

# **The Trouble with Culture: An Interpretive Case Study of Organisational Culture, Learning and Quality Improvement in the National Health Service**

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## ABSTRACT

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This interpretive case study investigates the relationship between organisational culture, organisational learning and cultural change in the National Health Service (NHS). Starting from a social constructivist standpoint, it conceives of organisational culture as a dynamic entity, socially and discursively constructed through engagement with surroundings, in contrast to the managerial discourse evident in NHS policy and research literature. The conceptual framework informing the research is based on cultural historical activity theory and a three perspectives theory of organisational culture. This allows exploration of individual and collective learning within the context of organisational social and cultural practice, exploring the organisation at the macro level but also through the lived experiences of individuals.

An interprofessional department in an NHS provider organisation was studied for four months as it went through a programme of service improvement. Data was collected and analysed iteratively through a combination of observation, interview, documentary reading and field notes. Analysis using an activity theoretical approach generated a 'thick description' of the organisation. Organisational stories were analysed to explore meaning making.

Findings suggest that organisational culture can be considered a shared epistemic object within fluid networks of activity. Individual and collective learning is linked through practice, mediated by external political motivations and internally generated contradictions. Understandings of professional power play a major part and can lead to unexpected directions of travel.

Conceptually, the study shows activity theory to be a useful framework for analysing learning and cultural change in NHS organisations. It adds to the debate on the self and the role of power and contradiction in activity theory through the application of a three perspectives approach to culture. It can help guide practitioners and policy makers in the NHS by encouraging them to rethink their understandings of culture and how cultural change is achieved through mediated practice.

I hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

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Signed..........

Dated...16.6.2014.....

Lucinda Etheridge, 2014

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## PERSONAL STATEMENT

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I was recently asked to give a keynote speech at a conference organised by and for young doctors interested in careers in medical education. The subject was to be my personal journey and transitions as an educator; essentially 30 minutes to stand up and talk about myself! The subject didn't lend itself well to wordy PowerPoint slides, with bullet pointed features of my personal professional pathway. So instead I began browsing an image library, trying to articulate through pictures of mountain ranges and distant sunrises what I felt I had learnt in the last 10 years that young doctors may wish to share. My final image was one of a pathway with multiple signposts, forks and looping paths that had a destination but not an end; one of choices and challenges and learning. Summarising my personal journey for this EdD is similar. I am certainly in a different place now to where I was when I began this journey, but I hope I am nowhere near the journey's end. However, summarising such an intense period of my life is quite daunting. Since I began my EdD in 2008 I have married, had my wonderful daughter, lost both my parents, run my first (and second, and third) marathon, finished my 11 years clinical training as a paediatrician and taken up a leadership post within the NHS. One of the biggest changes for me though has been the way in which I am now able to think about the social world I inhabit and my multiple identities; as doctor, leader, educator and researcher.

As I explained in the introduction to my IFS, when I began this journey I sensed that I thought about the world in a different way to many of my medical colleagues. This was a big part of the reason I left clinical practice for a time to take up the post in higher education which led to the opportunity to begin this EdD. I came to realise my increasing frustration with the positivist epistemology predominant in the medical world, applying to everything from trials of new drug treatments to ways in which to train future generations of doctors. I also became increasingly aware of the gendered and hierarchical nature of clinical training and practice and felt empowered to critically analyse this. My progress through the taught course component of the EdD really reflects these realisations and questioning. While there may seem to be little

link between the titles of some of my assignments, they all reflect my growing criticality and my ability to broaden my understandings from the nature of clinical *work* to the nature of clinical *practice*.

### **Foundations of Professionalism (FoP):**

*“Life and learning in the 21<sup>st</sup> century NHS: the challenges of defining a professional identity for doctors in training”*

My choice of topic for FoP reflected my own uncertain professional identity. Exploring the topic of professionalism with a multiprofessional group threw up some interesting questions for me. The classical discourse of professionalism focuses very much on medicine. Academic writing about the professions tends to view doctors as a homogenous group. Indeed, this view was often articulated in the discussions within the EdD group. As a trainee doctor myself at the time, I was aware of the significant changes taking place in medical training and certainly did not feel like a professional with a stable identity shared with many others. The writing of this assignment helped me develop my understanding of different discourses of professionalism and begin to think about learning as a sociocultural process of identity construction within communities of practice.

### **Methods of Enquiry 1 (MoE 1):**

*“An exploration of learning activity in a medical workplace”.*

While FoP allowed me space to reflect on my identity as a doctor, MoE 1 encouraged me much more to reflect on my identity as a researcher. I was used to research, and my professional role at the time was funded by a research project, but I was used to research in a clinical context – a way of finding the ‘truth’ about the way to do things. In MOE 1, I felt like I was learning a new way of thinking and speaking and began incorporating this into my academic life. MOE 1 encouraged me to think about research as a process and a journey rather than as a result. The main advantage of this assignment for me was that it gave me an introduction to activity theory, as I chose to use the module to try and get to grips with a new and complex (to



me) theory that I felt offered a different way of thinking about my area of interest; learning in the workplace.

### **Psychoanalytic Perspectives on Teaching and Learning:**

*“Talking of the Other: gender performativity in the operating theatre”.*

Soon after MOE 1, however, I felt like I had changed tack completely by exploring psychoanalytic research for my specialist module. My reasons for choosing this module were that I felt it would help me develop as a researcher, with its focus on theory and methodology. However, I had very little idea what psychoanalytic theory was all about and had certainly never read any Freud. It served as a turning point for me, however, largely because I discovered a body of feminist literature that I felt able to engage with. My choice of assignment sprung out of an impression in the first set readings that early psychoanalysis was hugely misogynistic. I was aware this was probably quite a naïve impression and wanted to explore further how feminist research in the last 100 years has changed the way woman is written about. This led me to a range of readings, from Foucault to Butler. In my personal reflections during this reading I began to explore my identity as a professional woman in two very male dominated worlds, medicine and academia. The small piece of empirical research done for the assignment also allowed me to develop further research skills, especially in narrative interviewing, and I made the most of some of the additional courses on offer in the Institute of Education. Of all the modules undertaken, it is this one that I feel has helped me develop the most in my thinking as a researcher. Although I have chosen not to carry out research from a psychoanalytic perspective again, I feel I am a much more developed critical thinker as a result of my experiences in this module.

### **Methods of Enquiry 2 (MoE 2):**

*“An exploration of learning activity in a paediatric workplace”.*

The assignment in MOE 2 took me back to my interest in activity theory. However, I had begun to critique my own thinking about learning in the workplace based on my experiences in the EdD. I, therefore, felt a sense of

frustration during MOE 2 as I felt unable to develop my thinking conceptually very much while confined to the structure I had begun in MOE 1. I used this module really as a chance to practice data collection techniques and learn some of the practical skills of research.

### **Institution Focused Study (IFS):**

*“Am I surgical enough? Problematizing gender to explore professional identity and career pathways in the figured world of surgical training”.*

The IFS allowed me to return to my interest in feminist research and build on some of the ideas developed in my specialist module. It also took me back to NHS policy but in a slightly different area. Just prior to the IFS I was involved in a large national research project, funded by the Department of Health, into how to best select doctors into programmes of specialty training. My experiences with key figures in the world of clinical training during this project led me to question some of the main assumptions inherent in policy, in particular gendered ones. The theoretical framework I used for this piece of research brought together my sociocultural ontology and feminist notions of power and discourse to explore positional identities and figured worlds. The feedback received from the IFS was vital in helping me develop my thinking as a doctoral researcher, especially around criticality. I had a small break between IFS and thesis after my daughter was born and I partly used this time to reflect on how I wanted to bring together my interests in the thesis in a much more coherent way. As I continued my scholarly reading, I changed my view of myself as someone coming across new topics to someone approaching old topics in new ways. Therefore, despite the slightly fragmented feel to my first three years of the EdD, I feel I have been able to draw on experiences from my time as a doctoral researcher and show the development of my conceptual thinking and understandings of my professional field in this thesis.

### **An educational researcher in healthcare: a fish riding a bicycle?**

So as I reflect on my journey at this final stage of my thesis, have I managed to resolve my various identities? No. But I now see this as a strength, and part of the professional ‘added value’ the EdD has brought to my career. The world

of healthcare is increasingly complex, as I argue in this thesis. Professional roles are changing and diversifying. There is increasing recognition of the need for high quality education at all levels and for transformative leadership. My professional development as a researcher and an educator has allowed me to also develop as a clinician, for the care of my patients, and as a leader in healthcare, for the care of all patients and for future NHS workers. I no longer feel that my identities are separate and irreconcilable. Rather I see that the perspectives, contradictions and experiences I can bring to the network of healthcare activity may be a factor in driving transformation and change. I hope to now continue on this journey of transformation in my new professional role, and offer this thesis as a contribution to professional practice in both healthcare and education.

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## ACKNOWLEDGEMENTS

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This thesis is dedicated to my daughter, Isobel. She has been an integral part of my personal development during my time as an EdD student, arriving during my IFS and so teaching me about time management and priorities, and giving me another good reason to critically explore the world for women. She has suffered countless days of mummy going to 'work' so that I could complete this thesis, and I hope that one day she will be able to read it for herself.

Without the limitless support of my husband Aaron, however, none of this would have been possible. For that I am eternally grateful.

Final thanks go to my supervisor, Professor David Guile, for his insightful questioning and always wise suggestions. He has patiently supported me as I developed my thinking in activity theory and allowed me breaks in study for my complicated career and personal life.

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## CHAPTER ONE:

### BACKGROUND AND INTRODUCTION

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*“The trouble with culture is everyone blames it when things go wrong but no-one really knows what it is or how to change it.”*

(Professor John Glasby, quoted in Francis, 2013 p1358, "Mid Staffs" Independent Inquiry)

#### 1.1 Rationale for the enquiry

This investigation sets out to further understanding of organisational culture in the United Kingdom National Health Service (NHS) by exploring how a healthcare organisation learns about its culture during a time of organisational change. It aims to inform clinical leaders, educators and policy makers by offering a fresh perspective on how organisational culture manifests in the NHS and add to the debate on whether cultural change is achievable.

This study has arisen out of previous work undertaken for my EdD Institution Focused Study (IFS), which explored professional identity and career pathways in the figured world of surgical training, with a particular focus on the role of gender in identity construction (Etheridge, 2011). In the IFS I critically explored the lived experiences of surgeons in training to consider how dominant understandings of power and gender shaped the figured world and their positional identities within it. While the analysis in my IFS focused on conceptions of gender and professional identity, the study also highlighted the process of socialisation that takes place during training. A distinct ‘culture’ was portrayed by all study participants, that is communicated to trainees both explicitly and implicitly, and which shapes their understandings of what it is to be a surgeon within the wider institution of the NHS. My exploration of this culture and its impact on professional learning was, however, necessarily limited by the scope of the IFS.

Since the IFS my own professional role has developed and I have taken up a position of increased leadership and responsibility within the NHS, while

continuing as both doctor and teacher. As I have entered a new workplace, in a more senior position, I have reflected upon the status of the healthcare organisation as a learning environment, with a continual need to adapt and change in line with new knowledge, technologies and expectations. As a healthcare leader with responsibilities for service improvement I am subject to a policy discourse that emphasises the importance of organisational culture in organisational change. However, organisational culture is a contested term, with both an academic and a lay use that often get conflated and confused in the management of NHS organisations. As such, some argue that the term has become almost meaningless and analytically empty (Savage, 2000). Within healthcare policy, organisational culture is articulated in a specific way, as an attribute which can be manipulated for organisational or system gain. It is easy to see why this position is an attractive one for healthcare managers, who are given a lever for improving healthcare organisations.

Since the initial enquiry into the deaths at Mid Staffordshire NHS Trust between 2005 and 2009 (Francis, 2010), issues of organisational culture in healthcare have been thrust into the media spotlight. Both the lay and health press have debated the role and nature of NHS culture and who is to blame for failings in culture (see, for example, Daily Mail Comment, 2013; Delamothe, 2013). However, there is little consideration given to deeper questions about organisational culture and limited attention as to what might be needed to achieve sustainable culture change. This raises questions for me as a professional within healthcare and education that I would like to explore in this further piece of empirical research, bringing together my role as a researcher with my role as a healthcare practitioner and clinical educator.

## **1.2 Aims and research questions**

The aim of this thesis is to explore the interplay between organisational culture, organisational learning and organisational change in the NHS. By moving away from the dominant managerial discourse evident in UK healthcare policy (Chapman, 2007) I aim to move towards a more theoretically enriched understanding of the relationship between the individual and the

collective and between organisational culture, organisational learning and change. I will argue that research into culture in healthcare has been largely within a neopositivist paradigm (see for example Berlowitz et al., 2003; Sylvester, 2003; Vandenburghe, 1999). By this I mean that there has been a search for the existence of a constant relationship between events, free of values and based on facts (Robson, 2008). The effects of this on policy, practice and education have been to focus on objective truths, reducing the complexity of organisations and focusing on development of individual knowledge and skill and imposed structural and organisational changes, while neglecting the social and pedagogical aspects of organisational life. By exploring within a more interpretivist paradigm, where the social world is represented through the eyes of participants, their language and their behaviours (Schwandt, 1994), I will argue that complex organisations cannot be characterised by a single unitary culture. Culture can be as dissonant and contradictory as it is shared and unique, and is consumed and used by individuals who interpret their cultural contexts ambiguously. I argue that the study of culture and change in healthcare has neglected the study of learning for cultural change. By taking a sociocultural perspective on learning I will attempt to address questions about the relationships between individual and collective learning in organisations and how this leads to cultural and organisational transformation.

This research will be interdisciplinary in nature, drawing on debates from a number of disciplines from anthropology to management studies to psychology. At this early point it is important to position myself in the enquiry. I have multiple identities that will come to bear on my research, being simultaneously doctor, manager, teacher and researcher. I consider reality to be socially and discursively constructed and all knowledge about it to be subject to interpretation. I adopt a broadly social constructivist epistemology in the enquiry, with emphasis on the value of social relationships, interactions and contexts in the construction of knowledge (Oxford, 1997). In line with social constructivist principles, I consider that humans construct meaning based on their interactions with their surroundings. Rather than culture being a static phenomenon 'out there' to be discovered, I consider that humans

engage with existing traditions and use that process to understand their world and, in time, seek to develop it (Postholm, 2008). Both individual and social processes of meaning making have central and essential parts to play. This thinking has led to the formulation of a set of research questions to guide me in this enquiry:

1. What is the interplay between organisational culture and organisational learning for cultural change in an NHS organisation?
2. What is the relationship between individual and collective learning within the organisation and how does this manifest?
3. How and why does cultural change take place, or not take place, in NHS organisations?

At this early stage there is a fundamental question that needs to be considered: what *is* the organisation in healthcare? In early academic explorations of organisations and leadership, Selznick (quoted in Scott et al., 2003a) distinguished between the organisation and the institution; the rational organisation directs human energy towards set aims, whereas the value infused institution is an organic social entity where there is resistance to change. He did, however, emphasise the interdependence between the two. Using these definitions, the NHS can be seen as the institution, with individual healthcare provider bodies the organisations. However, this delineation is not clear cut in much of the academic and policy literature, as I will show in chapter two. For the purposes of this enquiry, the NHS will be considered as an umbrella institution which provides a historical backdrop and orientation to the individual organisations that provide and deliver healthcare. However, the study will be located within a single healthcare organisation.



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## CHAPTER TWO:

### EXPRESSIONS OF ORGANISATIONAL CULTURE IN NHS POLICY

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In this chapter I will explore expressions of organisational culture in NHS policy discourse in order to build up a picture of the world in context for both practice and research. Since its inception in the 1940s, the NHS has undergone countless changes, been the subject of multiple policy papers and featured in numerous general election party manifestos. Aneurin Bevan's "biggest single experiment in social service that the world has ever seen undertaken" (Maynard and Bloor, 2008 p345) has long been a central part of the British political agenda. However, in my exploration of expressions of culture in NHS policy I will start in the 1980s because:

*"The changes begun in the 1980s by the Conservative governments of Margaret Thatcher inaugurated a period of 'permanent revolution' that has affected the scale, purpose, forms and social relationships of welfare" (Clarke, Gewirtz and McLaughlin, 2000)*

#### **2.1. From State bureaucracy to market place**

Almost 30 years ago, the Griffiths report (Griffiths, Betts, Blyth and Bailey, 1983) first began to question the culture of the NHS as an institution. In a now famous quote, Roy Griffiths, the managing director of Sainsbury's, said:

*"If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge"* (Davies, 2009)

Davies (2009), reviewing the impact of this report 25 years on, described it as launching a "cultural revolution" and a period of continuous change in the NHS. The Conservative government's acceptance of the recommendations in the report resulted in the introduction of general managers into NHS organisations, replacing the previous system of consensus management. This introduced a competitive business culture into the NHS and paved the way for the internal market reforms of the 1990s (Mannion et al., 2007). The driving force behind

these changes was the New Right ideologies of anti-welfarism and anti-Statism, which viewed 'marketising' reforms and competition as a means of reconstructing the assumptions and values underlying the concept of State funded healthcare (Clarke, Gewirtz and McLaughlin, 2000). There was delegation of responsibility for healthcare to the point of delivery, necessitating profound changes in organisational structures and financial models. However, resistance to these changes was widespread. Jones and Dewey (1997) found that clinicians, in contrast to managers and finance staff, were uncomfortable with the symbolism of formal accounting controls in a public service.

*"The thinking of [clinical directors] continued to be largely dominated by clinical rather than financial objectives. They displayed personal distaste for the style of financial objectives and controls which were becoming dominant, although...they realised they had to bow to the inevitable"* (ibid, p267)

This revised emphasis on financial accountability and organisational objectives led to a change in the power dynamic between clinicians in different roles, and between clinicians and managers. Clinical seniority and professional autonomy were no longer given central importance within healthcare organisations, which now had to shoulder significant financial responsibilities.

