping.

Boyce (2013) added another interesting concept, that of being a 'shareholder'. The argument she put forward is that prior to the 1980s the focus for allied health professions was very insular. It was about being a 'stakeholder' in one's individual profession. From the 1980s onwards, the focus was on resource allocation and service delivery, and the associated context changed to wanting to be 'in' on the allied health construct to be in control of resources. Making a conscious decision to be 'in' has resulted in an associated change from a stakeholder to a shareholder. As Boyce described this, stakeholders desire to protect their stake in what they have (in this context their profession), while shareholders desire to see the entity they are a part of to grow. A shareholder is also more willing to sustain short term losses for long term gains.

#### 2.6.2.3. Allied health in Scotland as a nation of the United Kingdom

A search of the peer-reviewed literature reveals an almost complete absence of published material pertaining to the historical growth of the allied health concept within the United Kingdom. To gain an understanding of the establishment and maturation of the term it is necessary to review policy documentation that has been produced by the UK's respective National Health Service (NHS). The Scottish NHS is used as an example here.

In the first document, *Planning together: Final report of the Scottish integrated workforce planning group* (Scottish NHS, 2002a) the term 'Professions Allied to Medicine' is used as an umbrella grouping for many of the professions that are considered part of allied health. Many of the themes and suggestions referenced in this document are progressed in a following policy document, *Building on success: Future directions for the allied health professions and Scotland* (Scottish, NHS, 2002b). Within this document there is specific use of the term allied health, as well as the term allied health professions to encompass the specific professions that fall under this umbrella term. What is interesting to note, however, is that the introduction of this document is authored by the Chief Nursing Officer for the NHS Scotland as opposed to an allied health professional. The third document that can be used to trace the development of allied health in Scotland is the document *From strength to strength: Celebrating 10 years of allied health professions in Scotland* (Scottish NHS, 2011). This document details the maturation of the workforce grouping and the contribution made to the overarching vision of

the NHS Scotland. It is also worth noting that the introduction was authored by the Chief Health Professions Officer with a specific remit to oversee the allied health professions.

#### 2.6.2.4. Understanding the term allied health in a New Zealand context

Allied health is a relatively recent term within a New Zealand context. It has almost entirely been associated with the advent of the Health and Disability legislation in 2000 which in turn led to the establishment of the current DHB structure. Within the published peer-reviewed literature there is a relative paucity of material that charts the development of this professional grouping. Mueller and Neads (2005) provide the major reference. They describe the formation of a defined allied health identity within the Auckland DHB.

The genesis of this formation was tied to the integration of four hospitals into one as a result of DHB formation and the associated drive to rationalise services. This was driven largely by a significant budget shortfall. Prior to this rationalisation process, the New Zealand experience was not dissimilar to the Australian experience whereby the individual allied health professions had operated in silos, or in what Boyce and Laws (2003; Boyce, 2001) described as a unit dispersement model whereby professional groupings existed within defined units or services. The integration of the hospitals provided the opportunity to review how the professions best facilitated integration and associated service delivery.

It is of interest to review the process where the most concerns were raised by the physiotherapy workforce which was the largest workforce initially affected. Conversely it was noted that many of the smaller workforces felt that any integration would allow for a redress of what was seen as traditional power imbalances. Through the service rationalisation process and associated consultation process the desire of affected staff was to see the establishment of a leadership role (DAH) to lead further change and integration of teams. Subsequently, the Auckland DHB was the first DHB to appoint a DAH in 2001.

What followed was a pattern of gradual establishment of the DAH roles. In 2006 the second role was established in Otago DHB, which was continued with its amalgamation into Southern DHB. Of note is the sharp increase in DAH roles from 2009-2010. This corresponded to the writing and publication of the *In good hands* (Ministerial Task Group on Clinical Leadership, 2009) which defined the concept of clinical leadership being integral to quality improvement as well as being integrated in all components of organisational decision making.



On review of these roles, it is noted that virtually all of the roles were dedicated strategic roles with any managerial responsibilities usually limited to small teams of dedicated professional leader roles for the specific allied health professions. More recently, in the New Zealand context, it is noticeable that these roles have taken on a more direct managerial responsibility for the allied health workforce.

## 2.7. Aligning allied health to a locality strategy

Understanding the international history of the term allows allied health to be placed into a local context, specifically in Counties Manukau DHB. In the 1990s there was the ability to position allied health within hospital divisions. Professional leadership was provided via professional leader roles, which were primarily profession specific. In the early 2000s mental health services established professional leader roles to mirror what was underway in medical and surgical services (often referred to as 'physical health'). Organisational history notes that the professions of occupational therapy and social work had professional leadership roles that went across both physical and mental health.

In the mid-2000s there was the beginning of maturity with seats at the clinical board table being reserved for allied health and an informal collaborative relationship was established between the professional leaders. Within Counties Manukau DHB, a major change occurred in 2007 with the appointment of Geraint Martin as a new CEO. He established for the first time a DAH within the DHB, which fits with the growth of these roles nationally at the time. For the first time there was an established leadership role for allied health strategically within Counties Manukau DHB.

In 2010 a new DAH (myself) was appointed to the organisation. An initial change implemented during this time was to review the reporting line of the allied health professional leaders, and to negotiate the transfer of the professional leaders in physical health to realign reporting lines to the DAH. This gave a broader organisational influence of the allied health professions.

As noted in section 2.4, it was during this time that the concept of localities began to re-emerge in Counties Manukau DHB organisational planning. With resource being allocated to this planning there was the opportunity to critically review what impact the evolution of localities could have on the allied health professions. A proposal was taken forward to dedicate project support to specifically look at allied health in the organisation, in anticipation of the Locality Strategy (Young, 2013). Initially a review was undertaken to better understand

where the allied health resource was allocated within the organisation. The result of this work was quite striking insofar as when placed on a simple organisation chart and printed out in size 12 font, the result was a organisational diagram five meters wide (see Figure 2, p. 22).



**Figure 2: Organisational chart of allied health**

The chart demonstrated that while the group was reasonable in size, as far as numbers, it was a resource that was well stretched across Counties Manukau DHB as an organisation. Localities had the potential to fracture further what was an already fragmented workforce. The approach to change and, in turn, how to manage the change occurring in the organisation, needed to be understood and approached carefully. The localities strategy had created the impetus for change.

## 2.8. Chapter summary

Counties Manukau DHB is the organisation legislatively mandated to provide for the health and wellbeing of its resident population. It has a challenging population from a health needs perspective, and it is a population that is growing. This mandate is made all the more difficult by a funding envelope that, while growing, is growing at a rate far slower than the current cost of the services. To address this challenge, Counties Manukau DHB embarked on a reshaping of services to deliver them in a locality approach, whereby services needed to be designed to deliver services closer to the communities they serve and in a way that is better aligned to the uniqueness of the populations within these localities.

In order to place the allied health workforce to support the Locality Strategy, specific work was undertaken to better understand how the workforce is placed in the organisation. The result was a realisation that the workforce was fragmented and stretched across the DHB. The Locality Strategy had the potential to fragment the workforce further. The challenge that arose was how to understand better the change that was occurring. The next step was to be able to

facilitate the workforce through a process of change, to be able to enact the Locality Strategy. That became the focus of both my work role and my research. Change is key, and understanding change is key to success.

## Chapter 3. Literature Review of Change and Change Concepts as Related to a Health Care Setting

### 3.1. Chapter introduction

My reflexive journey was informed by a variety of literature at different phases of the study. Some of it was research based while other reading took me back to philosophy. Jones (2018, p.819) suggests that a professional doctorate differs from the narrow specific literature searches of a PhD. Instead, professional doctorate students “read and study broadly”. It has been this opportunity to expand a broad knowledge base that has expanded my leadership development (Costley & Lester, 2012) and fostered the insights that led to the emergent workforce change framework.

The primary purpose of this review was not to reveal the gap in the literature which initiated the study. That impetus came from practice itself. Nevertheless, literature has proved valuable in stimulating my thinking.

The key questions I took to the literature were:

- Do theories and frameworks of change ‘work’ in the health care setting?
- How can I grow my understanding of professions in a way that will help me discern ways of facilitating professional boundaries to become more porous?

This review is presented in 5 sections:

1. Theories of change, and their limitations
2. Research in health settings that has looked at the effectiveness of change management, specifically using Appreciative Inquiry. Further, to identify how this approach has been used in healthcare previously and the effectiveness of this approach in imbedding change.
3. In seeking to break down the boundaries that keep each profession in a silo I explored the nature of professions, drawing on sociological literature
4. This took me on to read the sociological theory of Bourdieu and his concepts of field, habitus and doxa.

5. I conclude with a synthesis of how this diverse range of literature informed my leadership.

For the specific four areas where a literature search was completed, the search engines used were CINAHL Complete and Medline. The search outcomes are captured in the following table:

**Table 1: Focused Literature Review Undertaken**

Search Area	Number of articles identified	Vetting Process	Articles reviewed
<b>Theories of change and their limitation</b>	Between CINAHL Complete and Medline 61 articles identified, 4 duplicates removed.	15 articles identified after an initial abstract review with another 3 articles removed as duplicates.	12 articles submitted to a full critique.
<b>Change management and appreciative inquiry. Key words: Change Management AND Appreciative Inquiry</b>	CINAHL Complete 23 articles identified Medline 6 articles identified	4 articles identified as repeat articles in Medline capture. 6 articles on initial review were editorials or opinion pieces so eliminated.	19 articles were reviewed with a further article being eliminated due to non-applicability to the search focus.
<b>Professions and professionalism</b>	115 articles initially identified between CINAHL Complete and Medline	Removal of duplicated reduced the number to 97 articles. An abstract review removed non-English articles and identified articles specific to the review topic	15 articles were reviewed in depth and included within this review.

Further literature (e.g. Re philosophy and sociology) was accessed through the searching for books in the AUT library catalogue along with the reference lists of the identified articles.

### 3.2. Theories of change and their limitations

Cumming et al. (2014), in writing for the World Health Organisation health systems in transition series, detail the journey the New Zealand healthcare system has been on. The report traces the origins of the current system to the 1938 Social Reform Act and highlights the series of reforms that have been undertaken by successive governments, particularly over recent years. Changes ranged from the 1984 establishment of 14 Area Health Boards, to the early 1990 separation of funding and provision of services via four Regional Health Authorities purchasing services from 23 Crown Health Enterprises that ran hospitals and community services. Then there was the transition in 1998 to a single Health Funding Authority and the Crown Health Enterprises, to become Health and Hospital Services. This change was undone with a change in government in 1999 with a return to a model similar to the Area Health Board structure. In 2000, the New Zealand Public Health and Disability Act was enacted with the establishment of 21 DHBs, which has now become 20. In all the New Zealand health system has undergone five major reforms since the 1980s.

While in recent times there has been relative stability, with no major governmental reforms since 2000, the pressure for change has shifted from external to internal. Growth in demand for services has been detailed in Counties Manukau DHB review of Strategic Plans (Counties Manukau DHB, 2009). This resulted in the development of a new strategic plan for Counties Manukau DHB in 2016 (Counties Manukau DHB, 2016). As a document it detailed the ongoing and planned changes for Counties Manukau DHB to be 'Healthy Together' with its resident population.

Whether the view taken is an external or an internal one, there is a constant of change within healthcare in New Zealand. In order to be equipped to anticipate and work with this change, it is important to understand the process of change itself, acknowledging the complexities that exists within a healthcare system. The 'why' of these changes is often difficult to fully understand, and yet a large body of literature has been developed to better understand the mechanics and theories that support processes of change.

To this end a focused literature review was undertaken using the CINAHL Complete and Medline databases using the key words 'change theories'. Once duplicates and non-English articles were removed, and abstract review identified twelve articles that were subjected to a full review as they addressed specifically the issue of how change theories are applied in the healthcare setting. Of these articles that were reviewed, a significant number were found to have primarily a clinical focus, and specifically focussing on the mechanics of behavioural

change (Benova, Campbell & Ploubidis, 2015; Collins, 2011; Presseau, Mackintosh, Hawthorne et al, 2018; Gardner, Whittington, McAteer, 2010; Thompson, 2000; Whealin, Kuhn & Pietrzak, 2014). While behaviour change is a given for a process of change, these articles did not add to understanding around broader organisational aspects of change, change theories and philosophies. Harris, Lawn, Morello et al (2017) go further in examining why there is the gap between known best practice, and what practice is observed. Within this context they identified nine separate theories that could be used to better understand why this is the case, and then examine against the format of micro/meso/macro aspects of change. What they do not do is seek to outline what a preferred approach to knowledge transition may be and/or the prevailing theory.

A single theory analysis around change is presented by Scott, Mannion, Davies and Marshall (2003) when they focus on culture as one of the primary determinants to assist in a process of change. They highlight the difficulty in defining what culture actually 'is'. From this they provide broad guidance as to the key components that need to be considered in a process of change to address the components of culture in an organisation. Similar to the other research reviewed, they do not put forward an articulate framework or process that can be employed to better work through addressing the components of change during a process. This approach was not dissimilar to that adopted by Fagerstrom and Salmela (2010) in reviewing the constancy of healthcare change in Nordic countries. They argue that the Biological theory of change is the most applicable in this circumstance, but as with the emerging theme there is little in the way of guidance as to what the reader could take from this and in turn apply to their local context. Finally, in this grouping of research is the offering of Schierhout, Damion, Kennedy et al (2013) who examine the specific application of continuous quality improvement methodology to effect largescale organisational change. While not a prevailing theory as such, the specific application of the methodology is examined, and the benefit identified.

McPhail (1997) seeks to provide more of a generic overview of change and change theories within the premise that this has been one of the key roles of nurse leaders over the period of the 1990's. Her overview is cursory, but she does touch on the classic theories of Lewin and Bushy as they relate to change. The focus remains however on the nurse leader as a change agent, and within this context, identifying the key change strategies that they should be aware of, but no clear framework is offered. Potentially the most useful work is that offered by Dadich and Doloswala (2018) who in their work challenge the reader to understand that there are underlying theories and philosophies to the process of change, but the focus is often on the doing as opposed to understanding. They explore the specific theories of agency, situational change, and institutional. In turn they combine them into an integrated model.

They use this model to examine how GP practices have, or have not changed their practice, and put forward thoughts within their integrated theory as to why this is the case. Of the articles reviewed, this is the only article that sought to make an explicit link between theory, and application of that theory.

Underpinning the work reviewed is my desire to see change enacted more purposefully, and as such lead to a broader reading regarding change. Change generally has an intent, there is an intended direction of travel, and the process is to help deliver this change. But the process of change itself can often be clumsy and fall short of what was intended. Smith and Graetz (2011) potentially best capture this clumsiness:

although limited, the management penchant for n-step goal directed change models continues unsated. Seductively simple, the labels attached (Power Tools, transforming, commandments, magic) imply a guaranteed success followed to the letter. In addition, n-step models appeal to leaders by ensuring the top-down control of the change process. Management texts and business magazines Case studies perpetuate and legitimise the rational, leader centred change philosophy. (p. 3)

The Merriam-Webster Dictionary (2017) describes the term change as: “a transitive verb; to make different in some particular, to make radically different, or to give a different position, course, or direction to”. Essentially change is the description of how to get from A to B over time. How healthcare is provided needs to change in order to better meet the needs of the population. However, change, especially in large organisations, is never a simple process.

The above quote from Smith and Gratz’s (2011) work is part of a wider reading aside from the targeted literature review, that highlights an often-prevailing belief that change can be easily achieved. There are a multiplicity of authors and texts who offer various paths to success. Most will boil down their theories to a number of steps that will need to be taken in order to ensure success. The quote as an ‘n’ step approach, where the ‘n’ represents the number of steps that the author recommends will need to be followed, captures this sense of change as a step by step linear process.

To understand the position and direction that Counties Manukau DHB has taken, it is important to gain a grounding of some of the prevailing thoughts around change, and how they can be applied in context. A simplistic view is offered by Bridges (2001), who described change as the transition between two states, and in turn the challenge that is faced by those negotiating change as being able to negotiate the ‘neutral zone’ between one state and another. This attractively simplistic view does capture, I believe, the state experienced at Counties Manukau DHB. It is a state where the organisation neutral – the previous state is no longer tenable for the reasons described, yet the future state has not fully been realised. It is a

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place of uncertainty, where things are changing, there are plans to change and there are rumours of change, but change itself may be somewhat elusive. It is coming, but not quite here. There is a discussion as to what will be new but has yet to be realised. There is a desire to do things differently, yet there is an inability to let go of what is, as services still need to be delivered 'today'. The challenge becomes how to more actively manage this neutral zone.

Managing the neutral zone is examined by Cameron and Green (2012). They provide the reader with an overview of change approaches that can be employed. They take the time to review some of the prevailing thoughts that exist around change approaches. While useful in providing an overview of the prevailing models and techniques that can be employed during a process of change, it does not pretend to analyse why one approach may be preferable over another, or in turn to give analysis as to how these various models and techniques were derived. Aside from specific techniques and tools that can be employed to facilitate change, they also bring to the fore the point that change does not happen spontaneously. In order for change to occur there needs to be a hand that is directing the change. They highlight that change has a strong need for leadership, and that leaders have an important role to play during change.

Picking up on the notion of leadership during the process of change, Herold and Fedor (2008) devoted an entire book to the approach and specific strategies that a leader should employ to successfully negotiate the neutral zone of change. They provided specific guidance as it relates to the need to change context, and whether the role of the leader should be one which is positional, relational, or impersonal. They then lay the notion that defining the role of the leader within one of these contexts will allow for a shaping of employees in preparation to change. Placed in a Counties Manukau DHB context, the appointment of leaders (Locality General Managers) can be viewed as an enabler to oversee the change process and the subsequent shaping of employees to the coming change.

Similarly, Beerel (2009) has a focus on the role of leadership during change. He provided overarching algorithms to guide the approach that a leader should take and how these approaches relate to established leadership theories. He differentiated between leadership and authority, where leadership may aim to facilitate change, while those in authority may mandate the change and/or more directly manage the change. With the focus on leadership, Beerel noted that "the 'soft stuff' of change is the hard stuff" (p. 170). He concluded by providing a summary of the overall tasks of systematic leadership during change, in that the role of the leader is to identify the new realities and the associated change required, identify who will need to be involved in the change and whether they stand to win or lose, manage the

distress that may come from those who will lose, and finally look to mobilise the necessary resources to enable the change. In context, in a heavily unionised environment, much onus is placed on Counties Manukau DHB to ensure that there are formal processes in place through which change will be managed, leaning towards what Beerel would describe as the hard stuff.

As with Beerel (2009), Paton and McCalman (2008) also sought to provide a guide to those leading change management. They teased out the differences between hard and soft skills and give useful tools such as the TROPICS test where those leading change can review whether there is objective or subjective support around Timescales, Resources, Objectives, Perceptions, Interest, Control, and the Source or origin of the driver for change. They contended that working through these criteria and examining whether the support is primarily subjective, or objective will guide the approach the change leader will need to take; that is whether to focus on applying a soft skill set or rely more on hard change methodologies. Their overarching summary is in defining 10 key factors for effective change management.

If 10 key skills are too many, Heath and Heath (2010) undertake the challenge and reduce the needed skills from 10 to three, building the case that the focus of a change leader can be surmised using the analogy of the need to direct the rider (1), motivate the elephant (2), and shape the path (3). Their work is heavily focused on the psychology of change and the responses of individuals to change. The three metaphors used provide a useful check as to where Counties Manukau DHB is at. Directing the rider (1) could be viewed as providing the leadership structure to enable change to occur. Motivating the elephant (2) could describe a new way of working for staff to enable improved delivery of services to the population of Counties Manukau DHB. Shaping the path (3) could be interpreted as the intended direction of travel of the organisation

Potentially one of the foremost authors on achieving successful change within large organisations, Kotter (1996) crystallised the process of leading change into eight steps. He implored leaders of change to (1) create a sense of urgency, (2) form a powerful coalition around this urgency and from this (3) create a vision for change. Once this vision is established the next step is to (4) communicate the vision to the organisation with a view to (5) empower action around the vision for change. Enacting the change is based on (6) creating quick wins, which can be built on for (7) ongoing change, and then finally (8) making it stick within the institutional processes of the organisation.

As a template, it is possible to make a judgement call as to where Counties Manukau DHB is within this eight-step process. A sense of urgency has been achieved with both the population demographics and the health needs analysis of the Counties Manukau DHB population clearly

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defining the need for change to be able to continue to meet service need. Forming a powerful coalition has been managed over time both formally and informally in building the relationships necessary with the Primary Healthcare Organisation entities within the Counties Manukau DHB catchment area. The vision for change has progressively been built upon with establishing the goal of being the 'best' by 2015, and transitioning this goal to become the current Healthy Together 2020 strategy (Counties Manukau DHB, 2016). Empowering action has in part been achieved via a change in the hierarchical structure of Counties Manukau DHB with the establishment of General Manager roles to oversee and support the development of individual localities. There has been a gradual change in alignment of responsibilities within the organisation to support this change. Creating the quick wins could be viewed as the establishment of the general manager roles and the associated work that has been driven out of these roles. Using this template, I would deem Counties Manukau DHB as being in a state of seeking to build on the change and making it stick, reflected in steps seven and eight (Kotter, 1996).

Of the authors reviewed to this point, there is a strong bias towards the role of the leader of change, and the steps or strategies that the leader will need to employ or deploy to affect change. A counterpoint view is offered by Smith and Graetz (2011):

Traditional philosophies depict change as a programmatic, step-by-step process with a clear beginning, middle and end, largely choreographed by a charismatic leader. Change means establishing a new border using bold strategies, structures and systems, processes and often fresh people who personify the new ideology. However, a focus on re-establishing order and stability sidesteps real-world change. Traditional approaches ignore the complex and contradictory nature of organisations, not to mention the diverse range of people working in them. Such a linear, simplistic approach inevitably leads to one-dimensional thinking... (p. 19)

When the authors and their work are reviewed in light of this quote, there is no doubt that the approaches they describe are useful, but potentially flawed. What is mentioned but not fully addressed in the cited examples of Cameron and Green (2009) and Beerel (2009) are the underlying and underpinning philosophies of the change approaches they describe and how they are used. Smith and Graetz (2011) again, addresses this succinctly stating:

Some schools of thought and philosophies on organisational change cling to a logical process pivoting upon the leader's ability to conceive a new future and plan for it accordingly. Other philosophies focus on particular or distinguishing characteristics of an organisation, such as its culture. Others emphasise the psychological impact of change on individual organisational members. In practice, most change leaders wield numerous philosophies at once, use different approaches depending on situation, or change their preferred approach over time. (p. 1)

To rationalise the richness of available literature around change, Smith and Graetz (2011) are of the view that regardless of the approach taken, there is an underlying approach, an underlying philosophy to the way change is approached:

A philosophy with the change reveals the inferences that holds about the best way change can be delivered, typically delivered as theories that generate hypothesis and predictions about organisational change. Philosophies may generate numerous different theories, or based on similar assumptions and premises. However, without understanding philosophies, the relationship between theories becomes murky. Theories also evolve, adapt, and are revised or replaced. (p. 5)

In reviewing the authors referenced to this point, there is the ability to reference Counties Manukau DHB against what each is espousing. Doing so is useful, but potentially flawed, insofar as the authors have continued to look at the process of change as primarily a linear exercise. They also potentially fail to examine the underlying approach that is being taken to the process of change. If Counties Manukau DHB current state is to have a greater depth of understanding as to the change that is underway, and the ongoing need for change, it is of value to briefly examine these philosophical approaches to change.

The **rational** approach focuses on the process employed to enact change. Once a direction has been determined, the change itself can be achieved by manipulation of the parts of the organisational machine. It sees change as a linear process where “resolution seems no further away than vision, analysis and implementation” (Smith & Graetz, 2011, p. 45). The danger within this approach is the reality that change does not occur in a one-dimensional way, and it does not fully take into account the culture of an organisation that may have been established over many years. Such culture will not be changed by the application of a simple linear change process, let alone the fact that the application of such a change framework may in itself lead to significant resistance from those it aims to change in the first-place. The seductive danger of this approach is that it simplifies a change process to tangible bite size chunks for those in charge of change, but potentially at odds to those who will be affected substantively by the change. This philosophy is particularly useful as it provides an understanding to the approach that is often undertaken to change within healthcare, that a logical road map will secure success. As such, it allows for understanding as to why these approaches often fail.

The **biological** philosophy suggests that organisations “live and endure vulnerabilities like any fragile, mortal organism” (Smith & Graetz, 2011, p. 58). Within this philosophy, several approaches are noted by Smith and Graetz (2011). The life-cycle change model essentially equates an organisation life-cycle to the life-cycle of an organism where there is birth, growth, maturity, decline, and death. This cycle relates more to an organisation’s stage of development

as opposed to its chronological age. Of note within this model is that there is only one logical conclusion, death. Death can only be avoided through a process of re-birth. While useful, the authors conclude that this approach can only, at best, provide a rudimentary road map, and while providing potentially powerful analogies is lacking in the necessary detail to allow complex and substantive change to occur. A second approach under the biological philosophy is an ecological approach, which is equated to an archaeologist and the intent of learning why organisations have failed. This approach also does not provide substantive detail, other than the ability to identify change traps to avoid. The final approach identified is the punctuated equilibrium model, which promotes period of slow sustained growth and/or evolution, interspersed with periods of rapid disruptive growth and change. All these approaches are useful in providing powerful metaphors in retrospect, but do not necessarily provide guidance prospectively. They allow us to describe succinctly the cycle of Counties Manukau DHB from birth as a Crown Health Entity with the enactment of the Health and Disability Act in 2001, to growing in services and facilities to provide these services. Such change involves maturation of approaches to quality and improvement, and potentially a current state of decline as the scarcity of resources and the shift in demand for services highlights a system that is not fit for purpose current state. The lingering question within this metaphor is can death be a reality and/or avoided?

The **institutional** philosophy is based around the core understanding that the driver for organisational change arises when an organisation has become out of step with its environment. The external driver is that the organisation strives to remain legitimate by conforming to the wider environment; what is known in this context as the organisational field. This philosophy can be further broken down into 'old institutionalism' with a focus on "influence, coalitions, and interdependencies" (Smith & Graetz, 2011, p. 76), and new institutionalism with an emphasis on an organisation maintaining its legitimacy in its environment. Within this philosophy the term 'isomorphism' is used to describe the situation whereby an organisation is constrained to resemble others who are facing the same environmental conditions. This function is achieved through three mechanisms. The first is coercive means, when pressure is exerted by external agencies to achieve conformity, which may include governments. The second is mimetic, which is when there is an environment of uncertainty, that organisations that are deemed to be novel are sought out and actively copied as to how they enact their business. The third is normative, which relates to employees and especially professionalised employees exerting pressure to shape and define how it is that they do their work. There is much that can be gleaned from this philosophy within the context of healthcare as often there is pressure exerted on how DHBs perform, which may be further

enshrined in legislation. It also provides a mechanism to appreciate the pressure to conform with others, and how this can be difficult to achieve in healthcare with its highly professionalised workforce, and the active desire of the professions to shape services and service provision.

As the title suggests, the **resource** philosophy focuses on how an organisation chooses to use resources, and how it may adapt or acquire new resources in order to gain or maintain a competitive advantage. Within this philosophy, Smith and Graetz (2011) are at pains to note that resources are not just physical resources, but also encompass invisible assets and capabilities of the workforce. The aim within this philosophy is to be able to reduce uncertainty of the external environment by maintaining control of resources. This is particularly true in a context when there are rare resources at stake and a desire to create new resources through innovation in order to maintain a competitive advantage. Viewing healthcare through this lens is helpful in that while in the New Zealand context there is not competition as such between DHBs, resources both visible and invisible are often scarce. The scarcity of resources, especially skilled labour, often leads to innovation as to how resources, for example models of care, are deployed to maximise what resources are available and/or to create new resources. This is particularly relevant in the Counties Manukau DHB context whereby there is a well-documented gap between demand growth and revenue that is forecast to increase over time. This creates a scenario whereby resources will become increasingly scarce, and a growing focus on how these resources (money, people, facilities) are allocated to meet the service demand.

The **psychological** philosophy has at its core the belief that employee resistance to change is always the first instinct, and the challenge is in how to overcome this resistance. This core belief is rooted in the understanding that employees will seek to be proficient in their work and aim for their work to be performed in known and familiar ways. To change how the work is done will challenge the status quo and introduce uncertainty about the ability to perform tasks proficiently, questioning employees' ability to fulfil their roles. How this resistance can be mitigated is detailed through several approaches. The first, empowerment, aims to cut across bureaucratic structures and enact change through team-based organising forms. It does not necessarily seek to do this to give the locus of control of change to employees, but rather assumes that they will need to enact the change regardless. Employees themselves design and drive the change. Interestingly the authors make the comment that "some employees do not want the 'power' to make decisions if it means accepting accountability for the outcomes" (Smith & Graetz, 2011, p. 109). Another approach within the philosophy is organisational development, with a focus on employees and the need to positively manage them through

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change. As an approach it acknowledges the valuable contribution that employees have to make, but the need to be placed in environments to allow for this contribution to be realised. This approach does not necessitate that change be driven, rather it is to be facilitated with employees. The final approach explored is organisational learning which focuses more on the organisational environment and how this may be expressed within the culture of an organisation. As previously noted, healthcare is a highly professionalised workforce, with staff who are highly trained to provide certain tasks. To change these tasks, or the way in which they are provided introduces uncertainty. This in turn may lead to resistance. It is a useful philosophy to lean on as it provides tangible tools to begin to address these issues and will be explored further in this chapter.

The **systems** philosophy is based on the premise that an organisation can only be viewed as a whole, not as a constituent of parts. As a system it is open to influence from both internal and external forces. These influences can be varied and include the introduction of new information, which within a linked system of feedback loops can lead to both intended and unintended consequences or emergence of entirely new ways of working/going about the business. Smith and Graetz (2011) noted the challenge of creating solutions to challenges lies in maintaining a balance between equilibrium and disequilibrium and managing an environment to allow for creativity and innovation to emerge. They further contended that this may require an amplification of ambiguity and uncertainty. That healthcare is complex is beyond debate, as such this philosophy is useful in understanding that there is a need to consider the system as a whole, whereas often the focus is on a constituent part, leading to unanticipated outcomes. As a philosophy it provides a framework to begin to understand the complexities of what is occurring within Counties Manukau DHB. The system that is primary care is linked to services provided in secondary care and vice versa. How one system affects and influences another is not often understood and attempts at change potentially even less so. Yet the interrelationship exists within the wider system.

The **cultural** philosophy can be summarised as change occurring when the underlying beliefs and values held by organisational members change. It is built on the understanding that as countries have separate and identifiable cultures; so too do organisations. It is noted that the impact that culture has on behaviours is profound however identifying the dominant culture of an organisation is anything but easy. What is recommended is a process of culture mapping to be able to understand, through the stories that are held dear by organisational members, who they identify as heroes of the organisation and the rituals to which they adhere. All are indicative of the prevailing culture, and all give clues as to how the culture can be altered to facilitate change. Placed within the Counties Manukau DHB context, this philosophy holds

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value as the organisation is frequently one that is held up as having a 'can do' culture. It is proud of its transition from 'Muddlemore' in referencing to muddling through, to the strong belief that it is one of the premier healthcare organisations within Australasia. It has a strong culture of celebration through professional recognition days and social events such as the Winter Ball. All give clues as to what it is that makes up the culture of Counties Manukau DHB, and how in turn they can become levers for change.

The final philosophy in this section is the **critical** philosophy. Providing a simple definition for this philosophy is in its own right flawed as this approach rejects any singular or grandiose theory, rather it rests with reality being determined by those living it. As an approach it openly rejects that there can be a formulaic approach to change, rather it seeks to rest in the knowledge that there is ambiguity and contradiction in organisational life. But it does provide hope that effective and lasting change can be achieved. One of the concepts that is examined within this philosophy is the concept of 'palstiche' or the fusion of opposites into a new form (Smith & Graetz, 2011). There is the belief that fusion results a new way, but it requires working with multiple methodologies often in ways that would be rejected in traditional change approaches. There is value in this philosophy, in that while on the surface it may appear confusing and operating without rules, it is often a closer reflection of what reality is within the healthcare setting. With multiple professions in a myriad of settings, each group is essentially creating their own sense of reality. The challenge that is faced is the ability to facilitate 'palstiche' where contravening views can collide, long held beliefs can be challenged, and from this something new and potentially unexpected arises. This is especially true in healthcare and the Counties Manukau DHB context whereby long held approaches to how services are delivered are being challenged, and a new way described, but not always fully formed. I argue that within this philosophy there is a need to consciously create the space and frameworks for realities to be challenged, and to allow for new realities to emerge.

It is possible to validate the work of Smith and Graetz (2011) within the literature that summarises theories and philosophies of change. A similar exploratory work has been completed by Demers (2007). She also chose to take a step back and, rather than espousing one approach to change, she reviews the development of concepts around change from the perspective of how they have developed over time.

She grounds her work in the emerging theories of the 1950s and traces the development of these theories to the current day, demonstrating the progressive development and integration as to how change has been viewed and in turn researched. Beginning in the 1950's, she notes the main theories as being focused on either rational adaption, organic adaption, or life cycles.

