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John Rule Roger Dunston Nicky Solomon

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Learning and change in the redesign of a primary health care initiative

John Rule
University of Technology, Sydney, Australia
Roger Dunston
Centre for Research in Learning and Change, Sydney, Australia, and
Nicky Solomon
University of Technology, Sydney, Australia

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Abstract

Purpose – This paper aims to provide an account of learning and change in the redesign of a primary health-care initiative in a large metropolitan city in Australia.

Design/methodology/approach – The paper is based on research exploring the place and role of learning in the re-making of health professional practices in a major New South Wales Government health reform called HealthOne. The analysis and findings presented here make reference to data drawn from a longitudinal ethnographic study (2011-2014) conducted by an inter-disciplinary team of researchers from the University of Technology Sydney. Socio-material and practice-based approaches for understanding learning are used in working with the data.

Findings – There were substantial changes in professional practice, especially in the role of the General Practice Liaison Nurse. Changes, and the learning connected to the changes, were dynamically influenced by the macro-context. HealthOne was a reform initiative with a strong focus on achieving health service redesign and a consistent focus on staff developing new ways of thinking and operating. Although learning was often discussed, it was, for the most part, expressed in general terms, and there was a lack of a formal and well-developed approach to learning collectively and individually.

Originality/value – This research paper will inform future attempts at service redesign in community and primary health contexts and provides a site-specific examination of workplace learning in a context of rapid change.

Keywords Change, Primary health care, Workplace learning, Service redesign, Socio-material approaches

Paper type Research paper

Background

In this paper, data are drawn from a study conducted by a multi-disciplinary team from the University of Technology Sydney on an Australian Research Council Linkage grant, Remaking practices: learning to meet the challenge of practice change in primary health care. The research scheme is called "Linkage" because the aim is to link universities and industry in research partnerships to enable mutually beneficial outcomes. The research was conducted over three years, from 2011 to 2014, with appropriate and various ethics committee approvals. The Rouse Hill site, HealthOne Rouse Hill (HORH), was one of two

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case studies, whereas Auburn, also in western Sydney, was the second site. This paper focuses only on HORH.

Earlier research studies on learning and change (Scheeres *et al.*, 2010; Reich *et al.*, 2014) have used practice-based theory and explored Schatzki's (2006, 2012) ideas of practice as "complex bundles of doings and sayings" in particular workplace sites. In these studies, the sites of interest were a state-owned public utility organisation and the safety practices within that organisation, "SupplyCo" (Scheeres *et al.*, 2010) and a smaller scale study of engineers' learning and practices in an engineering company (Reich *et al.*, 2014). It has been argued that more site-specific investigations theorising practice-based approaches to workplace learning would be helpful in understanding the ways in which professional learning occurs (Hager *et al.*, 2012) – the research conducted at HORH provides another site-specific investigation of practice-based approaches to workplace learning. This paper is a unique contribution focussing specifically on professionals' learning in a primary and community health-care setting.

Our approach to learning and change

Using a practice-based approach to learning in the workplace, we draw upon the notion of a "texture of practices" (Gherardi, 2008) – especially because this notion does not involve a separation of concepts such as informal learning, formal learning, incidental learning, workplace learning, practice learning or organisational learning. Rather, practices are seen as a recognised, and perhaps temporarily, shared way of "doing things" which are agreed on at one point in time, and subject to contestation at any time as practices are attempted to be made stable and institutionalised. Out of this process, new practices may emerge.

The approach taken in this paper recognises that there are myriad definitions and approaches to workplace learning (Solomon and Boud, 2010). However, we are specifically taking a socio-material approach, and in doing so, recognise that finding learning in the workplace must engage firstly with complexity (Gherardi, 2009). Within this approach, learning will not be seen as an outcome or product of specific interventions. Rather, a major feature of learning at work is developing capacities to be "flexible, constructive and innovative" in response to change and in response to "continuous" and "non-linear interactions" occurring in the workplace (Hager, 2010). This approach to workplace learning fits well with the research, which was at a site and in a context described by participants, and observed by the researchers, as being one of constant change.