## **2.2 From markets to managerialism**

A change of government in the late 1990s led to further scrutiny of the NHS and a re-examination of culture. A plethora of policy initiatives were introduced to shape the clinical workforce. In their 1998 White Paper (Department of Health, 1998), the New Labour government foreground quality and performance improvement in their suggested NHS reforms. They proposed that:

*"Clinical governance needs to be underpinned by a culture that values lifelong learning and recognises the key part it plays in improving quality (para 3.28)...achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture"* (para 5.6).

However, examination of what was meant by culture was lacking. Was culture something inherent in the NHS or something to be produced by the NHS? What mediates culture and allows this “fundamental shift” to happen? The learning was seen as being learning *for* work, with continued acquisition of the clinical knowledge and skill necessary to function as healthcare practitioners. Emphasis in the policy was placed on structural and process changes that would lead to accountability and professional self-regulation within a performance framework. A new managerial language was propagated that has persisted in the NHS today, introducing NHS staff to governance, benchmarking and accountability. This unifying common language can be seen as an attempt to unite healthcare staff. However, examination of some of the concepts introduced found that the process of change adopted, contradicted most of the factors associated with creating receptivity to change.

*“The political agenda of rapid dissemination of costs, seemingly regardless of anomalies and errors, appeared to be paramount and may have prejudiced the successful implementation of benchmarking at local levels” (Jones, 2002 p185).*

A key factor in New Labour’s reforms was to address the interface between clinicians and management through the creation of clinical directorates and the doctor-manager role, a concept imported from successful private healthcare providers in the United States. This was based on post-Fordist assumptions that decentralisation of decision making and the self-regulation of skilled and flexible workers would lead to greater economic output and more efficient production (Savage, 2000). McKee, Marnoch and Dinnie (1999), undertaking qualitative multiple case studies shortly after the White Paper, characterised clinical directorates as either traditionalist, managerialist or power sharing. In traditionalist Trusts, the clinical director was primarily attached to his or her clinical professional perspective and traditional medical hierarchies remained intact. By contrast, managerialist Trusts showed concern with efficiency, control of professional work and new roles and relationships. There were far fewer Trusts which revealed innovative ways of working across traditional lines and which focused on reconfiguring services and approaching problems as a

team. They found little evidence that the NHS was able to embed doctors into managerial roles and identify or sustain managerial talent.

*“Very few Trusts had tackled the issue of short term clinical director appointments, or of succession. There were examples of organisational ‘lost learning’ as very capable and inspiring clinical directors ‘disappeared’ into full time clinical duties...This continued failure to embed clinical director innovation into wider systems was widespread. There were few examples of Trusts creating a new climate in which clinical directors of the future were being spotted, nurtured or sustained” (ibid p110).*

Organisational culture and its role in NHS accountability were again brought to the fore during the time of the New Labour government with the publication of the highly influential Kennedy report into paediatric cardiac surgery at Bristol Royal Infirmary (Kennedy, 2001). Examining the reasons behind a series of child deaths over a ten year period, Kennedy focused in detail on the culture of an organisation where things went seriously wrong. He described a “club culture” (ibid, p68) which focused power around a core group of managers. The second section of the report addressed lessons for the wider health service and an entire chapter was devoted to the cultural characteristics of the NHS that allowed poor practice and behaviours to go unchallenged. Culture was defined as “the way things are done round here”, in line with Deal and [Allan] Kennedy’s (1982) definition, and the “attitudes, assumptions and values of the NHS and its many professional groups” (Kennedy, 2001 p268). Kennedy set out what he felt were the strengths and weaknesses of an apparently homogenous NHS culture, praising the public service values and commitment to equity of NHS staff, but highlighting how staff often felt frustrated, beleaguered and suspicious of change and fostered a sense of tribalism between professional groups. The NHS was portrayed as a shadowy, divided organisation that felt it did its best in difficult circumstances and should be left alone. There was little exploration of the role of wider groups in NHS culture, apart from an examination of the responsibilities of health leaders, with culture seen as belonging to NHS staff. He concluded that there was a need to identify the organisational culture and values that were necessary for quality care and recommended promotion of a new NHS culture, centred on

partnerships of respect, openness and honesty between the organisation and the public and between patients and professionals. However, he stopped short of conceptualising culture change, instead simply describing what a successful outcome might look like.

The government's response to the enquiry was again structural changes and shifts in the balance of power through the development of new public bodies. At around the same time as the Kennedy report was officially published, the New Labour government published a new NHS Plan (Department of Health, 2000). This laid out procedural reforms that would enable cultural change and talked of empowering staff and patients and devolving power away from central government, a policy more in line with Conservative than Labour ideology. Again, culture was portrayed as an attribute that could be changed through new processes and structural reforms. However, the creation of new bodies to report to and the rigid imposition of numerical targets muddied the waters and led to the criticism that power was, in fact, being taken away from professionals (Castledine, 2003). The NHS Plan led directly to the creation of Foundation Trusts, who were allowed the freedom to manage their own accounts and have access to new additional funds; an apparent expression of the shifting power balance. However, this freedom was only to be granted if Trusts met certain centrally imposed performance targets. At the same time a new centralised system of payment was introduced (Mannion et al., 2007).

In his report to the Department of Health, Wanless (2002) for the first time considered the wider population as part of the NHS culture and recommended that the population should be fully engaged in healthcare in order to make services more responsive to their needs. There was an unqualified expectation that the public would exercise their right to choose and that NHS organisations and staff would respond to this. To explore performance further, the New Labour government also commissioned Lord Darzi, a prominent surgeon and Parliamentary Under-Secretary of State, to lead a review into the NHS. The subsequent report (Department of Health, 2008) focused on keeping quality of care at the heart of the NHS and, again, giving patients and the public more choice. Leadership was identified as a key factor in

developing a culture of professionalism in the NHS and all clinicians were tasked with driving up standards. However, despite a narrative of choice, freedom and jointly held power, a simultaneous policy of centralisation and top-down control was enforced which appeared to negate this. Empowerment through dilution of power was proposed, with a move away from identification of a few clinical directors, as in the 1997 White Paper, and instead the idea that power should be distributed amongst all professionals.

### **2.3 From central management to localism and choice**

The focus on patient choice has continued up to the present day. The coalition government's rhetoric of market choice and localism resulted in the Health and Social Care Act being passed into law in 2012. In a similar way to the previous Conservative government of the early 1990s, consumerism is wrapped up as choice and competition is portrayed as empowerment, while the ability to maintain control over the public sector is retained. The White Paper preceding the Act (Department of Health, 2010) spoke of a culture of open information, active responsibility and challenge, and referenced back to "coalition principles of freedom, fairness and responsibility" (ibid, p9), aligning these with core NHS values and principles. The Paper is rather provocatively entitled '*Liberating the NHS*' and claims to free NHS staff from the centrally imposed restrictions that have prevented them flourishing and improving. Despite this apparent liberty it is heavily focused around outcomes and success and how these will be measured and incentivised, with a clear emphasis on avoiding the errors made evident during well-known organisational failures. A managerial discourse is apparent, with the prominence of terms such as efficiency, bureaucracy and accountability. At the same time, however, it talks of removing layers of management. It encourages the NHS to become "less insular and fragmented and work much better across boundaries" (ibid, p9), while simultaneously encouraging competition between different elements. Other coalition publications, such as the NHS Constitution (Department of Health, 2012), similarly emphasise the core principles and values of the NHS and use these as justifications for the recommendations proposed. A common theme throughout these documents is the alignment of values with responsibilities.

*“The NHS Constitution codifies NHS principles and values, and the rights and responsibilities of patients and staff. It is about mutuality...” (Department of Health, 2010 p7).*

The NHS Constitution talks of binding together NHS staff and the people they serve and the rights and responsibilities of all, acknowledging, as the Wanless report did, the role of wider groups in the culture of the NHS.

While the Health and Social Care Act was being debated in parliament, Sir Robert Francis QC was reporting on the much publicised failings at Mid Staffordshire NHS Foundation Trust. Over a period of four years, there was a significantly high death rate at the Trust. This was largely caused by failings in basic standards of care due to pressure from managers to cut costs in preparation for Foundation Trust status application. These failings were apparently deliberately concealed from regulators (Delamothe, 2013). A large proportion of both Francis’s initial inquiry (2010) and subsequent report (2013) was devoted to problems of culture, both within the Trust itself and the wider NHS. He defined culture as “the predominating attitudes and behaviour that characterise the functioning of a group or organisation” (Francis, 2010 p152) and detailed numerous examples of poor attitudes and direct behaviours that impacted on care at both managerial and clinical levels. In his final report, Francis (2013) attempts to theorise culture using a framework based on principles of integration but, again, this views culture as a variable that can be taught, learnt and actively shared. He does acknowledge that the complexity of the NHS presents a challenge to notions of integration, however he then goes on to advocate a safety culture which can be transmitted throughout the NHS. The very complexity of culture is undermined in the neopositivist definition of patient safety offered:

*“Patient safety is a **discipline** in the healthcare sector that applies safety **science** methods toward the goal of achieving a trustworthy system of healthcare delivery” (Francis, 2013 p1359, my bold).*

At a time of major upheaval in the NHS, the key message in the Francis report is that responsibility for culture change lies at all levels of the NHS, from

patients through to parliament. Using examples from other industries he highlights the need for culture change to occur from both the top down and the bottom up. However, while a shared institutional common culture is advocated, there is recognition that the organisational culture at a local level may look different from place to place:

*“There is no one way in which a satisfactory common culture could be displayed, and if the culture is to be “owned” by those who are part of it, it is necessary for the local ingredients to be devised locally” (Francis, 2013 p1388).*

The current government strongly advocates a move towards localism while simultaneously denouncing the NHS for lacking shared values. The move towards localism seems to contradict the notion of a unitary, ‘strong’, NHS culture. The recent debate over the closure of Lewisham hospital in South East London has highlighted this distortion between rhetoric and practice. The current Health Secretary made a decision to downgrade services at a well performing local hospital based on the advice of a special administrator called in to assess financial difficulties at a poorly performing neighbouring hospital. This was despite widespread and well voiced opposition from the local public and NHS staff. The decision was apparently driven by financial motives, as the neighbouring Trust was committed to a large private finance initiative deal and, therefore, could not be downgraded without huge central cost (Triggle, 2013). The response to the anger felt locally at this decision was couched in a language of shared values and co-dependency, in direct contradiction to the written policy of competition and localism. Further confusion was generated when Mr Justice Silber ruled the Health Secretary’s decision unlawful in the High Court, as opposition by local clinical commissioning groups was felt to breach the provisions of the government’s own National Health Services Act (Dreaper, 2013). It is still unclear what the future of local services will be and well organised local opposition groups continue to fight central government.



## 2.4 Culture confusion

In summary, the notion of organisational culture and its potential for transformation has underpinned much NHS policy for almost 30 years but there is underlying culture confusion throughout the policy literature. There is no clear conceptual basis for the conclusions drawn about NHS culture and see-sawing structural and process changes have given rise to contradictory messages. The policy literature has generally adopted an organisational development perspective, with culture as a variable (Scott et al., 2003b). However, attempts to manipulate this variable have been largely reactive rather than proactive. There has been an extension of the notion of evidence based medicine to policy making, with a focus on weakness as a shaping force and an endowment of organisational culture with 'scientific' attributes, such as rationality and objectivity (Spurgeon, 1999). Lacking for me in my readings of the policy was any consideration of how individuals, groups or organisations can learn about culture, or learn how to achieve cultural change without it being imposed from the top down.

There has also been a continued move towards the development of a business culture in the NHS with a dominant managerial discourse; a focus on measurable targets and outcomes and an assumption that this will allow manipulation of cultural variables through changes in both NHS staff and the wider public. There is blurring of the boundaries between individual organisations and the wider NHS. As market reforms have resulted in discrete healthcare businesses there has been a move away from the NHS itself as an organisation towards individual providers as organisations. However, the distinction between the NHS culture and the culture of individual provider organisations is not clearly expressed or delineated in the policy narrative. The focus is on power but the locus of power shifts throughout the timeline. Power is poorly theorised, being expressed as a measurable and discrete entity located in both individuals and groups which can shift depending on structure. There have been several contrasting interpretations of the effects of policy and structural changes on the issue of power and dominance in the NHS (McKee, Marcnoch and Dinnie, 1999). My understandings of this from my readings of the literature are that there is a power balance between

clinicians, managers and patients that has fluctuated throughout the last 30 years. As policy emphasis has shifted, so has the balance of power, but in ways that are contested, disputed and poorly understood.

The overall effects of these multiple policies and NHS reviews have been to keep ideas of organisational culture prominent in the NHS but they have brought us no closer to a theoretically enriched understanding of what organisational culture is or, indeed, how it can be changed.

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## **CHAPTER THREE:**

### **UNDERSTANDINGS OF ORGANISATIONAL CULTURE AND LEARNING IN HEALTHCARE**

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Having recognised the absence of a theoretical basis for many of the expressions of organisational culture in NHS policy, I will now examine the theoretical and empirical literature further to explore perspectives on organisational culture and organisational learning. Through an exploration of some of the main literatures from a number of schools I will begin to develop the central argument of this thesis and lead towards my conceptualisation of organisations for research.

#### **3.1 Perspectives on organisational culture**

As demonstrated in the previous chapter, use of the term culture has become widespread in the NHS and its links with quality improvement are largely unquestioned (Savage, 2000). Theoretical examination of organisational culture is problematic, however, as despite the widespread use of the term there are multiple conceptions of organisational culture and little theoretical agreement on the meaning of the underlying concepts; a phenomenon Martin (2002) has described as “the culture wars”. Therefore, I will not attempt to offer a definition of organisational culture as such. My aim in this section is to draw on the work of some key writers to offer a sense of the development of the conceptual underpinnings of, and approaches to understanding and researching, organisational culture. I will then show how I plan to use one author’s framework to further my understandings of the concept for the purposes of empirical research into organisational learning and cultural change.

##### ***3.1.1 Organisational culture as unity***

The idea of organisational culture was first introduced into the management literature as early as the 1930s, being redefined through application of anthropological theories in the 1970s. The economic conditions and beginnings of globalisation in the 1970s led to increasing interest in

organisational culture as an analytical concept from the 1980s onwards (Tharp, 2009). In an early commentary on the concept of culture in the study of organisations, Smircich (1983) offered a useful way of considering the term that helps structure debate. She saw two opposing views; that culture is a variable that an organisation *has* or that culture is a root metaphor that an organisation *is*. Recognising that the concept of culture has been imported into organisation studies from the field of anthropology, she investigated the intersections between culture theory and organisation theory and how this concept could be used to ask questions about organisations. At this relatively early stage in the organisational culture debate, she explored the ontological assumptions underlying conceptions of culture and how these affect modes of inquiry. Those who consider culture as a variable propose that it serves as a stabilising device which shapes the behaviour of individual members and which can be manipulated to influence the function of an organisation. Those who view culture as a root metaphor see organisations as a manifestation of human consciousness and analyse organisations in terms of their expressive, ideal and symbolic aspects and the patterns that make organised activity possible.

A perspective taking researchers beyond the abstract to enable meaningful analysis of culture was offered by Schein (1985), who attempted to categorise the various dimensions of organisational culture. He described different levels of culture: level one being made up of cultural artefacts and creations, the visible means by which culture is expressed; level two consisting of the values which underlie this, which are not always directly expressed but which are espoused; level three consisting of the basic assumptions underpinning everything else, which are internalised and taken for granted. This conceptual framework for analysing and influencing culture in organisations proved highly influential and sparked a more widespread adoption of the organisational culture concept in the late 1980s (Hatch, 1993).

The basis of Schein's categorisation is agreement and consistency in culture, what Martin (1992) calls an integration perspective. There have been numerous other typologies based along similar lines which share the idea of

integration and an overarching, coherent organisational culture. These have led to instruments to measure culture and culture change (Mannion et al., 2007; Mannion, Konteh and Davies, 2009). Early influential empirical research was carried out from an integration perspective, reinforcing the idea that successful companies are those with strong and united beliefs and values. Deal and Kennedy (1982) studied a number of successful organisations and concluded that high performing companies communicated a set of shared values and beliefs that all employees were aware of and adhered to. Similarly, Ouchi (1981), at around the same time, stressed that successful organisations needed to focus on their cultures and work towards dominant, coherent cultures in order to achieve success. This research was largely managerially-oriented and viewed culture as “an internally consistent package of cultural manifestations that generates organisation-wide consensus, usually around some set of shared values” (Martin and Frost, 1996 p602). However, these highly influential publications have been criticised for their lack of theoretical rigour (Mannion et al., 2007) and many of the organisations described failed to stand the test of time and changing economic conditions (Martin, 2002). They also fail to take account of the complexity of organisational life and assume consistency and homogeneity. There is no accounting for dissonance between individuals or groups and it is not clear where the locus of the ‘strong’ organisation lies – who creates these beliefs and values that employees adhere to? This would seem to be especially important in considering culture in healthcare, which is made up of a number of discrete organisations, professional groups and stakeholders. However, my exploration of the policy literature in chapter two shows that a rationalist, integration perspective appears to be favoured, with the narrative of a highly performing NHS being a homogenous and unified NHS. The organisational development tradition favoured in NHS policy focuses very much on integration and change through the achievement of consensus (Ashburner, Ferlie and Fitzgerald, 1996).

### ***3.1.2 Moving away from cultural coherence***

Another approach towards researching organisational culture has been to look for differences rather than commonalities across organisations; the differentiation perspective (Martin, 1992). Heterogeneity is acknowledged and

the prospect of conflicting relationships is introduced, with multiple identities and diverse communities (Alvesson, 2002). Rather than consensus existing within a single, over-arching culture, this perspective favours consensus at a lower level of analysis; within subcultures. Several empirical researchers in healthcare have used this approach. Lok, Westwood and Crawford (2005) explored the relationships between leadership, organisational culture, subculture and commitment in nurses working in Australian hospitals. They found that the ward environment readily created organisational subcultures; groups that form on the basis of a number of factors, such as professional background, location, function and leadership. Scott et al (2003a) recognised the need to also consider ethnicity, class, religion, gender, division and specialty in considering organisational subcultures in NHS settings. Morgan and Ogbonna (2008) analysed subcultural dynamics of three different health professional groups and how these impacted on the implementation of service transformation activities. They found that there were further layers of division within subcultures, based on the perceived relative importance of different specialities, and that these divisions presented a significant challenge to hospitals attempting to achieve a cohesive cultural identity. A focus on differentiation has perhaps been popular in healthcare for the same reasons that a focus on integration has been; identification of differences, stable subcultures and measurable variables promises the prospect of organisational change.

