How health care managers weather change: Implications for management education programs

by

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‘Middle managers remain critical to change processes in organisations and need to continue to be given role-relevant recognition and support.’

(Balogun, Hope-Hailey, Cleaver, & Stuart, 2015, p. 5)

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ABSTRACT

Despite the documented importance of middle managers in the implementation of change, there has been little research on how middle managers in health care experience and make sense of contemporary radical changes and how they might develop the capabilities to deal with them. This research explores and analyses health care manager experiences of changes to organisational funding, structures, workforce and services in South Australia and identifies possible implications for postgraduate health care management programs at Flinders University and in South Australia generally.

A qualitative, interpretive research design in the form of a collective case study was used to elicit information about middle managers' experiences, views and responses to major change. A purposive sample of seven participants was chosen from managers who responded to a call for expressions of interest distributed by the South Australian Branch of the Australasian College of Health Service Management (ACHSM), the professional body for health care managers. The sample drew on different age groups, a variety of professional backgrounds and roles, and a range of organisations within the Greater Adelaide Statistical area (ABS, 2016). This area includes a few small country hospitals. The gender balance of the sample (six females, one male) reflected the balance within the health care professions.

Semi-structured interviews were used to explore the rich experiences of each participant. The theory of weathering change (Raffanti, 2005a; 2005b) provided the framework for documenting the various stages of coping with unrelenting change and analysing resisting and acquiescing response behaviours. This was combined with broader theme analysis to identify major managerial coping strategies and possible areas for further skill and knowledge development.

Weathering is 'a basic social-psychological process that enables individuals to endure changes in a manner consistent with their personal and professional needs, goals, and values' (Raffanti, 2005a, p. 28). Based on the sizing-up and filtering stages of weathering, individuals determine how they will cope with change. The theory acknowledges the combination of personal, professional and social factors determining behavioural responses to imposed change and describes behaviours, rather than attaching negative and enduring psychological labels such as 'resistors' to the individuals concerned.

As a result of the research undertaken, I propose a new category, *Carefully Shaping Up*, as an

addition to Raffanti's resisting and acquiescing categories of coping. *Carefully Shaping Up* comprises cooperative yet adaptive behaviours used by health care managers in weathering change, and reflects the layers of complexity in managers' roles and responsibilities. It involves: adhering to personal and professional values and priorities; maintaining strong support networks and personal wellbeing; developing knowledge and skills; keeping informed; and taking responsibility for shaping change.

The accounts of the health care managers indicated areas of skills and knowledge development for consideration by South Australian health management educators when they review curricula and learning processes that aim to foster development of managers' capacities to cope with change. Because radical change has occurred across Australia, these insights are also of potential interest to postgraduate management educators and researchers nationally.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed …

Date ...

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PREFACE

In qualitative research, it is accepted that personal and professional factors will influence all aspects of the research: the questions asked, the design, the analysis and conclusions. Therefore, I will locate myself in the research by describing some of the personal experiences, views and professional context that have shaped my research interests and approaches.

During more than twenty years of working in the health sector as an allied health professional and manager, I experienced numerous changes ranging from major structural change, with significant impact, through to relatively minor changes of a local policy, procedure or process nature. I was asked to implement change and given opportunities to initiate change myself. Similarly, during my academic and program management career, there have been many changes within the universities, including Flinders University undergoing highly disruptive change at the time of writing.

Certainly, I considered that some changes were managed more effectively than others. I observed my own responses and those of colleagues and staff in situations where changes were imposed with little discussion or apparent consideration of the impact on groups and individuals in organisations. At times, there was little evidence of decision-makers and senior managers listening to people's concerns, or considering their constructive ideas about alternative ways of handling the process of change, which might have resulted in outcomes that were more positive. An imbalance of power in change initiatives, with particular groups (stakeholders) or individuals having more influence than others on decisions, has often been noticeable. In my experience, change progressed more smoothly when managers and employees appreciated the reasons, expected outcomes and timeframes for change, had opportunities to express their concerns and ideas, and were able to participate more actively.

My emotional responses to change, and those of colleagues and staff, have varied considerably from immediate acceptance through to anger and desperation. My own response has often been situational, depending on the severity of the perceived impact on people to whom we provided services. Anticipated impacts on work processes and outcomes, directly on me or on the work group or working relationships, have also influenced my response. After some initial grumbling, my personal resources and support systems have enabled me to recover, adapt, question, embrace or accommodate the change and plan next steps. If I felt that my personal values might

be compromised, or when the work was for various reasons no longer satisfying, I made plans to move on.

I feel that I am able to empathise with postgraduate health students who are stressed by the nature and rate of change confronting them, amid the continued pressure to provide high quality services with reduced resources. Often change is implemented with minimal concern for the consequences for individuals or groups and as a result they become distressed or disempowered by the processes and unable to respond more constructively.

One of the reasons for my move from the health sector into an academic role was my belief that postgraduate health care management education provides health sector managers with the knowledge and skills to manage more effectively within such a complex environment. I sensed that the overall calibre of managers and leaders within the system might advance over time, thus improving people management practices and ultimately services to patients and the community. I thought I might have valuable experiences to draw upon and would be able to contribute more to the development of health managers and their abilities to cope within the complex, pressured health system, from an academic position than from within the health system.

I have a clear preference for participative, humanitarian approaches to leading people and managing change and more of a communitarian than a corporatist political alignment. I am not opposed to changes where they are clearly justified and where outcomes benefit service users and people or stakeholders who are more vulnerable and less powerful within our organisations or society. At the macro-level, I am concerned by the contemporary policies of managerialism, neoliberalism and corporatisation that privilege members of society with financial and structural power.

In summary, my background, experience and worldviews (*weltanschauung*) underlie my interest in how health care management programs can assist health care managers to develop their coping and management capacities in the complex context of large-scale imposed changes. I recognised that I could not dismiss or ignore my experience and views in the research process. They provided a foundation and level of understanding that could be used for further learning from my conversations with research participants, whose experiences may vary from mine. I have used recognised qualitative research practices for ethics, quality and rigour to manage potential personal and professional influences.

CHAPTER ONE: INTRODUCTION

The aim of this chapter is to provide an overview of the 2013 health policy environment and impetus for the study, and the research aims, questions, methods and potential significance. A guide to the remaining chapters of the thesis completes the chapter.

National and State health sector policy

Overall expenditure on health care in 2010–11 represented about 9.3% of GDP (Australian Institute of Health and Welfare [AIHW], 2016a, p. 13) with the Commonwealth Government spending approximately $61 billion on health care nationally (AIHW, 2016a, p. 40). The South Australian Government contribution was approximately $4.5 billion, representing about 30% of its overall State budget (Department of Treasury and Finance [DTF], 2011, p. 38). By 2014–2015 expenditure had risen to 10% of GDP (AIHW, 2016a, p. 13) with the Commonwealth spending about $66 billion (AIHW, 2016a, p. 40) and the State government about $5.3 billion (DTF, 2015, p. 36). There had been numerous structural and funding changes over many years in response to concerns, as governments tried to contain health expenditure and improve quality.

The National Health Reform Agreement (Council of Australian Governments [COAG], 2011), signed by the Commonwealth, States and Territories in August 2011, resulted in major changes to health system governance, structure, funding and service delivery. The initiatives were designed to increase the level of funding transparency while also increasing control at local and regional levels. They incorporated mechanisms intended to improve accountability for the use of funds, the efficiency, integration, quality of health services, and equitable access to them for all Australians.

Global financial uncertainty had also resulted in reductions in Goods and Services Tax (GST) revenue to South Australia and income from other state taxes and charges. This placed further pressure on the State budget. All public sector departments were directed to reduce expenditure, with SA Health being required to save $184m over three years, including approximately $47m in staff savings (DTF, 2012, p. 63; SA Health, 2012a). Prior to 2013, many corporate services had been centralised (e.g. human resources (HR), financial functions) and clinical support services amalgamated (e.g. pharmacy, pathology, radiology). This entailed major service restructuring that affected managers and staff. In 2012, SA Health offered Targeted Voluntary Separation Packages (TVSPs) to Department of Health employees, creating projected salary savings of about $20 million dollars (SA Health, 2012b, 2012c). Further significant changes to staffing, funding, service

arrangements, clinical governance and models of care had been made around this time, because of health sector reviews (Gruner, 2014; McCann, 2012; Monaghan, 2012; SA Health, 2012d).

In 2012–2013, the State Government sought a saving of approximately $24 million within the $79 million budget originally proposed for non-hospital services (McCann, 2012). Consequently, state-level health promotion programs were defunded and several state-funded health services, such as the Women's Health Network, were closed, reconfigured or integrated with other primary health care services. These measures were designed to result in the loss of around 200 full-time equivalent positions, affecting mainly youth services, health promotion, children's services and women's services. Primary health care was deemed to be the responsibility of the new Medicare Locals, (McCann, 2012), primary health care organisations funded by the Commonwealth Government to improve integration and coordination of services (COAG, 2011, pp. 50-51). In their analysis of this period of change in South Australian health policy, Javanparast et al. (2017) noted the shift in South Australian priorities towards provision of individualised chronic disease management programs and away from community-based health promotion programs that focused on the broader social determinants of health.

Before the aforementioned changes had been effected, the health system was to undergo another major wave of change, about which there was widespread apprehension. October 2014 heralded the release of the Transforming Health Discussion Paper (SA Health, Department for Health and Ageing [SAH DHA], 2014), the start of even more ambitious system reform aimed at improving the quality, flexibility and efficiency of health service provision in South Australia. Following a short consultation period, plans for this four-year transformation program were released in March 2014. They included a reconfiguration, consolidation or integration of services provided by the various hospitals, including the New Royal Adelaide Hospital, as well as closure of some facilities and services, new capital works and numerous changes to the way in which health care was to be delivered (SAH DHA Health, 2015).

The terms 'radical' and 'major' are used interchangeably throughout the thesis to refer to complex changes which significantly disturb, disrupt or redesign organisational funding, structures, workforces and services (Chreim, Williams, & Coller, 2012; Huy, Corley, & Kraatz, 2014).

Impetus for the research

Health care middle managers work in highly pressured and politically charged contexts that are

fundamentally shaped by neoliberal approaches to health policy (Labonté & Stuckler, 2016; Lovell, Kearns, & Prince, 2013; Mooney, 2012). In this scenario, change is imposed, with an expectation of rapid implementation that is often disruptive in terms of work structures, roles and relationships. Managers are required to implement efficiency and performance measures, respond to calls for greater transparency and accountability, and restructure services. This sometimes includes making one's own position redundant. Moreover, they are expected to keep abreast of radical clinical and technological initiatives such as e-health and the introduction of bedside clinical systems across the sector. As a former health care manager and academic program coordinator, I can empathise with our postgraduate students who were trying to handle the nature and rate of change confronting them amid the continued pressure to provide high quality services with reduced resources.

In 2013, when I was coordinating the Flinders University's Master of Health Administration degree, the South Australian (SA) public health sector students worked full-time and studied part-time. The majority were working in managerial or senior medical, nursing or allied health positions. Students reported that they were experiencing ongoing high workloads and increasing levels of responsibility and accountability. Their comments indicated a sense of disempowerment, a lack of control, poor workplace morale, job insecurity, and insufficient attention to the constructive management of change. Conflict and bullying, and verbal and physical abuse from patients or clients, were said to be commonplace. This had also been noted by Lanctôt & Guay (2014) and was reported recently in the media by Pich (2017, May 17). Students referred to constant negative media publicity, such as reports of ambulance ramping at Flinders Medical Centre (ABC News, 2013, May 16; Schriever, 2013, February 20), occurring when there was insufficient Emergency Department capacity to admit new patients arriving by ambulance (Monaghan, 2012).

The aim of the Master of Health Administration degree is 'to enhance the competencies of middle level health service managers, equipping them to move to more senior management positions' (Flinders University, 2018). Entry to the program requires at least four years of relevant postgraduate professional experience as a foundation for strengthening knowledge and practical skills, critical thinking and problem solving capacities. Students' comments suggested that they valued the the program's action learning approach as well as the attention to practical experience in discussion and debate about current theory and practice.

In the context of major changes in the work environment and the consequential changes in the

students' roles, I sought to better understand both the impact of change and the strategies that South Australian (SA) middle managers found useful in dealing with change. I formed the view that to better equip managers to deal with and engage with health reforms, there is a need for education programs to be based on contemporary knowledge of their experiences and responses to change and their perceptions of the knowledge and capabilities they need to manage effectively during such periods of transformation.

Aims, research questions and methods overview

Anecdotal reports indicated that major externally imposed structural and funding changes affected middle managers in health care at a personal level and in their managerial work, as well as in their professional roles and relationships. There had been little research on the impact of, and response by, health care middle managers to major changes, despite the documented importance of their role in the implementation of change.

Thus the aims of this research were:

- to explore health care middle manager experiences of major changes in health service structures and funding in South Australia
- to identify the implications for postgraduate health administration courses at Flinders University and elsewhere.

The above aims were pursued through two research questions, the first being the primary question, which provided a basis for the second:

1. How were health care middle managers experiencing and making sense of major structural and funding changes in the health care sector underway since 2011–12?

   Areas of focus were the management of work processes or tasks (the work role), personal factors that shaped their perceptions of, experiences of and responses to major changes, professional responsibilities and relationships (the professional role), and judgements on any consequences for patient care and services provided.

2. What might be the implications for post-graduate courses in health administration at Flinders University and elsewhere?

   Areas of focus here were the overall direction of the curriculum as well as specific components (topics), and learning processes.

An interpretive qualitative research design was used to explore how middle managers experienced and viewed radical change in health care. Final ethics approval for the research was received from the Finders University Social and Behavioural Research Ethics Committee (SBREC) in July 2014. Data were collected using semi-structured interviews with seven middle managers in health care, chosen to include a range of health professions, genders, ages and locations in Adelaide, South Australia. These individual case studies provided the basis for learning about, and from, individual perceptions and responses to rapid large-scale changes, together with the participants' thoughts on the role, relevance and usefulness of education programs in assisting them to deal with such changes.

All interviews were undertaken during December 2014 and January 2015, prior to implementation of the Transforming Health initiatives. The text from the transcribed digital recordings provided the foundation for a description of the participants' experiences of major change and for identifying relevant themes as a basis for comparison. The theory of weathering change, developed by Raffanti (2005a, 2005b), provided the framework for analysing the participants' experiences of, views of, and strategies for coping with pervasive imposed change. Raffanti (2005a) defined 'weathering' as 'a basic social-psychological process that enables individuals to endure changes in a manner consistent with their personal and professional needs, goals, and values' (p. 28) and as having three stages: '*sizing-up, filtering* and *coping'* (Raffanti, 2005a, p. 28 [original emphasis]).

Significance of the proposed research

There is a relative paucity of research on how middle managers in health care experience and make sense of contemporary radical changes in the sector, and about how they might develop the capabilities they perceive to be useful in dealing with such changes. While several studies (Balogun & Johnson, 2004; Balogun, Hope-Hailey, Cleaver, & Stuart, 2015; Bryant & Stensaker, 2011; Doyle, Claydon, & Buchanan, 2000; Huy, 2011; Teulier & Rouleau, 2013) have focused on non-health organisations, a few international studies (Buchanan et al., 2013; Hyde, Granter, Hassard, McCann, & Morris, 2013) have targeted the health sector. In an Australian study that focused on the lived experiences of health care managers and their broad training and education needs, Briggs (2008) suggested the need for more support, coordination of, and investment in, management training. Through her exploration of the emotional impact of system restructuring, Thornberry (2012) identified the need for more effective change management processes, especially communication.

From a different perspective, Hague (2015) indicated that it was important for organisations to identify and enhance health care manager 'hardiness' (p. 9), which assists them to deal with challenging and stressful situations. These Australian studies (Briggs, 2008; Hague, 2015; Thornberry, 2012) were completed during different periods and in different locations of health reform or in targeted specific aspects of individual responses to change.

Searches of the literature and South Australian government reports did not locate any studies focusing on middle manager experiences of major changes in South Australia, the personal and professional impacts of such changes on them, or potential implications for postgraduate education in health care management. My interpretive study was designed as a structured process to gain a deeper understanding of the contemporary experiences and responses of middle managers in South Australia. My purpose was to ascertain whether and how postgraduate management education might assist with the development of capabilities for dealing with change. The study will contribute to the literature on postgraduate health care management education and highlight areas for further research.

The research also provides health executives and managers in SA Health and the Local Health Networks with externally collected qualitative data and insights about manager perceptions of current changes and their impact. This may assist them with managing change more effectively in the future. Furthermore, it may provide opportunities for future health sector—university collaborative research on the impacts of, and processes for, implementing non-negotiable organisational change, as well as developing organisational processes and the capabilities of health care managers throughout the system to cope and manage constructively in such situations.

Structure of the thesis

Chapter 2 introduces literature relating to the nature of radical change and other definitions of terms used in the research. It addresses the roles of middle-level health service managers, the effects of and their responses to change, and introduces the theory of weathering (Raffanti, 2005a, 2005b). Research methods and design are discussed in Chapter 3. Chapter 4 details data from the interviews broadly covering the areas explored in the interview questions. Although these data have been influenced by my own background and experiences (as outlined in the Preface), numerous quotes have been included to allow participants to express their ideas in their own words. Using the theory of weathering (Raffanti, 2005a, 2005b), Chapter 5 is an analysis,

comparison and discussion of the participants' experiences and views of major change and how they coped with change. It introduces a new behavioural category called *Carefully Shaping Up*, to represent the coping responses of middle level health care managers. Finally, Chapter 6 discusses the main strategies used by health care managers to weather change, and possible ways of strengthening *Carefully Shaping Up* behaviours, for consideration by postgraduate management education programs.

CHAPTER 2: LITERATURE REVIEW

This chapter provides a background to the nature of radical or major change. It also provides a definition and classification of middle managers and outlines their tasks and roles in strategic management and change. It provides an overview of the psychological and social effects of organisational change and the theory of weathering (Raffanti, 2005a, 2005b), as the framework used for analysing middle manager responses to major change.

The literature review was undertaken as two interrelated parts. First, a broad exploratory review was conducted as part of the research proposal process. Secondly, following development of the research questions, the conduct of data collection, and substantial completion of the inductive analysis, I took a more systematic approach to searching the literature, targeting publications relevant to the research questions and the insights and ideas that I was forming during the analysis. Further details of the literature review procedure appear in Appendix 1.

The nature of radical or major change

There is an abundant and diverse range of literature on the types and management of organisational change. Several authors (Chreim et al., 2012; Greenwood & Hinings, 1996; Huy et al., 2014; McNulty & Ferlie, 2004) have used the phrase 'radical change' or 'transformational change' to describe major changes to organisational funding, structures, workforce and services provided. This type of change has been defined as 'intended and multidimensional change that departs radically from an organization's past precedents, aims at large-scale readjustments, and is complex and systemic' (Lee, Weiner, Harrison, & Belden, 2012, p. 116) or 'fundamental change within the organisation requiring a shift in strategy, structures, systems, processes and culture' (Balogun & Hope-Hailey, 2008, p. 21).

Burnes (2014) described two major historical approaches to change, namely 'planned' and 'emergent' (p. 415), as those directed from the top and those enabling broader employee involvement respectively. He noted that 'even taken together, [they] do not cover all change situations … [including those contexts requiring] … rapid and radical structural change' (p. 416). Incorporating the views of British, American and Australian change management experts, he developed a four quadrant model (p. 409) to guide the analysis and design of change. The focus and approach to change vary according to the speed and the scale of change. (See Appendix 2 for a summary of the four approaches). One quadrant represented the imposed top-down 'Bold

Stroke' approach described by American authors, Kanter, Stein and Jick (1992, pp. 492-495) for situations where rapid major organisational structure change is required as a strategic response to adverse environmental conditions.

Burnes (2014, p. 414) recognised the danger of using his contingency framework too prescriptively and emphasised flexibility in choice and customising to the context. Johnstone, Dwyer, and Lloyd (2006, p. 166) also noted that contingency approaches to managing change privileged the ideas and knowledge of organisational leaders over that of other employees. Nevertheless, I found the Burnes (2014, p. 409) framework helpful in understanding the reasons for using a top-down approach in South Australia rather than the alternative approaches for which more time was required.

The Australian large-scale health sector 'hard' (Lindorff, Worrall, & Cooper, 2011, p. 233) changes initiated by national and state-level governments within tight political (electoral) and budgetary timelines were implemented by government departments in a top-down manner (Javanparast et al., 2017, p. 11). Within such a context, there may be no time to employ slower consultative or participative processes (Burnes, 2014, p. 410). As indicated by Burnes (2014, p. 412) and Kanter et al. (1992, p. 492), radical strategic change to financial imperatives, technology and structures through restructuring or downsizing is not people- or culture-focused: it is implemented through coercive and directive means, which also aim to overcome internal power battles.

Kanter et al. (1992, pp. 492-495) argue that, for more sustainable transformation, the bold strokes approach can be followed by the slower 'Long March', where greater consideration is given to people in the organisation. This is more effective for initiating desired cultural change. These more democratic processes occur in a slower, planned and incremental way and involve employees from numerous hierarchical levels working together to develop more effective work relationships and operational processes (Burnes, 2014, p. 410-412).

What are health service managers and what do they do?

Huy (2001) defined middle managers as 'any managers two levels below the CEO and one level above line workers and professionals' (p. 73). Similarly, Wooldridge, Schmid & Floyd (2008) took a wide view of middle managers as 'located below top managers and above first-level supervision in the hierarchy' (p. 1192). They emphasised 'their access to top management coupled with their knowledge of operations' (p. 1192) and their mediating function in strategy implementation.

Although offering some guidance, the above definitions are insufficiently nuanced for the complex structures of the health sector. Managers are drawn from many different disciplines of health care, such as medicine, nursing, allied health (e.g. physiotherapy, pharmacy, speech pathology); central administration and support areas, such as human resource (HR) and finance departments; and investigatory services, such as radiology, pathology, and laboratories. Clinical managers or hybrid managers have a clinical background in medicine, nursing or allied health, and are responsible for leading a team of health care professionals, in addition to fulfilling organisational expectations for efficiency and effectiveness of service provision. The role is considered to be complex and varies according to the situation and profession. Furthermore, the term 'middle manager' tends to be shunned, as most clinician managers identify with their professional role rather than the managerial one (Hyde, Granter, McCann, & Hassard, 2012, p. 12), even for population census purposes (Martins & Isouard, 2012).

The Australian and New Zealand Standard Classification of Occupations (ANZSCO) provided a general definition of managers as those who:

> plan, organise, direct, control, coordinate and review the operations of government, commercial, agricultural, industrial, non-profit and other organisations, and departments (Australian Bureau of Statistics [ABS], 2013a).

The ANZSCO also described the expected qualifications, skills and tasks associated with this broad role while dividing the major group into several subgroups of managers. These were then further divided into unit groups. Health service managers were included in the unit group of Health and Welfare Services Managers with a number of occupations listed. These managers 'plan, organise, direct, control and coordinate the professional and administrative aspects of health and welfare programs and services' (ABS, 2013b). Nevertheless, this remains a rather broad category, spanning executive level positions, such as Medical Administrators and Directors of Nursing, through to departmental or service heads, such as Chief Pharmacists or Community Care Team Leaders, who would normally be considered middle management. It does not include Nurse Managers, regarded as a unit group within the Midwifery and Nursing Professional Group. It omits other middle managers, such as service deputy directors, managers responsible for risk and governance or quality improvement, human resources, finance, and information technology. The health categories need further development if managers in the health sector are to be identified more effectively (Martins & Isouard, 2012).

In the absence of a widely accepted definition of a middle manager (Davis & Fisher, 2002) or health service manager (Briggs, Smyth, & Anderson, 2012), they are described in terms of what

they do, their competencies or capabilities (see Table 1 for examples).

Table 1: Health care manager descriptors

Description	Sources
Tasks or activities performed	Arman, Dellve, Wikström, & Törnström, 2009; Braithwaite, 2004; Braithwaite et al., 2004; Braithwaite & Westbrook, 2011; Braithwaite, Westbrook, & Mallock, 2007, 2008
Functions or roles	Hyde et al., 2013; Mintzberg, 1994a, 1994b, 2002; Wooldridge et al., 2008
Competencies	Leggat, 2007; Liang & Howard, 2010; Liang, Leggat, Howard, & Koh, 2013
Capabilities	Briggs, Smyth & Anderson, 2012

Terms used for the role include 'manager', 'non-executive manager', 'mid-level manager', or the award classification level and title associated with the range of 'middle-manager' positions.

In South Australia, the definition of a 'middle' manager can be broadly determined from the relevant classifications in the South Australian industrial awards and enterprise agreements (South Australian Employment Tribunal [SAET], 2018a, 2018b, 2018c, 2018d) for the relevant professions. (See section on 'Case selection' in the next chapter for more detail on the relevant classifications.) These exclude executive and very senior management levels in the public health sector.

Middle manager roles in strategy implementation and change management

Much of the literature on strategic change and restructuring has focused on the roles of organisational leaders, with middle managers often depicted in a negative way. They are seen as resistant to change, scapegoated by their senior managers (Fenton-O'Creevy, 2001) and casualties of de-layering processes (Balogun, 2003; Currie, 1999; Huy 2001; Hyde et al., 2012, p.11). Nevertheless, there is a growing body of literature (Balogun, 2006; Birken, Lee, Weiner, Chin, & Schaefer, 2013; Canales 2012; Huy 2001; Kanter, 1982; Wooldridge et al., 2008) stressing the important role of middle managers in strategy development, innovation and change implementation. To gain a better appreciation of middle manager perspectives and how these affected the implementation of change, Balogun (2006) explored how middle managers 'make sense' (p. 29) of their experiences and responses to top-down change. Sense-making refers to the: 'ongoing retrospective development of plausible images that rationalize what people are doing' (Weick, 2008, p. 1404). It incorporates interpretation of information gleaned through interaction

with others. Given the influence of different individual backgrounds, experiences and cognitive frameworks, the sense made of situations varies from one person to another. Sense-making and agency are interlinked in that any resultant action leads to further sense-making. In particular, Balogun (2003) discussed the key 'change intermediary' (p. 69) roles undertaken by middle managers and their ability to 'make sense of' (p. 74) the required change, so that they could translate it into appropriate action.

As in other industry sectors, health service managers have important roles in managing change and reform (Briggs, Cruickshank, & Paliadelis, 2012; Carlström, 2012; Currie & Procter, 2005). Hyde et al. (2013), in a large ethnographic study within the UK National Health Service (NHS), found that radical policy and structural changes had had major impacts on the roles, behaviours and identities of middle and junior managers. Another British study by Buchanan et al. (2013) focused on understanding how middle and frontline manager roles and their intensity or pressures had changed in response to ongoing health reform. This study paid specific attention to identifying those skills that would strengthen the capacity of health care managers to manage change following 'extreme events' (p. 8), those serious incidents threatening patient safety.

Radical change, as described above, has implications for middle managers personally, for how they work, for their work group and for others in the organisation (Balogun, 2003; Worrall, Parkes, & Cooper, 2004). However, the significant amount of 'emotion work' (Clarke, Hope-Hailey, & Kelliher, 2007, p. 92) undertaken by managers goes largely unrecognised (Clarke et al., 2007, p. 100; Huy, 2002). Managerial emotion work, or emotional labour, refers to how managers express and suppress their emotions 'for the benefit of others' (Clarke et al., 2007, p. 93) while undertaking their responsibilities, such as managing the various stages of change initiatives.

Individual psychological and emotional attitudes and responses to change

Although their important role in the implementation of strategic change has been acknowledged, middle managers are also the recipients of change strategies. Like all employees, they have their own experiences and views of imposed change, as well as attitudes and responses to them. Many psychological studies analyse individual psychological and emotional responses to change. By contrast, social theorists and organisational behaviourists analyse broader aspects such as culture, power, politics, social identities, relationships, roles and structures.

Understanding the possible psychological effects of change and 'managing the reactions' to it pose

significant challenges for those seeking to implement change (Jick & Peiperl, 2011, p. xxiv). Furthermore, Dasborough, Lamb and Suseno (2015) and Huy et al. (2014) found that emotional responses to change depended on how individuals perceived and experienced the change and these emotional responses would be further modified by their ongoing experiences of the change process. With sustained major restructuring of systems and with failure rates of change activities reported to be as high as seventy percent (70%) (Balogun, 2006; Burnes, 2015), it is not surprising that middle managers react cynically to the next round of changes.

Employee resistance is often claimed as one of the major reasons for change process failure (Burnes, 2015; Oreg, 2006) that needs to be addressed actively by organisational leaders and change agents (Jones & van de Ven, 2016; B. C. Lines, Sullivan, Smithwick, & Mischung, 2015). It has been attributed to a perceived level of threat to an individual's or a group's livelihood, status, identity, work relationships, workload, work outcomes or services provided, and a natural desire to maintain the status quo (Johnstone et al., 2006, pp. 163-164). Perceptions of injustice or unfairness may also contribute (Georgalis, Samaratunge, Kimberley, & Lu, 2015; Oreg & van Dam, 2009). In addition to the attention at an individual level, other theories of resistance relate to the process of change. Relevant considerations include degree of employee participation, the context of change, level of cognitive dissonance between personal and organisational values, and any perceived breaches of the psychological contract between the individual and the organisation (Burnes, 2014, pp. 314-317).

