The Cult Value of Quality Improvement in Healthcare: Complex Social Processes of Working with Targets.

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ABSTRACT

There has been an ongoing debate on quality and what constitutes quality improvement in healthcare for several decades. Several authors identify that defining quality is an important part of that debate, yet recognise that quality is defined differently by different interests (Caper, 1988; Harteloh, 2003). Harteloh's distinction between quality as a property (a *descriptive* approach) and quality as a category of judgment (a *prescriptive* approach) has influenced the conception of quality as a property of participation emerging in this research. This is in stark contrast to the wide spread prescriptive approach set out in published accounts of quality and quality improvement.

In the mainstream management literature, conventionally organisations are understood as systems and this conceptualisation underpins many published considerations of quality. In this way of thinking, those involved in leading quality improvement are thought to operate as autonomous individuals who design improvement tools and control improvements according to plans. It is taken for granted that it is possible for a powerful individual to step out of the organisational system and treat it as an object for manipulation and change, following the diagnosis of problem areas and gaps. Yet at other times that autonomous individual becomes part of the system and is subject to manipulation and change by others. As with much of the literature of change management, this approach sets "thought" before "action". In other words, "thought" is understood as the formulation of a plan and "action" is the implementation of that plan. In this thesis, it is my contention that this way of thinking leads to a privileging of the more mechanical and cybernetic elements of quality improvement - such as tools and techniques of waste elimination and fault detection, and, of particular interest in this thesis, the use of national targets in the public sector.

My research is underpinned by a complex responsive processes perspective (Stacey, Griffin and Shaw, 2000). Central to this theory of human interaction is the importance of understanding everyday experience from the perspective of inquiring into "…just what is it that we are doing in our groups or in our organisations that leads to emergent patterns that are our experience…" (Stacey, 2003c: 32).

In this thesis, I take up a key question raised by Stacey (2006) concerning how those working in the public sector institutions are operationalising central government governance requirements. I explore my experience of working locally with nationally determined performance targets for access to emergency care. I argue for consideration of quality improvement as a cult value along the lines defined by Mead (1923). In conceptualising quality improvement in this way, my inquiry focuses on what happens as we try to make sense of the ways in which our daily activities are being influenced by competing ideologies, by power relations that are played out, and by the enabling and constraining aspects of going on together in patterns of conversation. These are the complex social processes of working with targets I refer to in the title of this thesis. It is my contention that this perspective draws attention to quality as a property of our own participation as managers, rather than the more usual exhortations to look for the next tool for instilling quality into the organisation. As such, I argue that this research makes an important contribution to the ongoing debate on quality, as well as managerial practice.

I propose that the participative and socially reflexive nature of the qualitative methodology involved provides a practical example of Mode 2 research, addressing what MacLean, MacIntosh and Grant (2002) identify as a current gap in the literature.

Finally, I posit a potential contribution to policy making seeking to address a growing recognition from some policy makers regarding what is now being seen as an increasing problematic reliance on traditional, modernist assumptions of programmatic change.

ERROR! BOOKMARK NOT DEFINED.**INTRODUCTION TO LAYOUT OF THESIS**

This thesis is an account of my research inquiry over the last three years, initially as a senior manager in a Strategic Health Authority in England, and latterly as a Director of Nursing in a National Health Service Trust. The research reflects a long-standing personal interest in change and improvement in healthcare organisations and the role of health service managers in these endeavours. In particular, I explore the experience of my day-to-day practice. During the process of my research I believe I have experienced a significant movement in my thinking as I have become aware of my unreflected, taken for granted ways of understanding and begun to question whether these help me make sense of my practice, or whether there are alternate ways of thinking and how this may impact my work. The research draws on four narrative projects, where I have increasingly engaged in a key question raised by Stacey (2006) as to how those working in public sector institutions are operationalising central government governance requirements. In my case I have been inquiring into how we are working locally with nationally determined performance targets set around the area of access into emergency care - and what some of the consequences can be.

I start with a synopsis which sets out the main themes emerging throughout the course of my inquiry, tracing the movement of my thinking and my line of inquiry.

The four narrative projects are then presented, followed by an account of where I think I am making a contribution to knowledge.

SYNOPSIS

Introduction

> Research can be seen as a fundamentally interpretive activity... method cannot be disengaged from theory and other elements of pre-understanding, since assumptions and notions in some sense determine interpretations and representations of the object of study… Different social interests are favoured or disfavoured depending on the questions that are asked (and not asked), and on how reality is represented and interpreted. Thus the interpretations and theoretical assumptions on which these are based are not neutral but are part of and help to construct, political and ideological conditions... Interpretation rather than the representation of reality on the basis of collected data then becomes the central element...there is no such thing as unmediated data or facts; these are always the result of interpretation. Yet the interpretation does not take place in a neutral, apolitical, ideology-free space. Nor is an autonomous, value-free researcher responsible for it. Various paradigms, perspectives and concepts, as well as research and other political interests, all bring out certain types of interpretation possibilities, at the same time as they suppress others...
>
> (Alvesson and Skoldberg, 2000: 8-9)

This synopsis sets out my research within the context the four narrative projects that constitute my inquiry. I set out what I see as the main themes emerging from my research into my own practice as a Health Service manager. The extended quote from Alvesson and Skoldberg struck me as an excellent summary of the task I believe is facing me as I reflect on the lines of inquiry I have pursued. Alvesson and Skoldberg underscore the centrality of interpretation in all research endeavours. Alvesson and Skoldberg are essentially using interpretation, here, in the hermeneutic sense, emphasising the importance of being able to appreciate the ways in which our understanding is influenced by our experience, history, psychology and social context. Johnson and Duberley (2005) argue that how we inquire, what value we place on our line of inquiry, what we take to be relevant research methodologies for pursuing our inquiry, how we evaluate any outputs of our research will vary according to our underlying epistemological commitments. This issue of epistemology has become a key consideration in my research. In other words, I am concerned with the study of knowledge. Epistemology relates to questions about;

- what do we mean when we say we know something

- where do we get knowledge from

- how do we know if it is reliable

- when are we justified in saying we know something

- what if any are the limits of knowledge

Johnson and Duberley (2005) add, importantly, that "even though they often remain unrecognised by the individual, such epistemological commitments are a key feature of our pre-understandings which will influence how we make things intelligible" (Johnson and Duberley, 2005: 1).

I describe in this synopsis how my inquiry has developed over time linked to a movement in my thinking from a Kantian epistemology to a complex responsive process perspective on knowledge and knowledge production. I describe the influence this has had on the emergent methodology of the research approach. I explain how my initial interest in the area of healthcare improvement and performance management moved to a consideration of cult values. I then trace the way in which considering quality improvement as a cult value for myself and colleagues in the health services led me to focus on day to day experiences that I am participating in with clinical and management teams as we work locally with a regimen of nationally determined targets. I argue what becomes important is to focus attention on complex social processes including patterns of interdependencies and power balances that shift with attendant feelings of anxiety (Project 2), paradoxical experiences of involvement and detachment (Project 3), and patterns of inclusion and exclusion (Project 4). My research highlights the way in which I believe my practice is changing through consideration of the quality of participation (including my own), rather than the more usual management exhortations to look for the next tool and fad for instilling quality into the organisation

Coming to understand my taken for granted way of thinking
As I set out in Project One, my motivation for joining the DMan programme was originally connected to a desire to be exposed to a greater rigour in thinking about and working in organisational change. At the outset of the programme, I was

working in a Strategic Health Authority in England and involved in monitoring the "performance" of local NHS Trusts in their efforts to translate Department of Health policy into practice. Although I had been involved in many change programmes in various roles since my qualification as a registered nurse in the 1980s, I felt that my undergraduate and post graduate education to date was exclusively biased to the discipline of nursing. I was excited to be accepted into the programme, thinking at the time this presented a fantastic opportunity to expand my change "tool kit" in a way that would be underpinned by strong scholarly considerations.

Project One is a reflexive narrative setting out what I took to be some of the major influences and experiences informing my practice. In Project One's development, a strong theme to do with an idealisation of care of a holistic kind was drawn to my attention. I was asked to consider what the term holistic meant to me, why it was important and where the origins of the term lay. Up to this point, holism was something I had never questioned – it had been a term that I had used unproblematically in talking about my daily practice to capture the importance of caring for the person in the "round", or, in other words, endeavouring to attend to the person's psychosocial and spiritual, as well as physical needs. In Project One, I trace the origins of the term to the philosophical work of South African statesman Jan Smuts (1926). Smuts posited the existence of evolutionary wholes within the natural sciences of biology and chemistry, and applied the notion that the whole is greater than the sum of its parts to humans, and by extension, society. Checkland (1999) identifies that "systems thinking in its various forms can be taken to be the very paradigm of thinking holistically" (Checkland, 1999: A3). Coming across Smut's work, I finished Project One recognising my need to explore the literature on systems thinking in an effort to develop a clearer understanding of my underlying theoretical perspective and its consequences for my practice. I did not realise at that time that this would lead to a growing dissatisfaction with my role as "performance monitor" as I increasingly questioned the extent to which systems thinking - underpinning much of my sense-making processes up to this point - did, in fact, assist in making sense of my practice in ways that I recognised as developing my

practice. On reflection, I now see the desire to be exposed to greater rigour was also linked to concerns about relevance that I had yet to make sense of and articulate. The exhortations to work in a whole system manner that I experienced in my day to day work, to participate in diagnostic identification of gaps in performance, and to invest a great deal of energy in designing recovery programmes with very variable impacts was becoming less motivating and less useful in my efforts to make sense of the work of quality improvement.

As I struggled to write in the early narrative drafts for each of the first three projects about what I was doing in my everyday practice, it became clearer to me that there were ways in which systems thinking had exerted a considerable, and often un-reflected influence - ways which I will elaborate on in what follows below. I realise I am not unique in this respect. It is a way of thinking that continues to dominate much management and organisational theories. Johnson and Duberley (2005) point out that certain ways of thinking are so embedded in our language and culture that it can seem to many of us to be simply a matter of common sense and, as such, natural and taken for granted. Johnson and Duberley are critical of this, asking readers to be aware that not only is epistemological commitment unavoidable, it is also highly contentious:

> It follows that there are no secure or incontestable foundations from which we can begin any consideration of our knowledge of knowledge - rather we have competing philosophical assumptions about knowledge that lead us to engage with management and organisation in particular ways...the most we can hope for in considering epistemology is to become more consciously reflexive. This involves an attempt at self-comprehension through beginning to notice and then criticise our own pre-understandings in a more systematic fashion while trying to assess their impact upon how we engage in the social and natural worlds. Such self-comprehension not only entails identifying our epistemological pre-understandings and their philosophical derivation, it also requires us to challenge them by noticing and exploring alternative possible commitments.
>
> (Ibid: 5).

In engaging in any management research and practice, we ought to be taking a reflective and reflexive approach. So what do I mean when I refer to systems thinking and what has been the influence of this as one of my "pre-understandings"

as I developed my line of inquiry regarding quality improvement in healthcare? Trying to make sense of systems thinking by engaging with published work and through the iterative process of talking about and re-writing my narratives has been key for me in being able to engage in the critical analysis of this taken-for-granted aspect to how I was thinking about my work.

Initial Kantian epistemological commitments

Moving from Project One to Project Two raised key questions for me as to how I have previously articulated and engaged in discussions about my day-to-day practice.

It was Kant (1790/1987) who claimed that none of us can know reality directly. All we can know is what we perceive of reality which can be formulated as hypotheses about reality, that is, 'as if' statements. Such perceptions and hypotheses determine how we see the world and act within it, opening up and closing down possible courses of action, and, importantly, influencing what we pay attention to. The focus for Project Two, and a key theme, was building my understanding of systems theories, their origins and the domination of this perspective in my day to day practice as a manager in the NHS, as well as in the contemporary approaches to policy development, strategic planning, performance management and quality within the NHS as a public sector organisation.

Immanuel Kant first articulated systems thinking (Kant, 1790/1987). Whilst acknowledging the input of mechanistic thinkers like Isaac Newton in the arena of inanimate nature, Kant postulated that the idea of the scientist, as 'an objective observer in the reductionist search for the definitive truth' was inadequate when applied to living organisms. For Kant, it was much more useful to think about living entities 'as if' they were purposive self-organising systems. For example, we could think of an oak tree - the component parts like the leaves, branches, roots and so on are not pre-designed and assembled, rather they emerge from the internal interactions as the plant grows from its acorn-seed, and in conjunction with the environmental conditions experienced. This process is a purposive unfolding of what

is already enfolded within the seed. Living organisms, then, are self-producing and therefore self-organising wholes, where the whole is maintained by the parts and the whole orders the parts in such a way that it is maintained. Stacey, Griffin and Shaw (2000) identified that thinking in this way points to a different type of causality than the if-then position of the mechanists. This type of causality when applied to living, self organising systems is referred to as formative causality. This is a systemic theory of causality arising from Kant's hypothesis that we can think of living organisms as if they are systems which unfold patterns of behaviour that are already enfolded within their structures in development to their mature states.

Kant, however, did not think that such systems hypotheses were appropriate in the case of human behaviour. He held that for humans, autonomous behaviour and the ability to make rational choices were key features mitigating against such a position. In other words, to be understood as parts of a whole or system would mean that humans would have to be subject to that whole, whereas Kant argued that individuals are free to set their own goals and choose actions to achieve them using their powers of reason. Kant postulated an autonomous choice of goal before action - essentially theory before practice. In this way of thinking, individual autonomy is understood to be constrained by pre-existing ethical universals, which Kant believed enabled individually autonomous beings to co-exist and organise with others. Kant, as such, adds to the purposive self-organising and formative causality held to be adequate for nature and introduces a rational causality explanation for human behaviour rooted in his view of individual autonomy.

However, Kant's caution against the inappropriateness of applying systems hypotheses to human behaviour has largely been disregarded. Systems' thinking has been taken up across a multitude of disciplines. Stacey (2005) points to consequences when he writes:

> It was soon accepted that human minds actually were cognitive systems and that human groups, organisations and societies were also actually systems existing at a higher level than the individual systems. It came to be thought that individuals, as subsystems, interacted with each other to form groups as systems, which

interacted to form higher level systems called organisations, which in turn interacted to form even higher level supra-systems called societies, and so on….we have come to think that rational individuals, governed by a rationalist causality, can objectively study higher level systems called groups, organisations and societies and redesign or re-engineer such systems. In effect these rational designers are enfolding visions, targets and so on, into the human system, which will then, it is assumed, be unfolded by the formative operation of the systems, that is, by the interaction of the individuals (parts) constituting them.

(Ibid: 44)

From a systemic perspective then, intellectually, an organisation is taken to be a system with functional subsystems - concerned with production, marketing, finance, human resources, and so on. In this way of thinking, knowledge of these systems are considered central to supporting better design and operation of such systems in practice. As I address in Project Two, the cybernetic idea of unfolding pre-designed patterns has been central to the increasing reliance on targets and performance management regimens, considered to be key tools in the drive for improvement in public services (National Audit Office, 2006). In Project Two, I reflect on my experiences of "designing" a change programme using the established methodology of an improvement collaborative (Ovretveit et. al., 2002) and the anxieties I experienced as my hitherto strong belief in the importance of programme design was subject to challenge through my participation in the activities of the DMan programme.

Thinking about quality improvement and targets from a systemic perspective
In healthcare, thinking systemically has led to expectations that performance can be measured in terms of clinical outcomes, patient satisfaction, error rates, waste, unit production costs, productivity, market share, and other metrics (Blumenthal and Kilo, 1998). Similarly, many continuous quality improvement methodologies highlight the central role of processes in transforming inputs into outputs in all organisations, including healthcare. For continuous quality improvement, organisational processes are the objects of improvement, and their improvement is key to better quality. Taking a systemic perspective, the organisation is conceptualised as if it is a system - "a thing". Process, in this sense, relates to the

interaction of the system parts, or subsystems, with the main purpose of forming and maintaining the integrity of the whole, i.e. the organisation. In other words, processes we might think of in this respect include: routines, procedures, plans, analytical tools and so on. Throughout Projects Two, Three and Four, I draw on the existing literature to illustrate how this way of thinking is very apparent in the development of healthcare policy. In 1997, the Labour government set out an ambitious 10 year reform agenda, at the core of which was an emphasis on the central role of quality improvement in the drive to modernise public services.

> The new NHS will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality. This must be quality in its broadest sense; doing the right things, at the right time, for the right people, and doing them right - first time. And it must be the quality of the patient's experience as well as the clinical result - quality measured in terms of prompt access, good relationships and efficient administration.
>
> (Department of Health, 1997: 3.2)

However, as Leatherman and Sutherland (2005), government-sponsored quality improvement research collaborators from USA and UK highlight, quality is a multifaceted concept, with multiple perspectives, values and priorities for quality and a range of ways in which quality is conceptualised, from the technical, for example the appropriate application of scientific evidence to an individual health problem, to the interpersonal, for example the relationship between patient and caregiver with the underpinning values of trust, respect and compassion. This leads Leatherman and Sutherland to claim that:

> The contested and kaleidoscopic nature of healthcare quality presents considerable problems to researchers, policy makers, managers and clinicians seeking to measure accurately and compare fairly health services…
>
> (Ibid: xxv)

Furthermore they assert that despite international concern regarding the apparent

deficiencies in quality of care, and that significant assets are spent on performance in the NHS in particular, there continues to be:

> ...a lack of information necessary to develop a common understanding of the key problems areas, acknowledge successes from which valuable lessons can be learned and inform health policy that will drive predictable improvements over time
>
> (Ibid: xxv)

In a similar vein, Ovretveit and Gustafson (2002), Scandinavian researchers who have collaborated internationally, propose there is little research evidence as to the effectiveness of quality programmes or the conditions for maximum effectiveness - in other words a dearth of evaluation research in this area. For Ovretveit and Gustafson "a quality programme is the planned activities carried out by an organisation or health system to improve quality" (ibid: 270). They further suggest that "quality improvement programmes are new social medical technologies which are increasingly being applied" (ibid: 270) and probably consume more resources than any treatment, having potentially greater consequences for patient safety and other clinical outcomes. They identify a series of questions that decision-makers and theorists have:

- do they achieve their objectives and, if so, at what cost?
- why are some more successful than others?
- what are the factors and conditions critical for success?
- what does research tell us about how to improve their effectiveness?

They identify that there has been little independent and systematic research about effectiveness and the conditions for effectiveness nor much descriptive research which documents the activities which people actually undertake when implementing a programme. The reason for this lies largely for these researchers in the methodological challenges posed, as they put it "the methodological challenges of measuring outcomes and attributing causality to these complex, changing, long term social interventions to organisations or health systems, which themselves are complex and changing" (ibid: 270). However, they do acknowledge that some

studies point to certain factors most associated with creating the conditions likely to produce results and motivating and sustaining implementation. Commonly reported are "senior management commitment, sustained attention and the "right" type of roles at different levels, a focus on customer needs, physician involvement, sufficient resources, careful programme management, practical and relevant training which personnel can use immediately and the right culture" (ibid: 270). Their research sought to identify critical success factors for quality improvement collaboratives, highlighting the structure of the collaborative and the steps to be taken are more prescriptive than other quality improvement programmes, they suggest that there is some evidence that quality collaboratives can help some teams to make significant improvement quickly "if the collaborative is carefully planned and managed, and if the team has the right conditions. It suggested that a team's success depended on their ability to work as a team, their ability to learn and apply quality methods, the strategic importance of their work to their home organisation, the culture of their home organisation, and the type and degree of support from management"(ibid: 271).

Baker (2006) argues that a fuller dialogue about quality improvement methods and their assumptions is critical. Baker proposes that "the goals of quality improvement practice are to enhance performance by setting aims, examining processes of care, testing changes in these processes, and implementing those changes that improve results" (ibid: 150). Nolan (1998) refers to the emphasis on using knowledge about how care is delivered to identify improvements, building better systems through the accretion of small changes. This leads Nolan to an assertion that quality improvement is a pragmatic science.

Ways of thinking about quality improvement and how improvements in performance happen have been key lines of inquiry in all of my projects. During Project Two, I became aware of my longstanding focus on accumulating change management tools and techniques. The importance I attached to this acquisition of tools is consistent with mainstream systemic thinking about improvement and quality management, and particularly prevalent in published health service improvement literature. In this

way of thinking the focus is on rational planning for intended results and subsequent performance management to this end. A consequence of this way of thinking has been to spend considerable effort searching for the right improvement tool, including the use of targets, depending on the nature of the change being sought, and a belief that if the tool was only used in the right way, then improvement would result and be reflected in the achievement of the agreed/selected performance measures. Through Project Two, I began to question the adequacy of direct application of systems thinking to matters of human behaviour, and, more immediately, its adequacy in helping me make sense of my practice.

In the literature that is taking a systemic perspective on quality improvement, there is a consistent call for a focus on research into quality improvement that provides details. It is this latter issue that I think my research is contributing – i.e. the careful articulation of quality in complex social process terms in everyday practice - but not with the same goal of prescription and control as Baker suggests.

As I have worked through the four projects constituting my research, I have come to think quite differently about the nature of organisation from the mainstream perspective being taken by researchers like Leatherman and Sutherland, Baker and Ovreveit and Gustafson. This has, in turn, led me to think differently about quality improvement in the context of my day to day work in an acute hospital as we try to make sense of and work with performance targets that have been nationally determined. There are some similarities, for example in Nolan's (1998) reference to small changes. However, I argue in Project Four that it is about focusing on the quality of interaction between people (including my own participation) rather than building better systems and thinking about interaction from the perspective of interacting parts. I agree with Stacey, Griffin and Shaw (2000) who point out:

> We are not trying to dismiss the tools of systemic thinking, but rather trying to understand how they are tools used in much more complex processes that are much more than the tools.
>
> *(*Ibid: 82)

I believe my research, set out in the four narratives of practice in this thesis, gives

such an account.

Coming to see Quality Improvement in Healthcare as a Cult Value
My thinking about my practice began to shift in the process of writing Project Two. In a perplexing learning set meeting in San Francisco, I shared with my learning set and supervisors my sense of outrage when I first read a chapter by Ralph Stacey (2006) setting out what he saw as the dominant mode of public sector governance. For Stacey and Griffin (2006), this could be thought of as:

> ...a rather crude form of first-order cybernetic systems thinking...(where) the cult of performance replaces purpose...the approach is characterised by the instrumental use of naming and shaming people and institutions to enforce compliance, aided by a form of emotional blackmail as people are exhorted not to let their colleagues down...the cult of performance is actually operationalised in ways that involve the manipulation of figures and the distortion of clinical decisions to ensure the appearance of meeting targets. The result is a culture of deceit and spin in which appearance/presentation/spin replaces substance and people become alienated from their experience. Instead of leading to quality, the whole approach amounts to a system of counterfeit quality.
>
> (Ibid: 10)

I was asked to consider why I was so outraged. I struggled to articulate my position at the time. On reflection, I can now see that Stacey's assertions struck to the core of what I had held as important in my identity as a health service manager, working in a Strategic Health Authority. I worked in the health service prior to the introduction of national access targets. I experienced the sense of despair and distress in circumstances where patients commonly waited more than 24 hours in Accident and Emergency for a hospital bed to become available. For me, these nationally determined targets had been useful in drawing attention to what I saw as the unacceptable conditions some patients were experiencing. I left the learning set being asked to consider whether my concern for improvement might be usefully thought of as a cult value, along the lines defined by American Pragmatist, George Herbert Mead.

Subsequently, reading Mead's (1923) paper *"Scientific method and moral sciences"* was for me an important moment for my research. I found the ideas being discussed

at residential meetings and in the smaller learning sets challenging the notion of organisations as systems intriguing. However, I felt I wasn't really "getting it". Thinking carefully about Mead's assertion, that, mostly, we are not consciously aware of our values and the extent to which they influence how we make sense of our day-to-day experience, proved enlightening. Mead emphasizes the compelling force of values in our day-to-day experience. As I reflected on instances where I have reacted strongly, usually associated with feeling angry, intolerant or resentful - a recurrent example relates to conversation with friends and family where criticism in relation to ways of working in the NHS is made - Mead's work is helpful in making sense of these reactions. I now understand these reactions from the perspective of the importance I have attached to an ideology of continuous quality improvement. In effect, quality improvement is an important cult value I subscribed to. Mead proposes that a cult value arises when leaders present to peoples' imaginations a collective belief in a hopelessly idealised future possibility stripped of all obstacles to its achievement. In subscribing to such a value, people experience an enlarged personality. When such values are made operational in a rigid manner where no exceptions are tolerated then a cult is formed which demands conformity and can become the basis of dreadful acts. However, Mead held that such values were the most important part of our heritage and were normally operationalised as functional values. Functional values are interpretations of cult values in specific situations at specific times and such functionalisation inevitably results in different views and so in conflict. The quote I refer to earlier from the Department of Health (1997) which states that the "new NHS will have quality at its heart…every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality" (ibid: 3.2) is one example of where policy makers can be said to be presenting an idealised future where, taken to its logical conclusion, all working for the NHS as an institution are expected to conform to the ideal of continually working to improve quality. This determines what is taken to be legitimate to talk about, in this instance it will be legitimate to talk about how personal responsibility for quality is being or will be discharged. Less likely to be happening, are the conversations about the conflicts people experience day to day as they try to

functionalise these ideals. This was exemplified for me very vividly when I recently witnessed a highly amusing piece of drama about working with "Six Sigma", an improvement methodology used in the automobile industry (Thomsett, 2004). Played out before the audience was a scene that I could now recognise as fairly typical of overzealous adoption of the abstract, special language associated with many quality improvement programmes and complete disregard for the day to day concerns raised by people on the shop floor as they struggled to make sense of what was being asked of them and to avoid being categorised as trouble-makers or risking being excluded altogether from the programme In other words, just how the cult values of improvement and quality are being fuctionalised is not a legitimate topic of conversation. Also, even as they are being functionalised, Mead identified how cult values easily divert attention from what people are actually doing. So if we think of quality improvement as a cult value, the tendency to idealise tools and techniques over and above day to day interaction becomes apparent. As Griffin (2002) identifies for all cult values, this in turn displaces attention from the ongoing responsibility and accountability we have to each other in our daily lives. I draw attention to how frequently I experience the tendency to displace attention in this way in my daily interactions in Projects Two, Three and Four. Mead's work points to the importance of studying ways in which cult values are functionalised in daily life.

Following this way of thinking, what becomes important is the emphasis on methodical articulation of the messiness of everyday practice as we work with others in the action of taking up and functionalising cult values. Mead emphasised the need to stay with the immediate and understand what is happening, rather than focusing attention on creating visions of some distant goal. Furthermore, as soon as we functionalise cult values in daily interaction, conflict arises and must be negotiated by people in their practical interaction with each other. This has become a central strand of my inquiry.

My inquiry has influenced how I am practising. Moving from Project Two I recall I was feeling rather uneasy. Taking Mead's work seriously, I sensed, was likely to change my own patterns of interaction with staff. I was becoming aware of how

often, during the course of discussions in meetings I was involved in, the conversation was much more around what should happen, rather than discussion of what was actually happening. This became increasingly frustrating, yet I was uncertain, as I started writing my narrative for Project Three, as to how I might usefully draw attention to this and what responses this might evoke.

Shifting away from a Kantian epistemology: Considering my practice from a complex responsive processes perspective

At this point, I would like to set out other key components, in addition to cult values, of thinking in responsive processes way. The complex responsive processes perspective developed by Stacey and others is a theory of human interaction (Griffin, 2002; Stacey, Griffin and Shaw, 2000; Shaw, 2002; Streatfield, 2001). Three major strands of thinking about human activity are at the core of this theoretical perspective. First, the human activity of communication is taken to be one of gesture and response, seen as a single social act in which meaning emerges. Second, human activity involves processes of power relating, inclusion and exclusion, and movement in identity. Lastly, human activity involves making choices and those choices are based on ideology. Complex responsive processes theory has its origins in dissatisfaction with the abstraction from the every day experience of human action when systems perspectives are adopted (Stacey, 2001). The complex responsive processes perspective takes as its starting point the importance of understanding our own every day experience, where the key questions for inquiry centre around "just what is it we are doing together in our groups, or in our organisations, that leads to the emergent patterns that are our experience." (Stacey, 2003c: 32) The theory draws heavily on the dialectical thinking of George Herbert Mead (1934), the process sociology of Norbert Elias (1939) - also referred to as figurational sociology - and, by analogy, from complexity science (for example, Prigogine, 1997).

A central tenet of responsive processes thinking is rooted in Mead's (1934) argument that humans cannot be understood in isolation and that the human mind and self emerge from social processes of gesture and response. In particular, his

assertion is that it is the social act of gesture-response that constitutes meaning. This is very different from the more usual cybernetic systems idea of sender-receiver models of communication where it is thought that what is important is the back and forth transmission of communication between autonomous individuals. Byrne (1997) problematises this perspective in her study examining the nature of nurse-patient communication in Accident and Emergency. Taking a symbolic interactionist perspective, she challenges the taken for granted conclusion that poor communication rests with the individual nurse. She calls for further consideration of factors influencing the quality of such communication. In my research, Mead's thinking has facilitated an ability to respond to Byrne's challenge. For Mead, meaning is not located individually in the gesture and the response rather meaning is created in the interaction between the two such that communication is thought of as a social, relational process. Poor communication, thinking in this way, means inadequate interaction. This has been a key insight for me and has made me much more alert to what sorts of interaction and the qualitative aspects of that interaction, I and my Board colleagues are participating in with staff, patients and their carers across the hospital. Mead also proposed that we communicate in the medium of significant symbols, where it is possible for us to evoke in ourselves responses to gestures that are similar to responses evoked in others, and furthermore that we have the capacity for generalising so that as we act we take up the attitude of what Mead described as the generalised other. In other words, we are concerned about what others might think about what we say or do. According to Mead we also have the capacity to be an object to ourselves – in this sense he talks of the I-Me dialectic. The "I" is my response to the "Me", i.e. what I perceive other people might be thinking of me. This is dialectic in the sense that the "I" and "me" cannot be separated, and are in paradoxical movement where there is opportunity for either continuity or transformation. In other words, I may respond in many different ways to my perception of the views others have of me. I may get stuck in a repetitive pattern with others, or as we, interact something new might emerge. Thinking in this way has been enlightening for my day to day work. In Project Two, I reflect on my sense of irritation with a colleague who seems to be dismissive of a project I am

leading. As I consider this from the perspective of gesture and response, I notice that I move from my usual pattern of responding, which is to simply negate what I think he is inferring, to a further exploration of what his intention is in making these remarks which enables us to work rather differently on both of our concerns. Mead proposes that our sense of identity emerges out of the interaction between how we continually respond to how we understand how others see us. By extension, identity is not as a fixed thing, rather identity emerges in the interaction of self with others and somewhat open ended and unfinished. In Project Four I notice the way in which there is a long history of the team within our A&E department being seen as problematic in relation to "delivering" targets set nationally. This identity is reinforced through the ways of talking, indeed gossiping, at our management meetings and in other conversations. I now am much more aware of my leadership role in entering into these conversations with an alternative perspective in an attempt to challenge this ongoing negative identity which I see as self-perpetuating.

Another key component of responsive processes thinking is the way in which conventional views of time as linear and the past as factually given are challenged. Stacey (2003b) elaborates on the alternative understanding of time in Mead's way of thinking:

> This social act (of gesture response) has the time structure of the living present. That time structure is a circular one in which the future, the response, changes the past, the gesture, all in the present. It is in the living present that the individual and the social continually emerge in forward movement into the future, a movement in which the past is continuously reconstructed.
>
> (Ibid: 224)

I have found Walker's (2006) exposition as to how Mead's notion of the present contrasts with the conventional view of time taken up in mainstream management literature helpful. He draws attention to the way in which, conventionally, time is often viewed as linear, where "the future is predictable from the past and the present is only a moment on the way to the future from the past" (Walker, 2006: 109). However, drawing from Mead's work, Griffin (2002) identifies:

> …the past is not factually given because it is reconstructed in the present as a basis for the action to be taken in the present. The past is what we re-member. The future is also in the present in the form of anticipation and expectation. It too forms the basis of action in the present. Furthermore, what we are anticipating affects what we remember and what we remember affects what we expect, in a circular fashion, all in the present basis of our acting.
>
> (Ibid: 207)

It has become important for me as I work with staff groups to focus attention on what is happening in the present rather than continue discussion about the "what ought to be's" and the "if onlys" that seem to be regular patterns/themes of many meetings. The present is the moment in which meaning and transformation can occur, rather than abstracting to idealised prescriptions of what ought to be.

Mead's thinking about cult values combined with broader issues of ideology provides another important aspect of a complex responsive processes perspective. In Project Four, I consider in detail the impact of managerialism as an ideology that continues to exert a considerable influence on ways of working in the NHS and shapes what is deemed appropriate ways of considering quality improvement. I expand on what I mean when I say managerialism is an ideology when I consider issues of research methodology below.

