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Introduction: Setting the Scene

Healthcare: a changing environment

Healthcare provision in Britain is dominated by the National Health Service (NHS). Its size, the scope and extent of its services, the range, levels and diverse skills of its work-force and its unique position in the political system, makes it unlike any other organiza-tion in the United Kingdom. It is reported to be the 5th largest organization in the world (Carvel, 2005) employing over 1.3 million staff (Winterton, 2004). Many parts of the ser-vice, such as local hospitals, specialist services, staff groups, and General Practice (GP) surgeries are known to have a unique and special place in the hearts and minds of the public (Klein, 1999; Smith, 2002). Hjul (2006) argues that GPs, as the public face of healthcare, are more likely to be known by people, who refer to them as 'their' doctor, than any other public servant.

The NHS was created by a Labour administration in the post-war policy drive of 'nationalisation' where the state extended its powers of control to major infrastructure industries and has been considered a cornerstone of the British welfare state since its inception in 1948 (Salauroo and Burnes, 1998). The road and rail services were nation-alised in the same year the NHS was created; electricity in 1946; coal in 1947; iron, steel and gas in 1949. All these services have, often in the name of efficiency, now been priva-tised, broken up or given quasi-independency. Except, that is, the NHS, leading a *Sunday Times* editorial to claim that it has:

> trundled along as an inefficient, centrally run command and control model that would be more at home in North Korea than a supposedly modern western economy. (*Sunday Times*, 2003: 18)

During its lifetime its principles have endured, however, the guiding policies, organiza-tion and delivery of health services have been subjected to continual reforms. The focus of changes in the NHS depend on the orientations and philosophies of its political masters

and involve everything from the macro level of funding, service planning and delivery to the micro level of personal care and ward cleanliness. For all organizations, change is an essential and ongoing process which, if carried out successfully, allows them to evolve and improve their products and services in order to meet the demands of consumers and be competitive. The arguments for and against any changes in health services are hotly debated from local ward to parliamentary level, in local and national press and in the pages of health and medical journals.

The NHS is highly politicized and the appearance of it being strategically and operationally managed by the government of the day remains a strong criticism. A *British Medical Journal* editorial suggests that the NHS is 'unusual in not having a leader' and claims that 'if there is a leader then it is the Secretary of State for Health' (Smith, 2003a). Reasons for this view are proposed by Walshe (2003: 108) who argues that since the NHS's inception, the Secretary of State for Health has been held accountable to Parliament 'for every dropped bedpan, trolley wait, cancelled operation or long waiting list'. The lines of accountability and responsibility, described by Walshe as a 'managerial nonsense but a political reality', have caused an increasing need to centralize and manage every detail creating an ever tightening cycle of control and accountability through a 'hyper-interventionist style of micromanagement' (2003: 108). Political pressure for change comes from the need for successive governments and Health Ministers to stamp their personal authority, usually by imposing structural changes, which give the appearance of important, strategic and instant change (Walshe, 2003).

The change agenda

The long history of change, the scope of policy implementations, the extent of their ramifications, and the ongoing effects on patients and staff within the health services, particularly in England and Wales, are almost overwhelming. There can be few governmental responsibilities to have endured such constant change at the hands of politicians as healthcare. Yet, at the same time, the service is berated, by the same politicians, for not changing sufficiently and requiring further and deeper reform. The Director of Policy at the King's Fund notes the pressure and dilemmas of the government's role:

> On the one hand it has been responsible for the huge central drive and investment to modernise the service. NHS staff are groaning from the number of policies they are required to implement. On the other hand, the pace of change has not been nearly fast enough to satisfy politicians, who demand nothing less than a 'step change' or transformation in the quality of patients' experience. Deep frustration has set in, and awkward questions are now asked at the highest level as to how best to improve performance in a large state-bureaucracy. (Dixon, 2002: 1900)

Walby et al. (1994: 1) further argue that health work has been at the cutting edge of a 'politically inspired attempt to restructure working practices in Britain over the last decade' and that this has turned the health service into a 'laboratory of experimentation

in changing work practices'. More recently, Goodlee (2006) bemoans the relentless change, aligning the NHS to a political football and expresses her concern at the waste of energy and goodwill of staff and patients affected by continual policy change. Yet the imperative for an organization to survive depends on its ability to harness and master the process of change.

