

An Exploration of the Maternal and Child Health Changes in Australia

Breach Rayleen, PhD candidate, RN, RM, M&CHN, Grad Cert Diab Ed, PGDipN

Jones Linda K, RN, RM, BApplSc (Nsg), PGDipEd (Nsg), MNA, PhD

RMIT University
Post Office Box 71
School of Health Sciences
Plenty Road, Bundoora 3083
Victoria, Australia.

Abstract

Background: *The Victorian Maternal and Child Health (MCH) profession is in the process of undergoing a number of changes as a result of initiatives at national level. Aim:* *The aim of the research was to explore and describe the knowledge, attitudes and beliefs of Victorian Key stakeholders (KSH) and MCH nurse's regarding these changes. Method:* *A qualitative, semi structured interview method was employed for this study with 48 participants. Results:* *The results indicated that participants strongly believed that change was imposed on them without a great deal of communication and consultation with them. Discussion:* *Kotter's framework was used to highlight what process was lacking and what could have been undertaken to assist achieving this change. A change of such a magnitude as the national registration and development of a national framework had never been undertaken previously. This framework explained why participants in the study were feeling so disenfranchised with these changes.*

Keywords: Maternal child Health, Organizational change, National registration, Consultation

1. Introduction

The MCH profession in Victoria is in the process of undergoing a vast amount of change as a result of a number of initiatives occurring at the national level. This started with the Australian Productivity Commission's position in 2006 to further raise the living standards and improve the nation's productivity and workforce participation over the next decade (COAG 2006). This brief lead to COAG requesting the Productivity Commission to conduct research into building a common national strategic framework to guide governmental action on increasing the productivity of the Early Childhood Services. In order to satisfy the brief, the scope of the research was to cover; future demands of the workforce and the mix of knowledge and skills required meeting service demands. Building the capacity, effectiveness and structure in the short to long term with workforce planning and development with policy, governances and regulatory measures to maximize the efficiency and effectiveness in achieving the intended outcomes was paramount (COAG 2011).

These reforms were inclusive of a national registration for health professionals. Previously 8 jurisdictions consisting of 6 states and 2 territories across Australia had their own registration requirements. Under the national proposal, all health professionals would be registered with individual specialty boards under one organization, being the Australian Health Practitioners Regulation Agency (AHPRA). This resulted in national registration and regulation of professional health services on July 1st 2010 (AHPRA 2010/11). In order to disseminate and implement this national approach, significant changes were required across professional practice, policy, governances, programs and service delivery throughout the individual jurisdictions (Schmied, Kruske, Barclay, & Fowler 2011). These reforms included a national Child and Family Health framework that will impose national consistency with standards of practice, qualifications and education requirements for the Child Health workforce.

A significant change of this proportion could have the potential to substantially change the current role of the MCH service in Victoria.

Victorian MCH nurses have qualifications as General Nurses, Postgraduate Diploma of Midwifery and attained a Graduate Diploma or Masters level in Child and Family Health. MCH nurses visit 95 to 98% of all Victorian mothers with newborns at home within two weeks following discharge from hospital (DEECD, 2011). The MCH nurses offer continued support and assessment of mothers, fathers and their families in local areas until children are kindergarten aged. In Victoria MCH nurses are employed by local government authorities. The MCH service is a universal primary health-care service offered across the state. Client participation in the service is voluntary. Services provided by the MCH nurses include health assessments, health promotion, preventative education, early detection and intervention. These assessments also include screening for postnatal depression, family violence, child abuse, Sudden Infant Death Syndrome (SIDS), safe sleeping practices and QUIT initiatives (DEECD, 2011). There is evidence supporting these services which indicates that the health outcomes for families and young children across Victoria are above in a number of headline indicators (AIHW, 2011). MCH nurses are internationally recognised, highly skilled independent specialist nurses who take a holistic approach to health care along with being at the forefront of Early Childhood service in the community (Edgecombe, 2009; Scott, 2011:7). It is well documented that the early years provide the foundation for lifelong physical, social and emotional wellbeing (Shonkoff & Phillips 2000; Shonkoff, Boyce, & McEwen 2009). The MCH nurses in Victoria are uniquely placed to influence these critical periods in a child's life by promoting consistency of services.