Paradox is crucial within a responsive process approach and differs from the Kantian epistemology which does not allow for paradox, favouring instead a belief that systemic thinking provides a way of resolving contradictions, tensions and dilemmas present in dualistic thinking. As Stacey notes:

> Some justify the retention of two inconsistent theories by claiming that it leads to a dialectic, by which they mean a discussion or dialogue, or a Kantian notion of synthesising two opposites. However, in the Hegelian dialectic, which is the basis of the process view I will be arguing for, thought moves by opposites negating each other and it is in this tension that new meaning emerges. This provides another argument against the "both…and" retention of two inconsistent theories, namely that such a way of thinking obliterates difference and eliminates paradox, so obstructing the evolution of new meaning.
>
> (Stacey, 2003b: 8-9)

From a responsive processes perspective, rather than think of the individual and the group in dualistic terms of "both and", the individual and the group are viewed paradoxically. In other words the individual and the group are paradoxically forming and being formed at the same time. I have found it helpful to acknowledge that as I am working to influence the patterns of interaction that constitute the organisation, at the same time I am being influenced by those patterns. In Project Three, I pick this theme of paradox up as I consider issues of detachment and involvement in my hesitation to make next steps in getting closer to the messiness of processes of functionalising a cult value of quality improvement.

Also key is the work of Norbert Elias. He introduced the concept of figuration as a way of overcoming what he saw as unhelpful dualisms and dichotomies in the work of other sociologists, particularly between the individual and society. Elias's figurational sociology highlighted that humans are social beings and part of complex networks of interdependent social relationships, which necessarily involve power relating. Elias argued that the individual and society are not separate concepts. It is not possible to step-outside our interaction with others and assume the stance of a detached observer. Elias also attached importance to considering broader social and historical context when analysing peoples' action. He argued that people and relationships are crucially affected by the activities of past generations. Figurations are historically produced and reproduced networks of interdependencies. Arising from this complexity and dynamic interweaving actions of a large number of people are outcomes, which no one single person has chosen or designed. Unplanned and unintended consequences, for Elias, were usual rather than unusual aspects of social life:

> Human beings may not be aware of the figuration of which they are a part, of the nature of prevailing interdependencies and therefore ignore or misunderstand the results of their actions. It is because of these unintended consequences of human actions that developments may occur as a blind process.
>
> (De Swann, 1988: 7)

Elias further proposed that this way of thinking leads to a particular way of

understanding power. Power, contrary to mainstream perspectives, is not conceptualised as a property which one person or a group has or does not have. In Elias's approach power is thought of as a structural characteristic of all human relationships. Power relations are based on the interdependence of those in figuration and both enable and constrain at the same time. My practice has also been influenced by the proposition that although we may have certain individual intentions as we move into interaction, it is not possible to predict the outcomes that emerge from this social intertwining. Furthermore, in the intertwining, there is constantly present power relating, and as our interactions go on power balances shift. Through the process of writing Project Three, what became meaningful for me was to focus my attention seriously on those patterns of interaction and interdependencies between those delivering the service, and how I am acting "within the flow". For me this has become about increasing opportunities to work alongside staff delivering front line service to patients. In these processes, I become more aware of the emotions involved, for myself and others, as power balances shift and identities are challenged and change as we grapple with the daily conflicts being negotiated in the clinical and managerial activities which are involved in meeting national access target times, or not.

Finally, analogies are drawn from the field of complexity science. Complexity in this sense emphasises a dynamic rather than linear pattern of activity which is both stable and unstable at the same time. It is these dynamic patterns of interaction that are self-organising. In complexity science the language is of agents involved in local interaction. Each agent only interacts with a tiny proportion of the total population. There is no central instruction as to the mode of interaction nor is there any centralised control of interaction. There is no blue-print for, or designer of the emerging pattern. Each agent is acting on the basis of their own rules. It is these analogies from complexity science that are then taken up, but in the context of human consciousness and self-consciousness. Focusing on key concepts of complexity, self-organisation and emergence, and evolution over time, Stacey et al., (2000) propose that human relating/interaction is characteristically complex,

paradoxically predictable and unpredictable, certain and uncertain, at the same time. In the local interaction between people, characterised by the social act of gesture and response, patterns emerge that become population wide patterns - but that individually no-one person can plan or design. When humans interact they do not simply follow rules, rather they interact on the basis of gesture-response and as such the patterns that emerge are thematic – for example, themes of inclusion and exclusion and power-relating. These are both themes that I take up in detail in Project Four. Stacey et al., (2000) identify that the non-linear nature of human interaction offers opportunities for any diversity in the process of interacting to be amplified and a new pattern evolves. In applying this to the area of organisational change, Stacey et al propose that organisations are seen as patterns of interaction between people, where the interaction is communication (Stacey, Griffin and Shaw, 2000). Organisational change, then, is a change in that pattern of interaction.

Before I set out just what I now think quality is from a responsive processes perspective and what that means for those who share my interest in improving quality, I would like to say something about the way in which a responsive processes perspective has influenced my emergent method of research.

Methodology

In my research, I consider the implications of understanding organisations essentially as patterns of communicative interaction that, at the local level, lead to further patterns of interaction - always with the opportunity of new population-wide patterns developing from the myriad of local interaction. I start this section on methodology by pointing to the contested nature of claims as to what constitutes acceptable management research. I also consider assertions of a theory-practice gap - an issue I raise in Project One in relation to nursing knowledge. Here, I consider the assertion from the perspective of issues of rigour and relevance in the production of management research. I argue that rather than splitting theory and practice as happens when we think in terms of a gap, it has become more useful for me to think in terms of a dialectical relationship, where theory is informing practice and practice is informing theory at the same time always with the opportunity that new

knowledge will emerge.

The contested field of management research

In the field of management research, as in other academic fields, it is possible to identify a certain set of dominant assumptions about what is valid knowledge and what is legitimate research. Consequently, certain research methodology and modes of research are given preference over others (Ospina and Dodge, 2005). Learmonth and Harding (2006), take a critical look at the way in healthcare that the so-called evidence-based approach with its origins in medical science is being increasingly recommended for policy and management decision-making in the public sector (Hewison, 1997; Homa, 1998; Iles and Sutherland, 2001; Walshe and Rundall, 2001). Evidence-based practice has been adopted in medicine in a attempt to generate and use better evidence in the pursuit of effective patient care. In the same way that evidence-based medicine has been "officially sanctioned" as reducing uncertainty in clinical practice, those advocating evidence-based management aim for evidence about organisational phenomena that will similarly reduce managers' uncertainties.

Learmonth and Harding (2006) note:

> ...the basic doctrine of evidence-based management remains one appropriated from evidence-based healthcare: that a consideration of evidence will increase the rationality and thus the effectiveness of managers' decisions. Both in medicine and management, approaches that base practice on "evidence" assume a science that is based on laws that can be elucidated for the benefit of all; and, in both, the "evidence" tends to be presented as if it were independent of the social circumstances of its production...
>
> (Ibid: 246)

Such a position is highly problematic from the perspective of Learmonth and Harding, as, in failing to take account of the socially situated position of management knowledge, including processes of power and conflict in the development of knowledge, much of the so-called evidence of evidence-based management reinforces managerialism, obscuring other ways of understanding organisational life. In referring to managerialism in this way, I am following Randle

and Brady's (1997) articulation of managerialism in the sense of a package of management ideas including strict financial management and budgetary controls; the efficient use of resources and an emphasis on productivity; extensive use of performance indicators; development of consumerism and market forces; and the assertion of the managers' rights to manage. Grey and Shelley (2005) develop this further arguing that this package of ideas constituting managerialism is taken up by advocates who believe it is possible to operationalise the ideas in ways that they understand as controlling work both directly and indirectly. Directly, in the sense, of a focus on continual efficiency and productivity, and, indirectly through "…incentives to elicit the work commitment of employees stressing notions of customer and quality, devolution and delegation, but with an emphasis on performance measurement and audit" (ibid: 4). In my own research, specifically Project Four, I reflect on managerialism as a dominant ideology. Beyer (1981) defines ideology "as a relatively coherent set of beliefs that bind some people together and that explain their worlds to them in terms of cause and effect relations" (ibid: 166). For Bendix (1956) managerialist ideologies are "...all ideas which are espoused by or for those who seek authority in economic enterprises, and which seek to explain and justify that authority" (ibid: 2).

In my work, however, I have found it useful to draw on Stacey's (2007) proposition that:

> The way one thinks about values and norms has profound consequences for what one does in organisations...consider how norms and values together constitute ideology. Values are themes organising the experience of being together in a voluntary, compelling, ethical manner, while norms are themes of being together in an obligatory, restrictive way...when humans interact, they enable and constrain each other at the same time...in their ongoing negotiation of these enabling-constraining actions, all are taking the attitude of others, specifically and in a generalised/idealised way...the criteria for evaluation are at the same time both obligatory restrictions, taking the form of what they ought and ought not to do (norms), and voluntary compulsions, taking the form of what they are judging it good to do (values). The evaluative themes forming and being formed by human interaction are norms and values at the same time, together constituting ideology...
>
> (Ibid: 347)

So an ideology of managerialism is underpinned by values of efficiency, effectiveness and economy - in public sector working these are taken by many to be essential values informing difficult decisions of resource allocation. The norms of control and rationalism legitimate beliefs that it is possible to control outputs and, indeed, employees' attitudes and commitment to organisation objectives.

In Project Four, I argue that an ideology of managerialism underpins many published conceptualisations of quality improvement and research into quality improvement in organisations. As with all ideologies, managerialism has the effect of making it appear that particular categories are natural and inevitable ways of thinking and experiencing. Furthermore, in taking Stacey's perspective on ideology as being mutually reproduced in ongoing activities of communication, determining turn taking and turn making patterns in the sense of enabling some to take a turn yet constraining others from doing so, I consider the impact of managerial ideologies in the quality of participation in day to day interactions.

Considering what counts as evidence in management research, Learmonth and Harding remind us that evidence is never simply out there waiting to be discovered by the researcher. It is the methods we use that interpret "evidence" in particular ways and we need to be mindful of the way in which some interpretations of evidence are treated in the mainstream as if they were universal. I develop this point it what follows in terms of a current debate regarding knowledge production, couched in the terminology of Mode 1 and Mode 2 (Gibbons et al., 1994), which I will explain shortly. What is becoming more widely accepted by many management research commentators is that solely relying on instrumental reason in the human sciences is inappropriate, given the contested politics, values and beliefs that precede empirical inquiry and shape approaches to research and what constitutes acceptable evidence.

Rigour and relevance in management research
Concerns have been expressed in leading management journals about the usefulness of academic research for solving practical problems leading to assertions that a gap

exists between theory and practice and is widening (Aram and Salipante, 2003; Anderson, Herriott and Hodgkinson, 2001; Rynes, Bartunek and Daft, 2001). Van de Van and Johnson (2006) identify three ways in which the gap between theory and practice is being framed. Firstly, using the terminology of knowledge transfer, the gap is understood in the context of an assumption that practical knowledge is a derivative of research knowledge. The emphasis is on translating and diffusing theory into practice (Dennis and Langley, 2002; Rynes, Bartunek and Daft, 2001; Tranfield, Denyer and Smart, 2003) . This has been described as the "trickle down" perspective. In other words, those thinking in this way propose that knowledge is created and tested by academic researchers, taught to students, adopted and diffused by consultants, and practiced by practitioners. Critics of this way of framing the theory-practice gap, argue that academics do not have a monopoly on knowledge creation (Starkey and Madan, 2001). My critique is rooted in an entirely different way of thinking about knowing as action in the local situation, which I develop further below (Stacey, 2007).

In the second perspective, rather than regarding practical knowledge as a derivative of research/scientific knowledge, the gap has been framed in arguments that theory and practice represent distinct kinds of knowledge, arising from different epistemological origins, contexts and professional communities (Aram and Salipante, 2003; Kondrat, 1992; Schon, 1987). Characteristic of this perspective is the belief that both forms of knowledge are valid. Advocates propose that knowing how to deal with specific situations encountered in a particular case characterises practical knowledge. Scientific and scholarly knowledge, by contrast, involves knowing how to see specific situations as instances of a more general case that can be used to explain how what is done works or can be understood. This is the frame where rigour and relevance have been hotly debated (Pettigrew, 2001). Aram and Salipante (2003) see relevance as a practitioner's primary interest, given that practitioners work with specific problems in specific situations and, as such, knowledge needs to be customised, connected to experience and the dynamics of particular situations. They suggest that knowledge becomes relevant when it is

context specific. Rigour on the other hand conveys the academic's commitment to build theory. Central to this debate is the issue of whether the relevance of knowledge to managers should focus on matters of control, i.e. prescriptions of what to do to resolve a problem, or if it should include a broader consideration of matters such as description and explanation, providing, in turn, ways of viewing and understanding "what may be and not to predict firmly what will be" (Brief and Dukerich, 1991: 328). It is in the latter definition of relevance that I locate my research. I take issue with the implication that rigour is less of a concern for practitioners, a point I return to below.

Yet it is the third approach, which frames the theory-practice gap as a knowledge production problem, which I think has been the most useful to considerations of methodology for my research. In 2001, the *British Journal of Management* published a special issue dedicated to consideration of the rigour and relevance of management research. Contributors were asked to consider a "think piece" by Starkey and Madan (2001) titled *Bridging the relevance gap: aligning stakeholders in the future of management research.* Starkey and Madan's piece took as its central thesis the nature of management knowledge created by research at what they describe as "the interface between business and academia" (ibid: S3). They build on Gibbons et al (1994) assertion that a fundamental shift is occuring in the ways in which knowledge is being produced, which in turn affects both what knowledge is produced and the methods deemed appropriate in its production. Gibbons et al developed the particular terminology of Mode 1 and Mode 2 knowledge to support the distinctions they advocate. In summary:

> ...in Mode 1 problems are set and solved in a context governed by the, largely academic, interests of a specific community. By contrast, Mode 2 knowledge is carried out in a context of application. Mode 1 is disciplinary while Mode 2 is transdisciplinary. Mode 1 is characterised by homogeneity, Mode 2 is more socially accountable and reflexive. It includes a wider, more temporary and heterogeneous set of practitioners, collaborating on a problem defined in a specific and localised context…
>
> (Ibid: 3)

Gibbons et al identify the ideal Mode 1 knowledge as the Newtonian empirical and mathematical physics.

> Mode 1 refers to a form of knowledge production - a complex of ideas, methods, values and norms - that has grown up to control the diffusion of the Newtonian model to more and more fields of enquiry and ensure its compliance with what is considered sound scientific practice
>
> (Ibid: 2)

Mode 1 has also been summarised as the pursuit of "scientific truth", primarily cognitive in nature (in the sense of seeming to be more concerned with theory than practice and how the world is thought to work at a theoretical level), where application, if it occurs, happens later. In Mode 1, rigour is strongly associated with a belief in the pursuit of universal laws (Huff, 2000).

Mode 2, by contrast, is an approach to knowledge production where practical problem solving is valued. Gibbon et al's (1994) exposition of the five features of Mode 2 knowledge production is helpful in thinking about key aspects of my research methodology. Mode 2 is characterised by knowledge produced in the context of its application. The aim is to be practically useful and this is a key consideration in framing the research aims, questions and practices. The research I have embarked upon has as its focus my work, exploring my experience where I am considering critical issues that are also important to my employers.

A second feature of Mode 2 is described as transdisciplinarity. Gibbons et al contrast this with what they see as the discipline based approach of Mode 1. Transdisciplinarity is used to convey the integration of different skills in the research approach, that MacIntosh and MacLean (2001) describe as the interweaving of empirical and theoretical perspectives in ways that cannot be reduced to disciplinary parts. MacLean and MacIntosh (2002) develop the concept on the basis of experiences of their own research, pointing to how transdisciplinarity is a feature of the solutions which emerge in processes of problem solving. Certainly, the transdisciplinary nature of the DMan programme needs to be acknowledged. Key to

the approach are analogies from the complexity sciences understood in relation to human behaviour that is informed by perspectives in sociology, psychology, group analysis and organisational theory. In addition, the broad mix of those on the programme ensures that, as a research community, we are each bringing distinct competences and areas of expertise, which intertwine in emergent, creative ways during the processes of the large group work (including the annual research conference), the small learning sets, supervision and the iterative writing practices.

Mode 2 is also characterised by heterogeneity and organisational diversity. Gibbons et al see this as key when facing complex, often transitory problems. Team members are much more transitory as situations unfold and new skills and disciplines are required. This is supported by technologies that enable much more socially distributed research capacity. Again, this concurs with my experience. Members of my learning set were based in the UK, New Zealand and Holland. The use of e-mail was a vital technology supporting our inquiries. I would also add, as important, that it is not just about heterogeneity in the research community, during the course of my research I have changed "jobs" three times and organisations twice, adding a richness in terms of diversity of experience to my line of inquiry whilst retaining continuity of focus.

The fourth feature is described as social accountability and reflexivity. I pick up issues of reflexivity as related to my own research in more detail below. Social accountability is linked to increasing sensitivity in matters of research governance. As a researcher, I am aware that I need to be able to account in a socially responsible way for what I write. Although I am writing about my sense-making and inquiring into my practice from that perspective, I also write about that in terms of my interactions and interdependency with others. There are ethical issues that this necessarily involves. I have found the ethical considerations in my work quite challenging. Several writers identify that, in the case of management research, business schools may be doing too little to equip novice researchers with the skills and sensitivity needed to address ethical issues (Bell and Bryman, 2007; Collins, 2000). In a useful article, Bell and Bryman summarise key ethical challenges in

management research as:

- conflicts of interest and affiliation bias;
- power relations linked to processes of "informed consent";
- harm, wrong doing and risk; and
- confidentiality and anonymity.

The issues of power relations, informed consent, wrong doing, confidentiality and anonymity have increasingly exercised my thinking as I have progressed my research. The literature on ethics and auto-ethnography resonates most closely with the issues I have found challenging. I identify similarities and difference between my emergent method of research and auto-ethnography below. On the matter of research ethics, auto-ethnographer Carolyn Ellis (2007) adds a third dimension of ethics to Guillemin and Gillams (2004) original two. Guillemin and Gillams delineate firstly procedural ethics – taken to be procedures mandated by ethics committees regarding informed consent, confidentiality, rights to privacy, deception and protecting human subjects from harm. The second they propose is a situational ethics (or ethics in practice) – pointing to those ethically important moments, often unpredictable and subtle, that come up in the processes of researching. The third dimension that Ellis adds is relational ethics. This has been a key concern for me. Although I am researching my practice, my "I" is inextricably linked to the "we" of the people I am working with locally; this unavoidably involves my reflections on how I make sense of what they are doing in the ongoing patterns of gesture and response. As Ellis (2007) points out:

> When we write about ourselves, we also write about others. In so doing, we run the risk that other characters may become increasingly recognisable…though they may not have consented to being portrayed in ways that would reveal their identity…we often have to make choices in difficult, ambiguous and uncertain circumstances. At these times, we feel the tug of obligation and responsibility. That's what we end up writing about…
>
> (Ibid: 14)

Although many of my colleagues are aware I am researching my practice, I have felt wary of sharing my writing. I am aware that some of my frustrations I point to in patterns of interaction in my workplace, I have not dealt with "head on" so to speak but have written about in candid terms in my narratives. Of course, my colleagues may entirely disagree with my interpretation and some may find it upsetting or insulting. For example in Project Four, I talk about my frustration with what I initially thought of as weak clinical leadership. Through the processes of writing and discussing with my learning set I found new ways of thinking about what might be going on. By further reflecting on these issues, I considered it more useful to think about what I saw happening from the perspective of established and outsider power relations (Elias, 1994). I have shared my written work with only a small number of those I work with. This is an ongoing ethical consideration, for me, that remains a key question. Coupal (2004) offers an interesting perspective on such challenges for practitioner-researchers. She critiques the naivety of most standard texts that emphasise the importance of gaining "fully informed consent". For her, standard ethical approval processes:

> …for obtaining fully informed consent do not acknowledge that when a practitioner researcher is the research instrument, he or she has already collected knowledge and constructed understandings about the research site, the participants and the research question under investigation. Placing artificial constraints on what a practitioner sees and hears cannot effectively restrict data collection and analysis…the essential question is "who owns an experience?"…practitioner-research is becoming more difficult within a politicised context of conflicting interests. To have knowledge production that includes multiple perspectives, we need to find new ways for regulatory controls…
>
> (Ibid: para 27 and 34)

I would argue that fully informed consent could also be more helpfully thought of as a cult value. However, I do think Coupal's challenge as to "who owns an experience" is an ongoing ethical consideration of considerable complexity.

Moving from consideration of some of the ethical issues, the fifth and last feature Mode 2 research relates to the quality control aspects of knowledge production. In

Mode 1, this is judged often by peer review or academic gatekeepers from within the discipline. In Mode 2, Gibbons et al propose that there will need to be more "multi dimensional" considerations as to what constitutes acceptable, good quality research. However, Nowtony et al (2003) point to a paradoxical difficulty for Mode 2 researchers and that is "how to describe and defend, in traditional academic discourse ideas that attempt to analyse how that discourse is being transcended…" (ibid; 180)

Pettigrew (2001) locates his arguments in what he terms the era of knowledge production "after modernism" - where modernism can be characterised by scientific claims for rationality, universalism and autonomy in the construction of knowledge. Whilst acknowledging that modernist forms of science continue to feature strongly in management research, Pettigrew sees the growing attempts to move beyond modernism in social sciences and management as creating new opportunities for experimentation and engagement between management researchers, social scientists and practitioners. Intellectual diversity rather intellectual closure is key in this respect. What becomes important is greater reflexivity in exploring accounts of our own research practice (MacLearn, MacIntosh and Tranfield, 2001). I consider reflexivity in further detail below.

Pettigrew also supports Whittington et al., (2001) in their suggestion that we should regard theory and practice as a more tightly linked duality, rather than the modernist conception of theory and practice as a dichotomy. He asserts that this will lead to a more comprehensive notion of rigour and relevance, rather than the dichotomous trade-off existing in much of the literature. Pettigrew (2001) identifies rigour and relevance is one of the "double hurdles" for management research. I have found it more useful to think not in terms of a gap or a duality, but dialectically.

Knowledge as emerging and social
Pursuing research influenced by complex responsive processes thinking, Stacey and Griffin (2005) advocate a perspective informed by Mead (1934) and Elias (1991) that disputes the dualism of individual and social, holding that both are aspects of

the same phenomenon, namely human interdependence. Furthermore, as indicated, Stacey and Griffin (2005) also differentiate on the basis of how "organisation" is understood, disputing the dominant perspective of organisations as systems.

There are a number of methodological challenges that emerge from taking up a complex responsive processes perspective to researching organisational change. Accepting that knowledge emerges and evolves in a history of social interaction, rather than being developed by an autonomous researcher, necessitates serious attention to research as a social process. The social aspects of my research involve sharing iterations of my writing, working in small and large groups, and engaging with the broad literature within which my practice as a health service manager and clinician can be located. Weick (1995) describes the engagement with the literature as "hidden dialogicality". In other words, the process continues to be social in the sense that we are engaging through our self-conversation with these influential authors. The key research question is, as previously indicated above, just what is it that I am doing together with others in groups, or in my organisation, and how is it that I account for my experience?

From this perspective the meaning of experience is as that taken by the parties in social interaction. The focus of my research is on the micro-detail of my experiences of interaction with others. It is a methodology about being able to articulate everyday experience and join in shared meaning-making. Articulating everyday experience is something I found particularly challenging. It was easy to describe tasks and tools, but I struggled to speak, initially, about what I thought I was doing in my day to day interaction with others. In this research approach these experiences, as interaction, are taken to be patterned as narrative. These narratives have been described as "the raw material from which propositional themes emerge for further reflection" (Stacey and Griffin, 2005). It is an explorative methodology in the sense that hypotheses emerge rather than being set in advance.

Project work as personal narratives of practice
Narrative methods are increasingly used in organisational research, linked to

growing dissatisfaction with attempts to apply realist assumptions from the natural science to understandings of social life (Reissman, 2002). Broadly speaking, narrative involves the unfolding of a story of experience over time. Human agency and imagination determine what gets included and what is excluded and how events are plotted and interpreted in the narration. Essentially, a narrative is retrospective meaning making. As well as organising events into a meaningful pattern of connections and consequences in describing what happened, the narrator also expresses emotions and interpretations. Czarniawska (1997) points out that narratives locate observations in time, rather than regarding those observations as "a logically formulated set of principles valid at all times" (174), i.e. all behaviour is historical. Narratives are both enabled and constrained by the range of social resources available, for example the language we have to describe and interpret our experience and that of others involved in the processes of meaning making, and by circumstance. In other words, narratives are socially situated and interactive. So what becomes important in both the interpretation and analysis of any narrative, is an understanding of the particularity of the narrative - recognising that the narrative is produced in a particular setting, for a particular audience and for particular purposes. It is this combination of the what, how and where that makes narrative actively creative and particular. Traditional questions of factual accuracy and validity are replaced by concerns with credibility and believability.

In this research, each project begins started as a draft narrative of my experience. The audience I am considering in my narrative is my peers, in the form of health service managers and those interested in organisational change and how to research and understand organisational change. As both narrator and researcher, each project represents interpretation and analysis in the process of making meaning of my experience as a practitioner. In each of my projects I start with an account of something that I have experienced in my practice. I explore what sense I made of it at the time, and whether that changes as I reflect on my writing with others in my learning set and as I explore associated literature as themes and questions emerge. I think about how I felt at the time and consider how others involved might have been

feeling. This can be quite disturbing at times, as occurrences I had not given much thought to, in the moment they happened, assume greater significance on reflection, challenging how I think of myself and the way I think others might be thinking of me. In Project Three this leads to feelings of shame as I acknowledge I have paid scant attention to the feelings of staff as they are conflicted in the processes of hitting or missing performance targets in their daily practice and articulate concern that directors are angry with them. In Project Four, I articulate how my anxiety of greater involvement may be interpreted as an abdication of responsibility by those reading my account. In analysing my narrative, I am making visible hitherto unreflected taken-for-granted ways of thinking, set out in the key themes I see as emerging from my ongoing inquiry which are influencing the way I practice and how that is shifting. However, key to the methodology I am pursuing is the recognition of the social nature of the interpretation and analysis. My meaning making is socially mediated through the interactive and iterative way in which the narrative develops through the questions and discussion of my colleague researchers and as I engage with the writing of others in the published literature.

Telling the narrative and then delving deeper, involves negotiating the evidence that makes the narrative convincing to others. An important aspect of the methodology involves the provocation to questioning from others, which I have experienced as a kind of "waken-up" to my practice, acknowledging my experience as credible research. Connecting with each other's work between and during learning sets is an important aspect of the methodology. We are engaged in attempts at shared meaning-making as we try to point to what we think the key questions are emerging from each other's work, endeavouring to highlight the gaps and weaknesses in the emerging argument.

Taking a reflexive approach
The principle of reflexivity is core to this research methodology. In other words, the acknowledgement that the horizons and prejudices that each researcher brings to their study are influential on the research process and require reflection. Researchers cannot "eliminate" their experience, which is inextricably linked to interpretation. In

my work I acknowledge that, in the same vein, readers are interpreters and will participate in processes of interpretation by bringing their own horizons to their reading of my research. Themes that emerge may differ for each reader. However, by taking an explicitly reflexive approach setting out the nitty, gritty process of interpretation and my emerging influences, it should be possible for readers to follow the pathway that leads to the interpretation given. Put simply, reflexivity requires me to address the position I am taking as a researcher on the fundamental issues of the nature of reality, knowledge and my way of being. The hope is that by so doing, I invite different forms of inquiry from the line I have pursued and as a consequence the possibility of new ways of understanding experience. Questioning taken-for-granted attitudes that constitute our prejudices, bias, thoughts and habits is challenging by the very nature of their taken-for-grantedness (Cunliffe and Jun, 2005). The rigour of my thinking emerges in the ongoing, iterative social processes that constitute the research methodology of the programme.

Reflexivity also offers a means of examining power relations in organisations - who determines what can or cannot be done, who is included or excluded, whose voice dominates. As Rhodes (2000) points out, far from being a neutral conduit of meaning, what I choose to write about is a fundamental process of power. The description I choose regarding events in my narrative and the way I ascribe actions to my colleagues is a form of manipulation, where I am privileging my version and this raises issues of ethics associated with this, which need to considered closely and transparently in my writing. Furthermore, in exposing my assumptions for scrutiny in this reflexive way, Cunliffe (2003) proposes research practice becomes much less ritualistic, offering a basis on which to develop more critical appreciation of practice and research.

Auto-ethnography
Stacey and Griffin (2005) identify that most of the points regarding the methodology of research informed by a complex responsive processes perspective have much in common with other qualitative methodologies informed by the perspective of post-modern and social constructionists approaches - including action research, ethno-

methodology and, I propose, the newer field of auto-ethnography.

I referred to auto-ethnography in the context of the consideration of relational ethics earlier in this synopsis. Auto-ethnography is a strategy of inquiry that caught my attention as I read about qualitative methodology in an attempt to locate my emergent methodology. Auto ethnography involves personal narrative in a way that appears, on the face of it, to have much in common with my experience of the research process. I was drawn to Holt's (2003) description of auto-ethnography as a "writing practice which involves highly personalised accounts where authors draw on their own experiences to extend understanding of a particular discipline or culture" (ibid: 2). Given that I am researching my practice as a health service manager, I considered whether my research could be seen as an auto-ethnography focused on management or organisational change. Foster et al., (2006) identify that in auto-ethnography, researchers focus on the use of self as a starting point for data collection and analysis. The experiences of the researcher are presented as narratives of self while remaining concerned with the broader context in which his or her experiences have occurred (Denzin, 1997; Reed-Danahay, 1997; Ellis and Bouchner, 2000). Often written in first-person stance, the writer of an auto-ethnography pays attention to her physical feelings, thoughts and emotions and constructs a self-narrative of lived, embodied experiences. Auto-ethnography recognises how the personal is always social; the private struggles and endeavours of individuals are always linked to social and cultural values and meanings (Denzin, 1997).

These ideas seem very much in line with the approach I am taking in my own research. In each of my projects I start with an account of something that I have experienced in my practice. Coming across the auto-ethnographic work of Mischenko (2005) resonated strongly with my own lived experience as a Health Service Manager. Her empirical data is in the form of a poem, entitled Pressure, Escape and The Return. She uses an auto ethnographic approach to explore concepts of identity, power and self in relation to her poem as narrative. She opens her article:

Well here I am telling you part of my story, totally queering the modernist take

on the role of an academic author to remain outside the text. Here I run through it, my assumptions, emotions, values and conflicting identities intermingle not just in my story but throughout the text: in my choice of theory to interpret my text, in my choice and presentation of my experience and in my wish to challenge the assumption that only ordered and objective prose is worthy output of academic endeavour. I feel I need to share with you my fear, my feelings of anxiety; I am consciously taking a number of risks in this work. I'm putting my story "out there", in the domain of "others", for you to judge and perhaps permanently fix my identity as an overwhelmed and insecure manager. Once a paper is produced and "out there" the resulting prose remains fixed and frozen in time

(Ibid: 204)

I feel this way myself when I submit my narrative to the scrutiny of my learning set and my supervisors. I am sharing my fear, putting my story out. However, I would differ from Mischenko, in my belief that while words may remain the same, meaning is subject to change in any reflexive consideration of her work. Mischenko reflects on the challenges of undertaking auto-ethnography, particularly where it involves exposure and publication of vulnerabilities on the part of the researcher. She identifies that auto-ethnography is a powerful approach to explore how narrative is used to create meaning and constitute identity, I would challenge this perspective. The ethnographic self is essentially a social constructionist concept, where the individual and social are thought of in terms of an "either or choice" as to which is given prominence and primacy over the other. In the auto ethnographic accounts I have read, I would criticise how the authors appear to privilege their individual account in ways that they hope will "act back" on the social, cultural issues of importance to them. In other words, the individual takes precedence over the social compared with complex responsive processes where the individual and social are viewed dialectically so neither the individual nor social takes precedence. I disagree with the underpinning assumptions of an ethnographic approach – that it is possible to step outside social interaction to study "the other". This is at odds with a complex responsive processes perspective. Given that auto-ethnography is proposed to be the study of self, this becomes even more puzzling.

In what follows, I move from matters of research methodology to further

developments in my line of inquiry.

Beginning to work differently

In submitting Project Three, I recall feeling disheartened. It had proven to be a difficult process of writing culminating in a late submission. On reflection, I think I was frustrated with myself. I was acknowledging some small changes in the way I was working with others, yet the key area where I knew we really had to do something "different" was in relation to our performance, as measured by national targets, in relation to emergency care. I struggled to write about my sense of responsibility to explore how I might work more directly with the clinical team in the Emergency Department, yet, at the same time, find a way of describing how personally risky it was feeling to make some first steps.

In the later stages of endeavouring to "conclude" Project Three, I read Elias's (1987) work *Involvement and Detachment*. In tracing the development of knowledge over time, Elias identifies how in conditions of uncertainty and stress, the emotional content of our thinking can overwhelm our ability to adopt a more detached stance that will enable a somewhat broader perspective, with more possibilities for action. This certainly resonates with my experience of working day to day with an intention to improve the quality of care. As I reflected, I began to acknowledge at times I had been so involved in the intensity of trying to move forward that I felt overwhelmed. At other times, I noticed I had been able to contribute more effectively in taking a more detached perspective.

What do I mean by quality improvement?