In 2002, in making the case for public service reform, the then Prime Minister agreed that the creation of the Health Service was a huge achievement and appropriate at a time of post-war austerity but admited that it is 'a product of that age' and 'it no longer meets the needs and challenges in an age of growing prosperity and consumer demand' (Blair, 2002: 1, 3).

On the whole, for the first 25 years of its existence, the NHS was relatively stable. However, post- 1974, reforms occurred with increasing speed and have culminated in virtually constant change since 1997 (Davies and Harrison, 2003; Greener, 2004). Walshe (2003) suggests that there has been some kind of organizational upheaval somewhere in the NHS almost every year for the last 20 years and that the pace of change is increasing.

Besides the 1974 re-organization when the service's flawed 1948 structure, problems of duplication and lack of co-ordination were finally recognized (Baggott, 2004), Harrison and Lim (2003) identify two other watershed reorganizations in its history: the 1984 implementation of 'general management' (DHSS, 1983) and the 1991 introduction of the 'internal market' (DH, 1989) – all derived from Conservative government initiatives.

The change cycle

In August 1972, in the White Paper which was the precursor to the 1974 reorganization in England, the Conservative Secretary of State for Social Services (Keith Joseph), stated that while respecting the 'massive performance' and achievements of the NHS, he had come to recognize 'that while this good work will continue, nothing like its full potential can be realised without changes in the administrative organization of the service' (DHSS, 1972a: v).

Twenty-five years later, and after many subsequent 'reforms', writing in the Preface to '*The New NHS, Modern, Dependable*' the Prime Minister reflected the same opinion:

> As we approach the fiftieth anniversary of the NHS, it is time to reflect on the huge achieve-ments of the NHS. But in a changing world no organization, however great, can stand still. The NHS needs to modernise in order to meet the demands of today's public. (DH, 1997: 3)

This watershed document was the first opportunity a Labour government had of reor-ganizing (variously described as 'reforming', 'modernizing', 'renewing', 'redesigning') the NHS for 18 years and was presented to the country within eight months of coming to power. It further states:

> But we also have to change the way that the NHS itself is run. The introduction of the internal market by the previous Government prevented the health service from properly

> focusing on the needs of patients. It wasted resources administering competition between hospitals. This White Paper sets out how the internal market will be replaced by a system we have called 'integrated care', based on partnership and driven by performance. It forms the basis for a ten year programme to renew and improve the NHS through evolutionary change rather than organizational upheaval. (DH, 1997: 4–5)

The ideas of 'integration', 'partnership', 'performance' and 'evolutionary change', key concepts in managing change in public sector services, are raised here as if new. However, in 1972, Keith Joseph made similar claims. In justifying the move away from a tripartite system, he declared he needed to:

> Concentrate instead on ensuring that the two parallel authorities – one local, one health … shall work together in partnership for the health and social care of the population. This White Paper demonstrates the Government's concern to see that arrangements are evolved under which a more coherent and smoothly interlocking range of services will develop for all the needs of the population. The aim would be to set objectives and standards and to measure performance against them. A sound management system would be created at all levels. (DHSS, 1972a: vi–vii)

The language of 1972 may be less 'modern' than 1997 but the aims and values are similar: good public sector management, efficiency, integrated quality care and cost effectiveness. This has led to criticisms that the process of reform is circular and the different administrations merely recycle and rename the same ideas (Walshe, 2003). Two and a half years after the 1997 White Paper, *The NHS Plan* (DH, 2000a: 2), promoted as a 10-year plan for reform with over 360 targets, again states that 'despite its many achievements, the NHS has failed to keep pace with changes in our society'. Moreover, in the Prime Minister's introduction, he claims that 'Its systems of working are often unchanged from the time it was founded, when in the meantime virtually every other service we can think of has changed fundamentally' (DH, 2000a: 8).