The data for this study was collected at the time of the change to a national registration in July 2010 and before the development of the national framework. With the change to national registration, the MCH nurses had lost their notation and recognition of additional qualifications on their registration certificates. This occurred because Victoria was the only jurisdiction that had this notation. As a consequence of national registration there needed to be a reconceptualising of how the MCH service would operate nationally. In other words, the development of a national service framework was required. What existed was disparity of practice across all jurisdictions that coexisted with the previous disparity of qualifications. With the qualifications becoming uniform across Australia with national registration, the services provided by the MCH nurse had to be made uniform, that is, the development of a national service framework. To date there has been no published literature exploring the Victorian MCH nurses knowledge, attitudes and beliefs to the perceived impact of these national changes in Victoria. This paper presents the findings from the data reflecting how the MCH nurses felt about these changes.

2. Methods

A qualitative exploratory descriptive (QED) research methodology informed by Patton (2002) and Sandelowski (2000) was employed for this study. This approach was undertaken as it is an appropriate methodology for collecting information when little is known about the phenomena and where data is too complex to be captured using other methods (Patton 2002; Maxwell 2006).

The aim of this study was to explore the knowledge, attitudes and beliefs of the MCH nurses in Victoria to the perceived impact of national changes to registration and service provision. Interviews were undertaken with KSH who were either in management, academia or service coordination from different influencing positions for example; Department of Education and Early Childhood Development (DEECD), Municipal Association of Victoria (MAV) or Coordinators of Family and Children's Services from local government jurisdictions across Victoria. Interviews were also undertaken with MCH nurses across Victoria.

2.2 Participants and Recruitment

The participants were recruited using purposive sampling through advertising in the Victorian Association of Maternal and Child Health Nurses (VAMCHN) journal and at DEECD state conferences. Interested participants contacted the researcher with their expression of interest in being interviewed. Recruitment continued until data saturation was reached (Patton, 2002). This resulted in 48 interviews being completed which included 12 KSH and 36 MCH nurses.

2.3 Data Collection and Analysis

Participants were interviewed and audio recorded taking approximately 45 minutes. The interviews comprised of 6 categories of questions related to national registration, national framework, Qualifications, Service Provision, Professional Development and Organisational Change. Content validity and piloting of the questions occurred prior to the main study being undertaken (Patton, 2002).

Data analysis followed steps specified by Day (2003) with content analysis as the chosen method for this study. According to Morse and Field (1995) content analysis occurs through reading the transcripts and identifying categories. This enabled the data to be categorised with two or more sub categories. Interviews were transcribed verbatim. Member checking occurred with transcripts being coded by both researcher and supervisor for reliability of analysis (Sandelowski, 2000). Annotated notes were made during the coding process and included in the analysis process. To limit the richness of the data being lost a systematic and rigorous analysis process using NVIVO coding ensured the data would not be distorted, reduced or be a fragment of the participants experiences (Bazeley, 2007), (Richards and Richards, 2003).

2.3 Ethical Considerations

Full ethics approval from RMIT University's Human Research Ethics Committee and permission was granted from the DEECD to engage the KSH and MCH nurses for the purpose of this research. Prior to interviews all participants were given consent forms and plain language statement. Transcripts were identified numerically to ensure confidentiality and anonymity.

3. Results

The age of the KSH ranged from 46 to 55 years. All had extensive nursing experience and held midwifery qualifications. The experience level of the KSH sample was between 1 to 20 years in upper management, higher service delivery and education with the majority having more than 10 years' experience in the field. The KSH qualifications ranged from Graduate Diploma to Masters with 4 holding a Masters of Business Management.

The age range of MCH nurse participants was between 24 and 65 plus years while their range of experience was 1 to 35 plus years. The majority of these participants had a Graduate Diploma qualification with 10 having a Master of Child and Family Health Nursing degree. All were nurses with extensive nursing experience and a midwifery qualification.

Categories were developed by identifying recurrent patterns from the data and organised into groups through a process of inductive reasoning. These categories were then defined from participants own words from the data. This article will only discuss the data from Imposed from above.

3.1 Imposed from above

3.3.1 KSH Perspectives

The KSH knowledge and understanding of what a proposed national service framework for MCH nurses would look like offered surprising results. The number of stakeholders who had limited knowledge was significantly more compared to the stakeholders who had a more comprehensive understanding. To date there have been a number of issues identified by the KSH in the data that may have attributed to this. One of the major concerns identified by the participants was the lack of involvement and consultation that had occurred between the governing bodies and the KSH with what was planned at the national level prior and during the national changes. In other words, there was a perception from the KSH that;

"... if it is something that is imposed from above it's not going to work...it has to come from the bottom up as well as from the top down..." KSH12

"... change can be positive... it is how it's implemented... if it's just sort of dumped on people they become more resentful..."KSH2