This has been key question for me. In the mainstream literature, I believe quality is mainly defined as an outcome, achievement of an, often, pre-specified goal. This is a consequence when we think of organisations as systems and that those involved in change management and quality improvement can operate as autonomous individuals who design improvement tools and control improvements according to plans. In this way of thinking, it is taken for granted that it is possible for a powerful individual to step out of the organisational system and treat it as an object for

manipulation and change, following the diagnosis of problem areas and gaps. Yet, at other times, that autonomous individual becomes part of the system and is subject to manipulation and change designed by others. As with much of the literature on change management this approach sets 'thought' before 'action'. In other words, 'thought' is understood as the formulation of a plan and 'action' is the implementation of that plan. Inherent in thinking about quality improvement from this perspective are abstract reviews and monitoring processes calling for further plans for improvement in order to reach targets and teamwork to implement those plans. I have come to realise, in my experience, that this dominant language around change, improvement and targets has resulted in, what I would assert as, the reductionist appropriation of the quality movement in healthcare and the ongoing experience of short-lived improvements at best, despite considerable energy being dedicated to planning processes.

What, then, am I arguing for in terms of what quality is; how do I understand how quality comes about; how do I think quality might be improved; in what ways does this differ from mainstream debates about quality improvement; and, finally, what might be the implications in my argument for others intending to improve services for patients?

In taking a complex responsive processes approach to making sense of my work, I have been influenced by a view of *intention as a dynamic* concept, emerging out of interaction and underpinned by the concept of human beings as interdependent (Elias, 1939). Elias identifies that although we each have our own individual intentions, as we interact it is not possible to predict the outcomes that emerge from this social intertwining. Furthermore, in the intertwining of many intentions, there is constantly present power relating, and as our interactions go on these power balances shift. Inquiring into my practice from this perspective has led to me to a rather different understanding of quality and improvement than that taken up in much of the mainstream health improvement literature. For me, quality improvement is more usefully considered in terms of the constantly iterated intertwining of intentions reflecting shifting patterns of power relations. This builds on the

perspective emerging from Project Two, where I come to understand 'quality improvement' as a cult value (Mead, 1923) which is functionalised in daily life. Mead's emphasis on the need to stay with the immediate and understand what is happening, in patterns of power relation and conversational themes, has become a central consideration for me in my daily practice as a health service manager.

In Project Four I endeavour to understand how my practice might be changing as I engage seriously with the consequences of thinking about improvement in social process terms. In the process of Project Four I became increasingly aware of the importance I give to my contribution and intentions and how others respond to these in the ongoing pattern of our daily working. It is my contention, emerging from my experiences in Project Four, that it is in paying attention to these interactions, that we begin to notice the importance of the quality of participation and the ways in which this is, often unconsciously, influenced by ideology and, the associated binary opposition (Dalal, 1998). A binary opposition is a pair of, supposedly, theoretical opposites and a key feature of all ideologies. Roland Barthes (1988) drew attention to the way in which we understand certain words as depending not so much on any meaning the words contain, but much more on our understanding of the difference between the word and its opposite - the binary opposite. One side of the binary pair is always taken to be more valued over the other. Power balance, then, is inherent in all binary oppositions. I have become particularly interested in the binary opposition best characterised by "us and them", and how this plays out in relating between managers and doctors. Thinking about quality improvement, in this sense, moves from concern with diagnosing problems, selecting the right tool, and abstract ideas of various system levels, to what is happening in the thematic patterning of our interaction from which choices, and responses to these choices, then emerge. For Stacey (2003a):

> Organising themes of an ideological nature are fundamental to human relating because it is these themes that make current power relations feel natural, so justifying them. Of great importance are the official ideological themes that determine what it is legitimate to talk about in the organisation.
>
> (Ibid: 363)

In Project Four, I reflect on the impact of the ideology of managerialism. Dominant ideologies influence what is taken to be normative. So in the mainstream literature, ideologies of managerialism and efficiency have led to a focus on quantification and measurement in the construction of what is taken to be quality. It is my argument that, as managers, we cannot stand outside a "thing" called an organisation and choose a tool or a target that will "install" quality into the service that people experience. Instead we are active participants in the processes of organising, characterised by communicative action. It is the quality of our interaction at a local level that determines the way we move forward together. This is a self-organising process and not something that as a manager I can direct or control beyond my own participation. What becomes important in my participation is how I am working with others to make sense of the thematic patterns emerging in that interaction; patterns of power relating influenced by both official and shadow ideologies, patterns of inclusion and exclusion, who gossips about whom and the nature of that gossip as either praising or blaming and how these, in turn, enable or constrain the quality of our participation together and opportunities to reflect on how we might proceed.

In the official ideology of managerialism, the power balance is taken to tilt in favour of managers, yet in my experience I often notice greater cohesion within the medical consultant groupings in my hospital. In Project Four, I draw attention to the ease with which the clinical directors I work with appeared to have been able to disassociate themselves from any obvious sense of responsibility to participate in generating possibilities for change in the activities of performance in meeting national targets for emergency care.

In Project Four, I work with Sarra's (2005b) argument, that gossip is central in sustaining existing power relations and it is only by entering into these ways of talking that the possibility of change arises.

Reflecting on this through Project Four, I found it helpful to pay attention to ways of

talking about leadership in the A&E department, within the executive team and the "organisational story" of the department as difficult to manage and metaphorically a poisoned chalice as characterising processes of gossiping in my daily experience.

Stacey (2003a) notes the way in which definitions of "quality" in relation to management action are understood differently. In conventional systemic perspectives, a quality action would be taken to be one that produces the desired outcome. I argue, from a complex processes perspective, outcomes cannot be known in advance. Stacey (2003a) offers a thought-provoking account of what we might then take to be quality in relation to this way of thinking about management action:

> ...in an unpredictable world, the outcomes of an action cannot be known in advance. It is necessary to act and then deal with the consequences. This does not make action impossible or futile. It simply means people select actions on the basis of other criteria for quality...a quality action is one that keeps options open for as long as possible. A quality action is one which creates a position from which further actions are possible. That is why doing nothing is such a poor response to uncertainty...another criterion for a quality action is that it should enable errors to be detected faster that other options. Finally the most important criteria for quality actions are moral and ethical in nature. An action may be taken without the actor's knowing its outcome simply because the action is judged to be good in itself. One is not absolved of responsibility simply because one does not know the outcome. Even though I do not know how my action will turn out, I am still responsible and will have to deal with outcome as best I can.
>
> (Ibid: 420-421)

In sharing my experience of working with national targets in a socially dynamic way, I exemplify what is emerging as I have increasingly paid more attention to the quality of my experience of relating and managing in relationship with others. In writing my thesis, I am taking up Stacey's (2006) question as to how central government governance requirements are being operationalised and sharing my narrative experience, as I set out in each of the four projects that follow, of some of the consequences. I hope that this resonates with other health services managers and encourages them to explore what happens in their day to day experiences as they reflect on the quality of their participation in the day to day interactions that constitute health service quality.

PROJECT ONE: KEY INFLUENCES ON MY PRACTICE

Introduction

Project One is a reflective narrative that identifies some of the major influences and experiences that informed my practice at the outset of my research some three years ago. As I reflect on this account I am struck by the language I use. I talk of "levers for change" and a "theory-practice gap". I notice my faltering steps at recognising that my experience to date had been significantly shaped by systems theories, and yet struggling to make sense of my experience in any other way. This narrative was written during my time at a Strategic Health Authority in the United Kingdom National Health Services (NHS).

Setting the scene

As Director of Education and Workforce Development in a Strategic Health Authority in the National Health Service (NHS), the focus of my work centres around a portfolio of activity aimed at recruiting and retaining staff in sufficient numbers, with the appropriate skills, to deliver health care for the people living within the geographical area of the health authority. This involves decisions around priorities for investment, including educational contracts with our local universities for both undergraduate and post graduate education and training, regeneration schemes with local communities that will bring local people into careers in the NHS, and supporting NHS employers to implement government policy and monitoring the associated performance management agenda.

My day to day working relationships are both internal and external. Within the Strategic Health Authority, a process of integration of the workforce directorate (my team) with the service transformation and performance management directorates is underway. In endeavouring to align our levers for change, I am keen to ensure that the workforce agenda remains visible and relevant. This will be an area for focus in my future project work. The main external relationships are with university health

deans and directors of the 14 NHS Trusts, and as a member on a number of national groups, endeavouring to influence the direction of policy development at the Department of Health.

I have experienced the last four years as an important transition period, in moving out from my primary discipline of nursing. By primary discipline, I mean the profession I joined as an undergraduate student in 1982, directly from leaving high school. This includes the nursing roles I have held and the experiences of my work in those roles during the time up to September 2000, and it includes my continuing professional and academic education to master's level in nursing. I have been aware of my desire and need to supplement my experiential learning during this transition with a more rigorous approach to identifying some sort of underpinning knowledge base. I have previously described this as a desire to build on my current underpinning knowledge of facilitating change in organisations to ensure a better balance of "know what" and "know how".

Overview

Project one has stimulated me to revisit and refresh the theoretical perspectives that have influenced both the way I have experienced and practiced in nursing, some key changes I have been involved in, and how this is beginning to shape questions I would like to explore further through this programme of study.

In thinking about how to structure this paper, I have taken a broadly chronological approach, but am also aware that it is difficult to "un-know" what I now know, and that some of the perspectives are not as chronologically neat as may be suggested in this structuring.

I start with brief reflections on my early experience of learning to be a nurse and chart my recollections of key influences in building insights into nursing theories and ways of thinking about nursing knowledge. I touch on my attempts to articulate the importance of the nursing contribution to patient care, and challenges to changing patient care and experiences of implementing these changes from different

positions and roles I have held.

I then incorporate more recent personal experiences in the major change programme of modernisation that has been building momentum since its launch as part of the Labour government manifesto pledges in 1997.

I conclude with thoughts about next steps.

Early experience of learning to be a nurse

A vivid memory of my undergraduate training comes to mind when I think about key influences. It relates to my earliest clinical placement experiences. It sticks with me as it raised serious doubts for me about what nursing was really "about".

The memory is of a clinical placement on a ward for elderly women with long standing psychiatric illness. Many of the women had been in this hospital for several years. Some of the nursing practices I observed and was asked to participate in caused considerable personal distress, both at the time and after, as I tried to make sense of what was happening. Continence was a key problem. A regimen of two-hourly, routinised toileting of all patients had been implemented. Little privacy and dignity was afforded those patients not mobile enough to be part of the "trek", on mass, to the toilet. Several of the patients were wheel chair dependent and it was not unusual for them to be put directly on to commodes in the day room setting, in view of others, to be wheeled into the dormitories. On one occasion I was allocated the task of toileting this group of patients after a meal time. I took each patient back to their bedside and, once there, transferred her to a commode behind the curtains surrounding the bed space. On this occasion, there were about six patients involved. I was asked to take my own meal break, once I had transferred all the patients to the commodes. On my return to the ward, I was surprised to see that other nurses had moved the patients to only two curtained off areas, such that they where positioned around two beds, facing inwards to each other, each side of the bed. It was one of several occasions during my undergraduate programme when I questioned what nursing was really about, and the need to challenge poor practice in ways that would

result in change for improvement.

That sort of experience, I was to discover later, was not unique. In exploring the underpinning theories being set out by nursing writers, I discovered both nursing and sociological literature, addressing the process of "socialisation" of students into health care professions. The term socialisation used in this way referred to the process of internalising the norms, beliefs and values of the professional culture to which the students wish admission. In the case of socialisation into nursing, studies have highlighted a disparity between the values espoused by the educational establishment and those expected in the clinical areas, often referred to as the 'theory-practice gap'. This theory-practice gap has a long history. Kramer (1974), in the United States of America, described the 'reality shock' experienced by graduate nurses as they moved from the educational environment to hospital wards and discovered conflicting values. Wilson and Startup's (1991) study of British student nurses notes that they "experienced a dichotomy between the values of the school and those on the ward, and had some anxieties in dealing with the conflicting expectations of conformity" (ibid: 1480).

The theory- practice gap
It was to be a little while later once I was practicing as a qualified nurse that I would begin to have more insight into why such practices were taking place.

The theory-practice gap was being located in the difference between what was being taught and what was being practiced. I am not entirely sure that this is an adequate account. Nursing education in the UK has undergone a series of changes since I started in the early 1980s. Conventionally, at that time, most student nurse training was taking place through hospital schools of nursing where the model was one of apprentice-style preparation, with its emphasis on practical performance rather than academic content. The undergraduate course I was following, leading to both professional registration and a BSc university award, was still relatively uncommon and had arisen from a growing awareness, on the part of some influential nurses, of the need for future nurse leaders and thinkers to experience preparation no less

academic than that enjoyed by others (Owen, 1998). It was envisaged that developing undergraduate nursing programmes would result in an improved knowledge base, extra insight, more advanced training, broader experience and a greater understanding of research (Reid et al., 1987).

The nature of the knowledge base for nurse education is worth considering. Since the beginning of the last century nursing has been firmly linked to medicine and largely based in institutions. Historically, the role of nurse as helper to the doctor is an enduring one. The massive expansion of hospitals from the 1920s and the growth in medical technologies demanded a development of workers subservient to doctors, who could apply and monitor this technology – the "eyes" and "ears" of the doctor. The focus of nursing became that of medicine – to cure.

The routine work – subordinate to the work of doctors – needed to be organised and supervised (Beyers and Phillips, 1971). The general trends in organisational theory advanced by the proponents of the classical management school filtered into nursing, and facets of "scientific management" were adopted – the organisation was viewed as a machine demanding that everything be run in an orderly fashion and highly structured.

The programme I followed was heavily based on biomedical science, with a strong emphasis on patho-physiology. We did study some sociology and social psychology – in particular, the work of Talcott Parsons (1975) and his exposition of the "sick role" as a set of behavioural expectations for an individual who is ill. Parson's postulated that the "sick role" legitimated exemption from "normal" social roles on the basis of medical diagnosis, pointing to the social control function and gate-keeping power ascribed to medicine. Goffman's (1968) seminal work on institutionalisation was another key influence within the undergraduate curriculum that I recall. There was an encouragement to take a whole-person view within nursing practice and I recall lecturers making the distinction that nursing was more holistic than the biomedical model. It was not until I began studying at Master's level that the a better understanding of what that meant in relation to ways of

thinking about nursing and its theories and practice became more explicit.

Goffman's perspective helped me to understand some of what I had experienced in the psychiatic ward story above. In Goffman's account of institutionalisation, powers are ascribed to the hospital, where staff are subject to (and must learn) various formal and informal rules and regulations; thus staff behaviour is shaped by the institution. In critique, some writers suggest that it would be misleading to suggest that hospitals, as institutions, possess a unitary culture. For them, the hospital is portrayed as a series of separate work locales, each with their distinctive cultures and working practices (Soares, 1978; Strauss et al., 1985). Nevertheless, they concur with Goffman's assertion that the consequence becomes practice by routine, organised around the requirements to keep the organisation functioning smoothly, as opposed to the needs of individual patients.

Goffman's proposition now seems less adequate since I have been introduced to the perspective of Stacey, Griffin and Shaw (2000). Stacey and Griffin (2005) critique the wholesale application of systems thinking to organisations. A key facet of their challenge lies in observation that human agents, unlike other natural world agents, "are conscious, self conscious, reflexive, often spontaneous and capable of making choices". Drawing heavily on the concepts of self organisation and emergence as set out in the sociology of Mead's theory of mind self and society (Mead, 1934), Dewey's theory of value (Dewey, 1934) and Elias's theory of power figurations, ideology and identity formation (Elias, 1939), Stacey et al propose an alternate perspective, namely complex responsive processes of human relating (Stacey et al., 2000). From this perspective, organisations are seen as patterns of interaction between people, where the interaction is communication. By extension, "it is only when people in an organisation talk differently to each other that their organisation will change. Facilitation of change is facilitation of different forms of conversation" (Stacey, 2003a: 350). I now find myself puzzling over what sense those staff working in this way were making of what they were doing, what opportunities and sorts of ongoing conversations were taking place, and the political processes which "legitimated" practice in this way.

The favouring of medical knowledge, and it emphasis on cure and, by default, care as a lower order activity, offered me further insight into what might have been happening to practice on the ward with those elderly women. Miller and Gwynne (1972) postulated a "warehouse" model - a hospital model imposed on those whose needs cannot be appropriately met by applying the medical model. Essentially, this involves "people processing" where cure is reinterpreted to mean the postponement of death.

I will return to my experience of the changing nature of nursing knowledge later in the paper.

New ways of practising and understanding
On qualifying, I went to work in a supra-regional, tertiary hospital. This was to provide me with the opportunity to be involved in a very different environment. I began to see first hand what was meant by practising nursing in a more holistic way, with a much greater emphasis on closer and sustained nurse-patient relationships. I began to become aware of a growing volume of literature critical of nursing historical subordination within the traditions of medical science, and advocating this new approach which resonated closely with my desire to work differently with patients and the ward team I was part of. There was a good sense of team amongst the nurses and doctors on the ward. There was a sense of pride in the work we were doing. Patients were referred to us for specialist treatment and care. The hospital was, as I was to later discover, comparatively very well staffed and equipped, with a high complement of qualified staff. On reflection, I am grateful that I started my qualified nursing career in such a setting, and over the years have come to appreciate more the power of experiencing this way of working as a point of reference and barometer for future experiences.

The new approach I am referring to here, referred to in the literature as the "New Nursing" pathway, emerged in the 1980s. "New Nursing" encompasses a holistic approach to caring. Its advocates argued that the traditional relationship between dominant expert and passive patient should be replaced by a far more egalitarian

form of interaction, promoting active participation by patients in their care (Porter, 1994).

In common with my position, many patients and other nurses also wanted a different sort of model of care that did not neglect care in favour of cure. There was a growing literature around the continued dissatisfaction of patients with the quality of care they were receiving, particularly the quality of the nurse-patient relationship. Annual published reports from the Health Service Ombudsman identified the common themes – failures in communication, uncaring attitudes, inattention to needs (including hygiene).

I was also not alone in being unhappy with some of what I had experienced during my training. Attrition from nursing was high, and several reviews identified nurses expressing dissatisfaction with a sense of powerlessness at being unable to practice nursing in the manner in which they felt they should (Dean, 1988).

Menzies (1960), taking a psycho-analytical perspective, explored nursing work. Her study was commissioned at a time when recruitment into nursing was causing concern, as was the high drop out rates of students. She suggested that, in part, the organisation of care in the conventional reductionist approach of allocating tasks was one way in which anxiety was being managed. Nursing work exposes both the nurse and patient to bodily functions and emotions not usually encountered in anything other than the most intimate relationships. She postulated that nursing was organised in this way to deliberately avoid personal interaction taking place with patients and that this was designed to avoid anxiety engendered by intimacy of the relationship. It is ironic – or perhaps paradoxical, that a system thought to be designed to prevent anxiety, was in turn provoking anxiety and frustration for both nurses and patients.

I return again to the area of nursing knowledge.

Several writers identify the need to look at the nature of nursing knowledge from an historical perspective. The work of Carper (1978) is frequently referenced in this

context. Carper identifies four patterns of knowledge. Firstly empirics, which is linked to the science of nursing; secondly aesthetics, which is linked to the art of nursing; thirdly, personal knowledge; and finally moral knowledge, which has its links within ethical decision making. Carper's position is that knowing within all experience can be framed within these discrete yet interdependent ways of knowing. Her work is widely acclaimed as a useful way to help nurses make sense of their practice worlds and to perceive the dimensions of their personal knowledge (Chinn and Kramer, 1991; Vaughan, 1992).

Within nursing, it is suggested that all these domains of knowledge are used, but, historically, some have more credence and value than others. Cull-Wilby and Pepin (1987) dissect the contribution that Florence Nightingale made to nursing knowledge. Florence Nightingale advocated that nursing had its own knowledge base, but she has been criticised for supporting a rapid development of a knowledge base for nursing that bore its roots amongst, what Carper (1978) coins, "the logical empiricists".

The language of logical empiricism is woven in terms such as measurement, tests, scientific hypotheses and control. Benner and Wrubel (1989) identify that the majority of nursing theories have adopted this dominant discourse of classical science. Believing that it is possible to take up positions as objective, detached observers, subscribers to this approach seek to build up portfolios of objectively determined and replicable, generalisable findings that can be used to predetermine theories about relations between events and processes, or generate theories which can then be objectively tested to map and predict what "really" exists and happens, all of this is bound up, as previously described, with medical dominance of health care and associated subordination of nursing (Friedson, 1984).

Webb (1992) writes that nursing has had a relatively short history in terms of its emergence as a scientific discipline. In an attempt to project nursing as a legitimate scientific discipline, there has been a tendency to conform to prevailing views. Doering (1992) proposes that the value ascribed to scientific knowledge in both

nursing and medicine reflects the power relationship between the two disciplines. Logical empiricism, because it is an essential part of biomedicine, has become greatly valued by nursing. In favouring the logical empiricist approach, the danger of dehumanising the process of nursing arises. Patient care gets broken down into a series of specific tasks, which are hierarchically distributed amongst the staff on duty. The patient has a passive role, with objective, expert knowledge firmly located with practitioners.

Struggling to articulate the theoretical basis coherently

Through my own experience beyond registration, I developed a passion to articulate and practice nursing beyond the boundaries of the medical model. But I have struggled, and continue to struggle with, theoretical expositions. In returning to this literature to write Project One, I alighted with eagerness on a couple of observations. McFarlane (1976) commented on the "utter semantic confusion" in theorising in nursing. Dickoff and James (1968), in a similar vein, proposed that "..nursing grasps at concrete, structural security too soon…like the world of the infant, the world of theory in nursing seems a blooming, buzzing confusion.." (ibid: 205).

This quote gives me comfort and concern at the same time. Comfort that others have found nursing theoretical expositions confusing, but concern at the same time that I see myself in the first part of the quote. I find it frustrating to not be able to immediately grasp meaning – either in written or verbal (or non-verbal) form – I do find it challenging and anxiety provoking until I work my way through it, or abandon the search for meaning and discount that "particular need to know".

I move now to ways of thinking that resonate in a more meaningful way with me. In the early 1990s while working as a ward sister on a general medical ward, I entered a part-time master's programme in nursing. I recall a meeting with the course leader early on in the first year, where I expressed doubts about my ability to do the course – I was struggling with the new vocabulary of "concepts", "paradigms", "epistemology"!!! Of course, he told me you just have to get to grips with it. I am glad I stuck with it. The experience of doing my dissertation led me to think

differently about my work and greater confidence in talking with others about nursing work.

Finding a perspective

My master's dissertation started from the perspective that biomedical research, derived from positivist science, had resulted in a predominant focus on disease, rather than on the person experiencing the disease. In other words, the scientist (for example, the health professional) 'knows' or has knowledge. In contrast, patients' 'subjective' experiences are seen neither as valid, nor as being valuable research resources. Biomedical research results in an undervaluing of the emotional, social and cultural aspects of illness.

Despite my lamenting my reading of nursing theories, on the whole they are united in emphasising the importance of viewing the patient as a whole person with emotional as well as physical needs (Munhall, 1981; Oiler, 1982; Tinkle and Beaton, 1983; Fawcett, 1984). Watson (1985) proposes that nursing knowledge must acknowledge, value and focus on personal experience. This in turn, she suggests, will facilitate an understanding of human responses to illness.

I had become very interested in the writing of Oakley (1990), Roberts (1980), and Westwood (1984) whose approach to research sought to transform what they described as the "patriarchal" approach to research which places the "researched" as data to be studied and the researcher as a detached observer. In the patriarchal approach stories of every day life are of anecdotal value only. However, within the alternative feminist perspective set out by these writers, self-reported experiences are valued as research resources.

The principle of reflexivity was one I endeavoured to adopt, which I believe is now a key part of that way I work. Reflexivity, linked with hermeneutics, in this sense, is the acknowledgement that the horizons and prejudices that each researcher brings to their study are influential on the research process and require reflection. In other words, these are the historically and culturally produced understandings that

influence interpretation and, consequently, constitute understanding. Horizons comprise pre-understanding or prejudices that enable us to make sense of events and people. Researchers cannot "eliminate" their experience, which is inextricably linked to interpretation.

In the same vein, readers are interpreters and will participate in the process of interpretation by bringing their own horizons to the work. The themes that emerge might through this process be different for each reader, and indeed differ from that of the researcher's interpretation. However, by taking an explicit reflexive approach setting out the nitty, gritty process of interpretation and the researcher's influences, it should be possible for readers to follow the pathway that leads to the interpretation give.

Coming across action learning

I think another major influence for me was being introduced to the concept of action learning. This came about when I was asked to take the lead in developing a career development programme during my time as assistant director of nursing in an acute hospitals NHS Trust. I recall going to my boss on several of our regular one to ones. She asked me on each occasion whether I had come up with a plan – which I hadn't. She suggested I visit the King's Fund College to find out more about some work they were doing, using action learning. At the time, I had heard of the approach, but had not experienced it.

At the Kings Fund I made contact with a woman called Jane Neubauer. She agreed to work on a consultancy basis with me to co-design the career development programme, and that we would use action learning as the vehicle. Jane had written an article she suggested I read, titled "Thriving in chaos" (Neubauer, 1995). The article was fascinating, it seemed to resonate with much that I had experienced. She used the Chinese symbols for change, opportunity and hidden danger, as the backdrop to the article – making the salient point that for most of us that is indeed what change means. It was in this article that I first came across reference to chaos theory, albeit very superficially to make the point that we can no longer – if indeed it

was ever – rely on predictable, rule governed behaviour to survive – either as individuals or organisations. We no longer operate in a time where jobs are for life. The era of relatively predictable futures, linear development, rationality, formality, tight hierarchies and specialisation is in decline (McGill and Beaty, 1995). Rather we need to develop ways of thriving at the edge of chaos, where change is accepted as a constant and that we can exercise choice in how we respond.

We used Jane's article to as a way of getting people to come along and find out a bit more about what we were offering. The awareness sessions proved popular and we got our first cohort of twelve nurses at various levels in the organisation signed up for the programme. I was one of the 12, in addition to being trained by Jane to take over the lead facilitator role after the first programme completed.

I, in turn, trained other facilitators for future programmes. The programme continued to run after I left the organisation. I still use the article for summer school workshops and it is consistently well received. There's clearly content that resonates with people, and those who followed the 12 month action learning set – on the whole – evaluated it very positively and described the profound impact that the process had for some of them, in dealing more effectively with their working relationships, and sometimes family life. During the first cohort, one senior manager came to the decision she no longer wanted to work as a nurse, and after some time of feeling angry and frustrated described the relief of making that decision.

I am curious as to what, if any, might be the connections I can make from this experience to the methods of the large group and other approaches emerging in the Hertfordshire programme.

The untold story (as yet)
A difficult time for me that continues to have an affect on the way I practice, both enabling and constraining, is my experience as Director of Nursing for a newly merged NHS Healthcare Trust. It was enabling in the sense that I feel I learned much about the importance of shared understanding, honesty in relation to intention, being

authentic, and keeping people engaged in moving forward through changes. It was constraining in the sense that I feel I have become much more cautious in some areas of my practice, connected to confidence in myself and my initial interactions with others. It is difficult to know whether this has always been the case, and it is fundamentally that I am now more self aware.

I was delighted to get this job. I felt that my experience up to this time prepared me well for professional leadership of the nurses and patient care. The new Board was established in April 1998 and I joined in September of that year. The driver for merger of the two former Trusts was driven by the need to integrate single handed, low volume and high risk departments in one hospital rather than across two. The main aims behind this were to increase patient safety, tackle a growing financial deficit, improve the quality of medical training posts by consolidating training experience in larger patient cohorts and the improve the ability to ensure high quality care. Developing the proposal for reconfiguring services to achieve this was a key task as I came into post.

In pursuing this task, a number of processes were established. A citizen's panel was recruited from local people. Options for the key services, including accident and emergence, maternity services, critical care and general surgery, were developed involving co-opted clinicians and managers, each with a director sponsor. The emerging options were presented to the citizen's panel, with an opportunity for them to call "witnesses". A weighted scoring system for option appraisal was designed and the preferred option for public consultation was arrived at. Reflecting now, our approach was heavily steeped in the dominant discourse of systems thinking. As I reflect on this process, I see the participant observer approach that Stacey sets out (Stacey, 2003). Stacey critiques the notion that as managers we can some how out stand outside our organisation, diagnose the problems and then pick the most effective intervention, which, when implemented, results in the planned change.

What was less apparent, in hindsight, was any attention to who "conversations" were happening with. A great deal of energy went into external briefing, endeavouring to

work through local media to raise awareness in the public. Briefing does not feel like conversation in the way Patricia Shaw describes her approach to organisation change (Shaw, 2002). For Shaw, it is important to pay attention to the often messy interactive processes of conversation. She calls for developing increasing appreciation of the craft of participation as self-organising sense making. The operational management team were involved in identifying the preferred option, much of that took place in structured meeting format, with one more open session, of preparing for launching the consultation. I recall we used external facilitators and concentrated on how best to "sell the messages".

During this time, of course, the core business of healthcare, treatment and care of patients, continued – the drivers for the merger were real. We had key staffing shortages, a financial deficit, crumbling estate in some parts, and outdated information systems. Star-ratings had not yet been introduced, but there were key targets for financial balance and access to emergency care and in-patient treatment.

Much of the summer of 1999 was taken up with 9 large group public consultation events. It was also the case that the preferred option did not have full support of some key opinion leaders amongst the staff. Our preparation, I believe in hindsight, was focused on external communication and, I now think, insufficient consideration of the conversation taking place with staff.

During autumn of 1999, the nature of our conversations with previously supportive health authority colleagues began to change. Concern was mounting around the need for financial recovery, patient waiting times and cancellations were growing. As a Board, we continued to talk about the importance of the clinical reconfigurations as the key to unlocking these issues, at the same time pushing service managers to make impact key over-spending areas.

In preparing for Project One, I looked at some literature associated with organisation turn-around and failure. It is heavily rooted in systems theory. It is an area that both the Department of Health and the NHS have recently become more involved in.

Recent publications have reviewed literature from the private sector and distilled lessons from working with zero starred NHS Trusts, and generated lists of reasons, responses, and typical approaches to tackling failure (James, 2002; Department of Health, 2004; Bevington, 2004, Walshe and Shortell, 2004). Organisational assessment is seen to be crucial, and one of these publications sets out the starting point for the qualitative aspects of such a process, in the form of five questions:

- To what extent is the leadership of this organisation confident and trusted, in itself and by others?
- To what extent is this organisation (or part of an organisation) connected, internally and externally? What are the number, depth and density of those connections?
- How is power distributed and used in this organisation?
- How many voices are heard in this organisation, and how many people (and who) have a sense of being "in the know"?
- To what extent are there common, shared and observed systems for core business processes? Is the performance of these systems monitored through good information, and is corrective action taken?

(Department of Health, 2004 : 54-5)

The reference to connections, the use of power, and who is being "heard" are areas I intend to explore further in the context of my current practice. Furthermore, I am becoming aware that I have more to do in understanding systems theory in order that I can expose and critique more effectively some of the underlying taken for granted assumptions within this sort of literature.

Towards the end of 1999, I enjoyed working less and less. This was something I had been fortunate enough not to have experienced before and would very much like to avoid happening again. Our chief executive was asked to leave the Trust, which I felt was unfair and made this known to the whole board. A new chief executive (CEO) was drafted in. I was open with him about my feelings and my view that, as one on the board members, I accepted shared responsibility for the situation we were in and offered my resignation. I recall, he said something along the lines of he did not think that would be good for the organisation at that time.

I continued in his team, but I think on reflection, I had already made a decision to go. The working relationships became more strained and I eventually confronted the new CEO on whether he had confidence in what I was trying to do. A difficult conversation ensued, where he set out what he wanted from a director of nursing, and I felt offended – at the time I felt it to be a direct attack on my professional integrity. Once the initial anger passed and with the wise counsel of my close friends and mentor, I resolved to leave on my own terms as soon as possible.

Joining the modernisation movement

My mentor was looking for some one to do some project work on a national work programme and asked if I would be interested. The project was with the NHS Modernisation Agency. The government had just published its national 10 year strategy for investment and improvement for the National Health Service. The NHS Plan followed an extensive consultation with public, patients and staff working in the NHS. It set out an ambitious agenda for increasing investment to bring English health service funding up to the level of the best in Europe, and committed to improve the quality of care by modernising services. A series of key targets were set out in the Plan against which progress toward achieving this goal could be monitored.

For the Plan to deliver success, it was acknowledged that for many working in the NHS this would require a fundamental change in thinking, practice and delivery of health care over the next decade. Lessons from how change had previously been introduced in the NHS were being reflected on at Department of Health level, with a growing recognition that previously much had been set out regarding the "what", i.e. what needed to change. Much less attention was given to the "how", i.e. what approaches and support might be effective in introducing and embedding the changes being set out. The NHS Modernisation Agency was established as an arms length body of the Department of Health (DH) to support the "how to" aspects of implementing the NHS Plan. Key to the work of the agency was a remit to identify tried and tested approaches to change management from both within the NHS and from other public and private organisations, nationally and internationally. The aim

was to help those working in the NHS make use of these tried and tested approaches in moving forward with the modernisation of health services. Indeed, in 1999 the DH Research and Development branch carried out a national listening exercise which brought together users health service staff. Participants were asked: What are the most important issues for those delivering and organising services and for those making use of those services? Why is there so often a gap between research evidence and implementation at policy and local levels? What can be done to help promote research as a lever for change in the NHS? One area of common concern was the implementation and management of change (Fullop and Allen, 2000)

Iles and Sutherland (2001) observed that many people in the NHS, however, are not familiar with the thinking about management of change which has come out of schools of management, psychology, sociology, and economics, over the last fifty years. Many who are aware of some of the concepts may not appreciate the contexts in which they were developed, nor possible applications in the process of managing change. As a consequence, important insights and guidance which the literature offers may not be being used to maximum effect. This observation resonates with my own experience, and the two years of working with the agency was a stimulating exposure to some further change management theories and, importantly, applying these in practice with clinical teams and professional associations involved in the improving access programme.