The focus on staff

The leverage used in the *NHS Plan* is the rhetorical device of '1948' whereby its founding principles and values are celebrated as good and constant yet its actions and the actions of its staff are dismissed as 'a 1940's system operating in a 21st century world':

> Staff in the health service have tried to lead change. In many places they are doing just that. Their efforts to modernize services all too often founder on the fault lines in the NHS which are a hangover from the world of 1948. (DH, 2000a: 26)

This motif was similarly employed by the NHS Modernization Board's annual report for 2000/2001 stating:

> Perhaps the greatest challenge is to achieve the cultural change needed to be able to meet patients' expectations. This requires a fundamental rethink of the way we work

together throughout the service to really deliver what people want. In this way the success of *The NHS Plan* rests quite literally on the people working in the NHS and social services. To meet the vision outlined in *The NHS Plan*, we will all have to embrace change on a massive scale. This means no less than a fundamental shift in our working practices and attitudes, some of which have remained unchanged since 1948. (NHS Modernisation Board, 2002: 5)

This is repeated in *Delivering the NHS Plan* (DH, 2002a: 3) when the model's ability to meet twenty-first century health needs is discredited. The outdated system of a 'monolithic top down centralized NHS' must be replaced with a 'devolved health service'.

One of the main differences between the changes foreseen in 1972 and those in 2000 was the message to health service staff and the different values placed on them. Joseph put his faith in the professional status and knowledge of practitioners and was clear that their roles would remain essentially unchanged.

The organizational changes will not affect the professional relationship between individual patients and individual professional workers on which the complex of health services is so largely built. [They] … will retain their clinical freedom – governed as it is by the bounds of professional knowledge and ethics and by the resources that are available – to do as they think best for their patients. This freedom is cherished by the professions and accepted by the government. (DHSS, 1972a: vii)

This contrasts with a section entitled 'working differently' in *Shifting the Balance of Power* (DH, 2001a). Apart from 'empowering patients' three key aspects are emphasized for long term reform:

  (i) breaking down demarcation between different professional groups and organizations;
 (ii) freeing 'frontline' staff to redesign services;
(iii) involving patients in planning their care.

Behind these aspirations were the twin aims of creating cultural and structural change and claims that 'working differently' means:

Giving front-line staff and patients the opportunity to think and work differently to solve old problems in new ways is the only way to deliver the improvements set out in the *NHS Plan*. The changes … will provide a structure that supports the devolution of power to frontline staff and patients. However a change in culture and new ways of working within organizations will be needed if we are to improve the quality of the patients' experience. (DH, 2001a: 23)

However, the report '*Making a Difference*' casts doubt on both the effectiveness of the context of care to support these ideas and health professionals themselves who could be more effective in managing and implementing change:

The context of care is changing but nurses, midwives and health visitors are often constrained by structures that limit development and innovation. The NHS and wider

> health arena needs a modern and responsive workforce of well-motivated, well-trained professionals equipped to respond to the challenges of change. (DH, 1999: 13)

The *NHS Plan,* described by Bradshaw (2002: 1) as a 'massively detailed mega strategy' suggests how this re-invigorated workforce would work:

> NHS staff, at every level, are the key to reform … to deliver the major improvements in patient services the country needs. Radical changes are needed in the way staff work to reduce waiting times and deliver modern, patient-centred services. This is not a question of staff working harder. It is about working smarter to make maximum use of the talents of all the NHS workforce … Managers and clinicians across the NHS must make change happen. (DH, 2000a: 82)

The supporting websites were more bullish. Under one of the 10 key priorities entitled 'Workforce' the target was defined as 'recruiting more staff to the NHS, enhancing their skills, and giving them the incentives and freedom to work in new, more flexible ways'. Staff across the health and social services are the linchpin of change – they will need to:

- work in new, more flexible ways;
- develop and demonstrate leadership;
- play a full part in re-engineering services around the needs of patients (DH, undated a).

Achieving the key priority 'Faster and easier access to services' (DH, undated b), means 'redesigning services and working in new ways so treatment is more convenient for the patient'.

Achieving the key priority 'Quality' means:

- Giving patients comprehensive information about how NHS organizations are performing;
- Regularly asking patients for their views and acting on them (DH, undated c).