It became apparent from the interview data that the KSH further believed the decisions regarding the service were being made by policy makers who had not thought through the implications of the change thoroughly enough. In addition, there was also a perception by the KSH that the policy makers and governing bodies did not have good knowledge and clarity of what the Victorian service offered. A further reasons why this was perceived as being problematic was expressed by one of the KSH in the following;

"... policy people bring one set of glasses when they are looking at things ...they just don't seem to know what the grassroots stuff is all about..." KSH12 In other words, the KSH believed that;

"... there needs to be more consultation with the grassroots practice and that's not happening..." KSH 12

Other reasons identified by the KSH as to why it was important that the practitioners themselves should have been included in the planning process was because;

“... many decisions are made when there isn't anybody around who has a practical view of what's happening on the ground ... unless you incorporate their point of view you are always going to have to drag the service along...” KSH3

This is not only about having the KSH on board, there needed to be consultation with the MCH practitioner themselves. More importantly this was identified as one of the main concerns highlighted by the KSH as something that in fact was not happening. In other words, from the KSH perspective there had been a lack of consultation and involvement in the national agenda of the Victorian MCH with the policy makers and service reviewers, as illustrated;

“... I think we have not had enough consultation as stakeholders in the national agenda...” KSH3.

“... getting people in right from the word go... grass roots involvement because if the grass roots don't accept it, that's the end of it... you have to be involved all the way up the line...”KSH10

The necessity of the importance of collaboration is outlined by the following KSH;

“... it needs to be relevant for people to feel that they own it... come to the table with goodwill... be prepared to give and take... we have an excellent service in Victoria but we could learn from the other states with things they do well...” KSH12

This is supported by other KSH;

“ ... getting people to come around in terms of where they were and where we have got to change to... not just change for change sake”KSH4

“... just because it's gone national doesn't mean we shouldn't be having an input...”KSH 3

In contrast, there was a small number of KSH that believed that in fact there was adequate consultation regarding the evolving framework. Instead that many practitioners ignored what was happening believing that Victoria would be immune because;

“In Victoria ... people thought we had the gold standard and therefore we would be fine without realising that we didn't have the research to back up and the data to say well yes a child in Victoria is much better off because of our service” KSH1

Policy makers may have had the vision for change, however, the importance of having good leadership for executing change was identified as vital by the KSH. The KSH believed, furthermore, that leadership on its own was not enough to ensure successful change. These leaders themselves, however, need to be involved in the consultation process to then be able to be the leaders of the change. The effect on the leadership champions from the change to a national platform was, however, that the change was still imposed from above and resulted in the KSH feeling disenfranchised with the lack of guidance on what was happening. In other words;

“... we don't know enough... we are doing this in the dark... I certainly feel ill prepared to lead a change in our team around this...”KSH4

It was obvious from this KSH perspective there needed to be more than what had been delivered. More specifically what were needed were the background and the lead up documentation to support the reasoning behind the decision for the national changes;

“... I like to see the rationale behind why we are changing... so I don't feel threatened by the change... “KSH2

Leaders cannot implement new change strategies on their own. They require a partnership of senior leaders which includes leaders from the different levels of management to establish and gain the cooperation of others;

“... you need to ... get the stakeholders on board... if they understand why then they're much more likely to be involved... it has to help the process... pre-anticipating anxieties and addressing the anxieties is essential...”KSH5

The responsibility of this guiding senior leadership is also to empower and encourage others to embrace the change effort and keep it on target. Success of the change effort primarily depends on the quality and attention senior leadership gives to its structure. In turn this is thought to minimize unsuccessful change efforts;

“... I am sick of the coordinators discussing this whole thing and no- body really knowing anything about it... it’s really hard to discuss the whole thing when you really don’t know...” KSH 4

More importantly the KSH indicated in the data that they believed there needed to be a more comprehensive and inclusive working leadership group to progress with the national service framework. It was clear from the following quote the KSH perceived the opposite was the case;

“...there needs to be a broader representation ... it is certainly being led by two states and they have given good leadership... but it would be good now to create a leadership group of academics from all states... as there’s good wisdom in all states...”KSH7

In addition, it became clear from the data that the KSH also believed there had not been adequate communication between the organising bodies nor the leaders implementing the changes about what was happening. The KSH further believed that good communication is essential for change processes to be effective and to have the desired transformations. Instead the KSH felt that;

“... we are reliant on gossip and hearsay... the odd comment at a conference or a paper... there is nothing structured... unless you get that you really cannot make a decision on what works or doesn’t work...”KSH10