HORH was a particularly interesting research site to investigate questions about the re-making of health professional practices, not only because of the context of rapid change but also because there have been very few studies which have addressed the complexity of adaptation and learning in primary health-care service redesign in Australia. The research explored: how learning was discussed; how learning was understood; how learning was enabled and supported and, more broadly, what could be learnt about learning from the HORH initiative. The research and this paper contributes not only to developing knowledge in the field of workplace and professional learning but also to the specific area of primary and community health service redesign, as this has never been done before in the Australian context.

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Methodology

Our research methodology was not one that was attempted to evaluate project outcomes; rather, it was an attempt to develop new knowledge and new insights about how practices were being remade within HORH and about the relationship between the place and role of learning and the remaking of practices. The research used an ethnographic approach, trying to understand the world as others see it, experience it and act in it; and every attempt was made to engage those participating in the research as co-researchers (Israel *et al.*, 2005; McIntyre, 2007). The ethnographic framework fieldwork included observation; shadowing; programmed and opportunistic interviewing; and participation in team and project meetings.

During two years of fieldwork, over 40 interviews were conducted and recorded with the general practice liaison nurses (GPLNs) and general practitioners (GPs) working with the initiative and 14 observational activities such as observing discharge planning and project planning meetings occurred, and four focus group activities were held with the senior planners. The industry partner (NSW Ministry of Health) guided the research team in the selection of participants for interviews and observation activities.

Health professionals associated with the initiative considered the research findings through reflexive conversations and meetings held during the course of the research. This style of collaborative research is often difficult to set up and not without dilemmas (Scheeres and Solomon, 2000; Solomon *et al.*, 2001), but as an investigative methodology, it aligns closely with Schatzki's suggestions of how best to use ethnographic methods to "uncover the world of practice (Schatzki, 2012, p. 23).

Introducing the research site

Rouse Hill in western Sydney was chosen as one of the first places to begin the HealthOne initiative in NSW. Rouse Hill ranked high in: difficulty of accessing health services; the number of people overweight within the population: the percentage of Home and Community Care clients living alone and had a higher than national average population rate of gestational diabetes (Wentwest, 2014). For the NSW Health Department, the location presented important challenges to address in terms of the HealthOne objectives of improving service access and health outcomes for disadvantaged and vulnerable groups and building sustainable models of integrated primary and community health.

Since 2007, 20 HealthOne sites have been developed throughout NSW, 4 other sites are under construction and 4 more are in a planning phase. Rapid change in community and primary health-care policy, funding arrangements, governance structures, community health organisations and health service delivery were evident at the time the initiative was rolled out.

Across the range of HealthOne settings in NSW, there were to be various combinations of health-care worker staffing – some were to be more focussed in aged and chronic care or child and family health – according to the locally identified needs. In the context of the HORH, there were two workplace-based roles where it could be observed that new practices were emerging, where things were "being done differently". These were the positions of the GPLNs and also the specialist general practitioner (SGP). This paper focuses particularly on the GPLN role as the one that, over the time of the research, was changed most significantly. Reference is also made to the GPs, working in community contexts, who engaged in new ways of working with HORH and other

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community health services. Notably, the GPs were engaged in new ways in managing patients and clients through the work of the GPLN; this has also been described in an evaluative study conducted at another HealthOne site, in Mt Druitt, also a suburb in western Sydney (McNab *et al.*, 2015).

At HORH, some of practice changes, reported and observed included:

- different referral patterns being used within the service;
- GPLNs operating differently in a community health context by being more pro-active in identifying patient needs and facilitating communication and care coordination across a range of services;
- GPLNs taking up the role of direct communication with GPs operating in the community to assist in patient care and management;
- GPLNs networking with non-health sector service providers who might be able to assist in the management of those with chronic health conditions;
- local GPs being linked in new ways to community health activities, with some GPs exhibiting a higher level of trust in the GPLNs because of their local knowledge; and
- patients being offered and undertaking care management in differently structured arrangements where the GP was not the sole focus for meeting patient needs.

These were new practices at HORH, and as new practices, they were a challenge to entrenched cultural notions of the roles of health services staff, in particular, medical practitioners and nursing staff.