The term 'resistance' is used mostly in a negative sense, implying that the problem rests with the employee or work group rather than with the nature of change, and its implementation or work context. Entrenched negative assumptions about employee resistance may dictate the manner in which changes are introduced, including not listening to employees labelled as 'resistant' (Durdy & Bradshaw, 2014), which may in turn lead to further resistance (Heynoski & Quinn, 2012). Burnes (2014, p. 312) suggested that change may have been poorly planned, not carry benefits for the organisation, and be influenced too greatly by vested interests. Therefore, rather than conscious resistance, managers and other employees often have genuine non-personal concerns (Jick & Peiperl, 2011, p. xxv), such as identifying potential problems with work processes or outcomes, or foreseeing negative impacts of change on patients and communities. In this way, resistance can be constructive (Burnes, 2014, p. 312; Courpasson, Dany & Clegg, 2012; Ford & Ford, 2010).

Table 2 provides examples of other literature addressing psychological factors and responses to

change.

Table 2: Other psychological factors

Factor	Sources
Perceptions of organisational change	Jones et al., 2008; London, 2001
Attitudes to organisational change	Bordia, Restubog, Jimmieson, & Irmer, 2011; Giauque, 2015; Watson & Chou, 2006
Motivation, job satisfaction, organisational commitment	Esteve, Schuster, Albareda, & Losada, 2017; van der Voet & Vermeeren, 2017
Resistance	Ashcraft, 2008; Bailey & Raelin, 2015; Burnes, 2015; Courpasson et al., 2012; Ford & Ford, 2010; R. Lines 2004; Oreg, 2006; Rafferty & Jimmieson, 2017; Thomas & Hardy, 2011
Uncertainty, "contrariness"	Bordia, Hunt, Paulsen, Tourish, & DiFonzo, 2004; Dopson & Neumann, 1998
Mental health, stress, wellbeing	Bamberger et al., 2012; Giauque, 2016; Kelliher & Parry, 2015; Lindorff et al., 2011; Noblet & Rodwell, 2009; Rafferty & Griffin, 2006; Smollan, 2015
Trust	Agote, Aramburu, & R. Lines 2016; R. Lines, Selart, Espedal, & Johansen, 2005

Social, relationship and role impacts

Context and organisational factors, as well as psychological and behavioural attitudes and responses to change, appear to be multi-faceted and highly inter-related.

The positioning and roles of middle managers within a health care organisation involve interaction with staff above, below and equivalent to themselves in the hierarchy, as well as with a broader network of internal and external work-related committees, working groups and professional bodies (Checkland, Snow, McDermott, Harrison, & Coleman, 2011). Radical organisational reform and restructuring often disrupts employee roles and identities, the distribution of power, established social networks within and beyond the organisational boundaries, and work-life balance. Examples of the literature in this area are listed in Table 3.

Table 3: Social and role factors

Social impact of change	Sources
Positions, roles, responsibilities, reporting lines, and thus working relationships	Fitzgerald et al., 2006; Hyde et al., 2013; Kippist & Fitzgerald, 2009; Morris & Farrell, 2007
Redistribution of power within the organisation	Buchanan & Badham, 2008; Kanter, 2010; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010
Middle managers experiencing pressures from above, below and from peers	Braithwaite, 2004; Braithwaite et al., 2007, 2008; McConville, 2006
Middle managers grappling with personal, professional and social identity issues	Elliott, Kennedy, & Raeside, 2015; Price & van Dick, 2012; Slater, Evans, & Turner, 2016
Work-life balance	Ford & Collinson, 2011; Ghislieri, Gatti, Molino, & Cortese, 2017

Organisational context factors such as leadership support and a change-oriented climate that encourages participation and information sharing have been highlighted as important in reducing resistance (van Dam, Oreg, & Schyns, 2008). Similarly, there is a growing literature on developing change readiness (Holt, Helfrich, Hall, & Weiner, 2010; Shea, Jacobs, Esserman, Bruce, & Weiner, 2014; Vakola, 2014) and the use of change agents in organisations (Burnes, 2014, p. 318-319; McDermott, Fitzgerald, & Buchanan, 2013; Vakola, 2013) to enhance the success of change initiatives.

The role of the interplay between social structures and employee agency in change has been analysed extensively by scholars such as Archer (2010) and Giddens (1984). Social structures, exemplified by the workplace, support individual and group processes and behaviour that in turn constantly re-shape the structures. Therefore, individuals and groups are not viewed as passive recipients of radical change. They have conscious choices about what they will do or how they respond. Power can be seen as an inherent component of agency, exerted through formal and informal relationships (Giddens, 1979, p. 93). Using the work of Giddens (1984) and Weick (1995), Braithwaite (2006a) explained how attempts to change social structure and employee behaviour through redesigned organisational charts in Australian acute health care settings, did not change underlying social structure or practices. Long-standing professional structures, values, behaviours and allegiances persisted, reducing the effectiveness of imposed structural changes aimed at improving professional collaboration. Thus, professionals, as agents, played a key role in shaping social structure (Braithwaite, 2006a, 2006b; Gover & Duxbury, 2012; Mintzberg, 2014, p. 363).

The theory of weathering change

The theory of weathering (Raffanti, 2005a, 2005b) was chosen as the analytical framework for this thesis because it considers only enforced, comprehensive change, and encompasses the combined influence of context, nature of change, and psychological and social factors on how individuals respond to change. Using the Glaser and Strauss (1967) grounded theory methodology, Raffanti (2005a; 2005b) developed the theory of weathering to describe employee behavioural responses to 'pervasive change' (2005a, p. 28). He defined 'weathering' as 'a basic social–psychological process that enables individuals to endure changes in a manner consistent with their personal and professional needs, goals, and values' (p. 28). Individuals focus primarily on 'getting through' (Raffanti, 2005a, p. 99) the change rather than on the process of implementation or the potential to thrive through the change. Responses to ongoing change are complex, fluid, unpredictable, and subject to continuous modification, while varying according to context and being socially mediated and constructed (Raffanti, 2005a, p. 81).

While Raffanti (2005a) was apparently not keen to use the term 'resisting', given its negative connotations, the term arose *in vivo* in his grounded theory study, thus necessitating its inclusion in the theory of weathering. By focusing on behaviours characterising various forms of resisting, he avoided attaching psychological labels to people or any need to apply judgements of positivity or negativity (Raffanti, 2005a, p. 83).

In contrast to 'resisting', 'thriving' on change was beyond the scope of Raffanti's study because the term 'thriving' is associated with embracing and facilitating change rather than weathering it. However, I have used the following definition of 'thrive' to provide a foundation for comparison: 'To grow or develop well and vigorously; to flourish, prosper' ('thrive, v.', Oxford English Dictionary, 2017). Like 'weathering', thriving is not a consistent behavioural response to change. As change progresses and personal and professional circumstances change, individuals may move from thriving to weathering behaviours and vice versa. Furthermore, as a sentient, social and emotional being, an individual's behavioural response to one change may differ from his or her response to the next change or those experienced previously.

There are a number of limitations to using Raffanti's (2005a) research. His study was conducted in the United States, which has a different political, social and economic context to Australia. The majority of participants were from education and not restricted to middle management roles, and so the sample groups are not directly comparable. Most participants in Raffanti's study were

educators, but he included a few from non-educational organisations for comparison. However, Raffanti did not seek to describe and explore their experiences per se; he sought to develop a theory for explaining behaviours. It is the theory in which I am interested. Some of Raffanti's terminology can be confusing but he developed this according to grounded theory principles, e.g. the use of 'overwhelm' as a noun and 'illusioning' as a verb. The word 'acquiescing' was used to denote a category of resisting behaviours, whereas its Australian use suggests compliance behaviour, with less emphasis on resisting.

Despite these limitations, I came to the view that the theory of weathering would serve as an illuminative framework for analysing health care managers' experiences, views and responses to radical change. It enables a more holistic approach to analysis that includes both the individual and social aspects of change and targets behavioural responses to radical change, as opposed to labelling individuals as resistors.

Five conditions for weathering

For weathering to occur, individuals must perceive that change is 'pervasive' (Raffanti, 2005a, p. 2), creates '*apprehension'*, is '*imposed'* by someone in '*authority'* and requires individuals to assume some '*accountability'* (Raffanti, 2005a, p. 28 [original emphasis]) for managing the process and outcomes. In the absence of these conditions being met, people are demonstrating indifferent or thriving behaviours.

Dimensions of weathering

'*Power, control, protection, time* and *culture'* (Raffanti, 2005a, p. 29 [original emphasis]) form five interrelated aspects of weathering which individuals seek to address as they work out how to survive the change. They try to determine their levels of power and control over change, or how to access other sources of these, as well as the protected or non-negotiable elements, the likely time period for change implementation, and the influence of an organisation's culture on change processes and weathering behaviours.

Stages of weathering

The weathering process has three phases: '*sizing-up, filtering,* and *coping'* (Raffanti, 2005a, p. 28 [original emphasis]). Initially individuals try to make sense of imminent change through their own reactions to it and their observations of it, but also through their workplace and other social interactions. Within the framework of their own backgrounds and personal and professional lenses and worldviews, they then determine their coping responses. Constant reappraisal of the

situation means that people's responses may change a number of times.

In his thesis, Raffanti (2005a) also paid attention to the concept of '*togethering'* (p. 97 [original emphasis]), which represents social support strategies that occur in all phases of weathering and in all coping behaviours. To endure change, people get together voluntarily with colleagues experiencing similar circumstances. They support each other, vent their emotions and discuss their issues with change and possible coping strategies. It requires empathy, honesty and trust. Raffanti (2005a) stated:

> It is quite natural for people who are feeling apprehensive to seek out sounding boards. People reach out to trusted colleagues to empathize about the personal and professional strains of change. This provides an important emotional outlet that forges bonds and friendships (p. 98).

Tables 4 – 6 summarise the key features or behaviours associated with each of the stages of weathering, as defined by Raffanti (2005a, pp. 81-100).

Table 4: Sizing Up phase

Sizing Up The initial socially-mediated reaction to, and interpretation of, the change directive A preparatory practice of observation- and information-gathering, including the personal immediate emotional reactions as well as those of others	
Behaviours or features	**Description**
Recording	Information from observations, discussions and other forms of communication inform a preliminary appraisal of the change which is then used in the filtering phase
taking note	Active process of discussion with others and seeking further clarification on the change, such as timelines, change processes, outcomes and possible implications
tuning out	Passive process where attention is selective, focused only on that information relevant to an individual's response to change Can range from a total lack of attention to the partial attention of people completing other priority tasks or socialising at the same time A way of coping with the volume of information or information that they don't really want to hear such as the possibility of increasing workloads
Taking Cues	The impressions that the views and behaviours of other people have on one's perception of an issue
nay-saying	Negative or non-compliant behaviour or that which is strongly critical of an initiative People can choose to agree or disagree with the nay-sayers
buying-in	Supportive of initiatives Does not depict weathering, but nonetheless is observable by those dealing with

	change

Table 5: Filtering phase

Filtering Individuals filter the data gathered in sizing-up, so that they can choose a response to change from several alternatives that they perceive to be available. The filters are highly interdependent. A more conscious process than sizing-up and so people can explain their choices	
Behaviours or features	**Description**
Professional filters	Response to change is influenced by professional background and relationships, and individual views about work and career
professional paradigms	The meaning attached to being a professional such as a teacher or nurse One's beliefs about acceptable behaviours, role content and expectations, role autonomy, professional respect, concepts of service quality
career orientations	Service duration, such as '*long-hauling'* (Raffanti, 2005a, p. 70 [original emphasis]), where one expects to contribute to an organisation for a substantial length of time versus *short-timing'* (Raffanti, 2005a, p. 72 [original emphasis]) when considering retirement or other employment opportunities Perspectives on work, such as people being concerned for the development of their careers and leadership responsibilities, called '*careering'* (Raffanti, 2005a, p. 73 [original emphasis]), differentiated from those who are more concerned with effects of change on everyday work, called '*jobbing'* (Raffanti, 2005a, p. 73 [original emphasis])
Personal filters	Influence of personal background and values on response to change
personal agendas	Attention is directed to how a response to change might affect the individual's financial and social or family situations and personal job satisfaction
emotions	Emotional responses to change depend on the perceived compatibility with an individual's beliefs, attitudes and agendas The most relevant emotions identified by Raffanti (2005a) were '*fear'*, '*frustration'* and '*overwhelm''* (pp. 76-79 [original emphasis])

Table 6: Coping phase

Coping Sizing up and filtering form the foundation for coping An iterative process during a time of change as the personal, professional and work contexts change Categories are not discrete, recognising the highly individual nature of coping strategies	
Behaviours or features	**Description**

Resisting	A range of possible responses or behaviours that do not totally oppose an initiative but strive to reduce the rate of change
sabotaging	Covert deliberate undermining and hindering change Big gap between the organisational vision for change and what is acceptable to the employee As well as the change initiatives, organisational leaders and structures may be targeted by individuals and alliances
hiding out	Partial implementation without drawing attention to oneself, 'keeping one's head below the parapet' Time pressures and lack of professional respect are contributory factors to creating a protective haven
biding time	Waiting for the change to go away or for leadership turnover The lack of engagement is also based on differences in leader and employee views about the changes and a perception of the cyclical nature of change
illusioning	Partial compliance but actively and overtly 'keeping up appearances' Giving the illusion of participating in change, including keeping of relevant documentation Driven by the fear of reputational damage Allows employees to become more engaged if the change persists
deflecting	Pretending to participate but redirecting discussions to related issues Introducing various, although superficially plausible, concerns or using delaying strategies Health care workers might use impact on patients as a cover for avoiding change Change might be compared with current practices, trying to find substantial overlaps to reduce the required work in the change process, which inevitably means that the load is transferred to others who support or acquiesce to change
bargaining	Reaching implicit agreements between the individual and the leader where liberal leeway is given on process, so long as the outcomes are achieved i.e. there is a degree of reciprocity in the arrangement 'Co-illusioning' (Raffanti, 2005a, p. 92), protecting both parties Some may try to bargain by ingratiating themselves with their leaders through performance of voluntary tasks or roles perceived to be of value to the leader. In turn, they will expect not to suffer negative repercussions when they resist change Can cause other staff to become confused about the need to comply with change
Acquiescing	People do not fully accept change but comply as it is in their interests to do so A sign of '*resilience*' (Raffanti, 2005a, p. 94 [original emphasis]) Enables people to 'endure the change (which they might believe to be merely a flavor of the month) or to at least get through the initial negative emotions' (Raffanti, 2005a, p. 94)
by the	Strict adherence to directives, even if this results in less optimal outcomes

booking	People decide not to use their professional judgement as they do not want to be held accountable Some might be trying to destabilise the change
good little soldiering	Individuals intend to make a 'good faith effort' (Raffanti, 2005a, p. 95) Rely on being able to use their professional judgement to make minor change to processes so that they can meet the desired outcomes Might be combined with bargaining to meet joint objectives Can lead to burnout and possibly resistance behaviours

Summary

The literature indicates that the changes in health sector structure and funding, as a result of national and state-level health reform policies, can be considered to be major, 'radical' or 'Bold Stroke' changes as opposed to more incremental approaches. Consistent with the literature, radical change implementation is typically top-down and autocratic in nature, and a much lower priority is given to the needs of people impacted by the change than to the financial and policy imperatives.

Middle managers have important roles in the implementation of such strategic and structural change, but their involvement is often regarded in a negative manner. Their contribution and the 'emotion work' in managing change are rarely acknowledged. Change processes have personal, psychological, emotional and social impacts on the people involved but few studies address the impact of radical change on middle managers in health care and their responses to such changes. Middle managers are not passive recipients of change. Through interaction with others, they try to 'make sense' of their situation or experience, which in turn leads to some form of action, indicative of personal agency.

There is little Australian or South Australian health sector research on how middle managers experience and make sense of major changes and how they might develop the capabilities that they perceive to be useful in dealing with such changes. The theory of weathering (Raffanti, 2005a) provides an illuminative framework for analysing health care managers' experiences, views and responses, as it incorporates the personal, professional and social factors determining behavioural responses to imposed change and does not seek to attach static psychological labels to individuals experiencing such change.

CHAPTER 3: METHODOLOGY AND METHODS

This chapter explains the principles used in choosing the qualitative case study approach, and describes the research methods, limitations and validation processes, while raising and dealing with some ethical issues.

According to Crotty (1998), methodology refers to 'the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes' (p. 3). The interpretive qualitative research design for this study is underpinned by a worldview that different people have varying understandings of their world and that their experiences cannot be divorced from the context and culture in which they live and work. Thus, people construct meaning as a result of their interactions with the world and the people around them. This reflects a constructionist perspective of knowledge (Crotty, 1998, p.9). The researcher then tries 'to make sense of (or interpret) the meanings others have about the world' (Creswell, 2013, p. 25).

My research questions sought to explore the similarities and differences in managers' actual experiences of, feelings about and responses to imposed large-scale change. This allowed me to gain insight into their perceptions about possible skills, capabilities and knowledge contributing, or potentially contributing, to their ability to cope with and manage such changes.

Research methods

A case study approach was selected from the range of possible interpretive qualitative research methods as the one most useful for answering my research questions. Yin (2009) defined case study as:

> an empirical inquiry that
> - investigates a contemporary phenomenon in depth and within its real-life context, especially when
> - the boundaries between the phenomenon and context are not clearly evident (p.18)

and suggested that it is an advantageous research method when:

> a 'how' or 'why' question is being asked about
> - a contemporary set of events,
> - over which the investigator has little or no control (p. 13).

I chose case study as a method because it enabled me to investigate the major question about *how* health care middle managers experience significant imposed structural and funding change (a

contemporary phenomenon or issue) where structure and funding and the health care delivery context are very clearly intertwined and over which I had no control.

Liamputtong (2013, p. 199) stated that case study research has been criticised for lack of clarity in its design and methods (p. 199) and lack of generalisability and rigour (p. 215). However, it provides a way of exploring phenomena in depth, adding 'new understandings and meanings' (p. 215). Case study research forms a valuable qualitative approach where 'the larger question is to understand the wider social phenomenon of which it is a case' (Richards & Morse, 2013, p. 76).

With their concentration on 'particularization, not generalization' (Stake, 1995, p. 8) or 'universalism' (Abma & Stake, 2014, p. 1150), individual case studies using semi-structured interviews offer the opportunity to learn about, illuminate and analyse the personal perceptions and experiences of radical change of a prescribed number of health care middle managers drawn from a range of professions in the public health sector in South Australia. The emphasis is on understanding each case well, developing a thick description (Geertz, 1973) which 'describes and probes the intentions, motives, meanings, contexts, situations and circumstances of action' (Minichiello, Aroni, & Hays, 2008, p. 5) or a 'rich picture – with boundaries' (Thomas, 2011, p. 21). At the same time, the case study method highlights the complexity of each case and promotes learning from it (Abma & Stake, 2014). Each case complements, broadens or adds depth to the picture of experiences, without losing the 'intrinsic value of the case' (Abma & Stake, 2014, p. 1150).

Case selection

Rather than sample size being the priority in case studies, case selection is based on participants having specific rich information addressing the research questions (Liamputtong, 2013, p. 14; Patton, 2002, p. 242) and providing a 'balance and variety' and 'opportunity to learn' (Stake, 1995, p. 6). The units of data input and then subsequent analysis (Patton, 2002, p. 228) for this research were seven individual health care middle managers from the Greater Adelaide Statistical Area (ABS, 2016), forming a manageable purposive sample. This included managers from a few small hospitals managed by the Country Health SA Local Health Network.

Middle-level managers were chosen as they form the majority of students in the Flinders University postgraduate health administration program and, as several authors (Balogun, 2006; Canales, 2012; Huy, 2001; Wooldridge et al., 2008) have argued, middle managers have an

important role in managing change. Enrolled Flinders University health care management students were not eligible to participate. The requirement for participants to have at least three years of management experience was discussed with established Australian health service researchers, who confirmed that this was a reasonable minimum timeframe for managers to acquire sufficient experience on which to base their comments.

To ensure breadth of perception, experience, insight and response, participants were sought from each of the disciplines of nursing, allied health, and administration. I aimed to achieve a balance in gender, a variety of age and years of managerial experience and to include people who had diverse educational backgrounds. The medical discipline was not included as it was difficult to identify positions at a similar level to those in nursing, allied health and administration. In addition, the nature of their employment is quite different, for example, many are sessional visiting staff.

The following occupational classifications in the relevant South Australian industrial awards or enterprise agreements (South Australian Employment Tribunal [SAET], 2018a, 2018b, 2018c, 2018d) incorporate managerial responsibilities or streams. These were used to guide case selection (see Table 7). (See Appendix 3 for further detail on the classifications).

Table 7: Management classifications: South Australian Public Sector

Occupational group	**Examples of position titles**	**Representative award classifications**
Nursing	Nurse Manager, Clinical Services Coordinator, Assistant Director of Nursing	Registered Nurse – level 3 or 4
Allied Health	Director, Manager, Deputy or Assistant Manager, Allied Health Department, e.g. Director Physiotherapy	Allied Health Professional – levels 3 to 5 (AHP 3, AHP 4, AHP 5)
Administration	Director, Manager, or Deputy or Assistant Manager, Administrative Department, e.g. Director Finance	Administrative Services Officer - Levels 6 to 8 (ASO-6, ASO-7, ASO-8) Manager Administrative Services Levels 1 to 3 (MAS1, MAS2, MAS3)

A letter and information were sent to the President of the local branch of the Australasian College of Health Service Management (ACHSM(SA)), the professional body for health service managers in South Australia, to seek support for distribution of the information and request for Expressions of Interest through their South Australian newsletter and/or email distribution list. This followed approval from the Flinders University Social and Behavioural Research Ethics Committee (SBREC)

(Appendix 4). The request for expressions of interest, emailed by the ACHSM(SA) in September 2014, sought participation of public sector health care managers because the public sector was the focus of the national and state reforms in 2011–12 (see Chapter 1).

Twenty people submitted an Expression of Interest directly to me. In this way, participant confidentiality could be maintained. Seven participants who met the inclusion criteria were chosen based on demographic and employment details contained in a form submitted with the Expression of Interest. (See Appendices 5– 7 for documents provided to participants including the list of details requested.) The rationale for the final selection of participants, such as diversity in age, gender, employing organisation, and professional background, was discussed with my research supervisors prior to interviews being arranged. The aim was to capture a broad spectrum of experiences from which to learn.

Those who were not chosen were contacted by email to thank them for their interest, noting that sufficient participants had been recruited. However, I sought agreement to retain their contact details in case further participants were required. I also offered to send them the details of any publication arising from the project.

The seven participants were health care middle-level managers who had experienced the major changes in health care structure and funding. A summary of demographic details and my comments about case selection are presented in Table 8.

Table 8: Summary of demographic details

Detail	Number	Comments about case selection
Professional background Nursing Allied health	 4 3	There were no expressions of interest from general management professions such as human resources, finance or logistics. In the final choice, I aimed for role variety rather than reflecting the distribution of professions in the workforce.
Organisation type Public hospital Central administrative unit Aged care	 5 1 1	 The hospital contexts comprised a large central public hospital, a smaller country hospital, a standalone specialised service, jointly managed sites of a larger hospital. The participant from aged care worked in a health-related role.
Management experience 3 to 9 years 10 or more years	 3	Expressions of interest were limited to people with 3 or more years of management experience. Years of participant management experience ranged from 4 to 18 years. Years of

	4	health workforce participation ranged from 9 to 37 years. The participant with the least management experience of 4 years had worked in health for 37 years.
Gender Female Male	 6 1	The gender profile reflects the composition of the health care workforce, especially in nursing, where ninety percent are female (AIHW, 2016b), and in allied health, where women also form the greatest percentage of those working in the public sector (AIHW, 2013).
Age group 30 - 39 40 - 49 50 - 59	 1 1 5	The choices reflect the age distribution of the eligible expressions of interest.
Postgraduate qualifications	6	These encompassed professional, management or research higher degrees.

Data collection – semi-structured interviews

While case studies would normally include a number of data sources, pragmatically, this was impossible. Documents for analysis were restricted to those in the public domain: these reports and media releases, identified in Chapter 1, address the imperative for change and some of the broader financial goals. However, documents addressing internal processes were not available.

Semi-structured interviews of approximately 45 to 60 minutes' duration provided the primary source of data. Participant observation was not possible due to heavy workloads, the pace of work in the public sector, and the confidential nature of the activities.

Interviewing is not a neutral process because it is 'inextricably and unavoidably historically, politically, and contextually bound' (Fontana & Frey, 2005, p. 695) for both the researcher and the interviewee. Although the researcher may commence the process, the interview is constructed by both the researcher and the interviewee, allowing discussion and exploration of areas of importance to both. Rubin and Rubin (2012) refer to a '*conversational partnership*' (p. 7 [original emphasis]) which respects the distinctiveness of each interviewee's knowledge and experiences and acknowledges the reciprocal roles between researcher and interviewee. Consequently, my own voice, experience and expertise in the area contributed to the interaction and later analysis.

Participants were invited to describe their own experiences, focusing and expanding on areas of personal importance. This is a valid way of capturing interviewees' views and understandings of

their experiences, which is how they construct their reality (Minichiello et al., 2008, p. 51), based on an assumption that they would tend to provide honest accounts to the best of their ability. Gaining an understanding of the 'interviewee's world' (Rubin & Rubin, 2012, p. 7) assists the researcher to provide an authentic account of the interviewees' experiences and views, to learn from them, and to develop potentially credible explanations or conclusions. At the same time, the researcher must be cognisant of, and sensitive to, areas of possible discomfort.

The literature review highlighted the important roles of middle managers in major change: that this entailed significant 'emotion work' and had psychological and social impacts. Questions were devised to explore participants' experiences of, views about, roles in, and responses to major change implementation in health care. They were also asked to comment on the knowledge and skills that they perceived useful in coping with the changes. Discussion with my research supervisors assisted in refining the questions and process. An interview guide provided a reminder of areas to be covered and the list of questions to keep the interview 'on track' (see Appendix 8). However, I acknowledge that time limits and associated restrictions on the number of questions could have reduced the volume and depth of individual descriptions (Patton, 2002, p. 228). In preparation, the interview process, questions, timing and recording were trialled with an experienced research colleague.

All participants nominated the Flinders University campus in the Adelaide Central Business District as the preferred venue for interviews. The interviews were undertaken during the summer semester break in 2014–2015, at dates and times convenient to the participants. This central location afforded a quiet, uninterrupted, relaxed and confidential environment, where there was no risk of identification by workplace or professional colleagues. All participants agreed to be contacted again by phone or in person if further details or clarification were required.

Data analysis

The first step in case study data analysis is to provide a detailed description of each case (Creswell, 2013, p. 199). Consistent with Creswell (2013, pp. 199-200), Stake (1995, pp. 74-88), and Liamputtong (2013, pp. 244-245), inductive analysis was undertaken through activities described below.

The interview transcripts were read multiple times to gain an overall appreciation of what each participant was trying to convey. Single comments or issues and topics of specific interest to each

case were identified without trying to find further examples, as salient points from individual cases may have intrinsic value and be interesting for readers to compare with their own experiences.

Meaningful sections of the interview data, which were potentially relevant to particular issues and the overall phenomenon being studied, were coded. These depicted experiences of, and responses to, radical change. The volume of data did not justify the use of qualitative text management software such as NVivo. Instead, several electronic copies of the MS Word transcripts and MS Excel spreadsheets were used to colour-code, categorise and manipulate text.

As there was a high level of flexibility in the interview process and participant responses traversed the questions, the first level of coding involved allocation of participant statements to the main areas covered by the interview questions. This process is referred to by Miles, Huberman and Saldaña (2014) as 'Attribute Coding' (p. 79). The theory of weathering (Raffanti, 2005a) provided the basis for the allocation of a second set of predetermined codes.

Use of a combination of predetermined and emerging codes is common in the health sciences (Creswell, 2014, p. 199). Although the literature provided some guidance for data analysis, maintaining an open mind and allowing ideas to emerge from the data were also important. Other codes, such as 'emotion terms', 'professional relationships', 'teamwork', 'professional power', and 'thrown in at the deep end', emerged from the interview data.

Themes, patterns, or consistencies and relationships emerged from the categories both within and across cases. These patterns included those gleaned from the literature or materialising through the analytical process. Examples included the experience of 'being a middle manager', the nature of change, the strategy-operations gap, work intensification and role expectations. The time cost of change, staff wellbeing, quality and safety of service provision, perceived fairness in decision-making and communication challenges were other relevant themes.

Propositions or 'naturalistic generalizations' (Stake, 1995, p. 85) were developed from within-case and cross-case theme analysis. These differ substantially from theoretical generalisation to a population: 'Naturalistic generalizations are conclusions arrived at through personal engagement in life's affairs or through vicarious experience so well constructed that the person feels as if it happened to themselves' (Stake, 1995, p. 85).