Furthermore the majority of KSH believed that communication is much more powerful and effective if it is delivered within a multi focus arena;

“... communication and letting people know what the change is... how they are going to be supported... having change leaders around... champions for people...”KSH10

More to the point the KSH indicated that keeping the message and communiqué pathways simple would assist therefore;

“... making sure the chains of communication are set up so that it is easy...”KSH8

A suggested strategy offered by the KSH to support communication was;

“... there needs to be funded seminars for people to come and give their opinions...” KSH12

In addition, the KSH recognised that to assist with major change there needs to be a vast amount of honest communication to address inconsistencies and eliminate mixed messages. Plus there was a need to gather as much information about what happened elsewhere and to be fully informed;

“... we should have a round table to work out what does happen in the other states ...”KSH10

3.1.2 MCH Perspectives

The MCH nurses were collectively grouped into three groups depending on their years of experience (A: 1 to 5 years; B: 6 to 14 years; C: 15 years and over). The quotes are therefore labelled accordingly. As previously identified in the data by the MCH nurses, the change to a national registration meant that there would need to be a reconceptualising of how the MCH service framework would operate nationally. It was clear from the data that the MCH nurses strongly believed that these changes were imposed on them and that others were in fact making decisions on how the service should function. In other words, top down change directives which rarely elicit long term success. As indicated;

“... governments bring in these ideas... they rush them through without much thought for the people that are implementing them or bringing them out... who in turn don't really understand them... so how can they then pass it on down the chain... by the time it gets to us at the bottom it’s a nightmare because nobody has understood it properly... the instructions are so muddled that it makes it virtually impossible to implement something new... the majority of people give it lip service and then they continue to do what they have always done... it is so confusing...” MCHB1

What this quote also highlights is the strong need for involvement from the grassroots’ practitioners when planning the changes.

This is in order to ensure all aspects of change are investigated to guarantee specifically a workable service framework thus reducing barriers to implementation of best practice at the coal face. A further reason identified from the data is illustrated in the following;

“Unfortunately it has been my experience that decisions made without actually consulting with practitioners... come up with a framework that is not going to work at a clinical level... such a waste of resources and time that creates enormous frustration for the MCH nurses who are actually trying to put the framework into practice... either they don't use it at all or they use it badly because it doesn't work in their practice...” MCHB3

The majority of MCH nurses in the data stated that they believed the most important aspects of organisational change were ensuring a culture of collaboration. This is where the fear and uncertainty of the unknown aspects of change are acknowledged and worked through with a collaborative process. They further stated that this should include the importance of a positive culture behind both the barriers and the enablers for successful change initiatives in order to proceed. This then takes time but is important for success;

“... it has to be a gradual process... a slow process... informed... everyone needs to know what's going on and when it is going to happen and why it needs to happen...” MCHA 2

“... making sure that people are aware of what's going on... why there is change and of what the change is going to mean for them... allowing people time to understand the change and to ask questions... to feel comfortable with that... change should never be done in a hurry... it should be a process that takes time and gives people time to move with it rather than to be carried along...” MCHB1

In addition, the MCH nurses also stated that they believed it was important to take the time to consult with the workforce about what the change initiatives could look like and how the change was going to be implemented. In other words, keeping everyone informed each step of the way. The MCH nurses further highlighted in the data that they believed the consumers of the services were also a major consideration for the future direction of services and should be involved in the consultation process. There was no evidence at the time that this had happened. The majority of MCH nurses stated in the data that they strongly believed that imposing any decisions of change on people without due consultation generally elicits a negative response. A collaborative culture in an organization, however, indicates the trust the people have in that organisations ability to implement increasingly more complicated and important change initiatives in the future;

“... there needs to be wide spread consultation... staff need to be involved... there needs to be an investment from management in allowing the staff to own the change so it's not top down driven... change has to be sold on the positive... it cannot be imposed it has to be through consultation... looking at what the community needs not just changing the service... it has to be well thought out...” MCHB11

“... people must be involved in the process of change and have input... an assessment of the benefits, as well as the disadvantages, there has to be consensus...” MCHC1

More importantly consultation with the workforce helps gain information about how the services work and could elicit ideas about how this could change. Specifically, there was a need for a process of consultation between the workforce and the Productivity Commission review panel prior to the implementation of national service framework;

“It would be nice if they had interviewed us like this beforehand or maybe focus groups with the MCH nurses to see what they thought of it ahead of time... if there were some way we could have some input on what was happening... and if there was another way about it...” MCHB2