In thinking about the underpinning theory that guided the work of the agency, it now strikes me that we were working firmly within a systems approach. Although reference was made to transformation and complexity science, this was in the context of taking an approach to "whole-system" change.

In drawing this paper to a close, I am presented with opportunities to think anew about themes running through my narrative. In particular, I have been exploring literature dealing with the concept of 'holistic' practice, described by Lawler (1991) as an "ideological corner stone in nursing" (ibid: 24). The origins of holism have been accredited to the political and philosophical work of the Jan Smuts (1926). He

posited the existence of evolutionary wholes, observable in the process of history, not only within the natural world in the case of plants and chemical compounds for example, but also applied the notion that the whole is greater than the sum of its parts to humans, and by extension, society. Tracing subsequent adoption by nursing theorists in the 1970s and 1980s has exposed just how inconsistently the concept and underpinning philosophy have been dealt with by both nursing and medical literature. Owen and Holmes (1993) in their review summarise my current understanding of the term well:

> Holism is a turbid, amorphic term…the meaning of which alters according to the context in which it is located. Coming to grips with holism has been likened to trying to hold ice, because it disappears in the attempt..the distinctive features of holism have melted away in the hands of nursing

> (Ibid: 1688)

There is more I need to tease out from this literature that is linked within the systems theory perspective in order that I may arrive at a clearer understanding of the consequences of this ideology and cogently argue my position. I will need to consider this further in the context of Project Two.

I am also struck by questions of the extent to which my experience of feminist, reflexive methodology will contribute to my emerging research methodology and the important contribution of narrative in developing an alternative research base to organisational change. Again, I see this as a key thread to take forward into Project Two.

Next steps
My own work is changing. My boss has taken a secondment, which means I am now acting into her role, becoming an executive member of the SHA Board and heading up the workforce directorate. The changes at work although daunting, have added to the sense excitement I am now experiencing as I begin to enter a new field of reading and thinking about practice.

In moving forward to Project Two, I have a series of initial questions that I want to pursue. These include:

- What is my contribution to the "discourse of organisational change"?
- How do I engage in a way that helps with the movement of everyday work in our team, building on the successes that we have achieved to date and in the context of an agenda pushing for greater integration?
- How might I attend to and participate in the every-day conversations to more powerfully influence the way we work in the team, including our work with our key stakeholders, people in the trusts and the universities?
- How do I develop a way of working that can effectively challenge the current emphasis on "whole system" change in the NHS, in the context of trying to improve care for people living with long term illness?

PROJECT TWO: COMING TO UNDERSTAND IMPROVEMENT IN THE NHS AS A CULT VALUE

Introduction

This narrative focuses on how I was making sense of my work in trying to bring about improvement in healthcare services for people living with chronic diseases. I start with the background to my involvement in this work and the approach I have been pursuing. I draw attention to the strong influence that contemporary systemic thinking in health service improvement, as set out in mainstream literature, has had on my practice. I discuss how thinking about health care services in this way focuses on rational planning for intended results, and subsequent performance management to this end. I identify that in my practice, a consequence of thinking in this way has been to spend considerable effort on searching for the right improvement "tool" depending on the nature of the change being sought, and a belief that if the "tool" was only used in the right way, then improvement would result and would be reflected in the achievement of the agreed/selected performance measures.

I explore key questions I had begun to consider in relation to my practice as I engaged in conversation and reading about complex responsive processes theory. I describe how uncomfortable I felt as I was challenged to articulate more precisely what I thought I was doing in my day to day work. I draw on Mead's(1923) work on cult values and the sense of compulsion associated with these, and on Elias' (1939) figurational sociology highlighting interdependency and power relating. These writers have provided some insight regarding my experience of this process as challenging.

Setting the scene

In this narrative, I recognise that my way of thinking is "in movement", as I am confronted with questions about how I work with others to improve services in opportunities that arise moment by moment, where systemic ways of thinking dominate. I notice how this initial interest in working with others to achieve

improvement has made me think more carefully about the issues of performance management that I face day to day as an NHS manager. I conclude by acknowledging that in coming to understand improvement in the NHS as a cult value, I am now interested in whether there are ways of functionalising that get beyond simply negating performance management and the experience of targets as deceitful and anxiety provoking for many working in the NHS. I hope that my inquiry along these lines will resonate with public service managers who find themselves similarly grappling with issues of improvement and performance management.

Becoming involved in service improvement for people living with chronic disease
In my current job I have, as part of my portfolio, a lead role in developing a strategy for facilitating improvement in chronic disease management across the 14 National Health Service (NHS) Trusts within our sector. Chronic diseases are defined as those where there is no possibility of cure, and include conditions such as diabetes, asthma, chronic obstructive pulmonary disease and congestive heart failure. There is no doubt of the importance of facilitating change in the care of people with chronic conditions. The World Health Organisation has identified that such conditions will be the leading cause of disability by 2020 and, if not successfully managed, will become an even more expensive problem faced by individual sufferers and society (WHO, 2002; Dixon et al., 2004). By way of illustration, a recent Department of Health report highlighted that in the UK, in terms of prevalence, 17.5 million people are living with chronic disease; around 6 in 10 adults in the household population report some form of chronic health problem; up to three-quarters of those over 75 years have a chronic condition and this proportion is rising; and 45% of those with chronic disease suffer from more than one condition. In terms of resource utilisation, the report identified that in the UK, around 80% of General Practitioner consultations relate to chronic disease; patients with chronic disease use over 60% of hospital bed days; two thirds of patients admitted as medical emergencies have exacerbation of chronic disease; for patients with more than one condition costs are six times higher than those with one only; people with more than one condition

make much higher use of health care; and 15% of people with three or more problems account for almost 30% of inpatient days (Department of Health, 2004).

The report, however, emphasised that improvements can and have been made, referring to some noteworthy programmes that have delivered tangible benefits to patients and local health services. For example, results from Castlefields Health Centre (UK) pilot of active management of conditions over the pilot period of one year:

- 15% reduction in admissions for older people
- average length of stay fell by 31%
- total hospital bed days used by this group fell by 41%
- more appropriate referrals and faster response times for social services assessments

In another example, and evaluation of Evercare model of case management for older people in US:

- 50% reduction in unplanned admissions, without detriment to health
- significant reduction in medications with benefit to health
- 97% family and care satisfaction rates and high physician satisfaction.

What is less clear is how to work with others to achieve similar improvements. It is this challenge that I have taken up in my day to day work in the chronic disease management programme.

Opportunity knocks

As I reflect on how I became involved in the chronic disease management work I am reminded that I did not originally come to work in the Health Authority. The organisation I was appointed to merged into the Health Authority around two years ago. I went from being director on an executive board pre-merger, to reporting into an executive director. After initial disappointment with what I essentially thought of as a demotion, I resolved to continue with the newly merged organisation and make the best of the circumstances I found myself in.

About a year ago, I was approached by the Director of Public Health, Sheila, who

asked if I would be interested in supporting one of the Primary Care Chief Executives in taking forward a sector-wide programme seeking to improve the management of chronic disease. I said that I would think about it. I was initially rather reluctant. I recall my first reaction was one of "Didn't people think I have enough work to do"?

Responding to Sheila's proposal

Having spent some time thinking about it, and after discussion with others, I found myself getting excited by Sheila's proposal. When she approached me, she made a point of saying they needed someone with clinical credibility. The work would involve staff in hospital and general practice, and people living with chronic illness.

In Project One I referred to the work I had done as a ward sister in exploring, through narrative, women's experiences of arthritis. More recently, I worked with patients' stories of their experiences of waiting to have diagnostics tests done, and the teams of staff involved in the diagnostic departments. I began to think that Sheila's approach offered the opportunity of getting involved in more clinically relevant change again – which I find stimulating and rewarding. This appealed to me and, of course, it was flattering to be considered. The management of chronic disease was also becoming a key focus in the health policy arena around this time.

I discussed Sheila's approach with my boss. We agreed that it would be a good opportunity for me and symbolic of further integration with the broader health authority agenda. The commitment was nominally two and half days a week. I met with Heather, Chief Executive sponsor of the chronic disease management programme, and agreed with her an initial work plan. Her Chief Executive colleagues had felt that a collaborative programme would be a good way forward. An initial scoping project had already been done, which identified many projects, euphemistically described by someone as "a thousand flowers blooming", but it lacked, according to the chief executives, clarity of deliverables or "whole system" working. I spent most of the first few months of the project talking to various people. I talked with the Chief Executives of the primary care trusts about their

expectations and hopes for participating in the collaborative. I talked to a number people who were identified as doing some good and different things across the country in the area of chronic disease management. I also linked into two national organisations already involved in collaborative improvement methodologies.

At the time, it seemed perfectly reasonable to me that I would develop a project plan, setting out clear aims and objectives, drawing on the available evidence of best practice in the field of chronic disease management services, with agreed measures that would enable us to track the improvement effort and encourage the teams I would be working with toward further improvement. I was comfortable with talking of a whole system approach. In this context, I took whole system working to mean developing an improvement approach that would actively engage those working in acute and primary care settings, include health and social care practitioners, patients and their informal carers, and service commissioners. However, since I started looking at the work of Mead (1923), I am now beginning to think differently about this terminology of "whole system" working, viewing it from the perspective of a cult value in the NHS. Although I take up Mead's thinking in greater depth later in this paper, I think it is important to say a little more at this point about what I mean when I use the term cult value. In referring to "whole system" working as a cult value I am suggesting that whole system working is an idealisation that has emerged over time and has been taken up as an important value by many working in the NHS. As with any idealisation, i.e. cult value, as soon as we try to act, in this case, in a whole system manner, we find ourselves conflicted by the practicalities of daily practice. We necessarily compromise as we work with some "parts of the system" – for example interacting with those working in primary care, while excluding others – for example, specialist medical consultants. In my own practice, I am now interested in how those I am working with are making sense of these idealisations and what emerges when they are functionalised in day to day practice. I am, also, aware that I have been using terms like "whole system working", "collaborative" and "modernisation" as reified symbols of communication. Here I am drawing on Stacey's (2003b) understanding of Mead's theory of communication. Stacey uses the

term "reified symbol" to draw attention to the way in which we have developed abstract, explanatory frameworks where words have particular meanings. He uses the example of physics as illustrative of what he means. Within this framework, the words "gravity" and "relativity" have particular meaning only if those involved in the conversation are aware of the abstract framework of physics. Stacey (2003b) suggests that:

> We seem to have developed a strong tendency, particularly in communication conditioned by abstract-systematic frameworks, to locate meaning in the word, in the gesture alone, and then proceed as if that word were the reality it stands for. We come easily to talk about words "gravity" and "relativity" as if they were things.
>
> *(Ibid: 72)*

I think I have been using terms like "modernisation", "whole system working" and "collaboratives" in this way. I am using the words in conversation and in reports as if they were things, rather than words that will make sense only if people are familiar with the abstract framework of healthcare improvement "science" that I am using as the context for these words. I will return to cult values in my reflections on my experience of a recent Board meeting.

The allure of the tool

Staying with my story of my initial involvement with the chronic disease management programme, I was particularly struck by the importance, as I felt at the time, of adopting a rigorous approach to the collaborative improvement methodology as a tool for improvement in the context of the overall programme. Before I move to an explanation of what I mean when I say I wanted to adopt a rigorous approach, I would like to touch on the origins of the underpinning model for improvement which is a key feature of this collaborative improvement methodology. Berwick (2003) locates this model within the post-mechanistic school of health care. In making sense of Berwick's assertion it is helpful to look first at what Taylor (1911) was proposing by mechanistic thinking, otherwise known has Scientific Management. Central to Fredrick Taylor's approach, which emerged at the

end of the 19th Century was his realisation that the existing "craft" model of production was inefficient in the move toward industrialisation and mass production. He proposed that work in factories could be divided into highly specialised tasks, and as a result less skilled people (rather than craftsmen) could staff the production line. Taylor's Scientific Management approach rigorously separated planning of the work, done by engineers, from the execution of the work. To make scientific management effective, workers on the shop floor were to perform their task as fast as they could and exactly as they were told. Healthcare has enthusiastically embraced Taylorist thinking as evidenced by the plethora of protocols, guidelines and the current enthusiasm for evidence-based medicine. The post-mechanistic view, however, challenges this "the read and follow the manual" approach. The post-mechanistic view suggests that good ideas for process improvement can come from anyone, and the more ideas that are available, the easier it will be to find ways to improve processes. Testing small changes and measuring the results and learning from that measurement becomes central. Langley et al., (1996) have developed the model for improvement, central to the collaborative programme, from this post-mechanistic perspective.

I mentioned above that I felt a rigorous approach to the collaborative improvement methodology was going to be important to the "success" of my work. I use rigorous here in the sense of trying to keep to the prescribed formula for what constitutes a collaborative improvement programme. My justification for this position was as follows: I formed a view, based on my experience of nationally developed emergency care and cardiac collaborative improvement programmes (NHS Modernisation Agency, 2002), that Trusts in my strategic health authority appeared to be achieving less tangible improvements than those being reported from other areas. Until recently, my "hypothesis" regarding this centred on the preparation of project managers for use of the collaborative methodology, and a seeming lack of senior leadership support. I saw relatively junior project managers being appointed to support the clinical teams through the change processes. The change principles were pre-determined by the national reference group, with the project managers

being "trained" in the collaborative methodology, and supported by workbook materials. Project managers were responsible for documenting the evidence of the change tests being carried out by their respective clinical teams. In my opinion, a key issue seemed to be the line-manager for these project workers, and, importantly, the extent to which these improvement projects were being seen within the organisation, by the most powerful, as key pieces of work.

On this basis, I felt it was going to be really important to pay attention to how, in my work programme, the collaborative methodology was being used. I felt it was important that we sourced expert help in this respect and I also searched the available literature for any evidence-base on lessons on implementation that might be available. I came across work by a group of international researchers reviewing available evidence (Ovretveit, et al., 2002). From evaluations to date, the researchers identified that some collaboratives have stimulated improvements in patient care and organisational performance. However, they noted significant differences between collaboratives. The researchers then generated 10 challenges that organisers and teams need to address to achieve improvement. They concluded that using the approach to identify the gaps between best and existing practice and showing that changes can be made builds conviction within teams that they do have power to improve patient care significantly; that learning methods and change strategies with peers and meeting as a collaborative are beneficial as ways of stimulating rapid improvement; that reporting progress and hearing how colleagues have made changes and overcome problems is motivating as well as giving practical ideas. The researchers proposed that failure or success for a team mostly depends on five general factors:

- their ability to work as a team
- their ability to learn and apply quality methods
- the strategic importance of their work to their home organisation
- the culture of their home organisation
- the type and degree of support from management

This work was key in reinforcing my initial assumption that there was "a right way" to run a collaborative improvement programme. The 10 key challenges became an important reference point for me, and one that I endeavoured to persuade others to think about in the context of their local team working between the large group learning events. I recall my sense of foreboding when I first met Robert, who was joining my team to help me with this work. It became clear during one of our initial conversations that Robert was using the term collaboration in the much more everyday use of the term, in the sense of teamwork and general partnership. I remember being adamant with him that I felt it was really important we stay true to the improvement methodology, if we were to have any chance of demonstrating improvement. At this time, I felt entirely justified in adopting this entrenched position in the sense of what I now realise as my taken for granted assumptions about managing change. Indeed, as I reflect on the Taylorist and post-mechanistic perspectives, I see, somewhat ironically, that I could be seen to have been pursuing a rather Taylorist approach to applying a post-mechanistic model! I am increasingly appreciating just how heavily influenced I have been by a systemic understanding of how I practice.

What do I mean by "systemic understanding"?

When I talk of a systemic understanding of my practice I am pointing to my particular way of perceiving the world. Such perceptions influence what we pay attention to, opening up and closing down possible courses of action. The term "systemic" can be defined as "of or concerning a system as a whole". Using the adjective implies a clear concept of what is meant, in turn, by the notion of "system". Boland and Fowler (2000) propose that the concept of "the system"

> …follows naturally from the observation that the universe comprises a multitude of entities or parts, most (perhaps all) of which do not act in perfect isolation but interact, in some way, upon each other. Hence, although each part may be clearly identifiable as a discrete item, possessing its own characteristics, behaviour and attributes, it is actually part of a greater whole, whose collective attributes exceed those of the constituent parts.

(Ibid: 424)

For Ackoff (1981) at its simplest, a system is a set of two or more interrelated elements with the following properties:

- each element has an effect on the functioning of the whole
- each element is affected by at least one other element in the system
- all possible subgroups of elements also have the first two properties

The comprising parts and processes (elements) of any system are organised around a purpose. Whilst structurally a system is thought of as a divisible whole, functionally it loses its emergent properties when broken down into its component parts. When an element is removed from the whole, that element loses its emergent properties, crudely for example a hand severed from the body cannot write, nor can a severed eye see. For Stacey (2003a) "a system is a whole separated by a boundary from other systems, or wholes. In other words, there is an inside and outside" (ibid: 24). Taking a systemic approach to thinking about the world, then represents a spatial metaphor resulting in a concern with component parts, boundaries, inside and outside and the unified whole (holism).

I feel it is important to emphasise at this point, that it was during Project One that I acknowledged that I was becoming aware that I would have more to do in understanding systems theory in order to expose and critique the underlying taken for granted assumptions and the influence that this way of thinking had had on my practice. I believe that my initial concern with rigid adherence to the collaborative improvement methodology was one of many consequences for me that arose from thinking in this way. Before I expand on this and go on to point to other consequences, I would like to build on the concepts set out above by exploring a little of the origins of system theories. In particular, how the thinking has been taken up in ways not necessarily consistent with early hypotheses, and, importantly, how I see these consequences in what I have deemed to be important to attend to in my practice to date.

Origins of systems thinking

Immanuel Kant made a seminal contribution to this way of thinking (Kant, 1790/1987), challenging the adequacy of applying mechanistic "if-then" causality appropriate for inanimate objects to living organisations. For Kant, it was much more useful to think about living systems from a perspective of purposive self-organisation. Stacey (2003b) uses the example of a clock compared with an oak tree to illustrate Kant's position. Stacey distinguishes between a clock, which is an example of a mechanism and the oak tree, which is an example of a living system. The parts of the clock, the cogs and wheels, the face and hands, and so on are designed on the basis of a pre-existing notion of the whole functioning clock. For an oak tree, however, the component parts like the leaves, branches, roots and so on are not pre-designed and assembled, rather they emerge from the internal interactions as the plant grows from its acorn-seed, and in conjunction with the environmental conditions experienced. This process is a purposive unfolding of what is already enfolded within the seed . Living organisms, then are self-producing and therefore self-organising wholes, where the whole is maintained by the parts and the whole orders the parts in such a way that it is maintained. This type of causality is referred to as formative causality. Kant hypothesised that we can think of living organisms as if they are systems which unfold patterns of behaviour that are already enfolded within their structures in development to their mature states.

Feedback is another key feature in so called first order systems theories . Particularly of relevance to health care and the field of continuous improvement is cybernetic systems thinking. A central heating system provides a simple example of a cybernetic system. The thermostat triggers temperatures that are set by the resident in the room. When the room temperature falls outside those tolerance levels, the system switches itself on, in instances of temperatures lower than that programmed into the thermostat, or off, in instances of temperatures higher than that programmed into the thermostat. In mainstream healthcare quality improvement this thinking has been enthusiastically taken up and is evidenced by an emphasis on increasing feedback throughout the production process, having good relationships with

customers and suppliers, measuring results, and testing innovations on a small scale.

Second order systems thinking arose, in part, as a response to the difficulty in applying first order methodologies to the rather more ill defined problems of human organisation. Questions bumped up against were "what is the system?", "what are its objectives?" and how to deal with the issue of human beings in social roles who are trying to take purposeful action to make a situation seen as problematical somehow better. Second order systems thinkers like Checkland (1999) identify the importance of reflecting on how those involved are understanding the situation. The focus then shifts to the perceptions of the various observers involved. However, the notion of moving toward an understanding of the "whole" remains central. Thus whole relates to taking the perceptions of the various observers as a set of activities connected together in such a way that the connected set makes a purposive whole.

Stacey (2003b) suggests that rather than replacing first order systems thinking, second order systems thinking provides its context:

> They are a duality of a process of science (first order) and the processes leading up to science (second order). While the basis of first order systems thinking is straightforward cognitivist psychology in which the individual mind forms representations of a pre-given reality and processes information rather like a computer, the second order tradition is based on constructivist psychology in which the individual brain-mind selects or enacts reality
>
> (Ibid: 269)

Even when the issue of reflection on perceptions of the observer becomes important, the dual positions of rational and formative causality continue to be central. In other words, it continues to be taken for granted that an optimal or archetype state is enfolded within the system, and rationalist in the sense of the assumption that it is possible to design the system and choose goals for it.

Kant cautioned against applying systems hypotheses to human behaviour. For Kant, humans are characterised by individually autonomous behaviour, i.e. they are free to set their own goals and make rational choices. I this way he postulated autonomous choice of goal before action introducing a rational causality.

Applied to health care

Despite Kant's caution, various forms of systems thinking has been enthusiastically taken up by influential policy makers, improvement consultants and service leaders in the NHS.

In 2001, the NHS Confederation published a series "Leading Edge: Rethinking Performance Management". The series drew attention to fundamental problems with, what the authors described as, 'the dominant managerial approach to the organisation of the NHS as a machine', originating from Taylor's classic work *Principles of Scientific Management* (1911). Thinking in this way leads to a belief that it is possible and useful, to consider parts of the system in isolation, to specify changes in detail, and that battling resistance to change and reducing variation will lead to better performance. However, Koeck (1998) asserts that this fails to appreciate the complexity of health care organisations. Changes processes frequently fail because attention is being paid only to one part of complex processes, where all knowledge, responsibility, authority and power is thought to be vested at the top of the organisation, from where it is delegated to lower levels, and interventions are being made on the basis of assumptions of simple, linear cause and effect. Koeck advocates greater attention to this complexity. Similarly, Fraser, Conner and Yarrow (2003) assert that:

> …the future of organisations and service providers will depend on their ability to apply the most appropriate improvement methodologies to the task they face. Organisations and leaders must have at their finger tips a range of methodologies if they are to be truly agile – delivering excellent quality care by continuously developing and co-evolving with changing demands and requirements…organisations need to have wide ranging competence, maintain it and deploy it wisely. The people within organisations need to learn about a variety of improvement approaches, understanding how to diagnose the underlying context and apply them appropriately will be a feature of those mastering the improvement agenda.
>
> (Ibid: 2)

For me this quote reflects contemporary thinking in the mainstream health care improvement literature. The authors reinforce a systemic perspective, focusing

attention on the search for the most appropriate tool, reify the organisation as they ascribe competencies to it, and imply that we can stand back and make a diagnosis and masterfully chose the right intervention. However, despite my immersion in a systemic approach to my practice, I acknowledge my own lived reality, as an NHS manager, is not so predictable and easily controlled. This issue of control, as understood from a complex responsive processes perspective, posits that our day-to-day experience is much messier than this "tidy" systemic perspective may suggest. The messy day-to-day reality of working with people, who will be interacting in a variety of ways, from which new directions might emerge, is absent from this account. Through the DMan experience I am now aware that whilst I may act with intention in my gestures and with the expectation of certain outcomes, I cannot control the responses of others and the meaning that emerges as we interact (Streatfield, 2001). Rather I need to work with the tension of acknowledging this lack of control and be prepared to handle the consequences of what materialises. Stacey, Griffin and Shaw (2000) point out:

> We are not trying to dismiss the tools of systemic thinking, but rather trying to understand how they are tools used in much more complex processes that are much more than the tools.
>
> (Ibid: 82)

The seduction of the model

As I did my background research into the area of chronic disease management, I came across work that the World Health Organisation had been doing with the Robert Johnson Foundation (USA). They had developed the Improving Chronic Illness Care model, comprising six key elements, asserting that real improvements in chronic disease management would require a series of linked actions, systematically addressing each of the key elements, rather that reliance on one or two single interventions (WHO, 2002). They also described the challenge as a paradigmatic shift as health care organisations endeavour to move from a focus on responding to the acute, episodic event, to developing approaches to care that are more appropriate for the ongoing self management needs of people living with enduring illness. I

recall being very excited about this model. I felt it offered an over arching framework for the work programme. I tested it out with a number of the key contacts I was beginning to make within the Trusts. As we talked about the interdependencies between each of the six key elements, others agreed that this model did provide a helpful focus for discussing our work. In looking back, however, I think that I would have had a different conversation had I asked not only if they thought it would be helpful, but explored what sense they might be making of it in the context of their own practice.

In the same way that I had been adamant about thinking that we needed to stay true to the collaborative improvement methodology, I see that my enthusiastic response to adopting the Improving Chronic Illness Care Model exhibits a similar pattern. Stacey (2001) warns that focusing attention on the tools alone leads to the belief that their function is to control actions so as to yield globally intended consequences. He suggests that

> …the intention behind using systems as tools of communicative interaction is to reproduce communication with little variation, in other words to control and so sustain existing power relations. The use of tools in the living present, however, requires spontaneous variations and this makes it impossible for anyone outside the local situation to stay in control.
>
> (Ibid: 233)

In pushing for the model to be adopted by the teams of people I was working with, I recognise now I was attempting, in part, to avoid addressing the anxiety I was feeling about not knowing in the context of this new programme of work. Streatfield (2001) puts this really well:

> It seems to me that we, as individuals, have a fundamental need to feel "in control" of situations in which we find ourselves. This need for control is connected to the experience of anxiety, in that the individual need for some sense of control is a way of dealing with the anxiety of not knowing…we generate the illusion of being in control through a variety of tactics…we measure things in the hope that this tell us whether they are performing as we would wish. We design and attempt to impose our own patterns on the world in the hope that this makes it more predictable and we set targets or goals which we hope come to

fruition. We try to emulate patterns of behaviour that we believe to be connected to particular achievements in the hope that repeating these patterns will lead predictably to repeated success…

<div align="right">(Ibid: 8)</div>

I was keen to build a network of key contacts in the Trusts that I was working with. My initial intention was to have a core group of named people, one from each Trust, with whom I could discuss what focus the collaborative programme should take. My ambition was to ensure that this work programme would help teams, locally, in taking forward their priorities around chronic disease management services, and try to secure their commitment to participate over the coming months. At that stage, I was anticipating that the programme would probably run for about a year. In these discussions, two key areas emerged. The people I talked with wanted help in making sense of Department of Health exhortations to implement case management and how they might work towards reaching the targets set nationally. We agreed it would be useful to come together as a group to talk together about our work and how we might support each other.

At the first meeting, we agreed to continue to come together on a regular 6 – 8 weekly basis with a view to sharing experience, and working together to influence the development of the collaborative programme. This is the group I call the Trust Leads. I worked with a smaller group of volunteers from this group, Robert, Heather, and others from my national round of visits, to plan a launch conference. The programme came together surprisingly easily. In part, I think this was due to the personal connection I had already had with a number of the speakers during the early stages of trying to find out what others had been doing within the field of service improvement for better chronic disease management. My boss also called in a few favours with policy makers at the Department of Health. I remember feeling anxious about who would turn up and how people would respond to the mix of plenary and workshop sessions. We had agreed that the Trust 'leads' would take responsibility for inviting people from their own organisations to the launch. We hoped to get their commitment to join the local collaborative project team. More than 150 people

participated in the launch. My next challenge was keeping people engaged, and demonstrating that by coming together in this way, we could achieve improvement in services for people living with enduring illnesses.

My concern with keeping people engaged was being influenced by my involvement in the DMan programme, where I was engaged in conversations and reading about a different way of making sense of organisational change. I read with interest the work of Patricia Shaw (2002) where she reviews a number of popular approaches to thinking about organisational change and draws attention to the variety of different ways in which practitioners explain or account for what they are doing. Shaw (2002) asks,

> How these different ways of making sense shift what is experienced as important, what really matters and so where the weight of attention, energy and resources of other kinds come to lie.
>
> (Ibid: 141)

I see, now, that although I was attracted to the desire to keep people in conversation, I continued to adopt a rational, systemic approach, akin to what Shaw critiques in Wenger's (1991) description of his work with communities of practice. Wenger (1991) focuses on investing more attention and care in the design of sense-making opportunities rather than as Shaw advocates encouraging us to focus on "the quality of our ongoing participation in the political learning processes themselves" (Shaw, 2002: 170). My attention was on designing the learning events to expose participants to different ways of understanding the meaning of case management and how they might learn from others. I recognise now that I had not yet attended to my own participation, and, indeed, still find it difficult to do so in retrospect. In writing this paper, from the perspective Shaw advocates, I grapple with making sense of my practice for this project. In part, I now see that as a consequence of my focus predominantly on trying to plan what the next steps in the programme "needed to be", I undoubtedly missed opportunities where paying attention to the gestures and responses of me and others, in the moment, might have led to rather different ways

in moving the work forward.

The place of measures

A key component of the collaborative methodology is identifying measures of improvement. In other words, what measures can be identified that will enable those involved to identify whether a change they implement results in an improvement. Thinking about what measures we might work with occupied a great deal time for Robert and myself. From the outset of the programme we knew that we would need to adopt any national targets set for chronic disease management. We pragmatically pulled together an outline set of targets. From national policy documents, we identified an expectation of being able to demonstrate a reduction in the number of emergency beds days occupied by people with chronic disease. The rationale was that as we improve our recall, review and readjustment of treatment with this group of patients, rather than relying on the current acute hospital emergency admission response to deterioration and crisis, patients would be less likely to require frequent hospital admission. The focus of the collaborative was to support implementation of case management. Nationally, measuring the number of case managers in post and numbers of patients being actively case managed were considered the other key target areas.

We sensed that simply issuing these targets to our Trust Leads was unlikely to be productive. I was also aware that in my previous experience, such national targets were usually issued to the finance and business planners in Trusts, who then developed "plausible" trajectories of how these targets would be met over whatever accounting period was chosen. In this process, it is not unusual for there to be very little, if any, involvement of the staff likely to be directly affected by this commitment. Robert suggested that he invited leads and their respective information and performance colleagues to a workshop, billed as an opportunity to share learning, identify good practice and look at some information pathways to support the chronic disease management agenda. We agreed that we might get more people involved if we took time to call/meet each lead and we split those pre-workshop conversations between us. Again, the conscious commitment to talk with people felt

a little different from the more usual approach of simply emailing the invitation to come together and await replies.

Paying attention to more than the tool

In the section that follows I describe my recollection of the board meeting and highlight key aspects of the content of a paper that was discussed. I then introduce a section setting out features of the work of Mead and Elias in relation to complex responsive processes theory. Following this, I draw attention to links I am making between my recollection of events in the Board meeting and making sense of these from the perspective of complex responsive processes theory.

The meeting was of the full Health Authority Board in one of our local libraries towards the end of March this year. I met one of the non-executive directors on my way into the building and we laughed about our ease in finding the venue. We had both set out from our homes allowing plenty of time to get to the meeting, as neither of us had been to this venue before. Consequently, we arrived about 30 minutes early. We were not, however, the first. Several of the other executive and non-executive directors and the administrative support team were already ahead of us. After saying "hellos" to those already there, I took my place at the table and proceeded to "busy" myself with my blackberry messages (emails). I was conscious that the others already there were taking the opportunity for catching up with each other in groups of two or three. I felt uncomfortable about not doing the same, but the thought of engaging in what I have until recently thought of as 'small-talk' created greater anxiety.

This was the third meeting I had been to in my acting executive director capacity. I still feel uncomfortable at these meetings and worry that I am not contributing the discussion. At times I feel I have nothing to say, rationalising this on the basis that some of the items being discussed are in areas that are new to me. At other times, I am aware that I feel that I ought to be contributing to the discussion – so much so that I am having palpitations. I am aware that when I do speak, I feel quite defensive, and aware of experiencing a high level of physical emotion. During this

meeting my colleague, Steven, Director of Service Transformation, was taking Board members through his paper that set out progress in relation to the modernisation of health services across the 14 Trusts in our Health Authority patch. It is a Health Authority programme of work that I am closely involved in. I have been excited about the potential of the approach that is being taken. I was initially drawn to the work as I felt it built on my recent experience of a national improvement programme to facilitate improvement in access to endoscopy services (ie, tackling long waiting times), which I touched on in Project One. In the meeting, Steven described for Board members what he saw as the particular features of our approach to innovation and improvement, summarised within the paper as:

- Driving whole system improvement
- Speeding up innovation and mainstreaming improvements
- Devolving resources and ownership to local level
- Building interdependence to support system change

This is the language of health service improvement, and more recently, modernisation, that I have taken for granted and been an enthusiastic advocate of for much of my career.