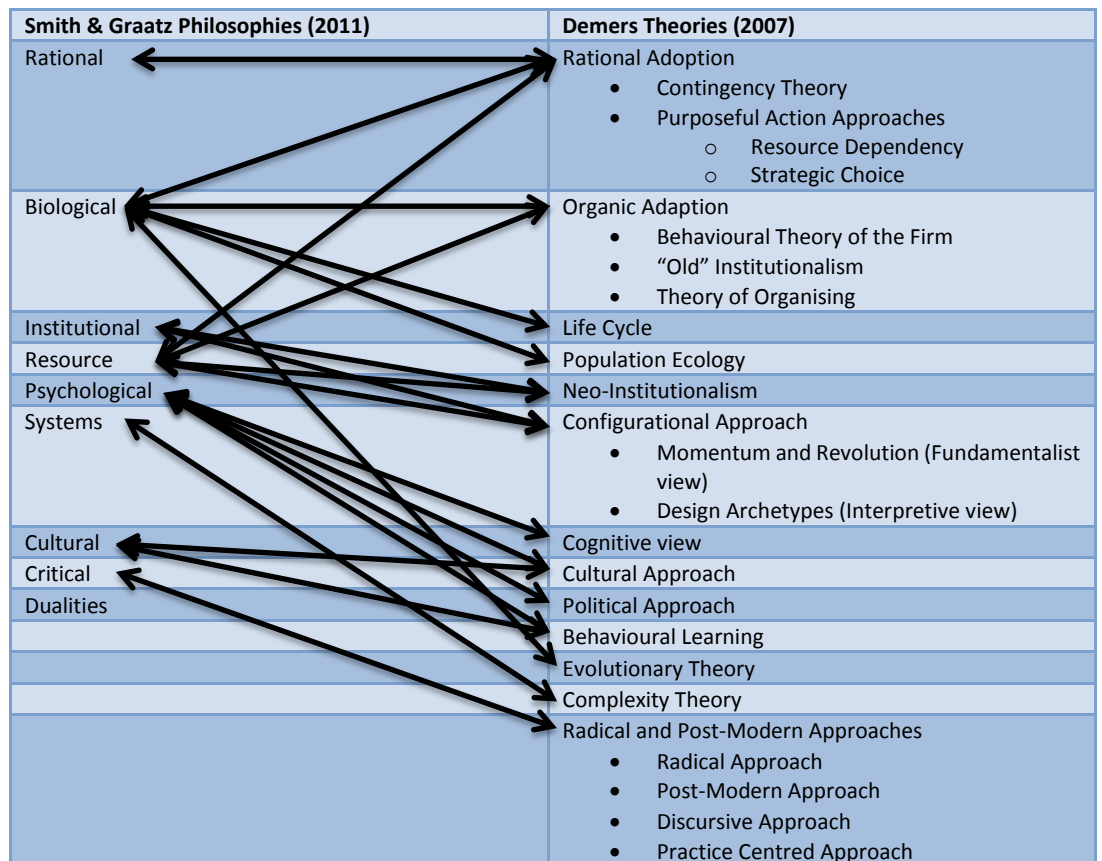


The first two theories reflect how an organisation responds to external factors, the third both internal and external factors.

Through the 1960's/70's and into the 80's she maps the dominant theories of the time. Arriving by the end of the 1980's, the dominant change theories have become focused on configurational, cognitive, cultural, political and population ecology. Each theory in her analysis can be traced back to their 1950's origin. From the 1980's to the current day, Demmers continues to identify how theories inform new theories, and how they may converge or diverge. She ends in the 2000's with a view that the theories of change have proliferated as opposed to aligning. She concludes with the dominant theories in the current era as being focused on radical, post-modern, discursive, behavioural learning, evolution, and complexity. So as a reader, one is left with a sense that change options/change theories have become less aligned over time and when viewing this work, it is of interest how some of the prevailing approaches and theories of the current era had their origins in the 1970s or earlier.

Comparing the work of Demers (2007) with a focus on theory development over time, as opposed to Smith and Graetz (2011), who seek to go beyond theories, to look at the philosophies of change can be achieved with a side-by-side matching table (see Table 1). While one chooses the term philosophies and the other theories, there is a synergy to what they describe.

**Table 2: Mapping the Philosophies and Theories of Change**



Both Smith and Graetz (2011) and Demers (2007) give a concise and detailed summary of the previous thoughts around change and the approaches around change. This synergy provides a basis to begin to view change within a local context. At the beginning of this chapter there was the statement that Counties Manukau DHB was *"in a process of ongoing change in order to better meet the growing demands that the population are placing on the healthcare system"*. The challenge within the context of this research is, in the first instance, to seek to understand this change and seeking, as with Smith and Graetz and Demers, to take a step back. My aim is not to propose an approach that has been taken, rather seek to gain a level of critique as to the process to date. In the examination of each philosophy, there is an ability to apply ideas within a Counties Manukau DHB context. In essence, each philosophy could be applied. How then to use this analysis to better plan for and implement change?

While Demers (2007) has no clear comment or bias as to a way forward, Smith and Graetz (2011) offer a potential solution in what they call dualities. Their philosophy of dualities attempts to deal with the conflict between the need to offer continuity of services, while at the same time achieving change goals. Such is the case for Counties Manukau DHB. The case for change has been clearly articulated. But there can be no interruption to service continuity. Therefore, continuity and change need to be held in balance.

To summarise, it seems there is a plethora of texts and peer reviewed literature that espouses an approach to change, the 'n' step approach. Within much of this literature, there is an articulation of the role of the leader and leadership to affect the change. While useful, these approaches are superficial and often do not review the underlying principles / theories / philosophies that are being adhered to in order to affect change. Smith and Graetz (2011) and Demers (2007) provide the needed overview to look at these underpinnings. How to then 'put this into play' I would argue, is best articulated via the dualities philosophy put forward by Smith and Graetz as it allows the process of change to deal with the multiple tensions that are in play at any given point in time. As noted, within healthcare there is an inability to close the shop door while change is undertaken. There must be provision for ongoing services. Similarly, while there is within New Zealand constrained resources for healthcare, which would align to the resource allocation philosophy, there is conversely the psychological philosophy which would purport the resistance to change that will be encountered by the very people who need to deliver the change. While much change leans towards a rationalist philosophical approach of an ordered and linear sequence of change, this can be at odds with a systems philosophical approach in which the process of change can lead to both intended and unintended consequences. Viewing change through a biological philosophy lens would lend itself to believing that we are at a point in a lifecycle and that it follows a known sequence, but does this take into account the institutional philosophy that describes how an organisation will take steps to retain its legitimacy within a changing organisational field? All of these comparators suggest that there is no one answer to affecting change, rather it is holding a balance between several of these approaches at the same time. It is these tensions that have formed the basis of the research undertaken. I seek to understand how these tensions can be maintained.

Maintaining these tensions by using the dualities philosophy proposed by Smith and Graetz (2011) provides a framework to reference. Within healthcare a key tension to be managed is the highly professionalised workforce, and the result of groups being trained to provide specific services. Yet change may require these groups to change the 'what' or 'how' services are provided. Within the psychological philosophy it would be argued that there will be resistance. However, this can be balanced by the critical philosophy and a drive for new realities. This tension and impact of professionals and professionalism is to be examined in the next section.

### 3.3. Change Management and Appreciative Inquiry

Chapter 5 describes in detail the actions spirals that were undertaken. The action spirals relied heavily on appreciative inquiry as a methodology. In preparation, a literature review pertaining to appreciative inquiry and change was undertaken using CINAHL Complete and Medline as databases. Nineteen articles were identified through the literature search that were specifically reviewed for applicability as to the use of Appreciative Inquiry (AI) as a change management process in healthcare. All described how AI had been, or could be used as a change management process, and built upon the established 4-D model (Discover, Dream, Design, Deliver) within the local context.

Some authors work with the similarities while others note the key differences. Of the articles I have found closely related to my work three specifically identified AI as a subset of Action spiral (AR) (Carter, 2006; Havens, Wood & Leeman, 2006; Watkins, Dewar & Kennedy, 2016). Of note was the article by Egan and Lancaster (2005) that challenged this view drawing attention to the 'problem' focus of AR whereas AI looks for possibilities.

Analysis of the articles identified highlights that there is sparse evidence to support the effectiveness of AI as a change management approach. Ruhe, Bobiak, Litaker et al (2011) come the closest as they describe the AI approach taken to impact clinical quality management and practice development in thirty primary care providers. They note that as a process it did not achieve the outcomes that were intended, but they do note that the process itself facilitated high levels of engagement amongst the practices that otherwise would not have been accomplished. Campbell (2013), Harmon, Fontaine, Plews-Ogan and Williams (2012), Keefe and Pesut (2004), Lazic, Radenovic, Arnfield and Janic (2011), and Tullai-McGuinness, Ballard, Gallegher and Carpenter (2010) all provide examples where by the methodology of AI was applied within a context. All reported positive benefits especially around the engagement of groups that the change was been enacted with, but none were able to report the empirical benefit of undertaking this approach.

An interesting approach was taken by Wadsworth, Felton and Linus (2016) in describing the process undertaken by a new Chief Nursing Officer within an organisation in defining and implementing a new strategic direction. Through their process they translated the well-known SWOT (Strengths, Weaknesses, Opportunities, Threats) to an appreciative model: SOAR (Strengths, Opportunities, Aspirations, Results). This reflects the different foci as proposed by Egan and Lancaster (2005) in that the traditional SWOT focus retains a focus on the problems, as opposed to SOAR providing a focus as to what the possibilities may be. While this article was able to again describe the process undertaken, and the outcome of the process, it was not able to articulate the results that were achieved e.g. what were the tangible results.

Completing the critique of the articles reviewed, there was an overview of the approach in medical education (Sanders & Murdoch-Eaton, 2017), linking AI to improvement science (Bleich & Hessler, 2016), and general overviews of the approach and potential within healthcare (Van Wyk, 2015; Trajkovski, Schmied, Vickers, & Jackson, 2013; Stoller, 2017; Modic, 2015). Learmonth, Henderson and Hunter (2017) give an insight as to how the methodology was deployed to effect health system change in the English NHS in gaining consensus around Health and Wellbeing strategies within Health and Wellbeing Boards. All reinforce the basic 4-D methodology within their context.

While the articles reviewed give consistency as to how the AI approach can be implemented in various contexts, there remains gaps in being able to robustly demonstrate how change has transpired and become ingrained as a result of the process itself. Strengths however do emerge, as most of the articles reviewed highlight the benefit of the process in being able to achieve high levels of stakeholder engagement within the process of change. It is also affirming that while the genesis of the 4-D approach arose from Cooperrider and Whitney (2005), they were very non-prescriptive as to the specifics as to how it should be applied and or adapted to the circumstance. What then emerges through this review is the benefit of the process being relatively non-prescriptive, and therefore easily transposed to a myriad of settings.

There is also an interesting paradox that emerges. The criticism that could be levelled is that there is little in the healthcare literature pertaining to AI demonstrating the quantitative benefits. Egan and Lancaster (2005) in identifying that there may be differing philosophical roots between AR and AI may have identified how this is born out in practice. AI is about identifying what the potential futures can be and working towards these futures. It does not start with a specific problem that the process aims to specifically solve. Rather it seeks to amplify that which is already working well in working towards potential futures. As such, it can become inordinately difficult to be able to baseline as the process may make it difficult to know what you need to be baselining off. Therefore, the ability to demonstrate the quantitative change over time becomes difficult. What can be captured is the narration of what transpired and the end result. This bears true in what literature was captured within this review.

As a summary, this review in my view affirmed that appreciative inquiry is an approach that has a history within healthcare. It has demonstrated its ability to be deployed across a myriad of settings. It has a strength in being a proven approach to ensure engagement of stakeholders in a process of change. It has the detraction of not having a strong history in being able to demonstrate quantitatively the effects of any change process being implemented. This point

however may be mitigated by understanding that as an approach it is rooted in developing future possibilities as opposed to quantifying a shift from one state to another.

### 3.4. Professionalism

#### 3.4.1. Social theories of professions

Much print has been dedicated to examine the construct of professions from a sociological point of view. To give context, a focused literature review was conducted within the CINAHL Complete and Medline data bases using the keywords 'sociology of professions'. Once vetted to ensure they specifically addressed the sociology of professions, 15 articles were specifically reviewed.

Hofoss (1986) makes a stance that the origin of many professions in health care originates from what medicine has 'given up' over time. This is specifically reviewed in the contexts of tasks that are given up in this context due to an inability or an unwillingness of medicine as a profession to continue to do so. He does not go into the specifics as to what it is to define a profession in healthcare, but this challenge is taken up by others. This 'giving up' is also reviewed by Pescosolido, Tuch and Martin (2001) who view this concept from an economic one where costs constraints lead to questioning of the physicians authority, and in turn what they should retain control over. The economic argument is continued by Martin, Armstrong and Aveling et al (2015) who post the argument that the economic environment has facilitated the transition from the 'heroic' individual, to service delivery that is much more focused on professional teams. In the process, such a change potentially disrupts established boundaries and in turn what it is to be a professional.

The concept of boundary negotiation is also critiqued from the view of NHS paramedics by Givati, Markham and Street (2017). They review how as a group paramedics have progressively increased their bounds, and the education that supported them as a group to the point where they could define clearly the bounds of what they provided and the education that was needed to support them in their endeavours. A not dissimilar process is identified by Waller and Guthrie (2013) with the professions of psychotherapy, counselling, and the art therapies. They put forward that each of these professions became so in a process paralleling to that of the paramedics, establishing and extending the bounds of their practice while aligning the education requirements to support the profession.

Physiotherapy is a profession that has been examined in some length as to how it has developed as a profession and the avenues that have been taken to do so. Kell and Owen (2008) review the profession from a UK context, noting its origins and initial alignment to medicine that allowed for recognition via a legislative route to be achieved. They make the point that this alignment gave adjacent boundary space with medicine. With the profession becoming progressively specialised, they note the concern that this in time may lead to fragmentation of the profession. Oliveira and Nunes (2015) undertake a similar review for the profession in Brazil. They note the emergence of the profession from several 'occupations' that over time coalesced into a single profession, and with that was able to contest fields of practice that were previously undertaken by others. In turn, this was formalised via the education that supported the profession. For physiotherapy, both of these articles address the establishment of the profession, and how they have dealt with determining their field of practice. Within this are warnings that becoming too focused within a field of practice may in turn lead to undermining that which the profession provided in the first place. With this being the focus, there was some relating within these pieces of work as to what it is that defines a profession, which has been explored more fully by others.

Brown, Knight, Patel and Pliant (1987) while reporting back on a study seeking to answer the question as to whether nursing is a profession, claimed that a profession requires three criteria: that the group has public recognition, that the group has political and educational control over the profession, and has relative control of the market price for the service provided. In turn they argue the relative prestige of a profession is affected by:

- Establishing minimum education standards
- Fulfilling an important societal need
- Self-interest being secondary to that of the client
- Autonomy of practice
- Some influences of its services
- Involved in, and the ability to influence the political and social machinery e.g. licensure

While this work gives specific criteria that is useful in defining a profession, it still does not give a social lens through which to view a profession. King, Borthwick, Nancarrow and Grace (2018) present a succinct work that reviews several sociological lenses that could be employed. They review a breadth of works, from a Marxist approach, to Bourdieu, and include the work of Foucault. While no specific lens is offered as a preferred approach as to how to view health professions, it does give oversight of major theorists in this area.

Kälble (2005) gives an interesting perspective from an economic lens with a focus on autonomy. Within this, he notes that “autonomy of knowledge, autonomy of organisation, and autonomy of clientele are therefore core elements of professional authority”. This is of interest insofar that he argues that the economic imperative has potentially eroded this autonomy. This in turn potentially alters the basis of the medical profession as other professions who are ‘cheaper’ can provide services autonomously that previously were the remit of medicine alone.

This concept of autonomy is explored by Timmons (2010). He specifically reviews Operating Department Practitioners (ODPs) and their professional journey. He notes that their drive to obtain registration which previous authors put forward as a mark of becoming a profession did not have the same effect for this group. Specifically, they did not achieve the same level of autonomy through their process of registration, failing to obtain access to restricted medication. While on one hand they had advanced their standing of a profession, it did not achieve increased autonomy which Kälble (2005) notes as key to promoting a professions status.

To return to the work of Brown, Knight, Patel and Pliant (1987), education is noted as one of the tenants they put forward as a mark of a profession. Their work was focused on nursing and is also reviewed by Trnobranski (1996) from the perspective of education. Their observation is the transition of the nursing education base from one based on the biomedical model, to a caring model. They put forward the question that in this shift, has it substantively changed what has been the traditional knowledge base of nursing. And in further doing so, has it eroded what has been its traditional base of power.

Eroding of power bases is also explored by Timmins, Coffey and Vezyridis (2014) when looking at the implementation of lean methodologies in an ED department. They choose to make a differentiation between occupational professionalism (professions providing services in the ED), and organisational professionalism (those overseeing the organisation and the ED). They note that previously occupational professionalism would have resisted attempts for change via organisational professionalism, but this has been eroded over time. Whether this is due to a greater understanding of the occupational professions of the need to change is not concluded, but they do draw a conclusion that this provides an example of the shift in power bases.

Similarly; Martin, Currie and Finn (2009) continue to view the concept of professionalism as a boundary issue. They review the instance and emergence of General Practitioners with a Special Interest (GPSIs), specifically in the geneticist realm. They were of the view that issues arose when the geneticists viewed the introduction of the GPSIs as a boundary issue as they

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were encroaching on what had been the unique knowledge of this group. While there was a legislative momentum behind the establishment of these roles they noted the subsequent barriers to such a role being established by the geneticists. What they further observed, is that over time and as the relationships were established, there was a negotiation in a sense of these boundaries and a gradual defining of what the geneticists chose to give up in this instance to allow for the success of these roles.

Understanding how this process unfolds has been articulated by Wolpe (1990). He uses the language of discourse (the language of a community), ideology (a discourse seeking to monopolise a view of the world), and orthodoxy (institutionalised ideology). Using the example presented by Martin, Currie and Finn (2009), a further definition is offered, the heretic, who attacks orthodoxy by challenging ideology but remains a part of the community by retaining the discourse. In this instance the GPSIs could be seen as the heretic, challenging what has been the status quo, while continuing to be a part of the medical discourse. This is now examined further in the next section.

### 3.4.2. Examining the boundaries of professions and professionalism in health

Healthcare is unique in that services are provided not by a single group, but rather by a myriad of groups who choose to be or are known as professions. What denotes a profession is explored by Abbott (1988) who stated:

...organised bodies of experts who applied esoteric knowledge ...elaborate systems of instruction and training, together with entry by examination and other formal prerequisites ...possessed and enforced a code of ethics of behaviour. (p. 16)

This definition contains common threads that can be found in many of the founding texts relating to professionalism. Potentially one of the most impactful was authored by Albert Flexner who, in 1915, gave a presentation at the National Conference of Charities and Corrections whereby he sought to answer the question: Is social work a profession? (Flexner, 2001). Within this presentation he put forward six criteria as to what it is to be a profession; 1) activity carried out by the profession is based on intellectual action along with personal responsibility, 2) there is a body of knowledge that underpins the profession and it is not based

solely on routine activities, 3) there is practical application of the knowledge as opposed to just knowledge development, 4) the practical application of the profession can be taught, 5) the profession is organised as an entity, and 6) a profession is motivated by altruism and not just for the benefit of the profession itself.

Taking this definition and six criteria into the setting of healthcare, it is apparent that there is a multiplicity of groups who fit the criteria of being professionals. Some can boast a history of over 100 years (medicine as an example), whereas there are others that could potentially be seen as 'emerging' professions.

How professions emerge over time is examined in depth by Abbott (1988). He introduced the concept of jurisdiction which relates to the professional work that the profession does. He then broke down professional work to that which is objective, and often relating to technologies, or how organisations are established around professions, hospitals as an example. He broke down sub definition of tasks further to "claims to classify a problem, to reason about it, and to take action on it: in more formal terms to diagnose, to infer, and to treat" (Abbott, p. 40). Thus, the work that a profession does and how it goes about that work establishes the jurisdiction of the profession. In further establishing jurisdictions, Abbott made the point that a profession will then seek to have society to recognise it via exclusive rights to the objective and subjective work. This recognition can be legal, or in the instance of New Zealand legislative whereby the Health Practitioners Competency Assurance Act (2003) provides a legislated recognition of a profession when it becomes registered under the Act. It may also be in the court of public opinion whereby a profession builds images as to what they do.

It is important to note that the establishment of jurisdiction under this definition is not stagnant, it can change and morph over time. How it changes can occur in a multitude of ways. One relates to division of labour whereby professional staff are replaced by paraprofessional assistants or untrained staff. This occurs secondary to organisational pressure around the efficiency of the work to be done and will lead to subsequent renegotiation of jurisdictions within the profession. There are often structures put into place in order for the profession to maintain overarching jurisdiction of the work which is being done (Chadwick & Smith, 2008; Saunders, 1997a). A jurisdiction of a profession may also be lost over time. Abbott (1988) described this as happening as a result of a profession ignoring a clientele group that paraprofessionals then provide the service to and in turn attack the previous dominant profession. It may also occur as the result of new technologies that create work that previously did not exist. The emergence of MRI Medical Radiation Technologists is a case in point.

Emergence of new knowledge and skills follows a similar path. Genetic Associates is an example of a profession that did not exist prior to the knowledge of the impact that an individual's genetic makeup will have on health. A profession may also choose to vacate a jurisdiction, allowing it to be subsumed by the jurisdiction of another. An example of this could be in the US where physical therapy vacated the jurisdiction around the provision of respiratory care, leading to the creation of a new profession of respiratory therapists. Abbott does not shy from the possibility of open conflict between professions, describing "bump" (p. 89) events when one profession attacks another, or when a profession moves into a vacancy thereby opening itself to attack what would have been previously considered its jurisdiction.

This work on professions is reviewed in order to highlight that healthcare utilises a highly professionalised workforce. There may, from the outside looking in, appear to be clear division of labour, but what has been described is the potential for high levels of competition to occur between professions, especially over what may be seen to be contested territory. It adds to the detail of why there could be entrenchment within current practice when a healthcare organisation seeks to change. There is the dual driver of an employee desire to be proficient in work, which may be threatened by change, and the conflict and battling for jurisdiction that may occur at the same time within the organisation. Both need to be taken into account when considering the process of change within healthcare.

### 3.4.3. Professions and professionalism as an enabler or detractor to changing boundaries

"Professional expertise and values are powerful inhibitors to innovation because of the vested mind-set they create in the status quo. However, expertise is essential to improvisation..." (Anderson & McDaniel, 2000, p. 87).

Anderson and McDaniel's (2000) quote encapsulates the primary issue that I see with implementing change within a healthcare setting. Section 3.3 highlighted the many philosophies that underpin the process of change. In the highly professionalised environment of healthcare, there is the ability to acknowledge the role that professionals and professions have in further complicating the environment. The vested interest more often than not may be in maintaining the status quo as the quote captures. But there is a counter point that they go on to explore. Building on the comment "expertise is essential to improvisation" (Anderson &

McDaniel, p. 87) they use an analogy of a jazz band and the role that improvisation plays in a highly competent band. In this context, improvisation is only truly successful when it occurs in an environment with highly competent musicians. Each musician can play his/her own instrument with a high level of expertise. It is this level of expertise that allows him/her as an individual to meld with the band, to anticipate the change in tempo, to build off of each other, to lead a riff when there is a need to do so, or to support other band members when they are leading. When this occurs within the jazz world, is when the magic of emergent music occurs.

In the healthcare context, improvisation could be translated to innovation and the associated change required for professions. The issue becomes how willing and/or able are professions to improvise? Hafferty and Castellani (2010) asked this question as part of a review inspired by the centenary of Albert Flexner's seminal work Bulletin No. 4, often better known as the *Flexner Report*. While the genesis of this report was to review medical education within the US, it provided the material for Flexner to develop the six requirements of a profession that were introduced in the previous section. Hafferty and Castellani took Flexner's original work and used it as the basis for introducing complexity science to understand professionalism within the medical profession. They undertook this work to review Flexner's systems like view to professionalism, his vision for change, and the role of professionalism in this change. Through this work they identified seven types of medical professionalism: nostalgic, entrepreneurial, academic, lifestyle, empirical, unreflective, and activist. What they identified was the tension that existed, most notably between nostalgic professionals and professionals they classified as activists.

...nostalgic professionals highly value autonomy and altruism in their work, with lifestyle and commercialism viewed as less important. Conversely, activist professionals highly value social justice and the social contract, with commercialism and professional dominance occupying less important positions. Parenthetically, it was only after developing all seven types that we discovered how the relative rankings of activist professionals seemed more faithful to the overall ideals of professionalism than what actually was been promulgated under the guise of nostalgic professionalism. (Hafferty & Castellani, 2010, p. 292)

To borrow and build on the term nostalgic professionalism, I believe Hafferty and Castellani (2010) have identified an issue that is fundamental to understanding the difficulty in affecting effective change in healthcare. The nostalgic professional will claim jurisdiction of tasks as noted by Abbott (1988), yet will tend to draw away from that which they claim. They may claim within this premise to fulfil the tenants of what it is to be a profession; yet Hafferty and

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Castellani identified that this did not bear out in their research. As with the dualities philosophy offered up by Smith and Graetz (2011), there is an inherent tension at play. The solution is potentially found within the work of Anderson and McDaniel (2000) and the analogy of jazz improvisation; it is the competent who can improvise. This is supported by Hafferty and Castellani and their belief that the activist professional more fully fulfils what it is to be a professional, to be competent in the work that is done, and yet not defined or restricted by it. There is an irony in that it is this tension of being able to let go of that which is nostalgic, and to be an activist which was identified by Flexner himself in 1915 as identified by Hafferty and Castellani (2010):

Flexner was unequivocal in insisting that this “professional spirit” had yet to be realised across professional groups in general and within medicine in particular. For Flexner, altruism was something that ‘may...come to be a mark of professional character’ and is something where the ‘pecuniary interest of the individual practitioner...[is] apt to yield gradually before an increasing realisation of responsibility to a larger end. (Hafferty & Castellani, 2010, p. 291)

To paraphrase, the nostalgic will hold on, the activist will seek to yield. Yet the argument is made that in the act of yielding, the professional may more fully realise what it is to be a part of a profession.

### 3.5. Bourdieusian concepts as an enabler to understanding boundary changes

If change is about managing the multiple tensions between current state and future state, and if facilitating change in the professionalised environment is about acknowledging the tension between the nostalgic and the activists, how then do we seek to understand and capture that which is happening during a process of change?

Much of the work reviewed around the sociology of professions had a focus on the boundary issues as to what one deems to part of a professional group or not. The work of Wolpe (1990) gives us the term of a heretic of how boundaries may be challenged, yet stay within the ‘discourse’ of a community. Given the myriad of professions that are in play in healthcare, how to then understand these tensions? A framework that is useful from this perspective has been developed by French philosopher Pierre Bourdieu [1930-2004], and his concepts of ‘social field’, ‘habitus’, and ‘doxa’. While work such as that by King, Borthwick, Nancarrow and Grace (2018) give light to the breadth of potential sociological views, Bourdieu in my mind gave a

depth to the concept of jurisdiction as put forward by Abbott (1988) and provided a framework to progress my thinking.

Bourdieu articulated the concept that we all operate within social fields and that they are a way of describing the interactions we have and/or encounter on an ongoing basis. Webb, Schirato and Danaher (2002) described the concept of the cultural field as:

...a series of institutions, rules, rituals, conventions, categories, designation, appointments and titles which constitute an objective hierarchy, and which produce and authorise certain discourses and activities. (p. 67)

This could be explained as the contrast and differences between the known 'field' that one will operate in when one partakes in a game of sport, and that one then will operate in an entirely separate 'field' when one walks into the front door at home and takes on the role of husband/wife and father/mother. This can be further contrasted by the 'field' that one encounters when entering the workplace. In essence it is an attempt to capture and articulate that there are different rules to the game in which we participate within the many spheres of our lives, and what may be acceptable in one sphere (robust debate in a steering group tasked with implementing change) would be entirely unacceptable in another (a face to face patient interaction). Understanding the social field in which one is operating will provide guidance as to what are the rules and rituals that one needs to abide by.

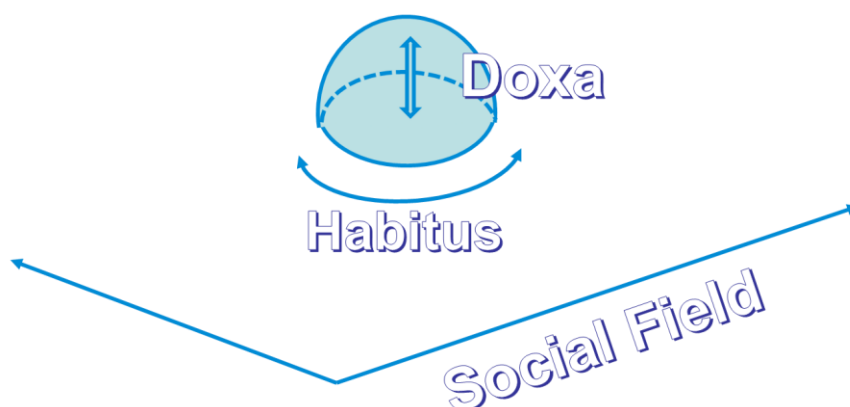
A field is a way of defining the social space which we occupy, be that as an individual or as a group. A clear definition of habitus is not as easy. Maton (2008) described habitus as:

...our way of acting, feeling, thinking and being. It captures how we carry within us our history, how we bring history into our present circumstance, and how we make choices to act in certain ways and not others. This is an ongoing and active process – we are engaged in a continuous process of making history, but not under conditions entirely of our own making. (p. 52)

While a field is a social space, habitus is the space that is occupied within that space. Using this definition, it is proposed that the concept of habitus can be applied to define the 'space' that a professional or a professional group may occupy within that space. As a profession we carry forward the history of that profession into its present 'jurisdiction' as defined by Abbott (1988). We are bound in some ways by legislation, professional ethics and code of conduct as to the choices that we can make towards how we act individually or as a group. This then forms the bounds of the social space that we occupy as a profession, the professional habitus within a defined field.

Field defines the social space that we occupy; habitus is the bounds that we occupy within that social space. To build further on the professional aspect, we are bound to a habitus by legislation, professional ethics, and code of conduct. However, there is a set of un-written rules that will further identify an individual or a group as to the social space they occupy. This is the doxa. While the habitus can be quantified (legislation, professional documents), there may not be the same ability to quantify the doxa. Deer (2008) quoted Bourdieu in stating that the doxa is “a set of fundamental beliefs which does not even need to be asserted in the form of an explicit, self-conscious dogma” (p. 119).

While the concepts of field, habitus and doxa need to be explained separately to gain a level of understanding, in practice they exist as inextricably intertwined entities, which I have represented in Figure 3 (p. 43) below.



**Figure 3: Diagrammatically representing the concepts of Doxa, Habitus and Social Field**

Each is informed by the other, and the response (or not) of one concept to a change in another may generate a completely unanticipated feedback loop. The concepts of Bourdieu provide a framework. This framework can be used to analyse and gain a level of understanding as to why things are the way they are. It is proposed that this is an effective framework to use in examining and understanding the change occurring within Counties Manukau DHB.

The use of Bourdieu as an analytical lens in healthcare is not unknown. Smith, Dixon, Trevena, Nutbeam, and McCaffery (2009) used his works to explore and understand the patient involvement in decisions that are made around care provision. Lynam, Browne, Reimer, Kirkham, and Anderson (2007) provided analysis using Bourdieu when they sought to examine the tensions that exist around culture and the provision of healthcare services in Canada. Lessard (2007) used another of Bourdieu’s concepts around reflexivity, and the need to

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examine in-depth the decisions that are made around healthcare as opposed to singular or biased reliance on economic evaluations. As a sample of the writings using Bourdieusian concepts in healthcare, they provide guidance as to how the concepts of social field, habitus, and doxa are useful in providing a level of analysis as to what is occurring during a process of change.

### 3.6. Other research that has been about creating a similar boundary change

Within this chapter, section 3.3 has reviewed the prevailing philosophies and theories pertaining to organisational change. Section 3.4 examined in more detail the issue around professionals/professionalism and change. Section 3.5 overviewed Bourdieu and how his key concepts can be applied to provide a deeper level of understanding of change. The intent is to go from a wide-angle lens of the literature to bring it to an increasing level of detail.

In this context, change is a multi-tensional process in which multiple philosophies/theories need to be considered in parallel. This is enhanced within the concept of healthcare as a highly professionalised workforce and the contest and/or conflict that may occur around the jurisdiction of one profession against another. The corollary view is that many professions have yet to realise the 'professional spirit' as proposed by Flexner (Hafferty & Castellani, 2010), and the potential for 'improvisational behaviour that enables innovation and creativity at all levels of the organisation' as proposed by Anderson and McDaniel (2000).

The literature tells us that this is not easy within healthcare. Pearson (2003) explored a nursing centric view and purported the need for a generic healthcare worker and clearer roles and responsibilities for nurses. Nugus, Greenfield, Travaglia, Westbrook and Braithwaite (2010) examined interprofessional learning and interprofessional practice in examining health occupational relations. They concluded that there was a tendency towards negotiated order which involved both collaborative and competitive power at play with doctors exerting power over other roles. This work is supported by Braithwaite, Westbrook, Nugus, Greenfield, Travaglia, Runciman et al. (2013) in which attitudes towards interprofessional collaboration were reviewed from the perspective of four professional groups (doctors, nurses, allied health, and administrative staff). Their results demonstrated that a positive attitude towards interprofessional practice was most evident in the allied health group, followed by nurses, then administrators, with doctors holding the least favourable views towards social or structural interventions in healthcare.



Nancarrow and Borthwick (2005) looked at the potential context for change (service demands, economic climate) and began to classify how disciplinary boundaries can be influenced by vertical substitution defined as delegation or adoption of tasks across disciplinary boundaries where the level of training or expertise are not equivalent between workers e.g. prescribing rights for nurses or dieticians. They also explored horizontal substitution where “providers of a similar level of training and expertise, but from different disciplinary backgrounds undertake roles that are normally the domain of another discipline” (p. 909) e.g. generic assistants across the allied health professions. Where they conclude their work is:

Workforce flexibility legitimises the blurring of interprofessional role boundaries by endorsing vertical and horizontal substitution; it does not however appear to be deprofessionalising the workforce through a loss of monopoly over certain aspects of work... To date, there are however no examples of role changes that have removed the attributes that are associated with the professional labels. (Nancarrow & Borthwick, 2005, p. 913)

### 3.7. Synthesis and implications

While the New Zealand healthcare system has been in a structurally steady state since the advent of the 2001 Health and Disability Legislation, it has, in practicality, been in a state of continual change to meet growing demands while adjusting to external events such as the global financial crisis. The example of Counties Manukau DHB is a caricature of the New Zealand healthcare system. It has a growing population with increasing complexity of healthcare needs and a funding envelope that is miss-matched to this growth. As such the decision to change its strategic direction and shape has been made.