“... there should have been workshops, more printed information... it has been clandestine in its operation and the way it has been carried out...” MCHC1

This was supported by other MCH nurses who reflected that they should have been better informed and involved in the decision making about the change they were part of. MCH nurses identified that this should have been a major priority in the process of the reform, not to just be told this is how it is almost after the event;

“... I think we should have been involved more in how it was going to play out even before it got to that point with a bit of input from us because honestly...” MCHA11

“... talk to us... let us have a right to respond to what's actually going on...” MCHB6

“... I believe as a body of existing MCH nurses that this should have been discussed... you cannot nationalise something that has no uniformity unless there is a lot of discussion taking place at levels beyond... what has happened in my opinion it has not been sufficient...” MCHC12

Being part of the consultation process also had other benefits, as identified in the following. This further emphasises the importance of the consultation process;

“Involving the people from the beginning in the change... it shows respect... a feeling of being involved not leaving it to the last minute to tell them... there needs to be an atmosphere where people feel open to speaking about things and not being told or dictated to...” MCHC5

“... preparation, discussion, brainstorming... time to debrief and adjust... meetings to make sure that everyone’s on board... get everyone thinking on the same tune... respect individuals to that are working for you...” MCHA4

In defence of this lack of consultation, however, it was identified by one MCH nurses that it was more complicated than that and that they should take some responsibility for their own inactivity. In other words;

“... nurses are notoriously bad at actually galvanising themselves into action and I feel that perhaps we allowed them to sneak up on us and it sort of just got railroaded through...” MCHB11

As a result of the lack of consultation, it was obvious from the data that the MCH nurses felt totally disenfranchised from the whole process and consequently felt despondent by the end result;

“... we were blind sided... the decisions were made for us... it was just implemented... they could have possibly sent a questionnaire around... if they cared about what our thoughts and what we had to offer... make us feel like we were part of the change...” MCHA9

“...contributes to feeling incredibly undervalued when you are not asked for your opinion on something that is so important to the actual people at the coal face...” MCHC3

Another important aspect of the consultation process is creating the opportunity to identify how to improve their ability to change by providing the necessary education. This was thought to then increase the chances of success. In other words, a new policy direction would require pre education prior to implementation of the new policy;

“... if you are not part of the change and you are not kept up to date... not given enough information on the research then you're left questioning change... there has to be a lot of support... when there is change the educational programs have to be timely with that change... it's no use implementing the new change and up skilling your work base and then six months later the changes come in...” MCHC11

“... you have to be flexible... I don't have a problem with change as long as we get enough training in the change or advice on the change...” MCHA11

An additional reason why consultation was identified as such an important component of the change process was that it provided an avenue for disseminating information. This dissemination of information was another part of this change process that many MCH nurses felt was lacking. As such the MCH nurses believed that all communiqué should have occurred at different levels through meetings. There were a number of suggestions made as to how this dissemination of information could have been done;

“... it could have been on the agenda at MCH meetings whether they were local or regional or state wide... knowledge is power as they say...” MCHC5

“... someone to actually tell us what the framework is going to be would be a good start... consultation with people within the areas...” MCHB1

“... I think it has to be transparent, clarity and in a timely manner... more educational support in different various levels rather than just one-off... workshops need to be a continue follow-on... there needs to be more consultation...” MCHA5

Furthermore, the MCH nurses believed that the communications should be timely, authentic, and credible. The need for constant updates was further highlighted as a must as this was thought to encourage an invested interest, foster acceptance and reduce the insecurity often perceived when people believe they have lost control over their territory;

“... we have our state conferences twice a year... no one talks about these things... you have got everyone from the state there... that’s a perfect opportunity... It doesn't have to be fragmented... that's always a difficulty with anything new if people aren't getting adequate information then there's a level of insecurity... then you get rumours and you are left less optimistic than others...” MCHC11

“... they would need to put the framework in very clear literature that people can understand...” MCHC12 and with a degree of “Consultation and Transparency...” MCHB8

“Communication... explanation... forums for discussion... the exercise of democracy so nurses need to be able to give an account and advocate for themselves...” MCHA12

In addition, the MCH nurses believed that candid, open discussion is fundamental to change, as it assists with the breaking down of barriers and reduces resistance. Without these influential conversations, the workforce often stays trapped in their current belief systems, unable to find new or different ways of promoting and achieving change;

“... formal discussions prior to them rolling it out... getting everyone on board... what they're thinking... their rationales for making the changes... everyone feels a lot more relaxed and reassured when they know that something is going to happen... they can prepare themselves for it...” MCHA4