HealthOne's service innovation aim (NSW Government Health, 2012) was to integrate the care provided by general practice and community health services – for this to occur, new ways of working, or new practices, had to be enacted. In this paper, it is argued that for these new practices to be emerged, new ways of being and operating in the workplace had to be learnt – especially by the GPLNs. An outcome evaluation of the HealthOne Mount Druitt (McNab *et al.*, 2013) noted similar changed referral patterns, though in our research and this paper, we are not concerned with evaluating service outcomes, but in identifying the different dimensions of learning observable as the health service redesign process occurred.

In the context of the service change remit of HORH, learning was dispersed through many levels – at the level of the nurse practitioner, GP (doctors managing in high case load settings across public and private health work) and system leaders. This paper uses the concept of systems leaders (Timmins, 2015) as being those people who were responsible for shaping and implementing the initiative. In the case of HORH, this refers to a few individuals who were able to influence the development of the initiative because of their positions working across health service programs and operating at senior policy or advisory levels within the NSW Health Department. Changed practices were not only observed at the level of implementation of the initiative but also were evident in our observations of the "system leaders" who were reflexively engaged as the initiative was developed.

Having provided some background to the research and described some of the details of the research site, the next section of this paper provides information about the macro-context. Especially, the context of rapid change that was occurring in the delivery

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of primary and community health care was prompted by significant policy and funding shifts at a national level and within the New South Wales state jurisdiction. The changes described below intersected and disrupted the development of HORH, and some of the changes, and the rapidity of change, had significant impact on the ability of HORH to achieve its remit.

Changing practices in a policy context of rapid change

A long-standing problem of primary health-care delivery and management of chronic disease world-wide is the integration and coordination of services (WHO, 2002; Starfield *et al.*, 2005; Zwar *et al.*, 2006; WHO, 2008). In Australia, there have been significant needs emerging in the areas of chronic health care, ageing and disability management, and meeting these needs has been complicated by a multi-layered funding and a constantly changing health policy landscape (Davies *et al.*, 2008; Jackson, 2013). Over the last 10 years, continual shifts have occurred in the language used to describe the preferred delivery of health services, with integrated care now being the preferred language instead of community and primary health care (National Health Performance Authority, 2014; NSW Ministry of Health, 2014). The overall context in which the HealthOne initiative was conceived and implemented was one of rapid change in government policies and health service models of care.

The changing context included the release of the National Chronic Diseases Strategy and associated National Service Improvement Frameworks for specific diseases by the Australian Commonwealth Government (NHPAC, 2006). During 2009, reports signalling major national reform and restructure initiatives in hospitals, primary care and preventative health were released (Kalucy and Bowers, 2010). Australia's first national primary health care strategy was released in 2010 after two years of consultation and included priorities such as the development of regional integration between providers and services; the better use of new technologies such as e-health; and more effective teamwork – in reviewing the strategy, it was noted that along with the critical challenge of funding not being resolved, reform and implementation had been "slow, painful and expensive" (Jackson, 2013). The New South Wales state jurisdiction health programs, as well as other jurisdictions, had to respond and adapt within this environment.

The situation of change was described clearly by research participants:

> […] all around is moving and there is the complicated work of constructing this thing called HealthOne, there's not a lot that you can regard as bedrock.

> […] we've been in a restructure I think, for five years, and the decisions haven't been made. Then, at the end of last year, there was another Community Health review, and so no decisions have been made […].

> Community health has been round for decades and general practice has been round for decades. They just haven't really pulled it all together […]. It's hard enough at this level, which is the micro level, but it's also at the governance/cultural level […].

The HealthOne NSW planning documents emphasised on local control and decision-making, partnership planning and the building of trust between different local health service providers (NSW Government Health, 2012). It was up to the system leaders, as that group of people operating at a senior policy and planning level, to direct

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the initiative and establish and maintain important trust relationships. Their approach was significant in setting the "tone" for the roll out of the initiative at a local level. The language used by these system leaders indicated that they saw HealthOne as an opportunity to implement a program that had a particular approach to planning and set of principles to guide actions and the program development. This approach and some of the language used by the system leaders could be summarised as:

- fluid rather than prescribed;
- iterative rather than linear;
- emergent rather than codified;
- responsive rather than planned;
- locally owned rather than driven through bureaucracy; and
- open to learning along the way rather than imposing a model.