Change has occurred and is occurring. To capture this change could be done as a simple narrative, but this fails to encapsulate the complexities that occur during a process of change. I would postulate that why change is or is not successful is due, in part, to a failure to acknowledge and understand the complexity of the process of change. What has been presented is a summation of the prevailing thoughts around change. I argue that what is already complex is made even more so by the professionalised environment within which the provision of services occurs. Whether this be examined via the context of jurisdiction or habitus within social fields, there is an interaction that occurs during a change process that affects the boundaries of what a profession may deem to be ‘theirs’.

The external environment is such that there is general acknowledgement that the current way of service provision is no longer fit for purpose, so change becomes imperative. How this

change is managed is the core of this thesis. The quest is to realise the professional spirit as postulated by Flexner and to allow a profession to be activist as opposed to nostalgic (Hafferty & Castellani 2010), to allow for the “improvisational behaviour that enables innovation” (Anderson & McDaniel, 2000, p. 90), and to be confident that it will not lead to “deprofessionalising the workforce” (Nancarrow & Borthwick, 2005, p. 914).

## Chapter 4. Change Process/Research Methods

### 4.1. Chapter introduction

The description of Counties Manukau DHB identified the challenges facing the organisation in meeting the growing demand for services. In order to better align the organisation to meet this need, the Locality Strategy was enacted. As a part of the workforce that is seeking to change and adapt service delivery of this strategy, allied health was key to successful implementation. As my role was the DAH, it fell into my purview to investigate how best the workforce could align to this strategic direction. The intention was to ensure that any strategy employed was one informed by the evidence. The following sections details the theories that sit behind action spirals, which informed the decision to adopt the appreciative inquiry methodology. While linked, these two approaches have a different genesis which has been described in the previous chapter. There is particular attention paid to the eventual shaping of the action spirals, that while undertaken within the scope of my substantive role, laid the foundation for the specific qualitative piece of work undertaken.

### 4.2. Why use a research informed strategy to facilitate organisational change?

With the organisational context detailed, the imperative for change is established. The Locality Strategy provided the organisational approach. I had strategic leadership of the allied health workforce, therefore the impetus was to simply go ahead and change. However, as detailed in Chapter 3, while there are multiple recipes for successful change, there are significant counter arguments that it is not a straightforward process as Smith and Graetz (2011) offered in their critique of the 'n' step approach. So, if a simple linear approach to change does not guarantee success, how then to best go about it? Coughlan and Brannick (2010) summated it as: "we ask questions about our experience and receive an insight (understanding) and we follow that up by weighing the evidence to determine whether our insight fits the evidence or not (judgement)" (p. 19).

I had observed change being done badly, thus I was asking of myself the question, was, was there a better way? Further, as we are disciplined to apply best evidence to the provision of

clinical care, was there an ability to similarly apply best evidence to an approach to change? If there was an ability to approach this empirically, what options were available to me?

In seeking to answer these questions, it became clear that any research approach needed to be prospective in nature, removing from consideration approaches that were retrospective in nature, either qualitative or quantitative. As this was an approach that needed to be occurring in real time and needed to be flexible to adapt to changes in the organisational environment, specific quantitative approaches that required adherence to stringent protocols were not appropriate.

The challenge became to identify a research approach that was appropriate to be conducted in the workplace. It had to be specific in that the approach allowed for acknowledgement of myself as the researcher being a part of the research and the research methodology must be able to adapt and change to the needs and demands of the workplace. Furthermore, the thrust of the research needed to be about creating effective change.

### 4.3. Identifying the research informed paradigm

Taking the points identified in section 4.2, the framework of change was based on an action spiral approach, which itself is based on the principles of action research. The rationale for choosing this approach was a pragmatic one and is reflective in much of the action spiral literature. Koshy, Waterman, and Koshy (2011) offered the view that action research allows for the following two simple questions to be answered:

- What am I doing?
- How can I improve what I am doing?

Action research has its genesis in Lewin's model of change in the 1940s (Lewin, 1951). His basic model of change was to first unfreeze a situation, where there is a realization that change needs to occur. In essence, he sought to create the environment where the status quo can be challenged due to the need to adapt to either internal or external drivers. Once these internal or external drivers for change had been addressed via a process of change, there is the phase of re-freezing whereby a new norm is established (McPhail, 1997). While this approach is attractive for its simplicity, it does not lend well to the specifics as to how the change should occur.

As an approach, the context identifies why there is a need to change without necessarily the assurance on how to change. Action spirals provided a methodology to explore what was being done currently, and what could be changed and/or improved to allow the health workforce to be better aligned to the unfolding Locality Strategy.

While there is no one single pithy definition of action spiral, there are clear themes that emerge in the literature. Koshy et al. (2011) reference a set of key principles that define action spiral:

- Action spiral is a method used for improving practice. It involves action, education, and critical reflection – based on the evidence gathered – changes to practice are then implemented
- Action spiral is participative and collaborative; it is undertaken by individuals with a common purpose
- It is situation based and context specific
- It develops reflection based on interpretations made by participants
- Knowledge is created through action and at the point of application
- Action spiral can involve problem solving, if the solution to a problem leads to the improvement of practice
- In action spiral findings will emerge as action develops, but these are not conclusive or absolute. (pp. 2-3)

These principles are not dissimilar to those offered by Morton-Cooper (2000) and Williamson, Bellman, and Webster (2012) who potentially capture the essence in stating that action spiral is “about research *in* action, rather than *about* action” (their emphasis) (Williamson et al., p. 8). To give another description, it is about determining what is to be researched as the research unfolds, as opposed to predetermining the bounds of the research and then being compelled by the methodology to stay within those constraints. To this end, Morton-Cooper offered the following warning: “action spiral is a muddy, murky, messy business reflecting the confusion and lack of coherence to be found in a real-world setting” (p. 22).

Within action spiral methodology, the research is informed by those whom the research encompasses. There is consistent reference to the practitioners in the research contributing to the formation of the research. Morton-Cooper (2000) used terms such as ‘collaboration’ and ‘devolving’. Williamson et al. (2012) also discussed collaborating and go further to describe it as a democratic process with regards to the involvement of participants. Koshy et al. (2011) described the researcher as being a “facilitator of change, consulting with participants not only on the action process but also on how it will be evaluated” (p. 10). This is reflective of the

feedback loops that are often described within a complex adaptive system such as that of healthcare settings.

In this context, action spiral provides a methodology that accepts myself as the researcher who is fully a part of the research. The two cannot be separated, as supported by the works of Koshy et al. (2011) who described the researcher as the “facilitator of change” (p. 10), and Morton-Cooper (2000) who detailed that it is “practitioner generated” (p. 21). Williamson et al. (2012) described “researchers and participants being on an equal level” (p. 19), and Coughlan and Brannick (2010) described “undertaking research in and on your own organisation while a complete member” (p. 95). Action spiral also allows for the murkiness of developing and testing a process as the research itself progresses, changing and adapting as new questions emerge, allowing for clarity to emerge over time. It provides a methodology well suited to the situation unfolding in Counties Manukau DHB.

#### 4.3.1. Principles and philosophies of action spirals

Riccucci (2010) described action spiral as an interpretivist approach. She placed the approach ontologically as being “grounded in relativism, that knowledge and meaning are acts of interpretation; researcher and reality are inseparable”, and epistemology as “knowledge as relative; objectivity does not exist; all truth is a social construct and is culture bound” (Riccucci, p. 47). McNiff and Whitehead (2011) described the ontological assumptions of action spiral as being value laden, morally committed, where the “researchers perceive themselves as in a relationship with one another in their social contexts” (p. 27). From an epistemological standpoint they describe the object of the inquiry as being ‘I’, that knowledge is uncertain, and that the creation of knowledge is a collaborative process.

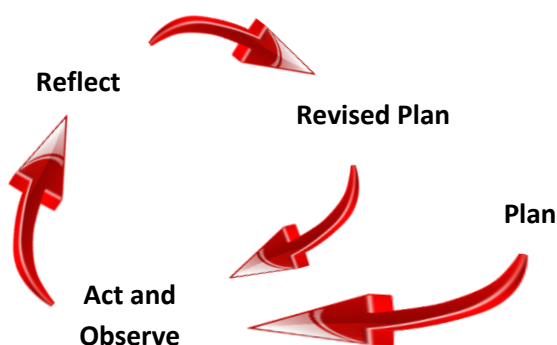
This is captured pragmatically by Coughlan and Bennick (2010):

While all research requires rigor, action spiral has to demonstrate its rigor more practically. This is because in action spiral you typically start out with a fuzzy question, are fuzzy about your methodology in the initial stages and have fuzzy answers in the early stages. This progression from fuzziness to clarity is the essence of the action spiral cycles. Accordingly, you need to demonstrate clearly the procedures you have used in achieving rigor and defend them. (p. 144)

They reinforced the epistemological assumptions of previous authors by stating the assumption of academic research and discourse is not just to describe, understand and explain the world but also to change it. This finds a good fit with the research undertaken, as it sought

to understand workforce change and design how to do it. In the context of this research, it had to generate change.

The actual mechanics of action spiral are consistent with the messiness as described by Morton-Cooper (2000) in that the conceptual models used to describe the process are non-linear and are usually described as loops. The Kemmis and McTaggart action spiral is referred to as the classic approach to action spiral (Koshy et al., 2011; Morton-Cooper, 2000; Williamson et al., 2012) and is depicted diagrammatically in Figure 4:

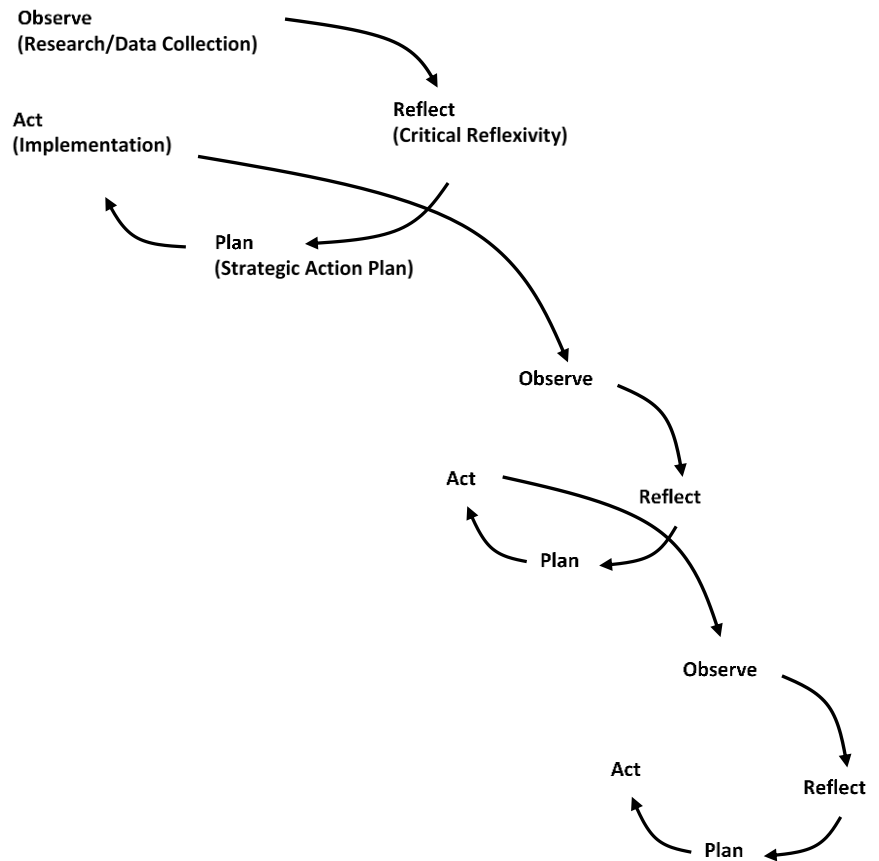


**Figure 4: Kemmis and McTaggart action spiral**

This spiral articulates the iterative nature of action spiral. As a specific intervention on the system is planned, the outcomes are reviewed and examined and, with critical reflection, will inform the next iteration, and so on and so forth. While the Kemmis and McTaggart action spiral is elegant in its simplicity, it has been developed over the years to refine or offer further clarity as to the potential steps that it may include. Koshy et al. (2011) describe a further iteration as the O’Leary cycle of research which is detailed in Figure 5 (p. 51).

The O’Leary cycle of research is potentially a more accurate reflection of action spiral in action as it articulates many cycles of inquiry, with the reflection thereof informing the next cycle.

As a methodology, action spiral is not without its detractors, and is not applicable in all situations. Both Koshy et al. (2011) and Morton-Cooper (2000) agree that action spiral should not be used in driving unpopular policies through an organisation or be used as a tool to manipulate employees. A cautionary note is also made that it is not a vehicle to be used to bolster a flagging career.



**Figure 5: O’Leary’s Cycles of Research**

Similarly, there are notes of caution for the researchers themselves, as they are essentially active participants in the research itself. Koshy et al. (2011) noted the need for the researcher to acknowledge their own worldviews and the impact that this influence may have on the research itself. The researcher must make every effort to ensure that all members of the group are actively involved as they will be involved in the research. This places a burden of clarity on the researcher to stay true to these principles.

Given the context for the research described here, action spiral as a methodology was well suited to be able to mould and adapt as initiatives continued to unfold. As will be described in more detail in the following chapters, by simply entering into this research process and writing the initial papers, this act has informed and influenced the following iterations and further informed the detail that was needed to be included in the next iteration. Morton-Cooper (2000) identified this as a key principle whereby action spiral should examine the key assumptions held by researchers and challenge their validity. This then fulfils another key



concept whereby knowledge is created through action, which in turn is understood at the point of application.

#### 4.3.2. Appreciative inquiry as an action spiral

Action research and appreciative inquiry are similar in their responsive approach to leading change. Action research is commonly related back to Kurt Lewin circa 1944, whereas Appreciative Inquiry has a definitive origin with David Cooperrider, being derived from his doctoral thesis (Cooperrider & Whitney, 2005). His genesis was observing a high performing team within the Cleveland Clinic and then drawing an analysis of what allowed this team to work in this way. He identified that the success was on focusing and amplifying that which is working well in the system as opposed to working on identified deficits. Over time this was developed into the Appreciative model. While there is high synergy between the two approaches, there are definitive differences as well.

Egan and Lancaster (2005) note the association of AI to AR but articulate the fundamental difference of AR is that it retains a focus on problem solving the problem at hand, as opposed to the approach of AI in identifying potential futures which may not be grounded in addressing a specific problem. They explore the philosophical differences between the two, considering AI to be a product of a socio-rationalist approach as opposed to the AR approach being based on empirical data collection and analysis, aligning it to a logical empiricist perspective. They do however note that there is much that is shared between the two approaches, namely that they both are conducted in real time, and require the involvement of stakeholders, allowing a theory of change to be built as opposed to being pre-determined. Within this context, the case has been made that they are philosophically different approaches, but this view is not uniform and continues to be debated within the literature.

As the action spirals progressed, a specific framework was adopted to take on board learnings from previous cycles. Bushe and Kessam (2005), and Cooperrider and Whitney (2005) detailed the history of the approach in quantifying how it is that successful healthcare organisations were able to continue to be successful. Bushe (2013) was at pains to note that there is no prescribed form for appreciative inquiry but goes on to describe the most common form of appreciative inquiry, the 4-D model.

The 4-D model describes the four phases of the appreciative inquiry process – Discovery, Dream, Design, Deliver. The Discovery stage aims to allow participants in the appreciative inquiry process to learn, and/or discover all of the known facts as pertains to the area that is

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undergoing the process of change. The appreciative portion is in that the Discovery stage has an explicit focus on what it is that is working well as opposed to deficits in the system, aiming to amplify that which is working well.

The Dream stage aims for participants, now having a shared knowledge base, to think through possibilities that could address the focus of the change process; in essence, to dream of the possibilities. The Design stage, aims to take what has arisen out of the Dream stage, and to look at the questions of what is possible within the change process, knowing the constraints that may be in play. The final stage, Deliver, takes what has been developed through the process of Design, and begins to answer the questions of what, where, when, and by whom.

Appreciative inquiry was derived from a healthcare setting. While it has been adopted within the broader organisational development approach, there have been more recent authors such as Trajkovski, Schmied, Vickers, and Jackson (2013) who have revisited the potential benefit of the approach in engaging the workforce in a strength-based way to effect positive change. The specific implementation of the 4-D model in this research is detailed in section 5.3.3.

## 4.4. Designing the action spirals

As noted in the discussion and analysis section, one of the limitations of this research is that it is artificially time bound. The described Counties Manukau DHB context provides an arbitrary start point, and while there is an endpoint identified for this research, the cycles continue. While the end point may be arbitrary, there is an ability to distinctly describe the cycles that occurred.

### 4.4.1. Action spirals and phases

The concept of Action Spirals is offered by Cardiff, McCormack and McCance (2018) as a way to articulate how one piece of work will then inform the next piece of work, without being specific research. The initial action spiral cycle was borne out of the progression of the Locality Strategy within Counties Manukau DHB, and the intent within my role to be able to ensure that the allied health workforce was appropriately placed to facilitate any transition to a new way of working within the Locality Strategy. What quickly emerged through this process was

that allied health does not exist in isolation to the other healthcare professions. Circumstance had highlighted the need for a process to be entered into that would review how the larger Home Healthcare team (beyond the allied health workforce and inclusive of nursing staff) could be better aligned to the emerging Locality Strategy.

Observing the outcomes from the initial action spiral cycle, there was the ability to build upon and take the lessons learnt in designing a more comprehensive change process to be used with the Home Healthcare teams. The second action spiral cycle was conducted in the Papakura Home Healthcare team having worked through the action spiral processes of observing what happened in the first cycle, reflecting (critical reflexivity) within a changing context, planning for a revised change process taking on board the lessons learnt, and then deploying the health WCF.

The unfolding of the second action spiral cycle highlighted many components of the change framework that had not been fully developed. Subsequent changes were made and fed into action spiral cycle three. A similar process was noted for action spiral cycles four and five.

#### 4.4.2. Choice of site

This work was particular to the enacting of the Locality Strategy within Counties Manukau DHB. As such the site was clearly defined as Counties Manukau DHB. The scope of the site did change as the associated action spirals unfolded. Initially the scope within the first action spiral was clearly defined as allied health staff working in the environment that was to be most affected by the Locality Strategy. The scope increased with action spirals two through five, as it expanded to include the broader Home Healthcare teams, and professions outside of the allied health grouping, for example, nursing, as well as linking to entities outside of Counties Manukau DHB e.g. General Practitioner (GP) practices. It did not, however, change the overall bounds being contained within the catchment area of Counties Manukau DHB.

#### 4.5. Undertaking the fieldwork

In preparation for the initial action spirals, clarity was gained via the AUT ethics process that the actions spirals were not research. Initially, data to be collected were to be restricted to

documents generated during the action spiral cycles, and personal logs kept during this time. As the action spirals progressed, it became apparent that the process would be further strengthened by validating and evaluating the data gathered by undertaking specific qualitative analysis, referencing those who were a part of the change process and had engaged with the change framework. In preparation, ethical approval was obtained via the AUT ethics committee for the qualitative component (Appendix A).

#### 4.5.1. Data collection and analysis methods

During the action spirals, data was collected from the documentation that was generated during the cycles themselves. This included, but was not limited to, project documentation, notes generated during the enactment of the action spirals, non-identifiable photographs taken during the action spirals, and entries made into a personal log. This provided the collation of data to be able to describe the action spirals.

#### 4.5.2. Action spirals timeframe

The initial action spiral (AS1) occurred in July 2013 and continued through to October of the same year. The second action spiral (AS2) essentially began immediately after, with the 'Act' part of the cycle occurring from March through April 2014. Due to the business of healthcare during the winter period, no work was planned over the winter months. Action spiral three (AS3) occurred substantively over September 2014, action spiral four (AS4) over October 2014, and action spiral five (AS5) during February 2015.

### 4.6. Evaluating the fieldwork

As the action spirals unfolded, what emerged was the need to validate and evaluate what was observed to strengthen the rigour to the process undertaken. This fits within what is proposed by Coughlan and Bennick (2010) in ensuring that multiple data sources are accessed to provide contradictory and confirming interpretations. As noted, Ruccucci (2010) described action spiral

as interpretivist and suggested that a qualitative approach is the best approach to record and validate the process undertaken during the action spirals.

#### 4.6.1. Qualitative process

The detail of the qualitative process is described in Chapter 6. Ten interviews were undertaken from a convenience sample. Interviews were conducted at a place of choosing of the interviewee. Interviews consisted of open-ended questions focusing on the change framework deployed and the associated processes. Interviews were recorded digitally and transcribed per datum by a professional transcriptionist who had signed a confidentiality agreement pertaining to the research.

The qualitative analysis undertaken was based on the work of Braun and Clarke (2006) and is considered to be a theoretical thematic analysis. This approach was chosen as it explicitly acknowledges that as the researcher I present with a bias, and I am conducting the analysis mindful of this bias. If, during the analysis, the data fails to support my bias it will be reported as such.

The process of working with the transcripts involved 'cleaning' the interviews in the first instance in removing repetition and verbal pauses and fillers. From this, each interview was edited into cohesive narratives. This fits within the first step offered by Braun and Clarke (2006) of familiarising oneself with the data. Once each interview was edited, it was reviewed to generate an initial set of codes, which were then themed and reviewed for accuracy, and subsequently named. This fulfilled the subsequent steps in the theoretical thematic analysis as described by Braun and Clarke.

#### 4.7. Rigour

Coughlan and Bennick (2010) noted the need for rigour within action spiral due the nature of the research often beginning in a fuzzy state and clarity being gained during the process of the research. They go further to articulate that rigour in action spiral be obtained by:

- Clearly articulating the action spiral cycles that were used
- Detailing the data sources that were used from multiple sources
- Giving evidence as to how personal assumptions were challenged during the action spiral process

- Detailing how personal interpretations and outcomes confirm or challenge the existing literature

To answer these points, the five action spirals as identified in section 4.5.2 have been clearly identified as a part of the process. The data sources have been identified, and a further layer has been added with the validation and evaluation of the research using a qualitative approach. Personal assumptions are articulated in Chapter 9 with my personal reflections of the research. The analysis and discussion, Chapter 10, reviews key findings against the literature and builds new knowledge that was obtained during the research process. Within the framework offered by Coughlan and Bennick (2010), rigour has been adequately addressed.

## 4.8. Chapter summary

In describing the Counties Manukau DHB context that has led to the formation of the Locality Strategy, there is the ability to understand how this process of change can be analysed using the literature pertaining to change. This provides a setting to review a good change-process fit within the context. This chapter has sought to review the research paradigm that informed my change process and why it was chosen. The associated principles and philosophies have been reviewed as pertains to action spiral. Specifically, the process that was undertaken with this research has been detailed, where it was undertaken, how data was collated and analysed, and how this was done with an appropriate rigour for this form of research. What follows is an in-depth description of each action spiral using the form proposed by O’Leary of Observe (Research/Data Collection), Reflect (Critical Reflexivity), Plan (Strategic Action Plan), and Act (Implementation).

The common thread that has been followed through to this point relates to change. Healthcare in New Zealand has been under an ongoing process of change. Allied health as a concept has been changing and adapting, taking on a unique understanding within New Zealand with a focus on leadership. Counties Manukau DHB as an organisation is faced with a situation of unchecked growth in demand for services, with a way of providing services that is progressively unable to meet this demand. The strategic direction that has been established is to mitigate this demand by aligning services to four geographic localities in the DHB that relate to geography and community make-up. The query that exists is how is allied health going to respond to the change?

Understanding change has become key; and time has been invested in teasing out an understanding of change. This is brought more into focus with the challenges of a highly professionalised workforce, and how professions do or do not interact with each other.

Using this understanding, a review of research methodologies that could be deployed to help effect change within the allied health workforce lead to action spirals being a good fit for what was being attempted. A key attraction of the action spirals is that it does not seek to test one approach against another akin to a randomised control trial. Rather, it explicitly allows for a solution to be progressively developed and tested through multiple cycles of change. Incorporating the appreciative lens ensured a strengths-based approach.

## Chapter 5. Cycles of Action Spirals

### 5.1. Chapter introduction

This chapter aims to describe the specific action spirals that were undertaken in order to better align initially allied health, but then the broader workforce, to enact the Locality Strategy that had been adopted by Counties Manukau DHB as an organisation.

### 5.2. AS1: Allied health in localities

The primary methodology of action research, and specifically action spirals has been explained. I believe this is best articulated in the O’Leary cycles of change as detailed in Figure 4 (p. 51). From this point, each action spiral will be described using the descriptors offered by O’Leary of Observe (Research/Data Collection), Reflect (Critical Reflexivity), Plan (Strategic Action Plan), and Act (Implement). The abbreviations AS (1-5) will be used to articulate the five specific action spirals that were undertaken, and to provide ease of linking the cycles to each other.

#### 5.2.1. AS1 Observe (Research/Data Collection)

The context of Counties Manukau DHB was one whereby a strategic direction had been set. That strategic direction, as outlined in Chapter Two, was working towards an alignment of healthcare services along the lines of geographic localities. In turn these localities are roughly aligned to the demographic make-up and unique population groupings within the catchment area of Counties Manukau DHB. One of the intentions of this strategic direction was to mitigate barriers that exist between primary, secondary, and tertiary services. The Locality Strategy aimed to do this by better aligning healthcare services to the population and associated health needs. The inherent challenge within this was determining what services needed to be re-aligned to localities in order to more effectively meet population health needs.

As the shape and form of localities began to emerge, there was use of language in fora around the devolvment of workforce from secondary and tertiary services to enable a shift towards meeting population health needs, and in a way that was most practicable to the population.



Allied health, as the second largest workforce grouping within Counties Manukau DHB, began to be mentioned as a workforce that would need to be devolved for the success of localities.

The context of my role within Counties Manukau DHB, while detailed in Chapter Three, was one whereby I held a role of strategic leadership of the allied health professions. Strategic leadership is one of influence as opposed to direct managerial control of the professional grouping. Representation at the level of the Executive Leadership team reporting to the Chief Executive Officer institutionalised this role. A small team of direct reports providing direct professional leadership of the five professions commonly associated with allied health in New Zealand (dietetics, physiotherapy, social work, occupational therapy, and speech language therapy) enabled more direct linkage with these professions. A proposal was tabled to the Executive Leadership team in 2012 to review how allied health, as a grouping, was structurally aligned and whether a more direct responsibility from the DAH to the allied health professions was needed. This was not progressed at the time as there was a general sense within the Executive Leadership team that there was not an appetite for creating the instability that any structural review brings.

Linkages with the broader allied health grouping has been facilitated by the use of an allied health forum. The allied health forum had a history beyond the tenure of myself in the DAH role, with an initial group meeting in the late 1990s. As professional lead roles became progressively more embedded within the organisation, this group became more formalised. With the initial appointment of a DAH role in Counties Manukau DHB in the mid-2000s, this became the primary forum that the professions that would fall under the allied health umbrella would collectively gather to be able to support the DAH role, and for the DAH role to begin to engage more purposefully with the wider workforce. However, a revamp of the clinical governance structure within Counties Manukau DHB in 2012, provided a mechanism to re-affirm the structure and intent of the allied health forum to enact representative and participative democratic principles within the functioning of the group.

### 5.2.2. AS1 Reflect (Critical Reflexivity)

The language that was being used around the development of localities was for devolvement of workforces which had direct implication for the allied health professions. While allied health as a collective is large within the organisational context, it is a collective of multiple professions. Taken as individual groups these professions are significantly smaller than the much larger workforces of nursing and doctors. The resource when articulated in whole

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numbers of FTEs is small considering the size of the population of the DHB. Smaller professions such as speech language therapy were often placed in a situation of splitting FTEs across community bases, and specialty services such as dietetic input for diabetes patients was a specialised role that covered both the inpatient environment as well as outpatient and community services.

In enacting my role of strategic leadership, a concern that emerged with the development of localities was how the devolvement of workforces would impact the allied health professions. Reflecting on the potential impact a secondary query presented itself that centred on the potential for fragmentation of the allied health workforce and the subsequent impact on patient/client care if the workforce was to be devolved fully to a locality. This was bought into contrast where the service in the current state was shared across the proposed localities and/or where the services that were being offered were specialised to a point whereby the service was being provided by an individual clinician across multiple settings.

Williamson et al. (2012) described reflexivity as “continual process undertaken by the researcher of reflecting on their actions and behaviour in relation to participants and the research process” (p. 40). Engaging in this process, the historical intent of a structural review of allied health was unpalatable at the time. Using the concept of organisational framing offered by Bolman and Deal (2013), four frames can be used to view any organisational process: structural, symbolic, political, and human resource. Applying this concept, the structural frame was ineffective in 2012, and unlikely to be effective in 2013. The enactment of the locality strategy by Counties Manukau DHB could be framed both politically and symbolically. The impact was potentially within the human resource frame. Acknowledging past actions, a frame that had greater potential for success was the symbolic frame especially acknowledging and building on the concerns relating to adverse impact on service provision and patient care.

### 5.2.3. AS1 Plan (Strategic Action Plan)

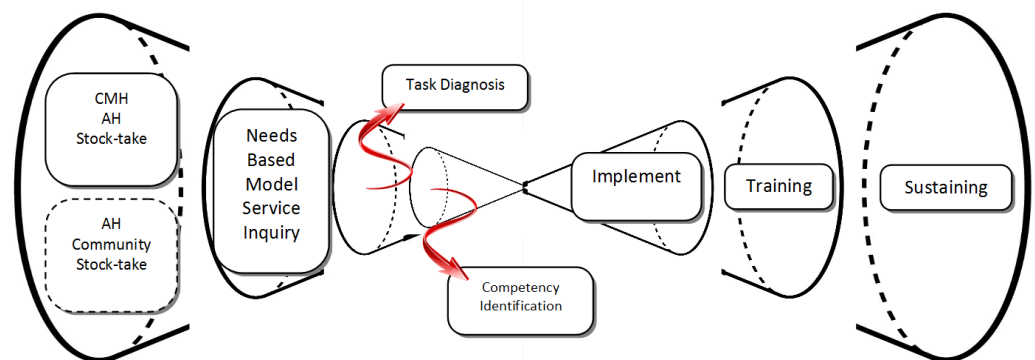
The initial plan was to submit to the Executive Leadership team a proposal to scope an organisational project that had the specific remit to examine how best allied health as a workforce could enable the ongoing roll-out of the locality strategy. The working title of this project was Allied Health Enabling Locality Development (AHELD). Submission of this project was approved by the Executive Leadership team and coupled with other organisational projects allowed for the recruitment of a dedicated project manager.

With the recruitment of the project manager there was the opportunity to examine how best this project should be approached. The underlying premise of the project was that allied health as a workforce could be better aligned to the locality roll-out, and as such there was a need to examine the current model of care that the workforce was operating under. Saunders (1997a) had detailed basic principles by which allied health professions (notably physiotherapy and occupational therapy) could effectively operate with assistants as an un-registered, un-regulated workforce. These principles were collated by Chadwick (myself) and Smith (2008), when detailing explicitly how to work with physiotherapy assistants. Further development of these theories have been noted by Smith and Duffy (2010) who developed the Calderdale Framework. This is a specific framework developed with a focus on the allied health professions, to systematically review what services they provide and the associated tasks that make up the service. In doing so, there is an ability to detail the skill required in delivering these tasks and whether they could be delegated and delivered across professions, or whether there was the ability to delegate to the assistant workforce. Work by Nancarrow, Moran, Wiseman, Pihills and Murphy (2012) has reviewed the success as well as the barriers to this process.

The original theories of Saunders (1997a and b), which were further developed by Chadwick and Smith (2008) and Smith and Duffy (2010), were reviewed by myself and the project manager and were noted to be promising as they provided opportunities to improve the efficiency and effectiveness of service delivery. Particular attention was paid to the Calderdale Framework given that it was developed specifically for the allied health professions. On further review, however, I concluded that they did not clearly link to better aligning the workforce to population health needs. Further, the drive towards localities was also looking to challenge what it was that Counties Manukau DHB needed to provide as a service provider. In addition, were there services that needed to be provided but could be potentially provided by service providers outside of the employ of Counties Manukau DHB? Attempts to define a whole of workforce required by population health needs had been attempted by others such as Tomblin-Murphy, McKenzie, Alder, Birch, Kephart & O'Brien Pallas, et al (2009) from a profession specific perspective and Segal and Leach (2011) from a condition specific standpoint. There had also been attempts to look specifically at allied health service requirements at a community level (Queensland Health, 2005). All provided material were worthy in their own rights but were also only pieces of the puzzle.

Combining these thoughts allowed the project manager and I to begin to mould a process that had a better fit with the direction of travel of the organisation towards localities, while pulling

on the best-known evidence in this area. Diagrammatically the AHELD project began to take the following shape (Figure 6):



**Figure 6: The emerging AHELD change framework**

Design of the AHELD framework began to pull on the theories of Complex Adaptive Systems (CAS) whereby change cannot necessarily be mandated effectively but rather should be seen as an ‘emergent’ process (Lissack, 1999) and the role of a project or change process should be to provide the time and space for the change to occur. This was a fit with observations made by the project manager and me. The benefit of the Calderdale Framework, as described by Smith and Duffy (2010), was that it provided a prescribed process for staff to work through, but it is this prescription that ran the risk of stifling the emergent process within a CAS. Wytenburg (1999) described it as:

Corporations cannot be truly controlled: control depends on certainty, predictability at the very least. Unfortunately, rigid control structures are optimally effective only when the environment within which they operate are sufficiently stable that the organisation and meaning of the information both constituting and describing the environment behave predictably throughout the relevant timeframes of corporate decision making, direction, control and production. (p. 42)

Within this context, the roll-out of localities is essentially about undoing many of the ways of current practice to design new ways to deliver services. Using a framework that was too rigid ran the risk of the original meaning and purpose of any change becoming lost as the environment around continued to change. Developing a framework that provided the time and space for allied health to review their current ways of working to better align to potential new ways of working within localities was a more desirable option.