The reasons why the dissemination of information is so important for the change process was clearly articulated in the following;

“... keep us all informed... keep us in the loop... there needs to be some timely consultations not just sprung upon us... set time frames between aspects of change being introduced...” MCHA1

“... make sure everyone is on the same page... be informed about a proposed change and have the ability to have input if it is going to independently or individually affect them to then deal with it...” MCHC12

Despite the fact information had been disseminated prior to the national registration being implemented, it became obvious from the data that the MCH nurses believed that the information dissemination was neither sufficient nor timely. Though interestingly there was admission that it was the nurses fault to some extent;

“... we could have been given a lot more information and prior knowledge of the changes... the benefits were never spelt out to the nurses as to why this was a more suitable way to go... the introduction was very poorly planned... It just felt like a rushed process without any time for us to have thought or input...” MCHC1

“... I knew nothing about it other than when AHPRA became our National Registration and that’s probably a bit my fault too... but I don’t think enough information was out there... I think it was kept secretive...” MCHA11

“I think advertising should have been a lot greater... so that all nurses being affected are going to be aware of what is happening and have a voice...” MCHB10

Admission to being their own fault was also expressed by other MCH nurses but for different reasons. There was, however, other MCH nurses who believed that information had been disseminated but they had difficulty comprehending exactly what was happening. This MCH nurse suggested some strategies as to how this information dissemination could have been undertaken;

“... more transparency... It could just be that I have not paid attention... the information we have received has been all in gobbledygook jargon which doesn't make any sense... the information needs to be presented simply, frequently in a much more consultative fashion. So that we have got the opportunities to feedback to a person not just an e-mail address...” MCHB8

More to the point, a number of MCH nurses believed that there should have been greater dissemination of information from various organisations including the Nurses Board of Victoria. In addition the MCH nurses indicated that the Australian Nursing Federation (ANF) could have played a more proactive role in the initial discussions that occurred around the feasibility of the changes;

“... I was very disappointed in The Nurses Board Victoria... they sent out very little information about what was going on... they quite happily took your money... your registration card had your other qualifications noted, but when it comes to National Registration nothing recognised... crazy... the ANF as a union didn’t push hard enough either to make sure that nurses with other qualifications were represented...” MCHB5

Furthermore the MCH nurses indicated that they believed it to be imperative that any Victorian leadership champions effectively represent them in the national political arena. This was thought to be particularly leaders that clearly understand the functionality that was required in order to move forward. In other words, have leadership and be an effective guiding coalition in any discussions working through the change processes;

“... I would like to see the main key stakeholders work together... by that I mean DEECD, MAV and VAMCHN to hopefully join in and lead the way...” MCHC7

“... having our co-ordinator have a presence in the decision making...” MCHA7

“... you need to get a large number of stakeholders together to work out what is the best option for the clients... you can't have people making rules for everybody if they don't know what people want...” MCHB5

Throughout the MCH nurses data there had been a positive atmosphere expressed regarding change, albeit they had recognised and acknowledged the disadvantages as well. The MCH nurses continually noted that there needed to be support and nurturing of good leadership along with the right resources in order to act. More significantly, they believed it was essential to get the right people driving the change management;

“... a lot of disadvantages are in the management of the change...” MCHC5.

4. Discussion

It was clear from the MCH nurse data that both groups strongly believed the change was imposed on them and that others were in fact making decisions on how the service should function without a great deal of communication and consultation with the workforce. The essence of the comments from the MCH nurses was that they believed there was not enough consultation with them regarding the national changes to registration and service provision. The depth of this concern was seen with numerous comments regarding not being involved and the lack of consultation from the organising bodies. Despite the fact that the KSH should have been more involved, the evidence from the data points to the fact that they were not. Instead they felt disenfranchised and ill-informed to precede with any implementation processes. This was an unexpected result from the KSH due to the fact that they were managers and therefore should be responsible for the change processes being implemented down the line. The MCH nurses data, however, indicated that they in fact wanted to know more about how these changes would be implemented and the impact on the MCH nurses themselves and the service they provided. Furthermore, the participants highlighted the importance that communication played to ensure that everyone was informed of the changes with the reasons thoroughly explored and not change for change sake. In addition, the KSH data indicated the importance of having a strong leadership of senior managers in order to lead the change. This was thought to include leaders from different levels of management which in turn was expected to establish and gain the cooperation of others. More significantly, they believed it was essential to get the right people driving the change management. The similarity of these comments from the participants about what they identified as lacking throughout the introduction of the change they were going through and the work undertaken by Kotter is exceptional. The biggest concern the participants identified in the data was that they felt that the changes were imposed upon them and that they were not informed or part of the process to plan what was happening. These national changes in registration and service framework involved large scale or transformational change, which had the potential to significantly affect the MCH themselves and the service. Such change needs to be introduced correctly.