Martin (1992) outlined a third perspective adopted by cultural researchers; the fragmentation perspective. This considers that consensus and dissent can co-exist and may change with context, preventing the formation of stable subcultures. Complexity and ambiguity are the essence of organisational culture and consensus is transient and context specific; a continually changing reality (Dube and Robey, 1999). Empirical research from this perspective has tended to explore organisations that are in flux, looking at contradictions and tensions (see, for example Alvesson, 1993; Hatch, 1997). Within healthcare, there are no published studies like this, perhaps because it subverts the notion that culture can be managed and changed by healthcare leaders, as espoused in healthcare policy.

### **3.1.3 A three perspectives approach**

Common to all three of these perspectives; integration, differentiation and fragmentation; is an objectivist ontology, with a 'correct' interpretation of how culture occurs and a search for the 'truth' about culture (Bercovici, Grandy and Mills, 2001). A more interpretivist approach towards studying organisational culture takes account of all three perspectives and recognises that they can co-exist, the goal being

*“not to establish a better theory of culture... but rather to challenge the foundations of modern cultural scholarship”* (Martin and Frost, 1996 p612).

Martin (1992) argues that organisational culture should be studied simultaneously from all three perspectives, with some aspects shared by most members, some aspects interpreted differently with consensus only amongst subcultures, and some aspects interpreted ambiguously with paradox and tension evident. By exploring all three perspectives, different aspects of the same phenomenon can be brought to light (Mannion et al., 2007). The three perspectives framework has its origins in early work by Meyerson and Martin (1987) and was further developed by Martin. Research using all three perspectives acknowledges that culture is not passively communicated to organisational members by their leaders, but rather is consumed, interpreted and used. This consumption takes different forms amongst different stakeholders, who have different aspirations and interests, leading to different but co-existing cultural possibilities.

*“Accepting this proposition means that culture ‘users’ will have to understand and accept that there is no ‘happy acculturated forever after’ ending to change attempts. In all likelihood there is no ‘forever after’ in the script. At best, there may be some combination of agreement, dispute, and confusion that can be stitched together by human agency, as managers and others move the action along, accomplish some objective, and then regroup around subsequent problems, issues and opportunities.”* (Martin and Frost, 1996 p614)

Dube and Robey (1999) used a three perspectives approach when studying a software development firm undergoing high level restructuring. They found

that practices undertaken by managers to improve production are often interpreted differently by different members of the team, who collectively redefine what might have been intended, leading to conflicting views from subcultural groups and generalised ambiguity. Rivard et al (2011) used a three perspectives approach when studying difficulties with the implementation of a new clinical information system in a hospital. They concluded that four values play a central role, with two; quality of care and efficiency of clinical practice; being key from an integration perspective and two; professional status and medical dominance; being key from a differentiation perspective. From a fragmentation perspective users had ambiguous interpretations of implementation practices in terms of their consistency with these four values. Using empirical examples, Martin (2002) demonstrates how a three perspectives approach can highlight issues of power, dominance and hierarchy in studies of organisations by offering a broader range of insights than if a single perspective had been used. In a re-examination of a much studied large multinational lauded as having a 'strong' culture, she demonstrated how a focus on similarity acted to exclude dissimilar others who did not share the same features and values of those at the top, especially in terms of class, gender and ethnicity. Aspects of organisational life that did not fit within the dominant conceptualisation were excluded as not being part of the culture.

The contested nature of understanding about organisational culture means that there will be diverse ways of assessing it and multiple definitions offered. Within this research, I am interested in the interplay between organisational culture and organisational change. Ultimately, viewing organisational culture objectively is problematic as it limits researchers to searching for a single correct way of doing things (Bercovici, Grandy and Mills, 2001). This can lead to change being an end in itself rather than a means to an end. An alternative approach is to consider organisational culture more interpretively, as a means of organisational sense making (Helms-Mills, 2003), which allows practitioners and researchers to question, understand and learn. I conceptualise organisational culture from my social constructivist position as a dynamic entity that is continually negotiated and constructed by individuals engaging with



their organisational context, with instances of agreement, disagreement and flux.

Neither the NHS policy literature nor the healthcare organisational research literatures explicitly attend to the issue of how people learn the culture and how they learn to change it. There is little distinction between the role of the individual and the role of the wider collective in affecting organisational change in culture. However, it is clear that one individual cannot change culture. Culture is a collective phenomenon. Martin's three perspectives approach appears to offer a promising way into this question by acknowledging the possibility of both individual and collective elements, with both coherence and dissonance and attention to questions of power.

### **3.2 Perspectives on organisational learning**

The term organisational learning is, again, a term that is contested and debated. Literature from the fields of psychology, sociology, education and management studies is replete with partially contrasting and partially overlapping conceptions of organisational learning. Organisational learning has been distinguished from workplace learning as an area of enquiry. The former has emerged from the field of organisation studies, driven by interests in management, and is concerned with organisational knowledge management and elements of success and failure. The latter has arisen from educational research and focuses on pedagogy and practices of learning for work (Engeström and Kerrosuo, 2007). Within this enquiry, I am interested in how organisational culture is learned by culture consumers and how that learning affects cultural change. I would, therefore, like to propose that these distinctions are somewhat artificial and divisive. To be of relevance to practitioners and employers empirical studies of organisational learning need to have practical relevance for organisational change. However, if pedagogical aspects are neglected then learning cannot be facilitated. Gherardi (2001) considers that the organisational learning literature suffers from a number of biases; namely that it is interpreted mainly in terms of a realist ontology, that learning is assumed to be an independent variable that influences

organisational performance and that it is assumed to be synonymous with change. This critique is similar to the critique I offer of the organisational development perspective on organisational culture.

Within social constructivism, learning involves the shaping of lived experiences. The context in which the learning takes place has an important impact on what is learned (Huang, 2002). The challenge of this thesis will be to consider what aspects of learning within organisational settings may have relevance to the question of learning about, and developing understandings of, organisational culture and how to affect cultural change. Engeström (2001) suggests that there are four main questions that need to be addressed by any theory of learning. Who learns? Why do they learn? What do they learn? How do they learn? I plan to use these questions as a framework upon which to base my discussion of organisational learning. It is not my aim to perform a comprehensive review of adult learning theories within this thesis. Instead, I aim to trace the development of theories of organisational learning from a sociocultural perspective, critiquing the work of some key theorists to explore how organisations might engage with organisational culture in order to achieve learning and change.

### ***3.2.1 Who learns and why?***

A key question in considering the concept of organisational learning is the question of who learns. Proponents of theories of individual learning would take the learning of individual members of the organisation as central in understanding this issue. However, focusing solely on individual learning neglects social and cultural aspects of learning and does not fully answer the question of how an organisation, a collective of individuals, learns. Is organisational learning simply the sum of learning of individuals within it or is it something more? If individuals acquire learning, can this be translated into the organisational context? What is the relationship between structure and agency? The dilemma inherent in the distinction between individual and organisational learning was encapsulated by Argyris and Schön in one of the earliest influential works on the topic:

*“There is something paradoxical here. Organisations are not merely collections of individuals, yet there are no organisations without such collections. Similarly organisational learning is not merely individual learning, yet organisations learn only through the experience and action of individuals. What, then, are we to make of organisational learning? What is an organisation that it may learn?”* (Argyris and Schön, 1978)

Argyris and Schön saw individuals as agents for organisations to learn, producing the behaviour that leads to learning and then further behaviour. Their major contribution to the field was to introduce the concept of single and double loop learning, asserting that learning occurs through the detection and correction of error. The recognition of a problem and the will to change it become the drivers for learning. Single loop learning occurs when matches are created or mismatches are corrected by changing actions. Double loop learning goes deeper and occurs when mismatches are corrected by questioning the underlying reasons and motives and then the actions. They developed models of “theories-in-use” (ibid, p79) that are continually constructed by individuals through inquiry and which enhance or inhibit learning. Argyris (1999) argues that for organisational learning to be effective, organisations need to maximise double-loop learning. To some extent, Argyris and Schön adopted a sociocultural dimension in their theories of organisational learning by identifying the importance of changes to underlying motives and assumptions, or culture, as the central process in effective learning and behavioural change. They began to link the individual learner with the wider world of the organisation, without seeing the individual as prior to the organisation.

Kim (1993), however, argued that a distinction needs to be explicitly made between the individual and the organisation to prevent either ignoring the role of the individual or glossing over organisational complexity. Organisations can learn independently of any specific individual but not independently of all individuals. He saw individuals as constantly taking action and observing their experiences, but argued that not all individual learning has organisational consequences. Groups were viewed as “extended individuals” (ibid, p43), influenced by organisational factors. Drawing on Argyris and Schön’s

concepts of single and double loop learning, he proposed that individual single and double loop learning leads to organisational single and double loop learning through the influence of individual mental models on organisational shared mental models and, in turn, organisational memory. However, analysis of the cultural dimension of learning is lacking in Kim's model and the means through which learning is transferred to the dynamic and complex organisation is unclear.

Engeström has used theoretical tools from activity theory to analyse this question of individual versus collective learning, particularly in work settings. His expansive learning theory was first developed in 1987 but has been refined since then as central ideas from its communist Russian origins have become increasingly accessible to other academic communities. This theory puts the emphasis on communities as learners, on transformation and creation of culture through learning and on horizontal movement between different cultural contexts and competences. In expansive learning, learners learn something that is not yet there (Engeström and Sannino, 2010).

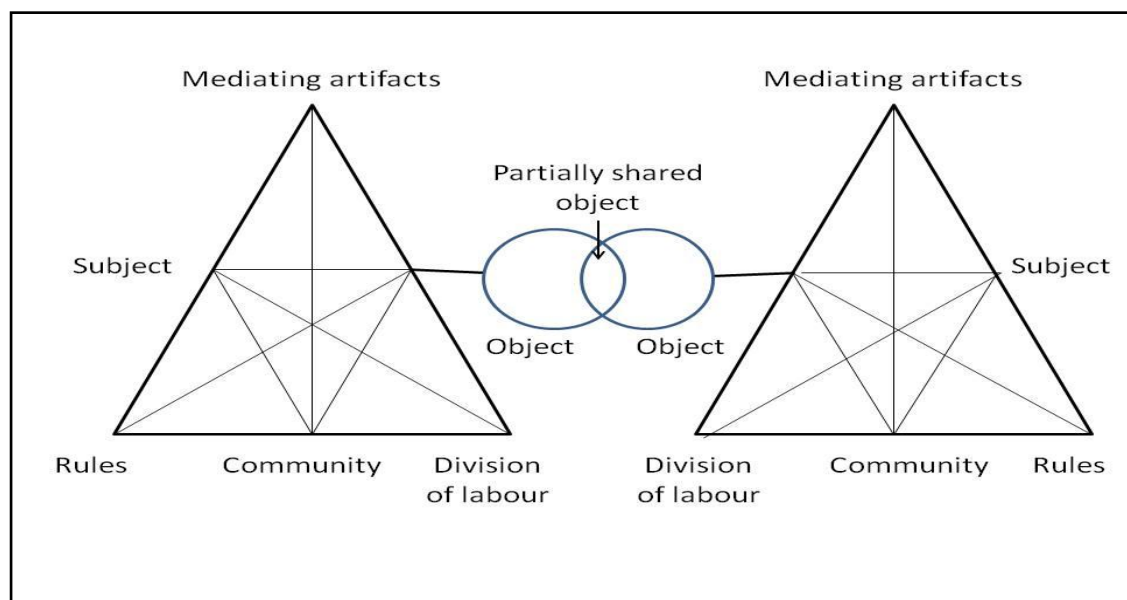
*"[expansive learning] begins with individual subjects questioning accepted practices, and it gradually expands into a collective movement or institution"*  
(Engeström, 2008a p130)

Activity theory has its origins in Vygotsky's concept of mediation and Leont'ev's concept of activity and was developed further by a number of theorists over the 20<sup>th</sup> century (Blackler, Crump and McDonald, 2000). Its philosophical roots are in the work of Kant, Hegel and Marx (Arnseth, 2008) and arose from Vygotsky's concern with overcoming the dualism between mind and world and instead identifying how we simultaneously transform and are transformed by the social environment (Guile, 2005). The original Vygotskyian model centred on the triangular relationship between subject, object and complex mediated acts. Vygotsky introduced the idea of cultural mediation, overcoming the split between the Cartesian individual and the untouchable societal structure. Human psychological functioning and development is seen as object-related. The individual could not be understood without their cultural means and

society could no longer be understood without the agency of individuals who use and produce artifacts (Engeström, 2001).

Engeström's third generation activity theory has concentrated on developing conceptual tools to understand dialogicality, multiple perspectives and networks of interaction by expanding the unit of analysis to a minimum of two interacting activity systems (Engeström, 2008b). His model for the actual structure of an activity system depicts the purpose of activity (the object), the context of activity (the rules, community and division of labour) and the cultural tools used to sustain or to transform the activity (the mediating artifacts). Activity systems, therefore, represent collective forms of practice and the history of that practice, its changes and developments (Langemeyer and Roth, 2006). As can be seen in figure 1, the object of activity is a moving target, transformed to a collectively meaningful object constructed by the activity system and to a potentially shared or jointly constructed object (Engeström and Sannino, 2010).

*Figure 1: Two interconnecting activity systems with a shared object of activity (adapted from Engeström, 2001)*



Engeström developed these ideas to explore learning processes in which the very subject of learning is transformed from isolated individuals to collectives and networks. Initially individuals begin to question the existing order and logic

of their activity. As more actors join in, a collaborative analysis and remodelling are initiated and carried out. Eventually the learning effort of implementing a new model of the activity encompasses all members and elements of the collective activity system and there is a qualitative transformation of the system itself. The process can be understood as construction and resolution of successively evolving contradictions (Engeström and Sannino, 2010).

Expansive learning theory, therefore, allows us to begin to envisage organisational learning as a form of collaboration between individuals, groups and the collective, precipitated by acts of questioning and sense making that arise from practice. However, the question of the relationship between the individual and the collective in expansive learning warrants critique and further theorising. Stetsenko and Arievitch (2004) consider that:

*“The goal of rendering an account of the self as a profoundly social phenomenon, yet at the same time as real, agentic and unique, remains to be achieved” (p476)*

Stetsenko’s (2005) critical rethinking of activity theory places the emphasis on the dialectical relationship between material production, intersubjective exchanges and human subjectivity, which co-evolve and influence one another in a dependent way. She considers that the self is not simply situated in a sociocultural world but is produced from within, out of and by evolving activity that connects individuals to other people and themselves. The motives that drive activity are socially produced by human collaborative practices and reworked by individuals. Her concept of the ‘self as a leading activity’ encapsulates the idea that collaborative transformative practices necessitate and produce the self through an individual’s engagement with the social world and the ways in which they do and perform (Stetsenko and Arievitch, 2004).

In a further critique of Engeström’s approach to activity theory, Langemeyer and Roth (2006) argue that his work neglects aspects of dialectical thinking and narrows the potential of activity theory to a socio-critical approach to societal practice and human development. Key in this, for them, is the notion of contradiction and how development is achieved. They highlight how

external factors can come to bear on activity systems and how motives to solve contradictions can be mixed in with other individual motives that may not be articulated. In particular, activity theory underestimates the motivation of individuals to avoid conflict by focusing too much on the collective (Langemeyer, 2006). Following on from this, Engeström (2011) has recently proposed five interconnected forms of participants' emerging agency: resistance to interventions; explication of new potentials; envisioning new models; committing to new actions; taking action to change activity. However he sees the characterisation of new forms of agency involved in expansive processes as a challenge for the study of expansive learning.

### ***3.2.2 What do they learn and how?***

As highlighted in the discussion above, knowing cannot be separated from doing. Knowledge is 'knowledge-in-practice', constructed by practising in a context of interaction (Corradi, Gherardi and Verzelloni, 2008). The intelligibility of concepts such as structure, system, meaning and action is constituted in social practice and the field of practice becomes the place to study learning (Arnseth, 2008). In this next section I will explore two main theories of learning that have their roots in social practice. An important and influential theory considering learning as a sociocultural endeavour has been the work of Lave and Wenger (1991) on communities of practice. Through a critique of this theory I will present some of its limitations when studying organisational learning for cultural change. I will then return to activity theoretical conceptions of organisational learning, critiquing a particular study by Engeström, in order to highlight further issues when considering what is learnt, and how, in organisational settings.

Through their work studying apprenticeships, Lave and Wenger (1991) offered a radical alternative to cognitive theories of learning, developing a theory of situated learning in communities of practice. They conceive of learning as "relations among people in activity in, with, and arising from the socially and culturally constructed world" (ibid p51). Learning is the gradual mastery of semiotic and technological tools, and making meaning through participation in a practice which is social and relational and which transforms identities

(Arnseth, 2008). For them, learning is constituted in the world as experienced in social practice and achieved through legitimate peripheral participation:

*“By this we mean to draw attention to the point that learners inevitably participate in communities of practitioners and that the mastery of knowledge and skill requires newcomers to move toward full participation in the socio-cultural practices of a community”* (Lave and Wenger, 1991 p59).

The community is conceived as a form of self-organisation that evolves over time, corresponding to neither organisational boundaries nor friendship groups but based on the sharing of practice (Corradi, Gherardi and Verzelloni, 2008). However, later critique has led to awareness that different types of community of practice exist, especially in relation to size, spatial reach and pace of change. As Roberts (2006) points out, in the contemporary world of work, with its accelerated pace of change, stable communities of practice may have difficulty adapting. Lindkvist (2005) instead considers that the formation of temporary collectivities of practice, with collective goal-directed interactions, may be more appropriate.