#### 5.2.4. AS1 Act (Implement)

Prior to the initiation of the project proper, the organisational requirements of project documentation were completed with the authoring of a Project Initiation Document (PID). The PID became an initial communication tool and was distributed to staff to provide a level of education as to the aim of the project. This also provided an opportunity to meet with newly instituted general managers who had a remit to oversee the four localities and to talk through the intent of the project. Reflections of these meetings highlighted the initial concerns that prompted the beginning of this process in so far that the general managers were employed to oversee the implementation of the locality concept, therefore any intrusion into what was seen as 'their' locality was not always welcomed and viewed with a sense of suspicion (M Chadwick, personal communication, March 23<sup>rd</sup> 2013).

Over the period 11/4/13 through 4/6/13 a series of 'road-shows' were held across Counties Manukau DHB detailing the project and the form that it had taken to this point. Themes that emerged from the feedback of these sessions centred on concern as to how this would fit with other work currently underway as well as concern that this was about job cuts (M Chadwick, personal communication, May 11<sup>th</sup> 2013). In parallel to this work, the project manager had undertaken the initial stocktake of allied health staff across the organisation, as well as known allied health staff that existed in a community setting (Young, 2013). The road-shows and the stocktake work provided a base to take into the initial sessions with professions focused on service inquiry which required detailing the services provided by the profession. This was done on a profession by profession basis with intent to bring the professions together.

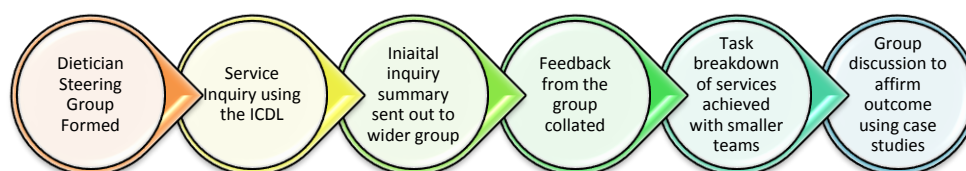
The initial session was held with the dietician workforce on 24/7/13. The scene was set for the group with a three-phased introduction. The first phase centred on the challenge of localities, the choice we collectively had in how to respond, and in turn how this had led to the establishment of the AHELD project. The second phase of the introduction highlighted that with this change there was essentially a choice between having the locality change '*done to*' the allied health workforce, or for it to be '*done with*'. The choice and intent of the project was to 'hand back to clinicians' the change process with a design framework that relied explicitly on clinician engagement and co-design. The third phase of the introduction highlighted that this work existed in the realm of a CAS, and that the outcome was far from pre-determined with the intent of the initial session being to begin to tease these points out via a service

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inquiry process. This structure of introduction was repeated in turn with each professional group (M Chadwick, personal communication, August 4<sup>th</sup> 2013).

The focus of this initial workshop sought to understand what it was that dietitians actually 'did' as the process of service inquiry. This began to take the shape of following the patient journey and the points of intersection that dietitians will have with this patient journey, and then in turn what their own internal processes were to enable services to be provided. A point began to emerge through this process of the impression that the service as a whole was designed to meet the demand that was placed on it. Systems and processes were designed to meet the demand, and in turn to manage the demand through a system of screening and prioritisation. The query became, was there any recognition of the actual need of the population that the service was established to serve in the first instance?

This initial workshop with the dietitians led to broader and more inclusive workshops of the wider workforce. The form that these workshops began to take was based on service inquiry linking to the International Classification of Dietetic Language and the associated components within this doxology of assessment, intervention, leadership, and administration. The basic flow that the dietetic group took is detailed in Figure 7 below:



**Figure 7: Service inquiry and task breakdown process undertaken by the dietetic profession**

A key outcome of these discussions was the arrival of the group to a point of recognising that while there were clear tasks within services that needed to be provided specifically by a dietitian, there was the identification of tasks that while falling under the delivery of a dietitian, potentially did not necessarily need to be delivered by a dietitian. This provided a fit with the original theories of Saunders (1997a), and the appropriate delegation of tasks.

On 3/9/13, the service inquiry process was initiated with the speech language therapy profession. As a smaller professional group there was an ability to keep the work undertaken to a single group as opposed to devolving to a wider group leading to a more streamlined process. As with the dietitian profession, professional standards were accessed to form the

basis of the service inquiry. For speech language therapy this took the form of the Royal College of Speech Language Therapy Guidelines. The service inquiry process raised a concern insofar as the profession is not a registered profession within New Zealand, therefore adherence to any standards such as the Royal College of Speech Language Therapy Guidelines is a voluntary process. The belief from the group is that this set up a situation that anecdotally had been noted whereby the confidence in the competence of services outside of Counties Manukau DHB could not be verified leading to variability in practice between Counties Manukau DHB and non-Counties Manukau DHB speech language therapists.

The ongoing roll-out of the service inquiry portion of the project took into account the social work profession on 30/9/13. As with the dietetic and speech language therapy professions a consistent introduction to the process was used. A distinct difference with this workforce was encountered. Whereas the preceding two professions had chosen to lean on professional standards, there was considerable debate within the group as to 'what is social work versus what is it that social work does' (Chadwick, 2013). As such there was a tendency for the group to focus on the tasks of what they do as a profession which was then built up to a statement that represented the services they provided. A result, the group advocated that the tasks that they carry out are specialised in nature, therefore there cannot be any substitution as to who carries out the tasks. The tasks were specialised to the profession as were the services that they provide.

Initial meetings with both occupational therapy and physiotherapy occurred over the period August to October 2013. The sessions with occupational therapy gave an interesting reinforcement of what was noted with social work insofar as the group tended to be fixated on the tasks that they performed, especially the task of issuing equipment. There was a moment in the session where they were challenged to think 'what would we do if we didn't issue equipment' (Young, 2014). This allowed the team to move past a block and then highlight the services and subsequent tasks that could be provided.

Physiotherapy as a group provided a much more linear process insofar as when worked through the process of service inquiry, they quickly came to a point of agreement that there were not many areas as far as services and subsequent tasks that could not be delegated to an assistant so long as the right training was in place (Young, 2014). Subsequent to the initial sessions with these two groups, there was ongoing work at which they continued to identify the services that they provided as well as the tasks that made up these services.

The result of the work with the five 'therapy' professions were aggregated spreadsheets where they collectively identified the key services that they provided within the organisation, and in

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turn the tasks that made up these services. In doing so there was reflection within the individual professional groups as to what tasks were uni-professional, that is, the task needed to be provided by a defined professional group in order to give assurance as to the quality and safety of the service/task being provided. Tasks were identified that could potentially be provided by other professional groups, but were not necessarily “owned” by a single profession. Some tasks were determined to be appropriate for delegation to the un-registered/un-regulated workforce with appropriate professional oversight and supervision in place. This aligns with the model proposed by Chadwick and Smith (2008) as well as the later work by Smith and Duffy (2010).

With the service inquiry and task analysis completed, there was the ability to collate the information generated into a summary document. The summary document affirmed the methodology employed, and detailed the key findings as to what it is that is core to each profession and as such what it is that they do, and only they can do, as a professional group. In turn the document identified the generic tasks that an assistant could carry out that would cut across all professions. Each profession in turn detailed the tasks that could be delegated to the assistant. To pull again on the concept of emergence, with each profession in turn beginning to identify what could be delegated, exemplars were developed and shared amongst the various groups. Using these exemplars as a starting point, the social work workforce moved to a point whereby they too were able to identify tasks that could be delegated to an assistant (Young, 2013).

A tangential but related piece of work had also been underway during this time period. Te Kaahui Ora, the Maaori Health Service within Counties Manukau DHB had been approached during this initial period to name the process that was underway. This required time to consider what it was that we were striving to achieve within the project. The initial project framework was viewed to be akin to the symbol for infinity and it was determined that this was an ongoing and forward-looking process, but one that may never be completed. As such the following name and proverb were attached to the project:

**He Pou Oranga**

Ma te aata titiro ki ngaa

Ia o te tei

Ka kitea ai to orange o te

Takutai



By closely observing the variations of the tide, one can predict the effects and wellbeing of the foreshore.

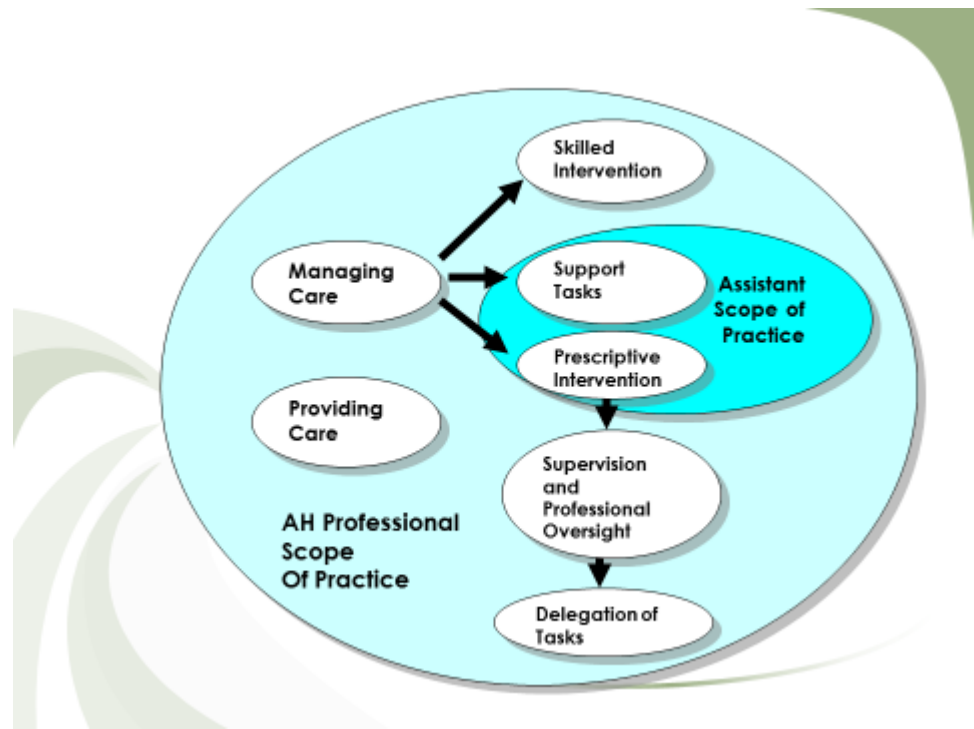
The importance of naming the process can be linked back to the work of Bolman and Deal (2013), and the initial focus of this process to operate in the 'structural' quadrant. As noted, this was unsuccessful, but with the work that was undertaken, the naming and gifting of a proverb, a strong statement was made in what Bolman and Deal would consider the symbolic quadrant, a quadrant they argued may actually be the most powerful of all.

### 5.3. AS 2: Papakura Home Healthcare redesign

#### 5.3.1. AS2 Observe (Research/Data Collection)

The initial stages of the AHELD project had been based on the principles of Saunders (1997a and b) which had been developed further by Chadwick and Smith (2008) and Smith and Duffy (2011). The basic principles were that the services provided by the allied health professions could be separated into key services and in turn these services could be broken down into specific tasks. By breaking down to this level there is the ability to determine if the individual tasks are unique to a professional grouping, or if they could be shared across professions, or potentially could be delegated to the unregulated/unregistered assistant workforce.

Working with the individual professional groups in the manner that we did within this project affirmed that this could be effectively done. Each profession was able to identify their key services provided and in turn break these services into key tasks. By a process of consensus, there was the ability for each professional group to determine whether the tasks sat within the profession, across professions, or had the ability to be delegated. I had expressed such a model (Figure 8, p.76) in 2008:



**Figure 8: The delegation model proposed by Chadwick (2008)**

The observation going through this process was that a process to determine tasks to be delegated could be effectively actioned, that there was the ability to constructively engage with professions to work through the framework.

At this point there came an organisational need to look at the broader model of care that was been enacted in the locality environment beyond the allied health professions. With the establishment of the locality general managers, there was an intention to begin to transfer services and teams from reporting into the hospital organisational structure, to more explicitly report to the locality organisational structure. This was achieved via a defined organisational change process. While this signalled the change of reporting lines, it did not necessarily answer the question as to how individuals and professional groups were to operate in this new environment. There was noted to be no established change process by which this could be progressed within Counties Manukau DHB.

### 5.3.2. AS2 Reflect (Critical Reflexivity)

The AHELD process was affirming insofar as it provided the time and the space for individual professional groups to work through a process of service and task identification. To attempt to explain what occurred during this process can be achieved using the lens of a CAS. The AHELD project was built on the CAS principle of simple rules, that is the innate and internalised rules by which individuals and groups operate (Plesk & Wilson, 2001). The simple rules that the professional groups had been operating under up until this point were that they had to provide all of the services and tasks that are commonly associated with their profession. The AHELD process provided an opportunity to challenge these simple rules, and to potentially alter them to where they focused on what as a profession they needed to do. This was opposed to what needed to get done, but as a profession they did not necessarily need to be the ones to 'do'. By changing these simple rules, a raft of possibilities became available including sharing services and tasks across professions and determining the tasks that could be delegated to the assistant workforce. This then was potentially creating a new way of working, a new 'attractor' as to how services could be provided (Lissack & Gunz, 1999).

While the concepts of a CAS allow an explanation of what occurred, it did not necessarily allow for a depth of understanding as to what unfolded. Applying a more critical lens to what transpired was beneficial in planning for further iterations with ongoing change cycles. The work of Pierre Bourdieu [1930-2002] as detailed in Chapter 3 became useful to this end.

Bourdieu's framework was used to analyse and gain a level of understanding as to why things were the way they were in the context of the AHELD project. Within the context of Counties Manukau DHB, there was a defined social field that the allied health professions existed in as employees. The space within this space, their habitus, was broadly defined by legislation, professional ethics, and standards. Previous to engaging in the AHELD project, it was argued that the borders to individual habitus were perceived to be well defined. The social space that the individual habitus occupied had not fundamentally changed for an extended period of time. The move towards localities as an organisation provided a fundamental shift in the social field in which the professions existed. Greenfell (2004) captured what Bourdieu describes as hysteresis where:

...mixed messages between field and habitus result in conflicting action – a kind of social schizophrenia. In other cases, the field moves beyond the habitus, whose structural dispositional possibilities can no longer respond to the activity of the field. (p. 29)

While it is not proposed that the move towards localities had provided a complete separation of the field from the habitus, it is argued that it had provided the environment whereby the field was changing, and the question was becoming whether the collective professional habitus were able to move and adjust with this change. AHELD provided a process by which the assumptions underpinning a professional habitus could be questioned and tested. Defining professional services and the tasks that made up these services challenged the doxa, or innate internalised rules by which professions operated. By challenging these rules, it in turn questioned the relative porosity of the bounds of the habitus; that is, did a profession fully occupy the space that it believed it occupied within the social field?

What began to emerge through this process was a question of 'do' versus 'done'. The 'do' was what a profession arrived at as a collection of tasks and services that via consensus were felt to be unique to their professional schooling. The 'done' was the tasks and services that when reviewed were part of the patient care episode but were not necessarily unique to an individual profession. There was potential that these tasks or services could be provided by one of many professions, or in turn could be delegated under supervision to the assistant workforce. By quantifying the '*do*' versus '*done*' argument, there was a challenge to the finality of what had been perceived as the bounds of a professional habitus. If these bounds were not as finite as they were perceived, if indeed there was greater porosity of these bounds than what was initially believed, how did this impact on the innate internalised rules of a profession, their doxa?

This question provided a means to understand why there was a difference in how the professions of physiotherapy, occupational therapy, speech language therapy and dietetics approached the AHELD process as opposed to social work. The first four professions approached this as a process by, in the first instance, identifying services and then breaking these down into tasks. By doing so, the observation was that they were able with relative ease to engage into a 'do' versus 'done' discussion. In contrast social work began with the tasks that they performed and then rolled these up into services. In doing so, each task was identified as unique, one they needed to do. There was not the capacity to define that which needed to be 'done' but was outside of their 'doing'. Placed within a Bourdieusian framework the 'do' versus 'done' argument allowed the first four professions to query the relative porosity of their professional bounds, whereas social work mitigated this discussion by encompassing all tasks as tasks they needed to do, therefore reinforcing the finality of their professional bounds.

In summary, there was the ability to detail the 'do' versus 'done' tasks for the five professions reviewed. On reflection, as a process it highlighted that there was the ability to challenge

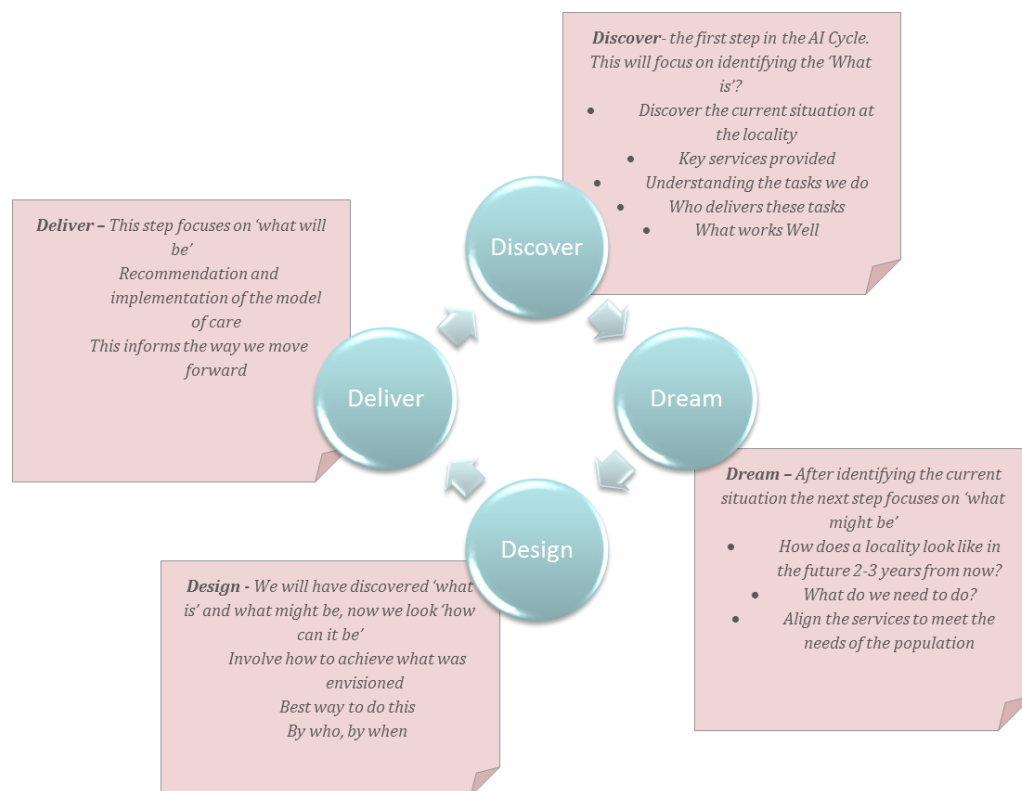
professional bounds in a constructive fashion. Doing so lay the groundwork for different ways of working across professions and quantifying further the use of the assistant workforce.

### 5.3.3. AS2 Plan (Strategic Action Plan)

As noted in the observe section of this chapter, there was the gradual establishment of the localities with the appointment of general managers and the subsequent shift of reporting lines of staff to their roles. What had not been addressed was how ways of working were going to be different under this new structure. The initial work of the AHELD project had demonstrated that on paper, at least, there was the ability to construct new ways of working across professions. Engaging with the Director Primary Health and Community Services, and the Group Manager Primary Care, a case was made that there was the ability to build on the AHELD project and broaden its remit beyond allied health alone. By integrating the lessons learnt in the first change cycle there was the belief that it could become a more inclusive change process of the broader community-based healthcare team.

With agreement to progress towards this end, there was a need to revisit the work done to date and build a more defined change framework for a broader team to be walked through. A lesson learnt from AHELD was that it had been a very time intensive process, and to engage in a similar process with a broader group was not going to be achievable purely from a time standpoint. We revisited the literature reviewed in developing the AHELD process to determine if there were other frameworks that could be accessed and adjusted to meet our local needs. On review, the organisational change framework of appreciative inquiry began to emerge as an attractive framework to build on locally. A fuller explanation of appreciative inquiry is detailed in section 4.3.2, but at its most base level appreciative inquiry can be described as: ...a form of action spiral that attempts to create new theories/ideas/images that aid in the developmental change of a system. (Bushe, 2001, p. 48). One of the attractive components of appreciative inquiry is that it is not an overly prescriptive process; rather it is open to interpretation as to how it can be best applied in a local context. A common version of appreciative inquiry is the 4D cycle of Discovery/Dream/Design/Deliver (Bushe, 2013). Another key strength of this approach is the engagement focus, acknowledging that the actual implementation of change in healthcare is carried out by frontline staff, and so the more engaged in the process the more the effective the partnerships and collaborations that are formed through the process (Trajkovski, Schmied, Vickers & Jackson, 2013). Working with the

project manager we were able to develop the 4D process to one that reflected our specific needs which is reflected in Figure 9:

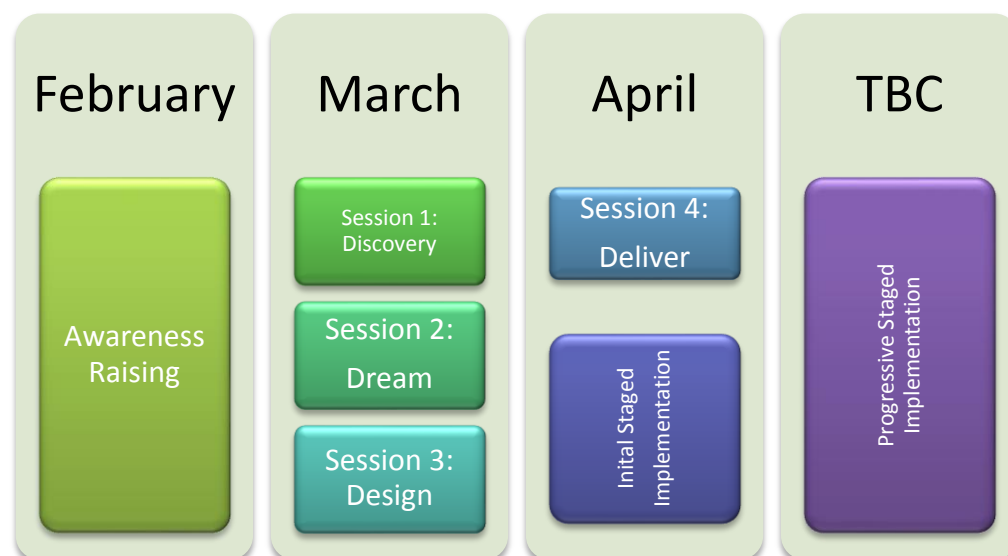


**Figure 9: The 4D process developed for AS2**

A key issue remained around time, and how to ensure that the process could be completed in a timely way. Given that the AHELD work was built on the theories of Saunders (1997a and b), it was beneficial to learn how others had developed these theories and the frameworks that they had employed. Smith and Duffy (2010), in developing the Calderdale Framework, had devised a key step in their process in being specific and systematic around awareness raising. When leading a group through their framework it ensured that there was a high level of understanding and buy in to what was about to be done and why. This was integrated as a key learning in developing our own framework.

As our change framework continued to be developed, it began to be known as He Pou Oranga (HPO). While this name had been gifted originally to the AHELD project, it became apparent that this was a more fitting name for a project that had a greater reach than the original piece of work. It began to live out the associated proverb insofar as the proverb speaks of observing the variations of the tide, in this instance the outcome of the AHELD project. We were able to predict the wellbeing of the foreshore; in essence how could we take the lessons learnt to date and then apply them in a broader context. The initial locality that was identified to be taken

through the HPO change framework was the Manukau locality and specifically the Papakura Home Healthcare team. The shape of the framework over the first part of 2014 is reflected in Figure 10:



**Figure 10: Timelines attached to AS2**

As the content of each session continued to develop, a challenge came to the process to be able to identify where in the change framework the voice of the patient would be heard. The concept of Experience Based Co-Design (Dale, Stanley, Spencer & Goodrich, 2013) was worked into the second session of the framework based on the premise of having a patient involved actively in the design process, or explicitly using patient stories to inform design.

#### 5.3.4. AS2 Act (Implement)

During the months of December 2013 and January 2014, the HPO change framework continued to be developed and each session developed with an initial learning plan for the sessions. The background mechanics were also worked through in terms of location for the sessions and blocking of schedules to allow for staff to attend. As part of the awareness raising, the framework was raised at team meetings and an initial session was held with a GP from another locality that had already progressed work with a Home Healthcare team in implementing multidisciplinary teams and the benefit of doing so.

In preparation for the framework roll-out, a project team was formed consisting of myself, the project manager, the general manager for the Manukau locality, the service manager for localities and the operations manager for the Papakura Home Healthcare team. There was also fortuitous alignment from a resource standpoint insofar as there was a cohort of employees who were working through the organisational leadership academy who were in want of projects to be able to report on as a part of their programme. This allowed for three individuals to then be linked in and essentially act as project assistants during the duration of this change cycle.

In preparation for the first session, the project team reviewed the flow of the first session and ensured that there would be as wide a representation as possible of all of the staff from the Papakura Home Healthcare team. Given the location of the team in Papakura and acknowledging the make-up of the staff, consideration was given as to how the session should be started in a culturally appropriate way. Consultation with Te Kaahui Ora (Maaori Health Services) led to the development of a mihi<sup>2</sup> appropriate to the audience and the intention of the session. Consideration was also given to the concept of knowledge transfer, and how knowledge could be shared amongst staff, especially if they could not attend a session. This led to folders being developed that had pre-reading material included as well as dividers for each session, so information could be added to as the framework progressed.

A summation of the second change cycle workshops, key agenda items, and outcomes are detailed in Table 3 (p. 94):

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<sup>2</sup> A mihi is a Maaori welcome used to acknowledge those in attendance and to give thanks for the event.



**Table 3: Detailing the content of the 4-D cycle for AS2**

Session	Key agenda items	Key outcomes achieved
<b>1: Discovery</b>	<ol style="list-style-type: none"> <li>1. Opening: Karakia<sup>3</sup>, Whakawhanaungatanga<sup>4</sup></li> <li>2. Context setting</li> <li>3. Current picture of Papakura HHC</li> <li>4. Group work: identifying strengths</li> <li>5. Feedback</li> </ol>	<ul style="list-style-type: none"> <li>• Understanding of whom everyone in the room is</li> <li>• Review of direction of travel with localities</li> <li>• What is known about what is done</li> <li>• Consensus as to what is currently working well</li> </ul>
<b>2: Dream</b>	<ol style="list-style-type: none"> <li>1. Karakia</li> <li>2. Locality video</li> <li>3. Recap session 1</li> <li>4. Affirming current patient journey</li> <li>5. Patient stories and identifying what good looks like</li> <li>6. Patient video</li> </ol>	<ul style="list-style-type: none"> <li>• Consensus as to what is working well</li> <li>• Affirming what good looks like from a patient perspective</li> </ul>
<b>3: Design</b>	<ol style="list-style-type: none"> <li>1. Karakia</li> <li>2. Recap session 2</li> <li>3. Affirm current patient journey</li> <li>4. Change idea generation and sorting</li> </ol>	<ul style="list-style-type: none"> <li>• Generation and sorting of change ideas</li> </ul>
<b>4: Deliver</b>	<ol style="list-style-type: none"> <li>1. Karakia</li> <li>2. Recap session 3</li> <li>3. Review change concepts</li> <li>4. Clarifying overarching ideas and themes</li> <li>5. Group work centred around themes</li> <li>6. Affirming where to from here</li> </ol>	<ul style="list-style-type: none"> <li>• A new model of care agreed to in concept</li> <li>• Agreement on key themes</li> <li>• Groups determined to continue to progress work via creation of work packages</li> <li>• New name for the service mooted</li> </ul>

## 5.4. AS 3: Mangere Otara Home Healthcare redesign

### 5.4.1. AS3 Observe (Research/Data Collection)

<sup>3</sup> A Maaori prayer that is often said as a blessing to initiate proceedings.

<sup>4</sup> A process of introducing oneself, and your origins. Important to enable connections to be made within groups.

The second change cycle focused on transitioning the key lessons learnt in the AHELD project with a focus on allied health to the HPO change framework that encompassed the broader healthcare team in a locality setting, specifically the Home Healthcare team. The planning for the HPO change framework had been intentional in its development to ensure that it was engaging of staff and aimed to build on the strengths of what was already working well. It also aimed to place the patient voice in the middle of formulating any new ways of working. As a part of this engagement strategy, a manual was developed for staff.

To provide a level of analysis of this change framework, it is of value to first note key observations during each stage. The planning for the first session provided a grounding to ensure that the start was one that was culturally appropriate for the team. By actively engaging the general manager, service manager and operations manager in the planning process there was the ability to mitigate the sense of being 'done to' through this level of management. Another observation was that it also gave some members of this team the opportunity to step up in a larger group environment and be seen positively in their role. The mihi and process of whakawhanungatanga assured acknowledgement of all people in the room, why they were there and how they could potentially contribute to the process.

The group work provided a means to have the staff engaged collectively and to begin to look in an appreciative way towards the services that they provide. A somewhat surprising outcome of this process was that the team already viewed that they operated in a strong multidisciplinary environment. The results are represented in the following wordles (Figure 11, p. 77); the more frequent a word or concept mentioned by staff, the larger it is represented in the diagram. Conversely, the smaller the word, the less frequently it was raised.

To me this raised the question as to whether we were getting good/much better at information sharing? Were we truly operating in a respectful, collaborative manner with equal weight of opinion? Another observation during this process was the difficulty in keeping the group focused on the positive, that the impression gained was that it would always be easier to go on a 'tirade of negative platitudes'. The sense gained from the sessions as a whole however was that it gave opportunities for the staff to be able to reflect the good that they do.

What do we do well?

PATIENT/CARER FEEDBACK  
REFERRAL DATA  
**EMPOWERING PEOPLE**  
LESS HOSPITAL ADMISSIONS  
QUALITY OF LIFE IMPROVEMENT

What would you do differently?

LINKING BETWEEN SERVICES  
MORE AH STAFF CONTINUENCE SERVICE  
COMPLEX PATIENT MANAGEMENT  
ACCESS TO MEDICINES  
BETTER ACCESS TO PRIMARY CARE  
SHARED INTERDISCIPLINARY SKILLS  
IMPROVE COMMUNICATION  
IMPROVE WORKING ENVIRONMENT  
TECHNOLOGY  
UTILISE SKILLS  
FLEXIBLE HOURS  
STAFFING COVER  
CARS WORK ALLOCATION

How do you add value?

Case reviews  
Skilled staff  
Trust  
flexible clinics  
Cars  
Clinical supplies  
Team support  
Communication  
MDT  
Home based care  
Problem solving  
Whanau  
flexible hours  
Wound care  
Phone Texting  
Empower patients  
Assistants  
Equipment  
Community respect

How to measure success?

CONNECTION OF SERVICES  
STAFF EDUCATION  
PROVIDE EDUCATION  
CULTURALLY APPROPRIATE SERVICES  
EMPOWERMENT  
PREVENT ADMISSIONS  
HOISTIC

Figure 11: Wordle diagram representing feedback from staff

At the debrief session there was positive feedback from the project team, and anecdotal feedback from staff after the session that it had gone well. This devolved into an extended discussion on how to run the second session. The session had been planned to review the current state of service provision. What quickly became apparent was that the session did not allow for the level of detail that a process mapping exercise or value stream mapping would require. To me it reinforced that the focus of the sessions was on staff engagement and that the focus needed to be more on the appreciative inquiry methodology. Others were more experienced in the more disciplined approaches such as an improvement science approach. To this end there was discussion amongst the planning group as to whether the next session should be managed within a large room when we progressed to breakout work or whether there was a need to use smaller rooms to allow for smaller individual groups. A personal preference was to keep the large group together in order to keep a sense of the group dynamics and to feed off each other. In the end this approach was vetoed in preference to allow quieter working environment for the groups. A key learning from the session was that by focusing on the positive we were not ignoring the negative per se but creating an environment whereby there was a group desire to move towards a more desirable future state.

Other points of discussion were raised around how the room was set up, how there was a tendency for like to gravitate to like. Could we work as a single large group was floated and rejected as being too unwieldy and not allowing for the quieter voices to be heard. In the end the template for the next session was set.

The running of the second session was relatively uneventful with good use of patient stories. Having the patient in the room allowed for good engagement with the staff. An increased use of stories to highlight what good flow looks like was well received by the group and in turn allowed for others to contribute their story to this process. The result was an affirmation of the current process flow and building recognition of what a good patient story/experience looks like. A review of the two sessions to this point could be summarised as having little in the way of good data to provide a meaningful snapshot of services, and that with the group it was difficult to get past the barriers in the current state.

The format of the third session was relatively set, as this session was focused on the group dreaming of 'what could be' with potentially a new knowledge as to what a 'good patient journey' looked like from a patient's perspective. The idea generation process is purposefully designed to be done in quiet. The intention is to allow the quiet voices within the group to be heard. Setting out the process, so that there could be borrowing of ideas from each other, aimed to equalise the playing field in that any ideas or knowledge generated was collectively owned and sorted by the group, creating a sense of positive group think. The result of the session was over 140 change ideas being generated by the group as captured in the photograph below (Figure 12, p. 79).