In 2004, the *NHS Improvement Plan* (DH, 2004a: 5) claimed that 'frontline staff are being incentivised to become increasingly innovative and creative'. Under a heading 'More staff working differently', it states that there is

> a significant appetite for developing new roles in the service. Attitudes to workforce flexibility have also changed … in addition to their extended clinical roles nurses will be given a lead role in improving the experience of patients in both the hospital and the community (2004a: 59).

In 2005, the plans for a 'patient-led NHS' argue that still not enough is being achieved. The Chief Executive of the NHS states:

> But the ambition for the next few years is to deliver a change which is even more profound – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in our relationships with patients and the public. In other words, to move from a service

> that does things *to* and *for* its patients to one which is patient-led, where the service works *with* patients to support them. (DH, 2005: 3)

The means of achieving this objective is through changing culture and systems, giving more authority and autonomy to staff, tackling the barriers which create rigidity and creating new models of change. Within the new 'innovative' NHS, there will be a 'new type of professional' with 'scope for more creativity' and this will involve 'freeing up the entrepreneurialism … and developing new types of provider organizations' (DH, 2005: 15).

It is with this background that health professionals are expected to implement a wide range of policy directives, develop new services, work in 'new, more flexible ways' and 're-engineer' services. They are encouraged and expected to embrace post-Fordist principles through being flexible, empowered and self-regulating whilst working in one of the most bureaucratized and centrally controlled institutions of the modern age (Klein, 1999; Bradshaw, 2002).

The challenge of change

Implementing change in healthcare is difficult, challenging and often results are short-lived (Parkin, 1997). The delivery of healthcare operates in complex systems where collections of individuals act in unpredictable and diverse ways, where tensions and paradoxes are created through opposing forces of competition and co-operation and where decisions and actions about care are dominated by the unique contexts, priorities and choices facing practitioners (Plsek and Greenhalgh, 2001). For example in mental health, Hall (2006) suggests that nurses' basic assumptions often focus on how difficult their role is and their lack of control or success in managing any change. These assumptions are embedded in their culture leading to poor patient and professional experience and, more worryingly, ambivalence towards implementing change.

The perpetual cycles of imposed change can therefore engender deeply cynical and dismissive attitudes by staff with reactions of 'we've seen it all before, nothing works, just ignore it and keep your head down as it won't last' (Walshe, 2003: 108). Concerns arise about whether devolution of power to frontline staff can actually happen in a system which is 'highly politicized, media sensitive and government-controlled' (Ferlie and Shortell, 2001: 300). Within the 'machine bureaucracy' of the health service, tighter controls mean fewer opportunities for local innovation; reducing opportunities for innovation will reduce variations in service provision; reducing variations means that comprehensive, adaptable and locally appropriate responses to clients' needs will be less likely and the aims of the plan will never be achieved.

It is these arguments that provide the underpinning motivation and rationale for this text. Its central concern is to enable health professionals and equip them with knowledge appropriate for the confident implementation of sound and worthwhile changes in the complex arena of their workplaces.

Table 1.1   Potential change initiatives for healthcare practitioners

- Quality assurance issues
- Clinical effectiveness and standards
- Cost effectiveness and waste reduction
- Client/patient participation and satisfaction
- Team effectiveness
- Service development
- Work content
- Target achievement
- Research implementation
- Management/caseload/workload audit
- Health promoting initiatives
- Continuing Professional Development (CPD)

Aim of the book

The book aims to provide a wide-ranging but practical text for 'frontline' health professionals whose work entails implementing change in its fullest sense; this may mean anything from developing a new multi-disciplinary service for the local community to introducing a journal club within a work team or an evidence-based procedure to a clinical team to improve the quality of care (Table 1.1).

Furthermore the *NHS* Plan requires 'nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs' (DH, 2000a: 83). These examples are simple to state but difficult to achieve. Implementing such change requires the creation of an environment where innovation can take place. Plsek and Wilson (2001) claim that this can be achieved through focusing on four key areas – direction pointing, managing boundaries, gaining permission and managing resources. The challenge is to find ways to gain mastery over these within the traditional roles and specialisms which dominate current healthcare organization and service delivery.