Use of Linguistic Inquiry and Word Count (LIWC2015) software

The LIWC2015 is validated software for text analysis (Pennebaker, Boyd, Jordan, & Blackburn,

2015), which allocates words to various categories, ranging from basic grammatical forms and punctuation through to psychological and social concepts. I used LIWC2015 to assist with the identification of negative emotion words in the transcripts and to provide a visual representation of their use in the combined set of transcripts. The concept of 'thriving', and the positive emotion words associated with it, was beyond the scope of Raffanti's (2005a; 2005b) research and the theory of weathering. Therefore, for consistency, I did not extend my analysis to positive emotion word use.

In quantitative studies, LIWC2015 enables comparison of word usage over a time period, in different contexts, or using different communication forms, such as social media, writing which is more formal, or transcribed speech. Given that this was a qualitative study with a relatively small number of participants, some more loquacious than others, it was deemed inappropriate to undertake quantitative statistical analysis or numeric comparisons between individuals.

One of the limitations of LIWC2015 for my purposes was that its natural speech analysis uses slightly different emotion categories to those identified by Raffanti (2005a, pp. 76-79). Where the theory of weathering uses 'Fear', 'Frustration' and 'Overwhelm' (Raffanti, 2005a, pp. 76-79), LIWC2015 applies categories of 'Anger', 'Anxiety' and 'Sadness' (Pennebaker et al., 2015, p. 11). Examples of how text words were categorised by LIWC2015 appear in Table 9.

Table 9: LIWC categorisation examples

LIWC category	Word examples
Anger	cynical, cynicism, frustration, ridiculous
Anxiety	fear, worry, scare, struggle, pressure, irrational, stress, distress, risk
Sadness	change fatigue, loss, unhappy, disappointment, overwhelmed

The text analysis software does not consider the context in which a word is used nor does it capture intonation, syllable stress and changes in volume. For example, the word 'critical' has different meanings in different contexts; its use might signify a feeling of anger, or might signify a judgement of importance. LIWC2015 also highlights words that are used colloquially, such as 'lose' in 'use it or lose it', and words used to describe medical conditions, such as 'pressure' in 'pressure sores'. These do not depict emotions and were not included in my allocation of words to Raffanti's categories. Although this introduced an additional source of researcher-oriented bias in terms of category allocations, the results did illustrate the participants' use of emotion-laden words.

Appendix 9 provides the raw data from my allocation of the participants' emotion words and phrases to the Raffanti categories. These include relevant words highlighted by LIWC2015 as well as those that I had identified.

Addressing limitations of the study

According to Patton (2002, p. 230): 'Qualitative inquiry typically focuses in depth on relatively small samples, even single cases (*N*=1), selected *purposefully*' [original emphasis]. For case study research, Creswell (2013, p. 157) recommended four to five cases. I chose seven participants from varied backgrounds and contexts who could provide rich and illuminating accounts of their experiences and views, from which I could learn. Case studies do not require increased sample size to reach the level of data saturation necessary in grounded theory approaches that seek to develop new theories.

Semi-structured interviews allow participants substantial flexibility to present or stress issues of particular interest to them. I engaged in pre-interview conversation to establish rapport and a relaxed style of interviewing to encourage openness and trust. Follow-up questions were used to elicit further issues or examples. In view of the consistencies in the seven reports, I had no reason to question their veracity or to suspect alternative motives or self-interest.

Practical constraints, associated with the participants' work roles and the scope of a 36-unit research study, ruled out incorporating triangulation methods, through, for example, participant observation, to enhance the strength and validity of the study or to test consistency between approaches. Furthermore, there was a dearth of organisational documentary evidence in the public domain about the required changes or implementation processes. Therefore, it was not possible to compare the interviewee reports of the change processes with any formal internal documentation. Publicly available documentation relating to budget measures, workforce changes and some of the effects of major changes in the South Australian public health sector was accessed, partially ameliorating this limitation. The relevant documentation included government-initiated service review reports, government treasury and finance reports and budget papers, media releases and media reports (see Chapter 1).

Creswell (2013, p. 250) used the term 'validation' for the process undertaken to assess the accuracy of qualitative research and further described validation strategies. The following strategies were used to assure the rigour and quality of the research.

Clarification of researcher bias

The Preface to this thesis was written and included to give an overview of my background, experiences and worldviews that influenced the research questions and could limit my capacity for objectivity in interpretation and analysis of the data. Because reflexivity contributes to the transparency of decision-making and interpretation in qualitative research (Bryman, 2012, p. 393; Creswell, 2013, pp. 214-216; Patton, 2002, pp. 494-495; Simons, 2009, p. 91), I kept notebooks (e.g. for the interviews) and annotated electronic and hard copy documents to record reflections. Several electronic versions of documents and spreadsheets and progress notes were kept to track progress in coding and analysis.

Process and peer review

Peer review is considered similar to inter-rater reliability tests in quantitative studies (Creswell, 2013, p. 251). By its design, individual research is limited by the absence of an expert team to moderate and check assumptions, code development and coding processes. However, meetings with my research supervisor(s) provided a means of reporting on and checking that processes, decisions and interpretation of the data were relevant and defendable. Throughout the project, my supervisors also fostered discussion of ideas, challenged my perceptions and assumptions and stimulated greater breadth, depth and clarity of thought. I viewed these processes as similar to peer review.

Member checking

Member checking is one way of ensuring that the interviewee retains control over the accuracy of transcription and the content to be made available to the researcher; it involves asking participants to check their interview transcripts and may include inviting their input into later analytical phases (Creswell, 2013, p. 252; Liamputtong, 2013, p. 32; Stake, 1995, p. 115). In this research, the digital recordings were transcribed by a professional transcription service. As a quality control measure, I checked the interview transcripts for accuracy, and made minor corrections prior to returning them to participants for feedback before analysis commenced. Five participants responded. Two of these suggested alterations, which were editorial, clarified statements or deleted potential identifying information. The deletions did not affect the overall content of the interviews.

The thick description

The aim was to provide a rich, ‘thick’ description (Patton, 2002, pp. 437-438) of participant

experiences of, and responses to, recent radical changes in the health sector and their insights into the role of education programs in the implementation of change. Chapter 4 of this thesis in particular enables readers to determine how well the cases relate to their own experiences or are transferable to other situations. Relevant quotes from the interviews are included.

Negative case analysis

Negative case analysis involves consideration of evidence that does not fit the themes (Creswell, 2013, p. 251). I identified two areas of interest where the participants' statements lacked clarity or detail (see Chapter 5, sub-section 'Further reflections on coping behaviours'). While these did not reflect major discrepancies in the evidence, they provided insights into other factors that potentially influenced coping with radical change.

Ethical issues

The Social and Behavioural Research Ethics Committee (SBREC) at Flinders University approved the project (see Appendix 4). As the research was not of a clinical nature and recruitment of research participants and conduct of interviews did not occur within SA Health agencies, there was no need for an additional application to the Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC). The participants in this research were adult middle managers who were accustomed to working in stressful contexts. Therefore, the level of risk, discomfort, or inconvenience of attending an interview was considered to be low (National Health & Medical Research Council [NHMRC], 2007, p. 16).

Issues of confidentiality, anonymity, informed consent, risk, and data security were addressed in the ethics application and in information provided to the research participants (Appendices 5 – 7). A professional audio transcription service signed a confidentiality agreement as required by the SBREC, and identifying information was removed from interview transcripts and any hard copy documents (except for the informed consent documents, which have been stored securely). Pseudonyms have been used in working documents and the thesis when referring to participants. This will also apply to any future publication.

As I had previous involvement in the SA Branch of ACHSM, there was a chance that people who volunteered might know me. However, I was no longer involved in the State Branch Council and unable to exert any influence from such a position. It was also many years since I had last worked in SA Health and so I had no immediate or past employment relationship with potential

participants.

Summary

A qualitative, interpretive research design in the form of a collective case study was chosen to explore middle managers' experiences and views of radical change. This provided the opportunity to learn from, and illuminate, the rich experiences of each participant. There was no intent to generalise, but rather to raise propositions and issues for consideration in educating health care middle managers.

South Australian industrial awards were used to identify middle manager levels in the public health sector. These were outlined in the call for expressions of interest through ACHSM(SA) and, from this call, a purposive sample of seven participants was chosen, covering a diversity of gender, age, professional background, role and employing organisation.

The scope of the study was limited by the small number of participants, restriction to the Greater Adelaide Statistical area (ABS, 2016), and lack of access to confidential documents about the changes. Most of the major changes were directed at metropolitan hospitals and so participants were drawn from this sector. The Commonwealth and South Australian governments, which provided the targets or outcomes expected but not the processes to be used, drove structural and financial changes. Internal SA Health documents relating to exact processes for change were not publicly available.

Other limitations included the lack of participants from general management functional areas, such as finance and human resource management (HRM). My experiences and views while working in middle management positions in tertiary levels of health and education during change processes also contributed limitations to the research process and interpretations.

Process and peer review by research supervisors, member-checking, provision of a thick description, researcher reflexivity and use of linguistic analysis software were employed as research validation strategies. The Social and Behavioural Research Ethics Committee (SBREC) at Flinders University gave ethical approval for the study.

CHAPTER 4: EXPERIENCES AND VIEWS OF MAJOR CHANGE

Introduction

This chapter provides an overview of each of the middle manager's experiences of and views about major change in the health sector. In this study, 'experience' and 'view' refer to:

> What has been experienced; the events that have taken place within the knowledge of an individual, a community, mankind at large, either during a particular period or generally ('experience, n.', Oxford English Dictionary, 2017).
>
> A particular manner or way of considering or regarding a subject; an opinion, idea, or theory formed by reflection or study ('view, n.', Oxford English Dictionary, 2017).

A separate section has been devoted to each participant and covers biographical and contextual details and their comments on the areas explored in the interviews, followed by a summary. Sub-headings, reflecting codes emerging from the interview data, are used to organise the descriptions further. For example, views on the impact of major change covered issues of powerful influences; service quality, integration and efficiency; equity or fairness in service provision; and future population health. The participants' experiences and views of change implementation processes covered issues of executive decision-making; communication challenges; impact on staff; impact on middle managers; and impact on patients. The sub-headings used are not consistent across the participants given differences in the focus of individual interviews. For example, future population health was not mentioned by all participants.

Quotations from the interview transcripts have been incorporated to illustrate points. To protect identity and privacy of participants sourced from a small state such as South Australia, each participant has been given a pseudonym, and details of age, background and workplace have been limited.

Bernie

Biographical and contextual details

As an education and training manager, Bernie is responsible for creating a positive inter-professional learning environment. Under her leadership, a large staff team from a broad range of disciplines focuses on inter-professional education and online learning as well as the more traditional single-discipline technical development and training. Clinicians such as allied health professionals and nurses, rather than human resources professionals, deliver non-technical training in the '*soft*' interpersonal and social skills, such as leadership, communication, conflict management, negotiation and feedback provision. Originally trained in an allied health profession, and then working in an academic role, Bernie admitted to being naïve about the health hierarchy when first recruited to the role. In contrast to previous roles, she commented that she '*actually had much more authority to make change in this job because of that line management responsibility*'.

Health system reforms and organisational changes

Monitoring the political and health environment enabled Bernie to respond and adapt her service as necessary. She felt that, '*as a big picture person*', her role involved facilitating change through taking a strategic view, and accepting responsibility for managing the results as '*they're paying me to manage that*'. With respect to future major changes, she remarked:

> *I just see in the role I'm in that we just need to actually pay attention to what's happening and then try and be as relevant to that change as we can be.*

Bernie referred to national and state-level policy changes and budgetary pressures. At the organisational level, financial constraints and savings targets had delivered a turnover of Chief Executive Officers (CEOs) and a number of changes to the governance structure. Even further disruptive change was expected under the Transforming Health initiative: '*They do have an opportunity to do something pretty radical and Minister Snelling seems to be up for it so I guess we'll see. Watch this space*'.

Views on the impact of major change

The constructive, positive aspects of change were noted:

> *There's a lot of staff there who've been there for a very long time and are quite entrenched in the way they do things and … so it may be a good thing to shake things up a bit.*
>
> *There is a little bit more openness to thinking 'well, some of this change could be really driven by patient care'.*

Bernie recognised that savings targets had been achieved following the period of severe reductions in delegations. Her misgivings related to powerful influences and service provision issues perceived to be arising from a short-term financial focus.

Powerful influences

Bernie referenced:

> *powerful, professional groups who don't want to change or who quite happily … say 'yes, we do need radical change' but 'oh that applies to me? No, that won't work'.*

She predicted that strong staff unions and associations representing professional groups would present a significant challenge for politicians and senior health executives wishing to undertake major system transformations. A possible outcome was that the '*political will won't be there*' and '*we'll just get tinkering again, in which case we'll be just back where we started*'.

Service quality, integration and efficiency

Bernie believed that there was a lack of a long-term strategic direction and that short-term financial goals were prioritised over service provision:

> *There's been a lot driven by money. I think there's a perception that a lot of the decisions are not rational and not very strategic, that they're very short term.*

She reported that the efficiency reviews had resulted in new structures, reduced the number of senior managers, and produced new reporting relationships. The centralisation of staff development functions had culminated in networks being unable to access sufficient staff development resources, bringing into question the level of commitment of the central state-level department to staff development.

Experiences and views of change implementation processes

Consistent with the literature on radical change, Bernie remarked that most changes were implemented by '*edict*' and '*forced on people*' and had not been '*thought through*'. The arrival of new CEOs had driven changes to structure, with rapid departures of redundant senior staff, and service amalgamations. In this autocratic approach, there was no negotiation or consultation about savings targets, also referred to as efficiency dividends. '*It wasn't "come up with a great idea and let's see how that works". It was, "you will do X, Y and Z"*'. The financial constraints, additional reporting requirements, and delays in being able to recruit staff presented ongoing challenges to maintaining staff development and an '*inter-professional focus*', had constrained management flexibility and '*actually completely shut down the capacity to do anything creative*' by a service which had been '*viewed as quite innovative*'.

Executive decision-making: Fairness and feasibility

One round of savings targets was reported to have resulted in a significant reduction in financial and human resource delegations for senior managers, with the CEO having to sign off on everything over $2,000 and reporting financial progress to SA Health and Treasury on a monthly basis. During this time, Bernie's capacity for taking small well-considered risks had become impossible. She said that '*it just seemed a bit ridiculous that you'd trust me to manage 40 people and $3.8 million but not sign off on something that was in my budget*'.

The most recent instance of perceived unfairness of decision-making occurred when Bernie was given a further '*unreasonable*' and '*unrealistic*' budget savings target of 20% to which other parts of the organisation receiving services were unwilling to contribute. Having had a '*history of fiscal responsibility*', she questioned the fairness of such '*measly-minded*' and '*punitive*' approaches which did not target less financially diligent staff.

Bernie believed that some decisions were being influenced by personal or professional relationships and that the advice of staff with expertise was being disregarded and disrespected:

> *Give me a budget to manage anytime because that is just straightforward. It's this lack of professional respect that in fact you might know something about what you're doing that drives me more crazy.*
>
> *I think if you serve … purposes that will be great and if you don't then you may find yourself gone.*

She asserted that decision-makers often lacked knowledge of the operational implications of decisions. Dramatic changes, including resource redistribution, had been proposed for her department with no consultation or negotiation. Feedback on the proposed change process was not taken on board, culminating in a predictable negative staff reaction and having to abandon the change process.

Communication challenges

Bernie considered that it was her responsibility as a manager to deal with any savings targets and administrative workloads rather than worrying her staff with these issues. She had to structure her communication in a way that would not '*panic them*' as '*it's not helpful to scare everybody thinking that we have to save money because then everybody worries about is it their job that's being lost*'. However, the size of the latest budget cut made this difficult as she needed to encourage staff to take long service leave or unpaid leave in addition to periods of paid recreation leave.

Impact on staff

Bernie indicated that the unrelenting nature of major change meant that staff members were suffering from change fatigue, with many becoming cynical and suspicious about change that was promoted as improving patient care. She had observed '*a sense of disengagement*' with the processes, while still '*making sure we're doing what we need to do*'. Her empathy extended to '*some very poorly treated'* colleagues, who had been redeployed as a result of the centralisation and ongoing restructuring of staff development services.

Impact on middle managers

She said the response of middle managers to non-consultative and non-participative means of driving change was cynicism and feeling '*undervalued and a little bit like why have you got this middle layer of managers?*'. Despite being well-paid, she maintained that she was not being '*utilis[ed] … from a strategic perspective*'.

For Bernie, change initiatives had produced '*peaks of stress and frustration more because of the non-strategic nature of the directives than the need to save money [and] … the irrationalness around it*'. She remarked that some senior staff did not have the breadth of understanding of additional services for which they were given responsibility, with consequences for the service's '*focus*' and '*profile*' and Bernie's '*capacity to influence up*'. This meant that Bernie had to perform '*work arounds*' and source information and support through other networks.

Thus, in line with other middle managers, her workload had increased significantly as a result of high levels of administrative '*micro-management*'. Moreover, she maintained that she was trying to maintain staff motivation and productivity as well as spending time developing strategic responses to ensure her department's survival.

Suggested improvements for change management

Bernie suggested that change processes could be improved through increased levels of consultation and engagement of people managing and impacted by the changes, development of public relations and communications processes, and extension of the timelines to allow time for identification and engagement of diverse stakeholders willing to collaborate in a change implementation. She advocated commencing with smaller projects that were likely to be supported and were successful: '*I would have had small wins "now, look, this is working. Let's try something"*'.

Skills and knowledge required to cope with and manage their roles in the change process

Bernie used a number of strategies in coping with major change, including maintenance of personal and professional networks within and external to the organisation. She thought that:

> *networking is a really critical one because I think for me that has helped me develop my skills, stay sane, as well as work on strategies for managing up. I think that sort of peer support and also knowing who's who in the zoo.*

On a proactive note, Bernie revealed how she had attempted to understand the new CEO's strategic direction and interests so that she could ensure service sustainability and relevance:

> *I guess for me the challenge is to try and work out what it is she's predicting so that we can position ourselves to actually provide what it is she thinks we should be doing so that we maintain our relevance.*

In turn, she highlighted that she involved her service team and organisational development staff in the creation of an organisational learning and development framework that emphasised transformational leadership while also contributing to a state-level initiative. She proclaimed that '*it's good to know that change can happen even when the whole system either is in turmoil or isn't appearing to change at all*'.

She stressed the value of important leadership capabilities such as systems thinking, reflective practice and understanding oneself, resilience, optimism, developing and managing relationships, managing up and having other non-work interests.

Suggestions for postgraduate health care management education

Bernie placed less importance on financial and operations management than people management and leadership skills:

> *You look at leadership or management courses and they're all about, you know, really operational things which actually don't make a jot of difference if you don't get the other bits right.*

In her own education, she had combined formal components with short courses or work-place learning in non-technical skills.

Summary

Bernie is an experienced education and training manager with a higher degree in an allied health discipline. Congruent with her keen interest in strategic management, Bernie talked about the policy drivers for radical change as well as organisational change processes. She claimed that middle managers were an untapped source of expertise, feeling under-valued and disrespected professionally.

Bernie expressed reservations about the leadership styles and expertise of decision-makers, the short-term focus on financial gains versus future consequences, the quality, fairness and operational implications of decisions, and the adequacy of engagement with staff and stakeholders. Furthermore, the level of '*micro-management*' had increased bureaucratic administrative processes and workloads, leading to staff frustration and limits to innovation and creativity.

Raising concerns about the impact of change on staff and services, Bernie referred to growing change fatigue, cynicism and disengagement, and the power of some professional groups to resist change. Through the judicious release of information, she had tried to reduce the anxiety levels of her own staff. In addition, she had developed strategies for her service area to remain relevant and sustainable.

Bernie suggested that management and leadership capacities and '*soft*' skills, such as communication, negotiation, reflection, relationship management and building resilience, were more important than technical skills. She also stressed the need to develop and maintain personal and professional networks for personal support and brainstorming of ideas.

Chris

Biographical and contextual details

Chris derives job satisfaction from '*a passion for health. I think there's a self-belief in the work that I do is good work*'. Over her extensive career in state and national jurisdictions, she has developed her abilities to be realistic about where best to direct her energies:

> *At my stage … I can feel a little bit more grounded in reality and I feel like I've got a better balance on what it is that I can and cannot influence.*

She holds postgraduate qualifications in health care management and in education and training. Leading a State multidisciplinary health service affords her a substantial degree of independence from the parent organisation. Her responsibilities comprise development and management of service strategy and accountability for service provision, including quality and safety. Referring to the broader organisational politics, she tries not to become '*embroiled in the day-to-day banter*'.

Health system reforms and organisational changes

Chris described Commonwealth government policy and structural changes, such as the formation of Hospital and Health Networks and Primary Health Networks (see Glossary for explanation of these terms), proposed changes to Medicare, and the enormous technological changes in the health sector over the last 40 years.

Views on the impact of major change

Chris reported that electronic systems had been upgraded and the organisation's practices had been reviewed against safety and quality standards, leading to modification of services or information as required. She stressed the importance of involving clients in these processes. In the upcoming Transforming Health initiative, she saw the benefits of consolidating similar services into '*centres of excellence*'.

Chris believed that financial constraints meant that '*everybody [was] feeling the thumb screws*' in South Australia. She acknowledged the political and organisational influences on change, but also described the moderating power of being a direct service provider or member of a strong industrial body. Concern for affordable and accessible services for the community underpinned Chris's comments on major system and structural changes.

Powerful influences

Chris questioned government expenditure on selling the '*dire financial consequences*' message while promoting new policies which had a very small effect on the budget overall. In trying to

advocate for best practice models of care in '*a fairly conservative*' environment, Chris had encountered significant problems negotiating the layers of decision-makers in the organisational hierarchy and dealing with outdated legislation. She suggested that '*wider societal views … can make capacity to change models of care and shape services difficult*'.

Responsibility for direct service provision and industrial agreements were said by Chris to have protected some services or professional groups from the most severe financial and structural changes. Chris's area of the organisation had experienced fewer budget cuts and no downsizing, as the Enterprise Bargaining agreement stipulated nursing staff–patient ratios. However, the non-nursing multidisciplinary resources were '*fairly thin on the ground*'.

Service quality, integration and efficiency

Chris expressed reservations about the outcomes of the move from Medicare Locals to Primary Health Networks (PHNs). While supporting the valuable work of the PHNs in areas such as domestic violence, she maintained that this should not have resulted in the non-renewal of the contracts of existing valuable primary health care services (see Glossary for explanation of this term).

At a local level, although her staff complement had been quite stable, Chris predicted future problems in service provision. She noted:

> *succession planning with an ageing workforce and having appropriately skilled clinicians across the Multi D team to be able to continue to provide services into the future; that's our biggest challenge.*

Equity or fairness in service provision

Referring to Medicare, Chris said that she '*would hate to see that dismantled*' and while a co-payment might make sense, she did not support increasing costs to the consumer, particularly for those with limited capacity to pay.

Experiences and views of change implementation processes

Chris recounted her experience of the introduction of major new technology and some service changes but admitted that other South Australian services had undergone greater change. There was no choice in, or consultation about, the change directives.

She reported that uneasiness about the processes was associated with challenges in decision-making and communication and the impact on staff, managers and patients.

Executive decision-making: Fairness and feasibility

Chris questioned the adequacy of data and resources to support decision-making aimed at increasing efficiency. She provided an example of an organisation with which she was familiar being threatened with service reductions when demand statistics had been used inflexibly. She noted that '*they're not providing a system, infrastructure underneath it*' for re-filling cancelled appointments. Potential difficulties in operationalising this decision had not been identified or discussed with concerned clinicians.

Chris questioned claims that major changes were being '*clinician-led and clinician-endorsed*'.

Communication challenges

Chris expressed frustration at the numerous hierarchical layers in the health sector that were an impediment to decision-making. She wondered whether other medical specialties encountered the same problem she did in the process of gaining proposal approval from so many layers of clinical and administrative staff before submission to the CEO and the Chief Executive of SA Health.

Chris maintained that it was essential to respect staff input, to encourage constructive feedback and discussion of change decisions and processes, and to give them some time to build their confidence in implementing change. She stressed the importance of honest explanations to staff about their lack of choice in the top-down decisions, while still demonstrating understanding of the reasons for opposition:

> *So it was as much about 'I understand that you feel that you provide better service, and maybe we do, but unfortunately that's out of our scope to be able to influence' so that was that.*

Impact on staff

The reasonably stable workforce was regarded by Chris as a positive sign of '*commitment*', but at the same time it could present '*a level of resistance*' to change. She emphasised accepting and acknowledging positive and negative responses to change and the discomfort felt by staff.

She believed that it was her responsibility to support staff, prevent them from 'sweating the small stuff', and to sustain their job satisfaction through provision of opportunities to contribute to the service as a whole. This was done through using the:

> *wealth of skills and experience that they bring … to their position every day … in a positive way [and] … get them involved in other things where they feel they can contribute, they can influence and they can effect change and have some ownership for it.*

Nevertheless, Chris stressed the need to monitor change processes for their workload effects. The introduction of new systems and processes, and an increase in the amount of electronic documentation, had increased workloads and required development of additional skills. She noted that pressure resulted from '*documentation, what's required in the job, … [and] familiarity [with] new systems*'.

Impact on middle managers

Chris reported a substantial increase in administrative workloads as well as using carefully constructed communication and task allocation to maintain staff morale. Advocacy for her service and its clients was a high priority, but she said that this '*can be professionally isolating*' and that it was frustrating and disappointing to be unable to promote or celebrate aspects of her work due to the political and social sensitivities of the area. '*You have to be careful what you say and to whom because [it] is highly politicised and stigmatised*'.

Impact on patients

Chris claimed that she was keen to provide '*best practice*' in patient care and that she advocated strongly for policy and procedural changes. A recent change, transferring some after-hours care to a third party, had been perceived by staff as creating a risk to quality of care. To reassure themselves, Chris and her staff developed a way of monitoring the follow-up care so that any reduction in quality could be addressed if it occurred.

Suggested improvements for change management

Chris described numerous strategies she perceived as valuable in managing change, including injection of '*a bit of fun and humour*', use of multiple communication channels such as electronic newsletters and team meetings, and allowance for a generous lead-in time and post-implementation review to enhance success. Where it was under her control, she emphasised the need for monitoring and management of workloads, advocating for best practice despite the barriers encountered, and paying attention to staff wellbeing and staff participation in implementation.

Skills and knowledge required to cope with and manage their roles in the change process

Chris declared that her role had demanded strong skills in communication, advocacy, care and diplomacy. Moreover, the appreciation of difference was considered essential to successful change management. She reported the need to '*explore the challenges that this decision is having for that person, or for that professional interest area*'. She reflected that different skills and

knowledge might be required for different middle management roles and career stage but that most roles depended on effective networking, relationship management and teamwork. The ability to network externally was reported as being important for engaging with interest groups, for discussing ideas and issues and for personal support. Chris disclosed that she was developing a national professional support network to address the professional isolation of working in a politically sensitive area and to establish a vehicle for service advocacy.

Suggestions for postgraduate health care management education

Chris implied that career goals and differences in capabilities required for strategic direction-setting roles and operational team-based roles might influence skills focus and educational choice:

> *if you want to be at the table to influence the change then you have to steer your career and your direction to get there so that you can have a stake in it;*
>
> *if … you see yourself as a manager of people within services that are affected by change well, then, that's a different skill set that you need in order to be able to do that.*

Key education areas suggested for health care managers included knowledge of national and international health environments, national health financing, and human resource management. She also emphasised a focus on respectful behaviours, understanding mental health problems, and developing capacities to support staff through changes.

Mentoring was raised by Chris as being an invaluable strategy for professional and career development but she noted that the purpose and style of mentoring might differ according to career stage:

> *So when you are a commencing manager it might be really helpful to have a stronger relationship with a mentor that can help you through those processes. As you become more experienced I guess what you tend to do is that you seek out different mentors for different things.*

Chris endorsed postgraduate health management education at masters' level '*which just opens your eyes and helps you to consider things from another perspective and that's a grounded and a more realistic perspective*'. She suggested that:

> *what we need to do is raise the status of the significance and the importance and the value of a Master of Health Administration for health administrators that are working in the area.*

Summary

Chris is a very experienced middle manager, leading a standalone health service facility within a larger network. She has postgraduate qualifications in health care management and education and training. Over a period of 40 years, she has seen numerous major changes, especially technological advances.

Her reservations about the impact of radical change were based on whether it had actually improved overall health outcomes, the health sector financial position, or access for health service users and the more vulnerable members of the community. She noted that there was a general cynicism about ongoing top-down change.

Chris advised that she was keen to ensure that her staff had fulfilling work and were able to contribute constructively during change implementation. She was a proponent of the saying '*Don't sweat the things that you cannot change*'. However, she expressed concern about the increase in workloads, the new processes and practices to be acquired, the numerous layers through which decision-making occurred, and legislation that had not kept pace with social change.