Potentially the most affirming aspect of this process was the ability to sort and group ideas that were felt to be within the ability of the group to go ahead and do something about. The criteria were that they did not necessarily require resource and were felt by the group to be able to lead to significant improvement within the team. This was achieved via a two-step process specifically involving staff. The first step required staff to take an idea and focus on whether the idea was one that they felt could be placed in one of four quadrants. That the idea could be progressed:

1. Entirely within the team and without new resource
2. Entirely within the team but would require additional resource
3. Would require engagement external to the team but not necessarily additional resource
4. Would require engagement external to the team and additional resource



**Figure 12: Change ideas generated by the group.**

The photo detailing the Step 2 (Figure 13) poster highlights that the majority of ideas ended up being sorted to the quadrant that was felt able to be implemented within the team without additional resource.



**Figure 13: The first sorting step result**

The second sorting step (Figure 14) allocated the ideas into quadrants of whether staff thought the idea was going to achieve:

1. Big gains within a short time frame
2. Big gains within a long-time frame
3. Small gains within a short timeframe
4. Small gains over a long-time frame

This provided a process driven by staff whereby their ideas were being progressively sorted to identify where the biggest wins were felt to be gained, and those that could be achieved quickly.



**Figure 14: The second sorting step result**

The most difficult part of this change cycle occurred within the debrief and subsequent planning session. What was initially intentioned was a process whereby the ideas that were sorted as being short term big gains and within resources/team would be identified as a set of change ideas that would form an initial cohort of ideas to be progressed. This would begin to form the basis of an overarching 'roadmap' for the team which could be built on with the ideas that were felt to be longer term concepts and still within resources/team. Next, we could begin to look at short term big wins that would potentially require resource. All of the time,

the intention was to build up the concept of the roadmap for the team that they could follow in their intention of moving towards a new way of working.

The point of tension that arose from this process was that it was not providing a clear sense as to what a future state for the team would look like, and in turn giving clarity as to what it was that the team was working towards. This led to considerable debate within the project team that continued well beyond the allocated time frame for the meeting and continued with the general manager after the meeting in my office. The end result was an agreement that the ideas that were generated would subsequently be themed in the concept of the patient journey, and that these themes would in turn begin to form a new model of care for the service. This agreement was reached at the end of the debrief session which in turn led to the work in preparation for the session preparation meeting.

The final session of this change cycle as detailed in Table 2 (p. 74) brought the team back together and detailed the work that had transpired between sessions. The main intent of the session was to sense test each of the themes that were generated by working through a checklist within smaller groups and in turn reporting this back to the larger group. The final step of this session was to determine the action groups that were going to continue to progress the change ideas outside of the process that the framework had followed to date. This essentially became the point of hand-off, where the work of the change framework ended, and was to be progressed as business as usual. A key outcome at this point was a revised model of care for the team that is captured diagrammatically in Appendix B.

#### 5.4.2. AS3 Reflect (Critical Reflexivity)

The process of AHELD had demonstrated the ability for the professional bounds of the allied health professions to be constructively challenged. The premise that I believe underpins this is found in the works of Bourdieu and his concept of habitus. To paraphrase, habitus is the social space that an individual or a group inhabits in a broader social space. The initial thinking was that the perceived bounds of the habitus of the individual professions were perceived by those professions to be set, impermeable. The extension of this is that it is possible when engaging with the workforces in a purposeful way and allowing the time and space for the discussion to take place, that these bounds can be challenged positively. In doing so the bounds of a profession can be found to be permeable, that is the porosity of these bounds can be challenged. AHELD demonstrated this to hold true.

Further, the bounds could be quantified, and the components of care shared across professions quantified and in turn built into a different way of working. The challenge that was encountered with AHED is that allied health as a workforce grouping does not exist in isolation, rather these workforces act and interact with a myriad of other health workforces in a multiplicity of care settings. The advent of localities and the need to look at how to best align the workforces to enable the locality concept challenged the need to look at allied health in isolation. The intent to undertake a service redesign process in each locality in turn provided the opportunity to address this point.

By undertaking the HPO service redesign framework, there was the ability for the social field that was being investigated to be expanded. No longer was the focus just on the allied health grouping; rather it was now on the broader healthcare grouping that provided services within a home healthcare team. Within this change cycle there was an intent to broaden further than the home healthcare team, to also look at the other entities with which the team interacted, for example home support providers such as non-governmental organisations and GP practices, especially the practice nurses.

A starting idea with this change cycle was that it would begin in a state not dissimilar to allied health insofar that within the social field professions each would inhabit a habitus that was clearly defined and a belief that the bounds of their relative habitus were impermeable. The extension was that by taking the group through a facilitated framework and giving the individuals the time and space to review practice, there was the ability to positively challenge the bounds of the habitus, to influence the porosity of these bounds.

This attempts to capture the transition from AS1 to AS2. AS1 demonstrated the ability to influence the porosity of professional bounds. AS2 placed the social field of allied health within the social field of the Papakura Home Healthcare team.

This transition can also be viewed through the lens of complexity theory. At an individual professional level there is relative complexity of how that profession interacts with the social field. At the level of interaction between professions, the complexity remains, it is just different. So, it is when looking at the interaction of allied health with the broader healthcare team. It remains complex, just in a different way.

Within the change framework that was developed for HPO, this complexity was managed in large part by keeping a focus on the patient, and by using the appreciative inquiry methodology to focus on what was working well as opposed to diving into what was not. Each professional group could readily identify the complexities of their own professional group, and



the difficulties in providing these services in a logical and seamless way. The complexity does not change, but the context does. The patient and patient stories provide the mechanism to keep zooming out, to keep a focus on how the various components interact with each other instead of a profession with its social field in isolation.

#### 5.4.3. AS3 Plan (Strategic Action Plan)

Reflecting on the previous cycle allowed the project team to integrate several changes. What was noted were the lessons learnt that were taken out of AS3, namely:

- The initial sessions of the change framework enabled good engagement of staff which was maintained throughout the process
- The idea generation process allowed for the generation of a large number of ideas which could then be subsequently sorted
- Implementing these ideas, and in turn aligning these ideas to a new way of working, was somewhat problematic once the specific change framework ended

Taking these points into consideration the project team was able to implement and plan for several changes for the next change cycle:

1. To work with the relevant general manager of the locality to ensure that there was as broad a representation as possible to reflect the diverse workforce and entities providing healthcare within a locality
2. Noting the difficulty in translating ideas to implementation, to have more focused time specifically looking at methodologies for implementation, most notably using common methodologies found within improvement science such as plan – do – study – act (PDSA) cycles

#### 5.4.4. AS3 Act (Implement)

With the timing for the next change cycle established, there was the ability to work with the locality general manager in broadening the group attendance and the entities they were representing. With the attendance broadened, attention was given to the structure of the change framework and there was subsequent tightening of the timeframes associated with the change framework.

The initial session followed a similar format to the previous change cycle. With the second session, a decision was made within the project group not to have a patient physically in the room, rather to rely more explicitly on videoing patients as they told their story. This allowed us in preparation to be more purposeful and to ensure that in keeping with the appreciative inquiry approach that the focus was on what was working well, that the patient story reflected what 'good' looked like from the perspective of the patient, while remaining true to his/her story. In the third session a similar format was followed to the previous change cycle with a similar high volume of idea generation. The most significant change occurred during the third and fourth sessions where there was considerably more emphasis placed on translating the ideas to PDSA cycles for implementation. This required a mini session to describe a PDSA cycle, and how in turn to implement into current practice.

Next, we transitioned to a session where each idea was sense-checked and allocated to an individual who had a vested interest in the change idea. This was within the session translated to a PDSA cycle with an attempt to allocate timelines to the cycle in order to give a sense of management of what was to be done, when.

## 5.5. AS 4: Eastern Home Healthcare Redesign

### 5.5.1. AS4 Observe (Research/Data Collection)

As with the second action spiral, the difficulties began to arise when we transitioned more explicitly to the implementation of the change ideas. While we had taken on board the lessons learned and worked to ensure there was greater access to resource to assist in implementation, the majority of the implementation process still lay with team members as opposed to specific project support. This led to issues of how to implement into business as usual.

### 5.5.2. AS4 Reflect (Critical Reflexivity)

Some key observations and key themes were beginning to emerge with this change cycle. Firstly, there was a general willingness for people to attend the sessions, and there was good engagement throughout the sessions. The commitment to attend was significant, and while a drop off of attendance was expected, this was not the result in reality. On reflection, this

reinforced that was a general willingness of staff to be engaged in the change process. The general difficulties arose when the transition to implementation occurred.

A second key reflection was the engagement of staff to take the lead within specific pieces of work. As the change ideas were generated and sense tested with the broader group, there remained a readiness for staff to self-identify which group they desired to be involved with, and generally there was a preparedness for individuals to take a lead within this work. What came to the fore was a general lack of understanding of improvement science methodology and grappling with a Plan-Do-Study-Act cycle, and how to roll into ongoing cycles of change.

A third reflection was the importance of the Discovery session. These sessions reinforced that there was often a lack of knowledge from staff as to some of the changes that were underway within Counties Manukau DHB, and for many this was the first time that there was devoted time to talk through the changes and the possible impact these changes would have. It further reinforced that there should not be an assumption as to what the level of understanding was amongst staff, and that there should be appropriate time devoted within a session to ensure that the group was brought to a common point of understanding.

### 5.5.3. AS4 Plan (Strategic Action Plan)

Taking these points of reflection into consideration, there was the ability to fold them into the planning for the next action spiral with the Eastern locality. The basic format of the change framework remained. The intention of getting as many people in the room as possible was also retained, with good engagement from the CEO of the Eastern PHO being in attendance for the first session. The videos that were used for the previous action spiral cycle were retained to be able to fold in the patient perspective. What was built into this change cycle was an attempt to have more specific training integrated around the use of PDSAs as a methodology to implement and progress specific change ideas.

### 5.5.4. AS4 Act (Implement)

The sessions were delivered in what was now becoming a familiar format. Each of the Discovery/Dream/Design/Deliver sessions followed a known format, from my perspective, and with project support there was a good ability to predict how staff would react to individual sessions, and how in turn we needed to prepare for these reactions. Each session was held in

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the same location at the Eastern Health PHO building. This was a good location that was familiar to most of the staff. It was also a non-DHB location which made for improved access from some of the PHO and GP practices.

## 5.6. AS5: Franklin Home Healthcare redesign

### 5.6.1. AS5 Observe (Research/Data Collection)

The previous themes observed with other action spirals were further reinforced in entering into this change cycle. Good attendance was maintained throughout the sessions. There was good engagement from staff, which was further enhanced with a stronger GP presence throughout. The transition of change ideas to implementation remained a key sticking point. While more time was devoted to explaining what a PDSA cycle was, there did not appear to be sufficient time to explore this fully and to ensure there was consistent understanding of staff before being transitioned to enacting a process of change. This was observed to place the general manager of the locality in a difficult position of needing to review resource allocation, and how this could best be used to achieve the desired achievement of the change ideas.

There was within this action spiral cycle good opportunities to explore the concept of tasks that needed to be done, and who was best placed to do them. The continence nurses provided a case in point whereby during the discovery session they highlighted the need for more resource to provide their services. As we progressed, there was a change in their approach to the point that when we reached the Design and Deliver sessions, they suggested that they did not necessarily need more resource, but what they did need was for staff to be aware of the questions they needed other health practitioners interacting with the patient to be aware of, and to be asking the patient. These questions would better identify if there was a need for their service to be involved.

### 5.6.2. AS5 Reflect (Critical Reflexivity)

The example given above of the continence nurses, in my opinion, gives a good example of how a change framework is able to identify and facilitate a thought process around models of care, and how they could be adapted to the changing face of service delivery. As a small team they began the process with a very clear view that there was unmet demand which could only

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be met with more resource. As they were led through a process to look at what the ideal could look like, and the ideas that could be implemented to help shift towards this ideal, their stance shifted. No longer were they wanting more resource, but rather they were wanting the broader workforce to be aware of the services that they offered, and to provide a mechanism that could more accurately identify if there was a need for their specific level of expertise. They had moved from wanting more of more, to 'actually if you just ask these three questions'. This gives an example where we could observe a significant shift in thinking, an example where the relative habitus of the group had been affected. Whereas previously they had desired to see an expansion of their habitus within the social field, the appearance was that they were now willing for the bounds of their habitus to become porous, and for others to potentially encroach on what they had previously determined were services that only they could provide. I believe they had arrived at a point whereby they recognised that they had a unique skill set that needed to be offered to patients, but the bigger challenge was determining when this skill set was provided. Of their own accord, and by moving through the change framework, they could determine that their services could be better triaged by three simple questions being asked by health practitioners interacting with their patients.

Another key observation and reflection was the power of networking. For many of the participants, pulled together from across the system, this was the first time that they had shared the same space in a room. Previously they had been disembodied voices on the end of a telephone, should they choose to take the call in the first place. But now after these sessions, they were people with faces, and with a desire to do the right thing by their patient. They were sharing a common goal, just doing so within their different roles. On reflection, this appeared to me to highlight what was once seen as the very finite bounds between services that could be viewed as being adjoining, or potentially overlapping. Whereas previously they could be seen as bounds to be reinforced, there was now a willingness to work across these bounds. To place in the context of Bourdieu, the bonds of an individual habitus had begun to overlap with another profession. This however did not occur with a detrimental impact on the doxa of the profession.

### 5.6.3. AS 5 Plan (Strategic Action Plan)

The completion of the Eastern locality process then led into the planning for the final action spiral with the Franklin locality. With the completed cycles to this point, there was an ability to feed in key points in the planning. This was about engaging with as broad a network as

possible, ensuring that time was allocated to education around PDSA cycles, and building in an appropriate level of resource to assist in embedding any change ideas.

#### 5.6.4. AS 5 Act (Implement)

Franklin, as a locality, had a well-established clinical network and there was relative ease in ensuring that we had broad representation within the sessions. This was expanded further from previous action spirals to include St John staff. The location that was chosen for the sessions was a church hall, so was seen very much as neutral ground on the part of DHB staff and GP practices/PHO staff.

A key difference with the Franklin locality, which is reflective of their community engagement, is that there were community representatives that were engaged and a part of all the sessions. While we still planned to use the patient videos, as we had done previously, the addition of the patient around the table being reflective of the Franklin locality was another added strength.

The timing of the sessions was first thing in the morning which was different from all of the other action spirals. This gave great assurance of attendance of non-DHB staff. All other aspects of the action spirals followed the pattern that has been established previously.

### 5.7. Chapter summary

This chapter has described the specific action spirals that were undertaken to align the health workforce to be able to deliver the Locality Strategy that Counties Manukau DHB as an organisation had established as a direction of travel. The initial cycle was focused on the allied health workforce and improving how the disciplines worked across professional boundaries. This provided an initial template to be used in developing a more robust change framework when it emerged that there was a need for this change process to be focused on the broader workforce as opposed to just allied health.

The action spirals allowed for the development and progressive testing of a change framework based on the principles of appreciative inquiry. As a form of action spiral, it provided good synergy with the adopted action spirals process of observe-reflect-plan-act. As multiple action spirals were detailed, there was been the ability to identify the themes that were observed in

undertaking the change process itself. As these observations contain the bias that I have as a researcher, there was a need from the point of rigour to test these observations. Given the action spiral approach used, qualitative analysis lends itself well as a methodology to validate and evaluate the findings to date.

## Chapter 6. Evaluating the Change: Qualitative Analysis

### 6.1. Chapter introduction

Chapter Five detailed the action spirals that were undertaken as a part of the Home Healthcare redesign process. Chapter Two gave the necessary back-story as to why such a change process was needed to be undertaken in the first instance. The planning and implementation of the HPO framework was gradually and continually refined to become the Workforce Change Framework (WCF) which takes into account many of the dominant change theories and philosophies detailed in Chapter Three. Clarifying the overarching research paradigm as action spiral and appreciative inquiry has been captured in Chapter Four.

What is missing is the ability to validate and evaluate the impact of the changes that occurred within the implementation of the WCF. Within this is the desire to answer the question of whether there is the ability to evaluate the changes within the workforce that were planned in the action spirals. As there was no established base line quantitatively to do a before and after comparison, and due to the nature of the change process itself, it lends itself more naturally to a qualitative evaluation process.

What is described within this chapter is the qualitative analysis that was undertaken. Aligned to this is the rationale as to why the approach was chosen, how it was implemented, and the associated rigour of implementation and subsequent analysis. The presentation of the data derived from the qualitative analysis is presented, which feeds into the analysis and discussion in Chapter Seven.

### 6.2. Description of analysis undertaken

A simple description of the change process and subsequent action spiral cycles undertaken is insufficient to gain a depth of understanding of the change that actually occurred in the ongoing months. Semi-structured interviews were conducted using a convenience sample. To achieve the convenience sample, a request for participants was made to all participants in the change process. This was managed through the line managers of the Home Healthcare teams, who forwarded flyers and emails outlining the request for participants and the process that would be undertaken for the interviews to be completed. The request highlighted that the



process had been approved by the AUT Ethics Committee and was approved and registered by the Counties Manukau DHB Research Committee.

Once a participant notified me of their willingness to be involved in an interview, a consent form (Appendix C) and an information pack was sent to the participant outlining the purpose of the interview and how this fitted within the broader project and the associated research being undertaken (Appendix D). A time to meet for the interview was established by the participant at a time and a place that was convenient for him/her. Prior to the interview being undertaken, the information pack was reviewed, as was the consent form which was signed prior to the initiation of the interview.

While it was a sample of convenience, there was a good spread of individuals involved in the change framework from clinical (3 allied health, 3 nurses), management (2), project management (1) and community representative (1). Each participant was interviewed using a semi-structured interview process. The opening question was “having been involved in the change framework, what was your impression of the process?” As an opening question, it provided a spring board for subsequent questions to be asked. All interviews were recorded via a digital voice recorder, which was consented to and affirmed at the commencement of the interview process once the recording started.

Each interview was transcribed in full by a transcriptionist. Where there were any queries as to what was said by the participant, this was noted by the transcriptionist with an associated time stamp. The recording was then reviewed by me at the noted time stamp and adjustments made to capture what was said. Through this process each recording was complete, with no loss of data. Once there was a complete transcript, the transcript was cleaned, removing duplications and language artefacts. The transcript was then reviewed again with a view to understanding the intent of what was been said by the participant. This resulted in the interviews being condensed into concise narratives. This narrative then became the piece analysed further.

The analysis undertaken was based upon the work of Braun and Clarke (2006) as a theoretical thematic analysis. They proposed a six-step process of (1) Familiarising yourself with the data, (2) Generating an initial set of codes, (3) Searching for themes, (4) Reviewing themes, (5) Defining and naming themes, and (6) Producing a report. Clarifying transcripts, cleansing the transcripts, and building succinct narratives all allowed me to become immersed in the transcripts as data.

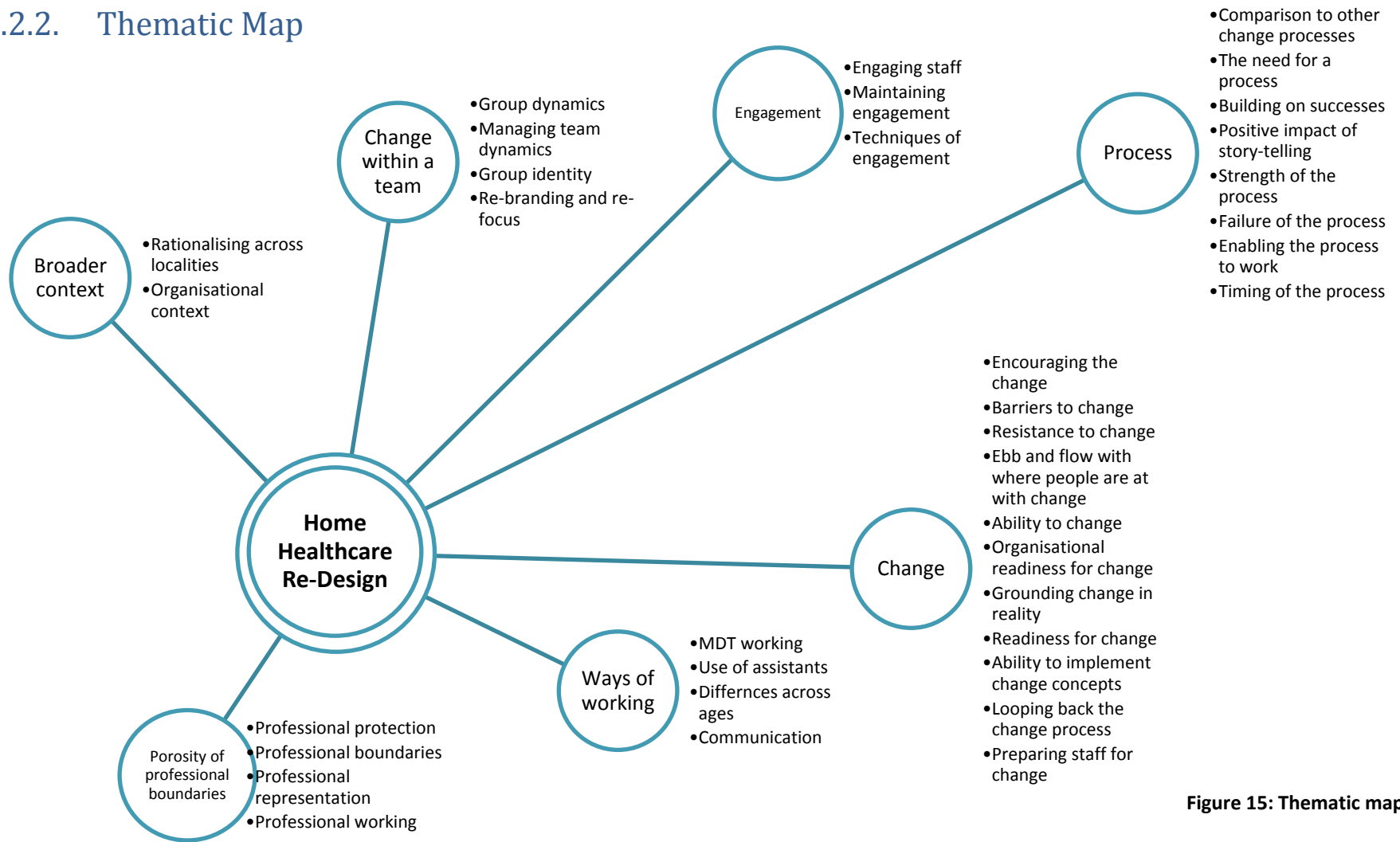
### 6.2.1. Searching for themes

Once the long list of codes was generated, they were viewed separate from the narratives and grouped into the themes. This purposeful process fits within the description offered by Braun and Clarke (2006) as theoretical thematic analysis where they stated:

...a theoretical thematic analysis would tend to be driven by the researcher's theoretical or analytical interest in the area, and thus is more explicitly analyst driven. This form of thematic analysis tends to provide less a rich description of the data overall, and a more detailed aspect of some aspect of the data. (p. 12)

This approach is not discordant to the overarching approach of action spiral, which is reflected in the work of Morton-Cooper (2000) and Williamson et al. (2012) who state the action spiral is about “research *in* action, rather than *about* action” (their emphasis) (Williamson et al, 2012, p. 8). In this context, the qualitative research was very much about exploring the impact that the change framework had on professional boundaries, which in turn defines my interest in the area, and links back to the philosophies and theories of change. As such the codes were generated from this perspective, and the themes that were identified captured a summation of the data within this context. This fits comfortably with the approach as an active process, whereby as the researcher I am actively seeking patterns within the data that will allow me to explore the original intent of the research undertaken. A summation of the initial codes and the predominate themes is captured in the Thematic Map (Figure 15, Section 6.2.2, p. 100).

## 6.2.2. Thematic Map



**Figure 15: Thematic map**

### 6.3. Reviewing and defining themes

Braun and Clarke (2006) described the process of reviewing the themes as ensuring validity of individual themes in relation to the larger data set and in turn “identifying the ‘story’ that each theme tells” and “to consider how it fits into the broader overall ‘story’ that you are telling about your data” (p. 88). With the data set that had been collated, each theme was revisited, and the narratives were reviewed against the initial coding. From this, specific quotes were pulled out that represented the theme. Each theme was reviewed with the quotes that were identified and was referenced back to the specific research within the project to ensure that there was consistency and relatability of what had been pulled through. What follows is a summation of the themes and supporting data.

#### 6.3.1. Theme 1: Engagement

Initial codes generated under this theme of engagement related to how the employed change framework engaged staff, and how during the process engagement was maintained. The specific techniques used to maintain engagement were described. In reviewing the specific narratives, there was the ability to cross reference from participants who were interviewed that helped to facilitate the change framework and those that participated in the change framework itself. The process of engagement was represented as when the process was perceived to be “bottom up”, and “staff were able to express what was important to them” (PM2). This was reflected by other participants who stated: “there was quite a buzz, everyone was engaged” (PMR), and “they became more animated, I think they felt valued” (NL). When the comment expressed by NL was explored further, he expanded his response:

*They felt valued because they were being asked for, how they thought. There was no judgement around it like no idea was a silly idea. And I think it was good to see. (NL)*

There was also a counter point view offered, describing what happens/happened when the staff during the change process were not engaged:

*It becomes sceptical and less engaged when they feel they’re not being listened to and their ideas not being represented in some way. (PM2)*

The intention of the employed change framework was that by using the principles of appreciative inquiry, a level of assurance that staff were fully engaged in the process itself would be achieved. The codes that emerged through this theme highlighted the need for this

approach as well as the dangers when it is not done well, the balance between engagement and scepticism.

Interpreted within the concept of dualities, as proposed by Smith and Graetz (2011), this is seeking to find the balance or potentially the right tension between the philosophies of psychology and rationalism. Within this is balancing the defensiveness that may arise with the challenge to the status quo as to a way of working and the loss of a sense of worth, associated with the perceived degrading of how work is achieved in a current context. The aim is to balance with a move towards a more rational use of skills and resources. Conversely it could be perceived as managing the tensions between a current culture and actively designing a new reality. The tension is between a cultural philosophical approach and a critical philosophical approach. Whichever of these tensions are being managed, it can conceivably only be achieved with engagement of the staff who will be undertaking the substantive change. The theme and supporting codes are broadly supportive of this having been achieved.

### 6.3.2. Theme 2: Process

The theme of process captured the codes that were generated around comparison to other change processes, the need for a process, building on successes, the positive impact of story-telling, the strength of the process, enabling the process to work, timing of the process, and failure of the process.

Across the participants interviewed there was consistent feedback that the process used was a “comprehensive process” (PMR); “clear, well planned and organised” (OM); and “the way it flowed through the process was good” (PN1). On review of this theme there was a degree of consistency that while the actual structure of the change framework was good, the timing could have been better, and the biggest challenge lay in the follow through. Further analysis of the data revealed the perceived benefits of the approach taken. The change framework pulled on the principles of appreciative inquiry, and this approach elicited some poignant responses from the participants. PN1 stated “it is not very often that we get an opportunity to stop and actually take stock of where we are at and how do we move forward”. This was echoed by OAH: “often when you look at these sorts of things, you do strengths, weaknesses, opportunities and threats but you never really look at the strengths” and CR: “it just opened their eyes didn’t it?” Potentially the most powerful quote within this theme was offered up by NL:

*I think it was the first time that we had actually sat down with all of our clinical staff on the front line and actually said, you are the experts at what you do, what do you see we can do differently to improve how we work more effectively together. And it was, often, the first time I had actually heard people think outside of the box about what could be possible, rather than what was restricting them from completing their work on time and thinking of all the barriers. The way that it was actually approached was to look at all the opportunities there are. And the opportunities that were free of organisational barriers. So, there was the ability for staff to actually think about their patients at the centre, to actually think about all the parts of the system that could actually make a difference and it was kind of, almost like a clean slate, blue sky way of thinking, but it was done in a way that was a bit more structured than a blue-sky event.*

The value of the process employed was reinforced with the use of story-telling, and the involvement of patient stories (either filmed or in person) as a part of the process. PN2 stated: “I enjoyed the couple that came. And their story... their story is powerful”. The use of stories was reported as an effective tool to focus on the hearts of the individuals, and to create a passion and vision for change.

There is balance within this theme with codes consistently arising around issues with the process. There was consensus that the timing of sessions was problematic with OM stating, “Monday was wrong, so I think there was a feeling that Monday was not a good day”.

An important code that was noted consistently across participants was the failure of the process “nothing’s really come out of it” (PMR). This was reinforced by OM: “things have fizzled, fizzled, fizzled, fizzled down”. Perhaps stated in a slightly gentler way by OAH: “the actual structure was good, but the follow up wasn’t”.

As an overarching theme, process offers much that can be gleaned from the change framework that was employed. As a process, the data suggests that it was robust, and well planned. It enabled change ideas to flow, and the environment was safe for people to engage in the process of change. The use of patient stories was a powerful enabler. However, a consistent criticism of the process was that it did not adequately plan for the ongoing process of implementation of any change ideas that were generated.

### 6.3.3. Theme 3: Change

Initial coding revealed a swath of codes that could be generalised under this theme including: encouraging change, barriers to change, resistance to change, ability to change, organisational readiness or change, grounding change in reality, readiness for change, capacity for change,

and preparing staff for change. Further analysis of the data revealed an ability to categorise the data further within the primary philosophies of change as detailed in Chapter 2.

PM2 articulated the issue of healthcare workers and a tendency to adopt a rationalist approach whereby we are: "...stuck in a particular mind-set... a traditional framework of identifying a problem and defining a solution". This approach highlighted the frustration of the sense of having change imposed, as described by OM: "it's kind of like it's happening so high up... like there is snow falling and by the time it gets to me, it's just water, and I don't know what to do with that".

Several participants highlighted the psychological philosophy towards change, highlighting that staff feel "threatened by change" (PM2) and the uniqueness that became a barrier to change; "their service was different from everyone else... clientele were different from anywhere else". Or more of an ambivalence as highlighted by OM: "a lot of them felt that this is all happening out there, but this really isn't going to penetrate me and make an impact on me... life is going to carry on as it always has, doing things the way that we do".

What does sit within the data is a willingness to change realities, as noted by PMR there was: "a state of readiness for change... preparedness to question current practice". However, as noted by PN1 there was a disconnect between the desire to create a new reality, and the new reality materialising:

*...even down to we really wanted to change our name, to Manukau Community Health. We all agreed on that, it hasn't happened. It's a little thing. And you think it would have made a difference but we're still Papakura Home Healthcare. It doesn't even include the fact that we see Manurewa, we're Papakura and for patients I don't think that's, you know, and it hasn't happened. And why not?*

The change philosophy of systems and CAS is also apparent from the data. This desire to understand the linkages and cause and effect is highlighted by PN1 who recalled: "it felt like we were doing it in isolation" and "what we needed to do in the first instance was to have a look at the big picture stuff, what is happening throughout the organisation, how do we fit in with that? Where are the bits that we can make a difference?" FAH captured the tension of wanting to understand the linkages and the frustration of it not always being able to be articulated:

*And I think it is just that sort of sadness and that frustration that you know that something can work really well and so when something comes and blows it out of the water, you know it is that moment where you just sort of hold your hands up and you sort of say, right well you know that's how you want it, you just really should be doing this completely different and you just tell whoever how you want it to be done. You*

*know, off you go, do it that way and let's see how well it works for you. And it is that sort of real annoyance really. Just because you know it can be so different.*

Within this theme, the challenge of change is well captured by OM:

*...I have come to the conclusion... that actually, things cannot be easily changed. Things are quite difficult. And harder than what people originally thought.*

What I believe can be surmised through this theme is that there is a multiplicity of tensions at play during the process of change. In reviewing the data within this theme, there is an ability to group with relative ease the data within the key philosophies that underpin change. It reinforces, I believe, that there is no "one" approach to change. The challenge within a process of change is to be mindful of, and to hold these many aspects of, change in a constant tension.

#### 6.3.4. Theme 4: Ways of working

'Ways of working' captures the initial codes of multi-disciplinary team (MDT) working. It includes the use of assistants, benefit of networks, differences across ages, and communication. Within the data there were several striking quotes that while not reflective of the majority of participants, is worthy of revisiting. PM2 expressed an observation of the differences between age groups when they engaged in the change process, stating:

*...younger individuals across professions are more open to change... to things being done in a different way, I think when you've worked doing one thing the same way for a very long time it's hard to see that it could be different.*

While a unique piece of data, it does represent a view on the generational differences that may be at play during a process of change. PMR similarly expressed an in-depth understanding of the dilemmas that often exist around the use of assistants in the provision of services, stating that the issue could be quantified as: "working with assistants who are not accredited and trained in a correct manner". The conclusion drawn is that this created an environment of difficulty in delegating tasks to assistants.

Within this theme there was a collection of data centred around networking. By engaging in the change framework PN1 noted: "...it was great to get to know some of them we had only spoken to on the phone but had never actually met in person... I think it forged some links for us as a locality". Similarly, NL noted: "...it was really good to see District Nursing and the nurses from the general practice actually coming together and working through a problem without thinking about what limited them, like there was no organisational barrier". FCR noted: "to see a bunch of people of that size, and being so diverse to listen to other people. They were asked



to make a contribution... because they could see the good that was coming out of this". From these quotes it can be summarised that there was strong benefit from the networking that occurred during the change framework process.

An expansion of networking under this theme is MDT practice that emerged out of and in parallel to the change framework. PN1 noted: "our MDT meetings which we didn't use to have, are really good... not only in trying to sort out what is best for the patient, but in that people learn from that". OAH found that it was a useful tool for induction for new staff stating: "some of the new staff, they have had the opportunity to see different points of view and different perspectives. Whenever you get a group of different professionals in a room you find all sorts of different ways of looking at things". NL explored this further: "it was organic how they actually spoke and actually developed their thinking around a single issue". PN1 potentially put it best: "If you add up all the years of experience... and put that combined knowledge together..."