This book, therefore, is about management within healthcare but particularly managing change, since this is essential in any reform programme and yet a significant challenge to staff with little power and authority in the workplace (Bolton, 2004). It aims to reflect the main elements of a project from problem identification and plan development to execution and evaluation. In so doing it provides a compendium of concepts, models, strategies and research which underpins the skills and understanding for managing change in a variety of health environments. It shies away from being a '"how to" recipe that prescribes a number of sequential stages (n-step manuals)' (Dawson, 2003: 3), recognizing the inadequacy of planned change approaches in complex organizations (Plsek and Greenhalgh, 2001; Rhydderch et al., 2004). Though each change project is unique, they share and deal with similar generic features such as political and power environments, territorial and cultural issues, setting aims, outcomes and resources, and these must be assessed and managed through a case by case approach.

Action research

The text integrates management with action research as the core strategy for implement-ing change in healthcare and this is a key difference from other comparable texts. Explanations of action research are generally found within research texts (Grbich, 1999), but there are few 'management' texts that promote it as a core strategy; indeed it has been claimed that the term is rarely used in management and organizational change literature (Badger, 2000). Yet action research is defined as a management and leadership tool for implementing social change in practical ways and in real situations. Reason (2001) claims that through research, education and socio-political action, action research achieves outcomes which are directly useful to specific groups. Through consciousness raising, reflection and collective self enquiry it empowers groups to develop knowledge and solve problems within their own organization or community thereby promoting organizational learning.

Coughlan and Coghlan unequivocally link action research to the practice of strategic management:

> [Action research] is fundamentally about change. [It] is applicable to the understanding, planning and implementation of change in business firms and other organizations. As action research is fundamentally about change, knowledge of and skill in the dynamics of organizational change are necessary. Such knowledge informs how a large system rec-ognizes the need for change, articulates a desired outcome from the change and actively plans and implements how to achieve that desired future. (2002: 225)

Hall (2006) argues that action research may be more fruitful than traditional models of change as the responsibility for it lies with teams in their workplaces rather than with cen-tralized policy-makers who may be far removed from the situation where change is needed.

MacFarlane et al. (2002) suggest that case studies provide valuable ways of sharing and learning amongst practitioners, particularly for Continuous Professional Development (CPD). Subsequent chapters are illustrated using two thematic action research studies, drawn from national or international health contexts, which demon-strate the relevance of action research to implementing change in healthcare. The generic term 'action research' is used throughout while recognizing that the terms 'par-ticipatory action research' (PAR), 'action learning' and 'community development' (CD) are frequently used in the literature (Macaulay et al., 1999). Normally PAR refers to the development of knowledge leading to social action; CD refers to the development of a 'functioning collective' or 'association of citizens' (Lindsey et al., 1999: 1238). Strong links with action research are clear.

The book aims to be of practical use to health professionals who are charged to implement change. The proposed model of change (see Chapter 6) needs a process to drive it and the philosophy and methods of action research, which enable the involve-ment and participation of practitioners, provides this. As well as meeting the needs of evidence-based practice, action research promotes a philosophy relevant to democratic methods of managing people at work.

Structure of the book

Chapter 2 discusses action research in more detail. It is increasingly recognized as a sig-nificant method available to practitioners and is now used frequently in the health and social care arena. It can be used in specific areas with groups of people needing to achieve a solution to a particular problem. Brown and Jones claim that it

> is premised on the assumption that human beings can become knowledgeable about their own situation … therefore [it] is a collaborative venture, where practitioner-researchers work together to achieve three things: first, a better understanding of themselves; second, a better understanding of their situation; and third, overall changes to a situation. (2001: 99)

Hart and Bond discuss a change management project to improve the standards of care in a hospital in the UK which illustrates the importance and relevance of this philosophy:

> Why was it that those involved in commissioning the research selected action research as a strategy to manage change, and what did it offer that other approaches did not? Conversations with key people … suggested that long experience of the National Health Service had convinced them that change imposed from above would be subverted by staff at grass roots level. Action research, with its 'bottom-up' philosophy, seemed to promise a means of overcoming such resistance by promoting a sense of ownership and involvement in those most directly affected by the change. Thus the regional health authority took an enlightened position with regard to the choice of approach. (1995: 90)

This chapter defines and discusses key aspects of action research locating it within the post-modern era as a contrast to the traditional methods of 'positivism'. It outlines key features of the process particularly relating it to the management of change in organi-zations. It tracks its historical roots, outlines its advantages, disadvantages and methods and considers the debates over rigour, validity, reliability and ethics.