Kotter (1996:2012) initially examined numerous initiatives aimed at producing organisational change over some 25 years and analysed why change failed in these circumstances. The result was a list of common errors and reasons why change does not easily happen and may fail. This list was useful in assisting leaders of change to understand specific instances of resistance to change in order to develop approaches relevant for a particular situation (Senior 1997). Kotter (1996:2012; Kotter & Cohen 2002) turned this list of errors around, resulting in identifying eight stages that should be present for achieving major change. Each stage was associated with one of the fundamental errors preventing change. These eight steps are likened to strategies that are about unfreezing the participants to plan the change, aiming to embed the change in the organisational culture. This is about a framework that is necessary to succeed with change (Kotter, 1996:2012; Kotter & Cohen 2002). The strategies that the participants in this research identified as being important to them were the need for collaboration and consultation in order for them to have input into how the change would be, in other words creating a sense of urgency and empowering broad based action (Kotter & Cohen 2002).

In addition, the participants identified that there was not enough information being disseminated to them in order that they were informed about what was happening, in other words, communicating the change (Kotter, 1996:2012; Kotter & Cohen 2002). Finally the participants identified that there was need for strong leadership of senior managers in order to lead the change, in other words, developing a vision and strategy and creating a guiding coalition (Kotter, 1996:2012; Kotter & Cohen 2002). The concerns expressed by the MCH nurses in this study therefore, equated to what Kotter identified as what needed to be present for achieving such major change.

The collection of forces, which underpins behaviour in organisations, is so formidable that, it is surprising that any change ever manages to be planned, let alone implemented (Managham 1979). As Flint (1993) notes, change in maternity care is both hard to initiate and hard to live through. For change to be successful, the path has to be appropriate for the situation in hand. A health service, as with any complex institution, finds change difficult for many reasons. This includes the fact that the situations are often complex, involving deep-seated, systems issues, which are embedded with complex social systems (Braithwaite, Hindle, Ledema & Westbrook 2002). Using some sort of process can assist in making the change achievable as other have found (McCourt & Page 1996).

In the current investigation, Kotter's framework was used to highlight what processes were lacking and what could have been undertaken to assist achieving this change. A change of such a magnitude as the national registration and development of a national framework had never been undertaken previously. This framework helped explain why participants in this study were feeling so disenfranchised with these changes. Furthermore, this philosophical unpinning provided a platform for the research to link those influential factors together and evaluate behavioural decisions that inform change. Both the KSH and MCH nurses indicated in the data that they had concerns related to the organisational change process of the move to a national registration and the development of the national service framework. Part of this was the fact that they strongly believed the change was imposed on them. Furthermore, there was concern that decisions on how the service should function were being made without a great deal of consultation and collaboration with the workforce in Victoria to assist in the development of these changes. In addition, the participants identified that there was not enough information being disseminated to the MCH practitioners in order that they were informed about what was happening, in other words. Finally the participants identified that there was a need for strong leadership of senior managers in order to lead the change and that these managers should align themselves with others. These all follow the change framework that Kotter developed. In other words, by creating a sense of urgency, empowering broad based action, communicating the change, developing a vision and creating a guiding coalition (Kotter & Cohen 2002). This framework was therefore an apt philosophical underpinning for this research as it provided a basis to help understand why the participants were so disenfranchised.

The process of change transformation is described by Kotter (1996) as being based on one fundamental insight that change will not happen easily. The central reason identified in this study as being a barrier for change was the differing jurisdictional governances and the lack of involvement of the practitioners in the process to plan the change. Kotter and Cohen (2002) model further embeds the change process with this study by stating that without credible communication and leadership the vision for change is never captured. It is obvious that the KSH and MCH nurses felt undermined in the change process due to the inconsistent communication and behaviour shown by the change leaders. Embedding change in organisational culture is crucial for achieving change (Kotter, 1996; 2012; Kotter & Cohen, 2002). This outcome involves anchoring change within an organization's norms and values so that the change becomes so much a part of the organisation that it is the organisation (Kotter 1996; 2012; Kotter & Cohen 2002). Kotter's eight step change model assisted the development of the current research by enabling a comprehensive understanding of the change process. The use of Kotter's model has therefore assisted in this current study by giving further dimension to the data by providing an insight as to why the participants felt so disenfranchised as a result of National registration and the development of a proposed national framework.

