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The Challenges of Leading Change in Health-Care Delivery from the Frontline

Vivienne Byers
Technological University Dublin, vivienne.byers@tudublin.ie

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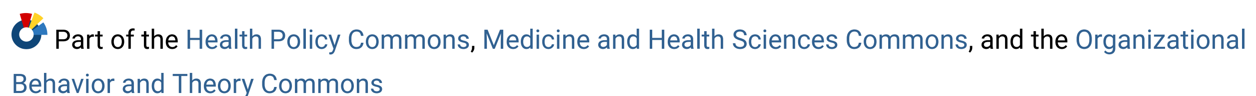
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3 # The challenges of leading change in health-care delivery from
4 the front-line
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7 VIVIENNE BYERS BA (Mod), MA, MSc, PhD
8
Lecturer, *Health Policy & Management, Dublin Institute of Technology, Dublin, Ireland*
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Correspondence
Vivienne Byers
School of Management
Dublin Institute of Technology
Aungier Street
Dublin 2
Ireland
E-mail: vivienne.byers@dit.ie

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The challenges of leading change in health-care delivery from the front-line

Aim The public sector is facing turbulent times and this challenges nurses, who are expected to serve both patient interests and the efficiency drives of their organisations. In the context of implementing person-centred health policy, this paper explores the evolving role of front-line nurses as leaders and champions of change.
Background Nurses can be seen to have some autonomy in health-care delivery. However, they are subject to systems of social control. In implementing person-centred policy, nurses can be seen to be doing the best they can within a constrained environment.
Method A survey of nursing practice in person-centred health-policy implementation is presented.
Findings Despite much being written about managing health-professional resistance to policy implementation, there is a gap between what is being asked of nurses and the resources made available to them to deliver. In this milieu, nurses are utilising their discretion and leading from the front-line in championing change.
Conclusions Empowering nurses who seek to lead patient involvement could be the key to unlocking health-care improvement.
Implications for nursing management Health services tend to be over-managed and under-led and there is a need to harness the potential of front-line nurses by facilitating leadership development through appropriate organisational support.

Keywords: change champions, front-line nurses, health policy, leadership, person-centred

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Introduction

Health-care services are facing turbulent times and this challenges the nurses who are expected to serve the interests of their patients as well as the efficiency drives of the organisations in which they work (Moynihan *et al.* 2009). Research has revealed the frustrations of clinical practitioners in dealing with these competing demands and looking to leadership from both within and without for support (Storey & Holti 2013). Much health-care policy has focused on integrating services and putting the patient at the centre of service delivery. Thus, this paper reports on fieldwork examining the implementation of person-centred policy from a nursing perspective, in which nurses can be seen to be doing the best they can within a constrained environment. It draws upon a wider literature examining the role of the champion

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or local leader in health-care policy implementation (Hendy & Barlow 2012, Shaw *et al.* 2012). It also examines the policy implementation literature through consideration of the reality at the front-line, or as Lipsky (2010) describes at 'street-level'. What is of significance in health care is that this 'place', the street-level intersection of the service user and the health-care professional is at the core of the policy-implementation space and should be at the core of implementing person-centred care (Beach & Inui 2006). It is here that the integration of work practices and processes will occur if the policy is to be successful. The complexity of discretion for health-care professionals such as nurses in implementing an overarching person-centred health-care policy and leading from the front-line or 'street-level' requires more attention in research (Tummers & Bekkers 2014).

Health care is a complex field due to contextual features such as clinical autonomy as well as the capacity for both inter-organisational coordination and fragmentation (Tenbensel 2013). In both the UK and Ireland there have been waves of centrally mandated policies intended to lead to change (Petrakaki *et al.* 2014). Health-care delivery models are changing due to governments responding to cost control demands. Some new public management approaches include restructuring, performance management, establishment of networks and trusts and new clinical governance structures, as well as changes in the roles and responsibilities (Greener & Powell 2008, Currie *et al.* 2009). Other approaches include organising care to be delivered in a more person-centred manner (Moynihan *et al.* 2009). Thus, leaders in health care, managers and policy makers, need to improve their support of promising practice to drive change rather than imposing processes from above (Essén & Lindblad 2013). The clinical practitioners' interest is in a democratic governance model that allows them to lead from the front-line in terms of practice-driven change, in teams with their colleagues, in a strong supportive environment and with multi-stakeholder participation (Janssen *et al.* 2015). These practitioners seek ways in which they can lead and be led (Ploeg *et al.* 2010).