This approach was summarised by one of the system leaders as being:

> […] an incremental process – of engaging all of the players in thinking differently about how we could actually work together and what would be. We had some really important principles right from the word go that we were joint partners in this change process.

There were elements of the initiative that required staff to learn, that is, to think their way from existing practices into new practices, then to enact those new practices in the setting of HORH. The learning of new practices was central to the success of the initiative.

However, there was clearly a tension between trying to be open to change along the way and needing to codify and direct the initiative. It was clear though that as the research project was ending, there was a move towards codification, less responsiveness, more prescribed roles and more traditional ways of recording outputs. It seemed that the aim of openness to process was being closed down because of the exigencies of having to achieve outputs, particularly under the pressure of funding constraints. During the course of the research and HORH implementation, there was a Ministry of Health-funded review of all health services (including HealthOne), with pressure to develop standard operating procedures and manuals that would then only be available electronically and conform to state-wide service standards. This review, another example of codification, was experienced by HORH staff as yet another pressure point and contrary to the previous open and local-led approach to program and service development.

Having now provided information about the research, the research site and scope of HealthOne, this paper now goes on to discuss the particular dynamics of learning and changed practices around HORH. We also draw on the conceptual work of practice-based theorists to frame our approach for understanding and theorising changes observed in the redesign of practices in HORH.

Professional learning

In this paper, understandings of learning, work and practices follow on from conceptual frameworks developed and elaborated by Schatzki (2006, 2012), Gherardi (2009) and Fenwick (2010). Although there has been considerable theoretical material developed in practice-based approaches to knowing, learning and "knowing-in-practice" (Fenwick,

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2010), the aim in this paper is not to revisit all the surrounding arguments, but rather to explore, from the specific study of HORH, the relationships between learning and practice change. One of the limitations of this paper is that we do not explore in detail the subjective dynamics of professional learning. Those dynamics being the way in which work and professional identity, in areas such as nursing or health-care services, are also linked with other subjective relations and identity constructions outside of and at times perhaps within the work sphere, those identity constructions would need to be considered from a "life history perspective" (Salling Olesen, 2001), which was not an approach taken in our research.

For Schatzki (2012, p. 16), practices are a "constellation" of individuals or different people's organised activities; practices are observable at any particular point in time but are provisional, emergent and subject to change both spatially and over time. According to Schatzki, the organisation of practices is made possible through the development of: practical rules and understandings; general understanding which might be understood through various and observable "doings and sayings"; and teleo-affective structures, that is, agreements about what are the purposive and ethical actions to achieve goals. Schatzki's theoretical explorations in practice-based education and research are broad, however, there are two elements from his theoretical work that are particularly relevant here – the first is the "general understanding", that any professional would bring to their work and, secondly, those more "particular understanding", which enable professionals to learn and practice in specific situations. This was very striking in the work of the GPLNs – as the need for the development of new and particular understanding was required for nursing staff to enter into their new roles. The GPLNs had general understanding of their professional nursing roles but this had to be particularised for them to work effectively with the HORH initiative. During the course of the research, there was obvious movement made by these health professionals from general understanding to particular understanding.

Both Gherardi (2008, 2009) and Fenwick (2012) provide accounts of learning that are pertinent to this research paper. The continuous refinement of practices that occur through participation in practice, or as described by Gherardi, the "dialectic between plans and situated actions" which become practices (Gherardi, 2009, p. 355), is a useful reference point. In the course of the research, it was continuously observed by the research team that the HORH participants planned, and even when the plans fell short, there was a change in practice and a learning that accompanied this change. Specific examples of this included the interruptions due to funding and staffing constraints – these events and interruptions were outside of the control of the research participants – nevertheless, learning how to manage through such interruptions was evident amongst the research participants. Fenwick (2012, p. 5) argues that a practice-based approach provides an analytic background that refutes a simple "cause and effect" in understanding how situated professional learning occurs. Again, as the research was undertaken, it was observed that there is no simple cause and effect in relation to how health professionals were learning. This is why, this paper continually refers to the importance of the macro-contexts in which the practice changes are initiated.