Exploration of issues of power has called into question the capacity of members to move towards full participation, particularly if their participation threatens to challenge or transform the practices of the community (Roberts, 2006). There is also potential for tension or conflict when individuals participate in more than one community, each with different practices and identities, which will impact on the negotiation of the self (Handley et al., 2006). Therefore, as a framework for exploration of learning for cultural change, the concept of communities of practice is problematic. Situated learning theory assumes a certain stability of learning and a single direction of travel, from the periphery to the centre. Learning is seen as constant, positive and unidirectional. The earlier critiques have highlighted that there is little room for dissonance, tension or contradiction or unexpected directions of travel, which are likely to be major factors in cultural change.

Activity theory interprets practice as activity. However, in complex work organisations the objects of activity and patterns of collaboration tend to be



difficult to see and represent (Blackler, Crump and McDonald, 2000). Engeström (2001) has explored the challenges of collaborative working across professional and organisational boundaries in a study of children's healthcare in Helsinki. Collaboration was developed between two different institutions aiming to overhaul the way in which children with long term conditions were managed. The drivers for change in this study were largely political and called for organisational change rather than simple changes in work practice. The study took place in a Change Laboratory, a protected space where practitioners and patients from three interconnected activity systems came together alongside a research team to think through their practices. Through interaction and questioning in this setting, Engeström reports that new concepts emerged, namely the development of a care agreement for children with complex needs. In expansive learning theory, he suggests, there is a move from the abstract to the concrete. An initial idea is transformed into an object, a new form of practice, through learning actions while, at the same time, new theoretical concepts are produced (Engeström, Miettinen and Punamaki, 1999). Engeström presents this study as an exemplar of expansive learning in an organisational setting. He introduced the term "knotworking" (Engeström, 2001 p147) to capture the idea of the new pattern of activity needed to achieve collaborative care. This concept moves beyond conventional teamwork or networking. It is a rapidly changing and partially improvised collaborative performance taking place between loosely connected actors, none of whom has sole authority, who tie and untie otherwise separate strands of activity to achieve co-configuration and a responsive, adaptive system (Daniels, 2004).

Langemeyer and Roth (2006) use this study to highlight issues for critique in activity theory, which I believe are relevant in the consideration of learning in organisations moving towards cultural change. Firstly, they recognise that the motives for change in this study were, to a significant extent, externally determined rather than internally produced. It is not clear from the study what influence members of the activity systems had on defining the problems at the beginning or whether they supported the changes suggested. Engeström and Sannino (2010) have subsequently suggested that political issues can be

presented as contradictions to drive expansive learning and transform the object. However, this is likely to occur in intermediate steps and how these issues are interpreted and used by the collective is poorly understood. Secondly, as discussed earlier, they also question how Engeström theorises contradictions as the motive for learning. They consider a need for a more critical analysis of power relations within the research (ibid). It is not easy to depict and analyse hierarchical power relations within an activity system. In third generation activity theory Engeström tends to put 'management' as its own activity system, separate to 'work' (see, for example, Engeström, 2008b). However, this does not address the issue of individual subjects who may have roles in both these activity systems, for example hospital clinical directors or matrons who have both clinical and management responsibilities. While the concept of knotworking addresses the issue of fluidity and instability, it has to be reconciled with the institutional and organisational foundations of normal life, such as policies, lines of reporting and control. Blackler and Macdonald (2000) approach power as both an ongoing product of collective activity and as the medium for it, seeing power, mastery and collective learning as inseparable. Engeström and Sannino (2010) suggest that issues of power should be analysed in terms of object related contradictions, with power as an instrument and not as a root cause. However, they acknowledge the need to research policies that make expansive learning possible rather than restrict it, and to investigate barriers to the implementation of new practices.

The third issue that arose in my reading of this study concerned the issue of change, particularly the context for change. Not every change in an activity system is transformative and not every change results in a change in the object of activity. Langemeyer and Roth (2006) consider that Engeström overestimates the process of learning as a process of societal change. Avis (2007) makes a similar critique when he describes expansive learning as realising only superficial changes rather than dealing with large scale foundational or political change. Through his chosen methodology, Engeström abstracts the change from actual practice. Within the Change Laboratory we can see the expansive learning that occurs to some extent. However, we are unable to see the changes that occurred in the object of activity when the new

care agreements were implemented in practice. In fact, Engeström seems to acknowledge this:

*“The model **implies** a radical expansion of the object of activity for all parties: from singular illness episodes or care visits to a long-term trajectory (temporal expansion), and from relationships between the patient and a singular practitioner to the joint monitoring of the entire network of care involved with the patient (socio-spatial expansion)”* (Engeström, 2001 p150, my bold)

Blackler, Kennedy and Reed (1999) have explored the ways in which activity systems were changing in a number of case study healthcare organisations, focussing attention on the processes that supported or inhibited collective learning and creative responses. In later related work, Blackler explored the processes central to the integration of different groups co-operating in the pursuit of multiple competing objectives (Blackler, Crump and McDonald, 2000). Through an activity theoretical case study of a high technology company they show how horizontal and vertical integration across and between communities of activity can be problematic. Their analysis of relations proposes three core organising processes that take place within networks of activity. ‘Perspective making’ refers to the different contributions that different communities of activity bring to an organisation and the evolving dynamics of the activity system. ‘Perspective taking’ refers to relations between communities of activity, how they understand and adapt to one another, and involves the management of influence and priorities. ‘Perspective shaping’ refers to the assumptions about achievements and possibilities and the general orientation of the communities to their work. They suggest that this framework can be extended to explore broader socio-structural and cultural factors in collective work practices.

Therefore, returning to the original framework for my exploration of organisational learning I can begin to answer the four key questions I posed earlier using understandings I have developed from sociocultural theories, particularly activity theory. The question of *who* learns hangs on the central issue of the relationship between the individual actor’s subjective agency and

wider collective forms of practice. The general objective of activity theoretical approaches to learning is to overcome dichotomies between the individual and societal nature of activity. However, the concept of self in its relation to the collective has been a problematic issue that has been subject to much relevant debate when considering learning in organisations. The basis of overcoming this dualism between mind and social structure, however, is practice; learning through the “failures, disruptions and unexpected innovations” (Engeström, 2005 p32) that take place in practice. This is *how* learning takes place. Learning is embedded in social and cultural contexts and is a form of participation in these contexts, with transformation of both social practices and the individuals who participate in them (Boreham and Morgan, 2004). However, the balance between individual and collective motivations needs to be considered when contradictions arise. When different communities of activity need to work together in the pursuit of multiple or competing objectives there are opportunities to make, take and shape perspectives which are integral to the ways in which the object of activity is defined and realised. Transformation of culture becomes an essential part of the *why* of learning, allowing both individual learners and the wider collective to engage with existing practice and permit change in a meaningful way. *What* is learnt is a new way of working, but also new theoretical concepts, driven by contradictions and tension, either externally offered or internally constructed.

With these factors in mind, activity theoretical approaches are well suited to the study of learning and change in organisations. When whole collective activity systems, such as work organisations, need to redefine themselves, traditional modes of learning only address relatively stable and pre-defined knowledge and skill (Engeström, 2007). Practice becomes the place to study situated learning, allowing exploration of the complexity of situations and the network of roles and communities of activity that constitute work settings (Corradi, Gherardi and Verzelloni, 2008). In the following chapter I will expand on this further, drawing in my theoretical understandings of organisational culture, in order to develop a conceptual framework for studying healthcare organisations, culture and learning for cultural change.

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## **CHAPTER FOUR:**

### **RESEARCHING ORGANISATIONS IN THE NHS**

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In the previous three chapters I have developed the idea that this research aims to theorise the relationship between culture, learning and change in healthcare organisations, recognising the importance of analysing these concepts as they occur in social practice. In this chapter I will use the insights I have gained to develop the conceptual framework I have used for the enquiry. I will then discuss my methodological approach to the research, my research design, the particular methods adopted for the study and the data collected and analysed. In this way I will align my ontology, epistemology and methodology to give a holistic overview of my research strategy. By outlining the decisions I made at each stage I will attempt to offer a transparent account of my research. Finally I will discuss my position as a reflexive researcher and the ethical implications of my research, in particular considering my position as an insider researcher.

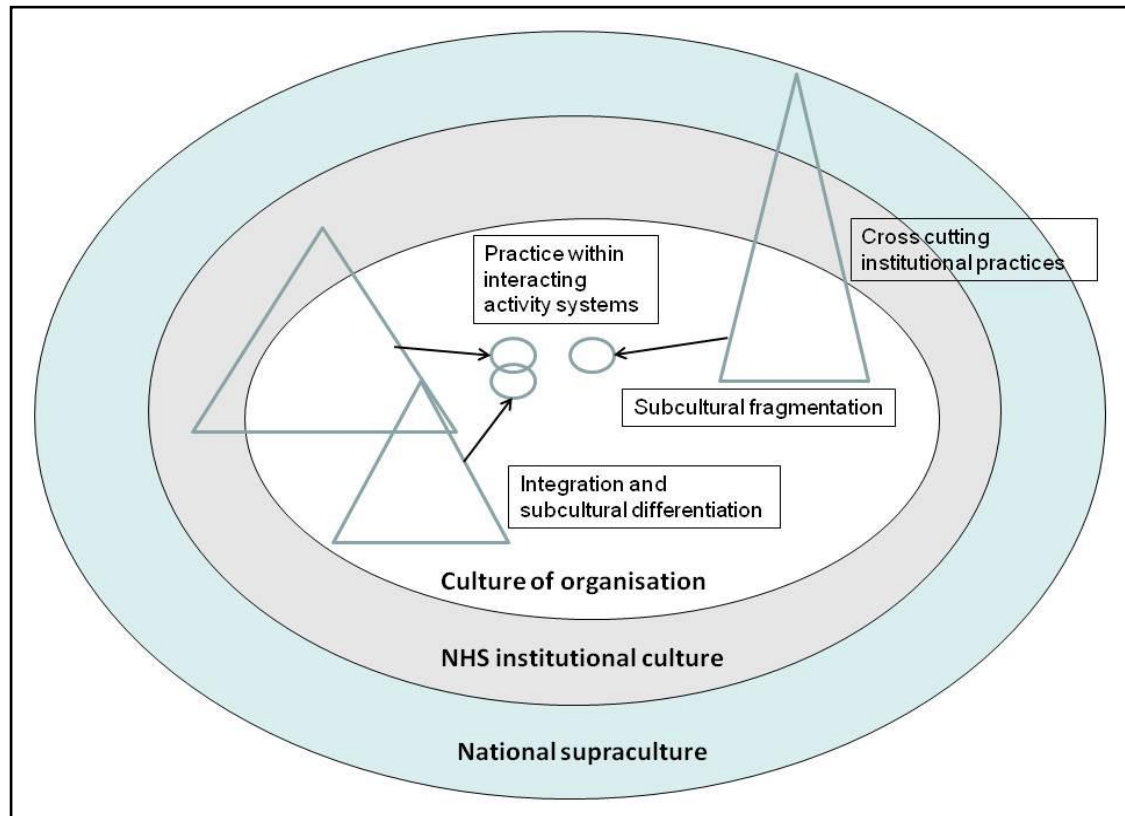
#### **4.1 Conceptualising healthcare organisations for research**

In my exploration of the policy literature in chapter two, I highlighted that there is some confusion as to the nature of the organisation versus the institution in UK healthcare. Seen as an institution, the NHS is a huge social entity, enshrined in our laws, our politics and our daily lives. However, it is also an employer and, through individual bodies, it employs an enormous number of staff for different organisations with both shared and separate work objectives. Employees within the NHS come from a variety of backgrounds, cultures, belief systems and professional pathways. Users of the NHS similarly are drawn from all walks of life and every individual member of the population of the UK can be considered a stakeholder in the NHS. This interdependency adds a complex element to the empirical consideration of NHS healthcare organisations. Any conceptual framework for empirical research into organisational culture and learning in the NHS has to allow for this complexity.

Conceptual frameworks provide a scaffold within which strategies for research design can be determined and fieldwork can be undertaken, giving coherence to the research by providing connections between theory, research design, fieldwork and the significance of the research conclusions (Leshem and Trafford, 2007). Using the perspectives detailed in earlier chapters as a theoretical lens through which to view the organisation, I can begin to identify the unit of analysis for my research. Drawing on the insights I have gained so far from my critique of the relevant literatures, I conceptualise the healthcare organisation as a complex cultural system, as represented in Figure 2 below. Here I am using my interpretations of Engeström's activity theory alongside Martin's three perspectives approach to analysis of organisational culture. At the macro-level, adopting an activity theoretical perspective enables me to theorise the organisation in focus by deconstructing the network of interacting activity systems that make up its whole. However, when considering the lived experiences of actors within the system, I can also explore the complexity of cultural practice by simultaneously looking for instances of integration, differentiation and fragmentation to explain human actions and further develop the issue of culture. In identifying the shared objects of activity, the tensions and contradictions, the core organising processes, and in considering how activity systems go through cycles of expansive learning, I can begin to develop a framework for the exploration of culture, learning and transformative change.

The complex cultural system is made up of layers of culture, some of which are cross cutting and overlap, some of which are shared and some of which are contradictory. There is consensus and ambiguity, cohesion and tension, as individual and collective actors engage with the cultural system. Practice occurs in networks of interacting activity systems, with the potential to produce shared and jointly constructed objects of activity. Through expansive learning, the object of activity can be transformed in various ways. However, the ambiguity in the system provides a barrier to changes achieved through these processes.

Figure 2: Initial conceptualisation of cultural activity in NHS organisations



In its current form, Engeström (2001) suggests that there are five principles of activity theory. I have used these to guide my analysis:

1. The prime unit of analysis is a collective, artifact mediated, object oriented activity system seen in its network relation to other activity systems. Within this study, the object of activity is organisational culture change. The unit of analysis will, therefore, be the networks of activity systems within the organisation that achieve cultural change through work practices and expansive learning.
2. Activity systems are multi-voiced. Through my analysis I will explore how different voices are expressed and heard within the organisation by exploring different professional groups, healthcare roles and stakeholder interests, and their artifacts, rules, conventions and traditions.
3. Activity systems have historicity and take shape over time. In considering cultural change as the object of activity I need to consider the journey towards this change; from the organisation's past, through

to its current practice and its future direction of travel. This will require an analysis of the different backgrounds of participants, how they interact with one another and how this may influence change, as well as analysis of the background of the organisation.

4. Contradictions have a central role as a source of change and development. Through analysis of the lived experiences of participants I can explore instances of organisational integration, differentiation and fragmentation, exploring these contradictions and their effect on the journey towards cultural change. Contradictions may come from a number of sources, in recognition of the many layers of the complex cultural system and I will, therefore, need to look for them in more than one location.
5. There is the possibility of expansive transformation in activity systems as contradictions occur. Through an exploration of the lived experiences of actors within the activity system I can explore the journey towards these expansive transformations, considering how the culture is consumed and interpreted at both individual and collective levels and how organisational meaning is made. This will include a critical analysis of power relations. By applying Martin's three perspectives interpretive framework to organisational culture analysis, I can theorise power in terms of differentiation between subcultural groups, both within and between activity systems, and explore the dynamics between these groups and how they relate to the shared object of activity.

#### **4.2 Methodological and analytical considerations**

My approach to this study, therefore, blends insights from social constructivism with insights from activity theory in an exploration of individual and collective learning within the context of organisational social and cultural practice. My research questions and my subsequent conceptualisation of organisations ask for a consideration of both individuals and the collective, within the context of a network of object-oriented activity systems. I am interested in the day-to-day lived experiences of practitioners as they learn and construct culture but I am



also interested in gaining a macro level perspective on cultural change activity within the organisation.

I consider that the task of the researcher is to understand the multiple social constructions of meaning and knowledge (Robson, 2008). I view culture as socially and discursively constructed through the activity and interactions of individuals rooted in society, all of whom interpret and consume culture differently. The reality of culture for me is a socially constructed reality, which is in a process of continual change. Consideration of learning requires consideration of the setting and the activity in which knowledge is developed, as these are inseparable from the learning (Oxford, 1997). Therefore, studying culture and learning for cultural change requires gaining insight into the meaning these concepts have for those who experience them in social practice. It requires me as a researcher to interact with participants and seek to understand their subjective reality. Rather than searching for external order, I am seeking to construct order from meaningful interactions with participants.

#### ***4.2.1 Research design***

As noted in chapter three, the activity theoretical approach used by Engeström to explore change in healthcare organisations relies on an abstraction of change activity from routine healthcare practice. In contrast, I wish to analyse cultural change within its organisational context, analysing the day to day lived experiences of practitioners and relating these to collective relationships in order to analyse how they learn to change culture in and through practice. Therefore, I have taken an interpretive case study approach (Baxter and Jack, 2008) to this enquiry. A case study allows me to analyse the world in context for a particular organisation and the individuals within it (Denscombe, 2007). It facilitates exploration of a phenomenon within its context using a variety of data sources and, therefore, a variety of lenses to reveal and understand multiple facets of the phenomenon (Baxter and Jack, 2008). Case study methodology has been widely used in the study of organisations, as highlighted in previous chapters. I follow Yin's (2009) approach to case study, which is based on a constructivist paradigm. He considers that case study is especially valuable when considering 'how' and 'why' questions, when

you cannot manipulate the behaviour of those involved, when you want to consider contextual conditions and when boundaries between the phenomenon under study and the context are not clear. In this enquiry, the phenomenon under investigation is learning activity in organisational culture change, but this cannot be considered separate from the context of the organisation within which it occurs. The study design was deliberately flexible, allowing for the presentation of multiple realities and a focus on participant views (Robson, 2008), in line with my ontological and epistemological stance. Conceiving of the organisation as a set of interacting activity systems, each with its own historicity, multi-voicedness and contradictions, I used a variety of data sources to build up a picture of the case. Data was interpreted iteratively as the study proceeded, drawing on my theoretical framework, with the interpretation guiding further data collection.