An important feature of our Health Authority programme is seen to be work with the Chief Executives and Directors of Modernisation from each of the Trusts that has resulted in identification of 18 sector-wide modernisation priorities. The priorities have been heavily influenced by national policy and the performance targets set for health services. For each sector-wide priority, there is Chief Executive sponsor identified, supported by dedicated project leads. This sponsorship role is seen to be key in signalling leadership commitment from the most powerful players, the Chief Executives, across the health communities. One of the 18 priorities focuses on improving the management of chronic disease, the programme of work I was leading.

Steven's paper set the programme work within the national policy context, referring

to recent policy documents, including the most recent *"Creating a Patient-Led NHS – Delivering the NHS Improvement Plan"* (DH, 2005). He drew attention to the introductory paragraph of this policy document which refers to the profound changes that will need to take place for the NHS to" become truly patient-led". The document states

> ...they affect the whole system and the way individuals and organisations behave… This document is designed to address these issues, offering a description of the major changes underway…describing how some of the biggest changes will be carried forward. It has been written primarily for the leaders of the NHS, the clinicians and managers, the Boards and everyone who is helping lead the transformation of the NHS. But it is vital that these leaders communicate its key messages – about the vision, the values and the major changes… These are complex changes in a complex system. Moving from a centrally directed system to a patient-led system inevitably increases uncertainty. We therefore need to develop even better systems for "feeding back", learning lessons and adapting our approach while maintaining overall direction…
>
> (Ibid: 3-4)

This extract from the document, for me, clearly illustrates just how dominant systems thinking is for NHS policy makers, and a way of thinking about human behaviour that favours the autonomous individual perspective and reifies the organisation.

Steven took us through what he saw as the achievements of the local modernisation programme to date. The thing that sticks in my mind from the meeting, is the point I recall him making about collaboratives. I remember feeling irritated by Steven's comment, which I heard as "collaboratives don't work in our patch". This is not the first time Steven had made such a comment. About three weeks previously he made a similar point in our bi-weekly executive team meeting. On both occasions, rather than tell Steven I took these remarks to be a direct criticism of my work – which was my strong initial reaction on both occasions – or ask him to say a bit more about why he was making that judgement, I went into an abstract justification of the importance of senior leadership buy-in and that the improvement methodology was only one key element of the model of Improving Chronic Illness Care approach I

had adopted in this work stream.

Our Board Chairman was the next to speak at the meeting, sharing her reflections on a recent round of visits to the Primary Care Trusts. A key theme of these visits was to hear about what progress was being made in improving services for people living with chronic disease. She expressed a concern that whilst there was a lot of project activity, she did not get a good sense of how it all fitted together and looked to me to respond. I think I said something innocuous like "Ummm, it's a challenge", resolving silently to check out with my Trust colleagues what her feedback had been like during the visits, and, indeed how they were thinking about the sustainability of the different approaches they were trying out.

How might I understand these responses? As I engage with the complex responsive processes perspective, I am beginning to see an alternative way of thinking about my experience.

Complex responsive processes – introducing a different perspective
The complex responsive processes perspective developed by Stacey and others is a theory of human interaction (Griffin, 2002; Stacey, Griffin and Shaw, 2000; Shaw, 2002; Streatfield, 2001). Complex responsive processes theory has its origins in a dissatisfaction with the abstraction from the every day experience of human action when systems perspectives are adopted (Stacey, 2001). The complex responsive processes perspective takes as its starting point the importance of understanding our own every day experience, where the key questions for inquiry centre around "just what is it we are doing together in our groups, or in our organisations, that leads to the emergent patterns that are our experience." (Stacey, 2003c: 32) The theory draws heavily on the dialectical process thinking of George Herbert Mead (1934), the figurational sociology of Norbert Elias (1939), and the work of complexity science (for example, Prigogine, 1997). For the purposes of this paper, I want to particularly focus on the key aspects drawn from Mead and Elias, as they feel most relevant to the issues I am trying to make sense of currently.

On Mead

Mead (1934) proposes that the human mind and self emerge from social processes of gesture and response, and, in particular, that it is the social act of gesture-response that constitutes meaning.

Mead proposes that we communicate in the medium of significant symbols, where it is possible for us to evoke in ourselves responses to gestures that are similar to responses evoked in others, and furthermore that we have the capacity for generalising so that as we act we take up the attitude of what Mead described as the generalised other (or social object). In other words, we are concerned about what others might think about what we say or do. According to Mead we also have the capacity to be an object to ourselves – in this sense he talks of the I-Me dialectic. The "I" is my response to the "Me", i.e. what I perceive other people might be thinking of me. This is dialectic in the sense that the "I" and "me" cannot be separated, and are in paradoxical movement where there is opportunity for either continuity or transformation. In other words, I may respond in many different ways to my perception of the views others have of me. I may get stuck in a repetitive pattern with others, or as we interact something new might emerge. I have experienced this acutely in writing this paper. I got very stuck at one point in the writing process, as I attempted to make sense of the literature and previous discussions about systems theories. My self-conversation became one of increasing anxiety and feeling unable to write. A conversation with my supervisor was necessary to move forward. Mead proposes that our sense of identity emerges out of the interaction between how we see ourselves and how we understand how others see us. In this way identity is not a "fixed thing", rather identity is emerging in the interaction of self with others and, at least in principle, somewhat open ended and unfinished.

Mead also draws attention to issues of ideology and cult values. In his seminal paper, "*Scientific method and the moral sciences",* Mead (1923) introduces the issue of social and moral conduct, and the place of values. In his introduction he identifies that

> It had become a common place of the psychologists that there is a structure in our experience which runs out beyond what we ordinarily term our consciousness; that this structure of idea determines to a degree not generally recognised the very manner of our perception as well as that of our thinking, and that structure itself is generally not in the focus of our attention and passes unnoticed in our thought and perceiving.
>
> (Ibid: 229)

I think Mead's use of the word structure could be understood as the values that underpin the ways in which we make sense of the world. He reminds us that mostly we are not consciously aware of our values and the extent to which they influence the way in which we are making sense of our day to day experience. He also makes a rather interesting contrast between social and moral conduct and the scientific method:

> Scientific method does not ensure the satisfactory solution of the problem of conduct, any more than it ensures the construction of an adequate hypothesis for the research problem. It is restricted to formulating rigorously the conditions of the solution. And here appears a profound difference between the two situations, that of moral and social conduct, and that of so-called scientific research. In problems of conduct we must act, however inadequate our plan of action may be. The research problem may be left because of our inability to find a satisfactory hypothesis. Furthermore, there are many values involved in our problems of social conduct to which we feel that we are unable to do justice in their whole import, and yet when they are once envisaged they appear too precious to be ignored, so that in our action we do homage to them. We do not do justice to them. They constitute our ideals. They abide in our conduct as prophecies of the day in which we can do them the justice they claim. They take on the form of institutions that presuppose situations, which we admit are not realised, but which demand realisation.
>
> (Ibid: 239)

I am drawn to Mead's comparison between the compelling force of values in our everyday, unavoidable action, comparing it to scientific research, where we can avoid taking action if we have no adequate hypothesis to proceed.

Mead uses the examples of democracy and Christianity to illustrate how strongly held these ideals are, despite the rarity of their realisation in daily life. He points to the ideal of " love thy neighbour" as illustrated in the parable of the Good Samaritan.

He contrasts this with the history of war and strife, in the name of Christianity. He highlights the way in which ideals become institutionalised in the form of cult values. The church is used as an illustration. Mead writes:

> The psychological technique of maintaining such a cult is the presentation by the imagination of a social situation free from the obstacles, which forbid the institution being what it should be, and we organize social occasions, which in every way favour such a frame of mind. We gather together in a place of worship, where we meet on the single common basis of all being worshippers of one God, or gather at a Thanksgiving, where all the differences and indifferences of family life are ignored.
>
> (Ibid: 240)

Mead also points out how difficult it is to reform such institutionalised cult values. they are, as he describes it, "the most precious part of social heritage". However, Mead does believe that the scientific method needs to be applied to the study of the ways in which such cult values are functionalised in daily life. He proposes that:

> It is to this task that a scientifically trained intelligence must insistently devote itself, that of stating, just as far as possible, our institutions, our social habits and customs in terms of what they are to do, in terms of their functions. there are no absolute values. there are only values, which, on account of incomplete social organisation, we cannot as yet estimate, and in face of these the first estimate should be to complete the organisation if only in thought so that some rough sort of estimate in terms of the other values involved becomes conceivable… and there is only one field within which the estimation can be made, and that is within the actual problem.
>
> (ibid: 243)

The relevance to my area of inquiry, is that it is only in working with others, in the action of taking up and functionalising the cult values, that we advance our theory of practice. The emphasis needs to be on the methodical articulation of reflection on the messiness of everyday practice, as we recall descriptions of what happened in the moment. for me, one of the most exciting things in mead's paper, is where he refers to the cult value of democracy and suggests that it is only by making the issues of democracy so immediate and practical to voters that "they can appear in the minds of the voter as his own problem" (ibid: 244). As Mead suggests:

It is the intensive growth of social relations and intercommunications that alone renders possible the recognition by the individual of the import for his social life of the corporate activity of the whole community. The task of intelligence is to use this growing consciousness of interdependence to formulate the problems of all, in terms of the problem of every one. In so far as this can be accomplished cult values will pass over into functional values.

(Ibid: 245)

Mead exhorts us to stay with the immediate, and understand what is happening, rather than focusing attention on creating visions of some distant goal. "We, none of us, know where we are going, but we do know that we are on the way" (ibid: 247)

Stacey (2003b) also emphasises the importance being taken on time in Mead's way of thinking:

This social act (of gesture response) has the time structure of the living present. That time structure is a circular one in which the future, the response, changes the past, the gesture, all in the present. It is in the living present that the individual and the social continually emerge in forward movement into the future, a movement in which the past is continuously reconstructed.

(Ibid: 224)

So focusing on what we are doing in the moment becomes key – as opposed to concentrating effort on an imagined future. For my practice this means paying more attention to what is happening in the interactions I have with people I am working with in the living present, being more aware of my own tendency (and that of many colleagues) to abstract attention to some future scenario based on the ideal, the "what ought to be", as opposed to working more immediately with "what is".

Paradox, in the sense of simultaneously forming and being formed, is another essential feature of this way of thinking. Stacey (2003b) notes that:

Some justify the retention of two inconsistent theories by claiming that it leads to a dialectic, by which they mean a discussion or dialogue, or a Kantian notion of synthesising two opposites. However, in the Hegelian dialectic, which is the basis of the process view I will be arguing for, thought moves by opposites negating each other and it is in this tension that new meaning emerges. This provides another argument against the "both…and" retention of two inconsistent theories, namely that such a way of thinking obliterates difference and eliminates

paradox, so obstructing the evolution of new meaning.

<div align="right">(Ibid: 8-9)</div>

In what follows below, as I explore my story of the Board meeting from a complex responsive processes perspective, I draw out what I see as a paradoxical position that I find myself currently grappling with in relation to global policies of targets and performance management that dominate as cult values in the NHS and how these are being taken up in everyday local interactions of staff I work with. I point to my emerging interest in how I might pay attention to my own practice as one of holding the tension between what I believe is a valuable tool – that is the performance management framework – and, at the same time, attending to underlying anxieties associated with shifts in power relations and identities as we find ways of translating performance improvement issues into the immediate problems of staff working in our Trust. Before I move in to the analysis of my story, I would like to touch on the work of Elias, who like Mead, has strongly influenced the complex responsive processes theoretical perspective.

On Elias

Elias (1939) has profoundly affected my thinking. In particular, his concept of figuration arising from his frustration with what he saw as unhelpful dualisms and dichotomies in the work of other sociologists. Elias was particularly critical of the convention to view "individual" and "society" as two independently existing objects. Or as he termed the "homoclausus" model, where the individual is taken to be self contained and separate from other people. For Elias (1978):

> …the image of man as a "closed" personality is…replaced by the image of man as and "open" personality who possesses a greater or lesser degree of relative (but never absolute and total) autonomy vis a vis other people and who is in fact fundamentally oriented toward and dependent on other people throughout his life. The network of interdependencies among human beings is what binds them together. Such interdependencies are…the figuration, a structure of mutually oriented and dependent people.

<div align="right">(Ibid: 261)</div>

Dopson (2001) in her Eliasian analysis of organisational change in the NHS, draws attention to the way that Elias used game models to better explain this complex interweaving of the actions of large numbers of people, of planned and unplanned process and, on changing balances of power, or power-ratios. Dopson points out that:

> Power, conceptualised not as a property which one person or a group has and another person or group does not have, but as a structural characteristic of all human relationships, is central to Elias's approach. Within the context of understanding processes of managed social change, the game models are useful precisely because they demonstrate that the outcomes of the complex interweaving of the actions of different players in the game, even when these actions are more or less consciously directed toward the attainment of certain goals, may include – in the case of complex games, almost certainly will include – outcomes which no single player or group of players intended. Within the context of managing organisational change, the "game" is, of course, the game of implementing, or resisting the implementation of, a given policy strategy.
> (Ibid: 519)

I think both the game-playing perspective offered by Dopson and the Eliasian insight that power is based on interdependence and both enables and constrains at the same time are crucial to how I might come to understand my practice rather differently than from a systemic frame.

The contributions of both Mead and Elias are central to the complex responsive processes perspective of human interaction. In applying this to the area of organisational change, Stacey and colleagues propose that organisations are seen as patterns of interaction between people, where the interaction is communication (Stacey, Griffin and Shaw, 2000). By extension, "it is only when people in an organisation talk differently to each other that their organisation will change. Facilitation of change is facilitation of different forms of conversation" (Stacey, 2003a: 350).

My reflections on the board meeting from this perspective has afforded me new insights and helped to give more focus to my line of inquiry.

On cult values

Steven's paper summarised for Board members what he saw as the key features of our approach to innovation and improvement, which he languaged in a particular way:

- Driving whole system improvement
- Speeding up innovation and mainstreaming improvements
- Devolving resources and ownership to local level
- Building interdependence to support system change

This is the language of health service improvement, and more recently, modernisation, that I have taken for granted and been an enthusiastic advocate of for much of my career. My learning set members first drew my attention to this and one raised the possibility of, what I thought a rather sinister side to this language as propaganda. I recall being rather puzzled and dismissive of this comment. I notice, now, that I am becoming critical of this terminology yet recognising the value I have ascribed to what I have believed these words stand for, for me that is, in terms of the care patients ultimately experience. I have found myself reacting strongly to recently published accounts of the experience of managing in the public sector, as viewed from a complex responsive processes perspective. The work asserts that:

> Current modes of public sector governance reflect a taken-for-granted way of thinking in terms of systems…Instead of recognising the hypothetical nature of systems construct, policy-making proceeds on the implicit assumption that public sector organisations actually are cybernetic systems. It also implicitly assumed that people are parts of the system and ignores this human capacity, constrained by interdependence, to make some choices in how they act in local, contingent situations which are always throwing up unexpected developments requiring to be dealt with by people in conflictual negotiations with each other….The targets and surveillance procedures are understood as tools that people in other local negotiations are being required to use in their communicative interaction with each other. As generalisations and idealisations, these tools have to be made particular and functional, over and over again, in the particular contingent situations people find themselves in. They cannot simply, directly apply the generalised and idealised tools specified by groups of people at the centre of government. If one takes this perspective, then the corruption of the tools and techniques, the game playing and deceit all become perfectly

understandable. They are the manner in which people find it possible to give at least the appearance of compliance and yet go on together to do the work of health care…

<div align="right">(Stacey, 2005: 57-58)</div>

Similarly, Stacey in his 2005 Foulkes Lecture writes:

We must comply, or at least be seen to comply, to avoid public humiliation, shame and even annihilation of identity. Identities, which can only be sustained in the recognition of important others, may come to be characterised more by appearance and spin than substance. Compliance means submerging values that may feel more important leading to feelings of alienation and inauthenticity because to survive we have to deceive. The cults of performance and quality assurance take the form of cultures of deceit, not just at the very evident level of national politics but in the lives of most of us who once felt that vocation is central to who we are

<div align="right">(ibid: manuscript)</div>

I was drawn particularly to the assertions of deceit being associated with cult values of improvement and was very aware when I first read this piece of a strong visceral reaction, one of disagreement. In trying to understand this reaction, I am beginning to notice how strongly I feel about the need for constant improvement in the quality of care patients experience and the importance I attach to being able to demonstrate that through the use of appropriate measures. I am aware that this might be taken as a strongly systemic stance, with the implication of some sort of "if-then" causality between improvement and measures. However, I have been considering whether this strength of feeling is reflecting what Mead described as cult values, in my case, pointing to cult values of improvement and performance measurement. During Project One, an observation made by my supervisor struck me. He wrote, "A theme you start strongly with, and which I think continues in one way or another throughout has to do with an idealisation around care of a holistic kind. In other words you are expressing an important value which shapes what you do and how you think". My immediate reaction was one of reassurance. After all Lawler (1991) describes the concept of 'holistic' practice as an "ideological cornerstone in nursing" (ibid:24). I was pleased to see it being recognised as a key value in my narrative. However, as I was challenged to write a bit more about what 'holistic' meant for me,

research its origins and why it was important to me, the term took on a rather more ambiguous perspective. Weick (1995) suggests that ambiguities of this sort, where individuals develop multiple and sometimes conflicting interpretations of words or sentences can be powerful occasions for sense making. And so it has been for me. I have embarked on a process where I am now aware that much of my way of knowing to date, that I described in Project One, has been made up of many concepts that I have taken for granted. As I began to explore the literature around "holism", another series of questions began to emerge for me regarding the concept of values, how values arise, ways in which values are sustained and ways in which they might change. Trying to understand the work of Mead in this respect has felt important for me and has been something I have found confusing as well as intriguing, as I have discussed what sense I am making of it in the context of both conversations with others at the residentials and in our smaller learning group. I feel I am currently at the stage of acknowledging and taking seriously those values, those cult values, which compel my actions and reactions. As I see it, my inquiry is strongly influenced by my cult values. In particular, I am interested in exploring, in my work with colleagues, just how we are taking up and functionalising this cult value of performance management.

On moving beyond simply negating

My reaction to Stephen's repeated comment that "collaboratives don't work in our patch" could be understood as a direct challenge to my identity, which was reflected in my initial reaction. However, as I reflect, I think I responded to the gesture of Steven's comment by simply negating what he had to say. There is, as ever, history to this relationship and my response in that moment was influenced by how I felt about the merger with the health authority and what I perceived to be a rather dismissive approach to the work of my team by Steven and his colleagues during the merger process. I now wonder what might have happened if I had engaged further – negating the simple negation of collaboratives don't work – inviting Steven to expand on this comment, moving beyond our polarised position. I can only speculate but I think this reflection (iterative process in writing the project and

discussions) has altered the way I am working with him. I notice in my interactions with others I am much more aware of trying to avoid getting into polarised positions as our conversation emerges.

Dominant ways of talking influence what is seen as legitimate work

There seems to be implicit in the comments made by Stephen about "collaboratives don't work" and the chairman's comments of lots of project activity - that bringing people together to engage in conversation and build relationships is not "legitimate in and of itself", unless we can quantify outputs or demonstrate that we are hitting targets. As I have indicated earlier, talk of measures and targets has been a key feature in the interaction with people involved in the learning events and beyond. In the collaborative project teams our experience of the targets, as they were taken up, was mixed. In two boroughs, the case management approach had demonstrable impact in reducing the number of hospital attendances for the group of patients being managed in this way. In one project, a case conference approach was adopted for a group of 38 patients who were identified as having attended their local A&E department five or more times in the previous month. Following six months of the case conference approach this group of frequently attending patients had been reduced from 38 to seven, and of those seven their cumulative attendances before the programme started had been 50 in the month prior to the project, it was now eight. So something was happening. In another project, however, attention was purely on getting the target number of case managers into post. Although the target was met, the consequences for the people being recruited and for the cash strapped organisation was looking high risk, illustrating the unintended consequences of an exclusive focus on one of the targets. At the Board meeting, I did not have this information. However, I think the more fundamental issue is how I might move beyond feeling silenced by this dominant discourse? This is a question I take with me into Project Three.

Conclusion

I have found moving from Project One to Project Two has raised key questions for me as to how I have previously articulated and engaged in discussions about my day

to day practice. My focus for this project has been on building my understanding of systems theories, their origins and the domination of this perspective in my day to day practice as a manager in the NHS, as well as in the contemporary approaches to policy development, strategic planning and performance management within the NHS as a public sector organisation.

In doing the work for Project Two, I realise now that to genuinely engage with exploring the messy and contingent nature of my day to day practice, it is important I write what I see happening in our ongoing conversation about how we are responding to and making sense of our day to day work, against this backdrop of national policy and performance management frameworks.

I conclude Project Two in a similar way to Project One – starting a new job. I am now working in an acute hospital NHS Trust as Director of Nursing and Quality. I continue to experience the challenge of operating within the performance management regimen established for the NHS by the current government. Now, however, I feel as if the challenge is somehow more immediate – in the sense that I am working with staff who directly influence the quality of care being experienced by patients using this hospital. I am keen to explore ways of working with my colleagues to develop an approach to the governance of the quality of care in our hospital that takes account of the locally contingent nature of interaction and explore what it might mean to work towards less deceitful and anxiety provoking ways of functionalising a cult value of improvement.

PROJECT THREE: MOVING FROM GLOBAL DESIGNS OF PERFORMANCE IMPROVEMENT TO A FOCUS ON PATTERNS OF INTERACTION AND INTERDEPENDENCE IN DAY TO DAY ACTIVITIES THAT CONSTITUTE PERFORMANCE

Introduction

This is a story of an experience of being a Board Director in an organisation struggling to meet some of the national performance targets that have been set for the National Health Service (NHS). This is not an unusual set of circumstances facing health service managers. In a recent article in the national *Independent* newspaper, health correspondent Jeremy Laurence writes that that health rationing is looming for the NHS due to the worsening financial problems that are facing the service. He blames the deficits on targets: *"Reasons for the crisis begin with targets… getting waiting lists down, cancer patients seen in two weeks, A&E waits cut, more heart patients treated, all swallowed bundles of cash."* Jennifer Rankin from the Institute for Public Policy Research, said: *"To secure the future of the NHS, there needs to be an honest and realistic debate about what the NHS can deliver in a cost-constrained system."* (Independent, 3rd March 2006). Since September 2005, figures being released by the Department of Health have been forecasting an overspend NHS finances. After an announcement that "turnaround teams" are to be sent into 61 of the worst performing trusts after the six month figures showed deficits spiralling towards £500 million, the Health Services Management Journal quotes the then Chief Executive of the NHS accepting the criticism that "we did not collectively pay as much attention to finance". In February of this year, Chief Executives of NHS Trusts received a letter advising that the NHS Chief Executive would be taking "a direct and personal interest" in how chief executives responded to calls to take immediate action to tackle deteriorating finances after the latest figures predict a year-end deficit of £800 million (Health Services Journal 9th March 2006: 9).

The narrative set out in this paper is a personal reflection on the conversations I am

involved in formal meetings and in the "corridors" of the hospital. I reflect on the way we are working as a board, drawing on my experience as a new member of the team participating in a recent Trust Board Away day. I notice how in our conversation we tussle with global issues of performance management and concentrate largely on ways of creating an idealised "ought to be", which has the affect of distracting our attention from more immediate issues regarding our interdependencies as board members. I draw attention to ways in which focusing on targets can generate conversation about figures rather than more important issues of the day-to-day activities and interactions that constitute performance. I also explore how I am contributing to the work in relation to patient pathways into and through the accident and emergency department. In effect, I endeavor to describe what I am coming to understand as my contribution to locally particularising targets for performance improvement set nationally and acknowledge the emotions arising during these processes. These are becoming increasingly important considerations for me in how I practice and talk about by work as a senior health service manager.

Setting the scene: The Trust Board Away Day

I start with reflection on my experience of an away day I recently participated in alongside my colleague directors on the Trust Board of the hospital. This was the first away day for the full Board of Non-executive and Executive Directors that the Chief Executive had arranged. She has been in post since November 2004. She told me that it had been difficult to persuade the Chairman and some of the other non-executives of the importance of having this type of event. It was not clear to me why this had been the case. And, rather puzzling for me now, I did not ask her why. What I sensed, however, was the anxiety that this caused for both the Chief Executive and our external facilitator. I have known our external facilitator for sometime from my previous job. He has had a long working relationship with the Chief Executive as her coach, and I have been in away days that he has facilitated, where I have not previously been aware of his anxiety. Both expressed that concern about how "it will go" – referring to the Board away event. Our facilitator had one to one conversations with everyone who was to be involved in the event. This is a pattern of preparation I

have noticed him use in three previous projects I have worked with him on. He uses the one to one conversations as an invitation to those he is working with to raise issues individually that we hope can be taken forward in the large group event that constitutes the away day. During his meeting with me he said he was anxious. I asked him why, and he said the Chief Executive was worried, and that both the chairman and vice chair had been very reluctant to have the event and proved elusive when he tried to talk with them in the one to one discussions by way of preparation. This was the backdrop to the day that followed. The event started just after lunch, running until we broke for dinner. We restarted following breakfast the next day, concluding our deliberations before lunch.

During the first afternoon the vice chair and the chairman said on several occasions that they have had these sorts of sessions before – all is enjoyable and motivating at the meeting and then, their assessment is, nothing changes. By that they mean the performance of the organisation, in terms of their key concerns – for the chairman this was described in his words as "the big and little things" – the big things are achieving the national targets, the little things are the things he draws to our attention most mornings when he gets in at 07.30 and before he leaves around 08.30. Sometimes, it is quite easy to do something about the "little things". His current bete-noir involves the appearance of the main corridor - incidentally the longest hospital corridor in England. The hospital is going through a major refurbishment, so it is often the case that some sort of building work going on in the corridor. In the time I have been there, he has brought to my attention a sign that had been put up in the main corridor above the new endoscopy unit. His concern was that the unit had not yet opened and the door way has not yet been created – yet we had a lovely new sign! The main hospital reception is another point of contention for him. The reception is some way down the corridor from the main entrance. During the hours of nine to five, the Welcome Desk is staffed by volunteers, outside these hours a sign advises visitors to report to the reception area further down the corridor. This is an issue that he has raised on a number of occasions and has not yet been satisfactorily resolved. The morning before the away day, the chairman asked me if

I thought "we were going to make it". I asked him what he meant, and he replied "Balance the books, get the new hospital scheme back on track and improve our patient satisfaction ratings".

When I first started, around six months ago as the new Director of Nursing and Quality, I found these early morning interactions frustrating. With respect to the little things, at times I am able to take corrective action immediately, at other times resolution is dependent on a greater involvement of others. The response to the more global question of "are we going to make it?", I now see, lies in the ongoing patterns of interaction happening locally as people across the organisation work together, and our respective roles as leaders in the organisation participating in that local interaction. How I balance my contribution to drawing attention to conversations attempting to tackle global issues of performance and improvement, which tend to achieve very little, with developing creative ways of activating local interaction is a fundamental issue in this paper. As one of my learning set neatly put it "discussing the figure will not change the performance", yet it is very common for whole meetings to be given over to just this sort of conversation. It happened a number of times during our Board Away day.

Endeavouring to design global patterns of performance management and improvement

On the first afternoon of the away day, we identified the things that were worrying us. The main theme we agreed to focus on is how we were managing the performance of the organisation. I pointed out that, from my perspective as the newest member of the Board, I felt, at best, we were performance reporting – but not consistently "managing" on the basis of the data being reported. To illustrate what I meant, I identified my own experience in relation to a work stream I had been asked to be involved in – the use of temporary staff. As I mentioned this example, the chairman began to challenge me on what I was doing to address what has been identified by an external financial review as an over reliance on temporary staff. This is a key issue for us as it is a significant contributing factor to the over-spending on staffing budgets across several services in the hospital. At the away day I had

with me copy of a management report that I had been working on since I joined the organisation and was asked to look at practices around use of temporary staff in nursing and midwifery as an early priority. I noticed that in the first few meetings I was in, many of the other people involved were anxious about the amount of money being spent on temporary staffing and would spend a considerable amount of discussion speculating as to the reasons – lack of control in who gets to book temporary staff, too many unfilled vacant posts, inappropriate rota planning, and so on. This would be closely followed by a range of ideas as to how this might be tackled. In these early meetings, I drew attention to amount of time we were spending in this speculative conversation with out anything other than the bottom line spend position available to us. I suggested it might be helpful to have a set of key information presented in the form of management reports, and clarity as to how these were being used to influence decision making and indicators of impact of decisions for various key people in the organisation – i.e. Local budget holder, unit management team, director management team and executive management. In the away day, I was able to give the chairman a summary of the indicators that had been developed in response to my suggestion and that we were now tracking across all wards and staffing budgets. He responded by saying he felt reassured. I was relieved to have been able to respond directly to the Chairman's challenge. At the same time I appreciate the need for an ongoing dialogue with staff across the organisation as we try to work differently, reducing our reliance of temporary staff. I see the management reports that have been developed primarily as a gesture, in the sense of Mead's (1934) acts of communication. As a gesture, the management report "calls forth" a response from staff, at least part of which I hope will be conversation about ways in which we are working and how we might alter the balance of reliance on more expensive temporary staff. I use the word "hope" advisedly, as Stacey (2005) identifies in relation to global and local processes in organisational life:

> A very important conclusion follows from this way of thinking, namely that it is impossible to design global patterns of order simply because such patterns emerge in local interaction. Emergence means that pattern arises in the absence of any plan or blue print or programme for that global pattern. It follows that when people do articulate some global pattern and attempt to design it, they are

doing nothing more than making a gesture, which could be a very powerful gesture. The pattern which emerges, however, is to be found only in the local responses to that global gesture. We think in a very different way about organisational change and corporate and national governance if we take this perspective.

<div align="right">(Ibid: 13)</div>

In other words, while I hope that the management reports will be used by staff in their local considerations of how they are working, I have no guarantee that this will happen. It becomes important for me, then, to engage in understanding what sense these staff are making of the reports and how, in their ongoing interactions, they might be using the information contained within the reports.

In a similar vein, during the away day I also drew attention to the importance of not only developing the performance management framework – but that, at the same time, we needed to think about how and where there will the opportunity to engage in the "use of it". My intention in asking these questions was to involve Board colleagues in a conversation as to where the opportunities might exist for groups of staff in making meaning of measures, and who would be included in this sense-making. This is an area where my thinking has changed noticeably during the experience of working through Project Two.

Performance management in the mainstream health care literature
During the process of Project Two, my initial interest in working with others to achieve improvement in the management of care of people with chronic illnesses developed through discussions with my learning set and through the iterative process of engaging in the literature and re-writing to consideration of issues of performance management that I face day to day as an National Health Service manager. I was encouraged to begin to explore underlying ways of thinking about performance management in the public sector. Storey and Sisson's (1993) definition, whilst arising in the context of human resource management, is typical of mainstream literature in this respect:

A way to link micro activities of managing individuals and groups to the macro

issues of corporate objectives with three steps: setting clear objectives for individual employees derived from organisation's strategy; formal monitoring and review of progress toward meeting objectives; utilization of outcomes of the review process to reinforce desired behaviour through differential rewards and/or identify training and development needs.

<div align="right">(Ibid: 219)</div>

In Project Two, I identified that policy makers in the National Health Service have enthusiastically taken up this type of systems thinking. Furthermore, that, on the whole, this has resulted in a way of thinking heavily conditioned by first order cybernetic systems perspectives where the assumption is that setting targets and monitoring against these will produce the feedback necessary for the system to self-regulate. My interest in performance management continues into Project Three. In particular, I am interested in ways in which performance management is being considered in relation to improvement. A considerable volume of literature now exists in mainstream healthcare management endeavouring to address this issue. Sheldon (1998) identifies that, internationally, developing, collecting, analysing and feeding back performance data from healthcare organisations is now big business. Smith (2002) traces trends in public service reform affecting public sector institutions with successive UK Governments. He suggests that there now exists "much more emphasis on conscious performance management of the health care system, rather than relying on the market to improve performance" (ibid: 104). He considers that performance management in the public sector has been promoted by increased devolution of responsibilities and the associated need to develop explicit models of accountability and performance management. For Smith:

Performance management in the NHS can be defined as a set of managerial instruments designed to secure optimal performance of the health care system over time, in line with policy objectives.

<div align="right">(Ibid: 105)</div>

He suggests it is possible to consider available performance management instruments under three broad categories:

- A guidance function which is" intended to transmit policy objectives to managers and then to front line staff in a meaningful fashion". In the NHS this includes the National Service Frameworks, National Institute for Clinical Excellence Guidelines, and guidance on planning priorities published by the Department of Health on an annual basis.

- A monitoring function which involves collection and analysis of information on whether guidance has been followed and targets fulfilled. It should also, in principle, check whether unintended side effects have arisen. In the NHS this includes the Performance Assessment Framework (Star Ratings) and the Health Care Commission Annual Health Check.

- A response function which is intended to stimulate appropriate remedial actions when performance problems are brought to light and to promote continuous improvement even when satisfactory performance has been secured. Inherent within the response function is a need to recognise and act upon an opportunity to improve performance.