Background

Kitson *et al.*'s (2013) review of person-centred care delivery notes that there are two discourses in the literature: one that is organisationally based and focuses on quality in care (i.e. Johnson *et al.* 2008) and a second discourse which takes a system-wide view; a health policy perspective where there can be a tension between the desires of policy-makers and the practices of health professionals to make person-centred care a reality (Kitson 2009). It is this second discourse that is relevant to this paper, in examining the link between the policy imperative which promulgates the involvement of patients in the delivery of their own care and its implementation on the ground from the nurses' perspective. This policy outlook has been advocated for over a decade or more in many countries.

Nurses can be seen to have some autonomy in the delivery of health-care services, but they are subject to a number of systems of social control: rule pressure, professional pressure and societal pressure (Hupe & van der Krogt 2014). In the person-centred care literature there has been some evidence that delivery of care brings challenges to the work of nurses, including its impact on their control over service delivery, and their willingness to work with, and share responsibilities with service-users (Bovaird 2007, Vamstad 2012). However, according to Petrakaki *et al.* (2014) nurses are typically trained to offer a more person-centred service. Nickel *et al.*'s (2012) study found health-care professionals are willing and able to engage in the delivery of person-centred care. The actual impediments to implementation of user involvement often are institutionally based (Abelson *et al.* 2007) or influenced by a limited willingness of politicians to place trust in decisions made by users (Bovaird 2007).

Leadership from the front-line

Research examining the top-down implementation of reforms and organisational change has proliferated over past decades in public administration as well as in the health-care field itself (Pettigrew *et al.* 1992, Ferlie *et al.* 2005). This research has grown in complexity as well as in understanding that crucial to implementation of policy is the role of front-line workers at 'street-level' in shaping that implementation (Lipsky 2010). The street-level research approach has emerged to analyse how the inconsistencies and ambiguities of policy foster an environment where professional discretion may flourish (Brodkin 2008).

The provision of health care is collective work but power remains unequally distributed amongst health-care professionals. This may be seen as related to a bureaucratic division of labour and, subsequently, to the differing degrees of health-care professional autonomy, authority and status (Currie & Guah 2007, Greener & Powell 2008). However, these professional roles are in flux as new policies aim to expand some roles, refocus on person-centric service, and as a result

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disrupt established power relations, whilst standardising more mundane tasks (Currie *et al.* 2010). Discretion and autonomy are two key mechanisms that health-care professionals use to employ judgement from the bottom–up. These parameters are grounded in norms or codes associated with professional practice (Lounsbury & Crumley 2007). Professional status not only has an influence on the discretion exercised but it also influences commitment to professional values that would inform such discretion (Lipsky 2010). This paper reports on nurses' responses to policy implementation and how in coping they lead from the front-line.

Methods

This paper draws, in sequence, on two sources. First, the results of a survey conducted over the period 2013–2014 are offered. The research was exploratory in nature and this approach was employed to obtain a snapshot of the current understanding and implementation of 'person-centred' policy from a nursing perspective across an extensive variety of practice areas and organisational contexts. The findings from this survey prompted an examination and a unique linking of a wider literature examining the role of the champion or local leader in health-care change efforts (Hendy & Barlow 2012, Shaw *et al.* 2012) with the literature on street-level discretion in leading policy implementation in health professional practice (Brodkin 2011, Gilson *et al.* 2014, Tummers *et al.* 2015).