Effective change management demanded the ability to understand, accept and address staff responses, ensure a reasonable lead-in time, and plan a post-implementation review. Communication, relationship-management, networking and advocacy skills were identified as essential to her role in managing change effectively. Chris strongly recommended specialised postgraduate education in health care management that would cover areas such as health systems, financing and people management. Opportunities for mentoring were considered valuable, with the choice of mentor and process being dependent on the mentee's career stage.

Jo

Biographical and contextual details

Jo is a very experienced health care manager working across two sites. Following hospital-based training, she completed a number of professional development courses, including one in leadership. She explained that family and work commitments prevented the pursuit of postgraduate study.

Her broad role covers corporate support, such as strategy development and implementation, quality and safety, financial and KPI monitoring and reporting, site management responsibilities such as security and catering, and human resource responsibilities encompassing recruitment, leave, rosters, and the respectful behaviour program. With her duties varying considerably across the two sites, she welcomes the flexibility to '*think a bit laterally with those kinds of issues that really aren't nursing specific but if they're not solved quickly would heavily impact on nursing and clinical services*'.

Jo stated that she was a '*conduit*' for information, managed issues for the Director of Nursing and gave her boss '*the heads up on things that she's probably going to be questioned on*'. She gained vicarious satisfaction through the work of her staff in direct patient care:

> *Even though I'm in middle management and I'm not looking after patients every day I still think that what I do benefits the patients and I think … supporting people through health issues is a real kind of honour and challenge.*

Health system reforms and organisational changes

Jo described national and state-level changes and their financial aspects. This included numerous restructures of the health system with consequent changes in organisational structures and higher-level positions. Some administration services had also been centralised in a shared services initiative and her organisation was re-organising, moving services between sites.

Views on the impact of major change

Jo acknowledged benefits in the standardisation of some policies and procedures, greater access to information about overall strategic directions, and increased opportunities to network across clinical disciplines to work on new processes and systems.

Noting the increasing pace and volume of change, with one change not yet '*settled*' before another one was initiated, Jo argued that structure and name changes could be a distraction: '*I think we kind of need to almost shut out the bigger stuff sometimes because you can get caught up*

in the frustration'.

She suggested that there had not been sufficient priority given to the quality of patient care and future population health.

Service quality, integration and efficiency

According to Jo, patient care was being compromised by more recent changes. She referred to ensuring that '*we're doing our core business well and our patients are receiving safe care*'.

Future population health

Jo voiced her disquiet about decisions being made in reaction to consistent health overspending with little regard for their future population health impacts. Through the process of:

> *shutting services or scaling back community services or health promotion services, yes, [in] this year's budget it might save you a bit of money but in ten years' time you've taken away that program from a particular community and their health problems will be dire and then they're all going to be in the emergency department and staying in hospital so it just seems a bit short-sighted I think.*

Experiences and views of change implementation processes

Jo advised that she was experiencing a major reorganisation of services and previously had been involved in the implementation of new software, which had required reversion to manual systems for a substantial period. She remarked that top-down changes with clear expectations '*were easier … to implement because there's really no choice*' but also described some areas where greater attention could be directed to how change is implemented.

Executive decision-making: Fairness and feasibility

Although changes were purported to have potential benefits for patients, Jo believed that a focus on budget savings targets, whilst ignoring increasing patient complexity, had given rise to less recognition of clinical judgement and a higher level of scrutiny. Decisions made without sufficient understanding of the operational context had created potential problems for service providers, such as the one that resulted in adding the tasks of ordering and inventory management to nursing roles following centralisation of administrative staff. '*Now we have to cope with the consequences of something that we really didn't anticipate*'. Jo referred to '*a big gap in the middle … the big, black hole that no-one can kind of see through*'.

In Jo's opinion, small resultant savings were not justified given the time cost of implementing change. This required extra administration and relied on many staff attending numerous strategic and operational meetings. Nevertheless, she stressed the importance of having an active role in

shaping change: '*We need to make sure that we've got a really strong voice on these meetings and committees*' to enhance the chances of policies being '*appropriate and relevant for everyone*', including being adjusted for different contexts such as community health services. Given that the input and feedback process had been time-consuming for those involved, she expressed frustration at the lack of feedback on meeting outcomes: '*You never actually see the final version of some things come out*'.

Jo was critical of the apparent growth in administrative positions and the lack of recognition of past diligence in budget management, maintaining that the requirement for savings was unfair:

> *They're spending more money on top to try and see where they can save money on the bottom, which doesn't make sense;*
>
> *That's our savings target because someone else has overspent.*

Communication challenges

Jo said that her role became particularly difficult in the context of '*a really broad directive*' when the rationale for the change was unclear. Deciding what to tell staff without raising anxiety levels was demanding:

> *it's really hard to know how much information to give them because you don't want to cause anxiety and distress unnecessarily about proposed things … but then they don't want to feel like they're in the dark and no one's telling them anything anyway.*

Jo called for messages to be consistent to reduce possible misinterpretation and the spreading of incorrect information by staff.

Communication with patients was professed to be an equally important consideration, with managers working hard to '*cushion the patient from the changes … [and being] conscious of not giving out too much information too early to cause that anxiety*'. They had developed a communication plan providing broad details of proposed changes along with reassurances about how patients would be supported.

Impact on staff

Jo commented on the pervasiveness of change fatigue: '*One change isn't even implemented before another comes along and … boots it out the way as a higher priority or changes what you're halfway through implementing already*'. She mentioned that some staff had coped well with the changes while others had tried to sabotage efforts. The long times taken to '*formalise the change*' had negative consequences for staff engagement:

> *It hasn't quite trickled down so we're all absolutely sure of exactly what's happening, which is a bit frustrating and you kind of lose your will to know about it because it's taken so long.*

Initiatives such as moving services around were reported by Jo to be stressful to staff due to uncertainty about the longer-term future, reduced job security and loss of a familiar place: '*the people coming to the … site are torn because they love the … site they work at but they also love the patients that they work with*'. Jo recognised the need to support staff and, in anticipation of further changes, her organisation had sought assistance from an organisational psychologist:

> *to try and get the team really strong and unified so they were in a better place to kind of deal with the major changes … to build up their resilience and support of each other.*

Jo claimed that staff workloads had increased markedly as a result of numerous requests for detailed data, increased justification required with spending and resource requests, tighter administration of general stock and pharmaceutical supplies, and implementation of '*quality initiatives and accreditation requirements*'. As Jo's budget had been static for a number of years, the responsibility was falling on the nursing staff and '*really that shouldn't be their job*'. She said that there were insufficient staff to meet requests for representation on many change committees and working groups.

Impact on middle managers

Jo commented that she worked directly with a small team of people ensuring that Clinical Service Coordinators (CSCs) and direct service providers had the resources required to deliver high quality care. Her role was to try:

> *to keep that balance, trying to meet the expectations and requirements fed down from the top with what's required by the patients [and that] things flow up and down … it's my role to flow it out wider to the level threes.*

She described the constant tension in priority setting across the two sites, having to address the email load and requests for information. She argued that '*if everyone up top knew what everyone else up top was requiring they'd actually realise that it's physically impossible*'. She said that her workload had increased to include attendance at strategic- and operationally-oriented meetings and to support staff even when she was unsure of what was happening. The intense workload impinged on other areas of life:

> *We do have people staying late and stuff, which isn't ideal … realistically the expectation is that, yes, you'll balance your work life but you'll still attend all these meetings and produce all this information and audit all these things and stuff too, so something's got to give sometimes.*

Impact on patients

Jo maintained that it is challenging for staff to balance the needs of patients and quality of care against those of the organisation, when the time needed to implement changes '*takes away from*

patient care'. Jo's priority on patient care was evident in the careful way she and her staff structured their communication with patients and their families to mitigate potential anxiety when services were reorganised.

Suggested improvements for change management

Jo highlighted the need for transparent communication about strategic direction and the benefits of change for services and staff. She supported the formation of multi-site, multi-disciplinary problem-solving teams so '*you don't feel like you're just muddling along'*. She called for greater involvement of people with operational experience in decision-making and planning so '*that someone somewhere would work out how to identify that middle bit and make that part of the process*'.

Skills and knowledge required to cope with and manage their roles in the change process

Jo suggested that middle managers had to be willing to be involved in change. She also welcomed the ability to work together with internal and external colleagues on addressing change issues.

In Jo's opinion, communication skills, the ability to translate change directives into action, resilience, confidence, flexibility and openness were essential skills and qualities for managing and coping with change. The role of a middle manager demanded '*a bit of a thicker skin … because you do kind of cop it from both ends sometimes*'.

Suggestions for postgraduate health care management education

Jo remarked that as a manager '*you kind of muddle along*' and emphasised the need for formal courses and in-house professional development activities. She suggested that middle managers need knowledge and skills in budgeting, human resource management, strategic management, and writing briefing and discussion papers. She had developed her own skills through completion of an in-house leadership development program. Backfilling for the Director of Nursing had been '*a big eye opener where the numbers flung around and stuff are quite extraordinary*'. Should she pursue a career at higher levels, Jo indicated that it would be essential to find a '*good nursing director*' as a mentor.

Summary

Jo stated that she has faced numerous top-down organisational changes. She raised concerns about future population health and questioned the fairness of decisions that privileged financial considerations over patient care and staff wellbeing.

Jo explained that she tries to balance the expectations of executives with the needs of patients, staff and colleagues. She claimed that the frequency of change had caused change fatigue, had increased workloads considerably, and had affected patient care. Jo expressed frustration with the time taken to implement some changes, the time commitment required of middle managers, and the lack of understanding of operational implications by change initiators. Managing change required clear and transparent communication about strategic importance, rationale, and the benefits and impacts for services and staff. Communication skills, resilience, confidence, flexibility and openness were cited as being important attributes in coping with change. The ability to work collaboratively with colleagues within and external to the organisation was also seen as important These capacities could be developed through a combination of formal education, short courses, experiential opportunities and mentoring.

Lou

Biographical and contextual details

Lou has worked in the public and private sectors, has qualifications in nursing, midwifery and law and is pursuing postgraduate business and health management studies. Her network-wide role encompasses governance, risk management, medico-legal work, safety and quality programs, accreditation, and monitoring of Commonwealth and State standards across numerous health and aged care organisations. She and her team of staff undertake projects and reviews and have won awards for their work.

Lou advised that her primary focus was on '*partnering with consumers*' and that she tries '*to bring the human component into health care because I think we do lose a bit of that over many, many years of working in the system*'. Consequently, she has substantial involvement with consumer organisations.

Health system reforms and organisational changes

Lou discussed the political environment and the drivers for radical change. Through her responsibilities in health network governance, risk, and quality and safety programs, she and her team have been heavily involved in the implementation of major changes in the state health system over the past ten years.

Views on the impact of major change

Lou felt that the national health reforms had been '*overdue for some time*' and had been designed:

> *to ensure that necessary services were provided and unnecessary areas were then trimmed down so that we had a lot more standardisation … and that … we provided a safe and effective service.*

Safety, quality and equity of service provision formed the main focus for Lou's comments on the impact of major change.

Service quality, integration and efficiency

Lou believed that organisational leaders '*value[d] coming in on budget rather than the safety and quality aspect*', with some reforms going too far and making the organisation '*too lean*' and unable to provide safe and sustainable services. In addition, pressure was placed on city hospitals to discharge patients to country facilities. Lou stressed that doing so prematurely, with subsequent readmission to the city hospital, was an unreasonable cost '*financially and emotionally*' to the

patient, their family and taxpayers.

She also implied that the level of care may not be adequate in some smaller hospitals and that there was a greater reliance on staff with insufficient expertise, as in:

> *a nurse looking after that patient or making decisions based on their levels of experience and expertise, which is very different to a registrar making decisions and treating a patient.*

Furthermore, medical resignations as a result of '*a budgetary requirement*' to reduce the number medical staff contracts meant that medical staff were flown in to country areas from interstate. She was concerned that these medical officers were not aware of local policies and procedures, leading to an increase in 'adverse events'.

Equity or fairness in service provision

Referring to a lack of services and support networks for patients returning to the country from a city hospital stay, Lou questioned the equity of services provided to country versus city-based patients. She also suspected that private medical practitioners were giving priority to their private patients over public patients or the local hospital, despite significant public sector payments being made to provide a service.

Experiences and views of change implementation processes

Lou advised that the network where she is employed had been confronted with a number of budget cuts, some of which had resulted in organisational restructuring. These budget constraints had affected staffing levels, workloads, service quality and patient care as well as staff and community morale.

From Lou's perspective, change was implemented through instructions from above. Observing that the pace of change had increased, she said that '*every month there was something coming out*'. She did not see much evidence that those above her were learning from experience. She reported that:

> *bad experiences are basically being swept under the carpet a lot of the time and ignored [and] people are seeing it as change for change's sake and if it's not effective then the next thing that comes around for change they're not going to take seriously because the last one failed.*

Executive decision-making: Fairness and feasibility

Lou disapproved of change decisions that were made without providing sufficient direction about a communication strategy or how to implement the changes effectively, and without any consideration of site differences. She did not think that sufficient attention had been paid to the

consequences of the efficiency measures for service-providers, their staff or their clients:

> *They often turn around to me and say 'oh, typical of exec to want this change to occur overnight without contemplating how it's going to affect us on the ground'.*

There was frustration at the chronic understaffing of her service and being advised to '*do the best with what you have*', which had meant curtailing activities or reducing service quality. It *'comes down to us just stretching ourselves a little bit thinner … every time'*. She thought health executives should simplify changes and ensure that implementation requirements did not exceed the capacity of the staffing levels needed to implement them.

Communication challenges

Communication of the need for change presents a significant challenge for health executives and their senior managers. Lou noted that '*it's not always about the 'what', it's about the 'why' and how they're impacted or how they can be supported in the future*'. With her interest in consumer input to health policy and process, involvement of all stakeholders in the change process was important to Lou: '*If you don't get people on board early on in the change process, I think you've lost them*'.

Given the lack of resources and difficulties in getting staff together, and with no payments for medical staff to attend training, Lou advised that she and her staff had to develop training videos. Staff had to watch these in personal time or at shift handover, with inadequate opportunity to ask questions, and this presented a significant communication challenge with an unsatisfactory resolution.

Impact on staff

Lou claimed that she and her staff were working substantial unpaid hours to manage their workloads. They were *'getting to that saturation point'*. The following comment illustrates how discouraged staff had become:

> *I think there's a sense of frustration that they know how good care should be delivered but there's just this stone wall of 'we can't provide that because we don't have the funding. We don't have the FTE allocation'.*

She admitted that this had culminated in loyal long-serving staff looking at other employment opportunities.

Lou reported that in country hospitals, there had been substantial reliance on staff goodwill to ensure that changes were successful, but there was no capacity to take on additional responsibilities and tasks:

> *I think country people … they've always had a sense of community … but I think they've got to that saturation point where they can't work any harder because they've just been taking more and more and more on board that now, you know, it's almost the straw that breaks the camel's back and they just can't do any more with any less.*

Impact on middle managers

Lou saw her role as a '*conduit*' between executive levels and other staff in the organisation, one of their numerous tasks being to develop the procedures for change. She described this role as:

> *people like me in the middle, are sort of that sounding board for the top down and the bottom up and we've got to actually make sure that we listen and that we can respond in a way that tries to bridge that gap between the junior staff and the executive staff to make sure that change can be seen positively.*

She expressed frustration at the lack of staff and resources, the increasing workloads, the never-ending demands to do more with less, and the inability to maintain a quality service. She was unable to envisage improvement in this situation.

Impact on patients

Lou commented that premature discharge to country hospitals had threatened quality of care, as there was a lack of available expertise and services, exacerbated by using non-local medical staff to provide care. Re-admission to city hospitals was not only costly for the health services but had emotional and financial consequences for patients and their families.

Suggested improvements for change management

Recommendations for potential improvements to change management processes encompassed communication; provision of adequate information, including the reasons for and processes of change and the benefits for all stakeholders; stakeholder and staff engagement and participation; careful planning, monitoring and evaluation of change; more deliberate consideration of the consequences of change; allowing sufficient time; and education and training. Lou illustrated her view with the following comment: '*Let's just get something implemented, embed it down, evaluate it before you move onto the next thing to make sure that we have been effective*'.

Skills and knowledge required to cope with and manage their roles in the change process

Maintaining a positive attitude, a willingness to share information, and the ability to manage relationships with staff and external providers and stakeholders were cited as key skills for managing change. Lou also highlighted the need to communicate at a personal level, as she did not think '*email [to be] a good form of communication*'. In her view, the manager had to convey a belief in change to be able '*to sell it to others*'. Like other participants, she stressed the importance

of building support networks for herself, her colleagues and managers, to enable problem-solving, and as '*a sounding board for issues that they haven't come across*'.

Suggestions for postgraduate health care management education

Lou advised that she had taken personal responsibility for her education. She remarked that '*a lot of people are elevated to positions of management that are just nice people but they've never done any kind of management training*'. She also questioned the lack of organisational support for education and training of middle managers.

Lou suggested that the standard areas of knowledge valuable to health managers were health financing, accounting and budgeting, corporate and operations management, human resource management, and change management and legislative requirements such as workplace health and safety, medico-legal and litigation processes. In addition, Lou recommended marketing knowledge and skills, including development of promotional and information materials, the use of social media by patients, and processes for effective consumer participation in decisions about their care and treatment.

Summary

Lou is an experienced health care manager leading a central unit responsible for complex network-wide functions. Her studies in nursing, midwifery, law, business and health management provide the foundation for her work in the areas of governance, risk and safety management, medico-legal inquiries, and organisational standards and accreditation.

Lou talked about changes in the national and state health systems. Although she recognised that some change had been necessary, she commented that perhaps this had gone too far and was affecting the quality and safety of care, workloads and staff and community morale.

She described her role as bridging the gap between organisational leadership and operational staff. This involved presenting changes in a positive manner and engaging staff and community members in change processes. She suggested that effective change management required skills in communication, information provision, relationship management and consumer engagement. In addition to formal postgraduate education, Lou encouraged the development of professional and personal networks for support and problem solving. Membership of a number of consumer organisations contributed to her desire to make '*a difference for patients coming through the health care system and … hopefully making it safer for patients as they enter hospital*'.

Morgan

Biographical and contextual details

Morgan is an experienced allied health manager who has been working in the health sector for over 30 years, almost 20 of these in a senior role. He has worked in a number of contexts ranging from community organisations to large public hospitals. His career progressed gradually from base grade professional through to head of allied health services, and he made sideways or downwards moves to secure a desired position or for release time for family priorities. Through many rounds of organisational restructuring, he has changed roles five to six times in the last 23 years, on one occasion becoming redeployed. In addition to his undergraduate professional qualifications, Morgan completed postgraduate studies in public health and health service management.

Morgan's role involves leadership of the allied health management team providing acute and sub-acute (see Glossary for explanation of these terms) allied health services. Responsibilities cover human resource, financial and operational planning and management, and working collaboratively with other senior executive and divisional heads to address service improvements or innovations, structural and financial issues.

Morgan's job satisfaction is derived from his involvement in client-oriented service provision:

> *Now my clinical exposure these days is limited but I really enjoy providing a clinical service that makes a difference so that the client, patient, consumer benefits in the way they want to and their life skills or their life situation is enhanced … whether that's direct responsibility or indirectly … I get a lot of satisfaction from being part of that.*

Health system reforms and organisational changes

Morgan discussed the major national- and state-level policy changes, their supposed rationales and their desired outcomes. He referred to structural changes in the health system resulting from 2011 national initiatives (COAG, 2011), such as the formation of Local Health Networks and Medicare Locals (see Glossary for explanation of these terms), as well as the related financial allocations to the State by the Commonwealth government. In turn, there were changes in the organisational structure and a reduction of senior level positions in the organisation for which Morgan worked but there was little immediate impact on the staffing levels or services delivered by the allied health disciplines. Historically, allied health had seen very little growth in staffing levels, despite increasing service demands. A more recent restructure had created a new division merging acute and sub-acute allied health services with a number of non-acute primary health care services.

Morgan mentioned a number of state-level reviews and Transforming Health, to commence in South Australia in 2015 (SAH DHA, 2014). Following the McCann Review (McCann, 2012) there were '*big changes in community health … health promotion has been really altered. Women's health state-wide has changed … so those community sections, the sub-acute, they've really had changes*'.

Morgan advised that, in the 1990s, a number of allied health departments in his organisation had been restructured into one allied health division, '*following a national trend of unifying allied health*'. This allied health profession-led change, as opposed to government change, moved supervision and reporting away from medicine and nursing. The creation of '*Program Manager positions*' resulted in allied health professionals reporting to a member of a different discipline with a focus on the '*area of service delivery rather than … profession*'.

Views on the impact of major change

Morgan declared that change is '*cyclical so if you stay in the one place, it'll come around again*'. He acknowledged the benefit of national and state initiatives, in terms of efficiency, cost and service satisfaction, and that the formation of an allied health division was innovative and gave allied health '*a voice … and … structure of their own*'.

Concerns with the inadequacy of health policy were reflected in his comments about powerful coalitions, service integration and continuity, equity of funding, access to services, and the future health of Australians.

Powerful influences

Politicians, unions and professional organisations were among the powerful bodies thought to influence the direction and outcomes of major change. Morgan suggested that major change was driven partially by political motives: *'the government's able to say … we've done away with so many managers, so many middle line managers … rather than those on the ground*'. The power of industrial and professional bodies was a potential source of resistance to new initiatives: *'We're all working together but then when things get tough we retreat back into our little silo and fight for the territory, which is unfortunate*'. However, compared to medicine and nursing, the allied health professions were regarded as '*the weaker party*' in change negotiations and decisions, and less likely to influence direction either constructively or negatively.

Service quality, integration and efficiency

Referring to the 2011 national initiatives of creating Local Health Networks and Medicare Locals, Morgan stated that '*a hospital within the health network [could] isolate itself*' from what was occurring in the primary and community health sector, affecting continuity of care and health promotion programs. Constant disruptive changes to funding arrangements and project support had resulted in attempts to maintain well-respected programs by '*taking something from somewhere else*', with negative consequences for the quality of services provided.

Equity or fairness in service provision

Morgan suggested that services across the Local Health Networks were not uniform, resulting in inequitable access. Likewise, at the national level: '*We've got the federal government giving out so much money and depending on what state you live you get a different deal*'.

Future population health

In Morgan's opinion, the reduction in primary health and health promotion services had produced '*a less complete health service model*' with the potential for '*health problems that … could have been prevented*' becoming more prevalent, and an increased demand for secondary and tertiary care (see Glossary for explanation of these terms). The discontinuation of '*critical*' programs, such as an evidence-based, internationally-recognised obesity program, could have negative repercussions, cynically expressed as: '*I look down Rundle Mall and I think wow, look at the population that South Australia's priding itself on*'.

Experiences and views of change implementation processes

Morgan's descriptions of structural change, '*it wasn't negotiable*' and '*they were forced*', reinforced that he was experiencing top-down radical change. He recognised executive prerogative to make such decisions and said that changes had been introduced '*in a positive, co-operative, consultative manner, generally speaking*'. Where this was not possible, the processes were '*as appropriate as they could be*'. He expressed doubts about the feasibility of further change at senior levels and contemplated that attention might then be directed at levels below. His concerns about change processes encompassed executive decision-making, communication challenges, and the impact of processes on staff, managers and patients or clients.

Executive decision-making: Fairness and feasibility

The impersonal aspects of radical change were confirmed by his inference that the choice of people to be made redundant was based only on position:

> *if you were to make judgements you would say there were others who weren't performing as well as her and yet they are still there and the organisation has lost someone who is a great worker and really influential.*

Morgan also questioned decision-makers' knowledge of the operational implications of their decisions. This was couched in statements about the formation of a new division where services were poorly aligned or where teams were disrupted to fulfil new reporting requirements:

> *Probably 80 percent of our work was tied up with the acute sector, tied up with the hospital wards, and yet we had that management, administrative link to primary [health] ... almost like they were manufactured teams and they had little to do with each other or they were forced into 'well this is your team' and they'd look around and say 'no, my team's over there. They're all elsewhere. There's no-one here that I work with'.*

Morgan reported that the closure of the health promotion department had meant that health promotion had become everyone's responsibility, culminating in activities being undertaken '*poorly*' by time-constrained, inexperienced staff.

Communication challenges

Communication challenges arose from the need to relay top-down change messages in a sensitive, honest and constructive way. An example was given, where one of the senior management positions had been made redundant at short notice and key staff were informed via rapidly-convened individual meetings with the CEO. After this, they were expected to relay the information to their teams:

> *Next was a communiqué to staff and that was reliant on individuals like myself who'd been briefed about what was happening being able to promote, publicise the reasons why it was happening in the positive sense.*

Impact on staff

Morgan expressed empathy for colleagues and staff whose work and workloads had changed when positions or programs were disestablished:

> *I felt for her … if that were to happen to me, you know, come to work one day and meet with the chief executive and at the end of the day you're gone, I mean that's quite a traumatic event.*

This empathy extended to professional colleagues working in other organisations. Reviews of community health and mental health services (McCann, 2012; Gruner, 2014) had prompted the introduction of new governance structures, job losses, changes to leadership positions, and redesign of many professional roles. Some allied health groups had: '*been knocked around … really been criticised*'.

Impact on middle managers

In addition to the emotional effects of change on his and other staff, Morgan referred to

increasing middle manager workloads. This included redistribution of responsibilities and work from redundant positions, leaving Morgan to question whether there was any capacity to cope with further senior position losses without affecting management processes or service delivery:

> *Obviously the cost of that has been there's been a shifting of some work and some responsibilities and the question is can any more be given? Are things stretched as tight as they can be?*

Impact on patients

Morgan highlighted the care that the decision-makers had taken to avoid negative consequences of structural changes on patient services, '*the same service is being delivered without those two salaries being drawn*', and noted that patient satisfaction had remained positive.

Suggested improvements for change management

Suggestions for improving change management processes focused on the need for evidence-informed decision-making, attention to the efficacy of change, and provision of a clear rationale and directions, including sufficient information about implementation steps. He said that it:

> *ought to be managed so it's not on a whim but it's really based on evidence and … efficacy, … [so they] know why we're doing it; that, to me, is the critical thing. … If the foundations aren't there and they can be washed away or chiselled away, blown away … it's really hard … to implement that change.*

Morgan proposed that middle managers be able to exercise discretion in how they implemented change.

Skills and knowledge required to cope with and manage their roles in the change process

At a personal level, Morgan stressed awareness of, and adherence to, personal values and how these infiltrated thinking about change, managing others, choosing career paths, and approaching work-life balance:

> *[I'm] still working hard for the values that I have and ensuring that I treat my staff as I'd like to be treated; there is life beyond work and it's a matter of keeping it in perspective; [I] consistently weigh up what's happening [against what] is good for the health of all South Australians or … for all Australians … it's good for my children and it's good for my community.*

In addition, he stated that it was important to establish '*positive working relationships*' with staff and leaders, to collaborate with other professionals, to have '*a long term view*' and commit to effective service delivery. Other admired qualities were diligence, reliability, impartiality and fairness.

Suggestions for postgraduate health care management education

Morgan referred to non-technical abilities such as being able to '*live by*' one's own values, maintaining work-life balance, having a broad, long-term view of work, as well as developing communication, relationship-building, leadership and management abilities, and the ability to reflect upon and improve personal performance, coping and resilience. These were seen as complementary to the usual curriculum offerings in understanding health systems, finance and human resource management, and appreciating a broad definition of health and wellbeing.

In Morgan's experience, formal university health management courses were good at providing '*a framework*'. However, he thought that other skills, such as reflection, self-analysis and how to talk to and manage staff, might be developed through experiential learning or short courses. These would involve '*working out …what sort of person you are and how you function and then how that fits with others and how to communicate; I mean the communication skills are critical*'.

Summary

Morgan provided an overview and critique of major changes in the health sector arising from national and state-level initiatives and expressed strong support for population health approaches and access to services. He reported numerous top-down structural and budgetary changes. While generally supportive of change, he questioned the fairness of some of the decision-making and implementation processes. His attention was focused on the quality of service provision and staff wellbeing.

To cope with the constant changes, he said that he relied on a strong adherence to personal values, maintaining a work-life balance and positive outlook, and supportive relationships with executive staff, colleagues and team members. He stressed the importance of evidence-informed change and the need for clarity and transparency of the aim, rationale and implementation steps. Managing his role in change required both technical skills and knowledge, such as understanding the meaning of 'health' and how health systems function, as well as important non-technical capabilities in relationship management, personal reflection, leadership and communication. He indicated that these can be developed through a mix of formal postgraduate studies, '*on-the-job*' training and short courses.

Pat

Biographical and contextual details

Pat is an early career manager with five years of experience, and is team leader of rehabilitation services across the sites of an aged care organisation. After training as an allied health clinician, she completed a diploma in management and is now contemplating postgraduate health care management education. While she aspires to senior management, she is aware of relatively few opportunities in allied health. Work in the public, private and community sectors of health and aged care had provided Pat with supervisory and management experience and opportunities for promotion.