New professional practices were developed in the HORH initiative. GPLNs played a key role in developing and using new referral and care management plans and new ways of working between the GPLNs and GPs were observed. We propose that the changes in practice were instances of professional learning through work, albeit that

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those "instances" or "moments" are not discrete and cannot be taken out of the context in which they occurred.

This paper includes a representation of the dynamics observed in the service redesign and change process (Figure 1), and Figure 2 represents the intersection of individual and internal dynamics of learning and change with other, larger changes in the redesign cycle.

How learning and change was talked about

The openness to a "knowing-in-practice" approach, working with emergent practices and understanding learning differently in the context of HORH resonated with one of the research participants who said:

> We had to learn […] that to be too proscriptive was to present impossible barriers […]. We had to […] embrace the possibility that [if] a locally built initiative was going to be a sustainable initiative we would have to work and learn differently […] […]. To set too many parameters from a central point […] was in fact an inhibitor.

In the quotes below, coming from the GPLNs, GPs and the system leaders, learning was often described as reflection, managing a process of change, of absorbing and working with new information, and as being a negotiated process. Even a more familiar (or traditional) learning approach of mentoring was described using a metaphor of "journeying together". Developing understanding as the initiative was rolled out, and learning from each other and reflexive practice seemed to be preferred approaches, as shown in quotes below:

> Over time, there has been a reassessment of models – are we doing it the right way? Are we working with the right groups of people? What are the result we are achieving? Is there some fine-tuning that is possible and available to us?

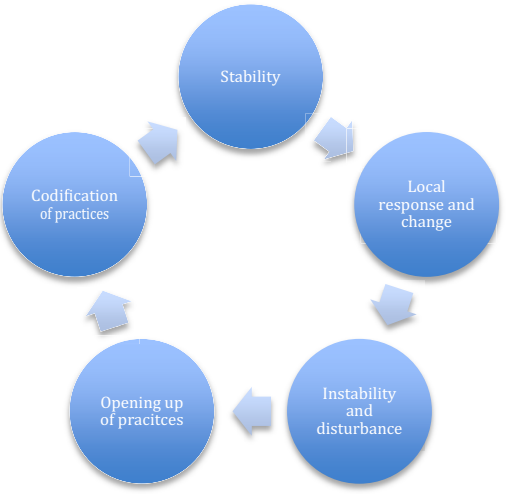

Figure 1.
Dynamics in redesign observed at HORH

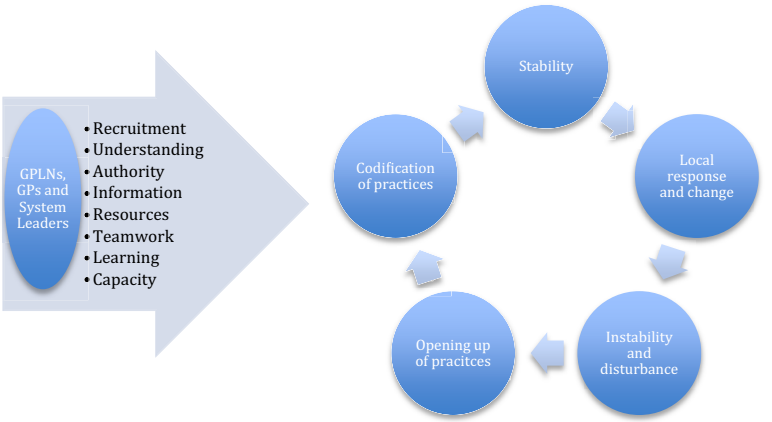

Figure 2.
Redesign of the initiative impacted by individual and internal dynamics

> We're really only in a state of perpetual trialling […]. Because what we always wanted was the capacity to challenge ourselves to see what worked, and to evaluate and make sure that what we put in place could be changed if it wasn't working.

> It's a huge information load that all […] have to hold, in terms of knowing all the services that are available, the clinicians who they can liaise with, or refer to and, then, the actual referral criteria, or referral pathways […]. You're always learning. Every day, there is new information and […]. We all integrate that into our practice.

> I think people learn by modelling […] you kind of need people to come with you on the journey so you need to give them time to absorb what you're talking about and think about things. The GPLNs in particular have needed to take a strong mentoring role with new GPLNs coming on.