Within this enquiry I use activity theory to identify my unit of analysis, to provide a lens through which to observe the practice of learning for culture change and to provide an analytical tool to assist in interpretation of data and the framing of conclusions. There is, however, an absence of debate about appropriate research methods which impacts on the use of activity theory as a methodological tool (Morris, 2009). Engeström favours the use of the Boundary Crossing, or Change, Laboratory described in chapter three (Engeström, 2001). This involves questioning and problematising current practice to acknowledge tension and contradiction, looking backwards and forwards to re-think the object of activity then identifying, and subsequently trying out, different practices to achieve the collective vision. However, this approach is problematic within the realm of a doctoral study. It also, as previously discussed, removes change from work practice and implies a manipulation of the behaviour of those involved in order to achieve an aim. That is not the focus of this research, which is instead asking exploratory questions of 'how' and 'why' and which aims to explore change activity in context. Other authors have interpreted Engeström's work in a broader sense. Guile (2009 p773) argues that communities of practitioners are able themselves to learn "to reconfigure and/or create new objects and practices". In a recent collected edition showcasing a range of methodologies adopted

when using the tools of activity theory, Daniels and Edwards (2010 p1) highlight how “contributions present activity theory as a developing resource encompassing core principles, yet flexibly responsive to fields of study”. Therefore, although I draw heavily on the work of Engeström, I am not limited to using his described methodology.

Studies of culture commonly adopt ethnographic approaches. However, this study aims to go beyond a simple description and interpretation of the culture and social structure of a group (Robson, 2008), instead exploring in more detail learning activity around cultural change. Ethnography typically seeks to identify the object of activity. However, my research questions have already identified the object of activity; organisational culture change. Therefore, although I aim to understand how a collective constructs its social world, my interest in activity and change makes case study a more appropriate methodological approach. However, many of my chosen methods and my approaches to analysis overlap with methods commonly used by ethnographers. Therefore, I consider that I have approached the case study ethnographically (Atkinson and Hammersley, 1994). By acknowledging that culture manifests not only through integration but also through differentiation and fragmentation I have rejected more quantitative or survey based research methodologies. These largely ignore the existence of subcultures through the use of predetermined and standardised instruments to access superficial patterns of values and behaviours (Pearse and Kanyangale, 2009).

#### ***4.2.2 The case study***

The starting point for the enquiry was a large general hospital on the outskirts of a major UK city – Olympic Hospital - run by a large acute Trust - Olympic Trust. Olympic Trust provides a mix of secondary care in all the main specialties to the local population, and tertiary care in some specialties on a regional level. The local population is socially and ethnically diverse. Due to a series of historic mergers over the last 15 years the Trust also runs a smaller hospital on another site – Gold Hospital. The two hospitals serve a local population of several hundred thousand people. Olympic Hospital is typical of many suburban NHS hospitals and faces similar problems and issues.

However, it also has some particular features which make it of interest for research in this field; in particular it has faced criticism by healthcare regulators and the popular press in recent years and is currently undergoing a quality improvement programme of organisational change, supported by external consultants and internal project teams. During the study period, I was employed by the organisation for a fixed term to work in the paediatric department as a senior clinician, with work designing and implementing specific paediatric service improvements.

It is important to place boundaries on a case to prevent the research from becoming unmanageable (Baxter and Jack, 2008). Therefore, my study concentrated on a particular area of Olympic Hospital, namely the maternity department. This is a large department with a focused workload and a specific patient group, making it relatively contained and suitable for a case study. Maternity was also a department that I did not have direct links with from my own clinical work and I was, therefore, able to approach the department as a researcher as well as a clinician. This balance between being an outsider and an insider plays a central role in this study, and is an issue to which I will return. However, from a methodological point of view being a relative insider; an employee in the Trust; allowed me access and legitimacy. Being a relative outsider, not an employee in maternity, meant that the study did not lead to direct conflicts with my own work in the Trust.

### **4.3 Approach to data collection**

Data was collected over a four month period in the organisation. Based on my theoretical framework, my unit of analysis is the network of object-oriented, interacting activity systems that characterise the practice of the organisation as it moves towards achieving cultural change through its quality improvement programme. Within these activity systems I am interested in both the individual and the collective, and the relationship between the two, recognising the importance of historicity, multi-voicedness and power, contradiction and coherence.

In the next section I will discuss the decisions I made in the various stages of the study before outlining in more detail the methods used and data collected. In line with my research design, I collected data from a variety of sources to build up a picture of the case, adapting the design of the study as I proceeded. I used four different methods to explore the processes of engagement with change in the organisation. These helped me to build up a narrative picture of the organisation and its culture; looking to its past, the current position and how it sees itself in the future. Through my own engagement with this organisational story and the collection of my own observations and interpretations in a research diary I was able to adapt my research design flexibly and collect data that built on my analysis.

My initial step was to gather historical and contextual information about the organisation and the department and to build up a picture of its background, the different, interconnected activity systems and the quality improvement programme taking place. I used a series of interviews with key informants, expert sources of information who are able to provide insight into their community (DiCicco-Bloom and Crabtree, 2006). The second phase of the study consisted of a period of observation of organisational 'change' activities that involved groups of individuals working towards specific goals or outcomes. This allowed me to frame my understandings of the activity systems, their objects and motives of activity, and to record instances of integration, differentiation and fragmentation in practice. I followed each observation session with interviews with participants in phase three. These used the observation session as a springboard to explore understandings of the organisational change programme, how the organisation was achieving change and the learning that was taking place. As I progressed through this period I undertook pairs of observation and interview, returning to my questions and theoretical framework at each point to decide where to progress next. I also wished to further explore how the department represented itself in and to the wider institution. I chose to do this by analysing a series of texts and documents through which the department constructs a story of change with an audience.

A summary of this flexible four-phase approach to data collection and analysis can be seen in Figure 3. As a flexibly designed case study, analysis was achieved through contemporaneous immersion in the data throughout the study, with careful reading and rereading of the transcripts and notes produced and an ongoing organisation of my thoughts in line with my theoretical framework and research questions. This is discussed in more detail later in the chapter.

The timeline in Figure 4 details the sequence of events throughout the 24 weeks of the study, highlighting where within the course of the study different data collection points occurred.

Figure 3: Four phases of data collection and analysis

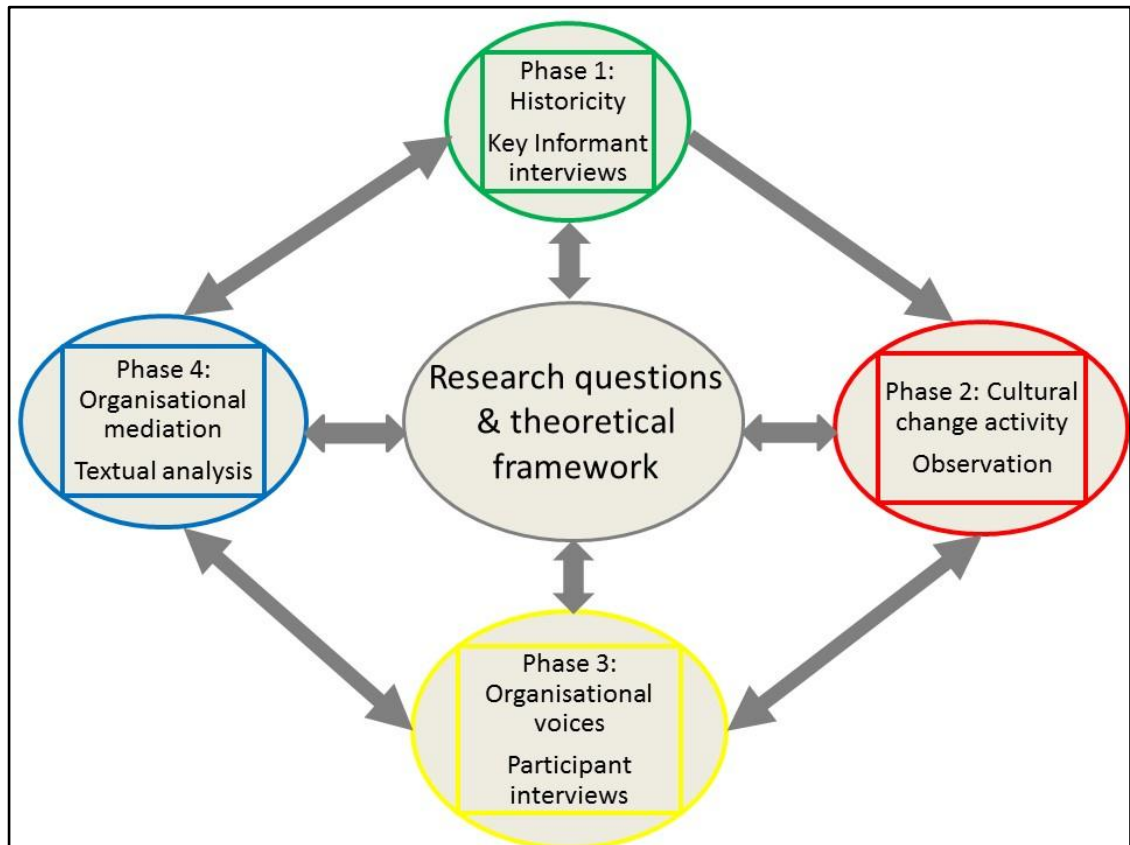
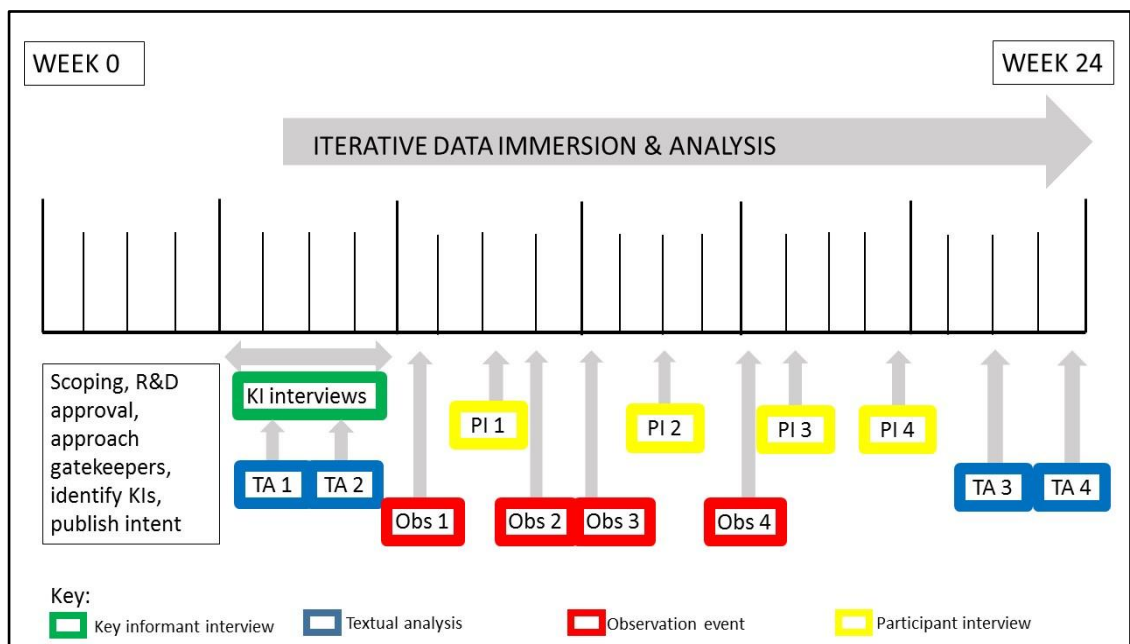


Figure 4: Data collection timeline



### **4.3.1 Interviews**

My initial set of interviews took place with organisational key informants who were chosen deliberately based on their role within the organisation. The advantage of using key informants as sources of data in research is that they can provide high quality data in a short amount of time, largely due to their role in the community. However, the disadvantages are that informants are unlikely to represent the majority view of the community and might only divulge politically acceptable information (Marshall, 1996). The second set of interviews followed the observation events and participants were chosen purposively based on their role within the observation events. The aim of the second set of interviews was to further explore change activity and learning in the organisation.

A dilemma has been highlighted in interviewing by authors such as Silverman (2006). Positivist researchers aim to create a pure interview, yielding factual data that mirrors reality. However, this approach has been largely discredited for many of the reasons described elsewhere in this thesis. A more unstructured, open ended approach to interviewing claims to elicit authentic accounts of subjective experience. However, Silverman suggests that these authentic accounts may actually repeat familiar cultural tales and dominant understandings. A more radical approach would consider that the interview is simply an interaction between two people and cannot represent the social world in any way. Clearly this is problematic for empirical research. Holstein and Gubrium (1997) suggest an interactional, interpretive interview method they call the active interview. Both sets of interviews in this enquiry followed this approach. Interviewing is seen as a form of interpretive practice involving interviewees and interviewers who articulate their orientations and understandings. Rather than seeing it as something concrete, real and objectified, I see learning as an interpretative device (Gherardi, 2001). Therefore, rather than seeking to explore deep understandings, I wished to co-construct knowledge with interviewees, exploring how they create their understandings of culture and learning in the organisational context. The stories and accounts given in the interviews were not treated as objective representations of the organisation's culture, but rather as symbols of the



socially constructed culture. The process of meaning construction is considered to be as important in active interviewing as the meaning that is produced. This aligns with my conceptual framework, where the importance of meaning making is highlighted as a core organising process within the activity system.

The exploratory nature of the interviews allowed me to probe values and assumptions and seek further information about learning for change. However, there is always the possibility that true motivations remain hidden, even from the individual (Pearse and Kanyangale, 2009). A challenge for my interviews lay in creating the rapport to enable the participants to share their views and perceptions and contribute to the co-creation of meaning. In a time limited scenario it is essential a positive relationship is established quickly. There are considered to be four stages of rapport building: apprehension; exploration; co-operation and participation (Rubin and Rubin, 2012). During the initial apprehension phase a broad, open-ended question, either about the individual's professional background or the observation event they participated in, was used to help get the interviewee talking. This was followed up by non-directive questions to seek clarification. During the exploration and co-operation phases questioning could go deeper and engage the interviewee further, clarifying and discussing points of interest or contention (DiCicco-Bloom and Crabtree, 2006). However, the achievement of rapport in my interviews needs to be viewed in terms of reflexivity, discussed later in this chapter, particularly in relation to my own positional identity relative to the interviewee. The interview schedules used (see Appendix 1) oriented me to my research questions but also allowed me to converse with respondents in such a way that alternate possibilities and considerations came into play, exploring multiple interpretations and diverse aspects of the interviewees perspectives, roles and orientations.

Key informant interviews were undertaken to enquire about the organisation's history, structure and goals, as well as the informants' perceptions of the organisation's culture and learning and priorities for change. The first step in my analysis was to collectively narrativise the accounts to tell the story of the

organisation, focusing on the facts that came out of the interview. This was subsequently supplemented by information gained from documentary analysis. While this rather positivist emphasis on facts may seem contrary to my social constructivist position, I feel it is possible to separate out information about history and structure in order to deconstruct the organisation and guide further data collection. The active interview approach allows the dynamic inter-relatedness of 'whats' and 'hows' to be analysed (Silverman, 2010). Therefore, in telling the story of the organisation through the interpretation of the facts, I also recognise the importance of the interpretations imposed on the story by both the interviewees' and myself.

Post observation participant interviews aimed to co-create meaning with the interviewees (DiCicco-Bloom and Crabtree, 2006) by reconstructing their perceptions of the organisation and the change events they were involved in, and their experiences of the organisational culture and learning. Although some pre-determined questions and themes were devised, there was space for other topics to emerge during the conversation and for digressions to be created by the interviewee, following their interests or knowledge (Johnson, 2002).

Individual interviews can be criticised for ignoring the collective aspects of culture. I considered focus group interviews as an alternative method to try and incorporate an element of analysis of group dynamics. However, arranging focus groups with practitioners who work in shifts and have a continual need to provide service to patients in an acute environment is problematic. I, therefore, made the pragmatic decision that this would be unlikely to succeed in a busy maternity unit.

#### **4.3.2 Observation**

There are different approaches to observation based around the degree of structure and the degree of participation of the observer (DeWalt and DeWalt, 2011). Formal approaches impose a high degree of structure and direction to what is observed and will consider anything outside this as irrelevant.

Generally observers will remain outside the situation being observed rather

than participating directly in the activity, adopting a true outsider role (Bloomer et al., 2012). More informal approaches allow the observer more freedom in what they record but require them to simultaneously synthesise, abstract and organise the data. The observer will generally seek to become some kind of participant in the observed group (Mulhall, 2003). However, this process requires total immersion in the field and a protracted period of time to produce meaningful data, something not possible for a professional doctorate researcher. I, therefore, chose to adopt a position somewhere between the two. As an employee of the Trust and a clinical professional, my place at the table was afforded certain legitimacy and this allowed me to be a participant to some extent. However, I also wished to capitalise on my outsider status. The benefits of being an outsider, particularly in a work setting, are that participants might feel safe to divulge information without fear of consequences (Bloomer et al., 2012). Therefore, I adopted a role as a marginal participant (Robson, 2008), with a lower degree of participation and presence than a classical participant observer. My presence in the room at the events observed was not completely out of character as I was generally one of a number of clinicians present. However, I advertised my role as an observer prior to sessions starting and remained largely passive, unless directly invited to join in the discussion by research participants.

In structuring my observation I also adopted a middle ground. I chose to keep a loose record with a running description of events as they happened. However, this was also supplemented with a matrix designed around my conceptual framework that allowed me to specifically note and record instances of learning and transformative activity. This can be seen in Appendix 2. This matrix was partly completed contemporaneously and partly completed immediately after the session through recall and interpretation. At this stage, I also supplemented my field notes with interpretation of events and my personal impressions and feelings, drawing on my experiences within the organisation.

The importance of undertaking whole group observation is in the recognition of the collective nature of culture and the sociocultural dimension of learning.

Observation as a methodological tool enables the researcher to see what people actually do in their real world context , to see how they work in relation to their environment and to learn about their social practices (Mulhall, 2003). Where interview explores participants' perceptions and recall of events, it does not account for differences between what they say and what they actually do. Observation can counter this difficulty by focusing on what is done and said in context. However, observation has drawbacks and issues that need to be considered. As Agar (quoted in Bunniss and Kelly, 2010) pointed out:

*“During fieldwork you are surrounded by a multitude of noises and activities. As you choose what to attend to and how to interpret it, mental doors slam shut on alternatives”* (p363)

Therefore, although I am guided by my conceptual framework and my underlying theory, as a reflexive researcher I need to remain open to the possibility of alternative interpretations of what I observed and how my role in the research affected both what happened and my interpretations of it. Observation is also far more unpredictable than other research techniques (Mulhall, 2003). This led to ethical considerations that I discuss later in this chapter. It also meant that I had to remain adaptable and ready to change my structure.