A nonprobability convenience sampling research strategy was utilised in order to gain access to a range of nurses working in different settings (hospitals, clinics, long term care, etc.) and in different specialties (emergency, oncology, etc.). The approach adopted was to access nurses in practice who were undertaking postgraduate courses (masters and doctoral level) in a university in Ireland. This research strategy allowed convenient access to nurses, with a wide range and length of experience (ranging from 6 months to 40 years) the access to which, by other direct approaches, was proving difficult. The population within the university cluster was reasonably heterogeneous in terms of work experience and specialty. Thus, the participants were practitioners reporting on their perceptions and practice in the field, and yet bringing to the study a reflection on this practice from an academic perspective. Although generalisations of findings to the wider population is not possible with convenience sampling, by employing this approach an initial snapshot of opinion can be derived to guide further research in the area.

The sample profile derived for this study is outlined in Table 1.

Ethical clearance was sought and granted from the university to carry out the survey. The survey was delivered on-site where participants were informed about the purpose of the study and its confidentiality. There were 63 responses from a survey population of 84 (75% response rate). The development of the survey measure was based on a literature review, consulting with health-care professionals and the author's experience of health-care delivery. In particular, it drew from Longtin *et al.*'s (2010) model of factors that influence the implementation of patient participation.

The survey consisted of several parts: (1) demographic, situational and organisational factors; (2) respondents' opinions on patient involvement, including its importance, its development over time, also drawing on Longtin *et al.*'s (2010) model with regard to factors influencing perception of implementation including acceptance of their role and person-centred policy, training and institutional support, leadership, time issues, professional category, beliefs and patient demographics. Questions required respondents to select from an options list or expand through open questions on details of initiatives and implementation progress; (3) the final section sought to explore possible barriers to patient involvement drawing on the literature (Shaller 2007, Eurobarometer 2012, etc.). Open questions required respondents to expand on the challenges and/or opportunities in the area of patient involvement.

Table 1
Respondents' clinical specialty

Specialty	*n*
Older persons care	12
Emergency care	8
Palliative care	6
Midwifery	7
Public health	5
Cardiology	5
Theatre	3
Oncology	3
Intellectual disability and education	2
Intensive care	2
Neurology	2
Orthopaedics	2
General medical	2
Paediatrics	1
Diabetes care	1
Cystic fibrosis	1
Renal care	1
n	63

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Results

The results of this initial study were analysed to gain an insight into the opinion and practices of nurses in relation to the implementation of person-centric policy. Certain trends can be identified from the survey and the qualitative elements derived from the instrument indicated emerging themes.

Demographic, situational and organisational factors

The respondents were all from the nursing profession working in different specialties. The years of experience ranged from 6 months to 40 years with an average of 15.5 years. The areas of the respondents' clinical specialty included: older persons care, palliative care, oncology, paediatrics, intellectual disability, neurology, orthopaedics, emergency, critical and intensive care, cardiology, public health, midwifery, diabetes care, theatre, psychology, general medical, intensive care unit (ICU) and renal care.

Patient involvement

When asked if patients should be involved in their own health care, the majority of the respondents (91%) were in agreement. They were also asked if patient involvement had changed in the past 10 years; 98% agreed that it had changed, with 94% believing it had increased. However, out of the total cohort, over 70% expressed a lack of satisfaction with the current level of involvement that patients have with their own health care, with 91% noting that patients should be more involved. The majority of nurses (81%) agreed that patients would be willing to be involved in their own health care. The entire cohort stated that they believed that patients could help to improve the safety and quality of health care. Of the responses, 79% agreed that patients do want more decision-making powers.

Patient involvement – barriers

The participants were asked about the main barriers to patients being more involved in health care; the barriers that were cited included the nurses' lack of time and lack of support as well as patients' attitudes. A key factor cited as a barrier was that of the organisational culture which could be resistant to practice development and patient involvement.

Emerging themes

The inclusion of open questions in this survey enabled the elicitation of qualitative data. These themes indicated the active role that the nurses played in leading change and implementation from the front-line. These are grouped under two headings: leading person-centric care in practice and implementation challenges.