> I think it's evolving and we're not quite really sure what the tasks involve […]. It's new and evolving and I don't think the end point is clear […]. I could come in with a vision and say "this is what we do" and I think they've avoided that and I think that's appropriate because that would just be one person's point of view.

Some of the research participants, especially the system leaders, were ready to conceptualise learning as beyond the standardised categories of learning as being informal or formal, individual or collective and workplace or organisational. In one sense, the research participants were already interested in exploring beyond these "unhelpful" (Fenwick, 2010) distinctions; unhelpful in the sense that pinning experience down to such categories cannot convey the adaptive responses, fluidities and uncertainties of situations where learning, knowledge and work are intersecting. The uncertainties that surrounded learning in the workplace at HORH resonated with previous studies in different contexts (Boud and Solomon, 2003; Boud *et al.*, 2009), and in terms of practice-based approaches to learning and workplace change, the overlapping dimensions of workplace learning found at HORH have previously been described by Gherardi (2008, 2009) and Hopwood (2014).

Although HealthOne may have been an opportunity to examine learning and remaking of practices, ambiguity and uncertainty about the potential for learning is

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shown in this exchange between one of the research team members and one of the research participants:

> Interviewer: […] as you know, our project is around the learning – it's the re-making and how things change and part of it is learning to do thing differently […].
>
> Participant: […] my perspective on that is people are not really confident enough in their own territories to really engage in cross-site learning at the moment. Everyone's a bit – struggling and not really secure where we are […].

System leaders were committed to building a culture of learning, however, what processes and activities would be required to support this achievement were not well defined. In terms of shared learning leading to clarity and shared understandings, it was observed that there was often a gap, with a number of HORH staff identifying their confusion as to where HORH was heading. This is, perhaps, not surprising given the dynamic unstable and often disrupting environment in which HORH was operating and the fact that HORH was requiring staff to step beyond their traditional roles and engage in new ways or working and new practices in the workplace.

One of the most consistent themes in the interviews – regardless of the position of staff – was about the degree of change, often experienced as disruption, and the inability to control this. A system leader comments:

> The other difficulty we've had […] is the divisions [of General Practice] have transposed into Medicare Locals […] and there's enormous turnover in those entities. The Area Health has become Local Health District, again with massive changes […].

The scale, impact and uncertainty produced by such significant external change cannot be under-estimated.

System leaders were involved in a level of reflection that moved beyond resolving the concerns of individuals in change processes and into areas of analysing organisational change. The system leaders were engaged in a "collective rather than individual reflection" (Cressy *et al.*, 2006, pp. 19-22) on the initiative; their reflexive stances, evident in interview data, were contextualised within the experience of rapid change, and they recognised and acknowledged the "contingent" and "unpredictable" nature of the issues they were dealing with. As one said:

> We have been working on this for five years and we revisit that quite often, surprisingly often, to test the groundwork again […]. Asking, is that still holding? Is that still robust? Have we reconceptualised that at all? I think we were always open for that that sort of learning […] the reconceptualisation of it.

At the level of day-to-day work activity within HORH opportunities for productive reflection, review and learning were limited, and we observed a situation that is well known and described, where:

> Ironically, when major change is in progress pressures of time […] can inhibit productive reflection at just the point when it is most needed and can potentially have the greatest impact (Docherty *et al.*, 2006, p. 204).

Before reporting on more detailed observations of learning and changed practices, it is important to recognise that learning and practice changes were occurring within complex and interconnected environments.

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What was observed by the research team during the research were some significant tensions at HORH which were never resolved:

- *The tension between stability and instability*: This refers to the need for clarity about aims, rules and accountabilities vs the impact of significant and frequent change, where existing stabilities easily become uncertainties.
- *The tension between opening up practices and closing down change processes*: By this, we mean that we saw a genuine desire to create a space for change to happen, to enable change processes to occur, and then there was often to need to close down the change process to stabilise the situation and codify processes once the aims of change have been realised.
- *The tension of deep engagement and motivation for change within the redesign process*: This occurs almost in a mode of co-production as described by Dunston *et al.*, (2009), but an expressed desire for stability or settling of the situation, which sometimes appeared to overwhelm those involved.