Within this theme, the data revealed the benefit that was and could be derived from working differently, namely around networking and MDT practice. There was also some evidence of the difficulties that may lie in new ways of working, namely generational differences and working with the unregulated/unregistered assistant workforce.

#### 6.3.5. Theme 5: Porosity of professional boundaries

This theme 'porosity of professional boundaries' is the most pertinent to the research undertaken, with rich data obtained. One of the codes which emerged through the process was Professional Protection, arising when the participants were asked to reflect on their observations as they progressed through the change framework. PM2 noted there was a: "lot of defending their patch and defending what they do and why they do it a certain way". They went on to note how this impacted on the ability to work within the framework, stating conversations were: "largely dominated by nurses, dominated by a nursing problem and allied health became disengaged". Reflecting on how they interacted within the groups as a part of the change process OM noted they: "...didn't allow some nursing personalities to dominate over others and not have a voice". FAH2 placed this more in the context of working with the assistant noting that: "there is risk and there is patch protection, so those are the two things around if we allow an assistant to do just basic equipment... where will it end?"

This reflection on determining where the role of the assistant begins, and ends was reflected by N1 in explaining the process of understanding what professions do, noting: “I think we always had an awareness of what they do. The difference is maybe an awareness of how we overlap and how we can work towards the same thing”. This was coded within Professional Boundaries, and when asked for clarification on what has happened during the course of the change framework N1 noted: “I think they have blurred”. Within this code, there was the ability to examine if this blurring as identified by N1 was universal across the professional groups, or more focused. This blurring is potentially best captured by FAH2 as they discussed pragmatically the changes they could see occurring in how services could be delivered:

*...since the accreditation [ability to prescribe equipment to assist with daily living] has changed and you can get a physiotherapist going out for a toilet seat or a bath board. You can get a social worker to do it, a Needs Assessor doing that. That is if we have to evolve from that. But I think we are quite pragmatic about it and think well actually we don't have time to go and see this patient that are on a waiting list, they have been on this list for six months, if the physio is going out and organise a walker for them and they can get there before I can, and all they need is a toilet frame or shower stool, you know what, how can you explain to a client well you've still got to wait another three months for us to come and see you, I can see this is not going to work. So absolutely, the sense in that I think we have evolved other ways of working and more sensible ways of working, to me the common goal if you like is to actually make sure the people can stay home and get seen.*

This evolving pragmatism of service delivery was also reflected by NL who, when reflecting on how he saw the professions interacting within groups: “saw them all as one... it wasn't specific to any one profession... I didn't see any of those professional boundaries”. This working together did not appear to wholly mitigate the different approaches that professional groups took when comparing nurses to allied health:

*they (nurses) get caught up in the business of their work... they are too focused on today and don't seem to have the ability to forecast... whereas I think probably for allied health are more focused on looking at the long-term outcomes rather than what is our demand for today. (NL)*

Of interest in this discourse was the tension in approaches; however, NL went on to identify the tensions between nurses and allied health, making the point:

*if someone can wait three to six months for an intervention, do they really need it at all? And I guess that's traditionally the way that the home healthcare team has managed its allied health referrals... home healthcare is a seven-day service, for allied health it isn't.*

Within this theme of profession/professionalism, a paradox and tension emerged between professional groups. Whereas there was a willingness to identify a lack of boundaries, as

identified by NL, participants did identify the differences in the ways of working between allied health and nursing staff, going so far as to identify home healthcare as a nursing service that operated seven days whereas allied health did not operate over seven days, and was not specifically considered a part of home healthcare. This separation of professions was balanced by FAH2 who went to lengths to define how within allied health there was emerging ways of working in which there would be much more cross-cover in how they provided services between professions. What potentially is still open to interpretation is how “blurred” the professional boundaries are in practice. What was evident throughout this theme was a willingness for cross-cover to be enacted within the allied health grouping, but an apparent separation remained between nursing and allied health.

#### 6.3.6. Theme 6: Change within a team

A small but consistent theme emerged around the concept of group and team dynamics. During the change framework process, it was consistently noted how the dynamics of individuals within groups would influence how the groups interacted. Simply stated by PM2: “some people dominated”. A point to ponder is whether this simply reflected personalities and dynamics or was another example of professional protectionism.

A code that was noted across multiple participants related to identity of the team. PMR noted: “they are all wishing to change the name and to rebrand the services... that’s what they wanted”. Later in the interview PMR commented: “they wanted the term home to be taken out... not everything we do now needs to be done in the home”. PN2 explored this in more depth:

*Home healthcare has always struggled for an identity. Its struggled within the hospital for an identity, its struggled in the community for an identity... we are still associated with the home care groups that do the shopping and the showering...*

The coding that was identified centred primarily on the use of the word home and the perceptions that this promulgated. The participants noted that if there was a change in name of their services, that this would better reflect what it is that the team actually delivered.

### 6.3.7. Theme 7: Broader context

The final theme that emerged focused on where the change process fit within the broader organisational context. Two predominate codes within this theme were participants gaining an understanding of where the process fitted within the broader organisational context, and the ability to rationalise the process of change across the four localities.

The initial code was reflected well by PN1 who stated:

*I think generally the team is more aware because localities was something that has been talked about for a long time but didn't have any substance, or any meaning. It has more meaning now and I think that this process is kind of set the ball rolling on how we fit within the locality perspective.*

As the initial phase of the change framework focused on discovery or understanding where the change framework sat within the broader context of change, this served as a reinforcement of the value of this phase.

The last code was one echoed by several participants and centred on the fact that the change process was completed on one locality at a time basis, yet there was so much that went across the localities. Some participants had difficulty rationalising the need for a focused approach as opposed to an approach across all localities. PMR stated: “there was duplication there” and “there are issues that need to be discussed across the four bases”. The tension around a local versus a consistent approach was further highlighted as PMR contrasted that: “anything we do has to be something that is only for us”. There was the pull between focusing on the needs of an individual locality as opposed to gaining consistency across all four.

## 6.4. Chapter summary

This chapter arose out of the necessity to further validate the initial observations and conclusions from developing and deploying the change framework. The context and need for the change had been established, and the relevant theories and philosophies relating to change were pulled upon in developing the workforce change framework. However, there was a fundamental unanswered question; had it all made a difference? Due to the nature of action spiral, qualitative analysis naturally lent itself as a methodology to explore the impact of the change process. The very nature of action spiral is that the shape of the research itself changes with each action spiral cycle. As such it is problematic to design prospectively an evaluation

framework; yet the research itself is prospective in nature. This naturally lends itself to a qualitative evaluation approach.

The inductive thematic analysis undertaken allowed for explicit acknowledgement of my bias. The theme of engagement identified that there was good engagement of staff in the process, but this was fragile at best. The theme around process identified two sides of a coin, with positives being identified in the structure, but strong codes that there was a feeling in continuation of change beyond the process itself. Change as a theme identified a willingness to be engaged in a process of change, but this easily evaporated without follow-through. Ways of working was a theme that demonstrated the ability to use different skill mix in providing services as achievable, and potentially one that had a correlation to generational differences. The theme around 'porosity of professional boundaries' echoed from the first action spiral cycle where there was a willingness to work across the allied health boundaries, but this did not come through as readily in working across the boundaries of allied health and nursing. The final themes around 'managing change within team dynamics' and 'change in a boarder context' highlighted the tensions between willingness and a reinforcement of the status quo.

What has been detailed is a summation of the interviews undertaken and the dominant themes that emerged through this process in an attempt to answer the question of whether change did actually occur. Much has emerged that can be built upon, and there is a clear lesson to be learned around the need to have assurance around continuation of commitment to the process to fully realise the gains of a change process.

## Chapter 7. Analysis and Discussion

### 7.1. Chapter introduction

The reflexive journey that has been described led to the development of my own workforce change framework. It incorporates both the principles of an appreciative inquiry/action spiral process and the insights I gained through immersing myself in the philosophical literature around change.

I have offered a progressive case that CMH was in the middle of a process of change to be placed to better meet the needs of the population under its jurisdiction. This was being achieved via the Locality Strategy which as a component is reliant on the AH workforce to enact the change.

It was by understanding change in the healthcare context with the added complexity of professions and professionalism, that a workforce change framework was developed. The cycles that were undertaken in the Home Healthcare Re-Design process were described.

To evaluate both the process itself and the changes that were subsequently undertaken, a specific qualitative analysis was undertaken, drawing on ten interviews of individuals who participated in the Workforce Change Framework. Themes were identified around engagement, process, change, ways of working, profession/professionalism, group/team dynamics, and the broader context in which the change was occurring. This qualitative analysis utilised a theoretical inductive approach, as it was undertaken to examine the change process and the impact on professional working.

While the change process can be described ‘what has been learnt’ remained open. Through reflexive analysis this chapter seeks to gain a level of understanding as to the “so what” of the work that has been undertaken. I will review what has been learnt against the key theories and philosophies of change drawing out validation of these theories and philosophies. As a contribution to knowledge I will offer my analysis as to how substantial change processes can be proactively managed in the health care context.

The progressive case has been made that Counties Manukau DHB was in the middle of a process of change to be better placed to meet the needs of the growing population. The aim

was to achieve this change via the Locality Strategy which as a component is reliant on the allied health workforce to enact the change.

By understanding change in the healthcare context, with the added complexity of professions and professionalism, a WCF was developed using the action spiral methodology. The cycles that were undertaken in the Home Healthcare redesign process were described. The previous chapter, which evaluated the aftermath, revealed that while participants had valued the process and glimpsed possibilities of working differently, little had changed.

This chapter acknowledges that big system change is challenging. It seems the commitment to change was not maintained once the action cycles came to an end. In this chapter, the question of what has been learned by reflecting on insights is examined against the key theories and philosophies of change, allowing for validation of these theories and philosophies, as well as a potential contribution to the knowledge as to how substantial change processes can be managed. The thinking/reflecting/discerning of this chapter equips me for my ongoing journey of change leadership.

## 7.2. Theoretical implications

A key component of the action spiral methodology used is the concept of reflexivity within the action spiral cycle or, viewed another way, to allow the time and space to critically reflect on what has unfolded and to seek a deeper level of understanding as to the why of what unfolded. In building the case for change and developing the framework and the process that was used, methodologies and theories were employed. To give the space to examine each fully, specific sections will be devoted to broadening the understanding of change in this context. I explore how the concepts of Bourdieu can be applied, and in turn how these can be folded in new ways of working. Lastly, action spiral has been described as messy and murky, so it is by no means a process that can be concluded cleanly, which from the point of rigour highlights the limitations of the approach undertaken.

### 7.2.1. Change implications

Within the literature review I explored some of the available literature that exists around change, specifically examining the underlying theories and philosophies. Deemers (2007) traced how the dominant theories emerged over time, and how there is a degree of inter-

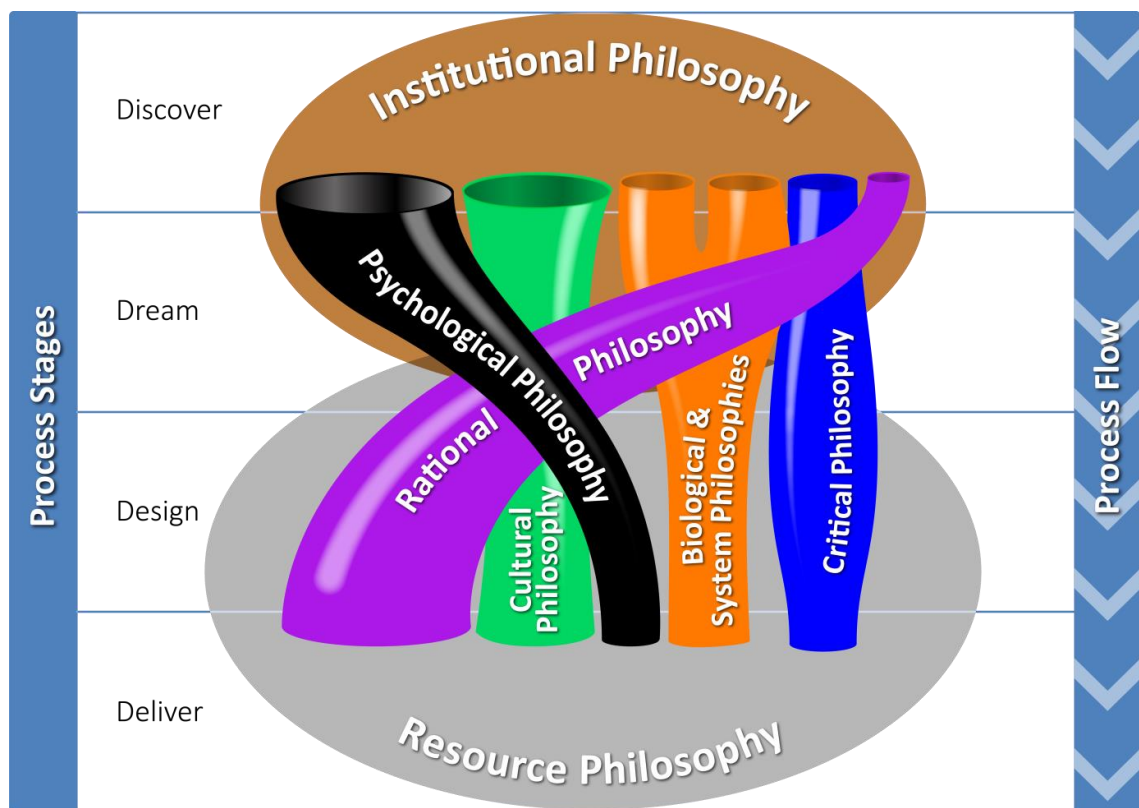
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relatedness around and between the theories. This is contrasted by Smith and Graatz (2011) who took a step back to seek the main theories that underlie change, building the case that philosophies inform theories that then build strategies and determine the specific tactics that are to be employed. Smith and Graatz are explicit in that they do not support “a way” of change. Rather they introduce the concept of dualities, that is to hold multiple philosophies in tension at the same time to allow for change to occur. Expanding on this concept, there is the ability to probe further and using the process detailed in this work ask the question, where and what should the tensions be focused on?

In Chapter 2, the philosophies that were presented by Smith and Graatz (2011) were reviewed in turn. Each was found to be applicable in greater or lesser ways during a process of change. When these philosophies are viewed more explicitly, with regards to the workforce change framework that was employed for this reason, I was able to observe shifts in workforce perceptions. This was backed up by the qualitative analysis, with the repeated reference to the process ‘falling over’. How then to interpret this finding within the concept of change philosophies?

Smith and Graatz (2011) were at pains to point out that change is not a linear process. Their critique of the ‘n’ step further highlights the futility of ascribing a simple sequential process to substantive change. Using the context of the process that unfolded at Counties Manukau Health also revealed that change was not linear. I came to understand that when reviewed retrospectively, one change philosophy is not sufficient, and the concept of dualities needs to be applied. What is captured in the following diagram (Figure 16, p. 114) is an attempt to do just that. To take the process that was undertaken, and the subsequent lessons learnt, and apply them into a future state, how a philosophical approach may change over time as a substantive change process unfolds.





**Figure 16: An integrated change framework**

What the above diagram attempts to capture, using the backdrop of the appreciative inquiry process, is the concept of dualities. Dualities may be an unfortunate term used by Smith & Graetz (2011), as it describes the philosophical tensions that are in play at any point in time. The reality I observed was that it is not just two philosophies that are in tension, rather multiple, which shift over time. To acknowledge Smith and Graetz, however, this term will be used, but in the context of multiple tensions, not just a couple. The philosophies will be colour coded from this point forward in the chapter to allow for ease of reference back to the diagram. Using the diagram to describe a change process, it should be viewed as a process that progresses from top to bottom, and the relative impact of the philosophical approaches can be viewed by reading across the diagram from left to right.

To explain the diagram, the **Institutional Philosophy** captures the notion that an organisation or entity will change when it has become substantively out of step with the environment in which it exists. This is the prompt to initiating a process. Much of the scene setting detailed in Chapter 2 highlighted the progressive nature of Counties Manukau DHB becoming out of step with the need for healthcare services. The current state was becoming progressively unsustainable. Therefore, this philosophy sets the scene. While not supporting a 'n' step

approach to change, it could be argued that this does align with what Kotter (1988) proposed insofar as creating a sense of urgency around the need for change to occur. Without the dominance of the **Institutional Philosophy** in the initial stages, there is simply not the clarity of need to motivate change. The impetus for institutional change begins when the status quo will no longer suffice. This philosophy provides the clarity and rationale. The organisation or entity needs to change to become re-aligned with its environment. In this instance, Counties Manukau DHB needed to become realigned to be better placed to meet the current and ongoing needs of its resident population.

The approach taken by Counties Manukau DHB acknowledged this change. Over an extended period from 2009-2013, Counties Manukau DHB progressively formed the strategic shape of the organisation to allow for change to occur. There is acknowledgement that the dominant form of change that will need to occur is alignment of the workforces to be working in different ways, to allow greater flow and coordination of care across the sectors from which healthcare is provided. Implicit is the need for the workforce to change. This brings the **Psychological Philosophy** to the fore, and the recognition that change can be perceived by the workforce as highlighting that they are no longer competent to be fulfilling their roles. They may perceive that change is necessary in order to have a workforce that is aligned to future directions, and that this may not require their specific skill set. This results in the all too often observed resistance to change, be it active or passive, and an unwillingness of workforces to engage and facilitate a process of change.

The change framework deployed during the process described in this work was explicit in its design to focus on employee engagement. Appreciative inquiry as a process is highly reliant on engagement, and the techniques described around this approach are aimed at ensuring that the process of change is 'done with' the group undergoing change, it is not dictated to. This is captured diagrammatically as the 'discover' phase, whereby the **Psychological Philosophy** takes prominence both in size and placement. It is the dominant philosophy employed during the initial phase. The tension that is maintained during this initial phase is the **Cultural Philosophy**, which acknowledges that undertaking change is about the here and now of the organisation. What are its dominant values? What are the artefacts, and stories that reflect who the organisation is? How must they be bought into a process of change? The argument being made is that this philosophy retains constancy throughout a process of change. While the actual culture of an organisation may change over time, the importance and continual referencing back to the culture of the organisation retains its place as a key point of tension.

Continuing to work to the right through the diagram during the discovery phase, the **Biological and System Philosophies** reflect the concepts of emergence, with the organisation evolving and shifting to adapt to its environment. While noted during this initial phase, it is argued from the work undertaken that these approaches have lesser importance during this initial phase. It is more about understanding what is, as opposed to what could be.

The **Critical Philosophy** leans on the localness of reality, and the need for reality to be defined by the individual. During this initial phase, it is argued that it is not so much about defining a reality, but rather understanding the current reality. As such, it initially maintains lesser tension. As a philosophy it is always there, but at this point it does not pull in tension as strongly as others.

As there is a move into the Dream stage, the shape of change shifts. The Discover stage seeks to understand what is; the Dream stage seeks to look at what could be. As a process of engagement, it continues to rely heavily on the **Psychological Philosophy**, to balance workforce fears that they are no longer competent to continue to provide services into the future; rather they are in the process of engaging in how these services could be provided into the future using their skills and expertise. The **Cultural Philosophy** continues to provide a reference point back to what is considered important to the organisation. What becomes more prominent during this phase of the process are the **Biological and System Philosophies** and the concepts of emergence and intended and unintended consequences. Change that is 'done with' the workforce acknowledges that there may be more than one answer, that it is about working with the workforce to begin to design what could be. This requires giving up on a predetermined notion as to what the answer could be. Rather it is about providing the context and then allowing potential solutions to emerge through the process of change. Within this the balance needs to be maintained between the philosophies of **Psychological**, referencing **Culture**, and leaning more heavily on **Biological and Systems**. The balancing continues to be maintained insofar as **Rational** as a philosophy has been predominately a background philosophy now begins to come to the fore. While the importance of engagement and collaboration take dominance initially, there is the need to begin to transition to a more finite 'of what by when'.

The change of change continues in progressing towards the Design stage. Whereas previously, the primary tension was between the philosophies of **Psychology** with **Biological and Systems**, there is a gradual fading of these as the focus becomes more on the 'what' it is that is to be designed. Also fading is the **Psychological Philosophy**. Up until this point this philosophy has

had to have prominence to create and maintain engagement and continues to be important. What becomes more dominant is the **Rational Philosophy**, as the intent is to begin to give shape and form to what has been derived out of the Dream stage. This is balanced by the **Critical Philosophy** which has a focus of defining new realities that individuals or groups will choose to inhabit.

Progression towards the Deliver stage sees the continued and progressive dominance of the **Rational Philosophy**, continually referencing to the **Cultural Philosophy**, as the **Psychological Philosophy** begins to take lesser role in the process of change. What has been present throughout but now becomes the primary driver of the change process is the **Resource Philosophy** and the associated strategies around how resource is to be allocated.

While a lengthy narrative, the analysis that can be offered is how to take the key learnings of Smith and Graatz (2011), and what was learned from the process articulated in this research and offer back a process of change that integrates both. Smith and Graatz promoted the concept of dualities, but do not offer the details as to how this could be borne out in practice. The process that was undertaken as a part of the localities strategy, in enabling workforce, identifies that the different philosophies can be mapped across. Failure of the process to 'make it stick' can be related to reliance too heavily on a single or dominant philosophical approach in ignorance to the others. Integrating the literature and the lessons learnt have been distilled into the diagram that has been described narratively. The role and dominance of the various philosophical approaches vary over time. It is proposed that this purposefulness as to how they are applied can aid and facilitate large scale change. Preference to one philosophy or allowing one philosophy to dominate through a process will secure the process itself but lead to limitations as to the impact of the change process.

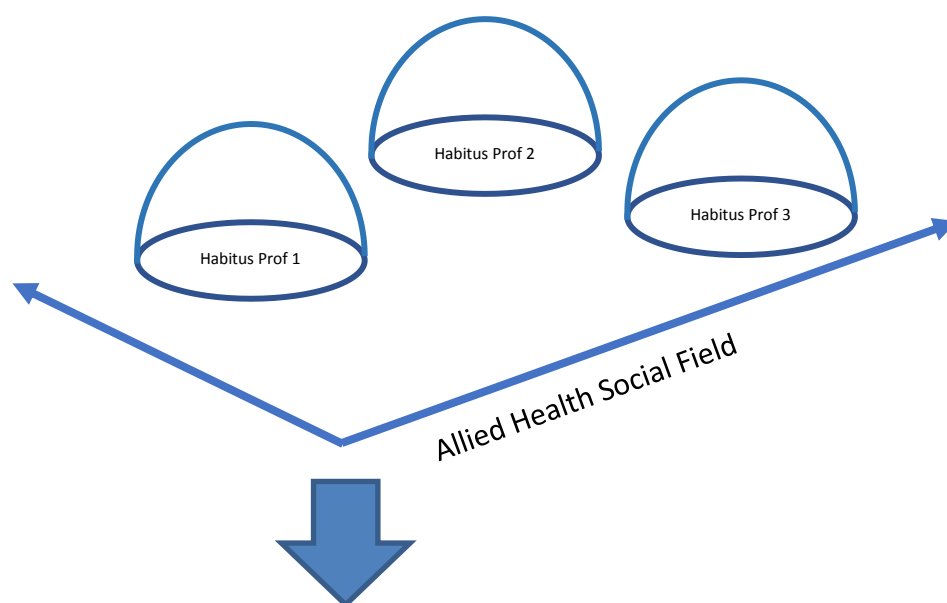
### 7.2.2. Using Bourdieu to understand workforce change

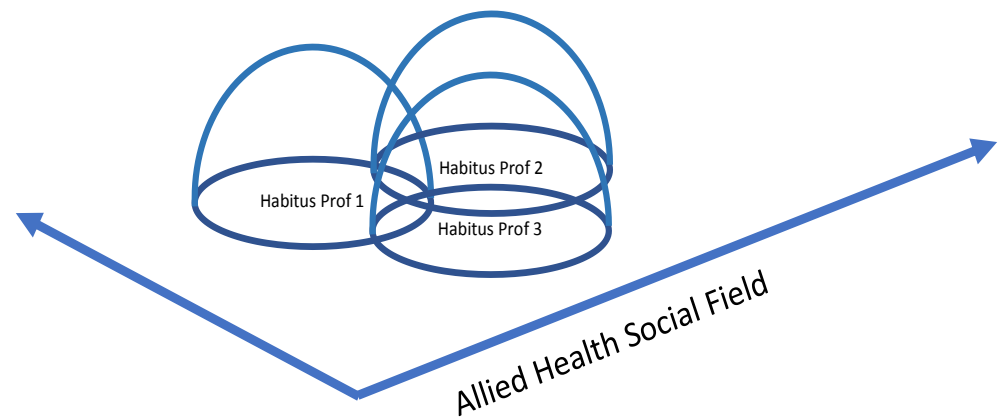
Examination of the philosophies of change provides insight at a macro level to gain greater insight into the process of change itself. There is a uniqueness in healthcare in that it is a landscape filled with many professions. Abbott (1988) goes to lengths to provide explanations as to why this is the case. He used the concept of jurisdiction, and how this is claimed by a profession, and in turn may be claimed by others. It provides a way to gain understanding to

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the growth of specialised technical professions, due in part to the progressive division in labour, and in part to the unwillingness for the medical fraternity to hold onto what they once saw as their domain alone. It is this examination that allows for understanding not at the macro scale, but more at the meso scale of change, and specifically change in the healthcare setting. Abbot's concept of jurisdiction is useful, and it is proposed that applying this concept to the theories of Bourdieu allows for further depth of analysis.

The original action spiral change cycle was enacted with a primary focus on the workforce grouping of allied health. It was enacted with a purpose to determine if there could be more in the way of working across professions. The change process began by determining if the tasks that were undertaken were skilled and unique to a professional group, or support tasks that could be delivered with the appropriate professional understanding or delegated to the assistant workforce. Conceptually, using the theories of Bourdieu, there is the ability to capture this diagrammatically whereby the assumption is that the social field that he described can be translated to the allied health social field, within which individual healthcare professions define their space within this space as their habitus. The belief that sits within is that at the outset the bounds of the habitus are set, very defined, and there is little in the way of integration between the professional groups. Further the initial cycle was built on the premise that it is possible by using a defined change framework to influence and impact the bounds of habitus. Our aim was to be able to influence the porosity of these bounds and to allow for much more in the way of overlap between the professions which is captured diagrammatically in Figure 17 (p. 118-19) below:





**Figure 17: Concept diagram of the change in habitus with the change process**

Whereas previously there was little in the way of overlap, the change framework as a process allowed for much more in the way of the support tasks being shared across the professions, while not losing that which is unique to the profession within the habitus.

Bourdieu's concepts provide a framework that allows for a complex workforce change to be represented diagrammatically. It acknowledges the habitus of the individual professions and the potential for there to be far greater overlap on how these professions choose to work together. A third concept proposed by Bourdieu is also useful. Doxa is used to describe the "unwritten rules" by which an entity will operate. Pragmatically, there is often the ability to identify professional groups by the way they act with each other and those external to their profession, their Doxa. Hafferty and Castellani (2010) looked at this further in their review of the medical profession referencing the centenary of the release of the Flexnar report. They identified seven groups into which medical professional groups can be categorised and noted the difference between the nostalgics and the activists.

The nostalgics desire to retain the status quo. Using the construct of Abbott (1988), this is protecting the jurisdiction. Or to use the works of Bourdieu, it becomes about protecting the bounds of their habitus. Activists, in contrast, seek to deliver their skill set to ensure the betterment of society. Their concern is not focused on their professional bounds, what is or is not their jurisdiction. Rather the argument is made that they more fully enact what it is to be a profession by focussing on what it is that they can contribute. Doing so lends itself to the bounds of their habitus becoming more porous. They are choosing not to protect, but act in a way that allows the profession and professionals to focus more on what it is that they can contribute, and, by definition, more fully exist as the embodiment of a profession (Hafferty & Castellani, 2010).

This model becomes useful when we begin to look at the action spiral cycles and what did and did not work, and why. Within the first action spiral cycle, with a defined focus on allied health, the result for the majority of the professions appeared to be a rapid ability to translate the services they do to their substantive tasks, and once this was done to be able to define whether the tasks were skilled in nature, supportive, or delegatable. For the professions of physiotherapy, occupational therapy, dietetics and speech language therapy this was achieved by using external documents that allowed the groups to work through the hierarchy starting at a service level and working down. Interestingly this was not the case for social work. Even more interestingly was that the group that was involved in the action spiral cycle for social work choose to complete the process differently to the other professional groups, starting with the tasks in the first instance and then rolling the tasks up to the services that were provided. When the process was completed this way, the observation was that each task then became special and unique to the profession. To use the framework offered by Hafferty and Castellani (2010), it is proposed that by starting this way, the social work staff began by defining the bounds of their habitus, and as they progressed through, the focus remained on how to further define the bounds as a part of their profession. The focus was on ensuring there was clarity that the tasks which they did were unique to their profession and could not be completed by others. They had become unwitting nostalgics. As nostalgics, as they progressed through the process, the focus was continually on protecting what was, and there was little in the way of room to understand which tasks could be deemed as supportive or prescriptive in nature and could then be delegated.

Another observation was with the occupational therapy workforce. When a summary Venn diagram reflected where tasks were unique/supportive/prescriptive, the issue became not on confirming tasks that were supportive or prescriptive in nature, rather on determining whether all of the tasks that were skilled had been captured. This led to a situation where it became difficult for the group to move on. They remained fixated on ensuring what they deemed to be skilled was captured. Within the framework offered by Bourdieu, this could be seen as the bounds of the habitus being initially porous in nature, but then becoming more finite, with a progressive focus on ensuring that the bounds became clearly defined. Again, unwitting nostalgics.

The progressive action spiral cycles give further insight into how this framework could be used. As AS2 unfolded, the process began with the various professional groups stating what their boundaries were. There was little in the way of what could be shared across professions, rather quantifying the 'what is'. For example, as the group moved through the framework, the process of triaging was confirmed as one that had to be completed by a respective member of

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each profession. There was little scope for other professions to be considered capable, from a skill perspective, of reviewing and triaging a referral from another profession. As the group progressed there was a shift in perception, and an eventual realisation that so long as the person doing the process of triage had the appropriate skill set, there was not the requirement that the individual had to be of a defined profession. Viewed through the framework of Bourdieu, initially the focus was on defining and reinforcing the bounds of individual habitus, but as the process was worked through there was a potential softening of the habitus bounds. There was an increased porosity of these bounds allowing for a greater overlap of the professional bounds to occur.

The use of the patient voice was noted to carry significant weight in cutting across much of the focus on professional bounds. Within AS2 a patient video was utilised where a carer of a patient described her experience and interaction with the Home Healthcare staff, in particular a 'speech nurse'. The actual healthcare professional was a speech language therapist, and while there was an initial reaction to not being recognised appropriately professionally, it allowed for the discourse, that from the perspective of the patient or his/her carer, did it really matter? The therapists may have initially been focused on defining and defending what they saw as their professional bounds, but when reviewed from the perspective of the carer, the point was somewhat moot. They did not mind if the care was delivered by a speech language therapist or a nurse, all they were concerned about was that they received the appropriate services in a compassionate manner. On reflection, the speech language therapist was in agreement. Relying on Bourdieu, this could be interpreted as what he termed hysteresis, where there becomes a separation of the habitus from the social field. While Bourdieu initially used this term in an anthropological sense, viewing populations relocated from traditional lands, the comparison could be seen as a professional who traditionally would only have viewed a mistake in their title as one that needed to be corrected. Instead they came to view it fundamentally differently... did it really matter so long as the patient received the appropriate care? The status quo of defending what is a first response is being fundamentally challenged in this example. What was once so important is now being rendered impotent when viewed from the perspective of the patient. Conceptually, it facilitates a transfer from a strong nostalgic viewpoint to potentially being an activist. The energy is no longer vested in defending what is, but rather letting go, and focusing on what could be, how better care could be delivered.

As a framework, there is benefit in what Bourdieu has to offer. It provides a methodology to be able to map a situation, allowing better understanding of the social space that is being inhabited. It enables mapping of the players and their habitus within this space, and to understand where there may be points of tension or conflict between groups in what they

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perceive to be the bounds of their habitus. This type of analysis can be used as a tool to understand why there may be the conflict between groups. Is there the focus on further defining the bounds of the habitus as opposed to looking at what can be done across professions? How could this be facilitated further? Conversely when the focus is on large scale transformative change, should the focus be instead on hysteresis and a desire to so fundamentally change the social field that there is a separation of the habitus with the social field. This would allow for a new social field to form, and the habitus of a profession to seek to establish itself in what is now strange and unfamiliar territory. Linking back to the concepts of philosophies of change, this could fit within the critical philosophy in which the intention is to essentially create new realities, which could be interpreted as a new social field.

While the framework proposed by Bourdieu is of use in understanding what is happening, it cannot necessarily be used to predict what will happen. It can, however, give the understanding as to what future possibilities could be, and provide for the situations and the potentials for these new futures to be realised.

### 7.2.3. Development of a reusable change framework

I have taken the lessons learned through applying the concepts of philosophies and the work of Bourdieu to plan for a more robust and re-usable WCF. While this is discussed in detail in the following chapter, the key principles are summarised here.

Applying the concept of change philosophies acknowledges that a philosophy will lead to strategy, and in turn the tactics to be employed. Smith and Graatz (2011) proposed the concept of dualities, where tension during the process of change is maintained between philosophies. What I have learned during the research process is that all philosophies are useful, some are important, and the importance of one over another varies with the process of change. The challenge that lies in planning for and delivering a process of large wholesale change is to be conscious of the multiple philosophies at play, and to make conscious and purposeful decisions as to what philosophy will dominate at what time. The following chapter breaks this down in detail, how it will change as a process unfolds. The primary lesson that I learned through this research is that ignorance of the many philosophies, or too heavy a reliance of one approach over another, will lead to stagnation or eventual failure of the process of change.