Pat detailed the complexity of hybrid clinical and management roles:

> *you've kind of got your clinical job and then you've kind of got your higher level management job but this particular middle role I would think is probably one of the busiest.*

She has responsibilities for strategy development and management of a diverse range of rehabilitation programs. Her work encompasses liaison with internal and external stakeholders, quality and governance, key performance indicator (KPI) development and reporting systems, human resource management, workplace health and safety, and conduct of the successful manual handling program. She derives job satisfaction from provision of high quality client services, through staff who she perceives as her customers, having fulfilling work, '*being competitive, being innovative and showing initiative*', and contributing to the organisation's sustainability.

Health system reforms and organisational changes

Pat talked about the State health system financial constraints and increased accountability as well as Commonwealth aged care policy and funding changes. In the change context and with the most significant changes still to occur, she advised that a number of not-for-profit and for-profit aged care providers had re-evaluated their strategic directions. She reported that one provider had been dissolved, another had restricted its services, whilst another had worked on strengthening national alliances. One company had decided '*to sell off all of their residential facilities and keep their community*' services.

Views on the impact of major change

Pat stated that increased attention to consumer-directed care, streamlining of services and growth of community services to enable people to age at home, were all worthwhile goals. The disruptive changes had also prompted greater transparency in decision-making and information provision,

the recruitment of transformational leaders with capabilities relevant to the new context, and the introduction of new roles and systems to improve business processes.

Nevertheless, she said that changes to Commonwealth aged care policy and funding had lacked clear direction and created uncertainty in relation to market-driven approaches, service integration, equity of access, and future population health:

> *We are preparing for the worst next year because we've got funding until June 30 but we can't see it completely dissolving because the need is there and we just don't know where these people are going to go if they decide not to fund it.*

Powerful influences

In Pat's estimation, non-government organisations (NGOs), such as her employer, were less expensive than for-profit services, but were '*having to look at the sustainability of certain programs*'. She pointed out that if consumers were given the funding, then '*it becomes a product for us and not a service*', entailing more market-oriented, commercial approaches to attracting clients, quite different from the '*old medical model*'.

Service quality, integration and efficiency

Pat observed that some of her older clients were unable to '*navigate the system*', felt unsure about the financial implications of the changes and were anxious. She expressed concern about the capacity of some to make beneficial care choices: '*What do you do when the person doesn't have insight to make a decision and you know they might be making the wrong decision?*'

Highlighting a potential policy conflict, Pat noted that attempts to reduce hospital length of stay at state level had been hindered by the lack of discharge options for older patients, which is a Commonwealth responsibility. State-level funding constraints were also attributed with lowering the quality of care in hospitals and their ability to integrate effectively with the aged care sector. She described instances where older clients were returned to aged care facilities with no discharge information and with pressure sores due to lack of mobilisation.

Changes to community health and health promotion services, transition care facilities, domiciliary care structure and funding, closure of rehabilitation hospitals, and changes to Medicare Locals had resulted in suspension of some joint initiatives and reduced clarity for staff and clients about which organisations were providing which services. She observed that:

> *we don't really know what's going to be out there in terms of health promotion for our people and [whether] it is going to sit with us, the day therapy centres, again?*

Equity or fairness in service provision

Pat envisaged that national and state-level policy changes would lead to greater competition from other private for-profit providers, greater reliance on fee-for-service, and more out of pocket expenses for clients in both the health and aged care sectors: '*it's going to be more about the business and sustainability and people having to fund themselves more*'.

Future population health

Pat revealed her disquiet about the longer-term impact of the changes:

> *Where's the quality of life?*
>
> *I actually worry sometimes about the future, about what the health system is going to look like when I'm going to need it the most.*

Experiences and views of change implementation processes

Pat stated that she welcomed change, understood its cyclical nature and endorsed ongoing change: '*We have to change in order to grow … be innovative*'. In the health sector, she had faced budget constraints and restructuring. Similarly, in aged care, there had been CEO and senior manager turnover, with revised reporting lines, roles, responsibilities and service arrangements: '*a new person comes in and they change things and another person comes in and they change things again*'.

Pat explained that implementation details of Commonwealth policy changes became available some time after the policy announcement, leaving aged-care organisations with little time to plan implementation effectively. Consequently, operational change was driven from above. Some of her concerns related to the quality of data for decision-making, communication strategies, and the impacts of policy uncertainty on staff and clients.

Executive decision-making: Fairness and feasibility

Pat had noticed an increase in administrative staff and data requests, associated with Commonwealth compliance, accountability and reporting requirements. She questioned the adequacy of the data and how they were being used:

> *It's a bit like when you work for a company and they don't know their employees, they don't know what they're doing or what services they're providing; they're sort of just walking in blind.*

Communication challenges

Pat said that she tried to communicate top-down changes to her staff constructively and supportively, to maintain morale and commitment. The middle managers were keen to be '*honest*

[in] that we're not really sure what's going to happen'. She recounted a time when a senior manager was '*burned*' and lost '*trust and respect*' through not explaining adequately the reasons for changes in employment conditions. Staff had become anxious and '*we ended up losing about 20 percent of our staff*'.

Impact on staff

According to Pat, the uncertainty of the policy environment and future employment requirements meant that the organisation had increased its use of short-term '*contracts rather than permanent positions*'. This had created job insecurity and staff anxiety.

Impact on middle managers

Frequent changes to reporting lines, roles and working relationships, required middle manager flexibility and continuous reconfiguration of responsibilities, exemplified on one occasion by Pat and her colleague dividing their work between two portfolios. Pat also referred to the competing priorities of maintaining a commitment to service quality, staff job satisfaction and client advocacy, and managing an increased administrative workload and difficult communication circumstances.

Impact on clients

Pat indicated that she was unhappy with increasing client throughput and reducing the quality of service, when compared to professional standards. In short, '*from what I've seen the ability to be able to care is being lost*'.

Suggested improvements for change management

To promote understanding of and confidence in business decisions, Pat reinforced transparent, open and honest communication with all stakeholders, provision of an evidence-based rationale for change and explanation of the implications for the organisation, its staff, clients and the community. She affirmed that stakeholder consultation and '*more planning*' of implementation could prevent negative outcomes.

Skills and knowledge required to cope with and manage their roles in the change process

Pat stressed that her role required excellent interpersonal and communication skills, noting that '*what you say and how you say it has an impact*'. Skills included the ability to motivate, empower and build trust with staff and being open to '*better ways of doing things*'. Having organisational and priority-setting skills, being prepared for meetings and possible questions, personal resilience,

emotional intelligence, and the ability to reflect on one's own behaviours and perceptions and those of others, all contributed to being able to manage change. She also recognised the value of her support networks in coping with change and gave tribute to the valuable advice received from human resource colleagues and her supervisors on how to improve her skills and how to deal with difficult situations.

Suggestions for postgraduate health care management education

Pat revealed that she had moved into a management role with little training or experience. She was '*thrown in the deep end and I did it … there were times when … I didn't do something well*'. She had developed her skills and knowledge through formal education, informal short courses, in-house professional development and leadership programs, as well as experience of acting in higher positions and learning '*from other managers*'.

Pat recommended further studies in creativity, time management, leadership and managing people, performance and difficult situations. The more formal knowledge areas of strategic, project and financial management and budget construction were also considered beneficial.

Pat was keen to advance her career and was contemplating entering a postgraduate health care management program:

> *I feel like I'm missing the qualification to be able to go to that next level. I look at the people around me that have master's degrees, and maybe even higher than that, and the positions that they're in and I do feel like I do need to have something more than a bachelor to get to that next level. It's not essential and I know there are people out there that are in higher up positions and they don't have more, they don't have the master's, but I do feel like doing something like that will put me in a really good position to be able to go to that next step.*

Summary

Pat has a background in allied health and has worked in health and aged care. As the youngest participant in the study she is aspiring to a management career, takes advantage of opportunities to develop her management skills, has completed a management diploma and is contemplating postgraduate studies in health care management.

Pat related experiences of major organisational change and noted that further radical change was imminent because of Commonwealth policy directions. Although focused on the quality of client services and the job-satisfaction of her staff, Pat emphasised her commitment to innovation and organisational sustainability.

Her recommendations for improving processes included open and honest communication about

the rationale, plans and processes of change, and increased stakeholder engagement. She nominated both formal postgraduate studies and professional development courses as appropriate means of acquiring capabilities for managing and coping with change.

Sam

Biographical and contextual details

Sam has ten years of experience in a middle management role and has worked in the health sector for more than thirty-five years. She holds nursing and midwifery qualifications and postgraduate qualifications in specialist clinical areas, and has completed an in-house leadership course. Her career has spanned city and country public and private health services including spending a number of years as senior practice nurse and team leader.

Working in a small hospital, Sam has hospital-wide responsibilities for admissions, bed management, discharge planning, discussing '*advance care directives*' with patients and their families, managing a designated service, and undertaking accreditation preparation and special projects:

> *I'm sort of that central point or if anybody doesn't know what to do or where to go I'm that person they come to, so that go between that's meant to know everything.*

Created following a successful trial, this new position enables her to '*work pretty much autonomously*', and to liaise internally and externally with clinicians, other agencies and non-government organisations (NGOs). She mentioned that she had gained the respect of her colleagues, patients and their families for her *'assessment … judgement and … recommendation'*.

Her duties incorporate human resource management and workplace health and safety, which had been handled by dedicated administrative staff prior to system reorganisation. Sam stated that she works in a very supportive team of the Director of Nursing, medical staff and other nursing middle managers. Periodically she is required to act for the Director of Nursing and, along with other managers at her level, is rostered for regular week-long '*on-call*', including the weekends.

Health system reforms and organisational changes

Sam described a '*rapidly changing environment*' in health care, including demographic influences, such as '*the ageing population*'. She also nominated national and state constraints on health expenditure that had prompted efficiency initiatives such as the regionalisation and centralisation of support services.

Views on the impact of major change

Sam conceded that the introduction of specialised services such as chemotherapy and renal dialysis was '*great for the people in our community*', but that she had noticed the need for the

organisation to diversify services due to low patient numbers in the specialties.

She commented on the high frequency and volume of structural and funding changes and questioned the impact on equity of access and service quality.

Service quality, integration and efficiency

According to Sam, the complexity and health care requirements (acuity) of patients being transferred or admitted to her organisation had risen significantly, placing greater emphasis on discharge planning for older patients who '*need care for longer and need home services for longer*'. However, smaller hospitals and communities did not have the resources to meet the needs of those patients with special needs.

Equity or fairness in service provision

Sam expressed the view that patients did not have access to important services in smaller hospitals and communities, thus compromising their potential for improvement following transfer from tertiary facilities: '*sounds great in theory … in practice there's no services out there for people*'.

Experiences and views of change implementation processes

Change was communicated through '*directive after directive after directive down*' via the health network hierarchy. Sam implied that there was no choice: '*well, stiff, you've got to do it so make it work*'. She raised issues with the fairness and practicality of decision-making, communication challenges and impact on staff and patients.

Executive decision-making: Fairness and feasibility

Sam alluded to inequities in funding allocation, with smaller facilities having to provide '*the same level of service*' with fewer resources than the larger facilities. Moreover, increased patient acuity, complexity and emergency department load had intensified the behavioural issues confronting staff, although there had been no funding for security services to ensure their safety.

Sam stated that central departments were '*making decisions and implementing things without understanding the impact*', failing to appreciate the degree of variation that might be required in different contexts, and not seeking clinician input into policy changes:

> *a lot of policies are made by people that [sic] are not nurses and really at the end of the day who has to implement these things in hospitals, most of them? The nurses. I mean really at the end of the day if it's not practical at the grassroots level it's not going to happen.*

Communication challenges

Sam was concerned with the capacity of middle managers to deal with '*too much information*' associated with change and having the time and structural support to enable adequate communication and education strategies:

> *every policy or whatever is often 70 pages long; they all have their own sets of audits and sets of guidelines and things like that. That's only one but there's about 500 different ones and you expect the people on the floor to do it; it's just overwhelming. It is overwhelming.*

Gaining staff commitment was considered important but '*often challenging*' with the doctors being contracted private practitioners and not actually on staff. For other staff, shift change over time was a period where the Sam and the middle managers tried to '*fit in as much education in as possible*', but at times, new policies had to be implemented with no staff training. In one example, the consequence of not providing training was that some staff were ticking boxes without undertaking the proscribed activities, which undermined the process. There was no actual change in practice as those who were already compliant of their own accord continued to be compliant, and the performance of others did not change.

Impact on staff

Sam viewed '*change fatigue*' as a major issue:

> *I think if anything, it has an impact on the relationship with the staff below you because you're the one that's [sic] always having to push it and they have got change fatigue;*
>
> *It's too much and then who does anything well?*

In addition, Sam remarked that the new specialised services brought their own complications. A lack of specialised clinical staff in mental health had meant that there was no support for ward staff caring for patients with mental health problems, and there was inadequate specialised leave cover:

> *You can only have certain nurses work in a 'specialty 'unit, who have done the 'specialty' training, and then if that person's off sick then they steal [staff] from the wards so then that creates the next issue.*

In the absence of adequate local support services, staff sought support from their close colleagues and sometimes from the Employee Assistance Program.

Impact on middle managers

Sam asserted that radical changes had resulted in excessive workloads, higher levels of responsibility than her equivalents in larger organisations, and the continuous pressure of encouraging and keeping her '*team on board*', while trying to maintain patient safety and quality. Centralisation had deployed administrative staff away from clinical service providers, adding time

consuming and bureaucratic administration and human resource management tasks to the already heavy clinical and management workloads:

> *When I started there they had somebody in payroll, they had somebody in HR, they had somebody in occ[upational] health and safety who used to do all those things but now all those people have been eroded;*
>
> *You've got no idea of the rigmarole it is to get a new contract for a person.*

Rather than improving patient care, Sam suggested that keeping up with the policy changes, administration, compliance tasks and auditing quality and safety were taking middle managers and nursing staff away from patient care. The many hours of unpaid overtime to complete the tasks unrelated to direct patient care were a source of contention: '*You're not just managing your ward; you're managing everything else as well. Sometimes it's just overwhelming*'.

Along with the other middle managers, Sam had acted in the executive position a number of levels above her classification and shared week-long '*executive on-call*' work, feeling vulnerable when having to make decisions that demanded '*a lot higher level training in regards to bushfires and all those major incidents*'. The workloads and higher duties had had a negative impact on her physical and mental health and family responsibilities, that she described as an '*unnecessary burden that's put on us and on our marriages*'. Sam assumed that this issue had been left unresolved, even with union intervention, due to the economic climate. Her exasperation was evident in the following:

> *I really don't think that's fair when we put in so many hours already. You know, you're physically fatigued and then you're expected to do that mental stuff as well. Like I've just come off a call this week – so yesterday was my last day – and like some days you'd have – or some nights you'd have five calls in the middle of the night, then you're expected to turn up at work the next day; it's not right. It's not right … You don't actually get a break.*

Impact on patients

Sam commented that patients and their families were largely unaware of the system structural changes. Nevertheless, they had noticed things that had directly affected them, such as untoasted bread for breakfast and a reduced number of nurses on duty. However, '*I think certainly patients or their relatives are a lot quicker to complain these days*'.

Suggested improvements for change management

Sam suggested that, for clinicians, opportunities to provide constructive input were essential because policies often '*sound good in theory but don't actually work*' in practice. Furthermore, attention should be directed to explaining the benefits of change for staff and patients, while recognising the need for variation between contexts and ensuring that workloads were not expanded. Consideration of the immediate and ongoing staff training costs of new initiatives was

also called for as this was '*a huge financial burden on the hospital*'.

When a staff member with specific skills '*or a passion about something*' had agreed to be a change champion, policy implementation had been more successful.

Skills and knowledge required to cope with and manage their roles in the change process

Sam highlighted the need for middle managers to understand change management, how to support and sell change, and essentially:

> *to be the change champion. They've got to show what benefit it is to the patient and to the staff, or to whoever it's the benefit to. They've got to believe in it.*

She identified the required skills and qualities as being '*a good leader*', committed, flexible, '*constantly positive*', and possessing a good sense of humour to '*lighten it up a bit*'. Interpersonal skills and the ability to encourage professional development and teamwork were considered essential to building '*a partnership*' with staff. She summarised as follows:

> *Some people are good at managing finances … and some people are good at managing teams and … we have to do both. But I think if you want to get the best out of your staff you've got to be good at managing your staff, being a good role model and a good advocate for your staff as well as enthusing your staff. You want them to have the same passion as what you do.*

Suggestions for postgraduate health care management education

Sam supported a mix of experiential and theoretical education and reinforced the value of her '*hospital training*' in developing '*a more realistic view of the health care needs of a patient*'. She implied that a focus on patient-directed care should be maintained in management education: '*at the end of the day there's a patient in that bed*'.

Summary

Sam is an experienced nursing manager, with clinical and managerial responsibilities. Since completing hospital-based training, she has worked in smaller private and public health organisations. Despite postgraduate clinical education and professional development in leadership, she admitted to feeling unprepared for, and stressed by, the regular higher duties that were an expected part of the role.

Sam expressed concern at the negative consequences of major funding and structure changes on workloads, staff '*change fatigue*', and the safety and quality of patient care. She believed that smaller organisations were not being treated fairly in staffing level determination, funding distribution and expectations of the levels of services to be offered.

According to Sam, effective change management would consist of simple processes that did not increase workloads. Consultation with clinicians and other stakeholders was essential for ensuring their engagement in change and determining variations required for smaller facilities. She drew attention to the cost of training and advocated for using a change champion where appropriate.

Important areas of skill and knowledge for middle managers included understanding change, leadership, interpersonal skills and the ability to foster teamwork. Sam stressed the value of experiential processes in addition to more formal education for developing middle managers.

CHAPTER 5: WEATHERING MAJOR CHANGE

Raffanti's (2005a, 2005b) theory of weathering provides the framework for comparing and analysing the experiences, views and responses of the participants to radical top-down change.

This chapter presents the analysis of the participant interviews in terms of the conditions required for weathering, the dimensions of weathering, and the three phases of weathering: '*sizing-up, filtering* and *coping*' (Raffanti, 2005a, p. 28 [original emphasis]).

The section on the conditions of weathering incorporates the themes of the nature of change, policy drivers, the severity of financial constraints, and the strategy–operations gap. The theme of 'being in the middle' introduces the section on the dimensions of weathering, '*power, control, protection, time* and *culture'* (Raffanti, 2005a, p. 29 [original emphasis]), with communication challenges being a specific feature of the control dimension. The participants' concerns for staff wellbeing and the quality and safety of service provision form the basis of the analysis of the protection dimension. Themes of work intensification and role expectations, and the time cost of change, illustrate the time dimension. A discussion on culture completes the section on the dimensions of weathering.

Raffanti's major categories and sub-categories of the stages of weathering are used to analyse the participants' coping responses. I then present some further reflections on coping behaviour, specifically focusing on appreciation of radical and emergent change, and the middle manager role in the strategy–operations gap. The chapter concludes with the introduction of an additional category of coping behaviours, which I have named *Carefully Shaping Up*.

Conditions of weathering

Raffanti's (2005a) conditions for weathering comprise change pervasiveness, '*apprehension'* by those affected, imposition by a person in '*authority'* and an expectation of '*accountability'* (p. 28 [original emphasis]).

The participants in my study conceded that there were some benefits from the changes. However, they expressed numerous concerns about the nature of change, the policies driving it, the severity of the financial constraints, and a perceived gap between strategy and its operationalisation. Their comments were consistent with weathering change.

The nature of change

All the health care managers in my study reported experiences of unrelenting widespread top-down change. Major change was imposed by governments, with consequent change at state health department and organisational levels in terms of funding, structures, workforce, administrative policies and procedures and service provision. All participants stated that changes and budget or funding cuts were decided higher up in the health and aged care hierarchy allowing no opportunity for consultation, discussion, input or involvement. The lack of consultation extended to radical changes initiated at executive levels of the organisation, such as the internal restructuring of Bernie's department. Terms used by participants to describe imposed change included '*fed down from the top*', '*being forced on people*', '*dictated*', '*directive*', '*edict*', '*mandated*', '*no choice*', '*no flexibility*', '*fait accompli*', and '*just do it*'. Messages from above related mostly to budgets and savings targets with Jo summing this up as '*constantly hearing about the dollars and cents*' and Pat as '*everything's coming down to money now*'.

While there was recognition by the participants of the cyclical nature of change, frustration with the pace, constancy and volume of change was evident. Jo captured clearly the frequency of change, saying: '*you just think you get your head around who's doing what and then suddenly it's changed*'. Lou described it as '*flooding people with change, change, change*'. Morgan related a number of changes in organisational leadership and structures. A reduction in the leadership team had resulted in the delegation of additional tasks to him, and a person for whom he had great respect was suddenly redeployed. His disquiet was described thus:

> *the question is can any more be given? Are things stretched as tight as they can be? If a further position were to go would there then be a loss, a spill and things would fall apart?*

The pervasiveness of change was leading to '*change fatigue*' (Bernie, Jo, Lou, Sam) and '*cynicism*' (Bernie, Chris, Sam). Lou summed up the general frustration with ongoing change:

> *people are getting sick of change so let's just get something implemented, embed it down, evaluate it before you move onto the next thing to make sure that we have been effective.*

It was suggested that health and aged care executives did not appreciate the number of changes that staff were being asked to implement at one time, and that change should be planned, paced and evaluated more effectively. Although my research did not encompass emergent change, such as ongoing service improvement initiatives, it should be noted that these may also have contributed to perceptions of the pervasiveness of change.

Policy drivers

The participants made direct references to the political aspects of decisions in health and aged care. The issue of spending money on selling budget messages rather than it being '*better spent*' on service provision was raised by Chris, who also had misgivings about the impact on vulnerable people of a proposed Medicare co-payment. Morgan noted the advantages to politicians of being able to say that savings had been made by reducing the number of managers and executives in health care and that this had no impact on service provision and satisfaction.

In Pat's opinion, the move to consumer-directed aged care had been politically motivated, with short time frames and insufficient guidelines. She reported material being disseminated from government too slowly, resulting in uncertainty and confusion for clients and aged care providers; '*no-one really knows what's going on*'.

Concerns were expressed that large-scale structural changes, such as replacing Medicare Locals with Primary Health Networks, would not improve provision of services or access to them (Chris, Morgan). Moreover, Chris, Jo, Morgan and Pat mentioned that disruption to community health and health promotion services had possible implications for the future health and wellbeing of the population.

According to Sam, when national and state policies in Aboriginal health, mental health and aged care were changed there was little consideration of the additional resources required to handle the flow-on effects to country services. Lou and Sam also claimed that patients being discharged to country hospitals were disadvantaged because allied health services were often unavailable and medical services were provided by doctors who were less familiar with local policies and procedures because they had been contracted from interstate.

In summary, some participants suggested that policy decisions were short-term or short-sighted and not strategic in terms of benefit to the community or the longer-term health of a population. A number of the participants favoured broader consultation with and participation by all stakeholders, including consumers, clinicians and staff, so that policies and procedures were relevant to all contexts, or adjusted as appropriate.

The severity of the financial constraints

From the participants' accounts, care had been taken by some organisations to minimise the negative impact of financial constraints on patient services. In other cases, whole services had

been de-funded or reorganised significantly, resulting in job losses and uncertainty, and confusion for staff and patients, clients or consumers. Although they understood why national and state governments were attempting to reduce health expenditure, participants commented on numerous deleterious effects of prioritising budget and financial goals over the safety and quality of service provision. Also of concern were the disruptive effects of frequent changes of Chief Executive Officers and organisational structures, and the destructive consequences for some services, staff and patients, especially in community health, mental health and health promotion. Jo questioned whether, in fact, there had been any real financial gains from the changes.

Blanket budget cuts, implemented without explanation and without evident consideration of previous diligent management control or implications for specific services, were reported. Bernie voiced her concern about a 20 percent budget savings target despite having made previous savings and having an excellent record for managing her budget. She questioned the level of analysis of the capacity for savings and the lack of consultation or participation of middle managers in such decision-making.

Across the board financial cutbacks were also reported by Lou to have resulted in a budget that was '*too lean*' for country health, when compared to other health networks, and that this in turn had a negative impact on services in terms of safety, quality and sustainability. Likewise, Bernie deemed the financial constraints '*measly minded*' and '*punitive*', and responsible for '*phenomenal micromanagement*'. She claimed that increased compliance measures had limited staff creativity and productivity.

The strategy – operations gap

Participants referred to a disconnection between strategy and its operationalisation. The managers expressed a lack of confidence in decision-makers' expertise and knowledge to gauge the potential operational consequences of their decisions for staff, and their patients or clients. Jo remarked that '*the finance people are running health and the clinical people aren't*' and that budgets did not reflect '*clinical need*', patient complexity or patient expectations. This view was reinforced by Sam who said that the change '*sounds great in theory*' but there was no regard for clinical or administrative consequences. Furthermore, Pat and Chris implied that the data used for decision-making was often inadequate.

The failure to seek input from people with expertise and direct service experience was said to have resulted in negative outcomes. Examples of these appear in Table 10.

Table 10: Examples of perceived negative outcomes of change

Participant	Example of perceived negative outcome of a change
Lou	Recruitment of interstate GPs for country services increased the potential for adverse events as they had insufficient knowledge of South Australian policies and procedures.
Morgan	Expecting health promotion to be everyone's business had reduced the amount and quality of health promotion work.
Sam	The centralised shared services model increased rather than streamlined the administration component of a manager's role.

Jo suspected that '*some things seem to just happen by chance and luck sometimes rather than good planning ... like it's all conceptual and strategic but the actual operations of it no-one seems to think about*'. She suggested that someone with an operational background should be involved in the decision-making as '*there's a really big divide between strategic and operational*'. This would facilitate the translation of directives into action and the clarification of the operational aspects of changes. The results of not planning effectively were also highlighted by Morgan: '*If the foundations aren't there and they can be washed away or chiselled away, blown away … it's really hard to … implement that change*'.

The participants recognised their responsibilities in managing change and had several ideas for improving the quality of directives and associated information so that they could undertake their duties more effectively. Ideas included ensuring that changes were based on efficacy and evidence; that the direction, rationale, benefits for clients and staff and expected outcomes were clear, transparent, and logical; and that sufficient information was provided to staff about expectations and steps for implementation.

According to Jo, changes placed in the context of an overarching '*master plan*', with clear expectations and rationale, were easier to implement. Broad, '*vague and non-specific*' directives, with little information, provided the opportunity for various interpretations. As middle managers '*don't have time to sit and think and ponder*', more information on implementation processes was vital. Lou supported these ideas, pressing for more direction on a communication strategy and on implementation processes, while giving due regard to keeping all processes and communications as simple as possible. The value of simple, clear, open and honest explanations, and demonstration of awareness and understanding of staff reactions and concerns, was also reinforced by Sam.

The strategy–operations gap and policy alienation

The strategy–operations gap at the organisational level is commensurate with the broader concept of policy alienation (Tummers, Bekkers & Steijn, 2009). Tummers et al. (2009) explored the experiences and attitudes of professional service providers who were required to implement new neo-liberal policies in their services. They defined policy alienation as 'a general cognitive state of psychological disconnection from the policy program being implemented' (p. 686). In a later study of doctors' willingness to implement the equivalent of Diagnosis Related Groups in mental health care, Tummers (2011, p. 555) described dimensions of strategic, tactical and operational powerlessness, and societal and client meaninglessness.

The seven health care managers in my study said that they had no input into, and therefore no power over, strategic decisions at broader political, departmental or agency levels. Moreover, they had no, or little, influence over resources allocated, or not allocated, to policy or plan implementation processes. Some of the managers had some control over, and flexibility in, plan implementation but were having to deal with unclear, broad directives, a lack of resources and poorly designed outcome criteria. This made it difficult to develop an effective change process. Policies perceived to give priority to budget constraints over safety and quality of client and patient care may be less meaningful to clinicians. This is especially so when less time is spent on service provision due to increased administrative workloads and when there is a lack of involvement of clinicians in organisational change decision-making and planning. The participants also suggested that the policy discourse about improvement in population health was being contradicted by practices that reduced or closed community health and health promotion programs.

Dimensions of weathering

Raffanti (2005a) identified five interrelated dimensions of weathering as '*power, control, protection, time* and *culture'* (p. 29 [original emphasis]). These applied just as aptly to the health care managers in my study as they did to the educators in Raffanti's research, but the health care managers reported additional layers of complexity in their roles and responsibilities and in their responses to change. Thus the theme of 'being in the middle' introduces this section. Sub-headings within each dimension are those that emerged from coding and analysis of the interviews.

Being in the middle

Expressions such as '*middle management level*', '*line manager*', '*conduit*', '*operational manager*', '*right in the middle*', '*bridge*', and '*mediator*' were used to describe various aspects of the role and location within the organisational hierarchy. However, the intensity and complexity of the participants' roles cannot be fully encompassed in these terms.

As noted in Chapter 2, it was clear that middle managers played a substantial role in the implementation of major organisational change, even though they had had no role in the decision-making process. They had strategic and operational responsibilities for their own services, and some retained clinical duties as well as facilitating, coordinating and motivating teams or services. All participants reported performing a broad range of functions including, but not limited to, staffing, recruitment, numerous other people management (or HRM) tasks, training and development, performance monitoring, policy and procedure development, quality and safety, risk management, budget management, compliance reporting, and data collection and provision. In addition, they were supporting their managers, staff teams and colleagues, attending numerous meetings and working groups relating to change and implementing changes, often with incomplete or unclear direction or information.