Chapter 3 discusses the social, cultural and organizational contexts of change in society and their influences on healthcare. It outlines the effects of globalization and new com-munications and information technology, as well as the growing significance of health consciousness and information in creating a more demanding consumer group and the effect of this on health professionals' expertise.

From global issues, it moves onto local, social and organizational contexts of change. It analyses Fordism, post-Fordism and post-modernism and their influence on the orga-nization of public service work. It tracks the rise of the supermarket approach to health-care, increasing patient knowledge and expectations and the creation of a patient-led NHS (DH, 2005) linking these to the wider changes in society.

Chapter 4 examines management and managing in healthcare and outlines managerial roles and functions. It briefly analyses two managerial approaches commonly applied in healthcare contexts, and contrasts approaches of 'general managers' with those of health professionals from medicine and nursing. Building on Chapter 3, it contrasts modern

flexible management with Taylorist/scientific approaches frequently seen within the sphere of nursing.

It concludes with an updated version of a model of management (Figure 4.1) (Parkin, 1998) highlighting key aspects of the management process.

Chapter 5 looks at the controversial place of leadership in the NHS. There are many debates about leadership and both researchers and practitioners appear far from understanding its meaning and complexities in the public sector. It is one of the features of dynamic language that words become fashionable and develop a cachet (Appleyard, 2005). Many recent health policy documents appear to prefer the term 'leadership' to 'management'. For example, under the heading 'Leadership' the *NHS Plan* states that hospitals should have 'a strong clinical leader … [who] … will be given authority to resolve clinical issues, such as discharge delays, problems such as poor cleanliness … [and] draw up local clinical and referral protocols' (DH, 2000a: 86) Whether these actions should be termed leadership, management or administration is debateable and an aim of this chapter is to question the extent of opportunities for leadership within large bureaucratic healthcare organizations. It discusses approaches to leadership, transformational and transactional leadership and the challenges of leadership within bureaucracies.

Chapter 6 forms the central thrust of the text. Views of change (and hence its success) generally hinge on seeing change as either a planned, episodic and discontinuous event or as a perpetually evolving, developmental cycle with no terminal point. Change models normally reflect these different views. The proposed model of change (Figure 6.4) has been developed from the management model in Chapter 4. This model of change attempts, through its process approach, to see change neither as 'episodic' nor as continuous but as an integration of the two where practitioners have to implement change (with an end point – therefore discontinuous) within an environment where change is characterized by 'the ongoing variations which emerge, frequently, even imperceptibly in the slippages and improvisations of everyday activity' (Orlikowski, 1996: 88–9). The model raises other significant factors that influence implementation success. These critical factors guide further analysis.

Chapter 7 explores the influence of culture in the workplace. Understanding organizational and professional culture is at the heart of managing change in healthcare. It has been claimed that in the public sector there is no room for the innovator (Oldcorn, 1996) and this can apply to the bureaucratic tendencies found within many healthcare organizations. The NHS is a multi-cultural society and each different professional group and specialty has its own image and identity, subcultures, roles and rules of behaviour. These professional cultures are transferred to succeeding generations and perpetuated through socialization processes of education, training systems, teachers, mentors and assessors and through occupational histories and stories.

Bauman (1990) has claimed that for the sake of coherence and identity, groups must postulate an enemy to draw and guard their boundaries in order to secure loyalty and

co-operation. This view may help to explain the ongoing conflict between doctors, managers and politicians played out in the pages of medical journals. Implementing change in any area of healthcare creates a potential cultural clash between the various organizational and occupational value systems (Drife and Johnson, 1995) and these forces need to be understood and managed. This chapter develops these ideas through the context of current health policies. It considers how culture develops, the meanings and effects of organizational culture, and the different professional cultures within healthcare, examining the challenges for managers and practitioners when initiating change across different professional groups.