#### **4.3.3 Documentary analysis**

In my final stage I analysed a number of organisational texts that told a story about the organisation to an audience. These included inward and outward facing texts, purposively sampled based on information collected during the earlier stages of the study. Atkinson and Coffey (2004) argue that:

*“Documents are ‘social facts’, in that they are produced, shared and used in socially organised ways. They are not, however, transparent representations of organisational routines, decision making processes or professional diagnoses. They construct particular kinds of representations for their own conventions”* (ibid p58).

The texts analysed were all accessed via the internet; either the Trust's external website or its internal intranet. Markham (2004) considers that the internet offers more than just a means of information transmission but is also a cultural space where meaningful human interactions occur. In the context of this study, the texts and documents can be viewed as mediating artifacts through which activity is executed within the activity system. They provide information on the rules and divisions of labour within the community and carry remnants of the historicity of the activity system while simultaneously shaping future activity. Texts are not only produced but are also productive (Prior, 2004), translating organisational information for use in other organisational contexts. In analysing these I was interested not only in their content but also in their place in the organisation, their function and the cultural values attached to them - their meaning. I used this analysis to further inform the social relations within the network of activity systems and consider how expansive learning might occur through the use and interpretation of mediating artifacts.

#### **4.4 Data collection**

I recruited three key informants for the study; one from executive level, one from a senior clinical level and one from a nursing managerial level, as shown in Table 1 below. Key informants were selected based on my insider knowledge of the organisation and two of the three informants were known to me professionally prior to the study starting. The third was identified through discussion with these two. I, therefore, capitalised on my insider status at this early stage of the research.

Sessions for observation were identified through discussion with key informants and were part of the 'facts' that came out of the key informant interviews. In exploring the work of the organisation as it moved towards change with the key informants, these sessions were interpreted as forming part of the organisation's change agenda. They were activities such as team meetings, learning sessions or governance events that addressed organisational issues, rather than clinical issues for individual patients. Any patients were discussed anonymously. In identifying these events as suitable

for observation I considered a number of factors: the aim of the event within the departmental and organisational context; the likely participants and the aspects of organisational change addressed. I aimed to include a variety of events, giving an idea of the change activity taking place within the department and wider organisation. A log of these can be seen in Table 2 below.

Post observation participant interviewees included employees from a number of roles. Selection of interviewees was purposive and pragmatic. I sought to include a variety of staff members; doctors both junior and senior, midwives both junior and senior and those in a more managerial role. I approached participants following the observation sessions informally, as I was able, and asked if they would be willing to be interviewed. However, the final number selected was largely opportunistic and limited by working pattern constraints and employees leaving the Trust during the course of the study. Although I originally aimed to conduct six interviews, I was only able to arrange four. Other contemporary researchers in the NHS have commented on the difficulty of negotiating time for interview in busy clinical settings (for example Dickinson et al., 2013) and I encountered similar problems. In particular, I was unable to secure an interview with a junior doctor or a general manager. A description of the final interviewees can be seen in Table 3 below.

Texts for analysis were similarly identified during the preceding stages of the study. They were documents that were either used or referred to in the sessions observed, or discussed in interviews. A log of these can be seen in Table 4 below. In selecting texts, I purposively chose a mix of outward and inward facing material. Outward facing material, available via the internet, was used to explore how the Trust and Department represents itself to patients and external stakeholders particularly. More inward facing material, only accessible to staff, was used to explore the department's representation of its goals and priorities to its staff members. I also chose a text that had been prepared on behalf of the Trust Board and which has been widely read by both external stakeholders and internal staff members. In this way, I aimed to sample a range of different cultural representations.

*Table 1: Key informant interviews*

Interviewee	Role	Time in organisation
A	Executive Board member	Less than one year
B	Senior clinician	Greater than three years
C	Nursing manager	Two years

*Table 2: Organisational observation events*

Event title	Origin of event	Description and aim	Frequency of event	Number and type of participants
Learning and sharing session	Identified by gatekeeper during scoping period and by senior clinician KI  Practitioner developed and led	30 minute multidisciplinary teaching session. Aim to address key clinical issues identified through analysis of recent departmental clinical incidents and learn skills to achieve different outcomes in the future.	Twice weekly	Consultant obstetrician : 1 (facilitator) Middle grade doctors: 3 SHO grade doctors: 4 Midwives: 3 Healthcare assistant: 1
Change project meeting	Identified by nursing manager KI  Organised and timetabled by project team	1 hour steering group meeting for a specified service improvement project. Aim to review project progress and agree an ongoing project action plan.	As needed, typically monthly	Project midwife: 1 (chair) Senior midwives: 2 Junior midwives: 2 Junior doctors: 1 Managerial staff: 2
Maternity business meeting	Identified by senior clinician KI  Organised at fixed time each month and administered by general manager's personal assistant	1.5 hour meeting of senior staff covering departmental management priorities and issues. Aim to update senior staff on the department's progress in line with the organisation's objectives and to agree an action plan to address new and ongoing issues.	Monthly	Consultant obstetricians: 9 Senior midwives: 4 Managerial staff: 3 Admin staff: 1
Clinical governance meeting	Identified by senior clinician KI  Organised at a fixed time bi-monthly, co-ordinated by a named consultant and administered by a dedicated member of secretarial staff	2.5 hour multidisciplinary meeting with presentation and discussion of departmental clinical audits and serious incidents. Aim to update staff on clinical governance priorities and issues and agree an action plan for departmental learning and quality improvement.	Bi-monthly	Consultant obstetricians: 12 Senior midwives: 4 Project midwives: 3 Middle grade doctors: 8 SHO grade doctors: 6 Managerial staff: 3

*Table 3: Post observation participant interviews*

Interviewee	Role	Observation session attended	Interview completed
Priya	Consultant obstetrician	Learning and sharing, business meeting, clinical governance	Month 2
Ranita	Project midwife	Learning and sharing, change project meeting	Month 3
Tracy	Senior midwife	Business meeting, clinical governance	Month 4
Desmond	Project manager	Change project meeting	Month 4

*Table 4: Organisational documents analysed*

Document	Type	Description
Maternity home page on Trust website	Web page with text and image	Accessed by external visitors to the Trust website looking for information on maternity
Care Quality Commission (CQC) Investigation report into the Trust	PDF document on CQC website	Accessible by internal and external stakeholders via the CQC website
Trust response to CQC report into concerns around maternity services	Letter to stakeholders on Trust website	Accessible by internal and external stakeholders via the Trust main website
Maternity policy for a specified clinical area, written as part of a service improvement project	PDF document on Trust intranet	Accessible by internal staff only

#### **4.5 Approach to data analysis**

Data analysis was an iterative and reflexive process, beginning as I started collecting observations in my research diary during the scoping period and continuing through the data collection period and after I had left the organisation. Through my interaction with the data I aimed to keep focus on the inter-relationships between the different aspects of the case, recognising the whole rather than the parts. Throughout the study, I used my research diary to write conceptual notes, and used these to orient myself progressively to what I was discovering as I engaged with the data. Miller and Crabtree (1999) describe this process as doing the dance of qualitative data analysis, and consider that it consists broadly of three elements: firstly a literal reading



of the data for content; secondly a reflexive reading of the data for orientation and focus; and thirdly an interpretive reading for meaning. During the dance, periods of immersion and crystallisation are interspersed, bringing the story of the case into focus.

In a practical sense, I began my first literal reading of interview data for content soon after collection. Interview data was audio recorded and transcribed by me after each interview, producing a simple text consisting of the spoken words of interviewer and interviewee. This was initially tabulated to break text up into sections and allow me to view content, using colour to highlight sections of text. Key informant interviews were analysed first to tell the history of the organisation. The content from these interviews was supplemented by content from the reading of key texts, organised in the same way, as highlighted in the timeline on page 54.

During observation events I collected written field notes that formed a factual account of events and my initial thoughts and interpretations. These extensive field notes formed the bulk of my observational data. Following events I used the field notes and my immediate recollections to complete the observation matrix and further focus down and guide my analysis.

Participant interviews were analysed in the same way as key informant interviews soon after collection, with transcription, tabulation and content analysis taking place. Initial coding was based on the main headings from my conceptual framework, as shown in chapter three. I used Holstein and Gubrium's (1997) approach again in analysing my interviews, looking for both content and form and how they are dynamically inter-related.

As the data collection progressed, key informant interviews, participant interviews and observation events were then analysed together in order to explore the concepts and interpretations of learning and change that emerged, in line with the third stage of Miller and Crabtree's dance. I continued to do this in a spiral fashion as I collected more data. Interview transcripts and the matrices from observation events were organised in a computer assisted

qualitative data analysis software package (NVivo 8, QSR International) to aid structuring and organisation of analysis. Codes were applied based on my earlier content analysis and my conceptual framework. As I gained deeper understanding, codes were sifted, sorted and linked and I began to selectively focus down. These codes were then manually applied to my research diary and field notes and referred to again as I analysed the final documents in my timeline to reconstruct the organisation and its activity networks.

Through this process I was able to construct a mind map of codes and linkages that were used as the basis for writing my data analysis chapters. In this way, I was able to begin constructing a “thick description”, in the manner of Geertz (1973). The commentary and interpretation allowed me to turn my factual accounts into complex layers of meaning in an attempt to decode the cultural context. Through the exploration of meaning making in relation to organisational culture and learning, I was able to explore the multiple organisational voices at play and how individuals construct learning within these networks. Appendix three shows a worked example of data analysis from an early observation event.

#### **4.6 Considerations of reflexivity**

I have had to be aware of the effect my own personal identities and epistemologies have on my research. I am researching an organisation I temporarily had a role in. The role I had was one which encompassed an element of organisational change. This will necessarily affect who I am and what I think. I acknowledge this at the outset and the study needs to be interpreted with this in mind. By researching a department I am not directly involved in clinically I am attempting to distance myself from this, but I do have to contend with my own preconceptions and how my experiences elsewhere in the Trust will impact on my analysis. As highlighted by Denscombe (2007), our age, sex, ethnic origins, roles and other aspects of our self will have a bearing on the perceptions of participants and the information they are willing to share, either consciously or subconsciously. Langemeyer and Roth (2006) point out that in viewing the unit of analysis in research as an activity system,

we as researchers need to consider our own subject positions in the system and the role we play in constructing the object of activity. While it is possible to take steps to try and minimise the researcher effect, I do not believe that it is possible to remove myself from the research entirely. My own position is that there is no objective truth that can be accessed via research, but rather that reality exists as interpreted social action. There were a number of decision making points in the study; in developing my conceptual framework, in choosing my methodological approach, in selecting my research methods, in the iterative approach to my data collection and the sampling strategy I used. At each of these decision making points I actively acknowledged my own position in the research and the factors that influenced me and I aim to present these as transparently as I can. However, I need to consider carefully both how I have explored the issues and how I interpret them, through the lens of my own experiences and my own preconceptions.

I also have to take into account my professional role in relation to my participants. In insider research such as this, I have a dual identity as both fellow clinician and researcher. Although being a doctor grants me some access rights and privileges, and may have allowed participants to talk more freely in a language I can be presumed to understand, I have to be aware that they may feel that I will judge them, and the organisation, professionally. My own positional identity relative to my participants is important and needs to be considered in my analysis. As someone exploring relationships between professional groups, my own professional group will undoubtedly have a bearing on this. When I approached midwives, managers or doctors I was approaching not just as a researcher but also as a senior doctor in the organisation. This may affect what I am able to learn as well as how I interpret it. I need to see myself on an insider-outsider continuum (Mercer, 2007). As an organisational employee with prior knowledge of the organisations routines and structures I can be viewed as an insider. However, I hadn't been there long and it was known that I would not be staying, therefore I may still be viewed as a relative outsider. The fact that I chose to research an area of the organisation that I was not directly involved in also places me towards the outsider end of the continuum, which will have affected my relationship with

participants and what they may choose to share. At different points throughout the study I acknowledge that I made use of my ability to move along this continuum, capitalising on my insider status to gain access and information, and on my outsider status to facilitate neutral relationship building. However, this is a subjective split and I may not have been viewed by my participants in the way I envisaged.

#### **4.7 Ethical considerations**

I have followed The British Sociological Association's ethical practice guidelines in guiding my ethical approach (British Sociological Association, 2002). Ethical approval has been granted by the Institute of Education Research Ethics Committee through their doctoral school processes. I have been granted exemption from NHS Ethics Committee approval from the National Research Ethics Service (NRES), the central NHS research ethics body. They produce clear guidelines for potential researchers on when NHS ethics approval is required and have a service to answer individual queries rapidly. As my research did not involve patients or access to patient records, exemption from their procedures was granted (see Appendix 4).

The main ethical issues related to this study are around the ethics of insider research and these have guided how I designed the study and how I interpret my findings. The first issue to consider is that of access. I obtained permission from the gatekeeper to the hospital, the Chief Executive, to carry out the research and also went through the Trust's Research and Development process in the same way as would be done for clinical research. However, I also needed to seek permission from the leadership in maternity. As hospital managerial structures are divided along professional lines, I sought permission from the Clinical Director, Lead Nurse and Associate Director. There was the possibility that there may be some disagreement between them and that one or other may feel coerced into agreement because I am a staff member. I endeavoured to control this by approaching each person individually, by email initially, and not sharing what the others said. I offered to meet with each individual in person to explain the study and what would be

involved, allowing each person to make their own informed decision. One person took me up on this offer and the other two agreed by email.

I also needed to consider what and how to tell other staff members about the research, both before and after participating. As any member of the organisation could have potentially been involved through observation, I sent out study information to all staff registered as working in maternity via the gatekeepers. I also placed a number of posters in clinical and rest areas announcing the study start date and providing my email address. This information sought to make clear when and how staff might be invited to participate, that they were free to refuse to take part and how they could do this before, during and after the study. Before individual interviews, participants were emailed a study information sheet and written informed consent was sought (see Appendix 5). Again, the freedom to refuse consent, or to withdraw at any time, was made explicit on more than one occasion. Before any period of observation I announced my presence and purpose to individuals in the room. However, I did not seek individual written consent from all people present as this would have disrupted the sessions and the work of the department. Individuals who did not wish to take part were invited to approach me after the session, in person or by email, so that I could discuss with them removal of relevant data. No-one took up this offer. However, a more difficult issue arose when individuals joined an observation session part way through, an event which happened fairly frequently. In this case, I relied on my posters and electronic study information sheet to alert individuals to my presence.

I also recognised that staff may approach me about the study outside of 'research time' as we worked in the same organisation. To avoid causing offence or potentially damaging working relationships I made it clear in the study information that while I was prepared to answer questions about the study methodology I could not discuss my own thoughts or my data analysis in detail. A further ethical issue concerns the use of incidental data; information that may have relevance to the study that I picked up otherwise in the course of my working life within the organisation. I acknowledge that I have used this

information as an entry point to the study, to select key informants and events for observation. My own research diary, which outlined my journey through the research process, will contribute to my data analysis. It records the result of barriers that I came across during the course of my research and illuminating observations that I made about the organisation. This includes information about the maternity department that I gathered in the course of my daily work, such as through Trust level Boards and Committees. If particular individuals disclosed information relevant to the study to me, either during an informal chat or in other meetings, I verbally sought specific permission to include the information anonymously in the study and recorded it in the diary. This information will contribute to my analysis.

A major ethical issue centres on confidentiality. I have aimed to keep all participants anonymous in my reporting. Techniques used included the use of non-descript job titles, minor changes to role description, indeterminate or changing genders and ethnicities, alteration of timescales and adaptation of sections of text to remove recognisable features. However, it is possible that many participants will be recognisable internally through their comments or opinions. By using key informants from the main sectors of the organisation, I have not needed to identify them by job title. Observation data and personal interview data are more difficult to keep confidential as people within the organisation may know who attended each meeting or agreed to interview. Therefore, my presentation of findings needs to explicitly consider anonymity and adapt to this. Within post-observation interviews, I directly discussed this issue with participants and agreed with them the approach to achieving this. However, it needs to be recognised that absolute confidentiality cannot, and should not, be guaranteed.

At this point, the question also arises about what happens to the data. As my study aims to be interpretive rather than simply descriptive, my analysis will interpret individual accounts and events in the light of my theoretical framework and my own subjectivity, and my account as a researcher may be very different from the participants' own understandings of their experiences. If individuals recognise themselves within the study, my interpretation of events

they were part of may cause offence. This was explained to participants beforehand, although it needs to be recognised that the nature of the study is such that I am interpreting information using a theoretical framework that is not fully accessible to them.

Insider researchers need to consider the audience for their research, in particular the audience inside the institution under study. The Executive Board of the hospital are invested in the change programme taking place and, therefore, are likely to be interested in the results of my research. I made it explicit in seeking permission from the Chief Executive that a condition of my undertaking the research is that I will not be sharing raw data with the Board. Unlike other insider researchers, who may fear for their own professional role if they do not comply with requests from senior management, I am in the position of being in a fixed term contract and will not complete the research until after this ends. However, I made it clear to participants, and the other gatekeepers, that the research is for my doctorate and not for the Board. However, if I aim to inform practice and policy as a professional doctorate researcher, then I aim for my research to be of interest to the wider NHS and possibly even to national media. I have, therefore, had to consider how to present my research in a way that acknowledges a potentially wide audience. My approach to confidentiality of individual participants has been outlined above. I also need to consider organisational confidentiality. The story that makes the case noteworthy is one that may be recognised. I have, therefore, omitted a level of detail that I have judged does not add to my analysis and I have altered timescales slightly. Readers of the thesis need to recognise that these decisions cannot be as transparently discussed as other research decisions I have made.