As already indicated in quotations provided, participants expressed that change was experienced as disturbing and provoking. However, the research methodology did not allow any assessment of whether the disturbances, changes and provocations always led to learning or whether they created a situation of potential collapse, both for participants and potentially for the initiative as a whole. To survive the rapid changes, we have no doubt that learning did occur, but the argument we develop is that without any systematic space built into the redesign process for reflection and reflection on learning, it is impossible to know how this was generally experienced. Rather, we have observed changed practices and argue that for these changed practices to have occurred, learning had also occurred.

Observed learning and practice changes

The use of ethnographic methods enabled the research team to get close to daily practice, aiming to understand how human and material factors come together to influence what occurs and what could occur. The research team wanted to understand how health professionals learn to practice differently.

Significant changes in practice were observed. This was particularly evident in the case of the GPLNs where their new role became one of co-ordinating, planning and liaising; which as one research participant noted was quite different to community nursing in the past, which had been "more a task based role" by which they meant tasks carried out directly with patients. In contrast, their new role was focused more on providing links, resources and referral pathways between GPs working in the community, community health services and acute public sector health services.

Reflecting on what was observed, it was clear to the research team, as it was to HORH staff, that practice change can only be meaningfully discussed or explained whilst recognising the critical impacts of the environments in which change is being developed. Figure 1, shown below, depicts the dynamic, continuous change and response that we saw being played out during the two years of our fieldwork. There were periods (although brief) of stability, there were times when local responses forced change to occur, there were times when instability and disturbance seemed to dominate the initiative and there were times when practices were "opened up" and things seemed to be done differently.

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There were times when attempts were made through the development of took kits, flow charts and detailed position descriptions to stabilise and codify what was occurring. Sometimes, the process of codification, for example, the preparation of detailed client referral documentation, caused a surprising reaction or resistance, again changing the dynamics. Such codification was at times experienced as setting new rules in stone, with the opportunity to experiment and innovate having been closed off.

The time in which HORH and the broader HealthOne initiative was designed and implemented was one of immense change at the state and national levels; it almost seemed that once any form of stability had been achieved, it would inevitably be disturbed by a new reform or new health governance arrangement.

It should also be remembered that the HealthOne initiative was aimed at changing practices in a situation where "community health" programs and "general practice" had not always worked well together. The institutional relationships prior to the intervention of HealthOne were characterised by degrees of mistrust between existing services and the lack of a culture of collaboration. The stops and starts, the instability and disturbances were significant and could have come from any direction as the quotes from research participants below describe:

> There are […] tensions and territorial issues between doctors and nurses and then between hospitals and general practice […].

> Who is the decision maker? The GP group, or the area health service, or the Medicare Local? That's all very contested […].

> We are faced with an unstable and shifting context at a number of levels and having to work out […] a satisfactory local arrangement in amongst all these other changes […]. Certainly some of the funding arrangements and governance arrangements are shifting.

> I think some of the difficulties [HORH] has experienced is the time it takes, and there's no quick fixes. So I think sometimes people get very frustrated and can become a bit negative saying "[…] well HealthOne's been going since 2007, what have you done?"

At another level, problems due to information technology systems being incompatible across services or difficulty in securing premises from which to operate the service added to the complex and frequently difficult dynamics of the redesign process.

In addition to the cycle identified in Figure 1, the research team observed that this cycle was also regularly impacted by internal events, for example, by the recruitment, development and exit of staff. This includes the GPLNs, SGPs, system leaders and local GPs, who had become connected to the HORH service through referral.

Figure 2, below, represents graphically, another important part of the redesign dynamics. The role of the individual GPLN, or any other staffing level, can intersect at any point on the development cycle and, therefore, impact program development. For example, a matter to do with "recruitment", either of the GPLNs or GPs may impact on the redesign cycle to create stability, alternatively, it might impact at a point of creating instability and disturbance. Individual levels of "understanding" also shaped what was happening at any particular moment. At any time, the "authority" which the GPLNs or GPs have in the situation around HORH could affect local response and change, perhaps

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in a positive way, and perhaps at times, in terms of progressing outcomes, in a negative way. The system leaders were also at times under political and institutional pressure, and this affected the way in which they may have interacted with the development of the initiative. Similarly, the availability of information and resources, teamwork dynamics and individual learning and capacity impacted positively or negatively as the initiative was being developed. The HORH site was affected by individual and macro-dynamics. Figure 2, below, is an attempt to represent the intersection between individuals involved and the larger dynamic redesign process.