From this I understand Smith to be implying a cause and effect relationship between performance management and improvement. At the same time he recognises that it has been difficult to demonstrate this in practice. He postulates a number of reasons; for example, he asserts that so far very little work has been done on establishing whether and how guidelines affect practice and even less on, what he describes as the "optimal modes of dissemination" to clinicians, and that the most under developed aspect of performance management practice is that associated with developing mechanisms for stimulating appropriate responses. Similarly, Sheldon (1998) cautions that there is a danger that performance management effort will not result in the anticipated gains in quality. He attributes this to potential conceptual and technical weaknesses in the performance management agenda. In considering performance management frameworks from technical and conceptual levels, Sheldon's view is that too much attention is focused on the technical characteristics of individual measures rather than the conceptual approach. Sheldon identifies that performance measurement is more than just a set of measures, it implies a mode of

management. According to Sheldon, the potential impact of applying a set of indicators depends not only on their technical characteristics but also on the degree to which those managing, working in, and using health care organisations support the programme, the existing professional cultures, and what change in the culture the introduction of performance management may produce. This is what I understand Sheldon to be meaning when he refers to the conceptual level of performance management. He proposes that any performance management structure can be usefully thought of as a "health technology" which has effects on people, organisations and system behaviour – in his view that is why people want to use such mechanisms for changing performance. Like all interventions applied to complex systems, Sheldon identifies that the effects are often unexpected and difficult to control and may even produce net adverse outcomes. He attributes such problems to the difficulties inherent in the three activities of measurement of performance, of analysis or interpretation of the results, and of the subsequent action in light of the results. He calls for high quality experimental evaluations of quality management initiatives alongside a better conceptual understanding of how to evaluate organisational performance. Smith (2002) identifies one such example of "adverse outcomes". The National Audit Office confirmed that the pre-occupation with inpatient waiting times led to widespread distortion of clinical priorities and misrepresentation of performance (National Audit Office, 2001). Smith's prescription is to identify that "a key task under the new performance management regime will be to alert to the potential of adverse side effects, to foster a culture under which they will fail to thrive, and to design incentives to counteract their worst effects" (Smith, 2002: 113). He concludes by stating that:

> The intention of performance management is to signal national priorities to local managers and to offer the information, incentives and capacity needed to respond appropriately...there is an urgent need to ensure that the signals emerging from each element of the arrangements are aligned; that adequate capacity is provided for the performance management process; and that the engagement of clinicians is secured...although there may be many early implementation difficulties, the system is in principle intellectually coherent. There will be a continual need to evaluate the initiatives...if the system is given adequate time to settle down, and if policy makers remain responsive to perceived weaknesses, it will lead to

greatly improved quality of care while retaining the strong spending control that has been a hallmark of UK health care

<div align="right">(Ibid: 114)</div>

I would suggest that the difficulty Sheldon and Smith both have in making the connection between performance management and improvement arises, at least in part, out of their way of thinking about the issues from a systemic perspective. This pushes them to focus on ever more precise definitions of the measures to be used and pursuing idealised system design in their attempt to control for improved outcomes.

In Project Two, I took up Stacey's (2006) rather different approach to understanding current public sector governance. He questions the mainstream systems perspective and takes a complex responsive processes approach, where the focus of interest becomes the "…ongoing, iterated patterns of relationship between people" (Stacey, 2006: 57). From this perspective, Stacey and Griffin (2006) consider issues of relational power and identity. They point to an asymmetry in power balance, which has moved from one favouring relative autonomy for professionals to one of centralisation and managerial control, where the emphasis is on government target setting and performance monitoring. Drawing on Mead (1934), Stacey and Griffin identify that government policy is at its most fundamental a gesture that has then to be operationalised, and that it is the acts of operationalisation that we ought to pay attention to and explore the consequences. What struck me strongly about Stacey and Griffin's work was their concern about the emotional consequences for those working in public sector institutions.

During the process of Project Two, I became aware of my own daily grappling in relation to global policies of targets and performance management, and the way I came to understand these, along with service improvement, as cult values in the way that Mead (1923) describes. In recognising these as values that compel my action, I notice ways in which I am now paying attention to how I hold the tension between what I believe to be a valuable tool - that is, a performance management framework

- and, at the same time attend to underlying anxieties associated with shifts in power relations and identities that can arise as people endeavour to particularise global targets in the context of day to day working.

In the process of writing this project, I am now recognising the importance of acknowledging these emotions, and I include those I experience, that are emerging and trying to make sense of these.

On reflection, I see that the Board Away day was, in the main a meeting that was trying to address global concerns about the need to introduce a performance management system. In this respect, I can understand the sentiments being expressed by the Chairman and Vice Chair that "nothing happens" - when we try to act at the global level in this way - nothing happens.

Drawing attention to local interaction and interdependence

Another key issue we discussed at the Board Away day was performance in our Accident and Emergency Department (A&E). Over the past two years, the department has seen significant investment in staffing. Indeed, decisions to put more money into staffing in the department has created a significant cost pressure which the rest of the organisation is endeavouring to support, by finding cost improvements from other budgets. The national target requires that for 98% of people attending the A&E, four hours is the maximum wait in A&E from arrival to admission, transfer or discharge. The Department of Health produces a league table of the percentage of patients waiting less than four hours for each NHS acute Trust (i.e. hospital) on a weekly basis. At the time of the Board Away day there had been a period of sustained performance improvement in respect of meeting the target over the summer period. However, performance had dipped below the 98% national target level on a regular basis in the previous six weeks. We were coming in the lower quartile of reported A&E performance on the maximum four hour wait for patients for decisions on treatment, and pretty near the bottom of that! There was a shared sense concern and a variety of questions about what needed to be done, followed by speculation about adequacy of leadership, strength of commitment to achieving the

target, the need to come up with a recovery plan and sanctions that might be employed in the event of no improvement.

Stacey (2005) in setting out the relationship between the global and the local identifies that:

> It is possible for individuals and groups of individuals, particularly powerful ones, to intentionally articulate and even design the general and the ideal but the particularising and the functionalising involves the interplay of many intentions and values, and this interplay cannot be intended or designed, except temporarily in fascist power structures and cults. Furthermore, the generalisations and idealisations will further evolve in their particularisation and functionalisation.
>
> (Ibid: 37)

As I am now coming to understand it, it is not as straight forward as asking for a recovery plan and expecting linear improvement to unfold. Whilst the Board's requirement is undoubtedly a powerful gesture, the ways in which it is taken up by groups of staff working in the Accident and Emergency Department, and indeed in the wider hospital and community is key. Focusing seriously on what I am doing in my every day interactions with staff begins to assume much more importance, following this line of thinking.

Thinking about particularisation and intention

Ways in which I might make a useful contribution to the experience patients have, including the time they are waiting, in our Accident and Emergency Department is something that I have been significantly focused on. In addition to issues of global and local patterns, the work of Elias, particularly his position challenging the conventional dichotomous position for understanding the individual and society in much of the mainstream sociological literature has felt important to me. Elias advocated a dialectical relationship between individual and society, and this is influencing the way I am practising. He critiqued the dominant view of the autonomous individual and society as a structure or system, advocating alternatively that conceptualising humans as interdependent was much more relevant to an understanding of the structure and dynamics of social life. Taking this

interdependent approach, in turn leads to a particular way of understanding intention, which I think is a crucial consideration for managers. For Elias (1991):

> The long-term planning of individuals, compared to the multiplicity of individual purposes and wishes within the totality of a human network, and particularly compared to the continuous interweaving of individual actions and purposes over many generations is always extremely limited. The interplay of the actions, purposes and plans of many people is not itself something intended or planned, and is ultimately immune to planning…what a person calls "we" is more powerful that the plans and purposes of any individual "I". The interweaving of the needs and intentions of many people subjects each individual among them to compulsions that none of them has intended. Over and over again the deeds and works of individual people, woven into the social net, take on an appearance that was not premeditated. Again and again…people stand before the outcome of their own actions like the apprentice magician before the spirits he has conjured up and which, once at large, are no longer in his power. They look with astonishment at the convolutions and formations of the historical flow, which they themselves constitute but do not control.
>
> (Ibid: 62)

Elias emphasised this interdependence of any given individual, regardless of his or her position, on the surrounding network of social, economic and political relations. "No individual person, no matter how great his stature, how powerful his will, how penetrating his intelligence, can breach the autonomous laws of the human network from which his actions arise and into which they are directed" (ibid: 50). In taking this position, Elias points to the importance of changes in social conditions or the structuring of social relationships rather than the decisions and actions of particular, supposedly powerful individuals or groups in understanding transformation. My initial response to this was to consider if my intentions and plans will be taken up in ways I cannot predict or control does that mean it is pointless to engage in planning? However, as Elias identifies "the person acting within the flow may have a better chance to see how much can depend on individual people in individual situations despite the general direction" (ibid: 48). It is equally unrealistic to believe that "people are interchangeable, the individual being no more than the passive vehicle of a social machine" (ibid: 54). "Crossroads appear at which people must choose, and on their choices, depending on their social position, may depend either their immediate personal fate or that of a whole family, or in certain circumstances, of

entire nations or groups within them (ibid: 49). From this I understand Elias to be proposing that what becomes important is being part of the ongoing interweaving and being open to opportunities where it may be possible to influence the triggering of a further chain of events. I will return to how strongly this way of thinking is now influencing my practice in working with others towards improving health services in what follows.

Acting within the flow

Since starting six months ago in my current post, I have already mentioned that the experience of patients in our Accident and Emergency Department has been an important issue for me. Most Fridays there is an Emergency Services meeting. It includes the operational director, medical director, and a non-executive director, and now I attend as often as competing priorities allow. The four of us are members of the Trust Board. Our participation in this Friday meeting indicates the importance this area of performance to the corporate agenda. Senior medical, nursing and management staff from the Accident and Emergency (A&E) department are also involved, as are a range of senior staff from departments of medicine and surgery. My story starts at the end of October last year, with a meeting that became significant in a number of ways which I will set out what follows.

I felt "upbeat" at the meeting, as were others. The national target had been met and exceeded for the week. It had been two weeks since the new A&E manager was brought in to the A&E department. His arrival was as a result of direct action taken by the chief executive and the director of operations. The chief executive had had enough of less than 98% of patients being seen within four hours in our A&E department. I shared her sense of frustration. I felt irritated by the interaction at the emergency care meeting in the weeks prior to this decision being made. There had been an increasing number of patients coming to the department during September. The number of patients being seen within the four-hour limit fell significantly short of the national average. The analysis of contributory factors suggested that delays occurred within the department itself. In particular, staff identified that when the

resuscitation room of the department became busy, i.e. when patients needed immediate resuscitation many staff went to help. This meant that the main part of the unit, with the greatest number of patients, was significantly depleted of senior clinical staff able to make decisions about next steps in care. My sense of frustration when staff discussed this observed pattern, was a sense of "fait a compli". All those involved in the Friday meeting acknowledged that this was happening, but seemed unable to effect any improvement.

Communicative interaction in the living present

In sharing the description above with my action learning set, they asked me to consider in more detail my reaction. A key question around whether it is justifiable to respond to resuscitation even if others have to wait now raises two issues now for me: The first follows the line of inquiry from project two and is in relation to what might best be described as a personal idealisation of performance delivery that influences the way I respond and the frustration I feel. The second is humbling – and regards the scant attention I have paid so far to what I understand of the views of staff, and the ethics as well as the conflicts, they might be experiencing in the "present" of having to choose – and how does it feel to them when this is then replayed retrospectively at the Friday meeting. I think it useful at this point to say a little more of what I mean in using the term "the present" in this sense. Walker (2006) presents a very useful exposition on differing views of time in leadership literature. He draws attention to the conventional view taken by mainstream literature, which sets out a linear view of time "in which the future is predictable from the past and the present is only a moment on the way to the future from the past" (ibid: 109). Implicit in the linear view of time the past can be thought of as factually given on the basis that it has already happened and that the future is ahead waiting to be unfolded. Walker contrasts this with Mead's (1932) rather different view:

> ...the past does not exist in its own right, although of course actual events have taken place, but only in how it is remembered, re-experienced and re-interpreted in the present. The present then becomes the moment in which the emergent appears, informed from the past and leading to the future...this notion gives

primacy to the present as the moment in which meaning and transformation continually occurs. The significance of the future is that it gives meaning as anticipation in the present…

<div align="right">(Ibid: 109)</div>

In addition to the questions I now have about choices the A&E staff are having to make, thinking more about what it means to give primacy to the present has raised issues in relation to my own behaviour. I have become aware of a repetitive pattern in the way I work, where I tend to resolve to pick things up outside the current conversation. In other words, I am coming to realise I sometimes do not engage as actively as I could in some discussions, and as I am now writing this I can see that in paying less attention to what is happening in the moment and working with that, in the moment, I might be "missing" transformative opportunities - in the sense of Elias's perspective of "acting within the flow". I pick this point up again, a little further on in this paper. In the meantime, how might I understand my habitual pattern of behaviour? I think that it may reflect a taken-for-granted assumption I have had about the ability to control the outcome of conversations that I engage in, if I have had the opportunity to prepare adequately ahead of the conversation. I now realise this points to a way of thinking that is becoming increasingly problematic for me as I explore the perspective of complex responses processes theory and, in particular issues of emergent intention and co-creation of meaning.

Returning to consideration for the views of staff in their work in the accident and emergency department. Why do I not ask questions to find out what they are feeling in the moment? Why is it that, in the moment are these questions are not the ones that come to me? What I usually ask is something along the lines of "Well, how do we sort it out?"

Does it matter? I think it matters from the perspective of consequences. A common consequence of going straight to asking for solutions is the closing down of exploration. This repetitive pattern of moving to identify solutions has the effect of distracting us from engaging in discussion about difficult issues of performance.

Instead, we often move into rather speculative conversation about what might help - the "ought to", rather than the "as is". I decided to explore this further with the new operational manager in the emergency department. The question prompted me to catch up with him as I had been meaning to do for sometime.

As I reflect on my resolve to follow up with the A&E manager, I notice that it is in this sort of action that I believe my approach to practice is changing as a result of my inquiry. Previously, I probably would not have followed this up. I continue to find I need to almost force myself into this sort of informal conversation. I use informal in this sense to contrast this, with the more formalised opportunity of the regular, diarised Friday morning emergency care meeting. I now wonder how I might understand my behaviour in this respect. For many years as a manager in the health service, in addition to wanting preparation time, I have noticed an associated concern with organisational structure. I have thought it important to establish which meetings make what decisions within the formal organisation structure. When I feel either the opportunity to prepare has been inadequate, in what I am now acknowledging as situations where I do not have a realistic solution in mind, or there is lack of clarity, from my perspective, as to where decision-making groups are, I begin to feel anxious. Although this could be seen as a detour from the main body of my narrative, it feels like an important consideration in better understanding my own practice.

Experiencing anxiety as a feature of organising –a psychoanalytic perspective
So how might I understand these feelings of anxiety associated with my desire to enter into conversations being clear myself about solutions likely to work and the need for clarity in decision-making structures/ meetings. A psychoanalytic perspective offers one way of making sense of feelings of anxiety. Central to all psychoanalytic thinking is the view that unconscious forces are at play in virtually all human endeavours and that these forces can stifle or stimulate creativity, cooperation, achievement and learning (Gabriell and Carr, 2002). These unconscious processes become more pronounced in cases where there is risk and anxiety. Proponents of psychoanalytic thinking identify that unconscious processes operate at

multiple levels, having an impact on role effectiveness, group identity, power balances, and relationships with other organisations and the external environment. Individual psychoanalysis seeks to help an individual master his/her anxieties and compulsions by gradually making him/her aware of the "contents" of the unconscious. Researchers at the Tavistock Institute, U.K. have developed a series of interventions aimed at understanding and addressing group processes at, what they describe as, the interface of social and technological systems. The work of Isabel Menzies (1960) is seminal in this respect. Her work offers a perspective that proposes my concern with structures and formal decision-making meetings may be a way of trying to contain and, indeed, defend against anxieties inherent in the nature of my work and that of others within the hospital. Menzies, coming from a background of economics and experimental psychology, adopted a psychoanalytic perspective in her exploration of the nature of anxiety associated with nursing work and techniques used in the organisation of nursing service to contain and modify this anxiety. Through her research, which sought to explore reasons for high turnover in nursing students, she developed a way of thinking about organisational social structures as forms of defence - as ways of avoiding experiences of anxiety, guilt, doubt and uncertainty. Menzies- Lyth (1992) proposed that:

> Nurses are in constant contact with people who are physically ill or injured, often seriously. The recovery of patients is not certain and will not always be complete. Nursing patients who have incurable diseases is one of the nurse's most distressing tasks. Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening…the work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of care given to the patient.
>
> (Ibid:46)

She identified a number of ways of organising nursing work that had developed in an attempt to support in, what she describes as, "the task of dealing with anxiety" (ibid: 50). She proposed that:

The needs of the members of the organisation to use it in the struggle against anxiety leads to the development of socially structured defence mechanisms, which appear as elements in the structure, culture and mode of functioning of the organisation. An important aspect of such socially structured defence mechanisms is an attempt by individuals to externalise and give substance in objective reality to their characteristic psychic defence mechanisms. A social defence system develops over time as a result of collusive interaction and agreement, often unconscious, between members of the organisation as to what form it shall take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms.

(Ibid: 50)

To illustrate this position, Menzies-Lyth gave many examples of the operation of the social defence mechanism. Decision-making in hospital can clearly be a matter of life or death. One defense against the anxiety that decision-making can cause is ritual task performance including splitting up of the nurse patient relationship into a series of tasks to avoid prolonged contact with any one patients; using other depersonalising techniques such as referring to patients by bed number and condition rather than by name, which further denies the significance of the individual; stressing the importance of professional detachment and denial of any disturbing feelings that may emerge; elaborate processes of checking and counter-checking which further diminishes onus of responsibility for individuals; delegation upwards; and finally, avoidance of change. Through her work, Menzies highlighted how such features of organisational structure function as social defenses - which may allay immediate anxieties but are likely to be at the cost of long term dysfunction.

If I accept this line of thinking in relation to my experience of anxiety, this leads to a way of thinking about the organisation social structure over and above every day local interactions. My concern with identifying the decision-making fora in the organisation can be interpreted as a way of defending myself against the anxiety of decision-making. For Stacey (2003b) there are significant problems inherent in the psychoanalytic perspective, in particular he argues for "...a move from psychoanalytic and systemic meta theories with their notions of internal worlds and

social systems, representations, memory stores, sender-receiver modes of communication and dualistic both/and thinking " (Stacey, 2003b: 330). Once again the issue of distracting attention from what I am doing in my interactions with others and ongoing action that emerges, by giving primacy to the meetings framework, is a consequence of thinking in this way. Stacey advocates instead for a move to a way of thinking that gives primacy the experience of participating in the conversational processes of human organising and, I think, an alternative perspective in the genesis and control of anxiety which I return to below.

I met up with the new A&E manager for a drink with the intention of exploring his thoughts on what was happening in the department. The conversation surprised me in two respects. Firstly, he did not think that the resuscitation activity was a key issue. He had been in the department now for six weeks and had not seen this response. He told me that the A&E team talked with him about their concerns as to how they are being seen by senior management. They shared with him their worries about their reputation in this respect. They had been at pains to get from him a sense of whether senior management were angry with them. This is an important issue worthy of further consideration by me and my director colleagues.

As I reflect on their concerns about reputation and whether others are angry with them, issues of identity and pride seem central. Closely linked to pride, are thoughts of shame. In thinking about these issues, I was reminded of the work of Goffman (1959), which he set out in " *The Presentation of Self in Every Day Life*". In this book, Goffman presents what he describes as a framework for studying social life that employs a theatrical analogy, and sets out to:

> …consider the way in which the individual in ordinary work situations presents himself and his activity to others, the ways in which he guides and controls the impression they form of him, and the kinds of things he may and may not do while sustaining his performance before them…the part one individual plays is tailored to the parts played by the others present, and yet these others also constitute the audience.

(Ibid: Preface)

Issues of impression management linked to performance

Goffman' interest is in the way in which a person presents himself and the meaning of that presentation in the broader social context. Goffman's approach is similar in some respects to the approach of those interested in understanding practice from a complex responsive processes perspective. He is interested in the analysis of everyday life, and proposes that our actions and the meanings and interpretation we give to these actions are fundamentally social in nature. It is worth considering other core concepts Goffman promulgates in his work. He suggests two distinct modes of communication: the "expressions we give", essentially conscious, intended verbal communication, and the "expressions we give off", relating to non-verbal communication which may or may not be intentional. He identifies that the relationship between these two forms of communicating may be congruent, which he describes as symmetrical, or inconsistent which he describes as asymmetrical. For example, an individual may be quiet and starring out of the window during a group discussion, yet at the end of group work state that they had found it very enjoyable. This would be what Goffman would describe as asymmetrical expression. Goffman points out that people may express different definitions of the social situation they share. Here, Goffman suggests there is a process that is entered into that involves the various participants arriving at what he describes as a "working consensus". This is based on the strength of initial information about fellow participants and, on the basis of this, whose definition emerges tentatively as the plan for co-operative social activity. The accepted definition then becomes the key influencer of how people ought to be in the situation and what they should do. Problems arise when there is a variance in the behaviour that has come to be expected. Goffman notes that people then engage in defensive practices to protect the validity of these definitions and will strongly resist the impact of such variant behaviour.

As I write this, I find I am asking myself a number of questions. I begin to think about the interaction that tends to happen in the Friday meeting. Much of the conversation is at the level of information giving – reporting statistics on the weeks

performance, A&E senior staff justifying variance, in what seems to me to be very controlled tone and "patient" body language, with various other key players suggesting what might be done differently in identifying ways of working that are used in those organisations that are consistently hitting the 4 hour maximum wait. That seems to be a ritual that has emerged, and seems to legitimate a particular style of interaction at the meeting. I see a pattern, where it is legitimate to talk about what has already past (i.e. the weeks performance) and what we ought to be doing (i.e. good practice from elsewhere), what is not talked about is the here and now, what is happening in the meeting.

In thinking about this behaviour in Goffman's terms, it is possible to point to asymmetry and it could be suggested that the pattern of behaviour played out in these meetings has taken on a form of working consensus – albeit from my perspective, and my concern with improvement in our performance rating, a frustrating working consensus. Following Goffman's thinking a little further, raises other key questions.

In addition to issues of asymmetry, Goffman uses the concept of "front" to describe the process by which the individual establishes a social identity. In constructing a front, it is important that the individual – actor – communicates in a consistent and, frequently, controlled manner – which Goffman refers to as "impression management" in an effort to convince the audience. He also points out that for the most part we take on established social roles where a particular front has already been established. For Goffman:

> ..it is to be noted that a given social front tends to become institutionalised in terms of the abstract stereotyped expectations to which it gives rise, and tends to take on a meaning and stability apart from the specific tasks which happen to be performed in its name. The front becomes a collective representation and a fact in its own right.
>
> (Ibid: 37)

Goffman uses the term "dramatic realisation" for the process by which we draw

attention to those aspects of what we are doing that we want others to notice. One consequence can be an increasing concern for expressing to others what we are doing, which distracts from a focus on what we are doing "for its own sake".

Goffman's dramaturgical perspective can provide an analytical framework for making sense of my description of what happened in the Friday morning emergency care meeting. Taking Goffman up in this way stimulates me to think about how I might describe techniques of impression management that are being used in the context of the A&E meeting I am describing in this narrative, the principal problems of that impression management, and the impact on the identity and inter-relationships of the "performance" teams. Taking the apparent discrepancy between what we are told in the meeting, i.e. when the resuscitation unit becomes busy, performance in meeting the four hour maximum waiting time for patients dips, with the A&E manager's position that he has not seen this happening, using Goffman's analysis it may be possible to understand this as a form of impression management. For Emergency Care clinicians most of their working day is spent differentially diagnosing the clinical symptoms that patients present. In the context of the Friday morning meeting, they are challenged to come up with reasons as to the perceived poor performance in respect of meeting the target of four hours. It would not be unreasonable to suggest, using Goffman's analysis, that in an effort to present an image of them selves as able to give a rational explanation (linked to their expertise in diagnosing problems) they come up with the workload in the resuscitation unit.

I find myself wondering about the way I have been engaging in the meeting, and outside the meeting and to what extent I have been able to influence the working consensus that has developed amongst the key players. In a recent Friday meeting a conversation struck up that has been played out now in three of the meetings I have attended. There is an issue about our pathology reporting system which I do not fully understand. The problem, as described by the A&E staff, relates to not knowing when the server is down and how staff in the pathology department then react when this becomes apparent. The staff in the A&E department talk about waiting for blood test results to inform clinical decisions about whether patients need to be admitted or

discharged. This is, of course, important in the context of the overall length of wait being experienced by the patient. On several occasions, it has become apparent that the computer server generating the electronic reports back to the A&E department has "gone down". There currently appears to be no way of knowing that this has happened, other than the A&E staff realising that there has been a longer than usual wait for results, and they then contact the pathology laboratory staff. In the Friday meeting, every time this is brought up, it triggers a heated exchange between the A&E senior nurses at the meeting and the pathology manager. The pathology manager expresses frustration at the reported lack of responsiveness of his team, and both sides get stuck in a polarised conflicted position at the meeting. I have described this to others as akin to a "baying for blood" – in that the three senior nurses join forces to attack the pathology manager, who in turn gets very defensive, criticising his team publicly for not doing what he has told them to do.

However, there may be a more relevant way of making sense rather than from the perspective of a working consensus that Goffman proposes. Drawing attention to the interdependencies of those involved and how people are dealing with these is central. To date, rather than exploring these issues, in the meeting people start blaming each other. There seems to be some kind of unconscious collusion not to talk about the effects of interdependence but to sustain a kind of fantasy that each department should be able to manage to target on its own and if they do not and so interfere with others then it is their fault. As the same argument emerged, I asked the senior nurses and the pathology manager what has happened previously when they leave the Friday meeting? Have the key players from A&E and pathology come together to try to resolve this? I draw attention to the heated discussion that has now been played out at the three meetings that I have attended – and I am aware from notes of previous meetings that this has been happening in the meetings I have not been able to get to. They identify that there has been no further discussion between the nurses and the manager outside of this main meeting. We agreed that there should be further conversation. I am reminded of the issues around conflict that have been discussed in my learning set. I realise that I cannot predict and control

outcomes that may emerge when the two groups come together. My intention is to contribute to moving forward in the manner Groot (2007) describes as explorative conflict – working with the conflict being experienced by the A&E staff and the pathology manager as part of the continuous process of relating, in the hope that something novel might emerge. Groot (2007) distinguishes between explorative and polarised conflict. Polarised conflict characterises the current position being taken by the A&E team and the pathology manager. In polarised conflict each side is in opposition, holding out to win at the expense of the other. I suggest that it might be helpful to have a facilitated meeting with the key players and I ask a member of my team, one of the assistant directors of nursing who I have seen working in a similar way with another service in the Trust, to facilitate. I leave the meeting intrigued as to what will come of this. I am aware of the paradoxical position I am adopting: on the one hand I am saying "I cannot predict and control", on the other hand my hope is that something novel might occur.

With these questions in mind, I have tried to draw attention to the interdependent nature of our work in my daily practice. In the example of relationship between people working in A&E and pathology a number of things have happened. The facilitated conversation did take place. A summary of the meeting was produced and circulated widely. I recall receiving it by email and having a further conversation with my assistant director of nursing who had facilitated the meeting, where I congratulated her on what seemed to be a step in the "right direction". I was somewhat disappointed then when at a more recent Friday morning meeting a sarcastic remark was made about the team in pathology in respect of their ability to respond when there were problems with the timeliness of result reports. Around the same time, I received an email from the pathology manager advising me that staff in A&E were working outside agreed protocols in using test equipment in the A&E department. I picked up with the A&E manager to express my disappointment and to try to understand how they were making sense of what was happening. For the A&E manager, the response was to point to what he saw as really unhelpful behaviour of the manager in pathology with a responsibility for quality assuring the testing

equipment used in the wards and departments, outside the pathology lab. After a particularly stressful morning where there had been two child deaths in the department, he received a photograph from the pathology manager of dried blood on one of the pieces of testing equipment being used in A&E. He was angry about this and felt it was not in the spirit of the agreement he thought had been reached. My response was to ask him to reflect on the need to find a way of working with the pathology team that got us "beyond" what I described as the "them and us" relationship. I had a similar conversation with the pathology manager. I notice, again, in my response a move quickly to wanting to get things "sorted out". Two further meetings between the teams in A&E and pathology have been facilitated since, where the focus was on talking about how the actions of one team impacts on the other, and, at least for now, there is a constructive working relationship between the two teams, reported back to me by one of the senior nurses through the forum of the Friday meeting - which feels like significant progress.

Returning to experiences of anxiety and performance management

As I try to make sense of the anxiety I am experiencing as I continue to work with the A&E team on matters of performance improvement, I am particularly drawn to another work by Norbert Elias (1987). Reading *Involvement and Detachment* has enabled further insight into why I might be feeling anxious. In *Involvement and Detachment,* Elias traces the development of knowledge - essentially a sociology of knowledge - contrasting knowledge development regarding the natural world with processes of knowledge development regarding the human-social world. In his exposition he identifies that:

> One of the major flaws in traditional theories of knowledge is their total neglect of the condition of not knowing...traditional philosophical theories of knowledge simply take the existence of a scientific, highly reality-congruent type of knowledge for granted... In its course, human mastery over non-human nature gradually grew to a point where the dangers which non-human nature constituted were sufficiently curbed for humans to learn to approach physical events with less fear and greater detachment. With regard to the dangers which human groups constitute for each other, humanity is still very much in the trap of higher involvement of knowledge about societies which steers their actions reinforcing the danger of humans for humans, and of the high level of danger in turn

reinforcing highly involved forms of knowledge. Living in the middle of a process of this kind makes it difficult to perceive its structure and even to notice its existence. Perhaps one can regard it as a hopeful sign that it is possible to calm one's involvement sufficiently to make the problem of involvement and detachment visible. Among the characteristics of high involvement I have so far omitted to mention is fear of the unknown and thus of innovations"

(Ibid: xxv)

What I understand Elias to be drawing attention to is our taken for granted perspective on the status of scientific knowledge of the non-human natural world, where we are able to rationally predict and control outcomes of many non-human natural world phenomenon, for example the behaviour of bacteria in relation to infectivity. He reminds that this has not always been the case, and in, for example Medieval times, bacterial infections where associated with high levels of fear and uncertainty. Elias proposes that the greater the feelings of uncertainty and lack of control, the more likely it is that we will engage in thinking of a magico-mythical kind rooted in fantasy. He calls this "involved" thinking. On the other hand, detached thinking is associated with more fact-oriented knowledge. To illustrate his point, he uses an Edgar Allan Poe story of the Fishermen in the Maelstrom. This is a story of two fishermen brothers who get caught in a fearsome storm. Their boat gets caught up the force of the maelstrom and they are being sucked towards the vortex of swirling water, which heralds, they fear, certain death. The older brother is paralysed with fear. The younger brother, somehow being able to detach himself from the fear that grips his brother, notices that cylindrical shaped objects moved down more slowly into the abyss of the whirl pool, as do smaller objects. He urges his brother to strap himself to a barrel in the way he was doing before jumping overboard. The older brother cannot detach himself from the fear he is experiencing and gets sucked down quickly on the boat. The younger brother, lashed to the cylindrical barrel moves much more slowly toward the whirlpool, which begins to smooth out, and he survives.

In this story, I see analogies to my practice, and I would suggest to the emotional consequences of targets and performance management regimens for those working in the public sector that Stacey and Griffin (2006) proposed. As Elias (1987)

identifies, sociologists participate in the facts they study. They are personally exposed to the dangers which the objects they study represent for themselves. It is understandable that in their field a more involved approach prevails.

He identifies that:

> The ascendancy gained, over the centuries, by a manner or style of thinking which has proved highly adequate and successful in men's dealings with physical events, but which is not always equally appropriate if used in their dealings with others. One of the major reasons for the difficulties with which people have to contend in their endeavour to gain more reliable knowledge about themselves is the uncritical and often dogmatic application of categories and concepts, highly adequate in relation to problems on the level of matter and energy, to other levels of experience and, among them, to that of social phenomena. Not only specific concepts of causation or of explanation formed in this manner, are generalised and used almost as a matter of course in inquiries about human relations; this mechanical diffusion of models expresses itself to, for example, in the widespread identification of "rationality" with the use of categories developed mainly in connection with experiences of physical events, and in the assumptions that the use of others forms of thinking must necessarily indicate a leaning towards metaphysics and irrationality
>
> (Ibid: 17)

Elias challenges the dominant approach to the investigation of human action through the lense of conventional scientific methods - the mechanistic thinking of Newton and others in the arena of inanimate nature and in the Kantian hypothesis of thinking of living organisms as if they were systems. Rather, Elias identifies that he sees the social as distinct from natural sciences because social sciences are concerned with conjunctions of persons. Here, in one form or another, people face themselves; the "objects" are also "subjects".