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**CHAPTER FIVE:****ANALYSING INTERPROFESSIONAL NETWORKS OF CULTURAL CHANGE**

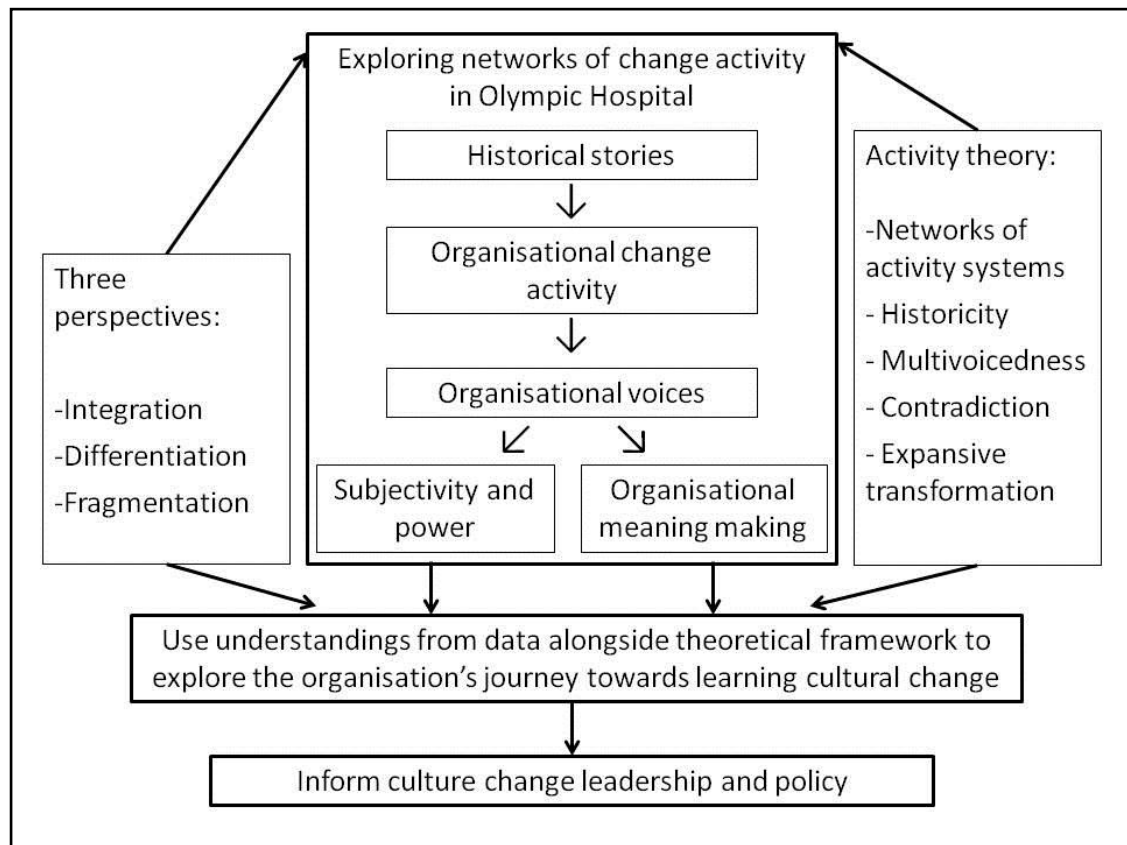
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The next three chapters will present and discuss the findings from my fieldwork, using my theoretical framework and conceptual understandings to explain and analyse my data. As outlined in the previous chapter, I have taken two approaches to my analysis. The first is to analyse data thematically, looking for the historical story and cultural content of the organisation to generate themes and concepts. The second approach explores the form of the data to hear the organisational voices and meanings that were constructed during the course of the study. My ethnographic approach to the case study means that analysis has not been a discrete stage of the research. It has taken shape both formally, in my field notes and transcripts, and informally, in my research diary, as my ideas have developed during the course of the study. This iterative approach to the research means that ideas have been used to make sense of data and data used to develop ideas. As Hammersley and Atkinson (2007) make clear, this interactive process is not limited to grounded theory research but is vital whenever a broadly ethnographic approach is adopted.

In writing the next two chapters I have untangled the multiple strands of the case in order to make analytic sense of them and give textual shape to the study, presenting the story of the case. In this way I aim to explore the organisation's journey towards learning cultural change and discuss the meaning of my findings in chapter seven, before concluding in my final chapter and answering the research questions I posed earlier. This research approach is summarised in Figure 5.



Figure 5: Summary of the research design adopted



In the first section, outlined in this chapter, the etic themes (Hammersley and Atkinson, 2007) used are structured around activity theoretical concepts. As discussed in chapter four, activity theory has provided me with a lens through which to observe organisational practice and an analytical tool to assist in interpretation of data. It allows me to view the organisation as a network of activity systems constructing a shared object of cultural change through mediated practice and learning. However, to explore the lived experiences within the activity systems in more detail, I have looked at the cultural practice within the networks of activity from the three different perspectives of integration, differentiation and fragmentation. This allows me to explore the dynamics of interprofessional teams; how they form, how they are sustained and how they engage with aspects of change, both as individuals and as a collective. It also allows me to further probe how that engagement is influenced by the rules and divisions of labour within the system, both for individuals and the collective.

## 5.1 History and background of the case

To begin my analysis it is helpful to present a background to the case and the chronological story of how the organisation developed. Information on the history of the organisation was gained through key informant interviews and through reading of material they directed me to and discussed with me, such as the Trust's CQC Investigation report. I also gathered information about the Trust informally in my research diary during the course of the study. One of the consequences of my insider status was that key informants often assumed I had knowledge about the Trust's background through my professional position. Therefore, much of the data that informs this section was gathered over a prolonged period through more informal conversations with participants, collected in a way informed by my ethical framework. It will be narrativised below.

Olympic Trust was formed by a merger between two Trusts in neighbouring boroughs. Prior to the merger, three acute hospitals had operated in the two boroughs. Initially there had been a merger between two small, turn of the century hospitals in one of the boroughs. On the creation of Olympic Trust a new hospital was built in that same borough, funded by a private finance initiative (PFI), and the majority of services from both boroughs moved there. The two old hospitals, Silver and Bronze, closed completely and their land was sold off. However, Gold Hospital in the neighbouring borough had been newly built around ten years before and continued to function with a range of services as part of the new Olympic Trust. Most nursing and administrative staff at Gold Hospital stayed there after the merger. However, nursing and administrative staff at Olympic Hospital comprised staff from each of the two smaller hospitals that had closed, and new staff were recruited over the next few years. Medical staff and managerial staff began largely working across the two sites, although most offices were based at the new Olympic Hospital. The Trust senior management and Board were based in Trust headquarters at Olympic Hospital. Therefore, a degree of separation persisted between the different sites, although they were nominally the same Trust.

*"It's an organisation that has been made of three...you know...in my living memory three hospitals who particularly, who originally had three different*

*identities. Admittedly once the build for this place had been agreed I think [Silver] and [Bronze] hospitals became almost like a single entity as much of the services of [Bronze] moved into [Silver] and it became...But at [Gold] hospital, it would have seen itself as a separate entity for a long period. So I think there are issues around...what I know of the place is that it was a merged Trust but not on a merged...not an integrated organisation, not fully integrated” (Key informant A, Executive).*

Soon after opening, Olympic Hospital was required to register with the Care Quality Commission (CQC), the independent regulator of health and social care in England. The CQC commented on the significant level of the Trust’s debts due to the PFI contract and placed a number of conditions on the Trust requiring it to demonstrate improvements in quality of care. Unannounced inspections over the next few years resulted in a series of concerns about quality and safety and formal warnings were issued. Eventually a full investigation was launched; hospitals in the Trust were visited, patients and staff were interviewed and evidence was sought from local stakeholders. The outcome of the investigation was to raise ongoing concern in a number of key areas. It became evident that the expected gains in efficiency and quality on which the mergers were based had not come about and the financial position of the Trust was deteriorating year on year. This meant that other bodies and organisations within the wider healthcare community were increasingly involved with the organisation and its strategic development, as the importance of Olympic Trust to the wider health economy became apparent.

*“And..err...in a funny sort of way hoped that we were...uhhh....would help by contributing in some of the...by dealing with some of the configuration debates as a whole area across [the region]...to, to, to take the flak in terms of dealing with what otherwise as a single Trust might be quite difficult” (Key informant A, Executive).*

Complaints against the Trust were rising, however, and there had been a number of serious incidents resulting in death. A long list of recommendations was made and follow-up visits continued to check progress against these. Some of the restrictions on the Trust were lifted after follow-up visits but not all

recommendations were met. This remained a source of concern for the local community and a number of media stories focused on the Trust's poor care record and huge debt.

*"It does help that the CQC restrictions have been lifted but it is demoralising that the press is still so negative and it feels like people still focus on the negative... Well the money is a huge barrier. I know they tell us that the PFI doesn't make a difference but it's hard to see how that's the case when so much of what the organisation earns goes on the building. It feels like we can never get out of it, so why bother?"* (Key informant B, Clinician).

During this time, the leadership at the Trust underwent multiple changes. All the main members of the Board, including Chief Executive, Chairman, Medical Director and Director of Nursing, were replaced at least once. A series of interim personnel were appointed to fill gaps, many remaining in post for only a few months. There had been no sustained period of stability in the Board since CQC registration. High numbers of permanent nursing, midwifery and medical staff also resigned their posts and there were large gaps in staffing at all levels and a high use of temporary locum, agency and bank staff.

*"I spend a lot of my time on staffing, a lot. We lost a lot of our old midwives a couple of years ago when the CQC inspections... especially ones that had come over from [Bronze Hospital]. At first they weren't replaced and then it seemed like there was a big panic all of a sudden, we had to recruit 10, 20 new staff. We tried in the UK and didn't get anywhere. Even though we have students here none of them wanted to come to work here after. We then launched a big programme in [overseas]... I still have gaps all the time, high numbers of staff on long term sick. I'm always having to employ agency staff and then that gets raised at Board meetings and in the budget"* (Key informant C, Nursing).

A new Chief Executive was recruited 18 months before the start of the study. They decided to implement a Trust wide programme of quality improvement with a number of facets. Initially this involved further changes in Board members and a change in the operational service structure of the Trust. Traditional large divisions led by managers were abolished and a number of

clinical directorates were formed. These were jointly led by a Clinical Director, drawn from senior medical staff, a Lead Nurse, from a nursing background but in an entirely managerial role, and a General Manager. Clinical Directors and Lead Nurses reported directly to the Board via the Medical Director and Director of Nursing. However, a further layer of management was sited above the General Managers. Associate positions were created from the old divisional managerial positions and these individuals assumed strategic and financial management for more than one clinical directorate, reporting to the Board through the Directors of Finance and Operations. This structure had been in place for seven months when the study began.

While the new structure was embedding, funding was sought from a number of sources for various service improvement projects within the Trust. People working on service improvement included a mix of external management consultancy firms, internal multidisciplinary project teams and fixed term clinical members of staff. Apart from discrete funding for fixed term personnel and the provision of an externally contracted course in management and leadership for senior staff, no additional money was made available for specific projects. Project teams were tasked with both improving quality and safety and also generating cost savings to tackle the Trust's significant debt. The Chief Executive reported the progress against these aims weekly to the Strategic Health Authority, who had contributed some of the funding for personnel, and the quality improvement programme was marketed extensively in both local and national press.

*"You know there's lots to do on the quality agenda here. If we deliver quality in the next 2 years, for instance, we are starting to get ahead of the game, but don't expect the reputation to have followed it because people won't believe it. You'll need to have done it for 2-3 years before someone actually starts saying 'actually' and the reputation really starts to follow, follow, follow. And I don't know, there is a view that that might start to change quicker in the days of Twitter, Trip Advisor, you know, and NHS Choices and stuff" (Key informant A, Executive).*

Local commissioning groups commission maternity and women's services from the Trust. The contracts for services had recently been negotiated under a 'block contract' arrangement. Under these terms an agreed level of service is purchased at a fixed price, based on the previous year's activity. Any activity beyond the agreed level of service is remunerated at a markedly reduced rate, which does not cover direct costs. Therefore, Trusts are effectively penalised if they carry out additional activity, although they do have the opportunity to generate profit on service provided up to the level of the contract if they are able to keep costs down. This arrangement was a source of discontent amongst senior staff in the organisation who felt that it contributed to the Trust's financial difficulties.

*"People are also, medical staff, very aware of the problems with commissioning too. There is a feeling that we are punished if we do more work because of the block contract, it keeps coming back to that. Again I know this is something that we have discussed at [the course] and they try to tell us that all activity generates some income, but we see things getting busier and busier, staff getting busier and busier, and there is this perception that we don't get anything for that, we just get punished"* (Key informant B, Clinician).

During the study period, the CQC undertook an unannounced inspection of maternity services and confirmed that the organisation was meeting its responsibilities around safety, care and staffing. The Chief Executive published an open letter to stakeholders congratulating staff on their achievements. This was distributed to local clinical commissioning groups, patient groups and patient experience groups, social care directors, the local Member of Parliament and members of the regional health authorities. It was also published on the Trust website in a section on quality. However, the positive news on maternity services was dampened by the news given in the letter that Emergency Department services were significantly failing to meet quality and safety standards. The letter focused on how busy the department was, with figures presented showing the rise in attendances and the view of the department as often too busy to provide high quality care. Concerns were acknowledged and reassurances given that the Trust had a plan to tackle these issues. Despite the encouraging start and the positive news offered

following the maternity inspection, the letter ended on a low note, promising that the Emergency Department findings would not compromise plans to reconfigure maternity services in the region. A rather bland reassurance of the Chief Executive's ongoing commitment to high quality care gave the impression of an organisation still struggling to make progress and achieve change, rather than one that was emerging from a difficult period. It was in this context that the study took place in Olympic Hospital.

## **5.2 Subjectivity, practice and the collective**

Analysis of the lived experiences of individual subjects revealed that many had roles in more than one activity system, which led to ambiguity and fluidity. At times, professional subcultures were readily apparent, but at others the boundaries between professional groups seemed to be more broken down as subjects moved between professional roles and organisational roles. The interpretation of contradictions by both individual subjects and the wider collective played a part in this. Subjects actively constructed their subjectivity during times of contradiction, mediated by organisational cultural artifacts and drawing on organisational rules and divisions of labour.

One of the early events observed was the Learning and Sharing event. Despite its name, which implied an integrated and cohesive event, professional subcultures were apparent, with a clear split along professionally based lines. Participants grouped themselves along professional lines in the way they took up their places in the room. Seats were arranged around a large square table with a small number of further seats scattered around the edge of the room. However, as the session began the doctors took up seats at the table while the midwives sat around the edges, even those midwives who had entered while there were seats available at the table. The facilitator of the session, a senior doctor, noted the seating arrangement as she set the session up and voiced her view that it would enable integration by bringing participants around a table to "*learn together*". It, therefore, seemed that this professional differentiation was an unintended and unanticipated consequence. The organisational function of the seating arrangement was interpreted

ambiguously by the group members. A similar feature was observed at the departmental clinical governance meeting, where seating was arranged in lecture style, in rows with a central aisle. Senior doctors entered via the central aisle and sat together along the front two rows, forming a discernible presence at the front of the room, directly in front of the presenters. Most questions came from the senior doctors at the front and most answers were directed to them. Junior doctors, in contrast, sat near the back on either side, in small clusters with spare seats between them, avoiding the centre of the room. This rather gave the impression of them being peripheral to the session. They also left and re-entered the room frequently to answer work related telephone calls. Midwifery staff sat largely in the middle rows on one side, keeping close together and appearing as a united group. As participants entered the room there seemed to be an unspoken understanding of where different groups should sit. The majority headed straight for an area of the room before then scanning the seats to look for spaces. This was not overtly voiced at any point before or after the event. However, it seemed to be a recurring theme as it was also evident in the business meeting, where the three managerial representatives sat together, as did the three matrons, with the more numerous medical staff scattered around the table. My interpretation was that these arrangements demonstrated part of the unspoken rules of the organisation, but also of the wider institution. Viewed from a differentiation perspective, integration was only apparent at a subcultural level. This appeared to form part of the rules and division of labour inherent in the activity system. The fact that junior doctors, who work in many different NHS organisations for short periods of time, also followed these rules means that they are likely to apply in other parts of the NHS as well and represent cross-cutting institutional subcultures.

The aim of the Learning and Sharing event was for the whole team to focus on learning a particular clinical assessment technique by looking at cases of past error in the use of the technique. The consultant obstetrician facilitating, Priya, also presented a new technological system that she wished to implement in the department to try and prevent cases of error. This system would require some changes in the way doctors and midwives worked together



and part of the session aimed to address these changes. As the session progressed ambiguity became further apparent in the way participants expressed their views of the cases presented. While there was some disagreement amongst individual doctors about the precise causes of the case and the findings, there was more generalised disagreement between professional groups about the role of the team members involved at different stages in the case. During discussion of the first case, the midwives largely remained quiet and the discussion mostly took place amongst the doctors. By the second case, the midwives became more vocal and expressed opinions on how the case should have been managed. This led to a lively debate on the role of senior clinical review. During the debate, participants developed a shared assumption that senior review was the 'gold standard' for safe assessment. The consequence of this was differentiation between senior staff; represented by Priya; and junior staff; represented by both midwives and junior doctors; when Priya began to discuss the new system she wished to introduce. At this point, both doctors and midwives voiced their concerns that the new system wouldn't add anything because what was needed was more senior staff presence and supervision to enable better shared working at a more junior level. The discussion shifted to become focused around the needs of professional groups rather than the clinical needs of patients. The need for senior review acted as a source of integration for all non-consultant groups, although the precise point at which this would become necessary and whose role it was to recognise the need was interpreted ambiguously and was a source of contradiction. Participants constructed their views of their own subjective roles in the system through this interprofessional discussion, exploration of contradictions and shared resistance to new technologies. The discussion allowed them to explore their own role in the organisation as well as the 'scientific facts' of patient care. They took this learning back into their practice, as highlighted by Priya, who had facilitated the session.

*"I haven't collected a formal feedback because it's still in a learning, you know it's still in a growing stage... but I'm getting the verbal feedback from them and this is what they say. It's very, very different what they've learned. It's helping them to improve their changes and talk openly about it and they've, er, it's also improving the way they're documenting and remembering. They don't need*

*this kind of, er, they are self aware and they have started doing that well. And I can see the juniors, when I work with them, if I tell them this is the way it has to be done I can see they know why they have to do it and they are all falling in line. The midwives, though, that has been the biggest area where I've had the huge positive response from them. Nobody else has taken the initiative, er, calling them, teaching them, keeping up to date. It's a combined thing, developing the relationship between them and us"* (Priya, consultant obstetrician).