Theme 1: Leading person-centric care in practice

Examples were reported where person-centred initiatives had been developed and had a positive effect. As the cohort was working across a variety of specialties, there was a diversity of initiatives being led from the front-line. Some examples included the involvement of patients in self-care, in discharge planning, in education and in care planning. Amongst others, these included leading regular patient focus groups and residents councils (in long-term care), developing education and planning around self-medication as well as structured education for patients with type 2 diabetes, assisting with developing birth plans and end-of-life planning (paediatrics and palliative). Across specialties, it included tailoring treatment options and assisting with decision-making. The cohort were keen to develop programmes to develop person-centred engagement for student nurses. The nurses were very engaged in these initiatives and were eager to drive and lead these developments.

Theme 2: Challenges to implementing person-centric care

A number of challenges to developing person-centric care were identified and many of these related to organisational support.

Time and resource constraints

A strong theme was that of lack of time and resources. Respondents noted that there were '*time constraints*' due to '*staff shortages*'. One respondent stated that this '*lack of time*' was due to the system:

> 'Modern nursing has taken nurses away from the bedside, more time is spent on documentation in a bid to promote health-care system delivery'.

Another respondent stated that there was a '*lack of resources to meet patient expectations*'. These resources often included access:

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> 'It can be an issue when patients seek medications or procedures that are not available or funded'.

Lack of support
Not only was there difficulty with resources but also of support in a wider context:

> 'Better leadership needed from managers and increased resources for staff'.

> 'Need better communication between senior management and front-line staff. We are barely listened to. If small changes are.. recognised – it will be transferred to patients'.

Communication
Issues arose in engaging with patients in different settings. Some difficulties suggested were due to mental capacity. However, the requirements suggested to overcome communication barriers were mainly for increased time and organisational resources provision:

> '.. ways to further educate or empower patients will require time and resources not currently available'.

> 'More staff, more time with clients, more resources'.

> 'Higher staffing levels equal more patient advocacy, more volunteerism and more family involvement'.

Discussion

This study scoped the perceptions of nurses in practice regarding the development and implementation of person-centric care, in light of the promulgation of a national person-centred health-care policy for over 10 years. The data indicate that regardless of specialty, length of service or type of organisation, the sample of nurses strongly agreed that patients should be involved in decision-making in their own health care. A substantial number of the sample (98%) believed that patient involvement had increased in the past 10 years. They identified initiatives that were being led in the development of person-centred care across their practice areas. However, what is significant is that they were not satisfied with the level of patient involvement in the health services at present and felt constrained in delivering on it. Available evidence would suggest that developing person-centred care is not a linear process but one that is complex (McCormack *et al.* 2010). The qualitative data from this small study will be discussed under the following headings (themes); user engagement, nursing professionals' experience, the organisational/policy context and leading policy implementation from the front-line.

User engagement

The respondents overwhelmingly agreed that patients do want more decision-making powers in health care. They also cited many positive examples of how the health-care system has benefited from involved patient decision-making from the development of birth plans, agreeing lifestyle changes for diabetic and renal patients, to end-of-life decisions in palliative care, as well as examples such as the setting up of a National Cystic Fibrosis Unit through an exerted campaign of both patients and health professionals leading to patient-care improvement. Further examples were cited in the area of Intellectual Disability with the development of courses and training in communication and advocacy that facilitated a richer development of services by both patients and health-professionals. However, in ranking the barriers to implementing a person-centric approach to practice, respondents cited patients' lack of knowledge and awareness. This is an interesting finding given the positive responses to increasing patient involvement. Martin and Finn (2011) note that service-users are in a difficult position in developing relationships of trust with health-care professionals as they lack the 'expertise' of their professional counterpart. However, respondents noted that they needed time and resources for the education of patients to improve engagement.

Nursing professionals

A threat to professional control can include a fear of the patient challenging the practitioner and result in ceding influence (Vamstad 2012). However, an overwhelming majority of the cohort agreed that patients had a role to play not only in their care, but also in the training and education of health-professionals and in improving health-care safety and quality. This concurs with research demonstrating health professional enthusiasm for patient engagement (Nickel *et al.* 2012, Kofahl *et al.* 2014). According to Tummers and Bekkers (2014) when street-level professionals perceive their work as meaningful to their clients, it can have a strong influence on their implementation of policy.