> The task of social scientists is to explore, and to make people understand, the patterns they form together, the nature and the changing configuration of all that binds them to each other. The investigators themselves form part of these patterns. They cannot help experiencing them, directly or by identification, as immediate participants from within; and the greater the strains and stresses to which they or their groups are exposed, the more difficult it is or them to perform the mental operation, underlying all scientific pursuits, of detaching

themselves from their role as immediate participants and from the limited vista it offers them... their own participation and involvement, moreover, is itself one of the conditions for comprehending the problems they try to solve as scientists"

(Ibid: 16).

John Tobin (2005) takes these ideas up in his paper exploring the emotional processes of leading. In line with Elias, he identifies that in conditions of uncertainty and stress, the emotional content of our thinking can overwhelm our ability to adopt a more detached stance that will enable a somewhat broader perspective, with more possibilities for action. This certainly resonates with my experience of working on a day to day with an intention to improve the quality of care. As I reflect, I can see at times I have been so involved in the intensity of trying to move forward that I feel akin to the older brother in the sinking boat. At other times, I believe I have been able to contribute more effectively in taking a more detached perspective, as in the case of the relationships between A&E staff and the pathology team. This is an area that I feel will be important to explore further in the context of project four as I move to consider issues of sustainability within the context of organisational change, where one takes the perspective of organisational change as changes in the ongoing patterns of communicative interaction.

Conclusion

I started this paper with reflections on a Trust Board Away day where much of the conversation circled around what we ought to be doing to improve the hospital's financial status and where a need for a better performance management framework was identified, as way of addressing this. In looking at the mainstream literature of performance management, this approach is understandable. The convention is to propose that delivering improvement requires robust performance information regularly gathered so that progress can be tracked and local variations in performance identified and addressed, enabling a shared understanding of what needs to be done. Although the potential for unintended consequences is now widely acknowledged, because performance management is being considered from a systemic perspective by most writers, the solution commonly recommended is to

redesign the metrics. In thinking about performance management from the perspective of complex responsive processes, I question what might be seen as an overly simplistic reliance on efforts to globally design performance frameworks and associated targets - prevalent in central government and across the National Health Service. What has become more meaningful for me is to focus my attention seriously on that patterns of interaction and interdependence between those delivering the service, and how I am acting "with in the flow". In other words, taking opportunities to work along side staff who are delivering front line service to patients. In these processes, I am becoming more aware of the emotions involved, for my self and others. I explored the extent to which a psychodynamic perspective, with an emphasis on the role of the unconscious as both direct and indirect influencer of behaviour offers insight into the way in which anxiety is both created and managed. However, in coming across Elias's work on Involvement and Detachment, I am beginning to consider whether much of the anxiety I am currently experiencing is reflecting an increasingly overly involved stance. These are considerations I will take into Project Four.

PROJECT FOUR: UNDERSTANDING QUALITY IMPROVEMENT AS A SOCIAL PROCESS

Introduction

In this project, I continue to pursue the line of inquiry from Project Three, where I began to think about quality improvement as a social process. Thinking in this way, I have come to see that working with performance improvement in the context of nationally set targets means continually engaging in local interaction. In this narrative, I explore what I understand to be happening as I follow a fairly clear set of intentions in my practice from the perspective of complex responsive processes.

My intentions in my practice that follow on from Project Three are to:

- Promote more varied conversation;
- Focus on the specifics of the day-to-day activities that are involved in meeting national access targets, or not; and
- Draw attention to the interdependent nature of these day to day activities

I stay with the experience of working with teams of staff who are involved in the emergency care pathways for patients coming to our hospital and how we are, together, making sense of the impact of national targets for patients and staff. I locate these reflections within conceptualisations of service quality set out in existing health service literature, drawing attention to the dominant ideology of managerialism running through mainstream perspectives. I write about what I understand is happening as I join the A&E team in an explorative conversation that focuses on making sense of their day-to-day practice of assessing and treating patients. This work involves us coming together to understand why some patients are not being seen within the target time that has been set, and, conversely, the actions and conflicts associated with why most are dealt with within the target set. I propose that it is more useful to consider issues of quality from the perspective of

these daily interactions. I argue that in paying attention to the quality of participation in the living present of our conversation, I begin to notice patterns of power relating that strongly influence the nature of that interaction and what it is considered possibilities "appropriate" to talk about in response to questions of "what are we doing?". Furthermore, in taking these processes of interaction seriously, I argue that I am more aware of the themes emerging in our ongoing conversation and can draw others attention to the small differences that are being amplified to produce what we experience as improvement in performance.

Historical context for performance improvement

The Accident & Emergency (A&E) department at the hospital has had a rather chequered history over the last 5 years, during which it has been the focus of much external scrutiny. Following the death of a patient in 2001, a national regulatory body for quality in NHS organisations, the Commission for Health Improvement, instituted a review that highlighted the following areas for improvement:

> The Commission found that some of the problems the external enquiry found in the emergency department also existed in other parts of the Trust. These include team working, support from managers and other departments, staff knowing about policies and procedures and a lack of sense of accountability. There has been a lot of work in the emergency department to improve emergency care services and strengthen nursing leadership, and significant progress is now being made particularly around the roles and responsibilities of nursing staff, documentation, team working and risks to patients. Team working between some managers and clinicians needs improvement to help progress improvements in services. Roles need clarifying for Clinical Directors, in particular, for the new lead clinician for emergency care. The lead clinician role has the potential to positively affect the difficulties between the ward based specialities and A&E which need addressing urgently. The encouragement of sharing of good practice is a stated priority for the Trust. Multidisciplinary team working needs development.

> (Commission for Health Improvement, 2002: 4)

Following the Commission for Health Improvement report, a variety of management consultants have been brought in to review patient flows into, through and out of the department. Many action plans were developed on the basis of these diagnostic

reviews, most of which do not seem to have made any sustainable impact on performance as measured by compliance with the nationally determined access targets within the department. In September 2005 I joined the Trust. The A&E department, although improved on some parameters such as serious untoward incidents, staff retention, and patient complaints, continued to struggle with achieving the four hour target.

Having a good quality, effective and efficient A&E department is central to our current role as a district general hospital and to our forward aspiration to maintain this status for the organisation. In a recently published clinical strategy for the hospital, we have identified that: "meeting the growing demand for emergency and unscheduled care without any comparable growth in our resources is the most substantial challenge which our clinical services will face over the next five years". There is also a larger review of the future of district general hospitals taking place within our city. Relative performance in matters of quality of access, safety and financial balance are all key concerns and will, at least in some part, influence emerging decisions. There have also been financial difficulties at the hospital and a "Turnaround Director", who has not previously worked in the National Health Service or healthcare, has been appointed from the private sector for a period of six to nine months to work with our Chief Executive to implement a recovery plan to bring the hospital back into financial balance. There is a desperate need for a change in the way we organise, that needs to secure current income and reduce expenditure - that is, we need to treat the same numbers of patients, train similar numbers of students (both key income sources for the hospital), with fewer staff (the key expenditure stream for the hospital).

The way of thinking reflected in this history and the perspective I am now taking
Over the past five years, then, areas for improvement have been highlighted and the approach adopted to bring this about has focused very much on the use of 'tools', as is the case across the NHS. For example, in a Department of Health sponsored literature review, the authors state that:

No single method, strategy or tool will fit all problems or situations that arise. Managers in the NHS need to be adept at diagnosing organisational situations and skilled at choosing those tools that are best suited to particular circumstances that confront them.

(Iles and Sutherland, 2001: 19)

Another writer, Plesk, proposes that:

The tools of quality management help us solve problems and redesign processes in order to improve customer satisfaction and reduce waste ... the invitation to add new tools to the kit of quality management will not be taken as threatening by those who understand history. The history of quality management is rich in acquisitions of methods from the fields of statistics, engineering, operations research, organisational development, market research, psychology and others...the field of quality management has a strong heritage of using techniques that work, regardless of their origins. Quality managers should be working now to supplement their traditional analytical, leadership, change management and group process skills, with new tools...

(Plesk, 1997: 20)

The exhortations of Iles and Sutherland and Plesk reflect a particular way of thinking about organisational change, where organisations are understood as systems and those involved in change management and quality improvement can operate as autonomous individuals who design improvement tools and control improvements according to plans. In other words, it is taken for granted that it is possible for a powerful individual to step out of the organisational system and treat it as an object for manipulation and change, following the diagnosis of problem areas and gaps. Yet, at other times, that autonomous individual becomes part of the system and is subject to manipulation and change designed by others. As with much of the literature on change management this approach sets 'thought' before 'action'. In other words, 'thought' is understood as the formulation of a plan and 'action' is the implementation of that plan. Hence we have the many reviews and monitoring processes calling for further plans for improvement in order to reach targets and teamwork to implement those plans. However, these efforts usually prove to be short lived, leading to the call for sustainable improvement:

> Sustainability is when new ways of working and improved outcomes become the norm. Not only have the process and outcome changed, but also the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed in support. In other words it has become an integrated or mainstream way of working rather than something added on. As a result, when you look at the process or outcome one year from now or longer, you can see at a minimum it has not reverted to the old way or old level of performance. Further it has been able to withstand challenge and variation; it has evolved alongside other changes in the context, and perhaps has actually continued to improve over time.
>
> (Buchan et al, 2005: 190)

In most studies the organisation is assumed to have its own existence, separate and distinct from the people who work in it or have some sort of other relationship, such a customer, with it. The organisation, in this sense, can be clearly defined and the organisation chart makes it visible. Within this structuralist and deterministic model of working life, the focus continues to be on ways of making this machine more efficient and more reliable (Harding, 2005). I will argue that it is such a perspective that leads researchers, such as Iles and Sutherland and Plesk above, to make the claims they do regarding the importance of tool choice and linear causality. I will propose that this dominant language around change, improvement and targets has resulted in the reductionist appropriation of the quality movement in healthcare and the ongoing experience of short-lived improvements at best, despite considerable energy being dedicated to planning processes.

My thinking about how I work with others *intending* to improve services for patients has moved significantly. In taking a complex responsive processes approach to making sense of my work, I have been influenced by a view of *intention as a dynamic* concept, emerging out of interaction and underpinned by the concept of human beings as interdependent (Elias, 1939). During the process of my inquiry, I have become aware of the way in which my intentions emerge in interaction with others in the conduct of my research. The research methodology involves iterations of narrative writing about what I do, working in small and large groups, and engaging with the broad literature. Elias (1939) identifies that although we each have our own individual intentions, as we interact it is not possible to predict the

outcomes that emerge from this social intertwining. Furthermore, in the intertwining of many intentions, there is constantly present power relating, and as our interactions go on these power balances shift. Inquiring into my practice from this perspective has led to me to a rather different understanding of quality and improvement than that taken up in much of the mainstream health improvement literature. For me, quality improvement is more usefully considered in terms of the constantly iterated intertwining of intentions reflecting shifting patterns of power relations. This builds on the perspective emerging from project two, where I came to understand 'service improvement' as a cult value (Mead, 1923) that is functionalised in daily life. Mead's emphasis on the need to stay with the immediate and understand what is happening, in patterns of power relation and conversational themes, has become a central consideration for me in my daily practice as a health service manager.

Understanding organisations as patterns of local communicative interaction that lead to further patterns of interaction, always with the possibility of new population-wide patterns emerging from the myriad local interaction has important implications. For example, diversity and difference within these processes of interaction are essential to the potential emergence of novelty in our patterns of going on together. In my inquiry, it has become particularly meaningful to focus attention seriously on the patterns of interaction and interdependence between those delivering the service, and on how I am acting "within the flow". This has involved increasing my participation in the operation of A&E. The main focus of the narrative that follows is work with the emergency department team. This is set within the context of the wider hospital and what might be described as "partner agencies". Much of what I do in the work with our emergency department team, I believe, is strongly influenced by relationships with other key groups, including the executive team, the hospital consultants, clinical site management team, senior nurses and the social services team.

Managerialism (New Public Management) as a dominant ideology
I begin with an overview of managerialism, arguing that this underpins the dominant way of thinking about improvement in organisations and exerts an, often unreflected

and taken-for-granted, influence in the context for my day-to-day practice as a National Health Service manager. Thomas and Davies (2005) suggest that increasing political attention on the management of public services has "been marked by the ascendancy of the managerial prerogative and the legitimacy of management" (Thomas and Davies, 2005: 684).

Essentially, whilst there may be no single or unified model, the discourse of managerialism advocates adoption, and privileging, of private sector styles of management by public sector institutions (Deem, 2001; Ferlie et al., 1996; Hewison, 2002). Hood (1991) identifies a set of doctrines that appear in most discussions on managerialism:

- Hands-on professional management in the public sector - shifting the emphasis away from traditional value placed on the policy skills for administrators to a regimen where accountability requires clear assignment of responsibility for action at the "top" of the organisation, not diffusion of power, challenging the traditional power base of professionals, such as clinicians, teachers, university lecturers, and so on;
- Explicit standards and measures of performance - with clearly defined goals, targets and indicators of success quantitatively expressed, challenging the deference to professional autonomy;
- Greater emphasis on output controls - with resource allocation and rewards linked to measured results, with less emphasis on processes;
- Shift to desegregation of units in the public sector - with a view to breaking up formerly "monolithic" units into more "manageable" units;
- Shift to greater competition - moving to contracts and public tendering procedures, with rivalry driving lower costs;
- Stress on private sector styles of management practice - moving away from the public sector ethos to an emphases on the importance of using "proven" private sector management tools, reflecting an "a priori" assumption about management efficacy in the private sector and;

- Stress on greater discipline and parsimony in resource use - promulgating the cult of needing to do more with less.

Hughes (1996) proposes that managerialism has it roots, at least in part, in a widespread perception that old-style bureaucratic controls had been largely ineffective in the delivery of agreed policy objectives for public sector institutions, and a growing interest in alternative ways of motivating staff and securing their commitment. Increasing managerial freedoms within a framework of decentralised cost centres and self-governing units are considered by proponents of this way of thinking to require a fundamental shift in orientation of the workforce. In the United Kingdom health service, the Griffiths Report (Griffiths, 1983) was a marked policy attempt to move away from consensus management models in the NHS, in which the medical profession was seen to dominate. The Griffiths report is often identified as a significant step in moving the managerial role from one of administrator, servicing professionals, towards what some commentators have described as "a more adversarial relationship between managers and professionals" (Sutherland and Dawson, 1998). In addition, the introduction of national performance measures, monitored at unit level, has been claimed to be significant in enhancing the importance of management within public sector organisation, since, from the managerialist perspective, managers are seen as responsible for the achievement of such targets (Cutler and Waine, 2000). Along similar lines in the health service, the desire to bring doctors into the same framework of accountability as managers, with a much clearer recognition of the economic consequences of clinical decisions has been perceived as crucial. This was followed by further reforms in 1989, with a change in tactic - still within the ideology of managerialism - where rather than seeking to impose managerial and financial discipline via managers, the push was to involve doctors in management and inculcate them with managerial values. The role of lead clinician can be seen as a legacy of this way of thinking in my hospital.

Supplementing the "efficiency" arguments set out in the policy documents supporting the reform agenda of managerialism in the public sector, has been the claim that service quality would be enhanced. Shortly after the 1989 reforms, a

further policy paper "Working for Patients" stated that devolving management powers to NHS Trusts, in the context of a competitive market, would mean that "...they will have an incentive to attract patients, so they will make sure that the service they offer is what the patient wants" (Department of Health, 1989: para 1.9). Again, we see here a claim to put consideration of quality in this case, as defined by patients, firmly on the policy agenda. Such an optimistic interpretation of managerialism as a way of focusing on the needs of the service users is not without its critics. Pollitt (1993) characterises as "neo-Taylorist", the managerialist emphasis on quantification and measurement. Within this, the role of managers to taken to be predominantly about controlling members of the organisation to work as efficiently as possible. Pollitt also identifies how ideas from the literature of "quality, excellence and improvement" have been incorporated into the New Public Management perspective, which he contends is a rhetorical ploy in presenting the neo-Taylorist strand in a more acceptable way. As Walby and Greenwell (1994) argue:

> Quality indicators, outcome targets, performance review, peer review and so on could be used to improve the service to patients, but in the context of fierce "cost containment" they are as likely to be used to squeeze workers. Underlying new wave management theory is a conception of human nature which is optimistic, one in which people will be productive if they are treated well and will use autonomy creatively or customers; but this rhetoric is assimible to Taylorist techniques, with its tight control over a set of workers who are deemed untrustworthy.
>
> <div align="right">(Ibid: 77)</div>

Dalal (1998) proposes that a key aspect of any ideology is the construction of binary opposition. A binary opposition is usefully thought of as a way of expressing extreme forms of difference - for example, birth/death, us/them, man/woman, manager/doctor. A sort of hierarchy exists in binary oppositions, whereby one term of the opposition is always dominant (e.g. man over woman, birth over death, and so on), and the binary opposition itself exists to confirm that dominance. In the ideology of managerialism, the binary opposition could be thought of as manager/doctor - where in the official ideology the manager is dominant. For

Eagleton (1983) "...Ideologies like to draw rigid boundaries between what is acceptable and what is not" (Eagleton, 1983: 133). Being, for the most part "invisible to the conscious mind", ideology makes it appear that particular categories are natural and inevitable ways of thinking and experiencing. For Stacey (2003a):

> Organising themes of an ideological nature are fundamental to human relating because it is these themes that make current power relations feel natural, so justifying them. Of great importance are the official ideological themes that determine what it is legitimate to talk about in the organisation.
>
> (Ibid: 363)

Referring back to the historical context of the A&E department, it is possible to see how a managerialist ideology provides the basis for both the ways in which the problems have been presented and the potential solutions, in the forms of increasing scrutiny and calls for ever more precise role clarity for lead clinicians and recovery plans. Furthermore, the thinking that underpins the drafting-in of a private sector "Turnaround Director" is entirely consistent with the doctrines of named senior accountability and privileging the skills of private sector managers (Harvey et al., 2004; Jas and Skelcher, 2004). I will, however, point in my narrative to an unofficial ideology that operates within the hospital, which essentially flips the official binary opposition of managerial domination, becoming doctor/manager - where, in the shadow conversations of the organisation it is often the doctors who are thought of as dominant. This has a powerful effect on daily interactions. It is also worth noting that with a binary opposition, the structure of domination is codependent, in the sense that one side depends on the other in a much more complex way that the simplistic binary structure suggests. Interestingly, Spurr (1993) identifies that efforts to break down various kinds of binary separation tend to be located in an emphasis on the interactive and dialectical effects of the "binary" encounter. I take this as emphasising the importance of paying attention to the encounters between doctors and managers through the processes of their daily interaction. It is my contention that it is in paying attention to these interactions, that we begin to notice the importance of the quality of participation and the ways in which this is, often

unconsciously, influenced by ideology and, the associated binary opposition. Thinking about quality improvement, in this sense, moves from concern with diagnosing problems, selecting the right tool, and abstract ideas of various system levels, to what is happening in the thematic patterning of our interaction from which choices, and responses to these choices, then emerge. These are the issues of quality I endeavour to expand on in my narrative below.

Performance begins to deteriorate

In this narrative, my experience of quality improvement emerged from my initial fixation on our weekly performance as measured by achievement of the four hour emergency access target. At the beginning of the year, our percentage "results" began to deteriorate. As our performance trend began its downward trajectory, Bill, Director of Operations, and I talked together about what we might do. A new manager, Bob, (on a temporary consultancy arrangement) had been recruited following a similar, but less dramatic, dip in performance against the emergency access target in the Autumn. I wrote about experiences of working with Bob in project three. After an initial positive impact in bringing some new processes into place, something was changing. Both the lead clinician and the head nurse had been to see me separately to raise concerns about strained relationships in the department. It seemed, to me, that Bob was being increasingly excluded by senior staff in the department. An allegation of falsifying the performance figures was made. There was a discussion with Bob regarding the growing concerns about credibility that culminated in him leaving. Now, requests for a recovery plan were being made by the Chairman and by the Department of Health. I felt helpless, anxious and very responsible.

The Friday meetings I discussed in Project Three continued to take place but now I was recognising the need to do something in addition to these. The anxiety I was experiencing felt like somewhat of a double bind. To continue as a relative bystander as performance deteriorated was not an option. The Chairman and Chief Executive were understandably looking for leadership on this issue from Bill and I. It is my personal experience, which I touched on in Projects One and Three, that prolonged

deteriorations in performance result in intense external scrutiny of senior managers from the performance management teams at Strategic Health Authority and Department of Health. It is not uncommon for that to lead to external teams being identified to "come in and sort things out". It has also been the case that this sort of performance deterioration, as measured in failure to hit national targets, can result in a change in leadership at the top of the organisation. Indeed, in one of the Chairman's morning chats with me, he asked me whether, what he perceived as, the current inability of the Emergency Department Team to achieve 98% constituted a failure of leadership. I took that as a challenge to my contribution.

At the same time, I was aware that there was another aspect to the anxiety I was experiencing. On the one hand there was the risk associated with the implied threat of sanctions externally and from the immediate hierarchy of the Chairman and Chief Executive. There was also another issue for me connected to the personal risk I felt in getting closer to the day-to-day activities. I believe, for a period of time, this constrained taking any action. This personal risk of closer involvement is linked to what I can only describe as a pervading "organisational" story of the department, a story of how difficult it is to "manage" the staff in the department and a long running management frustration with the perceived inability to command and control improvements in performance. There was another dimension to this. In common with other highly specialised areas, for example, Intensive Care and Maternity, the A&E team have a reputation for being inward looking and elitist, with little engagement with the wider workings of the hospital. By involving myself very visibly in the day-to-day activities of the department, I could become part of that "internal" dynamic. I could become strongly implicated in the stories of success or failure. I experienced this as a real personal risk that did affect my ability to think clearly about how I might work with the team. Yet, in acknowledging this, I now feel rather cowardly, and imagine others being quite horrified by what might be seen as an abdication of responsibility. But at the time, the anxiety in the moment outweighed any fears of what other members of the management community might think of my behaviour and resulted in a period of avoidance.

The threads of managerialism run through the organisational "story" of the A&E Department as difficult to "control", the exclusion and eventual removal of Bob, the threats of external sanction, my feelings of anxiety and my avoiding behaviours. As Sarra (2005a) succinctly puts it "the new managerialist rhetoric is a powerful, coercive tool with which professional identities and relationships are shaped" (Sarra, 2005a: 250). The mainstream literature on quality improvement, which I consider in what follows, frequently fails to address such issues of risk and anxiety bound up with competing ideology.

Conventional notions of quality improvement and the place of targets
From the broad literature
Patrick Dawson, an academic researcher who has studied the introduction of quality management programmes in a variety of industrial and public sector organisations in Australia, New Zealand and the United Kingdom (Dawson, 1994; Dawson, 1996; Dawson, 2003) suggests that "definitional ambiguity" is an integral part of the quality phenomenon. He asserts that:

> ...academic attempts to find a truly comprehensive definition of quality - rather than an identification of broad elements - are misplaced as they fail to recognize the fluid nature of many quality programmes...
>
> (Dawson, 1996: 149)

Tracing the historical emergence of quality management and connections to workplace change, Dawson identifies Armand Feigenbaum's work in the 1950s as seminal in the identification of quality as an important business component in pursuit of competitive advantage:

> Consumers - both industrial and consumer - have been increasing their quality requirements very sharply in recent years. This tendency is likely to be greatly amplified by the intense competition that seems inevitable in the near future
>
> (Feigenbaum, 1956: 93)

Since that time it would not be unreasonable to suggest that there has been an explosion of quality techniques, which has added to the confusion over what constitutes a quality initiative. Dawson proposes that part of the explanation for the

ongoing confusion is found in the historical development of the quality movement. He identifies essentially three phrases in the historical development process. Despite the chronology of these phases coming one after the other, the defining characteristics of all three phases continue in the myriad of explanations of practice in contemporary accounts of quality improvement.

The first phase - Quality Assurance and Accreditation - is associated with the use of statistical techniques for measuring the actual quality against established quality control standards and to identify variability (seen as undesirable) in the production processes before defects were produced, rather than removing unacceptable components after production. The quality assurance and accreditation approach promotes formal documentation of procedures for controlling quality at each step in the manufacturing process. Typically, standards are established and evaluated by appointed assessors. Successful assessment is often connected to certification, which can be thought of as a symbolic representation of quality, although critics argue these documentary reviews of procedure may have little, if any, impact on efficiency or improved performance (Wilkinson and Wilmott, 1995).

In the second phase - Quality Control - we see a move to encompass what is described as employee commitment. Feigenbaum (1956) was one of the early advocates of quality being the responsibility of all groups in organisations. The assumption was that by promoting systematic joint effort to satisfy customer requirements, there would be a concomitant reduction in costs associated with errors, rework, and customer dissatisfaction. This rhetoric of joint systematic effort is an issue I explore in more detail a little later in this paper.

The third phase - total quality management, continuous quality improvement and cultural change - moves from quality being the responsibility of all, to what Dawson (1996) describes as "total" employee involvement:

> Greater communication and a more open management approach is deemed more appropriate to developing systems which engage employees in continuous process improvement...devolved responsibility...new teamwork

arrangements...the old adversarial approach of "them" and "us" is replaced by a dominant quality culture which promotes collaboration and employee involvement...by defining quality on the basis of customer expectations rather than developing quality systems on established specifications and standards, the ongoing dynamic of continuous improvement is built into the approach and contrasts with traditional conceptions of quality based on the setting of internal standards and measurement

<div align="right">(Ibid: 59-60)</div>

What constitutes greater communication, more open management and new team working arrangements is less clear.

The mainstream literature is replete with a variety of prescriptions since Feigenbaum's early work. Influential quality exponents since Feigenbaum include: Demings (1982), who argued that reducing variation in every process is key to producing predictable degrees of uniformity and dependability at low cost; Ishikawa (1985) who advocates the use of tools, such as Pareto charts, flow charts, cause and effect diagrammes, for those engaged in quality management; Juran (1991) who identifies three managerial processes of quality consisting of planning, control and improvement, with top management retaining responsibility for quality within the system, while employees are trained to control the quality of processes they have been assigned to; Crosby (1980), who emphasizes the importance of doing things right first time, arguing for "Zero Defects" to avoid the costs of fixes or re-dos; and finally, Imai (1986) who uses the term "Kaizen" which means improvement in Japanese. Kaizen, in Imai's use of the term, centres on the notion that individuals on the shop floor, so to speak, will be the most knowledgeable about their work and if given the chance, will want to be involved in activities which may serve to eliminate the daily headaches caused by persistent hitches in either the manufacturing of a good or in the delivery of a service. He sees a key management task to support and facilitate employees in their ongoing pursuit of quality improvement. The Kaizen approach particularly interests me from the perspective of involving staff through a focus on their day to day work. However, Morris and Wilkinson (1995) make an interesting assertion regarding the "global applicability" of Japanese management techniques when they observe that in their international experience:

> The extent of teamwork and employee involvement in quality circles and the like vary greatly, but the more basic tenets such as waste elimination, continuous improvement and fault tracing are pursued relentlessly whether it be in autos in the USA or electronics in Malaysia...successful transfer depends more on the establishment of management prerogatives than an amenable societal culture.
>
> (Ibid: 728)

For all of these writers, thinking about organisations as systems underpins their considerations of quality and improvement. I propose that it is this perspective that leads to a privileging of the more mechanical and/or cybernetic elements of quality improvement - such as the tools and techniques of waste elimination and fault detection - over the emphasis on social interaction which takes place in employee involvement programmes, team working and quality circles. Before I expand on a rather different set of ideas about quality, firmly located within the social - ideas about the quality of participation and the quality of conversational life (Stacey, 2003a) - in the following section, I look specifically at how quality is dealt with in the main health care literature. In particular I draw on the work of Kim Sutherland, who with a variety of co-authors, has published extensively on the subject of quality in the NHS (Sutherland and Dawson, 1998; Sutherland and Leatherman, 1998; Leatherman and Sutherland, 1998; Iles and Sutherland, 2002; Sutherland and Dawson, 2002; Leatherman and Sutherland, 2003; Sutherland and Leatherman, 2004; Letherman and Sutherland, 2004).

From healthcare literature

Leatherman and Sutherland (1998) report on their study funded by the Nuffield Trust which sought to "evaluate the context, policies and processes in the NHS that influence the capacity for quality improvement in health care" (Leatherman and Sutherland, 1998: S54). Their methods included a literature review, documentary analysis and interviews with what they describe as key opinion leaders. In conceptualising quality they identify that:

> Quality...has lacked a shared understanding, a set of common standards, and any explicitly stated common goals which are universally subscribed to, thereby making it difficult to drive forward a meaningful quality agenda. Yet health care quality is an agenda that must rely on objectivity and rational measurement. It is

essential to make explicit the objectives and rationale for a quality agenda as well as to specify the expected contributions of quality evaluation and improvement

<div align="right">(Ibid: S54)</div>

Leatherman and Sutherland hold that quality improvement efforts, rooted in an ideology of efficiency, effectiveness and economy, can contribute to performance improvement. Clearly, these researchers are working from a managerialist perspective. They propose three constituencies "to whom quality is delivered" - individual patients, patient populations, and the health system. So individual patients may see quality as unlimited expertise and technology directed toward their particular problem. Quality from a population perspective may involve notions of the greatest good for the greatest number. Leatherman and Sutherland also argue that there is a healthcare system that requires specific quality considerations and initiatives if it is to function effectively. They proceed to evaluate NHS quality on the basis of the extent to which current and proposed policy initiatives deliver quality to the three constituencies. Where they end up involves a proclamation that the package of reforms set out in " *The New NHS: Modern and Dependable"* (Department of Health, 1997) is "the most ambitious, comprehensive and intentionally funded national initiative to improve healthcare quality in the world". However, they are also of the opinion that the reforms lack coherence, and they argue that so far there has been much greater impact at national and regional levels than at institutional levels or individual levels. It is their contention that " ...by and large, control of quality at the individual patient level has been left to processes of professional values, trust and clinical autonomy" (Leatherman and Sutherland, 1998: S56).

Sutherland moves to consideration of the "institutional and individual level" from the perspective of the doctor-manager relationship and a view on how this relationship impacts on quality in an article co-authored with Sandra Dawson, Director of the Judge Institute of Management Studies at the University of Cambridge (Sutherland and Dawson, 1998). They take a perspective whereby issues of control and power are inextricably linked to quality, embodied by key questions

such as who can judge and regulate performance, who should decide what is to be done, and how should resources be allocated. So in terms of what they see as the key questions, the assumption of the ability to control for pre-determined outcomes remains central within their conceptualisation of quality. Power, in this way of thinking, is taken to be this ability to control and a "thing" that some have and others, by implication, do not.

I take up issues of power, diversity and doctor-manager relationships in relation to ways of thinking about quality improvement later in this paper. At this point, however, I want to summarise what I see as key issues in the mainstream perspectives on quality improvement. The literature I have referred to in the preceding sections reflects a mix of both cybernetic and humanistic ideas. From the cybernetic perspective (Bowland and Fowler, 2000), the emphasis is on the ability to control for pre-specified outputs and/or outcomes (e.g. achieving targets) with strong feedback mechanisms (e.g. performance management systems). Difference, in this way of thinking, is something to be avoided, or corrected where it does arise. The humanistic perspective focuses attention on the importance of emotional and inspirational factors that are taken to motivate human beings (Maslow, 1954). Key to this way of thinking is an argument that people are naturally creative and motivated by achievement and will direct and control themselves, pursuing self-actualisation. The emphasis is on the individual and his/her latent potential. This can be summarised as an ideology to with control and caring, where it is taken for granted that rational individuals can, if so motivated, improve and modernise organisational systems to achieve what they have decided in advance to be efficiency and quality improvement. Essentially, underlying this way of thinking are notions of rationalist and formative causality - in the sense of quality being enfolded into the system by the designer and assumed to unfold in response to appropriate performance management. My lived experience has been somewhat different. Working in an environment where the dominant discourse reflects these ideologies, I employ similar rhetoric to avoid the risks of exclusion and have no choice (I believe) but to take seriously, the issue of performance as measured in relation to compliance with

meeting the targets that have been set nationally. I may be using the rhetoric, but as I have identified above, through the experience of my developing inquiry in projects two and three, I have come to think of quality improvement as a social process. Thinking in this way, I have come to see that working with improvement in the context of nationally set targets means continually engaging in local interaction, in contrast to attempting to design solutions for teams to implement. My interest is now on what I understand to be happening as I follow a fairly clear set of intentions in my practice from the perspective of complex responsive processes as I join the A&E team in an explorative conversation that focuses on making sense of their day-to-day practice of assessing and treating patients.

Moving from Taylor's machine metaphors to the organisation as conversation
In Projects Two and Three, I focused on two of the major theoretical strands of complex responsive process thinking, Mead's (1934) theory of communication and Elias's (1939) figurational/processual sociology. In this project, in addition to the importance of ideology as the basis for our intentions and power relations, I have been struck by the usefulness of the analogies drawn from the field of complexity science as employed by Stacey et al (2000) in the development of the theory of complex responsive processes. Focusing on self-organisation and emergence, and evolution over time as key concepts of complexity, Stacey and his colleagues draw attention to the thematic patterning of human interaction. Conversation is the activity in which we either sustain or change possibilities for going on together. In this sense, conversation is understood as a non-linear process characterised by self-organising patterns of meaning in the form of ideas and themes, and patterns of power relating. They adopt Elias's (1978) critique of the conventional use of the word "power" as misleading, as he sets out in *What is Sociology*:

> We say that a person possess great power, as if power were a thing he carried around in his pocket. This use of the word is a relic of magico-mythical ideas. Power is not an amulet possessed by one person and not another; it is a structural characteristic of human relationships - of *all* human relationships. The [game] models demonstrate the relational character of power in a simplified form. In order to use the models of game contests to bring a series or power figurations into close focus, the concept of "power ratios" is replaced...by the term "relative

strength of players". Even this phrase can be misunderstood as an absolute. However, it is obvious that a player's playing strength varies in relation to his opponent's. The same goes for power, and for many other concepts in our language. The game models help to show how much clearer sociological problems become, and how much easier it is to deal with them if one reorganizes them in terms of balances rather than reifying terms

(Ibid; 75).