Denis et al. (2009) defined sense-making activities as:

> *those associated with attempts to understand and define organizational strategies – that is, the nature of the organization's mission and mandate, including which programs it should be implementing and how it should be changing the way it delivers services (p.227).*

Focusing on the sense-making activities of middle managers, Balogun and Johnson (2004) referred to the importance of the horizontal organisational relationships and networks in the strategic top-down restructuring processes. The development of useful interpretations and approaches relies on a plethora of formal and informal communication processes. From their accounts, health care managers focused on sustaining cross-disciplinary interaction and constructive working relationships with their managers, their colleagues and staff to make sense of what was happening and to respond to change directives. In addition, they engaged with, and sought advice and support from, extensive networks of individuals and teams within and external to their organisations. Relationship management, communication and networking were cited as valuable capabilities in the performance of their roles.

Clarke et al. (2007) highlighted that managers may refrain from showing their true emotions and feelings about change so that they can encourage staff and colleagues to participate in the change

process. Some of the participants talked about taking a positive approach to change, despite their own opposition or reservations. According to Pat, '*[s]ometimes it can be really difficult because you really want to say what you really feel about something but you actually can't*', and Jo recalled that managers '*cop it from both ends sometimes*' and were '*trying to hold it all together until we all know exactly what's going to happen, which is tough*'. These statements captured the emotion work undertaken by middle managers during change. Clarke et al. (2007, p. 92) suggested that 'the emotion work performed by managers be both acknowledged and supported by the organisation'.

Power

In top-down imposed change, formal power is seen to be in the hands of senior executives. However, as Raffanti (2005a, p. 30) indicated, employees also exert their own informal power in choosing how to respond to the change through thriving or weathering behaviours.

Some insights on the use of executive power to implement imposed change were provided in the section on the nature of change earlier in this chapter. Other comments (see Table 11) alluded to the power associated with position in the organisational hierarchy.

Table 11: Comments on positional power

Participant	Comments on positional power
Bernie	Bernie had no power to influence the size of budget cuts or a process of service reorganisation. She inferred that if senior managers did not agree with the CEO's ideas, '*then you may find yourself gone*'.
Chris	Middle managers and staff not expecting to have a role in strategic decision-making
Jo	Demands being made from above for data and information.
Lou	Being told to *'do the best with what you have'*. Negotiation not supported.
Morgan	The CEO had arranged non-negotiable meetings with senior managers at short notice when making a major structural change.
Pat	Decisions on creation of redundancies.
Sam	Lack of choice in undertaking some tasks.

The effect of differences in professional power was raised by Morgan when referring to allied health being weaker than medicine and nursing. Most participants (Bernie, Chris, Jo, Lou, Morgan and Sam) also mentioned the power of professional and industrial groups to disrupt or resist major change processes such as Transforming Health. An issue with external social interest groups influencing change was raised by Chris. The power of any of these groups could result in a lack of

political will to persevere with constructive change (Bernie). Offering an alternative perspective on industrial power, Sam implied that her union had had no power to change her working conditions.

Control

Control and power are interdependent. Each participant had risen to a middle management position where she or he might have had greater influence over change. Morgan stressed the importance of establishing '*positive working relationship*s' with organisational leaders and executives in order to remain informed about change and, in turn, he had been a member of executive change implementation teams. Jo and Sam had gained the respect of their direct supervisors and acted in their positions on a regular basis.

In response to directed change, the participants sought to determine what they could and could not control in their areas of responsibility. Bernie sought to control the future existence of her department by trying to establish how they could contribute to the new organisational direction. Chris was keen to ensure that her staff had meaningful work that affirmed their capabilities, diverting attention away from the change decisions and processes and preventing '*sweating the small stuff*' (reducing potential anxiety about minor problems).

The participants' comments about communication challenges provide additional insights into their abilities to exert control over their roles and change processes.

Communication challenges

As noted above, several participants raised the importance of adopting a positive approach to communicating with staff. Bernie, Chris, Jo, Morgan and Pat related their struggles in balancing how much to tell staff and controlling the flow of negative information. Honesty, consistency and clarity in communicating about top-down change and clarifying the areas or decisions on which staff could have input were considered essential to avoid misinterpretation. Negative outcomes had been witnessed when this had not occurred. Pat described a situation where inadequate communication of change had led to high staff turnover and a consequent backlash from the staff against the senior manager concerned.

One of the challenges for Chris was in the numerous hierarchical layers impeding change approval processes and advocacy for patients and staff. For Lou, communicating with, educating and training staff was made difficult and complex given insufficient provision of structural support, time and resources to implement change. Staff in her organisation were often unavailable because

of their rosters, working in several locations and being dispersed across large networks; and there was a lack of funds to replace staff who were attending meetings, or to pay contract staff, such as medical officers, to attend. The use of video recordings instead of personal communication and meetings represented a loss of control of the communication process, resulting in sub-optimal outcomes, and providing insufficient opportunities for asking questions and for evaluating the effectiveness of knowledge transfer.

Although Morgan was unhappy with a redundancy decision and process, he was able to control communication to his staff so that the change would be supported. Chris recommended the use of multiple channels of communication, as well as repetition and allowing sufficient time for discussion of concerns. Sam mentioned that identifying and resourcing a dedicated change champion, with the time to communicate with and encourage staff to participate, had assisted in implementing a change.

Some of the managers also had to carefully plan their communication with patients, balancing how and what information to provide so that patients and their families had sufficient details whilst not becoming overly anxious. Jo described an approach that reflected that of other participants:

> *I guess that was a really planned approach to kind of inform patients and their families about 'okay, so we know this is happening and this is how we're going to do it'. We didn't just want to chuck a bit of information at them without the background of 'this is when it's happening and this is how we're going to support you through this change' and reassurances with 'we know that this is going to be an anxious time for you but you'll have the same doctors and you'll have the same nurses and this is how we're going to do it and this is how we will transport you there and this is how we will let your family know' and all those kinds of things. We tried to pre-empt the questions and worries that they would have with that so I think that kind of prevented a lot of issues.*

Protection

Raffanti (2005a) found that 'individuals … protect what is held dear as they endure organizational changes' (p. 38). Two themes illustrate the dimension of protection. The first details how the participants were concerned for staff and colleagues during major change and how they tried to protect them. The second is oriented to protection of the quality and safety of patient or client services.

Staff and colleagues

There was immense empathy among the managers for staff and internal and external colleagues who had been made redundant, subjected to numerous restructures, or who were experiencing

high workloads and other challenges associated with change. This is demonstrated through sample statements provided in Table 12.

Table 12: Examples of empathic statements

Participant	Examples of empathic statements
Bernie	*She was quite damaged. It's not helpful to scare everybody.*
Chris	*Know how to support the staff effectively, particularly when times get tough.*
Jo	*If you've worked somewhere for 20 years or 30 years, you know, it's really distressing.*
Lou	*She's just continuing to put on a brave face.*
Morgan	*I really felt for her. That's quite a traumatic event.*
Pat	*We didn't want them to ever feel like they did that day again so we were upfront and honest about everything.*
Sam	*Sometimes she can spend four hours on the phone just trying to find somebody.*

The participants stressed that they devoted time to supporting staff, listening to their complaints, and trying to minimise anxiety levels, as discussed in the section on 'communication challenges' above. Chris, Lou and Pat suggested that it was important to maintain and protect staff job satisfaction. Chris was eager to provide satisfying work that generated positive outcomes for patient care, while developing staff confidence and familiarity with change, and maintaining their motivation and productivity. The section below on work intensification discusses concerns about the negative effects of high workloads on participants and their staff.

Quality and safety of service provision, client and family engagement, client wellbeing

Provision of safe, high quality, 'best practice' patient care or client services featured most prominently in participants' statements about direct or vicarious job satisfaction. This is not surprising, given participants' employment in the 'helping' health professions. Jo and Sam respectively encapsulated the general sentiments as follows:

> *What we need to do is make sure we're doing our core business well and our patients are receiving safe care;*
>
> *At the end of the day there's a patient in that bed. That patient in the bed hasn't just got one need; that patient in the bed often has multiple needs, multiple co-morbidities.*

Active engagement of the patient and family in their care was reinforced (Jo, Lou, Pat, Sam).

As mentioned in the earlier section on policy drivers, participants expressed concerns about the ramifications of disestablishing or reducing health promotion and community health services for maintaining healthy lifestyles and preventing future demand on the health system as the

population aged. Committed to the wellbeing of their patients and clients, the participants did not support policies that would create additional costs or access difficulties for vulnerable, marginalised, low income, or older people and families. A conflict in aged care policies between the Commonwealth and State governments was seen by Pat to be producing poor quality care. For example, patients had been returned to aged care facilities with bedsores and in worse physical health than before their transfer to hospital, and there was immense uncertainty for patients and their families about the costs of, and processes for, accessing appropriate services.

The section on policy drivers also introduced some of the negative impacts of radical change on country health services. In addition, attempts by city hospitals to reduce hospital stays had placed significant pressures on those services to which patients were discharged or transferred prematurely, with readmission having negative medical, psychological, and financial consequences for patients and their families (Lou, Sam). Lou maintained that budget cuts had resulted in services not being provided at a safe and sustainable level. Responsible for maintaining and updating staff knowledge and skills in managing service safety and quality, she also expressed her unhappiness about having to reduce the quality of her education and training services in this area.

Jo and Sam proposed that time spent on compliance tasks, change processes and a myriad of other non-clinical tasks diverted staff from clinical duties. This in turn had negative outcomes for the quality of patient care. Managers and clinicians found the new procedures for ordering supplies time-consuming and restrictive, resulting in some supplies not being available when required. Even simple things, such as toasting bread for breakfast, had been discontinued in one facility. For Pat, '*the ability to be able to care is being lost*'.

Time

Time constraints relating to high workloads, and difficulty in prioritising tasks, were problematic for all participants. The following sub-sections cover this work intensification and the time costs of change.

Work intensification and role expectations

Work intensification and its implications for middle managers and professional staff have been well documented (Hyde et al., 2013; McCann, Morris & Hassard, 2008; Omari & Paull, 2015). In a large study of health care managers in England, Buchanan et al. (2013, p. 41) referred to 'extreme jobs' as those reflecting the intensity, long work hours, breadth and high levels of responsibility of the work. In my study, work overload reported by health care managers in an environment of

constrained resources was exacerbated by requirements to address short-notice demands for information from superiors, while attempting to balance staff, patient and organisational needs. Organisations were being asked to manage the increases in patient numbers, acuity (health care requirements) and complexity, and new service initiatives, within existing workforce and resource allocations (Chris, Jo, Lou, Morgan, Sam). However, seeing an increasing number of patients or clients within a specified time period had placed further pressure on staff (Chris, Pat). Examples of other additions to workloads are given in Table 13.

Table 13: Examples of workload items

Examples of workload items	**Participants**
Increased justification, compliance and reporting requirements	Bernie, Chris, Jo, Lou, Pat
Volumes of new and revised policies and procedures to read, comprehend and then implement	Lou, Sam
The need to become familiar with new technology	Chris, Jo
Having to attend numerous meetings regarding change	Jo, Lou, Pat
Responsibility for duties, such as supply ordering and numerous human resource management tasks, previously performed by administrative staff before they had been centralised	Jo, Sam
Duties delegated from above	Morgan

In comparing her role with people above and below her in the hierarchy, Pat referred to '*this particular middle role*' as '*probably one of the busiest*'. The significant out-of-hours work performed by the managers to keep abreast of the workloads implied a '*lot of goodwill*' (Lou) and high levels of professional commitment to staff and services. However, it was reported to affect work-life balance (Bernie, Lou, Sam). In particular, following a week-long period of '*on-call*' work, Sam commented on her '*overwhelming*' workloads: '*It's just too much. It is just too much; It's just another thing on top of your already full workload*'. Likewise, Morgan opined '*can any more be given?*' and Lou mentioned that she and her staff had reached '*saturation point*', with goodwill eroding rapidly. Lou expressed frustration at being given tasks that were in the '*too hard basket*' and being asked constantly to '*do the best with what you have*'.

Epitomising the tension between competing priorities and balancing the needs of staff and patients with those of the organisation, Jo remarked '*if everyone up top knew what everyone else up top was requiring they'd actually realise that it's physically impossible*'.

Time cost of change

From what the participants said, the planners had not factored the time costs of change into the change processes or resource allocations, with Jo alluding to the small savings not being justified by the time spent on administrative tasks. She commented on the lack of staff available to attend the numerous meetings. When they did attend, she reported that draft or final documentation for further feedback often was not provided or was delayed so that priority policies and procedures were not produced or implemented in a timely manner. This amounted to a waste of valuable time as well as having to rely on outdated policies and procedures.

Moreover, there was said to be little consideration of the work required to adapt large organisation and metro-centric policies and procedures to other contexts (Jo, Lou, Sam), or the consequences for the effectiveness of policy implementation when the process had not been adequately resourced (Bernie, Chris, Jo, Lou, Morgan, Pat, Sam) or if inadequate modes of communication and education were used (Bernie, Chris, Jo, Lou, Pat, Sam).

In summary, direct costs of change included time spent by staff on meetings and administration, and there were potential opportunity costs to the efficiency and quality of service provision, to completion of other administrative tasks, and to work–life balance.

Culture

Organisational cultures influence participants' weathering behaviours. Raffanti's study (2005a) differentiated between '*command*' and '*participatory'* leadership cultures (p. 41 [original emphasis]). While a 'command' approach was used in the top-down nature of the radical changes that are the context of this study, health system culture has some more participatory aspects.

Mintzberg (2014) described the 'professional organization' as one in which professionals use the power of their expertise to maintain control, coordination and discretion over their professional work, rather than being directed by others in the bureaucracy. They place the interests of their profession, their work and their patients or clients above those of the organisation and can be resistant to changes that threaten their control or autonomy. Braithwaite (2006b) also found that when multidisciplinary structures were introduced in health services to gain greater coordination or cooperation between service providers, the old professional structures persisted for support, advocacy and the pursuit of profession-based interests.

The research participants commented on potential resistance to change by strong professional

bodies (Bernie, Morgan), individual professionals (Lou, Pat, Sam), or long-serving professional staff (Chris, Jo). Some of the managers voiced suspicion of decision-makers driving savings under the guise of improving clinical care. They referred to the paucity of clinical input to policy and change decisions at health and aged care departmental and organisational level and the lack of consultation with managers charged with implementing changes. Chris commented:

> *I think there's a fair degree of cynicism that says decisions are made and this is just a process that is seen to be clinician led and clinician endorsed but it's also being manufactured to look that way.*

With health care organisations relying on professional expertise to provide their services, some professionals and professional groups have become accustomed to being involved in strategic decision-making. The participants recognised their lack of choice in the radical change decisions, but affirmed that use of a participative approach in implementing the changes in their professional areas of control (Bernie, Chris, Jo, Lou) is compatible with expected professional behaviour. According to the participants, they were trying to balance the 'command' aspects of radical change with the participative approach expected by the professions.

The participants' comments about the conditions and dimensions of radical change, including the nature of change, the strategy–operations gap, and the power, control, protection, time and cultural issues of 'being in the middle', indicated that the foundations for weathering change were present.

Stages of weathering

The participants' reflections on radical change were analysed using Raffanti's framework of three stages of weathering: '*sizing-up, filtering* and *coping'* (Raffanti, 2005a, p. 28 [original emphasis]).

Sizing-up

Because sizing-up is subconscious and preparatory, such behaviour is unlikely to be described or explained by participants in the context of a semi-structured interview. However, their statements indicate what they might tune into, take note of, or have an emotional reaction to, when a change is imposed.

Having experienced numerous changes, and being 'weathered *by* change' (Raffanti, 2005a, p. 37 [original emphasis]), the participants addressed concerns about workloads, responsibilities and accountabilities for themselves, their staff and colleagues. They also raised concerns about the adequacy of resources, maintaining quality of service provision, the adequacy and volume of

information provision, communication processes, the knowledge of actual operational implications of directives, and the processes of implementation. In addition, the interviews revealed factors that were important to individual participants, for example, greater involvement in strategic decision-making and enabling innovation (Bernie), stakeholder engagement and patient involvement (Lou), service integration and efficiency, and maintenance or improvement of allied health and health promotion services (Morgan), and consumer-directed care (Pat).

In summary, the interests and concerns of each of the participants shaped their preliminary reactions to proposed change. Their sizing-up behaviour provided the basis for the next stage of filtering.

Filtering

Responses to change are also dependent on several professional and personal filters, which are constantly evolving. These are considered below in terms of professional, career, personal agenda and emotion categories (Raffanti, 2005a, p. 63), along with sub-categories that arose from my analysis of the interviews.

Professional factors

The participants' descriptions of the policy and work environments, their access to professional networks for information and issue discussion, and their completion of various courses demonstrated their professional commitment to keeping abreast of what was happening in health and aged care. This enabled them to place changes in context.

The participants were not averse to change and all could identify some benefits of the changes that had been implemented. Bernie asserted, '*I quite like change … there's always something good that comes out of change*', while Pat noted, '*it doesn't scare me or bother me anymore*'. Nevertheless, because they held undergraduate degrees in nursing and allied health, typically referred to as the 'helping professions', it is unsurprising that they would want to have sufficient resources to ensure a level of quality and safety of care acceptable to their patients and professions. Several managers (Bernie, Chris, Jo, Lou, Pat) expressed their desires to consider alternative options for implementing the changes and to be creative and innovative in order to ensure that actions were context-appropriate, and to contribute to the development of 'best practice' approaches and positive outcomes for their patients or clients and their organisations.

The participants had accepted management responsibilities and were expected to advise their

staff and colleagues about new structures, policies, procedures and processes. Often they were afforded significant autonomy and professional discretion in how they implemented changes (Bernie, Chris, Jo, Lou, Pat). However, all mentioned the importance of teamwork in being able to implement change effectively.

Respect, trust and integrity were important professional values held by research participants. Chris recounted efforts to demonstrate her respect for the knowledge and skills of her staff by ensuring that they had satisfying and challenging work, and Morgan emphasised that he tried to '*treat [his] staff as [he'd] like to be treated*'. In keeping with their ready acceptance of authority, responsibility and accountability, the participants also valued the respect, trust and support of their colleagues, senior managers, and clients or patients. They testified to being respected by their staff, teams and colleagues for their knowledge and expertise, with Bernie, Chris and Lou also citing their state-wide or national professional reputations.

The participants reinforced professional expectations for consultation and participation in decision-making and planning. They argued that greater input from clinicians, managers, other stakeholders and expert sources increased staff commitment to change and the likelihood of local decisions and change processes being well informed, evidence-based and practical.

According to the participants' reports, they placed priority on patient or client service and staff wellbeing. This meant that, in the absence of resources to help them manage increased workloads, the participants undertook a lot of out-of-hours work. Bernie encapsulated how seriously they all considered their responsibilities: '*so it doesn't come as a surprise to me that we need to do that and I guess I figure that's why they're paying me what they're paying me to manage that*'.

There were suggestions that some professional expectations were not being met. Examples are provided in Table 14.

Table 14: Unmet professional expectations

Expectation	Example of unmet expectation	Participant
Fairness	Decisions made to offer less than optimal care to ageing patients in public hospitals	Pat
Fairness	Priority given to budget performance over safety and quality	Lou
Fairness	Continuation of programs without funding	Morgan

Fairness	Perceived inequities in service provision across local health networks and states	Morgan
Fairness	Inequity in budget and resource allocation between services or networks	Lou, Sam
Fairness	Allocation of a significant budget cut despite a '*history of fiscal responsibility*'; overspending by others who were less diligent	Bernie, Jo
Fairness	Making a particular staff member redundant when others appeared to be performing less effectively	Morgan
Autonomy, professional judgement	Perceived lack of autonomy and flexibility to exercise professional judgement: '*It just seemed a bit ridiculous that you'd trust me to manage 40 people and $3.8 million but not sign off on something that was in my budget*'	Bernie
Respect	The time nurses were expected to spend on non-nursing duties	Jo
Respect	'*It's this lack of professional respect that in fact you might know something about what you're doing that drives me more crazy.*'	Bernie
Respect	Statement that health care managers felt undervalued and under-utilised from a strategic perspective, that consultation with the managers was often not sought in planning change, and that when feedback was provided it was often ignored	Bernie

The participants' statements echoed findings by Huy (2001) that organisations had undervalued the contributions of middle managers to the implementation of radical change. Areas of contribution highlighted by Huy (2001, p. 73) comprised innovative ideas, ability to tap into informal networks internal and external to the organisation, closeness to and understanding of the needs of operational staff, and an ability to balance change with ongoing service provision.

Career orientations

In their interviews, most of the participants alluded to what Raffanti (2005a) called '*careering*' (p. 73 [original emphasis]), but other career orientations were also evident. For example, Bernie presented aspects of '*long-hauling*' (p. 70 [original emphasis]) in her commitment to the longer-term sustainability of her service, '*careering*' in her desire to be involved at the planning level and to use her strategic knowledge and skills, and '*jobbing'* (p. 73 [original emphasis]) in terms of the day-to-day education and development work. Lou's frustration with the ongoing budget cuts, the high workloads, and the impact on the quality of her service, had led her to seek alternative employment, signalling a phase of '*short-timing*' (p. 72 [original emphasis]) in her current role. As an early career manager, Pat was actively pursuing leadership roles, reflecting '*careering*'. If she perceived that she had potential opportunities elsewhere, she may also adopt a '*short-timing*'

orientation.

Referring to his allied health profession, Morgan wanted '*that sort of interaction with people*', and received job satisfaction from attempting to enhance clients' lives. He had pursued leadership roles that enabled him to have some influence over the quality of patient care. After some initial moving between jobs, or '*short-timing'* (Raffanti, 2005a, p. 72 [original emphasis]), he has been committed to the same organisation for 23 years, although in different roles, an orientation of '*long-hauling*', which fits with his professional and personal values. There are also aspects of '*jobbing*' in Morgan's approach, where he thinks carefully about, and places more importance on, the outcomes of a decision for staff and patients than on himself and his career. At one point in his career he did not accept a position because he '*didn't think that [he] could approach it with sincerity*'. Now financially stable and approaching retirement, Morgan indicated that he would not be worried if his job was made redundant, as he would '*dabble in this and dabble in that*'. This is a sign of moving into a '*short-timing*' phase.

Personal agendas

Personal interests and job satisfaction factors for each of the participants (see Table 15) contributed to how they might view an impending change.

Table 15: Personal agenda examples

Participant	Personal agenda examples
Bernie	Involvement in strategic decision-making. Innovation. Retention of professional autonomy.
Chris	Advocacy for clients and staff. Protecting vulnerable members of the community. Staff having meaningful and satisfying work as personal motivators.
Jo	Lateral thinking. Flexibility. Networking with colleagues. Delivery of high quality care.
Lou	Stakeholder and consumer consultation. Benefits of change to the community and consumers.
Pat	Protecting vulnerable members of the community. Innovation and creativity. Service sustainability.
Morgan	No financial concerns. Work-life balance, family and fitness.
Sam	High quality care. Continuity of patient care. Professional teamwork. Family time.

Emotions

Raffanti (2005a) categorised emotions associated with weathering change into '*fear'*, '*frustration'* and '*overwhelm'* (pp. 76-79 [original emphasis]). In discussing these emotions, I retained Raffanti's

use of ‘overwhelm’ as a noun. The participants used many words and phrases that expressed or qualified the strength of emotions. Their descriptions incorporated both their own responses and references to those of staff, colleagues, and clients or patients.

Figure 1 below summarises the allocation of the emotion words from the combined transcripts to Raffanti’s three categories as a percentage of total words (see Appendix 9 for the raw data). LIWC2015 allocated similar categories of negative emotions (see Figure 2) but, while interesting as an alternative approach, the categories were not interchangeable with Raffanti’s.

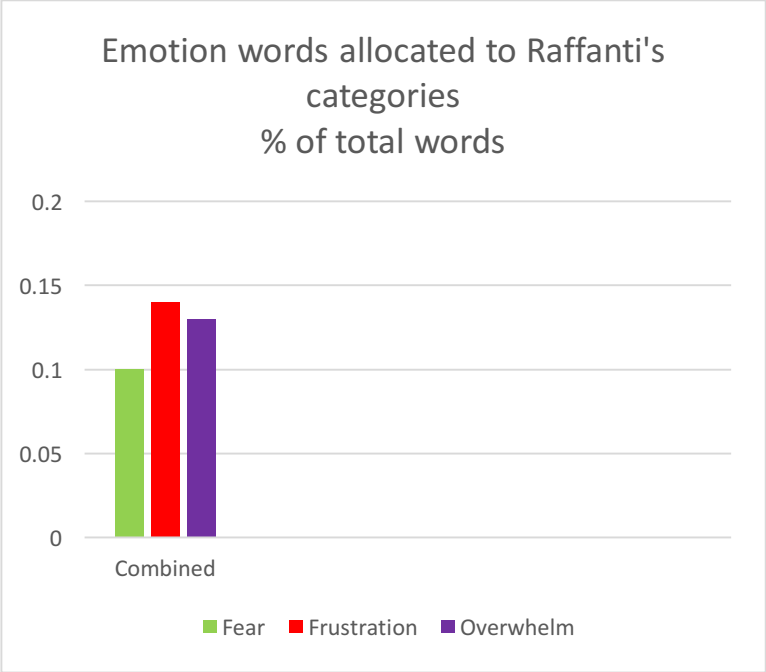

Figure 1: Emotion words allocated to Raffanti's categories

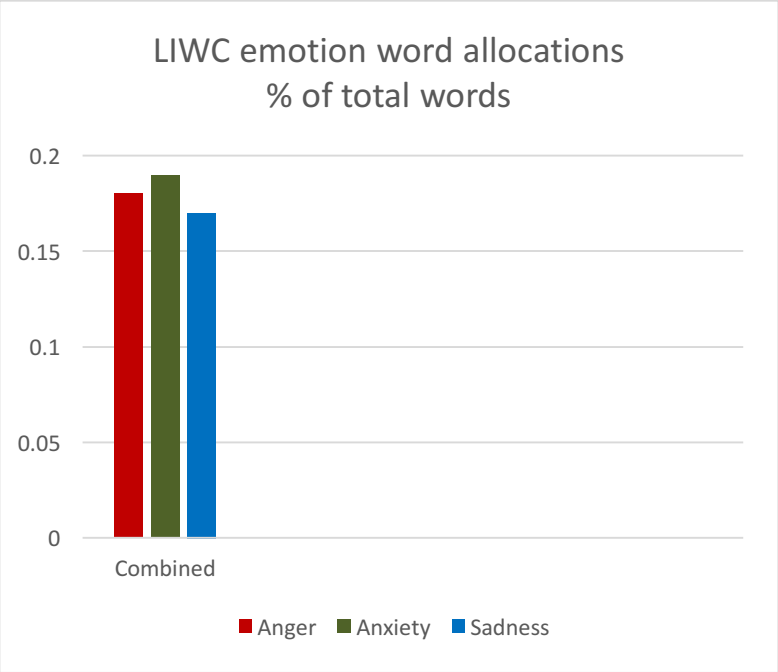

Figure 2: LIWC emotion word allocations

In summary, the analysis of emotion word use in the semi-structured interviews supported Raffanti's (2005a) findings that people weathering pervasive major change experienced negative emotional responses that could be categorised as fear, frustration, and being overwhelmed.

Coping

Based on sizing-up and filtering stages, individuals who are weathering change determine how they will cope. Coping behaviours vary with changes in personal, professional and organisational contexts.

Raffanti's (2005a, pp. 81-100) coping categories (either acquiescing or resisting behaviours), summarised in Table 6, provided a basis for analysing the responses to change reported by the health care managers in my study. Close to retirement, Morgan could have had reason to bide his time. However, his statements about the importance of maintaining relationships that provided an ongoing source of information and his involvement in implementation groups suggested that he chose to remain engaged. With the continuous nature of change, Jo commented that at times she and her staff just needed to '*shut out the bigger stuff*' and get on with the '*core business*' of '*looking after patients*'. While this could be construed as biding time, Jo revealed that that she was still trying to communicate the need for change and support both staff and patients, signalling a more constructive engagement in the change process. Likewise, Chris explained that she was keen to ensure that staff had challenging tasks and responsibilities and were not focusing on issues

beyond their control. Bernie's comments on her frustration with the lack of professional respect for her input could have provided a basis for her to hide out, yet she gave examples of her continued efforts to sustain her involvement and find constructive ways to proceed.

Some of the reported responses could be viewed as bargaining, but in the participants' accounts there was little evidence of reciprocation from executive levels. Despite his admission of unhappiness with the redundancy management processes that created trauma for individuals, Morgan advised that he had followed instructions on providing information to the staff. While he may have been garnering some advantage for the future, the frequent changes in CEO occupants required constant re-building of executive–manager relationships, potentially reducing the effectiveness of such a strategy. Bernie's attempt to develop a learning and development framework for her organisation could also be viewed as bargaining to secure a future for her service. To me, as an outsider, Morgan's and Bernie's behaviours reflected pragmatic responses to difficult situations by diligent middle managers.