Chapter 8 draws on and explores the use of analytical tools. Organizational analysis is often the missing link in change plans as managers are so convinced by their ideas that they do not consider they may be wrong (Harvey-Jones, 1990). This chapter considers organizational learning, examines conditions for its development and proposes methods for analysing and assessing the environment of change. It further explores action research philosophy and its relevance to organizational development (Eden and Huxham, 1996). It proposes a series of questions to ask when planning change (Parkin, 1997) as a means of assessing the organizational climate which is so vital when analysing change opportunities.

Chapter 9 recognizes that resistance to change is an important and natural reaction to change. It defines resistance and examines the roots, forms and characteristics of resistors and resistant organizations. It proposes a range of models of intervention to manage resistance to change.

Chapter 10 proposes that conflict is essential to the growth, change and improvement of organizations. Without conflict, organizations would stagnate. This chapter suggests a positive perspective towards conflict which is often interpreted as a failure in interpersonal relations or organizational systems. It examines the nature and meaning of conflict in healthcare and proposes strategies for its management.

Chapter 11 brings the preceding chapters together to examine strategies for implementing change. It discusses key interpersonal processes and roles from the management model in Figure 4.1 and stresses the importance of self-awareness and flexibility in implementation style. It examines a range of people-based interventions and builds on the attributes of the learning organization – with person- and team-centred management and participation as key strategies for success.

Chapter 12 provides concluding comments on the main issues surrounding managing change in healthcare. It is intended that the book will act as a compendium but with a strongly articulated and realistic statement of caution. Despite a sound idea, the best intentions and the highest motivation, there are innumerable obstacles to disrupt and prevent progress. There are few situations in healthcare which have a high degree of certainty and health professionals need to cultivate a flexible approach to change implementation.

Integrating chapter themes and action research studies

The text aims to integrate action research studies from a range of health and social care fields with implementing and managing change. Major databases including Academic Search Premier, Blackwell Synergy, CINAHL, Emerald and Sage were searched using the key words 'action research' linked each chapter's theme (e.g.: 'manage*', 'leader*', 'change', 'culture', 'conflict').

Regarding currency, although action research has a longer history in healthcare, databases were searched from 1995, recognizing Hart and Bond's (1995) publication as a significant trigger in raising awareness of action research in health and social care.

This search method produced copious material. Most studies however, though often service wide in scope, originate from a 'nursing' perspective and academic nursing journals. Searching the *British Medical Journal* for example, captured only a handful of genuine action research studies. Furthermore, many citations were limited to analyses of methodology (such as rigour, ethics, validity) or the challenges of action research processes rather than following the convention for research publications of context, method and outcome. This may be a case of 'fighting the corner' for action research and dealing with the enduring methodological criticisms.

To qualify as exemplars, the inclusion criteria are that studies should:

- report a real issue of change management and research significance
- be triggered by a clear and definite problem geared to service improvement
- relate directly to the chapter theme
- involve a group/organization process rather than an individual reflection
- report details of the recursive process of planning, action, reflection and re-planning (see Figure 2.1) rather than single methodological issues.

Following Grbich's (1999) classification, cited studies generally follow an 'organizational' or 'professionalizing' focus where researchers and practitioners work in collaboration to improve practice rather than exploring 'experimental' or 'empowering' approaches.

Livesey and Challender (2002) make two useful points in assessing action research studies. Firstly, they acknowledge that the absence of a declared methodology limits the reader's ability to appreciate the process used to obtain results. Secondly, all studies face the impossibility of capturing the many deep complexities involved in the action world. The boxed examples are further précis to illustrate and emphasize chapter content and readers are encouraged to access the original papers. Finally, there are many terms available to identify the groups to whom this book is aimed. Though it promotes action research as a method of implementing change, frontline staff may not see themselves as 'action researchers'; though they may have a management role, they may not see themselves as 'managers'; and though they wish to make changes, they may not welcome the somewhat pretentious label 'change agent'. The term used throughout the text is 'health professional' as this is inclusive, accurate and the term preferred by NICE (2005).