### 7.3. Implications of the action spiral model

Koshy et al. (2011) boiled down the concept of action spiral to asking two questions: what am I doing, and how can I improve what I am doing? They go further in describing the researcher as a “facilitator of change, consulting with participants not only on the action spiral process but also on how it will be evaluated” (Koshy et al., p. 10). This research explicitly used action spiral methodology and could not have occurred without myself, and my involvement in the research. It allowed for me to capture what was occurring during the process of change, reflect on what occurred, and then feed into my understanding of change. It is this process of the learning and feeding into the next process of change that allows for the richness of learning to occur.

#### 7.3.1. Linking change cycles and associated learning

Fundamentally the first change cycle (AS1) had a focus of understanding whether the concepts found in the literature pertaining to the Calderdale Framework (Smith & Duffey, 2010) could be adapted and applied to the Counties Manukau DHB context. The process itself provided opportunities for learning and the application of the principles of Bourdieu in understanding why barriers exist between professions. Abbott (1988) provided another perspective, and more recently Hafferty and Castellani (2010) examined change from the perspective of nostalgics and activists as to why a profession would seek to actively protect what they saw as the bounds of their professional working. This was borne out in what was observed with the professions, some seemingly at ease getting to the point of allowing for sharing of tasks across professions, while others sought to actively protect what they saw as theirs, with no intention of sharing tasks. These differences were unpredictable. The process moved each profession’s standpoint.

This led into the second cycle (AS2). The process of observing and critical reflexivity allowed for identification that the process was focused on the ‘doing’ of the process. Reliance on a rational approach did not allow for full engagement of the staff. While the resistance offered up by some professional groups could be explained using the framework articulated by Bourdieu, I believe it would be better achieved using the approach of change philosophies. This allows for an understanding that solely leaning on a rational approach comes at the cost of the psychological philosophy. The resistance to change encountered by some groups could be better understood through the knowledge that this was challenging their way of working, and

this challenge undermined what they saw collectively as the value they add to the provision of services and care to the patient. Resistance to the change can be either passive or active. While not necessarily intentional, I believe the passive resistance came from the belief that all tasks were unique to their profession, and therefore could not be seen as supportive or prescriptive, to use the terminology of Chadwick (2005). This greater depth of understanding allows for analysis as to what could be done differently.

In planning for AR2, while not consciously understood at the time, there was the redesign of the change framework to incorporate appreciative inquiry as a methodology to give assurance that there would be greater employee engagement throughout the process of change. This introduced a much greater bias towards the psychological philosophy.

In essence the WCF was an untried process and within this, as an overarching action spiral cycle, there were multiple smaller cycles of learning in developing the process itself. The result can be analysed as an ongoing reliance on the psychological and cultural philosophies, accompanied by an uncertain understanding as to how a rational philosophy should be applied as the process continued to unfold. This became evident at the end of the second cycle, at the deliver phase, when there was not planned specific allocation of resource outside of the framework which resulted in limited ability to follow through with the implementation of the change ideas that were generated.

Observing this was a key learning. It allowed for better planning, to look at how to mitigate the risk of the work falling over again. With the subsequent three cycles there was the ability to feed forward and have an improved effort of ensuring that project resource was allocated and available for the implementation phase. While this specific resource could be accounted for, there was another component of resource not taken into account. This was for staff who had generated the ideas to be able to have time to further develop and then implement their change ideas. As an extension, if time was to be spent on developing and implementing the change ideas, there was also a need to ensure that any release of time could be back-filled to allow for the clinical work to continue while new ways of working were developed concurrently. This continues to reinforce the importance that the resource and rational philosophies play in the latter stages of a process of change. While the dominance of the psychological philosophy is critical in the early stages, and the cultural philosophy needs to be retained throughout, the psychological philosophy needs to be supported in the later stages to give a level of assurity that appropriate resource can be allocated, and this can be distilled into tangible steps to give further assurity around the pace of change.

### 7.3.2. Key lessons to take forward to ongoing change cycles outside of the study

One of the key difficulties of action spiral is that when the research is reported, it is often artificially constrained. The beginnings of what becomes the research often has origins well before what is documented as the research proper. Also, the end of the research is often arbitrary and not the end of the process of change. So it is with this research.

The action spirals undertaken and described here was done so to give a greater level of rigour to a process designed to meet organisational need and direction. The cycles that I have described captured a period of time; yet the process of change within Counties Manukau DHB continues outside of the bounds of what was captured. The inherent benefit of undertaking this work lies in the rigour associated with an academic approach. This is reflected in the action spiral cycles allowing for the associated literature to be collated and integrated as the cycles progressed. It was a process of continually adding to the robustness and knowledge of what was learned from the previous cycles. Yet the process itself failed to achieve what it fundamentally set out to do, to re-design and implement a future state of working for the Home Healthcare teams. The benefit, however, lies in the process of critical reflexivity in examining what occurred and continuing to seek out the relevant literature to gain deeper levels of understanding as to why it occurred. Within the thesis, Chapter Two on change is a direct result of this process, as it came about from a need to gain a deeper level of understanding as to what occurred during the process of change.

In collating and relating information to gain a deeper understanding to the process that was undertaken, there has been the ability to apply this learning beyond the defined research. As Counties Manukau DHB as an organisation continues to change and shape itself towards the Locality Strategy, there has been the ability to reflect on what occurred and to ask the question, how could this have been done better? The answers will feed into the ongoing processes of change. The writing of the chapter on change, and the summative chapter of 'where to from here' allowed for a collation of why things are the way they are, and offer options as to how the change could be enacted more effectively. This is not captured within the research proper, yet it is the writing up of the research that has provided a vehicle to critically look at how the organisation is enacting wholesale change, and how this could be enacted differently, and potentially more effectively. I describe this within my personal reflections in Chapter Nine and how this has placed me to better critique and contribute to how change is enacted. It has been the process of writing that has allowed for thoughts and ideas to be progressed beyond the bounds of the research proper.

Writing Chapter Two on change and where to from here (Chapter 8) has provided a tangible product, for want of a better descriptor, that can be passed on to colleagues and has provided the basis for discussion and analysis. Further, the methodologies that were uncovered through this process have continued to have a life beyond the research itself. The process of appreciative inquiry was experienced for the first time by many of the project managers and those who provided project support. As a methodology, their observations reinforced what was revealed through the qualitative analysis, that it allowed for good engagement of staff, and contributed positively to the process of change. As such there have been several opportunities for these individuals to deploy this methodology in initiatives separate from the work that the original research undertook. Similarly, the methodology of action spiral has been noted and deployed in circumstances separate from the original research. Given that this has been occurring in a healthcare environment where quantitative research and a positivist view is considered the norm, it has provided an avenue of discussion on how to manage the rigour that is associated with research. This occurs in an environment where it may be difficult, if not impossible, to separate the researcher from the research. Action spiral is explicit that the research and the researcher are inseparable and has provided an alternate avenue that may not have been considered previously as to how research is approached in a large organisation.

Potentially the greatest learning perpetuated outside of the research itself has been the ability to apply the concept of the philosophies of change to the ongoing change in which I have been involved. As change progresses and succeeds, or does not, I now have the ability to provide a much greater level of critique and analysis as to why there was success or failure. I am able to identify that when there is resistance to change, that is not a behaviour to be eliminated, rather a behaviour to be understood, and is symptomatic of a group demonstrating their concerns that change may change the relevance of their jobs and the roles that they fill. As leaders, this should be recognised and managed constructively and respectfully as opposed to a need to aggressively eliminate. Similarly, it provides a process to understand that even when there is good engagement of staff and ideas the desired change may not result. I now have a tool to ask which philosophy was not present during the process of change, and how in turn this could be better integrated and managed. In the process of writing up this research, I took on a new position as the Executive DAH, scientific and technical at another DHB. I have embarked on that role with a clarity of insight as to how I might lead change. My 'diagram' has proved itself effective.

## 7.4. Limitations of the study

As noted in the previous section, this research is artificially time bound. As such it has provided the necessary space for the significant lessons learnt to be compiled; yet the sheer nature of the artificial end of the research process did not allow for the lessons learned to be integrated, tested further, and validated or discarded. This limits the applicability of the conclusions. There is good rationale that supports the Chapter 'Where to From Here' (Chapter 8), but essentially it can be argued that it is an un-validated approach. It summates and distils the lessons learned, but it was not tested within the rigour of academic research to quantify whether or not it would be successful.

A further issue that arises from the action spiral methodology, and the focus on addressing the issue of the moment, is the inability to establish a baseline of what was. As this was a process of examining and understanding change, without the establishment of clear baselines, there is an inability to quantitatively determine the success of change. There is the ability to establish baseline measures that could have been revisited after the application of the change process to give further depth of understanding as to the effectiveness of the change framework.

In carrying out the qualitative evaluation, it was acknowledged that as the instigator of the research I would also be the one performing the qualitative analysis. While this was acknowledged and worked through in the ethics process, it does introduce an element of doubt with regards to the willingness for the individuals interviewed to give full and frank answers to the questions posed. The contrary view is that the richness of the qualitative feedback gives a level of comfort that this was not the case.

## 7.5. Chapter summary

This chapter reviewed the work undertaken, and explicitly sought to analyse and discuss the context of the research as it pertained to the associated theory and the methods used. With regards to the theory, there was the ability to review against the theories and philosophies associated with change. The literature reviewed gave a contrast for the process that was undertaken and understanding within this context. There has been the ability to build on the concept of 'dualities' and to offer a model that takes this concept and applies it more pragmatically when undertaking large scale change.

Bourdieu was reviewed, using his framework of social fields, habitus, and doxa. As a framework, this was discussed as being useful as a tool to map the environment and obtain a deeper level of understanding as to what is occurring in a given scenario. It was also postulated that an end goal of large-scale change may be to achieve what Bourdieu describes as hysteresis, or separation of the habitus from the social field, to allow for re-formation within a new social field.

An analysis of the methods used highlighted the benefits of the action spiral process in being able to fold lessons learned into the next cycle, and in turn build the body of knowledge around the process as it unfolded. Limitations of the process were identified, in that the time limits of the research were artificial and there was not the time with my doctoral enrolment to further test the proposed model. Nevertheless, this chapter has captured what I claim to be valuable insights to guide change leadership.

## Chapter 8. Where to From Here

### 8.1. Chapter introduction

While the research undertaken adds to the knowledge pertaining to undertaking change in an organisation, it does leave a fundamental question unanswered: how to improve on the change framework to affect better outcomes? The intent of this chapter is to further synthesise the learning from the change process undertaken, as well as building on the reviewed literature to present a reusable change framework. The goal is for this change framework to be deployed and to further add to the learning around change within an organisation. For consistency, this change framework will be referred as the WCF.

### 8.2. Designing a re-usable change framework building on the research undertaken

The change framework deployed as a part of this research was based on the 4D concept found within appreciative inquiry, itself a form of action spiral. Using this approach was found to be beneficial during the Home Healthcare redesign process, with the qualitative research confirming that it was a robust methodology. It engaged staff, and generated thoughts and ideas that could be fed into the redesign process itself. Where the process was found wanting was in regard to ensuring that there was supporting resource to implement the change ideas that were generated.

It was by undertaking this process and generating the change ideas that enough data were generated to inform the business case to support redesign of community services. Given that there is the recognition of the need for resources to be made available to implement change ideas, there is the ability to feed this into the WCF.

### 8.3. 4D revisited

The appreciative inquiry 4D framework is designed to be non-prescriptive and adaptable to a local situation (Cooperrider & Whitney 2005). This allows us to take the lessons learned and apply them to a more robust process. What follows is the re-designed process presented in a



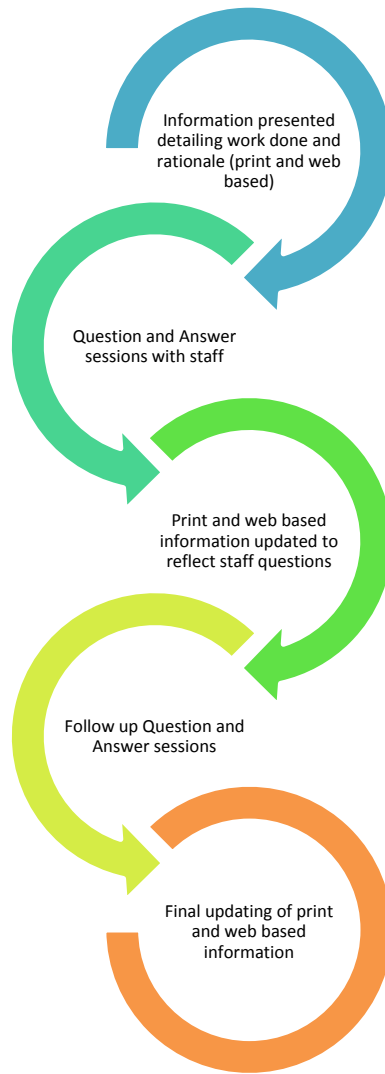
way that it could be picked up and used again. In other words, this is the contribution to knowledge/practice that has emerged from my research process.

### 8.3.1. Stage one: Discovery

Before any process is undertaken, there is a clear need to establish the why, to discern the misalignment of an organisation and its current environment. There needs to be buy-in that continuing on in a current shape is no longer sustainable for an organisation to be relevant in the environment. This creates the impetus for change. In this context, the initial stage continues to be focused on allowing for the information supporting the need for change to be presented in a transparent and up-front manner. What was learned throughout the change cycles was the need for information to be presented over time and in multiple formats to allow staff to absorb the information and formulate points for clarification that can be addressed within question and answer sessions. The overriding intent of this stage is to not push change or direct any process to be undertaken, but to simply allow staff to review information, clarify what they have been absorbing, and seek clarification. This approach has been well evidenced and supported in the literature (Cullen & Adams, 2012; Diedrick, Schaffer, & Sandau, 2011; Schaffer, Sandau, & Diedrick, 2012).

Presenting such information is best done in multiple formats (e.g. print form, accessible on-line) to enable staff to take the information away and access it at their convenience. Once this information has been made available, and a period of time has passed, the next step would be to hold question and answer sessions in order for staff to clarify what it is that they have been reading, and gain a depth of understanding as to the 'why' of the change process. Taking this back to the philosophies offered by Smith and Graetz (2011), this approach aims to hold a tension between a rational philosophy of having a clearly defined process, and the psychological and cultural philosophies where the intent is more focused on ensuring staff retain a confidence in their roles and the services they provide, yet are able to begin to picture how they could contribute to a much greater extent to the changes occurring around them.

As questions are raised, and answered, they will in turn contribute to the information that is being presented to staff so there is a growing body of understanding around the process of change. In essence this becomes a cycle of change and may result in three to four iterations before this process is closed off as represented diagrammatically in Figure 18 below.



**Figure 18: Iterations undertaken to build understanding**

Due to the iterations detailed, it would be anticipated that this stage would occur over a two to three-week period. There needs to be enough time to bring staff on board, while simultaneously having a sense of energy and urgency. Resource would need to be made available to produce the print material and keep a web page current and updated as new information is added.

Keeping multiple philosophical approaches in tension is a desired outcome of this process. Specifically, a goal would be to allow for the stage to occur within known timeframes (rational philosophy), while giving staff confidence in their roles and the intended direction of travel, knowing that how they will be doing their roles will change over time (psychological and cultural philosophies). The tension that is maintained, is defining the direction of travel, while not defining the specific changes. The quest is to provide the environment for staff to begin to

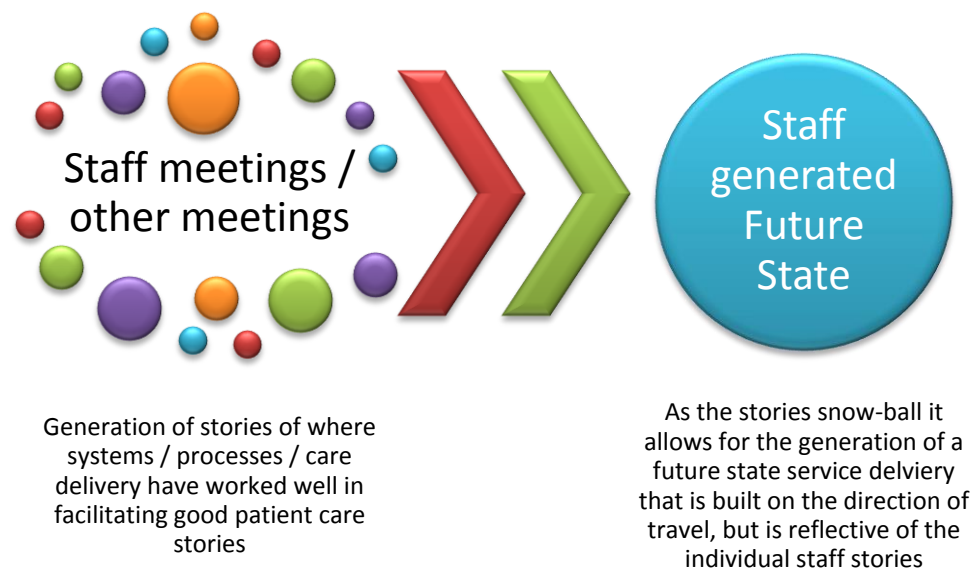
investigate what those changes may be. This is contrasted by a 'normal' change process which has high reliance on describing a process and changes which are tied to time frames. Such a linear approach predominately relies on the rational philosophy. In the model I present there is a conscious design to keep the tension between several philosophies within this stage.

### 8.3.2. Stage two: Dream

Stage one is based on understanding what has been and an intended direction of travel. The second stage aims to give detail as to how this direction of travel could be achieved. Bushe (2013) described this stage as one where the group is "asked to imagine their group, organisation or community at its best and an attempt is made to identify the common aspirations of staff members..." (p. 10). During the initial application of the change framework, the use of experience-based design and patient stories proved to be a powerful enabler to assist staff members to recognise that there are times where as a system we do 'get it right' in how services are coordinated and provided. The qualitative feedback reinforced that this provided a mechanism to reflect on the 'good' that they do on a daily basis as opposed to identifying the deficits in service delivery.

The process that has been undertaken to date, and the subsequent organisational changes, provided staff with opportunities to gain greater understanding of the intended direction of travel of the organisation. A progression within this stage is to take this work and enable staff to envisage what this could function like in the near future, acknowledging that there are times where they are already getting it right.

Learning from the previous action spiral cycles, this stage is designed in the initial part to be conducted within the normal business structure of the organisation. Stories are collected of when work flow has occurred in a timely and/or seamless way. This is fed back to the teams via established meeting structures and is used to generate new stories, continuing to snowball the image of what 'good' looks like to the team, all the while referencing back to the material that has been presented within the first stage. Diagrammatically this is represented in Figure 19 (p. 133).



**Figure 19: Generating the future state**

The key philosophies upon which this stage aims to build is pulling in the psychological and cultural aspects. It is important not to immediately detail how roles are going to change. The general direction of travel has already been detailed in the Discovery phase, but the 'how' this is to be achieved has been left undescribed. It is described in part through this phase, but using an appreciative inquiry approach, highlighting what is already working well reflects the direction of travel of the discovery phase. This allows for staff to continue a process of discovery, recognising positively that their roles, while they may change, are able to morph and adapt into a new way of working. Reflecting back the stories of others and snow-balling the feedback aims to give growing confidence and further lays the ground work for staff to think as to how they could contribute to the intended direction of travel.

With the ongoing generation of stories, there is the ability to reflect back to staff what a more complete revised model of care could look like. The key difference with this approach is that it has not been dictated to the staff. Rather they have had during the Discovery phase some detail of what is intended, but by reflecting on what is already working well, they are able to begin to identify more directly how they can contribute and realise more fully a new way of working. This leans heavily on the critical philosophy by which staff are in the process of creating a new reality for themselves. They achieve this by also referencing the psychological philosophy, whereby the change detailed has been through the generation of stories and has been identified as not being a threat. The resistance that might have otherwise emerged as a defence mechanism, fearful that their current way of working will no longer be needed, is replaced with a notion of how they could actively contribute within the changed context.

The next component of this stage is to present back to staff what a more complete model of care could look like, reflecting an amalgamation of their stories of what is currently working well. The intention is to specifically test that what is being reflected back to staff is a fair and reasonable reflection of what has been fed into the process to this stage. This begins to build a tangible journey for staff, while not removing the desired direction of travel of the organisation.

From here, the next component is to generate and/or confirm the specific change concepts that can be implemented to achieve the future state. The driver of this component is to allow for all participants in the process to be able to generate the thoughts and ideas, and for these to be displayed publicly. As this is occurring across multiple sites, there is the ability for the thoughts and ideas to be collated at an individual or small group level, and for them to then be represented back virtually, to be able to be viewed and accessed by the wider group. The intent is to allow for the thoughts and ideas to be generated without referencing current constraints, rather envisaging what would need to change in order to achieve a desired end-state.

Referencing back to the core change philosophies, this component leans on the concept of emergence, or allowing the pieces of change to be generated in a potentially random way, significantly different from what was envisaged by the architects of the original process of change. It is, however, balanced by the process itself fitting within the institutional philosophy and the systems and biological philosophies whereby the driver for the change itself is contained within the construct of the organisation becoming out of step of its environment and needing to change to be better aligned. Underpinning this is the rational philosophy whereby the generation of thoughts and ideas is contained within a defined process.

The generation of thoughts and ideas as a way to work towards an ideal future state is in itself not sufficient. In order to make the process tangible, there is a need to enter into a process of sorting the ideas generated, and in turn prioritising them which is captured in Figure 20 (p. 135) below.



**Figure 20: Idea generation to idea sorting**

The process employed during the previous action spiral cycles was found to be effective in being able to sort a large number of ideas in a concise and engaging way with staff. This process required staff to actively sort the ideas through a two-stage process. The first requires ideas to be sorted into quadrants of whether the idea requires additional resource/or can be achieved within current resources, and whether the implementation of the idea can be implemented wholly within the current team/or whether it would require accessing expertise external to the current team. The lesson learned during the action research cycles was that this process inevitably led to the majority of ideas being sorted into the quadrant that was identified as being able to be implemented within the current team and did not require additional resources. This in itself is powerful as it is demonstrating to staff that there is an ideal future state that they can agree on, and that the pathway to this future state is potentially within their power to act.

Referencing back to the core change philosophies, this mitigates barriers in that change can be perceived as a threat. By having staff sort ideas this way, and if the trend identified within the action spiral cycles continues, it reinforces that this is a process staff are capable of implementing of their own volition, and therefore they have the notion of control and ownership over their own destiny. It continues to be balanced however by the process itself fitting within an overarching change process rational philosophy), that is meeting a defined need of the organisation (institutional philosophy).

This first process has a focus on sorting the ideas, to generate a cohort of ideas that are within the team's control and resources yet will enable progress towards a desired future state. The

second process within this work seeks to prioritise how the ideas that have been generated could be implemented. It further aims to sort the ideas into groupings of ideas that are judged to be implementable within a 120-day period/or requiring a greater than 120-day period to be implemented, and those ideas that are judged to have the ability to have a large impact on progress towards the desired future state/or would have a small or minimal impact on progressing towards the desired future state. The result of this process is to create a cohort of ideas that can be classified as “quick wins”, that is, they are change ideas that can be implemented within the team and do not require additional resource. Further they can be achieved within a relatively short timeframe and are judged to potentially have a big impact on progressing towards the desired future state.

Once this two-stage process is completed, there is the ability to sort the ideas that were judged by staff to be within resources but requiring input from staff external to the team, with regards to the judged timeframe of implementation and perceived impact of progression towards the desired future state. The process would then be repeated for ideas that were judged to be within the ability of the team to implement but requiring resources, and finally prioritising the ideas that were judged to be implementable with resourcing from outside of the team and requiring additional funding.

A key change recommended during this process that pulls on the lessons learned during the action spiral cycles, is to reserve the right of management to promote ideas that have been identified as crucial to the successful achievement of a future state. Tangibly, this is seeking to keep a balance between the resource and rational philosophies and arguably ‘managing’ the change process. Nevertheless, the other philosophies need to stay in play. Staff need to feel engaged in an ongoing manner, key cultural values need to be protected and upheld. At the same time there needs to be a growing openness to a new construction of reality.

### 8.3.3. Stage three: design

The previous two stages have had a conscious bias towards balancing a biological/systems philosophy with a psychological/cultural philosophy to ensure engagement of staff.

The impetus for the change itself is argued to be within the institutional philosophy. However, as the process of change progresses, the previous action spiral cycles have highlighted the need for the process to become more definitive, to be more biased towards a rational philosophy and to give greater certainty as to how the specifics of the change will be managed.

Specifically, this requires the change ideas generated being tied to the desired future state, to demonstrate the link between the two.

While this addresses one of the key lessons learned through the previous action spiral cycles, it does not address how the change ideas can be sequenced appropriately over time and the potential relationships and reliance on one change idea to another. This continues to reinforce this phase leaning on the rational philosophy, as it is focused on giving increasing levels of certainty of how the change can be implemented and in turn sequenced.

While the previous two stages were heavily reliant on engagement of staff, this stage is more reliant on the management of the change and the associated mechanics of implementation. The balancing of philosophies continues, as while a rational philosophy dominates, it is balanced by the psychological philosophy in continuing to demonstrate the relevance of staff in a new way of working, and the cultural and critical philosophies as a new way of working is developed.

#### 8.3.4. Stage four: Deliver

The design stage aims to translate the thoughts and ideas into a tangible road map of the work to undertake, as well as relating the thoughts and ideas back to what was initially envisaged as a desired future state. The delivery stage aims to work through the process of implementation. As a continual process, it is important, as was identified during the previous action spiral cycles, to continually loop back to the process and the 'how we arrived at where we are'.

While leaning predominately on the rational philosophy, implementation benefits from taking on board the lessons learnt from the action spiral cycles and ensuring that there is ongoing participation and engagement of staff. The change ideas have been tied back to the preferred future state, and have been sequenced in a way that makes the most sense from a sequencing and resource perspective. The balancing comes from the implementation itself and ensuring that the change ideas are driven by the staff and appropriately supported organisationally, whether this be in the form of dedicated time to progress implementation, or project resource to be able to assist in the implementation process. A process of prioritisation would support a rational philosophical approach in reviewing the following criteria when determining the implementation methodology to deploy:

- Size
- Complexity of the number of players involved and facilities required
- Funding required



- Anticipated time for implementation
- Whether it is implementation of a known solution or an unknown/untried solution
- Implementation support required (ranging from none to improvement advisor or project management)

The size and scope of the change ideas will vary, which will require a scaling of implementation methodology and resources accordingly. For change concepts that are limited in scope using the noted criteria, methodologies such as Plan-Do-Study-Act cycles may suffice. This allows for the process of change to be fully within the control of staff conducting the change, and associated lessons learned feeding into the next cycle of change. This is also appropriate when it is implementation of an unknown solution, and there is the need to 'test' the change concept for effectiveness and imbedding into the local environment.

If the change concept is larger in scope from the perspective of time required and/or resources, a defined project methodology would be more appropriate. This will allow for monitoring of progress, to keep within the established limits of time and resources, as well as avenues for escalation if either is breached.

The decision-making process surrounding the process to be used and associated resources lies in the management domain. How this is balanced lies in the continual referencing back to the implementation road-map as it is established and communicated to staff. This reinforces the psychological/critical/cultural philosophies as the valuing of staff is retained as they collectively create a new reality and way of working, while maintaining and reinforcing the culture of the organisation.

Looping this process back to the institutional philosophy and the need for organisational change to improve alignment with the external environment, accountability of the success of the road-map can be built in. This is achieved by having definitive points in the road-map whereby progress and implementation of the change ideas can be monitored and reported back both at a management and at a general staff level. These check points also provide an opportunity to review and loop back the work that has been completed to ensure that it continues to align to the desired future state. It is entirely conceivable that as the work progresses some of the intended change ideas need to be adapted or wholly changed to better reflect the changed environment. The scope of these changes to the overall environment would dictate the level to which only the change idea is reviewed or, conversely, whether there is a fuller review of the entire process underway and a reinitiating of the broader process.

With each stage quantified, there is the ability to lean heavily on the rational philosophy and to monitor the progress of each change concept, whether it be a PDSA cycle or more of a defined project. This becomes more relevant, especially when there is reliance on one change concept being completed before another can commence.

Being able to report in this format enables tracking of the individual change concepts, as well as telling the overall story of how the progress is being maintained. This continues to seek a balance between the rational philosophy of describing and tracking the change, and the psychological philosophy of maintaining staff engagement, and the critical philosophy of designing a new future state. It also reflects the complexity of the process. There is no 'one way' of going about the process of change. As Smith and Graetz (2011) noted, the classic 'n' step approach to change is littered with failures. What I describe is a process that seeks to balance the many philosophies at play, and actively acknowledges the complexity of the change process itself.

## 8.4. Chapter summary

This chapter was purposefully titled 'Where to from here'. A process was engaged to facilitate redesign of how Home Healthcare services were provided. The qualitative feedback gained was that while it was a well organised process, it failed to deliver the substantive changes that the organisation was intending to see. There were lessons learned from this process that have been captured previously. From an organisational design perspective (psychological philosophy), these lessons could be lost and not feed into how as an organisation Counties Manukau DHB could improve the process of change, or how I myself could more effectively lead change.

What has been detailed in this chapter is a synthesis of the lessons learned and building on what worked well with the initial implementation of the change framework. It aims to provide a blueprint to be able to pick up and implement and gain maximal benefit of a change process. By referencing the dominant change philosophies, and the intention of how to balance these philosophies, it provides further check and balance. While there may be a dominant philosophy in play, there is a conscious attempt to balance it through the detailed process with other philosophies. This reflects the proposal offered by Smith and Graetz (2011) in what they term a dualities philosophy, as summarised in Table 3.

**Table 4: Summary table of the revised workforce change framework**

<b>Stage</b>	<b>Purpose</b>	<b>Complexity</b>	<b>Primary Philosophy(s)</b>	<b>Balancing Philosophy(s)</b>
<b>Discover</b>	Bringing all staff to a point of common understanding	Managing the different levels of understanding and established biases	Psychological Cultural	Rational
<b>Dream</b>	Building a common understanding of a desired future state	Negotiating current ways of working and focusing on what it is that is/could work well	Biological Systems Critical	Resource Rational Institutional Psychological Cultural
<b>Design</b>	To define the changes that need to be made, and how these changes can be sequenced	Maintaining linkage with staff generated thoughts and ideas and the logical sequencing of implementation over time	Rational Institutional	Resource Psychological Cultural
<b>Deliver</b>	Allocation of resource and specific implementation methodologies for change, and checks and balances	Maintaining linkages between specific change concepts and monitoring the process of implementation while maintaining BAU	Rational	Psychological Critical Cultural

What is noted in this table summary is that the complexity associated with each stage does not change; rather there is simply a change in focus. As such each stage needs to be viewed equally from the standpoint of the associated difficulty and the multiple tensions that will need to be negotiated before transitioning to the next stage.

## Chapter 9. Personal Reflections

### 9.1. Chapter introduction

As events within this research continued to unfold, I began to realise that there was more at work than undertaking and capturing the research. Action research as an approach is explicit in the researcher being the research; the impact of the research may not just be the research outcomes but also within the researcher himself. This chapter is an attempt to capture the process of progressive realisation that occurred for myself as the researcher. Chapter Nine, not part of my original plan, comes with the recognition that perhaps this is what the thesis experience was really all about. In this chapter I explore my reflections to capture the impact of the research on myself as the leader undertaking a process of change.

### 9.2. An original intent

There was a simple original intent for this research – I was to address the issue of creating a change framework to improve how allied health professions work across professional boundaries. There were others in the international allied health domain who had gone before and demonstrated the ability to implement change successfully. This was not proven in a New Zealand context, and did not necessarily consider the system level of change that was being attempted in Counties Manukau. As such my naïve belief was that what had been proven by others simply needed to be tested in our context. But, and there was a substantive ‘but’, what did this mean for the process of change itself, how was change successfully (or not) being enacted?

These challenges became the core of the original intent, for me to begin to understand more deeply what it is to enact successful change. How can one do so effectively, given the prevailing theories and philosophies that exist around change? Initially I explored the thoughts around complexity theory and how this could be applied. Within this microcosm there were the beginnings of a greater level of understanding of change.

This awakening to an understanding of change gave me pause to reflect on what I observed around me and, in time, began to challenge many of the precepts that I had based my previous thoughts and beliefs on pertaining to affecting change. The phrase “critique of the ‘n’ step” began to stick in my mind as an issue that I saw time and time again... if only we followed the

“7” steps we could guarantee success; yet when we did that as an organisation, success was not a foregone conclusion. A guru I was not, yet through this process of thinking deeply and learning I began to feel that I was gaining a deeper understanding as to how to lead change effectively. I felt the challenge I was faced with was what obligation did I have to do with this attained knowledge?

### 9.3. An opportunity

Louis Pasteur is accredited with the quote “chance favours the prepared mind”. Did I really know what I was doing... no. Did I feel I was better placed than most to give it a try... yes. The organisation that employed me was in a cycle of rapid change, or at a minimum desiring to facilitate rapid change. The question that began to arise was how best to go about this change. Common change strategies were clear in what needed to occur; it was assumed that to simply lay out the necessary steps and follow them would lead to the intended end state. Yet the process that I had been through with the initial stages of the research had highlighted that this approach, while addictive with its simplicity, did not guarantee success, and often the opposite was the case. I was in a place of some perplexity. My research had taken me to a place of deeper understanding. When with my researcher hat on I went back to some participants to ask them about the change that had eventuated, I discovered little had in fact changed. The change process we had initiated, while it seemed promising, had not followed through. I began to explore how sustainable change could potentially be achieved more effectively. This led me to a fundamental question of whether I was willing to test my emerging insights in a broader environment. Was I willing to put this forward and to be tested beyond what I had originally intended?