Sam related an instance of 'by the booking' acquiescing behaviour by some staff when directed to record hourly patient monitoring, which was introduced hurriedly and with very little training. She said that consequently those staff not committed to the process just '*ticked boxes*' without concern for improvement in patient care. Meanwhile those staff who had always been diligent continued to provide care of high quality. In relation to the changes described, there was no evidence that the participants themselves engaged in 'by the booking' behaviours.

The participants' commentaries did not indicate the use of resistance behaviours, such as sabotaging, illusioning, hiding out or deflecting, in response to radical change. However, the lack of description of a behaviour does not mean that it never occurs. If we reflect honestly on our own behaviour over time, we might all recall instances of using any number of the resisting or acquiescing behaviours described in the theory of weathering.

The participants' reported responses were consistent with their personal and professional needs while also allowing them to continue to support and advocate for staff and patients and contribute to the organisation's longer-term strategic direction. They attested to this in their comments on their responsibilities in managing change, taking a positive approach and bringing both staff and patients or clients along in the process. This could perhaps be construed as 'good little soldiering' described by Raffanti (2005a) as 'a good faith effort to meet leadership expectations' (p. 95) occurring out of 'a sense of organizational duty' (p. 96). However, the participants' accounts

describe more assertive, constructive behaviours not consistent with 'good little soldiering'. I concluded that a new category of behaviours was required to describe the coping behavior of health care managers in this study.

I first considered two alternatives. Firstly, Raffanti's category of thriving on change was considered, but was not consistent with the participants' expressions of dissatisfaction with the nature and processes of change nor with their continuing attempts to change or ameliorate the operational impacts of the changes.

Secondly, their coping behaviours could be seen to represent organisational citizenship behaviour (OCB), defined by Organ (1997, p. 95) as 'performance that supports the social and psychological environment in which task performance takes place'. Entailing 'helping behavior' and exceeding formalised job requirements, OCB has been shown to have both positive and negative consequences for individuals and organisations (Spector, 2013, p. 540). However, the five commonly recognised OCBs, namely 'altruism', 'conscientiousness', 'civic virtue', 'courtesy', and 'sportsmanship', as described by Deery, Rayton, Walsh and Kinnie (2017, pp. 1040-1041), express OCB at work generally, not specifically during change, and they are not specific to either weathering or thriving on change.

A more specific category of behaviours was required to describe the coping behaviours of health care managers, which I have named *Carefully Shaping Up*.

Further reflections on coping behaviours

On further reflection, I noted some areas of inconsistency, reduced clarity or limited detail in the interview reports. In part, this represents one of the limitations of the interview method, where time is limited and interviewees have greater control over the process and the information provided. Additionally, the structure of the prepared questions may not have elicited more complete responses and I may not have recognised the need for more probing follow-up questions at the time.

Even with these constraints, statements or views that appear contradictory or less well enunciated can provide potential insights into other factors that influence coping with radical change. The areas of interest encompassed the distinction between radical and emergent change and the role of the middle manager in the strategy–operations gap.

Appreciation of radical and emergent change

The participants' descriptions of their experiences confirmed their understanding that imposed radical change affected organisational budgets, structure and services and that they had little influence over the original strategic decisions. In discussing changes with staff, Chris acknowledged that some decisions were not theirs to make: '*this is not your space*'. In relation to suggestions of how change should be managed, most participants indicated that they would prefer to have greater input to planning and implementation discussions at organisational level. Bernie, Chris, Jo, Lou and Morgan gave some examples of involvement in change management meetings, but these did not involve higher level planning and decision-making.

It is conceivable that the participants may have overestimated the time available and the power of their chief executives and senior management teams to accommodate stakeholder input. There were very few comments on the effects of government and health department directions and expectations on chief and senior executives that may have influenced the time, flexibility and processes for change implementation. Bernie talked about the different responses of two CEOs, one who was prepared to question instructions and one who did not do so. Although the former had been able to negotiate on some strategies, she was still described as authoritarian and directive when implementing changes in the organisation.

I formed the impression that in coping with radical change, the participants may have lacked a full understanding of its nature and implications, as compared to smaller-scale and emergent change. In particular, they seemed not to understand the differences in how these types of change are executed by organisational leaders, and thus the expectations placed on middle managers in their implementation.

The middle manager role in the strategy-operations gap

As discussed earlier in this chapter, participants had identified the possible existence of a strategy–operations gap and suggested that this could be resolved by involving key staff and stakeholders in identifying the operational consequences of change decisions, and in implementation planning. They also commented on the importance of evidence-based decision-making and provision of clear directives, including expected outcomes and evaluation plans. However, as highlighted by Burnes (2014, p. 410), the context of radical change is not conducive to the application of these principles by decision-makers and leaders.

This uncertain and challenging environment provides potential opportunities for middle managers

to assume greater control over the processes, to be innovative, and to develop their change and project management capabilities. Most of the participants described changes that they had implemented, focusing inter alia on strategies that could be conceived as efforts to bridge the strategy–operations gap.

Carefully Shaping Up – an alternative coping behaviour?

I am proposing *Carefully Shaping Up* as a category of behaviours additional to the resistance and acquiescence coping categories described by Raffanti (2005a, p. 81). The term describes cooperative yet adaptive behaviours used by health care managers in weathering change. It reflects the additional layers of complexity in managers' roles and responsibilities. The participants' reports indicated that the following strategies were useful for surviving change: adhering to personal and professional values and priorities; maintaining strong support networks and personal wellbeing; developing knowledge and skills; keeping informed; and taking responsibility for shaping change.

All the participants talked about their empathy for their colleagues within and external to the organisation and the need to support, protect and encourage their staff. They reported their concerns for the quality and safety of care or service provision, and the health and wellbeing of their patients or clients. Use of 'carefully' is an attempt to capture this caring attitude. They had to make sense of and 'shape' the situation so that it could be endured by themselves, their staff and the patients or clients, and so that at least some potential unintended consequences could be avoided. This effort could also be seen as an attempt to bridge the strategy–operations gap.

The participants also listed a broad range of responsibilities associated with planning and coordinating service provision in the change environment. These included people management (or HRM), budget management, quality management, accreditation, compliance tasks and information provision and dissemination. They were not only 'shaping the change' process but also 'shaping up' to the challenges of their broad roles and responsibilities under often difficult circumstances in terms of communication, workload and practical operational challenges.

As noted in 'good little soldiering', there is a risk of burn-out or the ultimate adoption of the resistance behaviours such as 'short-timing' (Raffanti, 2005a, p. 71) with the increases in role complexity, workloads and responsibilities, lack of recognition of their contribution, and the volume and increasing speed of major change. Similarly, it is conceivable for *Carefully Shaping Up*

to be accompanied by 'bargaining' behaviour, which allows individuals and leaders to avoid negative repercussions of resistance by giving the impression that directions are being followed. In this context, some individuals continue to have significant freedom in how they achieve the desired outcomes, or they are given concessions for other 'good works'. Thus there is an implied reciprocal agreement between the leader and individual staff. There was little evidence in the interviews of bargaining to gain individual benefit over others or that there was leader reciprocity. Bernie illustrated this in her comments that previous budgetary diligence was not recognised when establishing savings targets.

'*Togethering'* (Raffanti, 2005a, p. 97 [original emphasis]) plays a significant role in weathering change, and this was apparent in the coping strategy I have named *Carefully Shaping Up*. I gained the impression from participants that they relied heavily on internal and external personal and professional relationships and networks for support and problem solving throughout change processes. Examples of 'togethering' cited by participants appear in Table 16.

Table 16: Examples of 'togethering' behaviour

Participants	**Examples of 'togethering' behaviour**
Bernie, Lou, Pat	Internal peer and colleague support and strong external professional and personal networks.
Chris, Jo	Existing or developing national support networks, where they were able to raise common issues in their areas of expertise.
Morgan	Close relationships with his allied health team, and other colleagues with whom he could discuss issues. Strong family support.
Sam	Receiving support from family and small team of Clinical Service Coordinators (CSCs) in her organisation.

Summary

The theory of weathering was an effective framework for exploring how people who hold health care management positions, with responsibilities for the coordination of service provision, endure major change. As in Raffanti's study (2005a) in an educational setting, the coping behaviour of the participants was influenced by their personal and professional backgrounds, capabilities, knowledge, aspirations and values, the change context, and their professional, personal and work-based networks and organisational relationships. The responses of health care middle managers weathering change indicated that there is another level of complexity in the coping behaviours,

involving cooperative, constructive action. Therefore, I propose that, at management levels, there is a set of coping behaviours additional to those of resistance and acquiescence found in relation to educators. I have named this additional category of behaviours *Carefully Shaping Up*.

CHAPTER 6: DISCUSSION AND IMPLICATIONS FOR POSTGRADUATE MANAGEMENT EDUCATION

Introduction

The aims of this research were:

- to explore health care middle manager experiences of major changes in health service structures and funding in South Australia
- to identify the implications for postgraduate health administration courses at Flinders University and elsewhere.

The first of these aims has been addressed in Chapter 4, which described the individual managers' experiences and views, and in Chapter 5 in which their descriptions, experiences and coping responses to radical change were analysed, using Raffanti's (2005a; 2005b) framework.

The purpose of this chapter is to discuss how South Australian health care managers weathered major change, and to stimulate discussion by management educators at Flinders University, and beyond, about how curricula and learning processes might be enhanced to foster development of managers' capacities to weather radical change.

Weathering major change through *Carefully Shaping Up*

Resilience has been defined as '*a dynamic process encompassing positive adaptation within the context of significant adversity*' (Luthar, Cicchetti & Becker, 2000, p. 543 [original emphasis]). From their reports, the health care managers had weathered numerous and ongoing major changes, and exemplified individual levels of resilience that enabled them to 'endure the change (which they might believe to be merely a flavor of the month) or to at least get through the initial negative emotions' (Raffanti, 2005a, p. 94). While experiencing a range of emotions, the managers had remained apprehensive rather than thriving on change. Nevertheless, they had cooperated and adopted constructive approaches to adapting to and managing change.

Their *Carefully Shaping Up* behaviours build on Raffanti's (2005a) good little soldiering, which occurs out of 'a sense of organizational duty' (p. 96) and 'a good faith effort to meet leadership expectations' (p. 95), while still being able to exercise some professional judgement. The managers' professional backgrounds and their roles of 'being in the middle' provided additional space for shaping the implementation of change and layers of complexity that expanded their

behavioural responses.

Use of the coping strategies below varied between individuals, but taken together they contributed to sustaining *Carefully Shaping Up* cooperative behaviours. Nevertheless, as in good little soldiering, the risk of burnout and of the development of the negative overt or covert resistance behaviours of weathering remained.

Adhering to personal and professional values and priorities

As revealed in the analysis of the filtering stage of weathering change (Raffanti, 2005a, p. 63), the participants' responses were influenced by a number of dearly held personal and professional values and priorities, including integrity, respect, trust, fairness, taking responsibility, autonomy and exercising professional judgement. Typical of the 'helping professions' they stressed priorities to ensure safe, high quality services, to protect the safety and wellbeing of their colleagues and staff, and to facilitate their work. As Morgan stated, they were keen to '*treat … (their) staff as (they'd) like to be treated*'. The participants professed that they tried to meet professional expectations for clear, honest, consistent communication and for participation in decision-making about change and its implementation, within their areas of control. They had also gained greater access to information, and significant autonomy, control and ability to exercise professional judgement in some change initiatives. This reinforced their personal agency, defined as 'capacity for intentional wilful behaviour, sometimes in spite of social structural obstacles' (Côté & Levine, 2002, p. 219).

The emotions experienced by the participants reflect that some aspects of change were not aligned with their values. For example, their concerns over work intensification and increase in out-of-hours work challenged their expectations about fairness. It was evident in their statements that the priority given to safe, high quality service provision and staff wellbeing often outweighed the personal priority for work-life balance.

Maintaining strong support networks and personal wellbeing

Raffanti (2005a) highlighted personal aspects, namely personal agendas and emotions (p. 74), that influence responses to change, and integrated the concept of 'togethering' (p. 97) as a supportive mechanism in all stages of weathering. Despite the many years of management experience of most of the managers in my study, there was evidence that radical change generated emotional responses of frustration, anger, anxiety and sadness. All participants gave accounts of their concerns about changes and the processes used, the work intensification and increases in

responsibilities. They described using their internal and external personal and professional networks for support and as '*sounding boards*' for discussing impending changes, their opinions and possible responses. Trying to maintain personal fitness and work-life balance, and involvement in other activities of personal and professional interest were also cited as important.

Developing knowledge and skills

Most participants had recognised that additional knowledge and skills were required to manage and cope in their positions, including formal and informal education and training. Six of the seven held post-graduate qualifications, three in health care management or business administration and three in clinical or education fields. Two of the six were contemplating further studies specifically in health care management. The seventh participant said that other pressing work and family priorities had precluded completion of health care management postgraduate studies. A number of the managers had pursued professional development courses in health care leadership and management, communication and reflection skills, and people management. Several mentioned the value of on-the-job, experiential or action learning processes and expressed interest in possible opportunities for being mentored or coached by more senior managers.

Keeping informed

Keeping informed involves keeping abreast of, and maintaining an interest in, developments in the external health and aged care political, policy, financial and socio-economic environments. It also relies on paying attention to organisational environments. Managers accessed information about imminent changes and their implementation through a number of activities including completion of short courses, attendance at meetings, discussions with supervisors and colleagues, undertaking higher duties, and engagement with other internal or external networks. Furthermore, as study participants were recruited through the ACHSM membership distribution lists, it can be assumed that they were already ACHSM members or had attended ACHSM professional development activities. This implies a level of commitment to maintaining currency in knowledge and practice.

Taking responsibility for shaping change

The achievement of service outcomes relies on effective interactions with external professionals and organisations, in addition to managing diverse relationships and interactions with internal supervisors, peers, subordinates and colleagues from a number of disciplines. In imposed radical change, the health care managers in this study revealed that they were trying to balance the

'command' approach from above with the more participatory expectations of the professions, staff and multidisciplinary professional colleagues. Bernie and Lou also expressed a commitment to involving patients, clients or consumers in determining how change would be implemented.

Being 'in the middle' required making sense of and 'shaping' change directions, so that managers, their staff, their multidisciplinary teams and patients or clients could get through change, while continuing to provide existing services. Despite the workload implications, participants sought involvement in numerous meetings about change thereby accessing information and gaining opportunities to shape policies, procedures and practices. Instructions were interpreted and translated into actions in ways that informed and encouraged the participation of staff, colleagues and patients in the change processes. This was particularly complicated when information was incomplete or unclear, and at times voluminous. Managerial judgement was needed to guide just how much and what sort of information ought to be conveyed, and how best to do this. Substantial 'emotion work' was apparent in dealing with communication challenges, in sustaining a positive approach to change, and retaining a sense of humour.

Some of the middle managers had attempted to understand and adjust to the styles of the leaders. The participants also provided examples of their attempts to influence executive decision-making and approaches to change management (see Table 17). They experienced varying success.

Table 17: Examples of attempts to influence

Participant	Examples of attempts to influence
Bernie	Some success in identifying the interests of the CEO and developing compatible service strategies to enable the ongoing existence of her service.
Chris	Trying to engage leaders in her organisation in discussions on best practice service provision, while encountering barriers in the form of multiple decision-making layers and perspectives.
Lou	Advocacy for resources to manage the change processes being met with instructions to do the best that she could with existing resources.
Morgan	Establishing positive professional relationships with superiors, but time was required to renew this with each change of CEO.

In determining what could and could not be controlled in the gap between strategy and its operationalisation, managers and staff sometimes decided to '*shut out the big stuff*' and take responsibility for shaping change within their areas of responsibility. None of the participants explained exactly how middle managers might address this gap, but their descriptions of changes

that they had implemented could be construed as attempts to do so and recognition of their roles in translating strategy into operational outcomes.

Developing and strengthening Carefully Shaping Up behaviours

The above five strategies have been used as the basis for considering how the Flinders University postgraduate program can foster the capacity of its health care middle management students to cope with radical change. Moreover, with the 2011-12 structural and funding changes affecting the whole of Australia, the findings are of potential interest to health management programs in other Australian states, and postgraduate business or public health programs that attract health care middle managers.

Adhering to personal and professional values and priorities

Personal and professional values are often explored in core general management, leadership, governance, health law and ethics subjects, when they incorporate discussion and debate about ethical, legal and management dilemmas. Such approaches build skills in critical self-reflection and analysis of personal and professional values, as well as how values guide and limit thinking and behaviour. In many programs, critical reflection is an inherent requirement of action learning and experiential project management subjects.

Several participants mentioned self-knowledge and development of skills in reflection as assisting with their ongoing personal and professional development. This suggests that opportunities for understanding one's value systems and the development of critical self-reflection skills remain essential. The frequency of the managers' comments about work intensification and expanded roles and responsibilities indicates that knowledge and skills in priority-setting, work-life balance, workload negotiation and time management are important issues for education programs to consider.

Maintaining strong support networks and personal wellbeing

The health care managers in this study stressed the importance of their personal and professional networks to their emotional wellbeing, for issues discussion and for problem-solving. Several mentioned the value of opportunities to network and learn from others within courses that they had attended. Where this does not occur already, programs may wish to consider how they could assist in developing these skills through educational processes used or other activities with health and aged care organisations or professional bodies.

The emotional aspects of change, and workload problems that contribute to stress and burnout, would also justify added focus by educators on stress symptom recognition and the development of strategies, such as resilience building, and hardiness (Hague & Leggat, 2010).

Developing knowledge and skills

The participants' responses supported the acquisition of knowledge and the frameworks provided by formal post-graduate education. They also backed the inclusion of experiential learning and supplementation of formal education with less formal skills development through in-house, sector-based or on-the-job learning activities. All had engaged in ongoing professional development, characteristic of a commitment to continuous or lifelong learning.

Core content items of health care management programs, such as those at Flinders University, provide a foundation of skills and knowledge required by health care managers to lead, adapt and shape change. One of the participants noted that in view of the contemporary emphasis on consumer-directed care, principles of marketing, marketing communications and selling ideas should be incorporated in health care management programs.

The participants' sentiments about authentic, practical experience reinforce the use of self-directed, independent adult learning approaches that have been shown to be beneficial to further competence development of managers who have already acquired extensive professional experience, knowledge and competencies. Existing programs of action learning and action research have contributed significantly to experiential work-based learning for management and leadership development (Leggat, Balding, & Anderson, 2011; Leggat, Balding, & Schiftan, 2015; Raelin, 2016, 2017).

The managers' references to the adoption of positive attitudes, positive approaches to change and working with colleagues on change implementation, indicate the potential usefulness of processes such as Appreciative Inquiry (AI), 'the cooperative co-evolutionary search for the best in people, their organizations, and the world around them' (Cooperrider, Stavros, & Whitney, 2008, p. 3). With its participatory, positive, strengths-based orientation, rather than deficit-based problem solving, AI has started to gain traction in the health sector (Dadich et al., 2015; Trajkovski, Schmied, Vickers, & Jackson, 2013; Watkins, Dewar, & Kennedy, 2016). Cooperrider et al. (2008, p. 5) highlight that AI entails reflection and learning, as in action learning and action research, and supports innovation and creativity through its cycle of 'appreciating', 'envisioning', 'co-constructing' and 'sustaining'.

Generally, action-oriented approaches entail significant collaboration between education programs and employers in the provision of observational and practical experiences in managing change in authentic and safe environments. Several managers were also interested in being mentored or coached by senior managers and leaders with expertise in leading change. Mentoring and coaching initiatives may provide further opportunities for collaboration between educators, employers and professional leadership and management bodies.

Insights from my study indicate that it would be beneficial to pay particular attention to the different types of change and leadership, power and influence. I suggest that an improved understanding of these areas provides a stronger foundation for coping with radical change.

The different types of change

In the contemporary neoliberal political environment, at national and state levels, it is likely that there will be ongoing pressure to balance budgets and to contain health, education and social expenditure. In this context, further radical disruptive change is inevitable and will flow down through health departments and organisations.

While this research focused primarily on change imposed because of external political decisions, radical change is at times initiated and imposed by senior executives or executive teams, with little or no consultation with middle managers or other stakeholders. In contrast, the changes arising from safety and quality improvement activities are 'emergent' (Burnes, 2014, p. 415) or 'Long March' (Kanter et al., 1992, pp. 492-495) and enable more incremental participatory approaches deemed unsuitable for the urgency required in radical change. The context and requirements of middle managers in radical change are different from emergent change in terms of the information provided, communication, participation, power and influence.

The participants' responses indicate a need for managers to appreciate the inevitability of radical change in the current political and social context and to understand that it is managed differently from the more collaborative 'emergent change'.

Leadership, power and influence

The interviews revealed some aspects of the way superiors managed change that, if addressed, might increase the potential for middle managers to *Carefully Shape Up* to change. Examples of desired changes are fairness in decision-making, respect for professional knowledge and expertise (foregoing micro-management), valuing professional input and participation, acknowledging and

managing unrelenting workloads, and the toll of emotion work. In relation to actual change processes, they nominated clarity of instructions and information, justification for change, and inclusion of monitoring and evaluation processes. In this political environment, and given the nature of radical change and the results-oriented performance expectations of leaders, there is a real risk that autocratic, coercive leadership styles at executive levels will also continue.

A constant churn in government and health service leadership positions, noted by the managers, forms part of the contemporary context in which they are employed. Although middle managers have very little influence over how their leaders execute their responsibilities, a number of the participants indicated that their learning about leadership had been useful in increasing their awareness of the various styles of leadership. This informed their expectations of the supervisor-subordinate relationship and of how to adjust their own behaviours accordingly, to determine their own preferred leadership style and how they might need to use a different approach in different circumstances.

At the individual level, how managers and staff choose to respond to change is an expression of their personal power and approach. An understanding of the theory of weathering and *Carefully Shaping Up* behaviours can help managers identify weathering behaviours in themselves and their staff, without applying negative labels such as 'resistant' to individuals. The various coping behaviours provide helpful triggers for discussion about coping responses and potential ways of managing these.

Studies in organisational behaviour, management and leadership, and people management (or HRM), generally enable students to develop an understanding of systems thinking and complexity, organisational and professional culture, leadership styles and behaviours, and power and influence. The participants' responses support the value of discussion of the various forms, sources and real examples of the judicious use of power and influence and the identification of ways in which these might be used and practised in their management roles.

Keeping informed

Amongst health care management programs, subjects with titles such as health care systems, public health, health policy, financing and economics raise the appreciation of the constitutional foundation for health service provision. Attention is paid to the political, social and economic environment, the impact of broader health system and policy changes on communities and individuals, and strategies for accessing and using relevant information. Other subjects covering

health informatics, health information management and evidence-based management build on concepts of data, information and knowledge and how to evaluate and use data, information and various forms of evidence in their broad management roles.

The participants' comments suggest the merit in considering the foundations of radical change, in terms of the structure and function of the Australian political and social systems, the core values of the various political parties, and stakeholder influences on health policy. The ability to identify, source and evaluate relevant media and documents such as government budget statements and policies, contributes to their abilities to make more informed judgements. Even though middle managers may not agree with externally imposed changes, such knowledge provides a broad explanation and framework for radical change.

All the above contribute to keeping informed as a way of coping with change.

Taking responsibility for shaping change

Despite their misgivings, all participants affirmed their willingness to take responsibility for change management. Often with unclear or incomplete directions, rationale and information, they gave examples of attempting to shape change so that professional, practical and context-specific issues were evaluated and resolved or reconciled. Most management programs encompass the leadership or management of change within a range of subjects, or through standalone subjects in leading change, strategic and operations management, and project management. These may be accompanied by practical experience through participating in or leading change projects.

The participants described challenges in dealing with communication issues and the strategy – operations gap.

Communication and managing relationships

The development of communication skills is embedded in postgraduate management programs along with methods for the development of critical and analytical skills, as I found through interactions with other health management educators and knowledge of programs in Australia and New Zealand. The programs provide opportunities to analyse and debate issues and practices and to prepare evidence-based and practical presentations and reports on an individual basis or within multidisciplinary teams.

Participants in this study referred to the challenges they faced in communicating change directions. They noted that it was essential to be clear, honest, sensitive and positive to encourage

staff, team members, colleagues and patients to participate or engage in constructive activities. This supports the need for excellent communication and relationship management skills. Their interactions with large networks of staff from many different backgrounds, professions and levels of organisations, also rely on strong mediation and negotiation skills. The participants' comments suggest the potential value of providing opportunities for them to discuss and practise how to handle challenging communication, negotiation and mediation situations, and how to build strong professional relationships with superiors, staff, colleagues and clients.

Some managers had responsibilities that required the verbal or written presentation of fully justified implementation proposals to other colleagues or to supervisors. This suggests that managers would benefit from multiple opportunities to refine skills in oral and verbal presentation for various management purposes, such as change implementation proposals, briefings and reports. These should preferably be related to real issues or activities.

Translating, shaping and implementing radical change

Middle managers in health care have substantial involvement in initiatives aimed at improving the safety and quality of service provision or developing new models of care. These are largely collaborative interdisciplinary endeavours, driven from within the organisation, where the team has considerable control and professional investment in the process and its outcomes. They are generally bottom-up rather than top-down approaches.

The perceived gap between strategy and operations is hardly surprising given that there is no time for consultation and participation in radical change decisions. Also at issue is the structural distance between leaders and service provision and the fact that organisational leaders have broad responsibilities that do not require detailed clinical knowledge. The middle manager has responsibility for evaluating an often-ambiguous change directive, developing justifiable options for implementation, and then translating or adapting these into some form of action. Thus, in spite of its top-down nature, radical change may present an opportunity for managers to exercise their relative autonomy, judgement and creativity in meeting the desired outcomes, within prescribed role boundaries.

Insights gained from the interviews reinforced the need for abilities in critical evaluation of change, its impact on various stakeholders and proposed outcomes. Creativity, the ability to develop, plan and evaluate innovative approaches to radical change, to negotiate roles, responsibilities, scope, decision delegations, workloads, resources and communication and

feedback mechanisms are also required. These skills are essentially those required for project and innovation management, as described by Dwyer, Liang, Thiessen and Martini (2013, p. 63).

Conclusion

The participants volunteered for this study at a time when the South Australian health system was undergoing radical change. The accounts of these seven very experienced and resilient health care managers provided insights about the skills and knowledge required to weather radical change through cooperative *Carefully Shaping Up* behaviours. These insights create a basis for further discussion and consideration by management educators about the weighting given to the nature and management of radical change in the contemporary curriculum and the processes used to foster development of managers' capacities to weather and manage change.

The theory of weathering change (Raffanti, 2005a; 2005b) provided the framework for describing and analysing the conditions of weathering and individual resistance and acquiescent coping behaviours in response to radical change. Middle managers are faced with unrelenting change, high workloads, and professional and personal priorities to sustain safe and high quality service provision, as well as maintaining staff job satisfaction and wellbeing. Based on my study, a new category, *Carefully Shaping Up*, is proposed to describe an extra set of coping behaviours used by health care managers to respond to major change. Additional layers of complexity are introduced to middle management roles through the managers' professional backgrounds, their people and relationship management responsibilities, and their 'in the middle' 'sense-making' roles. These roles incorporate balancing the needs of decision-makers, staff, colleagues and patients or clients. This is compounded further by other management responsibilities such as people management (or HRM), budget management, quality management, accreditation, compliance tasks and information provision and dissemination. Shaping change, maintaining positive approaches and encouraging participation by staff, colleagues and other stakeholders, produces significant communication challenges and 'emotion work' for the middle managers but assists staff, colleagues and clients to accommodate and endure the changes.

Carefully Shaping Up is a category of behaviours additional to the resistance and acquiescence coping categories noted by Raffanti (2005a; 2005b). It incorporates a level of agency that is associated with complex management roles and responsibilities and constructive action in shaping change. These cooperative yet adaptive behaviours build on the good little soldiering behaviours identified in Raffanti's study of educators. Nevertheless, circumstances of continuous and

pervasive change bring in an ongoing risk of burnout and adoption of other less constructive resistance and acquiescent behaviours by the middle managers.

This research indicates that *Carefully Shaping Up* helps health care managers to weather radical change through adhering to personal and professional values and priorities; maintaining strong support networks and personal wellbeing; developing knowledge and skills; keeping informed; and taking responsibility for shaping change. Health care management programs at Flinders University and elsewhere already address development of management capacity in these areas, but it is conceivable that a review of curriculum and processes of learning could identify mechanisms for further strengthening these behaviours. From the participants' accounts, understanding their own values and behaviours as well as those of others, being able to empathise, possessing high level reflection, communication, networking and relationship management skills were very important to their roles.

Insights from the research revealed the potential need for improved appreciation of the Australian policy and political systems and the foundations of radical change; the different types of change and possible responses to them; and leadership, power and influence and how to use these judiciously. In taking responsibility for shaping change, middle managers address the gap between strategy and operations. Therefore, it would be beneficial for programs to review how they can best prepare health care managers to undertake this translation and shaping role, incorporating critical evaluation of change, the impact of change on various stakeholders, proposed outcomes, creativity, and project and innovation management capabilities. The participants expressed preferences for authentic, practical adult learning approaches with positive, strengths-based orientations.