In drawing attention to balances of power as an integral element of all human relationships, Elias argues that, similarly, power relations are bi-polar at least, and usually multipolar. He gives, as a most basic example of the bi-polar figuration the balance of power between master and slave:

The master has power over his slave, but the slave also has power over his master, in proportion to his function for his master- his master's dependence on him. In relationships...power chances are distributed very unevenly. But whether the power differentials are large or small, balances are always present wherever there is functional interdependence between people.

(Ibid: 74)

In taking Elias's perspective, power relations, then, are about dependency. In continuing in any relationship there are enabling and constraining aspects to the nature of dependency where the power balance, influenced by relative need, is tilted in favour of some and against others. In my experience of working with the A&E team, I am dependent on their expertise in relation to the clinical care being experienced by patients. This forms a vital aspect of the day-to-day activities constituting performance. Equally, in relation to accessing the support of senior managers and clinicians beyond the A&E department, I might be seen to offer the team a possibility of senior support through access to fora and conversations they have previously been excluded from. I return to the importance of shifting power relations and the connection to quality improvement a little later in this paper.

Building on the perspective of the non-linearity nature of conversation, Stacey et al point to the way in which the direction and content of conversation emerge spontaneously in turn-taking interaction. So while themes may be introduced

intentionally by a participant, how these are taken up and what emerges cannot be controlled - in short, a conversation cannot be designed. New themes and patterns of relating continually emerge, which may or may not be taken up and carried forward, or may be transformed. In other words, both stable and novel patterns are possible in the living present processes of communicating. The organisational "story" of A&E as a difficult to manage department can be understood, from this perspective, as a stable, or stuck, theme. It is not only patterns of meaning that develop, patterns of relating also emerge. So, in the case of A&E, we begin to see a way of behaving towards that team, as evidenced in the frustration being expressed by Board members in the story that follows, which ignores the essentially co-created aspects of the organisational story.

Suchman (2004) provides a useful summary of the non-linear properties of communicative interaction, that have become important considerations for my day-to-day practice:

- Patterns of interaction are self-organising. Pattern emerges without conscious design, made possible by simultaneous enabling, (i.e. the wide latitude of possibility, in each person's next conversational move) and constraining factors (i.e. we cannot always say exactly what we want if we want to stay in relationship with others).

- Patterns are created and maintained in the living present of ongoing interactive process of relating. If the interacting ceases, if there is no relating, then there is no pattern. Patterns must be continually re-enacted and maintained in either public conversations between people or in the silent conversation we have with ourselves.

- Amplification of small differences is always a possibility. Responses to an unexpected word, glance, novel association or misunderstood meaning can cascade into a whole new, transformative pattern. Without diversity and difference novel patterns cannot emerge.

- Outcomes are unpredictable and uncontrollable. The potential for small differences, that we may not even be aware of, to start a cascade of amplification

and transformation means we cannot know in advance what the outcome will be.

The idea that patterns are being formed and maintained in every moment, and subsequently that every moment holds the potential for change provided a key insight for possibilities in how I might approach my work with the A&E team. What the possibilities might be in practical terms, emerged slowly in the conversations I was participating in which, initially, focused almost exclusively on how to improve our relative performance in relation to the 4 hour target.

Opportunities for some new openings - beyond the rhetoric of joint systematic effort
As the pressures for change mounted, Bill and I began to consider alternative patterns of engagement. I was also thinking about the importance of diversity. How might we invite different voices into the discussion about opportunities to improve performance, i.e. the day-to-day activities of performance? Our interaction to date felt to me as if it was always through the filter of the senior staff in A&E. By this I mean my interaction was pretty limited to the group of senior staff in the context of the Friday meeting or through meetings with Eddie, the general manager, and Bob, the temporary operations manager, prior to his departure. As performance against the 4 hour target deteriorated, the meetings with Eddie and Bob became more frequent. They produced several papers during this time, which reported on quantitative data on the "footfall" of patients presenting and moving through the emergency department alongside some of the initiatives that were being put into place to try to improve performance. I recall an increasing sense of dissatisfaction being the response from the CEO and Chairman to the papers. They felt that the papers offered explanations for why performance had deteriorated, but little assurance as to where solutions might lie. These papers, however, have since proven to be helpful from my perspective. I have found them to be a useful narrative of ideas of how things might be done differently. Bob had summarised in these papers the new ways of working he had tried to introduce. His papers provide a personal perspective on how these new ideas had variously been responded to, and sustained in practice or not.

The reason that diversity and difference became important aspects of my thinking stems from an emerging sense I had of rather impoverished and routinised interactions / conversations at the Friday meeting. I had begun to notice that interaction was constrained by focusing repetitive conversation around a standing agenda. Outside of the Friday meeting, the recovery papers mentioned above were coming through to the executive team. It seemed to me, however, that there was very little discussion in response to these papers and the prevalent view seemed to be that it was for A&E and clinical site managers to "sort out".

Building on the analogies from complexity science following Stacey et al., (2000), which I touch on above, Fonseca's (2002) account of the way in which new openings emerge, as he considers innovation from the perspective of complex responsive processes, helped me make sense of what was happening during this time:

> ...the process of communicative interaction, in which habitual patterns are continually reproduced, is at the same time the process in which even small variations in the reproduction of habits are potentially amplified. The possibility of the emergent new lies in the inherent property of non-linear interaction to amplify small differences ... amplification of the diversity between participants in communicative interaction, even when that diversity is quite small ... We do not then think of an organisation as something finished and complete that has to be changed by some external operation to something new. Instead we think of iterative communicative interactions in which habits and potentially amplified variations around them are paradoxically emerging at the same time. In this way of thinking no organisation is fixed but is always potentially changing in its perpetual reproduction.
>
> (Ibid: 78)

This suggested to me that there were opportunities and possibilities for different things to happen:

> And if it does not change then this must be because communicative interaction is continually reproduced with very little variation and as themes that damp rather than amplify what little variation there is. In understanding why and how an organisation is, or is not, changing, attention is focused on the way people are reproducing themes organising their experience in their conversational life and

what it is about such themes that amplify or damp difference. Attention is focused not on sharing and conforming to common cultures but on how in their participation people are spontaneously disturbing them with the consequence of increased diversity.

<div align="right">(Ibid: 79)</div>

I now see that I was very much part of the dynamics that have contributed to the prevalent view of "its for them to sort out" that has persisted as a theme within the executive team meetings. Although my silent conversation reverberated with wanting to do something that would help in moving our discussion on, for a time I remained quiet. The challenge, as I was coming to understand, and the discussion I was having with Bill, was how to get more directly involved in the patterns of interaction. At first our focus was in trying to interrupt the patterns in A&E. As I reflect, the challenge was also how to interrupt the patterns that persisted in the executive team conversation. Focusing on A&E dynamics, one proposal we considered, that we hoped might have the effect of interrupting some of the "stuck-ness" in the patterns of interaction, was to run a workshop. A workshop would be an opportunity to involve different people in conversation about the challenges of day to day working. My hope was that this might strike up some new relationships that would continue beyond the duration of the workshop. At the same time, I realised it might not.

The second idea involved our more immediate presence within the A&E department. We discussed options for a different management presence. Initially, we began to think through whether there were any of our other managers who could be transferred to the emergency department. I was interested in understanding more about the history of management input into the department. This was for two reasons. First it is more usual, in my experience, that emergency departments are clinically managed either by a lead nurse or doctor. Whilst Mathew is the Lead Doctor and there are 3 Heads of Nursing, overall management of the department has sat with a variety of general managers. There have been two different managers during my year at the hospital. Second, I felt that reflecting on some of the history might help us to make sense of what was currently happening and open up different

possibilities. We talked with Sue who had previously managed the department and who had moved in an organisational restructuring to focus on managing theatres and intensive care. I silently hoped she might want to consider taking on this challenge. While she shared her view of ways of working within the department, it was clear she was happy not to be so directly involved. Bill and I agreed that it seemed, given the frequent changes in management, the external scrutiny over the previous 5 years or so, and the continuing difficulty in appearing to sustain improvement in national measures of performance, responsibility for improvement in our emergency care pathway was metaphorically a poisoned chalice.

As a director in the hospital, getting closer to the day-to-day activities that constituted our performance on this national target was entirely consistent with the new way I was beginning to think about processes of improvement. How to approach this posed a dilemma for both Bill and I. It would mean a very visible involvement in the day-to-day issues of practice in A&E and the problem was how were we to do this in a way that would allows us both to maintain our broad portfolio of responsibilities and yet contribute meaningfully toward generating possibilities for improvement in performance.

Presence at the "breach meeting" - joining the conversation
Bill and I agreed that as a start we would join the daily discussion taking place that involved review of what are described as "the breaches" from the day before. For some time, a daily performance report of the previous day's results had been coming out via the hospital email. I have come to experience this as a daily "breath-holding" exercise. The covering email is always "Thank you, Sheila". You have to click open the spreadsheet to see the percentage that was achieved the day previously. Those patients who experience a stay in the emergency department greater than four hours are presented as "breaches", their booking in time is recorded, as is the time to triage, to review by emergency doctor, to onward referral (if necessary to specialty doctor), to decision to admit or discharge, to when the patient leaves the department. This became our way into conversation about activities that constitute performance. In addition to meeting with the senior clinicians in the department to review these

reports, we also began the process of committing to bring others into the conversation who had been part of whatever reasons where identified for the breaches discussed the previous day. During the first few meetings, the constant challenge from my perspective was to get people to focus on the specifics of the individual breaches, as opposed to the very much more abstract propositional discussion about "if only" - if only we had more staff, if only we had more beds, if only we had....".

The question that I stuck with during these early meetings was the extent to which each of the reported breaches was explainable in specifics and perceptions of whether any were potentially avoidable. I was asking staff to review each of the reported breaches. From the information we had in relation to the patient's "journey" through the department, which included consideration of what overall numbers and severity of cases were recorded as in the department at that time, my questions focused on what sense people were making of why the patient had not been fully reviewed in the four hour time slot. These conversations have variously involved staff members actually involved in the care of the patient who had "breached" and those responsible for co-ordinating activities in the department - the lead nurse and lead clinician - and the clinical site management team who have a key role in determining which wards receive those patients who have had a decision to admit. In the early days of these conversations, some interesting themes began to emerge during our discussion related to perceptions of how various groups of staff were working. These themes might best be described as "us and them". These themes arose within the A&E department and in other conversations taking place elsewhere in the hospital. Two examples of this are given in the following vignettes.

While I joined the conversations in the breach meeting, Bill was spending time "on the shop floor". He noticed a number of patients getting close to breaching and asked what was being done. It was apparent from the responses he got that there was a lack of clarity about any specific action. Some of the junior doctors he spoke to were unaware of the four hour standard. These instances provided further focus to the discussion at the breach meeting. When we explored why the junior doctors were

unaware of the standard and how this affected their contribution to meeting performance targets, there was an intriguing (for me) reply from one of the consultants to this question - "we don't like to give them bad news". In the uttering of this reply, I was compelled to draw attention to the words he used and how we could make sense of what had just been said. This opened up a discussion about how to go about involving the junior staff, doctors and nurses, in ideas about improving current performance. From this came a suggestion to introduce more regular team reviews throughout the day of what patients were currently waiting for during their stay in the department. This practice of pulling all staff together for a team review of patients currently in the department had been an idea put forward by Bob before his departure. At the time it had been tried for a short period of time, and, then like many initiatives, had simply not been sustained. Now, however, those involved in the conversation about how junior doctors were participating appeared to have some sort of "aha" moment. This, in turn, has lead to more consistent supervision and guidance for staff assessing the patients, and enabled earlier identification of those issues involving speed of response by specialty teams which needed escalation to their consultants. This led, in turn, to the articulation of another long-standing issue. I can only describe this as deep rooted reluctance, even from the senior medical staff in the emergency department, to involve senior doctors from other parts of the hospital in reviewing complex patients or assisting when there are surges in the numbers of patients arriving in very short periods of time. This is an issue that has continued to come up and, until, very recently has seemed very much a stuck theme.

Around the same time as Bill and I started getting more directly involved in this work, I asked the Chief Executive to agree that the weekly performance report was to go to the executive team meeting attended by all executive directors and clinical directors in the hospital. Despite the anxiety being expressed at the most senior level in the organisation about our seeming inability to meet the target, this had not yet become a regular discussion item at this meeting. On reflection, the absence of discussion in this forum is worthy of further consideration given that the membership at the executive team meeting does offer an opportunity for

conversation that involves both senior clinicians and senior managers. Around the time I made this request to the Chief Executive, our new medical director had just been appointed. He is a consultant who has been working in the hospital since the late 1980s and who has the respect of his medical colleagues broadly across the hospital. His joining the executive team meeting coincided with us hitting the bottom of the national league table - 155th Trust out of 155 - spectacularly missing the performance target. His presence at the executive team brought a different and, for me, vibrant contribution. Previous attempts to get the issues of performance seriously discussed by the clinical directors at this meeting had been met with, at best, lukewarm interest. It was as if the issue belonged solely to the A&E department and, consequently, "for them to sort out". The medical director did something rather different. He expressed astonishment that the reputation of the hospital was not causing more consternation - both to his colleagues in the A&E department (where the response of the lead consultant had been that the only way from there could be up), and to his fellow consultants around the executive team table. In the discussion that followed, issues about the adequacy of leadership in the department were raised - again. This had been a repetitive story that I had heard in several different informal discussions and in more formal meetings. It was linked to the pervading story of how difficult the department was to manage. There continued to be little acknowledgement of the contribution that the clinical teams in the wider hospital might make. The other issue the clinicians pointed to as contributing to the current problems was connected to delays at the other end of the patients' journey - that is delays in the discharge of patients from the hospital. They were particularly exercised by delays experienced by those patients who could not go home and were waiting for nursing or residential home accommodation. The delays for this group of patients meant that these beds were not then available for the emergency admissions, which could have a deleterious affect on patients waiting for admission in the A&E department when bed availability was tight - which regularly happens. However, this group of patients accounts for a small proportion of our daily discharges from the hospital. Resolution of these cases lies in the availability of both funding and bed capacity outside the hospital, both issues where these senior consultants have little

influence. I agreed to follow up on our joint working with social services around the patients with delayed discharges. The Medical Director agreed to a discussion with Mathew, the lead consultant in the A&E department, as part of his induction into the medical director role.

A few days later, I asked him how this discussion went. He told me that he had spent some time going around the department, allowing Mathew to tell him about what he saw as crucial issues in relation to achieving improved performance. A number of issues related to the speed with which his consultant colleagues in specialties outside emergency care responded to requests for speciality reviews and length of time they took to discharge patients from the short stay ward - both important in terms of the flow of patients through the department. The medical director asked Mathew what he had done to pursue these issues with his colleagues - whatever the reply was, it was not enough from the medical director's perspective. The medical director agreed to support him in getting stronger messages to colleagues about the importance of their contribution, at the same time he advised Mathew that, in his words "my tank is parked on your lawn". At the time I understood this as a powerful metaphor, underlining the importance of Mathew taking a much stronger leadership role in clinical discussion outside the A&E department for the purposes of improving overall performance. Since then, I have encouraged Mathew to come to meetings outside the department and although there have been more discussions between speciality consultants, backed up by breach data, regarding the impact of their joint ways of working on the achievement of the four hour standard, my sense is of much more to do in this respect.

So how am I to make sense of what has been happening in this work in relation to thinking about quality improvement and how would I describe the impact that this effort has had?

Us and them: patterns of power relating
A key theme running throughout this paper is to do with various aspects of "us and them" in relation to a number of key relationship groupings or figurations, in the

terminology of Elias (1939). Within the A&E department we have managerial and clinical groupings; groupings within the clinical teams of doctors, junior and senior, of doctors and nurses; beyond the A&E department we have groupings of managers and doctors within the multitude of clinical departments - general surgery, orthopaedic surgery, paediatrics, general medicine, gastroenterology and so on; and, of course the executive team and clinical directors, and the Trust Board.

These dynamics feature strongly in the work of Elias and Scotson (1994), in their joint study of relationships between established and newcomers in two neighbouring zones of a working class area on the outskirts of an industrial city that explores the nature of strained relationships between the two groups. In this work, Elias and Scotson identify that across many parameters, for example occupation, education, class, and type of housing the two groups are quite similar. Yet they observed clear social barriers and marked differences in perceived status between the two groups. One feature emerged as key to the tilting of the power balance in favour of the families who had much longer history of living within the "Village", established prior to the neighbouring newer housing development, the "Estate". This was the way in which "oldness" of residence led to a greater social cohesion amongst the families in the "Village", who employed this cohesion in ways that denigrated the newer inhabitants, principally through mechanisms of gossip. As Elias and Scotson identify:

> The term old in this context was not simply a reference to the greater number of years during which the one neighbourhood had existed compared to the other. It referred to a specific social configuration which one can present without leaving much scope for uncertainty. In fact one can set it out as a general model, a template of configurations of this kind. Summed up in this form one may hold it against other similar configurations...In strictly scientific terms "old" in this context is a purely sociological category, and it is a sociological, not a biological, problem to which it refers...If one speaks of some families as "old" one singles them out from others which lack this quality, and it is the reference to this contrast configuration with its specific status differences and tensions which gives to this use of the term "old" its specific social flavour. In its social context, in phrases such as "old families" the term "old" expresses a claim to social distinction and superiority. It has a normative connotation. The families who refer to their own circle of families as "old" regulate their conduct so that it

stands out from others...they represent inheritable chances to exercise power in relation to others which, as a group, have only limited access to, or are excluded from, them...That "old families" are known to each other and have strong ties with each other, however, does not mean that they necessarily like each other. It is only in relation to outsiders that they tend to stand together.

(Ibid: 150)

This sociological use of the term "old" interests me when I consider the work I am involved in at the hospital and the official ideology of managerialism. A key feature of my narrative involves relationships with clinical staff, and, in particular, doctors. The relationship between the clinical directors, including the medical director, and the executive directors in the context of the executive team is one aspect. The relationship between Mathew, the lead clinician, and the A&E team with the consultant group across the hospital provides yet another. In the official ideology of managerialism, the power balance is taken to tilt in favour of managers, yet in my experience I often notice greater cohesion within the consultant groupings. For example, the ease with which the clinical directors have appeared able to disassociate themselves from any obvious sense of responsibility to participate in generating possibilities for change in the activities of performance around emergency care - as evidenced by the pattern of discussion at the executive team meeting. Studies of the longevity of appointments of senior managers in the health service identify that the average tenure of a chief executive, for example, is around 4-5 years. The average for the majority of consultants at the same hospital is around 20 years. I contend that there exists a powerful unofficial ideology, whereby the power balance tilts toward the older established group - in the case of the hospital that is often the doctors.

For Elias, the process of group identity, the sense of I and We, is formed through the interdependent power relating that occurs in an ongoing way between the activities and attitudes of different social groupings towards each other. Elias explores gossip as a feature of interaction that fosters group cohesiveness and insider/outsider identities. Gossip establishes a particular power ratio that favours the gossiper and his/her group at the expense of others. Outsiders with less "chances" in power

relations may identify with and begin to believe in the gossip directed towards them by established groups. For Sarra (2005b):

> Especially in large, complex organisations such as the NHS, groups with various umbrella identities (e.g. nurses, doctors, managers, community teams and inpatient teams) are continually adjusting to each other in the ongoing interplay of power relating. Gossip is a key technique within the process of doing so. By gossiping, one may be covertly, perhaps even unconsciously, creating alliances and processes of alienation which bolster one's own or one's own group's power chances while attempting to diminish those of others... the way we talk about each other at work influences our quality of communication and participation...
>
> (Ibid: 179)

I now see the ways of talking about leadership in the A&E department within the executive team and the "organisational story" of the department as difficult to manage and metaphorically a poisoned chalice as characterising processes of gossiping in my daily experience. Sarra continues:

> ...and in turn, these ways of talking can only be influenced by further conversation. It is therefore only by entering into and participating within the organisational conversation in a way that encompasses difference that a shifting of rigid conversation patterning will occur.
>
> (Ibid: 179)

So Sarra is arguing that gossip is central in sustaining existing power relations and it is only by entering into these ways of talking that the possibility of change arises. More recently, I have been talking with the medical director about the importance of supporting Mathew, not simply in attending meetings with consultant colleagues and executive team members outside the A&E department, but in talking into the discussions taking place. The last month has seen some pretty amazing (from my perspective) steps forward in this respect. Three weeks ago, a discussion was started by the clinical director for critical care denigrating the way the A&E team were calling on intensive care staff to support when the resuscitation area of the department became busy. The general manager for A&E happened to be at that meeting representing her clinical director. I could see her beginning to "prickle" at this. I invited her to respond to the perception being expressed by the critical care

lead. She suggested an off-line discussion outside the meeting. I persisted that it was important we take the opportunity whilst a number of key people were around the table to continue the discussion in the present. The medical director then came in and reinforced the importance to all of our futures of having a good quality A&E service, and that whilst there had been significant improvement in performance in relation to the four hour standard, we remained vulnerable. Something surprising to me then happened. The clinical director for surgery - a long time critic of the A&E team - allied with me and the medical director - A FIRST - he suggested that it would be helpful as he put "in a non-threatening way to have Mathew and the lead nurse (who is now the service manager for A&E) join us next week to explore what we can do to support further improvements". My sense is a significant shift in the power balance, and hopefully processes of gossiping, is beginning to happen.

Within the daily breach meeting, I think the impact of my participation has been to draw attention to ways of talking that abstract us from focusing on how we are to make sense of what has happened the recent past, that is the day before. This, in turn, has become a conversation not simply about the patients who have "breached" but has moved into consideration of the issues of safe practice around some of the measures being employed by staff to prevent breaches - which includes moving patients before they have been fully assessed into the Emergency Medical Centre. This prevents a technical breach of the four hour standard, but is not in the spirit of the standard which is about completing the assessment process and making a decision within the four hour period. A group of staff, comprising an A&E consultant, a clinical site manager and nurses within the Emergency Medical Centre have been auditing this practice and are working through what needs to happen to work to reduce this practice. This is work these staff volunteered to do in response to noticing how often we came back to this as a theme of concern in the breach meeting conversations. My participation, I now realise, is open-ended. What I mean is that I have come to appreciate there will not be a point when I will be able to say "everything is now sorted in relation to A&E" and move on to the next challenge. We have repetitive conversations about many issues, ways of working in

resuscitation and escalation of delays to senior consultant staff being two examples, and I also continue to be surprised by new things (for me) that crop up - for example the patient seen in the department 56 times in the last year, despite an ongoing history of being verbally and physically abusive to staff. However, the opportunity exists in this ongoing pattern of participation to be involved in those moments of small differences, which arise in the process of working with targets in a dynamic, socially interdependent way.

Conclusion

In concluding this paper, it is important to summarise, then, what I think I have been arguing for in terms of what quality is; how I understand how quality comes about; how I think quality might be improved; in what ways this differs from mainstream debates about quality improvement; and, finally, what might be the implications in my argument for others intending to improve services for patients.

It is worth restating at this point, Dawson's (1996) assertion regarding definitional ambiguity as integral to quality phenomena. Harteloh (2003) draws attention to the ongoing debate on the quality of health care, straddling three decades, where definition of quality as been a key issue. It is Harteloh's contention that:

> Discussed are topics such as the effectiveness, efficiency and access of healthcare, the values and satisfaction of patients, the attitude of healthcare workers, and problems such as medical errors and practice variations. The quest for a (good) definition is an important element of this debate. A definition is considered to improve uniformity of thought or speech, and to facilitate meaningful actions, such as quality assurance or quality improvement...we study the meaning of quality by studying its use.

(Ibid: 260)

The overview of mainstream literature I have presented in this paper, identifies a range of definitions of quality. In some, quality is defined as the degree to which care delivered meets pre-determined standards. In others, quality is defined as application of all possible techniques appropriate for the presenting problem. In yet others, quality is defined as the degree of compliance between targets on the one hand and the care delivered on the other. Harteloh highlights the abstract nature of

the term "quality":

> Quality doesn't exist as such. Quality, the thing, is the capacity of an object with its properties to achieve a goal. The more completely the goal is achieved, the higher we will judge the quality. Quality is not the property (the metaphysical quality) or the object or the goal. Quality is an abstract entity. We cannot refer to it as we refer to a table or a chair. Quality is constructed in an interaction between possibilities realised on the one hand and a normative frame of reference on the other.

<div align="right">(Ibid: 261)</div>

I have drawn attention to the way in which dominant ideologies influence what is taken to be normative. So in the mainstream literature, ideologies of managerialism and efficiency have led to a focus on quantification and measurement in the construction of what is taken to be quality. It is my argument that, as managers, we cannot stand outside a "thing" called an organisation and choose a tool or a target that will "install" quality into the service that people experience. Instead we are active participants in the processes of organising, characterised by communicative action. In writing about what I understand is happening as I join the A&E team in an explorative conversation that focuses on making sense of their day-to-day practice of assessing and treating patients, I propose it is more useful to consider quality from the perspective of these daily interactions. It is my contention that it is in paying attention to these interactions that we begin to notice the importance of the quality of participation and the ways in which this is often, unconsciously, influenced by official and unofficial ideology and associated binary oppositions (in this paper I have looked particularly at the binary opposition best described as "us and them"). I argue that in paying attention to the quality of participation in the living present of our conversation, patterns of power relating that strongly influence the nature of that interaction become more evident. These patterns of power relating, in turn, influence the possibilities for change that are considered "appropriate". It is this quality of our interaction at a local level that determines the way we move forward together.

Conversation is the activity in which we either sustain or change possibilities for going on together. From the complex responsive processes perspective, conversation

is understood as a non-linear and self-organising process. Conversation is not something that as a manager I can direct or control beyond my own participation. What becomes important in my participation is how I am working with others to make sense of the thematic patterns emerging in that interaction; patterns of power relating influenced by both official and shadow ideologies, patterns of inclusion and exclusion, who gossips about whom and the nature of that gossip as either praising or blaming and how these, in turn, enable or constrain the quality of our participation together and opportunities to reflect on how we might proceed.

Stacey (2003a) notes the way in which definitions of "quality" in relation to management action are understood differently. In conventional systemic perspectives, a quality action would be taken to be one that produces the desired outcome. I have argued, from a complex processes perspective, outcomes cannot be known in advance. Stacey challenges us to think about how, in our participation, we are contributing to processes of conversation that keep options open, rather than prematurely shutting down conversation. Shutting down happens in many ways including; the rhetorical ploys we use, processes of simply negating what others are saying, rigid adherence to agendas, and, of course, simply avoiding conversation. As Stacey (2003a) points out:

> ...in an unpredictable world, the outcomes of an action cannot be known in advance. It is necessary to act and then deal with the consequences….One is not absolved of responsibility simply because one does not know the outcome. Even though I do not know how my action will turn out, I am still responsible and will have to deal with outcome as best I can.
>
> (Ibid: 420-421)

I hope that in sharing my experience of working with national targets in a dynamic and socially interdependent way, I have given an insight into what I understand to be emerging as I have increasingly paid more attention to the quality of my experience of relating and managing in relationship with others. I hope that this resonates with other health services managers and encourages them to explore what happens in their day-to-day experiences as they reflect on the quality of their participation in the day-to-day interactions that constitute health service quality.

WHAT IS MY CONTRIBUTION?

A different conceptualisation of quality

In a recent publication, Stacey (2006) poses a question:

> ...how are we to develop forms of public sector governance that do take account of the essentially local nature of human interaction, the essentially contingent and conflictual manner in which people are able to go on together to do their work. Instead of importing mechanistic notions of quality from manufacturing, we need to be asking ourselves what quality actually means in the local situation in which healthcare... (is) actually delivered.
>
> (Ibid: 40)

My inquiry provides such an account. While not advocating uncritical acceptance of the work of Stacey and colleagues, I hope I demonstrate the utility of a complex responsive processes perspective to a different understanding of quality - from the perspective of paying attention to the quality of our participation in our day to day interactions. I am not suggesting that recourse to cult values represents the only analytical possibility for considering the issue of quality improvement in healthcare. Rather, I believe I am demonstrating a line of inquiry facilitating a conceptualisation of quality improvement as a cult value that focuses attention on the complex social processes involved in what many take to be a key activity in quality improvement in healthcare - namely working with nationally determined service targets.

What can managers do?

I believe that my inquiry also points to a rather different way of encouraging managers to "walk the patch". From my inquiry, I now realise this needs to be more than simply being seen around the physical accommodation of the organisation. It is about paying attention to the patterns of conversation, noticing who talks with whom and about what, what sort of gossip you pick up, and what sort of gossip you find yourself participating in. It is in the everyday conversations that managers have with staff - and those members of staff have with others - that local opportunities for

change arise. Ideas may be taken up as new themes in our conversations, or not. Providing opportunities for staff to get together, for drawing attention to the importance of focusing on what we are doing in the present, being alert to changing themes or repetitive themes in the ongoing interactions and facilitating others recognition of these issues is an important aspect of this process.

Methodological contribution

In the synopsis, I consider the methodology of my inquiry in the context of discussion about knowledge production within the literature on organisational and health services research. Gibbons et al (1994) argue that a shift is taking place in forms of knowledge production from traditional (academically based) Mode 1 research towards novel (socially distributed) Mode 2 research. MacLean, MacIntosh and Grant (2002) assert that there is a gap in the literature of empirical accounts of Mode 2 research. In this inquiry I have aligned the approach I have taken with the five features set out by Gibbons et al (1994) to constitute Mode 2 research. Consequently, I am suggesting that this inquiry goes towards addressing the gap identified by MacLean et al.

In this research, I challenge conventional notions of a theory practice gap and considering instead a dialectical relationship. In Project Three I draw on Elias's analysis of Edgar Allen Poe's poem "*The Fishermen in the Maelstrom*" to highlight that theory is not an academic indulgence. Theory enables researchers to problematise research questions and sharpen their line of inquiry. At the same time practice informs the development of theory. In connecting managerial ideology with the sociological conception of "old" in the context of thinking about relationships between doctors and managers and the influence I postulate that this has on their day to day interaction, as I do in Project Four, I think I am, in a small way, contributing to the development of Elias's model of Established and Outsiders, in the context of healthcare.

Contribution to policy making

Setting targets is appealing to policy makers because it appears to offer a simple

solution to their task of improving health services. Traditional modernist assumptions about our capacity to control and guide society through public policy interventions need to be challenged. Such a technical conception focuses attention on the role of management action based on rational analysis and strategic choice. Effective implementation becomes synonymous with rational management and abstracted from the social relations of the organisation. Ignored in this proposition is evidence from the social sciences research. The influence of ideology and power balances are rarely considered. Consequently, as Thompson and McHugh (1995) state "...many deep rooted features of organisational life: conflict, domination and subordination, manipulation...are written out of the script" (ibid: 14). My research offers an account of the social processes missing from most accounts of policy "impact". My research highlights the need for policy makers and managers to understand they are part of a figuration that affects their practice and that their practice is constrained by complex social processes. What becomes evident, when we pay attention to our day to day participation in these interactions, is ways in which power relationships between groups have significant impact on our practice - an issue that is rarely acknowledged in the mainstream literature on quality improvement, and that many of us may well be largely unaware in our day to day practice. I believe this thesis address a gap Sanderson (2002) points to when he argues that "descriptive approaches need to be given more weight in developing a better understanding of how policies...are implemented in practice...and how the effects depend on contextual circumstances and inter-relationships with other...processes" (ibid: 447).

Opportunities are, however, emerging. A section of the Department of Health is recognising the heavy reliance on approaching the challenge of organisational change and quality improvement from the classic, planned, incremental "programmatic" perspective (Bate, Robert and Bevan, 2004). They assert that quality improvement work in the NHS is under conceptualised and lacks reflection and analysis. They agree with the line of argument I take in this thesis that there continues to be heavy reliance on outmoded theories of control and standardisation.

They propose that there is a need to strengthen the underpinning theoretical base to recognise the essentially emergent and self organising characteristics of organisational change. They have been exploring the contribution that social movements theory (Zald, 2005) might make in this respect yet recognise that "...social movement theory may not necessarily be the "right theory"...for the next stage of the NHS improvement journey. It may not be an exact fit. However, the theory provides insight into perspectives unavailable through the prevalent... paradigm" (Bate, Bevan and Robert, 2002: 42). I believe there are real opportunities to influence these policy makers as they search for more useful ways of conceptualising quality. Complex responsive processes theory has the potential to make a significant contribution to the development of explicit theories of large scale change largely absent from current thinking. This thesis could be a useful contribution to their deliberations. The field of policy making, more broadly, would be a useful focus for further research of this nature.

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