5. Conclusion

This study explored the knowledge, attitudes and beliefs of the KSH and MCH nurse's, to the perceived impact of national changes to registration and service provision in Victoria. This is the first original research that has examined the perceptions of the Victorian KSH to the national health workforce changes and the perceived impact in Victoria.

The findings indicate that the KSH believed there was a lack of consultation and communication with decisions regarding what changes were being proposed prior to implementation, resulting in frustration and a lack of confidence in the national agenda.

Knowledge derived from this study has assisted with identifying important gaps in the transfer of information and communication for change processes. This further emphasises the need for consultation, communication and leadership for the change process to be facilitated at all levels with any future changes.

It is recommended that further investment in collaborative research on child health services be attended by all jurisdictions to inform future policy development. In addition it is further recommended that representation of KSH and significant peak professional bodies are included in any further review of the development of the national service framework.

6. References

- Australian 15th Health Practitioner Regulation Authority, (2010/2011) *Annual Report*: ISSN: 1858-5060. Retrieved November 2013 from: www.ahpra.gov.au
- Australian Institute of Health and Welfare. (2011). National outcome measures for early childhood development: development of an indicator-based reporting framework. Cat. no. PHE 134. Canberra: AIHW.
- Bazeley, P. (2007). *Qualitative data analysis with NVivo*. London: Sage Publications Limited.
- Braithwaite, J., Hindle, D., Ledema, R., & Westbrook, J.I. (2002) Introducing soft systems methodology plus (SSM+): why we need it and what it can contribute. *Australian Health Review*. 25(2), 191-198.
- COAG, 2006 Council of Australian Governments Meeting 14 July 2006 Communiqué. Retrieved 10th February 2014 from: <http://ncc.ncc.gov.au/docs/Council%20of%20Australian%20Governments%20Meeting%20-%202014%20July%202006.pdf>.
- COAG Productivity Commission Report. 2011. Early Childhood Development Workforce (November 2011). *Report*.
- Day, I. (2003). *Qualitative data analysis: A user friendly guide for social scientists*: Routledge.
- Department of Education and Early Childhood Development (DEECD): *Maternal and child health service: Service Guidelines*. Melbourne, Victoria: State Government of Victoria. (2011).
- Edgecombe, G. (2009). Seminar discussion after presentation of PhD work, *Mum's the word: Exploring Early Motherhood* at RMIT University, 20th November 2009.
- Flint, C. (1993). *Midwifery Teams and Caseloads*. Oxford: Butterworth-Heinemann.
- Kotter, J.P. (1996). *Leading change*: Harvard Business Press.
- Kotter, J. (2012). The 8-step process for leading change. *linked from The Kotter International Home Page at http://www.kotterinternational.com/kotterprinciples/change_steps* Retrieved 7th March 2014.
- Kotter, J.P., & Cohen, D.S. (2002). *The heart of change: Real-life stories of how people change their organizations*: Harvard Business Press. Boston Massachusetts.
- Managham, I. (1979). *The Politics of Organisational Change*. Westport, Connecticut: Greenwood Press.
- Maxwell, J. A. (2006), *Qualitative research design: An interactive approach*: Sage.
- McCourt, C., & Page, L. (1996). *One to one Midwifery Practice: Report on the Evaluation of one-to-one Midwifery*: Centre for Midwifery Practice, Thames Valley University.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals*: SAGE Publications, Incorporated
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. California EU: Sage Publications Inc.
- Richards, T., & Richards, L. (2003). The way ahead in qualitative computing. *Journal of Modern applied statistical methods*, 2(1), 16-26
- Sandelowski, M. (2000). Focus on Research Methods-Whatever Happened to Qualitative Description? *Research in nursing and health*, 23(4), 334-340.
- Scott, D. (2011). Transcript of Proceedings from the *Protecting Victoria's Vulnerable Children Inquiry*, Broadmeadows 7 July 2011.
- Schmied, V., Kruske, S., Barclay, L., & Fowler, C. (2011). National Framework for Universal Child and Family Health Services. Australian Health Ministers' Advisory Council
- Senior, B. (1997). *Organisational Change*. London: Pitman Publishing.
- Shonkoff, J. P., & Phillips, D. (Eds.) (2000). *From neurons to neighbourhoods: The science of early child development*. Washington, DC: National Academy Press.
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities. *JAMA: the journal of the American Medical Association*, 301(21), 2252-2259.