This qualitative project has concentrated on individuals' experiences, views and responses to radical change and the implications for health care management programs. This may somewhat erroneously give the impression that the primary responsibility for development rests with the individual, thus reinforcing neoliberal approaches to personal versus organisational responsibility. However, exploring factors such as the responsibilities of organisational leaders in change and the framework of organisational policies and procedures was beyond the scope of my study. Further research to address the balance between individual and organisational responsibility would be advantageous.

APPENDIX 1: LITERATURE REVIEW PROCESS

Basic elements of the Boolean search string

chang* OR restructur* OR reform* OR transform* OR reorgani*

AND

manager* OR administrator* OR executive* OR leader*

AND

experienc* OR view* OR opinion* OR perception* OR perceiv* OR cop* OR weather* OR react* OR sens* OR story* OR stories OR observ* OR report* OR reflect* OR respon* OR narrative* OR attitud* OR adapt*

AND

middle OR “middle level” OR middle-level OR mid-level

AND

health* OR hospital*

NOT

“climat* chang*” OR “life* chang*” OR “middle-age*” OR “middle school*” OR “middle class*” OR “middle east*” OR “middle income” OR “middle and high* school*”

Search modifications and limits

Modification of the search string was required to adapt to the idiosyncrasies of the various databases. For example, in PubMed a search of combined titles and abstracts was performed, as PubMed does not support searching of abstracts alone; Ovid does not support the use of double quotation marks in phrase searching. Searches were limited to publications in English, where this limit was available, but not limited to specific time periods or to source type, such as full text or peer-reviewed. The row ‘health* OR hospital*’ was too restrictive for the title searches but was retained for the abstract searches to ensure that the numbers of documents retrieved were manageable but also relevant to the health and hospital contexts. Google Scholar could not cope with the Boolean string detailed above but retrieved broader organisational change and the middle manager articles and was used to follow-up on some citations.

Databases and journals

As the general literature on change management is extensive, and full-text searching generated

excessive irrelevant results, the searches were limited to document titles and abstracts in the following databases: Web of Science (core collection), ProQuest, Scopus, Ovid (inclusions: Journals @ Ovid; Econlit; Ovid Emcare; Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE and Versions(R); PsycINFO), Informit, CINAHL and PubMed. Unfortunately, this strategy also eliminates potentially relevant articles without abstracts and so the primary searches were supplemented with a 'snowballing' process (Aveyard, 2014, pp. 90-91) where citations of, and references to, the most relevant articles were scanned. Further references were found by scanning the work of prominent authors in the change management field as well as more recent issues (2015 – June 2017) of relevant journals, such as Asia-Pacific Journal of Health Management, Australian Health Review, Health Care Management Review, Health Services Management Research, Journal of Health Organization and Management, Journal of Advanced Nursing, Journal of Nursing Administration, Journal of Nursing Management, Journal of Change Management, and Journal of Organizational Change Management.

APPENDIX 2: APPROACHES TO CHANGE

A brief summary of the four approaches to change proposed by Burnes (2014, pp. 409-412), follows. Emergent and Bold Stroke approaches are more appropriate for fundamental and significant changes required to respond to a turbulent environment.

Emergent

This approach is equivalent to the Long March described by Kanter et al. (1992, pp. 492-495). When comprehensive change in the culture of an organisation is required, the emergent approach allows more time for collaboration with stakeholders and consideration of political elements.

Bold stroke

Large, rapid changes to organisational strategy, structures, operations and service provision may be required to respond to significant shifts in the organisation's environment. This situation supports use of a top-down and autocratic process, with little emphasis on collaboration or participation.

Tayloristic or *Kaizen*

Small-scale procedural or technical improvements to processes may be achieved through top-down approaches using discipline specialists or consultants, or through more collaborative strategies. As the focus is not on attitudinal change, the pace of change may be swift.

Planned

As it seeks to alter individual and group attitudes and behaviours, planned change allows more time for employee participation and collaboration. These efforts to improve performance are usually smaller in scale and more localised.

APPENDIX 3: SA PUBLIC SECTOR MANAGEMENT CLASSIFICATIONS

This appendix summarises middle management classifications described in the relevant industrial awards or enterprise agreements. The sources for each of the occupational groups are listed below:

Nursing (RN3, RN4)
Nurses (South Australian Public Sector) Award 2002 (SAET, 2018a)
Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2013 (SAET, 2018b)

Allied Health Professionals (AHP3, AHP4, AHP5) – management stream
Originally, these positions were classified as Manager Professional Services (MPS1, MPS2, MPS) in the industrial award but were modified to AHP3, AHP4, AHP5 with managerial responsibilities in a subsequent enterprise agreement.
S.A. Public Sector Salaried Employees Interim Award (SAET, 2018c)
South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2012 (SAET, 2018d)

Administrative Services Officers (ASO-6, ASO-7, ASO-8) and
Manager Administrative Services (MAS1, MAS2, MAS3)
S.A. Public Sector Salaried Employees Interim Award (SAET, 2017c)
South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2012 (SAET, 2018d)

Registered nurse level 3 (RN3)
RN3 must hold the relevant professional qualification, usually a degree, be registered with the Nurses Board of South Australia, and have at least 3 years of experience after registration. Employees in this role may lead and coordinate nursing or multidisciplinary teams to deliver health services. In addition to responsibility for professional standards, service quality, safety and risk management, they may undertake resource management functions such as staffing, recruitment and supply and financial monitoring. Other RN3s provide management support to services or have project management responsibilities. Their roles may involve financial and information systems management, policy implementation and contribution to policy development, risk management, human resource management, process improvement, bed management and accreditation processes.

Registered nurse level 4 (RN4)

RN4 must hold the relevant professional qualification, usually a degree, be registered with the Nurses Board of South Australia, and have at least 3 years of experience after registration. The RN4 may lead a team of nurses or a multi-disciplinary team of a larger, more complex or professionally isolated service than expected of RN3. In addition to responsibility for professional standards, service quality, safety and risk management, they may undertake resource management functions such as staffing, recruitment and supply and financial monitoring. The role may also entail new system implementation or service in a consultancy capacity. Other RN4s provide management support to larger more complex services, lead a management team or portfolio, or manage complex projects or programs. Their roles may involve service evaluation and development, outcome measurement and reporting, financial and information systems management, policy implementation and contribution to policy development, risk management, human resource management, service and organisational process improvement, and accreditation processes.

Allied Health Professional level 3 (AHP3)

The AHP3 holds qualifications, usually a degree or above, relevant to their chosen profession and has professional accreditation or registration. The AHP3 with a management focus will often retain a clinical workload as well as being responsible for leading a specialist or multidisciplinary team or project in a unit, region or network. They may be accountable for maintenance of professional standards, clinical and line supervision, project management, service quality, efficiency and effectiveness, risk and safety management, operational policy and planning, financial management, staff training and development and human resource management.

Allied Health Professional level 4 (AHP4)

The AHP4 holds qualifications, usually a degree or above, relevant to their chosen profession and has professional accreditation or registration. The AHP4 with a management focus will often retain a clinical workload as well as being responsible for leading major functions or complex multidisciplinary projects or programs in a unit, region or network. They serve as a specialist consultant and contribute to the strategic management of the organisation or network. They may also be accountable for new program development, maintenance of professional standards, clinical and line supervision, service quality, efficiency and effectiveness, risk and safety management, operational policy and planning, financial management, staff training and development and human resource management.

Allied Health Professional level 5 (AHP5)

The AHP5 holds qualifications, usually a degree or above, relevant to their chosen profession and has professional accreditation or registration. The AHP5 with a professional management or advisory focus may retain a clinical workload as well as being responsible for leading major specialist or multi-disciplinary programs in an organisation or network. Their highly strategic role includes the development and implementation of major new programs and investigations. They have considerable autonomy and are accountable for program strategy development, priority-setting, and the standards, quality, training and resource management tasks expected of all managers.

Administrative Services Officer level 6 (ASO-6)

ASO-6 is responsible for managing and evaluating projects or programs. This entails significant knowledge and expertise and high levels of independent judgement, decision-making and delegated authority.

Administrative Services Officer level 7 (ASO-7)

Compared to ASO-6, ASO-7 is responsible for managing and evaluating more complex policy implementation, or larger projects or programs. It has significant scope, autonomy and delegated authority.

Administrative Services Officer level 8 (ASO-8)

ASO-8 carries responsibility for major programs that may be state-wide or critically important for the organisation. To deal with the complexity of the projects and programs, these positions require significant independent thinking and judgement, and creativity. They have very high levels of delegated authority and manage substantial resources.

Manager Administrative Services Level 1 (MAS1)

A MAS1 reports to an executive and manages a branch, unit or function(s) within an organisation. They have substantial delegated authority and autonomy in decision-making. Their responsibilities may include maintenance of service quality, efficiency and effectiveness, operational policy and planning, financial management, people management, and numerous human resource functions.

Manager Administrative Services Level 2 (MAS2)

A MAS2 reports to an executive and manages a large branch, unit or function(s) within an organisation. They have greater autonomy than MAS2s in determining priorities and processes.

Similar to MAS1, their responsibilities may include maintenance of service quality, efficiency and effectiveness, operational policy and planning, financial management, people management, and numerous human resource functions.

Manager Administrative Services Level 3 (MAS3)

MAS3s report to an executive or chief executive and manage a very large program(s), operation(s) or function(s) of the organisation. These positions require significant independent thinking and judgement, and creativity. They operate with considerable autonomy and delegated authority. Similar to MAS1 and MAS2, their responsibilities may include maintenance of service quality, efficiency and effectiveness, operational policy and planning, financial management, people management, and numerous human resource functions.

APPENDIX 4: ETHICS APPROVAL

From: **Human Research Ethics** human.researchethics@flinders.edu.au
Subject: 6537 Final approval granted (17 July 2014)
Date: 17 July 2014 at 9:51 AM
To: **Janny Maddern** janny.maddern@flinders.edu.au, **John Halsey** john.halsey@flinders.edu.au, **Judith Dwyer** judith.dwyer@flinders.edu.au

HR

Dear Janny,

The Chair of the Social and Behavioural Research Ethics Committee (SBREC) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. This means that you now have approval to commence your research. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.:	**6537**
Project Title:	Health care middle managers' experiences of major change
Principal Researcher:	Ms Janny Maddern
Email:	janny.maddern@flinders.edu.au
Approval Date:	13 July 2014
Ethics Approval Expiry Date:	**31 December 2018**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

APPENDIX 5: INFORMATION SHEET

Ms Janny Maddern
Department of Health Care Management
School of Medicine
Candidate, Doctor of Education
School of Education

Level 2, Health Sciences Building
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GPO Box 2100
Adelaide SA 5001

Tel: +61 8 8201 7762
Fax: +61 8 8201 7766
janny.maddern@flinders.edu.au

CRICOS Provider No. 00114A

INFORMATION SHEET

Project Title: Health care middle managers' experiences of major change

Investigator
Ms Janny Maddern
Candidate, Doctor of Education
School of Education
Flinders University
Ph: 8201 7762

Supervisors
Professor John Halsey
Rural Education and Communities
School of Education
Flinders University
Ph: 8201 5638

Professor Judith Dwyer
Department of Health Care Management
School of Medicine
Flinders University
Ph: 8201 7769

Description of the study

The National Health Reform Agreement signed by the Commonwealth, States and Territories in August 2011 has resulted in major changes to health system governance, structure, funding and service delivery. The initiatives are designed to increase the level of transparency in funding but also increase control at local/regional levels. They incorporate mechanisms intended to improve accountability for the use of funds and the efficiency, integration, quality of health services and equitable access to them for all Australians.

Despite the documented importance of middle managers in the implementation of change, there has been little research on the impact of the recent major changes on healthcare middle managers and their responses. This project seeks to explore the experiences and responses of middle managers in the public sector to major structural and funding changes resulting from health reform processes. We are keen to interview a small number of managers with at least 3 years of management experience in nursing, administration or allied health/clinical professions such as Physiotherapy.

We are seeking participation from managers employed in non-executive positions such as Nurse Manager, Clinical Services Coordinator, Assistant Director of Nursing (i.e. Registered Nurse levels 3 or 4), Director/Manager or Deputy Director/Assistant Manager of an Allied Health/Clinical Professional Department such as Physiotherapy (i.e. Manager Professional Services, MPS 1 to MPS 3) or of a department such as Finance, Supply, Catering or Human Resources (i.e. Administrative Services Officer ASO6 – ASO8, or Manager Administrative Services MAS1 – MAS3). However, participation is not limited to these positions and classifications alone as there may be numerous other roles, such as significant project coordination roles, that carry management responsibility.

Current students of the Flinders University health care management programs are not eligible to participate.

Purpose of the study
This project aims to

- To ascertain and explore South Australian health care manager views and experiences of recent major changes in health service structures and funding
- To analyse the implications for postgraduate health administration courses at Flinders University.

The small number of individual cases is intended to illuminate the diversity of experiences rather than summarise general experience across the health sector and to assist in identifying skills and knowledge that should be addressed in the postgraduate education of contemporary healthcare managers.

What will I be asked to do?
You are invited to attend a one-to-one interview with Ms Janny Maddern, a candidate in the Doctor of Education, about

- your experiences of recent health reforms, specifically the major changes in the structure and funding of public sector health services in South Australia and
- your views on the skills and knowledge required to optimise personal and professional responses to change.

Not everyone will be required for interview. On receipt of your expression of interest, Ms Maddern will ask you to complete a form (attached) to provide some details about yourself, your management role and experience to assist her to select a small number of participants from different backgrounds. Following the selection process, Ms Maddern will contact you by telephone or email to arrange a time and place for an interview or to seek your permission to contact you later if she requires further participants.

The interview is to be conducted in a quiet place to be agreed with you, but not the workplace where anonymity cannot be guaranteed. The expected duration of the interview is 45-60 minutes with a rest break if you would like one. Prior to the interview, you will be asked to sign a consent form and Janny will seek your permission to contact you again by email or telephone if she requires clarification, further explanation or extension of points that you raise in the interview. She will discuss this with you at the interview.

The interview will be recorded using a digital voice recorder and then transcribed for ease of reading and analysis. The transcript will be sent to you so that you can check it for accuracy, and deletion of any identifying information or statements that are sensitive; and for giving any feedback that you wish to provide before analysis is commenced. Ms Maddern will also take some handwritten notes during the interview.

You may decline to answer particular questions or to respond with 'no comment'. Your participation is entirely voluntary and you may withdraw from the research at any time without disadvantage.

What benefit will I gain from being involved in this study?
Although you may not receive any direct benefit from this research, the sharing of your experiences will provide a deeper understanding of the impact of major changes on middle managers in health care in South Australia and from these insights, inform the ongoing development of postgraduate education that aims to equip middle managers for their roles.

Will I be identifiable by being involved in this study?
With a small group of 6 – 10 participants, it may be difficult to guarantee total anonymity and confidentiality but every effort will be made to protect anonymity and confidentiality through the use of the following processes:

- Once the interview has been transcribed and saved as a file, any identifying information will be removed. The transcribed document and accompanying audio file will be stored on a password protected computer only accessible to Ms Maddern.
- Any de-identified hard copies of the transcripts, researcher notes and electronic backup storage media will be kept in a locked filing cabinet only accessible to Janny Maddern.
- The text will be stored as a computer file and any audio files and hard copies destroyed once the study has been finalised. The computer file will be kept in a secure location for 5 years and then destroyed.
- Only the researcher and the supervisors will have access to the interview transcripts and any hard or electronic copies will be stored securely.
- You will have the opportunity to review your transcript so that you can check it for accuracy, and deletion of any identifying information or statements that are sensitive; and for giving any feedback that you wish to provide before analysis is commenced. Information that you consider too sensitive will be deleted from the transcript and not included in any publication or presentation.
- A professional transcription service will be asked to sign a confidentiality agreement which outlines the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained. The recording will not be made available to any other person.
- Your comments will not be linked directly to you.
- You will not be individually identified in the thesis, other publications or presentations.
- You may withdraw at any time without consequences.

Are there any risks or discomforts if I am involved?
The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator.

If you experience anxiety or distress by recalling your experiences, you may stop the interview. Continuation of the interview then or at another time will be at your discretion entirely. You may withdraw from the research at any time without any consequences whatsoever.

If you require further assistance, we would like to draw your attention to the free-of-charge services of:

- Lifeline at http://www.lifeline.org.au/Get-Help/ or phone 13 11 14 and
- Beyond Blue at http://www.beyondblue.org.au/ or phone 1300 22 4636

How do I agree to participate?

- Participation is voluntary.
- The first step is to complete the Participant Data Collection Form which provides information to assist with selecting participants from different backgrounds. Please email the document to Janny Maddern janny.maddern@flinders.edu.au by close of business on Friday 3 October 2014.
- Following the selection process, Ms Maddern will contact you by telephone or email to arrange a time and place for an interview or to seek your permission to contact you later if she requires further participants. If selected for interview, you will need to sign a Consent Form.
- When the transcript of interview becomes available, please check it for accuracy, and deletion of any identifying information or statements that are sensitive; and for giving any feedback that you wish to provide before analysis is commenced.
- Ms Maddern may wish to contact you again by email or telephone if she requires clarification, further explanation or extension of points that you raise in the interview.

If you have any questions about the research, please contact Janny Maddern direct by email janny.maddern@flinders.edu.au or by phone on 8201 7762. To enhance the diversity of the potential participants, feel free to provide this information to other healthcare managers who may be interested in participating. Please do *not* use workplace email, notice boards or websites to distribute the Information.

How will I receive feedback?

Outcomes from the project will be summarised and given to you by the investigator if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6537). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

APPENDIX 6: CONSENT FORM

Flinders UNIVERSITY

CONSENT FORM FOR PARTICIPATION IN RESEARCH

(by interview)

Health care middle managers' experiences of major change

I .....

being over the age of 18 years hereby consent to participate as requested in the Letter of introduction and Research Information sheet for the research project on health care middle managers' experiences of major change

1. I have read the information provided in the Letter of Introduction and Information Sheet.
2. I am not a current student of the postgraduate health care management program at Flinders University.
3. Details of procedures and any risks have been explained to my satisfaction.
4. I agree to audio recording of my information and participation.
5. I am aware that I should retain a copy of the Information Sheet, Data Collection form and Consent Form for future reference.
6. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, individual information will remain confidential and research processes described in the Research Information sheet will be used to reduce the risk of being identified.
   - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
7. I agree/do not agree* to further contact by email or telephone for the purpose of clarification, further explanation or extension of points that were raised in the interview. * *delete as appropriate*

Participant's signature.....**Date**.....

I certify that I have explained the study to the participant and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....**Date**.....

NB: Two signed copies will be obtained; one for the researcher and one for the participant.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6537). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

APPENDIX 7: PARTICIPANT DATA COLLECTION SHEET

Ms Janny Maddern
Department of Health Care Management
School of Medicine
Candidate, Doctor of Education
School of Education

Level 2, Health Sciences Building
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janny.maddern@flinders.edu.au

CRICOS Provider No. 00114A

Participant data collection sheet

Project Title: Health care middle managers' experiences of major change

Investigators:
Ms Janny Maddern
Candidate, Doctor of Education
School of Education
Flinders University
Ph: 8201 7762

Supervisor(s):
Professor John Halsey
Rural Education and Communities
School of Education
Flinders University
Ph: 8201 5638

Professor Judith Dwyer
Department of Health Care Management
School of Medicine
Flinders University
Ph: 8201 7769

I .....
being over the age of 18 years am interested in participating in the research project on health care middle managers' experiences of major change

1. I have read the Letter of Introduction and Information Sheet provided.
2. I understand that:
   - I must not be a current student of the Flinders University health care management program
   - The data provided by me on this form will be used for initial selection of participants and not for any other purpose.
   - I am aware that I should retain a copy of the Information Sheet and Participant Data Collection sheet for future reference.
   - I may or may not be selected for the study.
   - I may not directly benefit from taking part in this research.
   - If selected, I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, individual information will remain confidential and the research processes outlined in the Information sheet will be used to reduce the risk of being identified.
3. If not selected for the initial interviews, I agree/do not agree* for my details to be kept on file to enable future contact if more participants are required * *delete as appropriate*

Participant's signature.....Date.....

Please forward this Data Collection form to
Ms Janny Maddern
Email: janny.maddern@flinders.edu.au
Fax: 8201 7766

Any questions on the requirements should be directed to Janny Maddern by email or phone 8201 7762

Participant data

Please provide the following details about yourself. This information will be used to assist with selection of a small but diverse group of participants. These details will be stored in a locked cabinet in the Department of Health Care Management at Flinders University and will be securely destroyed at the end of the study.

Name				
Preferred contact phone number				
Preferred email address				
Gender	Male	☐	Female	☐
Age group (years)	20-29	☐	30-39	☐
	40-49	☐	50-59	☐
	60-69	☐	70+	☐
Position title				
Number of staff reporting to position				
Position classification				
Employing organisation				
Educational qualifications				
Total years of working (full-time equivalent FTE)				
Total years of work in the health sector (FTE)				
Years of management experience (FTE)				
Brief description of current role				

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6537). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

APPENDIX 8: INTERVIEW GUIDE

Health care middle managers' experiences of major change

Interview protocol
(aide de memoir)

Areas to cover at the beginning of the interview – most of these have been mentioned in the Information Sheet:

- Test digital recorder before interview
- Introductions & thank you
- Brief overview of the research

  As we know there have been numerous major changes to health system governance, structure, funding and service delivery such as those resulting from the National Health Reform Agreement signed by the Commonwealth, States and Territories in August 2011 and then more recently those introduced at Commonwealth and State level. However, there's been relatively little research in the health sector on how middle managers in health care experience and make sense of these radical changes and how they might develop the capabilities that they perceive to be useful in dealing with such changes. To my knowledge, there have been no such studies in South Australia.

  Aims:
  - To ascertain and explore South Australian health care manager views and experiences of recent major changes in health service structures and funding
  - To analyse the implications for postgraduate health administration courses at Flinders University

- Consent form signing (**sign 2 copies – give one to participant**)
  - voluntary nature of participation
  - ability to withdraw without any consequences
  - reinforcement of confidentiality (transcriber will sign agreement) and anonymity processes (ID removed from transcript and any publication)
  - Secure and pass-word protected storage of all data
  - permission to record
- Ensure that participant is not a current student of the Flinders University health care management program
- Potential for follow up conversation by phone, email or in person?
- Arrangements for checking of transcript
  - check accuracy
  - delete any identifying information or statements that are sensitive; and
  - give any feedback that you wish to provide before analysis is commenced
- Time commitment about 45 – 60 minutes with a break if required – check if need to get away by particular time
- Start recording (after consent form signed)
- Review of demographic data
- Interview
- Further questions from interviewee
- Final thank you

Interview guiding questions

1. To help set the scene, could you please tell me about your current role?

2. The National Health Reforms that established the Health Networks (and Medicare Locals), and State and SA Health budgetary measures, have now been in place for about 3 years.
   a) I am interested in your opinions of these reforms, and so can you please tell me what you think of them?
   How did you come to have these opinions?
   Have your opinions changed over the time? Can you please talk more about this? (If response was 'Yes').

   b) Over what period of time have the changes been occurring in your organisation?

   c) Can you describe for me how the changes were implemented in your organisation?

   d) Have any of these reforms influenced or impacted on you and your work? If so, how? Can you give me a specific example of a change and its impact and how it influenced you and your work? (As required, follow with questions on what it was, how the change was implemented, who was involved, personal perceptions, personal reactions, and impact on relationships with others at work).

3. Reflecting broadly on the changes that have occurred, can you tell me about your experience of any benefits?

4. Can you talk about any limiting aspects of the changes?

5. How do you think such changes can best be undertaken and managed?

6. Based on your experience, what do you think are the three most important skills or areas of knowledge that managers require to (a) cope with such changes and (b) manage their roles in the change process?

7. Have you had any formal training for the management aspects of your current role? If so, what were the most helpful things you learned and how have they influenced your practice? If you could talk to your teachers now, what would you ask them to include that wasn't covered, or not covered in a way that was useful to you?

8. Is there anything else that you would like to say about your experiences of the changes resulting from the health reforms or about the preparation of health service managers for their roles?

9. Thank you.

APPENDIX 9: EMOTION WORD COUNT AGAINST RAFFANTI CATEGORIES

		Participants							
Raffanti Emotion category	**Emotion words**	**B**	**C**	**J**	**L**	**M**	**P**	**S**	**Combined**
Fear	fear, afraid, scare/d, scary, alarmed, panic, terrified, shock	6		6			12		
	anxiety, anxious, discomfort, nervous, concern/s/ed, worry/ies, bother/ed, dwell/ing, fussed	2	3	7	1	8	3	5	
	unsure, uncertainty, unknown, taking a gamble, security			5		1	4		
	Total	8	3	18	1	9	19	5	**63**
Frustration	frustrating, frustration, drives me completely spare/mental	7	4	11	2	1			
	cynicism, cynical, disengagement, disconnect	6	1					7	
	angry, hates			4			1	3	
	bitter, resentful, nasty, twisted			3				1	
	ridiculous, unrealistic, irrationalness, short-sighted, crazy, laughable, unreasonable, unfair/not fair/not right, impossible, pointless, appalling	6		4	2		1	11	
	critical	9	1			7			
	Total	28	6	22	4	8	2	22	**92**
Overwhelm	overwhelming							3	
	struggle/d		1	4		4		1	
	pressure/s, cost (personal), 'knocked around'		5	2	2	1	3	3	
	stress, stressful, distress/ing, upset, heartache, traumatic, damaged	4		4	1	2	1	1	
	vulnerable, powerless		1	1				2	
	change fatigue, fatigue/ing, exhausted, getting sick of change, change for change's sake	2		2	2			5	
	workload, overload, burden, saturation, burn out, inundated, stretched, too much, so much, astronomical			1	7	1	1	22	

	Total	6	7	14	12	8	5	37	**89**
Other	disappointment/ed/ing, regret		1		1	1	3		
	loss, lost, lose/ing, miss/ed/ing	5	4	4	6	4	13		
	unhappy, sad, tears, grief, despondent			2	4		3	1	
	isolating, alone, neglected, abandoned, unsupported, undervalued	3	2	1	1	2	1		
	fight, attack, battle, opposed, against that	5	3		1			3	

GLOSSARY OF TERMS

Explanations of some of the health-specific terms used by study participants are divided into three categories depicting types of care, levels of care and health system structures. Further information can be found in Medical Dictionaries and books about the Australian Health Care System (e.g. Willis, Reynolds & Keleher, 2016)

Types of care

Acuity

Severity and complexity of illness that determines the intensity of care required.

Acute

Onset of illness is rapid, and duration is often short. Severe illness with potential complications requires urgent medical attention.

Sub-acute

A less rapid onset of illness. Less severe conditions require a lower intensity of care e.g. rehabilitation services. Often multi-disciplinary.

Chronic

Long-term often complex illness or disease requiring ongoing or long-term care.

Levels of care

Primary health care

Primary health care, including health promotion, is provided by medical, nursing, allied health and other health professionals in general practices or small community-based health services. Usually, they are the first contact point for patients. No referral is required.

Secondary health care

In general, access to secondary health care requires referral from a primary health care provider. These more specialised or investigatory services are provided in smaller hospitals or private practices.

Tertiary health care

This is the highest level of specialty health care for complex health conditions and emergency care. It is generally provided in large technologically advanced hospitals in major cities. Access usually requires referral from a heath professional working in the primary or secondary levels and may

require staying in hospital for treatment as an inpatient.

Structures established under the National Health Reform Agreement

(Council of Australian Governments [COAG], 2011).

Local Health Networks; Local Hospital Networks (LHNs)

Local Hospital Networks were established to improve public hospital accountability and service provision. Each network comprises a group of public hospitals and some health services based in the community within a geographical region.

In South Australia the networks are called Local Health Networks (SA Health, 2018). The five networks are:

Central Adelaide Local Health Network (CALHN)

Northern Adelaide Local Health Network (NALHN)

Southern Adelaide Local Health Network (SALHN)

Women's and Children's Health Network (WCHN)

Country Health SA Local Health Network (CHSALHN)

Medicare Locals (MLs)

Medicare Locals were established as primary health care organisations under the National Health Reform Agreement to improve the coordination of primary health care and general practice (GP) services. They partnered with Local Health or Hospital Networks to enhance integration of health services. South Australia had five Medicare Locals.

Primary Health Networks (PHNs)

Primary Health Networks replaced Medicare Locals in July 2015 (Commonwealth of Australia, 2014). Their aim is to improve health outcomes for their communities. In contrast to Medicare Locals, PHNs do not provide services themselves. Instead they use commissioning processes to meet identified service needs for their region and to ensure efficiency and effectiveness of provision. They work with all levels of care providers to enhance access to services and coordination or integration of care across the health sector.

South Australia has two PHNs (Commonwealth of Australia, Department of Health, 2015):

Adelaide Primary Health Network

Country Primary Health Network

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