At the operational level, there were several challenges to how the new ways of working could be implemented and sustained. Apart from the issue of never having a full complement of staff positions, there were difficulties in establishing who should manage the contact with GPs in the community, how patients should be referred or recruited and whose patients might be referred to HORH. There was also pressure on the GPLNs to be engaged in outreach work, and so availability for critical team meetings and case conferencing and review also arose as a problem. In terms of team work, deficits were noted by the research participants: "[…] the way to negotiate change is not clear […]" and "[…] we haven't really had any training on team building […]", and this included "poor demarcation" between roles.

Despite these difficulties, it could be argued that HORH provided new opportunities and legitimation for GPLNs in the public sector and GPs in the private sector to work differently within a system where existing rules created a strict demarcation between nursing and medical roles. The developing credibility and acceptance and noted values of the GPLN position as part of a more integrated primary health-care approach were observed as two of the most significant service redesign and practice changes to be achieved through the HORH initiative.

At the level of the system leaders, substantial changes in practice were also observed. As demonstrated by Woodard and Weller (2011), working across and spanning organisation boundaries in health service change and redesign, what they term "clinical leadership", is not just the responsibility of health professionals working on the front line but also is more likely promoted by those who can encourage and support inter-organisational working. That is achieved by changing the practices between organisations and by effecting changes in the relational behaviour of individuals operating in different parts of the health system. In HORH, it was the system leaders, that is, those who had some power within the health bureaucracy who were able to effect significant and potentially lasting change. Reflecting on their engagement within the initiative, system leaders identified changes in their practices as the initiative developed; some of the system leaders said:

> We've been interlocutors […].

> […] communication, information sharing, understanding of each other's business; that in itself has got to do something about strengthening what we do […].

> […] There's a lot of […] underlying attitudes that I see this process as ultimately being able to challenge, in a gentle way […].

The language used by the system leaders may be a reflection of their own personal strategies or ways of working, but might also point towards some effective leadership practices, for example, "interlocution", "information sharing" and "gentle challenges".

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Conclusion

A saturation of "change" and "reform exhaustion" had been noted many times by the research participants. Also, change "uncertainty" was another word that is found throughout our interviews and through various interactions with the research participants. Despite these difficulties, moving towards integrated community and primary health-care services always remained the goal:

> HealthOne was never about new funding; HealthOne was always about a systems change […].

Although there were significant achievements made through the HealthOne initiative, structured opportunities for teamwork reflection and opportunities for assessment of the effects of events, as the initiative rolled out, did not exist in any formal way. An explicit learning agenda (Salling Olesen *et al.*, 2010; Price *et al.*, 2012) may have been useful in this context and may have assisted individuals negotiate the complicated changes that occurred, but this was never achieved.

However, in this paper, it has been argued that there was the "emergence of a new practice-arrangement bundles" (Schatzki, 2012), seen especially in the work of the GPLNs. In this paper, it has not been argued that a new, good, improved or more integrated community and primary health-care initiative has been created – this would require a longer study designed within an evaluation framework. This paper has provided examples of professional health practices changing. This paper has identified instances of professional learning as the HealthOne initiative was emplaced, and we have demonstrated the importance of understanding macro-contexts and external dynamics if learning is to occur and practice change is to be supported.

This paper has contributed to an emerging body of research focussed on learning at work and engaging with practice-based and socio-material frameworks to understand learning dynamics. We note that a particular contribution of both the research and this paper is that it is about service redesign in an important social area of primary and community health. Research in this area should be attempted in other contexts and places.

Change in healthcare services to best meet the needs of populations is a critical goal of primary health service delivery and health service redesign; developing new kinds of health professional practice is an important part of the redesign process. This paper has provided a situated examination of a change process in a primary and community health-care context in Australia and provided a site-specific examination of workplace learning in a context of rapid change.

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Corresponding author
John Rule can be contacted at: John.Rule-1@uts.edu.au

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