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The organisational context

A significant finding of the study was the lack of time that nurses had to engage with patients. So although policy pushes the concept of person-centred care, the structures and processes of care delivery have not been changed to accommodate this alteration. In a recent paper, practitioners' lack of time was stated as a concern in the sustainability of self-management methods after stroke (Jones *et al.* 2013). This lack of organisational accommodation to the delivery of person-centred care has been reported by other studies (Abelson *et al.* 2007). McCormack *et al.* (2010) notes the importance of the 'care environment' as an influencing factor in how 'person-centredness' is experienced. Another significant barrier is the lack of organisational support despite policy objectives (Byers 2010). However, this can be due to the unchanging nature of the organisational culture itself. Supportive organisational elements include an emphasis on non-hierarchical multidisciplinary collaboration and a build-up of staff capacity (Renedo *et al.* 2015). This requires a supportive context and resources, which the data in this study indicated was a significant problem for respondents.

Leading person-centred policy implementation

The nurses in this study were strong in their support for improved patient involvement. The messages emerging were of limited person-centric policy implementation, only occurring in certain contexts and mainly driven from the front-line. These findings prompted a further examination and unique linking of the literature on champions and leaders of change and that of autonomy and the use of discretion in implementation at the front-line or 'street-level'.

Although these preliminary findings are from a small study; it revealed individuals identifying with the vision of person-centred care policy and attempting to implement it as personally interpreted, in spite of organisational resource limitations. This front-line leadership behaviour sits well with the literature on the role of champions in health care (Ploeg *et al.* 2010, Hendy & Barlow 2012). A number of healthcare initiatives in the UK explicitly identify local leaders implementing change as 'champions' (Hendy & Barlow 2012). These champions are organisationally supported in their role. According to Ploeg *et al.* (2010) the literature suggests involving these change-agents to influence a change in practices of their peers. These champions are informal leaders and 'practising' nurses. Shaw *et al.* (2012) note that the literature outlining the work of champions in nursing and medicine is extensive, but it lacks description of the champion role. They warn that the assumption can be that the role results in standard behaviours. In contrast, the present findings and the literature on discretion at 'street-level' indicate that health professionals when under pressure resort to coping behaviours. Therefore, leadership can emerge spontaneously (Hendy & Barlow 2012). The literature on this emerging leadership behaviour links well with the literature on front-line worker coping and identifies champions as individuals who go beyond their operative responsibilities (Mantere 2005).

Grouping the literatures of street-level discretion and change champions reveals a process, in which the clinical practitioner seeks to adapt their practice to contribute to their individual ownership and personal understanding of the policy being implemented (Mantere 2005). Leadership, thus, becomes part of discretionary behaviour at the front-line, not imposed by the social structure but produced through involvement in 'relations of power through which conceptions of identity are generated' (Martin & Learmonth 2012, p. 282). Therefore, discretionary practice need not be seen as subversion or compliance with policy, but as in this case, a nuanced means of doing the best they can within a constrained environment (McDermott *et al.* 2013). For many front-line workers when there is a mismatch between policy and reality, they practise pragmatic improvisation (Maynard-Moody & Musheno 2012).

Implications for nursing management

The data speak to us of nurses who are leading engagement with their patients despite the lack of organisational support to do so, in terms of time, training and support (Renedo *et al.* 2015). Although the focus of policy makers has been to reshape the model of care with the patient at the centre, it is recognised that doing so in a budget constrained environment and with staff cuts is a significant challenge. Understanding the leadership roles that nurses can play at the front-line can help organisations and the nursing profession benefit from their potential to influence and implement change practices in advancing positive patient and organisational outcomes.

Preliminary data in this paper indicate that empowering nurses (through appropriate organisational support) who are seeking to involve patients in their care

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could be the key to unlocking improvements in health-care delivery and patient outcomes.

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Ethical approval

Approval for Human Subjects Exemption from Full Ethical Review (Reviewers): Dr Mary Casey, Associate Dean for Taught Graduate Programmes, UCD School of Nursing, Midwifery & Health Systems, University College Dublin. Dr Martin McNamara, Dean of Nursing and Head, UCD School of Nursing, Midwifery and Health Systems, UCD Dublin.

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