The opportunity arose within the action spiral cycles to meet an organisational need for a broader change framework to be deployed beyond allied health, and to encompass the broader healthcare team that makes up the community services. But the simple fact remained that this was an untested framework. It had been developed from the work undertaken previously with allied health, but its development was slanted towards the professions that are commonly attributed to the allied health grouping. Could the same principles be applied beyond this grouping?

On reflection, I experienced a growing sense of confidence that what I had been reading, integrating, and deploying through the initial action spiral cycles could have a broader impact than I had originally intended. This growing confidence was contrasted with the tension of

doubting that I had a deeper insight than those senior leaders I was working with. Was the knowledge that I had gleaned sufficiently different that it could contribute effectively to the change processes underway? To circle back to the Louis Pasteur quote, I had a sense that my mind was prepared for the challenge that was placed before me, but the doubt lay in whether I had the confidence to see it through, to put into play what it was that I had been developing over the preceding months.

#### 9.4. A realisation

Much of what I had been learning and integrating over the months was that the response to change is often predictable. The patterns of response could be planned for, and change could be a process that is done collaboratively. The theories I had been reviewing all reinforced this to be true. The realisation that began to emerge for me was that the theories and philosophies I had been immersed in could also be directly applicable within my own local context. There was the ability to take them from the academic to the pragmatic through the processes of change that I had been developing. Why should I be surprised that within the context of healthcare, where there is often a constant around change, that there is such resistance to the change itself? Yet the literature is quite clear within the psychological paradigm that change can be seen as a direct affront to one's competence. That by implementing change, the change makers doubt the ability of the workers to carry out the work. There is a perception that staff need to be instructed on a new way of doing, that they are no longer competent to be carrying out the work that they have been employed to do. With this type of perception, is it any wonder that change encounters resistance? The literature reinforces that this is the case and, more often than not, this is what transpires in practice.

This had been my observation over time. Yet with the limited change process that I had conducted to this point, what emerged for me is that this did not need to be the case. It was possible to enact a process of change whereby the engagement of staff allowed for the issues of competence challenge to be circumvented. That it was possible to conduct change in a way that engagement came to the fore instead of resistance. The principles of appreciative inquiry that I had become enamoured with over time allowed for this to occur in a systematic fashion. It was a progressive realisation that change could be achieved and achieved in a way that honoured and respected the very people who had to undertake the process of change themselves. Such change needed to be a done 'with' as opposed to a done 'to' process. Yet what I saw around me was all too often a process whereby there was a reverting to what could

be classed as a rational approach, to set up the known number of steps that were going to achieve the desired change, and then to progress through these steps. Too often I was part of conversations of wondering why a particular change process had created so much resistance and did not achieve all of the promise that it had at the outset.

## 9.5. A reflection

A key step in the action spiral methodology that I adopted was reflexivity. Bourdieu put forward a similar concept. It is a process to think deeply about what one has observed. It is to reflect upon what is known in associated literature, and then to draw similarities with the current context. This process of thinking deeply carries with it profound responsibility. In short, what is one going to do with the knowledge that is obtained through the process of reflexivity? My own personal journey had been one whereby I started with an original intent, which in turn presented itself as an opportunity. In seizing this opportunity, it led me to a point of realisation that there was much to draw upon, but often during the process of change we choose not to. Situating my work role as a leader of change within a Doctor of Health Science programme opened doors to reading and thinking that might otherwise have remained shut. My observation of this was the impact of expectations of change was significant insofar as the pressures that it placed on the very people who were perceived as needing to change in the first instance. Concepts around change fatigue begin to come to the fore, whereby it is perceived that the pace of change has become such that there is an inability for staff to tolerate any further change, that there is a need to 'pause' in a process of change.

Upon reflection, the query that began to form in my mind was whether it was change fatigue, or whether it was more of a reflection of change done badly. There is much in the way of literature that can guide the process of change, yet what I perceived was that it was not accessed readily, nor a process of thought given to how a process of change could be undertaken. Healthcare is fundamentally based on the constant drive to integrate new best practice in clinical care, yet this same drive appeared absent to me in how we were choosing to go about change. More often than not, an end state would be designed, and the process of change then became about how to transition to this new state. Yet this grounding in a rational approach remains discordant to the psychological view or other views on change grounded in emergence and co-design. Again, I found myself questioning why we should be surprised that large change efforts are not successful or do not achieve the expected fullness of change. The promise remains, but the fulfilment remains elusive.

Personally, I became drawn to the work of Coughlan and Barrick (2010) in describing how to undertake action spiral within the workplace. What ultimately emerged was a warning, that the process of action spiral holds huge value in enacting a process of change within the workplace, but the outcome may be one where the researcher finds that he/she begins to question whether one's own values remain concordant to the place of employment. The collaborative process of action spirals means the leader may find his/herself at variance with how the organisation is choosing to enact change, and whether his/her personal set of values continues to be aligned. It may lead to a place where separate paths need to be trod.

## 9.6. A determination

Hahrie Hahn (2014) in her book *How organizations develop activists: Civic associations and leadership* described a transition of process from public issues to issues public. To paraphrase, public issues are issues that we may care about or have an active concern of, but it does not prompt action or change of behaviour. In contrast, issues public is where concern of a particular issue is elevated to a point whereby it prompts action or changes in behaviour. The process that I have been attempting to capture in this chapter has been a gradual transition from what was in my mind a public issue, to one that was now an issue public. As with most I can recall being involved in a process of change that I felt was not done well. To note this as a public issue would be to note my concern, but to not do anything further. To transition to an issue public, it was no longer enough to note what it was that I was observing around me, it had to now prompt action.

However, what I had gleaned from the action spirals I had undertaken, and in reviewing the associated literature, is that direct action is often futile to affect a desired change. I had, over time, become comfortable in using the analogy of a stream. A stream will flow whether we are there to observe it or not. To change the direction of a stream by oneself is not easily achieved without inordinate effort and/or significant external assistance, with the use of machinery or the like. We cannot necessarily direct the flow of the stream, but we can help to facilitate different flows. This can be achieved by placing rocks in the flow of the water, digging alternate channels for the water to flow through. Another tactic is that we may choose not to change the path of the stream at all but rather to redirect how a vessel moves down the stream, be it by a nudge or a gentle direction.

I use this analogy to describe how I have come to view the flow of events within an organisation. Within a current state, time and processes will flow in a certain way. Attempting

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to directly work against this flow can be an exercise in futility. But to link back to the concept of issues public, I now find myself in a position whereby I cannot in good consciousness sit idly by, I am duty bound to attempt to facilitate change in a way that is better informed by the available evidence. It is not by direct intervention that a change or an influence on the flow of time and processes can be achieved. Rather it is by seeking the opportunities to influence the direction of the flow, or to ignore the flow altogether and rather focus on how to work within the flow, to be a vessel within the flow, or alternatively to seek to nudge that which is in the flow, to be able to alter its course.

I see this being achieved by using the tools that have emerged while undertaking the action spiral cycles. I have learnt how to be comfortable with the concept of multiple cycles of change as opposed to a singular change event. I am committed to embracing the concepts that underpin appreciative inquiry as a framework to facilitate engaged change, focusing on positive possibilities. I have become comfortable with the concepts of complexity whereby there will be consequences, both intended and unintended. Similarly, I embrace the biological concept of emergence, allowing solutions to simply emerge as opposed to dictating or attempting to force a change. These concepts bring to the fore a realisation or understanding as to what my role is within a process of change. Traditionally or previously I would have seen this as being the designer or implementer. I now see my role as being a facilitator, an instigator, but not one who is to determine an end state. If one is to work 'with' others in an authentic manner, then there must always be opportunity for the direction to be set by the team.

The challenge that remains is to be able to hold true to these concepts when we exist in an environment where change is often attached to a pre-determined timeframe. It must be achieved within certain bounds, as opposed to beginning with a vague sense of where the ending will be and allowing the end to determine itself. Change will be a constant within healthcare, but I remain resolute to ensure that it is enacted in the best way possible. Whereas before I had my eyes set on the pre-determined outcome, I now understand the most important role of the leader as being to hold the collaborative process of working towards change in an appreciative manner with those directly involved. The reason behind this significant change of how I lead is that I have learned through experience that driving change from the top down simply does not work. It takes a collective non-hierarchical effort to find the best way forward.

## Chapter 10. Conclusions

### 10.1. Chapter introduction

As a thesis that set out to answer an original research question but morphed into one whereby the reflection on the research process became the essence of the thesis, this chapter seeks to summarise the process and the key findings. The original intent was to use the rigour of an academic lens to develop and in turn deploy a change framework. The aim was to use this change framework to be able to mould the allied health workforce to be better aligned to the way services needed to be provided in Counties Manukau DHB. Describing this change was to have been achieved by using the writings of Bourdieu to describe the observed changes to professional boundaries or habitus.

Opportunities arose during the course of initial development to extend the scope to the broader healthcare team providing services within a locality. While action spirals were chosen as the methodology, this was refined further during this stage to adopt the appreciative inquiry approach, a form of action spiral. This is captured and described through the action spiral cycles, which in turn details the process that occurred within each of the four localities defined by Counties Manukau Health. While appreciative inquiry was the process employed to capture the change process, the broader action spiral cycles captured the process of reflexivity, and how this fed into planning for the next cycle of change.

To evaluate the process of change, qualitative analysis was used in interviewing participants in the change process. As this was approached with a specific interpretive lens, a theoretical inductive approach was utilised. It was through this qualitative process, and the process of reflexivity embedded within the action spiral cycles, that I began an internal process of questioning my beliefs around change. In a sense I became duty bound to ensure that the learnings captured during this process would lead to a tangible change in how I would choose to work as an agent of change.

### 10.2. Synthesising the theoretical outcomes

Being a DAH at Counties Manukau DHB and an employee/student, I was afforded the luxury of thinking deeply on the workforce that I was charged with responsibility for in my employment. Having gained a base understanding of the writings of Bourdieu, I could use his works to

explain why there were differences in the allied health workforces internationally. The concept of social fields in which we operate and the concept of habitus, or the space within this space, allowed me to describe the different predominant social fields that allied health operated in internationally e.g. legislative in the US, managerial in Australia, and leadership in New Zealand. Synthesising Bourdieu to thinking about allied health provided a mechanism to understand why New Zealand is unique and gave a form to describe how there can be greater working across perceived professional boundaries which was evidenced during the initial action spiral cycles.

As opportunities presented themselves, and the initial scope of the work broadened to be inclusive of the wider health workforce employed in community teams, the focus shifted from seeking to understand ways of working across perceived professional boundaries, to the process of change itself. This expanded scope allowed for integration of thoughts/theories and current literature around change and change philosophies. What became apparent to me during this phase is the reliance of change processes in health on what can be classified as a rational philosophical approach to change. While multiple theories and philosophies abound, reliance on a predominant approach correlated with my personal observations of oft failure of approaches to change. My assumption being that the reliance on a singular approach did not consider the complexities of the process of change. This resulted in the ongoing development of the change framework that was developed. This process demonstrated the ability for multiple change theories and philosophies to be integrated into a practical framework to take into account the changing focus of change as the process itself unfolded.

The overarching research process employed was action spiral. A component of the variant of action spiral used was critical reflexivity or, as described by Morton-Cooper (2000), the capacity for discrimination and judgement, in particular complex, human situations. Without this process, there would not have been the ability to look back at what had transpired within each action spiral cycle and to then integrate key learnings into the next cycle. It was this flexibility within the process that allowed for changes to be made in the process to enable a more effective action spiral cycle with the next cycle. It was this integration that was especially critical in the ever-changing paradigm of healthcare.

While a result of the action spiral cycles was a change framework, potentially the most significant personal gain was the ability to view change not as a linear process, but one that needs to be moulded and adapted to the situation itself as it unfolds. To be able to seek understanding of the interaction of workforces and professions using frameworks such as the one offered by Bourdieu. To be able to view an unfolding process of change through the

various lenses of change philosophies and purposefully reflect on what has transpired, and in turn to be purposeful as to what can be integrated into the next cycle of change.

I believe what has been derived from this work that can contribute to the broader body of knowledge around change, is the benefit of the fluidity of application of change philosophies. While healthcare continues to go through change, there is often little thought given to the underlying theory or theories of change, and how they can be applied to enhance the process of change itself. This is often counter to the approach that occurs with the application of health services to the delivery of healthcare, whereby theories are developed and tested to validate effectiveness. Yet this same type of rigour is often lacking when it comes to the process of examining how it is we go about the process of change. What has been offered through this work is a summation of learnings in the development of a reusable change framework, and the theories and philosophies that sit behind it. Most importantly, it offers an insight into how the approach and philosophical underpinning needs to change and adapt over time to ensure the greatest effectiveness from the time invested.

### 10.3. Links to other research

Action spirals are not static. As an approach it may change as the cycles progress. Such is the case with this research with the focus of the research developing and changing over time. To ensure the currency of this research and to align with developments in similar research fields, a review was undertaken of the period that this research was conducted. While this differs from the initial literature review, it ensures the currency of what is being presented.

A continued focus of change within healthcare was undertaken by Jacobs, Rouse, and Parsons (2014) in a New Zealand context. They noted the high failure rate of change initiatives, between 65-75%. They make the point of a need to form a “dominant coalition” (Jacobs et al., p. 74), and as a leader of change to move from “managing to navigating the process of change” (p. 75). They proposed a model that highlights the non-linearity of the process of change. Their commentary fits comfortably within what I have offered, insofar as it too is a process that embraces a non-linear approach to change. Lawrence (2015) reinforced that the process of change needs to take into account multiple realities, and as such the need for “sense making” (p. 233). Lawrence focused on the components of Dialogue/Perspective/Purpose/Identity/Power and Politics in presenting the “Emerging Change Model” (p. 267). The components presented could, in my view, easily be mapped against the change philosophies and the change model that I have proposed. Similarly, Joyce and Kinnarney (2014) spoke to the

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“unspoken politics and defensive behaviour” that presents itself during the process of change (p. 171). This links with the psychological philosophy, and my observation of the need for this to be at the forefront during the initial stages of a change process.

While not directly related to the health environment, Gaziulusoy, Ryan, McGrail, Chandler and Twomey (2016) took time to investigate transdisciplinary working in the research environment. They arrived at conclusions that this type of working requires “emergent responses in management and execution” (Gaziulusoy et al., p. 62). This is not at all dissimilar to my observations that the reliance on emergence as a process allowed for engagement and in turn ownership of staff as they worked through the framework that I have proposed. Espedal (2017), offers a contrasting point, and one that I disagree with, in which he focuses on the role of the leader in a process of change. The proposition put forward is that the role of a change leader is to manage the tension between autonomy and power and the discretion required. This is in contrast to the model I have proposed and the specific reliance as the process progresses to rely on the philosophies of systems and biology to allow for solutions and a direction of travel to emerge from the staff involved in the process itself.

Within this section, I have undertaken that the research remains current and relevant to healthcare and the allied health professions. A specific review was undertaken using the keywords Change AND Action spiral with a specific focus on nursing and allied health professions for the period 2013 through 2017. In total, 85 articles were identified, and seven were specifically reviewed as having relevance to this research.

Rich and Misener (2017) highlighted the impact that undertaking action research can have on the researcher his/herself as the agent of change. This is supported by Evans and Hopkinson (2016) who noted the anxiety that can arise through a process of change. Both of these commentaries reinforce the need for a focus on the psychological philosophy during the initial stages of a change process. Duffy (2014), in a similar vein to Espedal (2017), focused on the role of the leader in the process of change and proposed frameworks for this to occur at a system level. As a critique, and taking into account the lessons learnt through this research, too stringent a framework does not allow for the process of emergence to occur, to the detriment of the process itself. Christofilos, DeMatteo, and Penciner (2015) focussed on an academic environment undergoing a change process. They noted the benefit of allowing for emergence of ideas to occur in developing an end result. This is supported by Dewar and Sharp (2013) who advocated the use of an appreciative approach to allow for new thoughts and ideas to emerge through a change process. Both of studies are in alignment with using a

process to allow for the very thoughts and ideas that are going to enact change to emerge through the process itself.

While current evidence was identified in support of emergence as a concept, Deusinger (2011) provided a cautionary note as to the multiple tensions in play during large scale change. It is these tensions that are identified and mitigated in the works of Patterson, Comans, Pitt and Currin (2015) and Nancarrow, Smith, Ariss, and Enderby (2015) who focussed on the benefits of transdisciplinary team work and a process to facilitate this occurring. Both are concepts that I believe can be understood by using the work of Bourdieu and the concept of the porosity of professional bounds. These are concepts that similarly emerged through the course of this research and have the ability to provide a further lens through which to view this work.

The last piece of work reviewed was authored by McKee (2017). A key concept to pull through in relation to my research was the need for time and space for the process of change to occur. This is particularly affirming as the change framework that was developed out of this research has a heavy bias in ensuring that the process itself allows for the time, and the space, for staff who are undergoing change to be able to direct and take ownership of the change process.

After reviewing the more recent literature there was an overall sense of affirmation. While different terms were used, and different contexts were examined, there is an ability to tie closely to the work that has been completed with this research. Affirmation in that the role of leadership and being a change leader is not so much to lead, but to navigate; to acknowledge the multiple tensions at play, and to be purposeful in managing these tensions. Time and space must be created for change to occur. Professional boundaries do not necessarily need to be protected; allowing greater porosity of professional boundaries can in turn lead to more effective team working over a period of time.

#### 10.4. Implications for practice

As the employee/student undertaking the 'research/change-process' captured in this thesis, what primarily emerged for me was the ability to manage the process of change in a different way. Healthcare can be different from other industries as there is not a readily accessible workforce. Any loss of a worker cannot always be easily replaced. The cost of replacement makes it more desirable to keep current staff employed. Yet, the case has been made in Chapter Two that the status quo of service provision is untenable. Our models of care by which we provide services need to change to allow for more efficient and effective service delivery

models. To force a change runs the risk of losing the very people needed to deliver the new model of care in the first place, as is confirmed with the psychological philosophy of change. The argument made is that change in healthcare must be delivered in different ways to allow for staff to be engaged in a process of change, and not lost to the process of change itself.

The process that was developed and explored during this research aimed to do just that: to allow staff to be engaged in a process of change, develop the change itself, and be the driving force of the change. The key lesson learned through this process was the need to change the focus of the dominant change philosophy being employed as the process of change itself continued to unfold. The specific learning from the example detailed was the need to have the resource philosophy come to the fore towards the implementation phase of change. That is, to ensure that resources are made available to affect the changes that have developed over the course of the change framework.

Throughout this process, an additional focus was on how the perceptions of professional boundaries could be managed to allow for greater sharing of care across these boundaries. What was demonstrated was the ability for this to be actively managed. The perception of a professional boundary as finite and impermeable was challenged. It was in turn demonstrated that there could be greater porosity of what was perceived as a professional boundary. As healthcare moves towards an ever-increasing reliance on team-based care provision on networked care, the ability to work across these boundaries will come evermore to the fore. This was managed through the change framework developed and demonstrates that this can be done in a purposeful and systematic way.

## 10.5. Implications for education

Healthcare is not stagnant. Yet we educate clinicians to provide clinical care in a steady state, rather than educating them to be prepared for an environment of change, or in turn to lead change. Often when we educate to lead in the workplace, we give a very truncated view of change, a reinforcement of the 'n' step approach to change. Yet the drive for change in healthcare continues unabated. While it is fully acknowledged that our undergraduate programmes are often too full of critical components, there is potential loss in not teaching how to be adaptable and able to manage the constancy of change.

The challenges that exist around the provision of healthcare are not likely to abate in the foreseeable future. Therefore, it behoves educators to consider how we train the next

generation to be competent in their craft, and competent to be an 'activist' within their craft. To be willing to test the bounds of what is. To enact change in ways that take into account the key lessons learnt from this research.

## 10.6. Strengths and limitations

Beginning the action spiral cycles as leader, there was a general sense as to what the result should be. The challenge was that the cycles were conducted in a context of ongoing change, and the demands that were required of the process changed over time. A strength that lay within the process itself was the ability to change and adapt with these changes. If the research methodology had been different, there is potential that it would have been too stringent to allow for adapting and changing as the circumstances dictated. To have not been able to do so would have rendered the entire process of limited value to this environment of flux. This allowed for some of the key learnings to be gained during the stages of reflexivity in each cycle. It allowed for the capture of data that reinforced the need to adapt change philosophies as the process of change continues to unfold.

A more traditional application of research methodologies would include a reflective component at the end of the research process. By choosing action spirals, the use of the action spirals cycles explicitly allowed for a process of reflecting to occur at multiple points as the larger process continued to unfold. This enabled the nimbleness of the change process to adapt to the environment. The strength lay in the ability for the constancy of reflection being built in to the process itself.

An underlying goal in this project was that it would never be a one-off process. My ongoing reflexivity allowed for the development of a process that could be applied in different organisations, and in different contexts. The development of a transferrable and re-usable change framework became a goal. The ability for the framework to be adapted for each change cycle demonstrated the ability for the framework to be adapted to different contexts.

While the process itself was found to be transferrable and reusable, a major limitation was in the fact that the process itself did not result in the sustained change that was anticipated. A key learning from my reflexivity was the need to reference the stages of the framework to the various change philosophies, and in turn identify how the reliance of one philosophy over another needs to change as the process unfolds. Within this, and while it was a constant throughout the framework, was the need for the resource philosophy to come to the fore



during the later stages of the process of change. Without clearly identified resource to facilitate the implementation of change ideas, the entire process was at risk of folding.

The qualitative process revealed that the changes that were achieved were not sustained, and the overall impact was difficult to quantify. On further reflection, this could have potentially been captured if more detailed interviews were conducted with a wider group of participants. It would have been of value to dig further into what was perceived as benefits, and what change (if any) this had on how individuals chose to view their work, and the ability they have to change the work themselves.

Ultimately, I would put forward that the greatest strength of this overall process is the impact that it has had on me personally. While this thesis ended with a clear focus on understanding change to a deeper level, in doing so it has changed me. It has changed me to view my role in a process of change to not be the architect, but rather to be the facilitator, the navigator – the enabler of change.

## 10.7. Future research

Determining the quantitative impact of deploying my change framework could form the basis of further research through taking a group that can be appropriately baselined, determining appropriate success criteria, and deploying the change framework. Measuring against the pre-determined success measures established at baseline could form the basis of analysis to quantitatively test the effectiveness of the proposed change model. Yet such a mechanism is built on pre-determined outcomes. There is danger and limitation in that worldview.

The work of Bourdieu was used to give a framework to better understand the allied health workforce grouping in the healthcare landscape. Bourdieu described the concept of capital in various forms to establish one's habitus within a social field. This becomes a useful framework to begin to describe and evaluate how the allied health professions have created capital over time, and how, in turn, this has translated to power and the ability to capture a greater habitus. While somewhat simplistic to describe in this context, there is potential for it to be examined in depth and provide further corollary of the development of the concept of allied health. This approach could be applied in a broad, developmental context or in a more localised context to examine the changes in capital in the allied health grouping within an organisation.

## 10.8. Concluding statement

Marshall Ganz (2009) described leadership as the 'ability to do'. Yet the paradox is that often we can become so fixated on the doing, we may fail to pause and reflect on why it is that we do what we do in the first place. Undertaking this piece of work, and collating the thesis, has given me permission to think deeply on a topic. This is a privilege that cannot be taken lightly. By thinking deeply, there is a process of change which comes with a degree of responsibility to 'do' something with what has been learned. Change is a seeming constant in the world of healthcare; yet it is the same people who undergo a process of change who will need to deliver the change. I have come to believe that 'the doing' must be done in a way that respects people, honours their contribution, and facilitates them through a process of change. Too often we damage the very people we need to contribute more. There is a better way.

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# Appendices

## Appendix A: Ethics Approval



**AUTEC Secretariat**  
Auckland University of Technology  
D-88, WU406 Level 4 WU Building City Campus  
T: +64 9 921 9999 ext. 8316  
E: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)  
[www.aut.ac.nz/researchethics](http://www.aut.ac.nz/researchethics)

6 April 2017

Liz Smythe  
Faculty of Health and Environmental Sciences

Dear Liz

Ethics Application: **15/85 Managing change: The porosity of professional boundaries.**

On 20 May 2015 you were advised that the Auckland University of Technology Ethics Committee (AUTEC) had approved your application.

Following a routine check of our files, it appears we have not yet received a progress report of your research. As part of the conditions of your ethics approval, submission to AUTEC of the following is required.

- A brief annual progress report using the EA2 Research Progress Report / Amendment Form, available at <http://www.aut.ac.nz/researchethics/forms>, or
- A brief Completion Report about the project using the EA3 form, which is available online through <http://www.aut.ac.nz/researchethics/forms>. This report is to be submitted either when the approval expires on 20 May 2018 or when the project is completed;

It is also a condition of approval that AUTEC is notified of any adverse events occurring during the research, or if the research will now not be conducted. If there has been any alteration to the research, (including changes to any documents provided to participants) then AUTEC approval must be sought using the EA2 form.

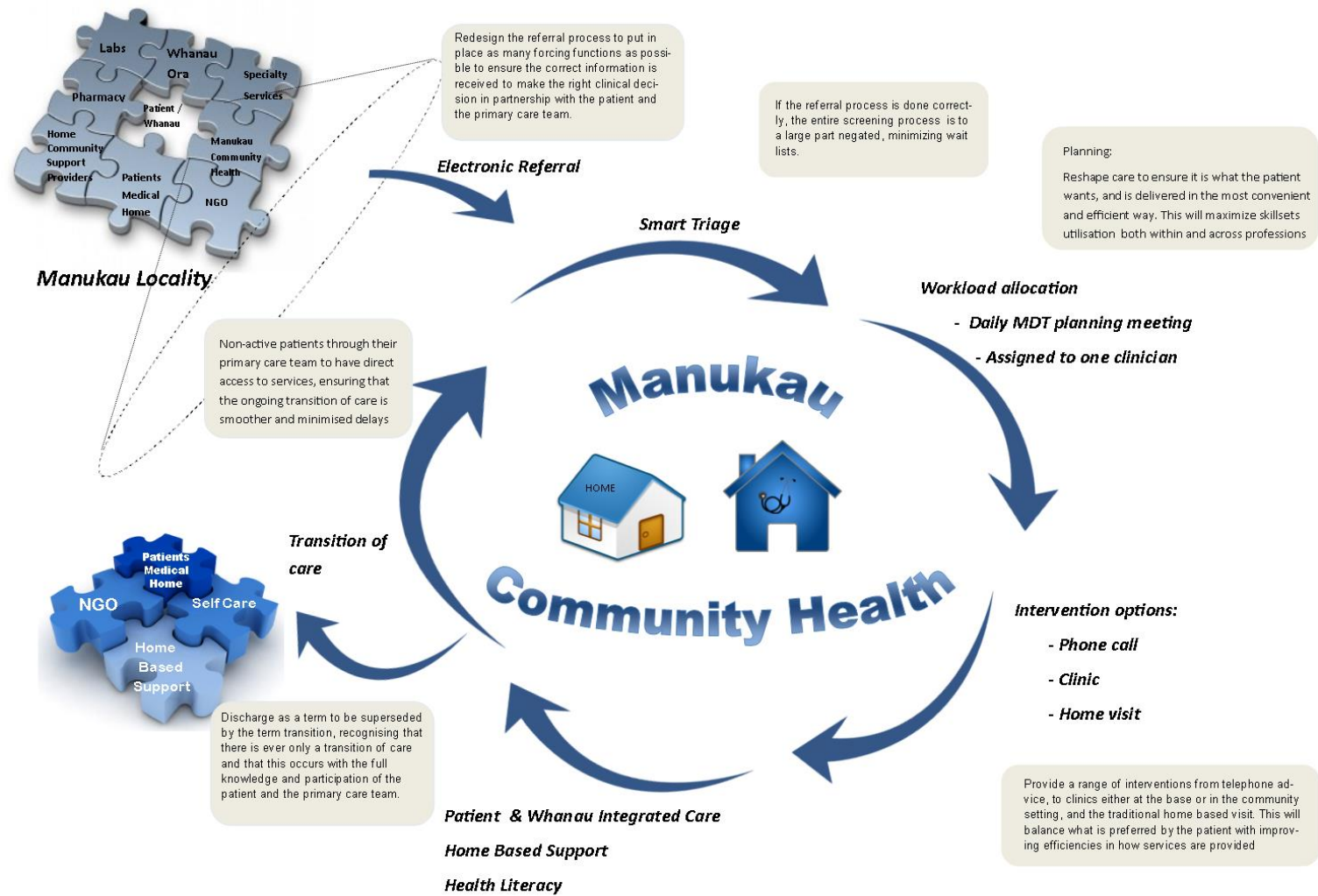
To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

Yours sincerely



Kate O'Connor  
Executive Secretary  
Auckland University of Technology Ethics Committee  
Cc: [martin.chadwick@middlemore.co.nz](mailto:martin.chadwick@middlemore.co.nz)

Appendix B: Redesigned Model of Care for Manukau Community Health



Consent Form



Project title: *Managing change and the impact of change on professional boundaries*

Project Supervisor: *Liz Smythe*

Researcher: *Martin Chadwick*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 15 March, 2015.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant’s signature: .....

Participant’s name: .....

Participant’s Contact Details (if appropriate):

.....  
.....  
.....  
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number***

*Note: The Participant should retain a copy of this form*

# Participant Information Sheet



**Date Information Sheet Produced:**

18 March, 2015

**Project Title**

Managing change and the impact of change on professional boundaries

**An Invitation**

I am Martin Chadwick and I am currently undertaking research as a part of my Doctorate of Health Sciences. As a part of this research I am conducting a retrospective analysis of a change framework that I have used within my role as the Director Allied Health at Counties Manukau Health (CMH). As a part of this retrospective analysis I am undertaking interviews of staff who participated in the change framework in order to gain an insight to their perspective of participating in the process.

Within the scope of this research, I am inviting you to be a part, and to be interviewed.

**What is the purpose of this research?**

This research is being conducted as a part of my Doctorate in Health Sciences, and will inform the thesis that will be produced as a part of this course of study.

The project that is the subject of this research was initiated to allow allied health as a workforce to enable the ongoing roll-out and development of the locality concept of services better aligned to the unique communities within CMH. Examining whether an increased level of rigor could be added to the project process lent itself to having an academic lens applied to its development, roll-out, and evaluation. The project roll-out led to the development of a change framework that was applied to facilitate transformational change within the allied health workforce. Action spiral has been the methodology applied to the framework development and deployment, and the philosophical works of Pierre Bourdieu has provided an analytical lens to critique what unfolded. Interviewing staff who have been a part of the change framework will add a greater depth of understanding as to how effective the change framework is.

**How was I identified and why am I being invited to participate in this research?**

You have been identified to be interviewed as a part of this research as you were involved in the deployment of the change framework. You may have responded to information posted on a flyer, or in response to information shared at team meetings, or via emails sent to staff, or in response to communication with your immediate supervisor.

**What will happen in this research?**

As a participant in this research, your role will be to be interviewed by myself. The interview will consist of open ended questions aiming to gain an insight into:

- Being a participant in the change framework

**What are the discomforts and risks?**

The main discomfort will be spending dedicated time re-telling your experience. There may be a perceived risk that if you are too forthright in your views that for CMH employees it could impact your relationship with your employer.

**How will these discomforts and risks be alleviated?**

In order to mitigate the noted risk, the interview will only be conducted once full consent has been obtained. Further, as a participant you will have the right to stop the interview at any time, and/or to request portions of the interview be deleted. You will be asked to select a pseudonym so that in the



write-up of the interviews, specific data will not be attributable to yourself as an individual unless you request to be specifically named. Confidentiality will be maintained throughout the process.

### **What are the benefits?**

Potential benefits of this research include:

- a) As a participant, you are likely to benefit in being given an opportunity to reflect on the change process that you have been through.
- b) I will benefit by finding out the common themes that emerge around professional boundaries, and how in turn these boundaries adapt and change during a change framework. This will contribute to my DHS thesis.
- c) The wider health workforce community will likely benefit as the findings will reveal factors that enable change of professional boundaries.

### **How will my privacy be protected?**

You will be invited to select a pseudonym to be known by in the study. The identity of participants will be protected at all stages in the research process and during any publication or presentation arising from this study. I will not disclose or discuss any of the participants' names or any information that could identify that participant.

Consent forms will be stored by my primary supervisor in a locked cupboard at AUT and kept separate to data in order to assure confidentiality of participants. Data will be stored in a safe and secure place as per AUTC requirements and electronic data will be password protected on my computer.

### **What are the costs of participating in this research?**

No cost is anticipated for participating in this research other than giving an hour of your time to be interviewed.

### **What opportunity do I have to consider this invitation?**

Once you have received this invitation to be a part of the research you will have 10 days to consider your participation. I will follow up with an email within this period, and if you choose not to respond this will be noted as a desire not to be included in the research.

### **How do I agree to participate in this research?**

If you agree to participate in this research by being interviewed, you can signal this by reading and completing the attached consent form and returning to me. This may be done via email, or physically returning the form.

### **Will I receive feedback on the results of this research?**

A summary of findings of this research will be offered to you. I also intend to publish journal articles from this study which will be made available to you.

### **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Liz Smythe who can be contacted at: [lsmythe@aut.ac.nz](mailto:lsmythe@aut.ac.nz) or via phone at +64 1 21 351 005

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), 921 9999 ext 6038.

### **Whom do I contact for further information about this research?**

#### **Researcher Contact Details:**

Martin Chadwick  
[Martin.chadwick@midlemore.co.nz](mailto:Martin.chadwick@midlemore.co.nz)  
+64 1 21 220 3044

#### **Project Supervisor Contact Details:**

Liz Smythe  
[lsmythe@aut.ac.nz](mailto:lsmythe@aut.ac.nz)  
+64 1 21 351 005

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTC Reference number *type the reference number*.