Priya's choice of phrasing tells us something of what she thinks about cultural development in the organisation. She considers that the junior doctors are learning and developing if they are "*falling in line*" with what she thinks. From an integration perspective, she expresses solidarity with junior doctors who will learn over time to be more like her, a senior version of them. However, from a fragmentation perspective her view of organisational practice seems to be that there are senior staff who know the way things should be done and junior staff whose role it is to learn to do them. Behaviour outside this pattern is problematic. At the same time she acknowledges that involving midwives and working with them collaboratively will help foster relationships. The phrase "*them and us*" perhaps explains some of this apparent difference. My interpretation is that she sees the midwives as a distinct subcultural group and her aim is to achieve horizontal integration with them, whereas the junior doctors are part of her own subcultural group and she aims to achieve vertical integration through a top down approach. Priya's understandings of the organisational culture are ambiguously presented. On the one hand she expects the junior doctors to do as she dictates but on the other she criticises other consultant colleagues for seeing things in a very rigid and self centred way and suggests that their approach impacts on cultural development.

*"But if it's not beneficial or, like, to one colleague then she demands they have to change the way they are working, demands more time and work from them. So they became more defensive and they consider that what she says is not going to work and 'we don't believe in that' and all kind of negative responses"* (Priya, consultant obstetrician).

Through both her construction and her interpretations of these contradictions Priya is learning about herself but also about the roles of the wider collective, while at the same time she attempts to change the collective.

A further example of developing agency through practice was given by Ranita, a project midwife, new to the organisation, who was involved with a change project group. Ranita's contract at the organisation gave her time to work in a more managerial capacity implementing the project, but also required her to work midwife shifts in different clinical areas where she was one of a team of midwives on duty. At the change project meeting observed, Ranita was influential in steering the group and communicating the vision of the project. She was clearly passionate about what needed to be achieved, as evidenced by her language, tone and mannerisms, and she gave the impression of striving for agreement from colleagues. However, she told me afterwards that she had struggled to ensure her vision fit with the rules of the organisation and the way things were done, drawing a clear divide between 'them' and 'us' in terms of junior and senior staff and the way issues were interpreted.

*"Well I was very excited about being involved in the project from the beginning, and then overall looking back I think it's been good, but then along the journey there's been periods where I had mixed feelings... it was very difficult to always get the co-operation of everyone. There were times when I felt that people were paying lip service to the programme rather than actively participating. ..And I was quite surprised because most of the time when things go wrong people assume that it's the clinical people at the shop front, who lack the basics, who aren't doing stuff. But in reality I think it's a problem more high up in the organisation. No, instead those people were acting more as gatekeepers, protecting information, not sharing information, and not necessarily raising the project when there was a meeting. So like when I got feedback when there was a meeting I found out that senior people weren't always defending the project, they were making excuses and not...they didn't have any belief in the project" (Ranita, project midwife).*

Ranita spoke about how she had learned to drive change through changing her view of herself and her role in the project. She told me how she had reconsidered her approach to getting things done after discussion with a

colleague. By adopting techniques that mirrored work done elsewhere in the organisation, she was able to engage with other members of the collective and subsequently achieve change. She voiced this as “*not wasting my time*” but I interpret it as a reworking of her own subjectivity through her relationship with the work that needed to be done, the exchanges with the wider collective and her own view of herself.

*So why do I do this project? Sometimes if you can't tell people there's a problem then show them... So my job was to demonstrate to them that their time spent there was needed... And I decided I was willing to take the criticism, because by giving people the opportunity to criticise me in the process they highlighted what their concerns were, especially in areas I might have missed”*(Ranita, project midwife).

Despite this voicing of her own emerging agency through her collaborative engagement with the wider collective, Ranita clearly still sees herself as ‘othered’ from the organisational leadership and approaches the culture of the organisation in terms of differentiation. She wanted to be seen primarily as a midwife, referring to herself as a “*shop floor worker*” on several occasions and senior people, whether clinicians or not, as “*management*”. She actively voiced her role as that of an outsider and had her own interpretations of what others within the department were trying to tell her and why.

*“The project team was seen as a threat from an outsider, more than somebody coming to the rescue, offering their time and their support and eagerness to change. And that's what I think was happening, but I found that kind of negativity was subtle. Because all senior people give the impression that, that they were actively, sort of, actively wanting to see us succeed. So the negativity was really subtle”* (Ranita, project midwife).

Other participants also had dual roles within the department and organisation. The departmental business meeting involved only senior staff; consultants, matrons and managers; who were invited by email to attend on a monthly basis. The meeting was minuted and resulted in an agreed set of actions each month, which were circulated to the invitees only. It followed a standard business format, with a Chair, an agenda and nominated speakers. The

nominal Chair was a senior clinician who had one day a week in his job plan for managerial responsibilities, including line management, service planning, quality reporting and budget control. However, for many aspects of the meeting the Chair was given over to a matron or the General Manager, depending on the aspect of the department being discussed. From an integration perspective, this can be interpreted as collaborative working based on shared values. However, from a fragmentation perspective it seemed as though no one person had an overview or sense of responsibility for the whole department. At these times, the Chair adopted the role of a clinician, contributing to the discussion from a clinical point of view and defaulting to subcultural groupings. At the other times, he adopted a role as a manager, steering the discussion, inviting views from others and offering explanations to questions. His own subjective role in the activity system appeared in flux.

During the meeting, the Chair presented a summary of discussions from a Board level meeting he had attended that discussed a recent serious incident resulting in the death of a patient. The department and certain individuals had been criticised by the Board for aspects of the management of the case. The assembled group were clearly familiar with the details of the case and it provoked strong reactions amongst the clinicians. At times, the Chair struggled to keep the discussion on track and was required to act in his managerial role to present the views of the Board. However, at other times, he joined in the discussion as a clinician, talking about what "*we do with our patients*". At one point, two consultants started shouting at each other across the table, debating what the role of the consultant should be in similar situations. One agreed with the findings of the Board that consultants should retain responsibility in all situations. The other disagreed and felt that the consultants were being unfairly blamed for an error that was not their fault. At this point, the Chair fell silent and one of the matrons had to step in to calm the situation down, requiring her to rise from her chair to stand above the group and raise her own voice. I got the feeling at the time that this was not an uncommon occurrence with these particular individuals and perhaps the Chair had seen this before. Indeed, no-one in the room seemed surprised by the turn of events, with most just quietly looking at their notes. One or two

consultants tried to contribute to the argument in a more measured way and voiced agreement or disagreement. However, I was struck by how the Chair seemed unable to adopt either role once the meeting became heated and a dichotomy was set up between consultant staff and the Board, failing to bring the meeting to order as a manager or to contribute to the discussion meaningfully as a clinician. The meeting ended with no consensus achieved on how to take the issue forward and no actions were agreed, despite the seriousness of the case. I do recognise that my place in the group may have affected this; in the presence of a representative from another department in the organisation it may have been harder for the Chair to manage the behaviour of his colleagues. I had spoken to him as a key informant prior to the observation and he alluded to the fact that he found this aspect of his role challenging, articulating the effect on his subjectivity of the contradiction between roles in the two activity systems when trying to achieve change, and expressing where his natural preference lay.

*“I find the mediation between my colleagues very hard sometimes. It is well recognised in this department that there are one or two individuals who don't get on with one another, who will always disagree with one another. I find that at meetings I feel forced to mediate between them and I don't, erm, find that easy. They are both very strong characters and I'm not certain that they recognise my, erm, my authority...if that's the right word. We try to reach consensus on decisions about services and quality but it doesn't feel like it is ever possible to reach consensus. It's sometimes easier just to keep momentum going and hope that things settle... I feel I have to pick my battles sometimes and take what victories I can. I haven't had any training in this though so it feels outside my comfort zone sometimes.... I see myself, and what has come out in [the course] is that I am someone who likes to support people to find their own way and try and steer the middle ground. I am not someone who likes conflict and I, you know, I would rather try and compromise. But I know that sometimes that won't work... Sometimes I find it really interesting seeing the bigger picture, I realise I knew very little about this before. Other times I just want to escape back to being a normal clinician”*  
(Key informant B, Clinician).

However, he also recognised the importance of clinicians having these dual roles when the object of activity was cultural change.

*“Some people would never want to do that sort of...but I think it has to be done and we wanted to make a lot of changes, or try to make changes, and I felt that I could help make those changes if I was in the right position. I think [the] structure is the right structure, I think clinicians should be in the position to influence the way things are run and have that ability to communicate with the Board and with colleagues”* (Key informant B, Clinician).

Therefore, although the Chair had perhaps not seen himself as someone with a managerial role, he recognised the value of clinician managers in organisational transformation and took steps to try and develop this aspect of himself in order to play a part in change. Through a combination of organisational challenges and structured reflection he was negotiating his identity as a clinical leader but found the process layered with tension and disruption. His subjective interpretations of these tensions affected how he was able to perform in practice in his role and, in turn, affected the collective and their interpretation of management.

In all these examples, subjective change was constructed over time out of object-related activity within a collective. In the Learning and Sharing sessions, the object at which activity was directed was safe clinical care and the outcome of that activity was learning about roles in patient assessment and management. Through the mediation of case based discussion participants went through stages, sometimes resulting in shared thinking, sometimes only achieving consensus at a subcultural level. Priya learnt about herself and the wider organisational culture through her relationships with colleagues. However, her interpretations of cultural change were continuously in flux, sometimes striving for horizontal integration across subcultures and communities, sometimes desiring top down vertical control. Ranita dynamically constructed the object of activity as she progressed through the change project and encountered different constraints within her relationship with the wider collective. She continually redefined the intentions of the wider organisation in her interpretations of the culture, learning about the

organisation and herself through these interpretations. In the business meeting, the Chair continually negotiated his subjectivity through his interaction with the collective and by making use of artifacts such as patient cases and Board meetings. At times he was predominantly a clinician and at times a manager. There were no clear subcultural boundaries and he shifted between the two roles depending on context. At times these two roles were irreconcilable and this affected the object of the activity for the collective. He recognised this and it played a part in his developing agency.

### **5.3 Power, tension and collective relationships**

Analysis of the practice and learning of the department as it moved towards achieving cultural change revealed a network of overlapping activity systems, which functioned in an interconnected way. These were more than work units or professional groups, and could be recognised based on their goals and the more long term objects of their activity, rather than their short term actions. The relationships within and between activity systems were mediated by the rules of the organisation, its divisions of labour and the tensions these produced. These factors sometimes disrupted the activity. As individual subjects developed through their relationship with the collective, so the collective developed through the perspectives taken by individual subjects. In moving towards the construction of shared objects of activity, there was evidence of cultural integration but also evidence of subcultural differentiation and ambiguity, with strong power dynamics that shaped the collective and the object of activity.

One interprofessional collective was a steering group for a change project aiming to improve the quality and safety of a particular clinical area within maternity. The group included individuals with roles in the maternity department but also individuals from within the wider organisation. It had been put together in a very fluid way, with different members joining at different times, some by choice and some through direction by their line manager. There was no clear leader of the group: some members had senior clinical or managerial roles in the organisation but were in the group in an advisory



capacity; other members had a more junior role but took more responsibility for the day to day running of the project. I observed a meeting where progress against agreed project actions was discussed. In contrast to other events observed, participants from all professional groups sat together at this meeting. The meeting was steered by Ranita, who stood at the front of the room and assumed responsibility for ensuring points were covered, relevant information was presented and that action plans were made. However, it was markedly less formal than the departmental business meeting and gave the impression of being much more united around a common goal with members sharing a common motivation. Contributions were actively invited and offered by all group members, junior and senior, clinical and non-clinical. It is worth noting that Ranita's professional role in the organisation was quite junior and that her professional background was as a midwife. Her steering of the meeting may have been one of the factors that encouraged professional mixing, in contrast to the Learning and Sharing session run by a senior doctor.

In the meeting I observed, the major issue on the agenda was the reworking of an operational policy for the clinical area. One of the senior midwives in the group had been given the responsibility of putting her name to the policy but two more junior midwives, including Ranita, would work together to produce the written text. As Ranita told me, initially the production and finalisation of the policy acted as the object of the activity and the actions of the group were directed coherently towards this.

*“So [we had to] try and tap into existing meetings, and then people's emails...I created a folder on the ward and put in copies of the...the...project documents in, copies of the pathways so staff could open up the folder and see what was happening. So those who didn't read emails could have seen my folder. Plus I was working in the clinical area constantly so everybody I saw when I worked with them I said, 'oh do you know..?' and I would bring it up in a conversation. And try and reach as many of them as possible” (Ranita, project midwife).*

However, later in the course of the project the policy itself acted as a mediating artifact and was interpreted in multiple ways by different group members. The group worked to redefine the object of activity through their orientation to the

project, as mediated by the developing policy. A major source of contention was the issue of medical staff cover for the area and this affected the perspectives shaped by the group and how they prioritised issues. The midwives in the group, junior and senior, all agreed that a dedicated junior doctor was required to be present in the area and take responsibility for assessing all patients. The medical staff however, both within the group and in other activity systems, felt that medical time was better spent elsewhere and that the area would function safely and efficiently if the midwives were more organised, took more responsibility and were better trained to recognise potential problems. This tension affected the dynamics and perspective making and manifested in the emergence of tribal groups, or subcultures, within the wider department as the contradiction within this activity system had a knock on effect on other activity systems.

*“Well, for instance, there is a big disagreement amongst the medical staff and the midwifery staff about where doctors should be deployed to work...I have to balance the service needs in all areas with the training needs of juniors and make sure the consultants are working to their job plans. Whenever we try to find a solution to making sure that [the clinical area] is covered by staff there is a disagreement amongst some people. I have my consultant colleagues complaining to me that they are being expected to write [discharge paperwork] as the juniors are never around and the midwives can't do anything, I have the juniors complaining that they don't get any training because they are being pulled between different parts of the service, I get the midwives complaining that the juniors are never there so patients are being missed or delayed. We need to look together at the whole work flow and organisation, but it feels intensely tribal” (Key informant B, Clinician).*

It also affected the perspectives taken in relation to other collectives, which were set up as competitors affecting the work of staff in the project area. These perspectives affected horizontal integration across different collectives.

*“You know, [staff] kept their head down, did what they could, and basically didn't take on anything extra, even simple things, and that made the patient journey difficult. Say you had a patient, and that patient needed to go to another ward, if that ward were busy they didn't think that this is a process and*

*that patient needs to be admitted, they made it difficult and was irritable on the phone and made excuses. Because they saw that this person coming in was extra work. So everyone kind of protected themselves in that way, they didn't think" (Ranita, project midwife).*

As the project progressed, the project group united around a shared goal of improving the clinical service but the interpretation of different group members as to how this should be best achieved was fragmented. This was summed up by Desmond, a project manager whose role was to support the project teams throughout the organisation in implementing change projects.

*"Everyone is agreed on what needs to be done. I don't think that is rocket science... But it's harder to get everyone to agree on how it should be done. There are some people who seem to only see the problems and whatever is suggested they find a difficulty, a reason it won't happen. They have change fatigue. I'm used to that from lots of other places but it seems to be especially strong here... I see my role as trying to drive the project forward, keep the momentum up and not let everyone get too..too many wedges driven between them all" (Desmond, project manager).*

Analysis of the final operational policy produced demonstrated this drive for integration with resulting fragmentation, and demonstrated how concepts had been interpreted in a number of different ways by the collective who had produced it. A RAG (red, amber, green) system for clinical assessment and management acted as a common theme throughout the document, demonstrating integrated thinking about patient safety. However, the same information was presented in a number of different ways at different points in the document with different amounts of clinical information, as though written for different audiences. There was also a heavy emphasis on values and the attitudes to be taken by non-medical staff, as well as detailed descriptions of what midwives should record, measure and document. While the emphasis on shared values can be interpreted as promoting consensus and consistency, from a fragmentation perspective it can be met with multiple interpretations, especially as it seems inconsistently applied to different professional groups.

*“All staff working within Maternity [clinical area] will comply with [Olympic’s] Code of **Behaviour and Values**”* (page 1, policy document, my bold)

*“If there are alerts the midwife needs to **respond proactively** to ensure the woman receives the appropriate treatment in the right place”* (page 3, policy document, my bold)

*“On arrival into [clinical area] the woman will be **greeted** by a [sic] reception staff”* (page 4, policy document, my bold)

However, the roles and responsibilities of the medical staff were written more vaguely and it was evident that the policy had been written by people who had a less clear conceptualisation of the specific roles and duties of medical staff in the area.

*“All women who need obstetric review will be **seen by** an obstetrician within 1 hour of admission”* (page 1, policy document, my bold).

*These women **would normally** be transferred immediately...without delay; the coordinator and **Consultant/SPR**<sup>1</sup> should be informed* (page 4, policy document, my bold).

Alongside this vague description of the responsibilities and duties of doctors, however, was a detailed and repeated description of how midwives should escalate concerns if targets were not being met.

*“Serious or potentially serious incidents occurring in the Maternity [clinical area], or related to its use, should be reported immediately to the Matron or manager on call, if out of hours, who will implement the Trust escalation process”* (page 2, policy document).

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<sup>1</sup> SPR is an outdated job title for a middle grade doctor that has not been used since 2007. It is used informally still by some who have been working in the NHS since before then but is not an allocated job title and seldom used by junior doctors now.

*“If this is not achievable for women who have been rated as Amber then the situation should be escalated...The escalation must be documented on the proforma”* (page 5, policy document).

In my reading of the final policy document, the power dynamics within the project group and the power dynamics within the wider organisation are evident. Despite the fact that activity systems comprised members of more than one professional group who attempted to direct activity towards a common object, the structures and rules of the organisation and institution sometimes encouraged divisions of labour along professional lines for short term actions. In this case, professional and organisational roles were in contradiction. In the example of the change project, this manifested in the power struggle around responsibility for staffing between the medical and midwifery professions. With my knowledge of the background history of the struggle, my final interpretation was that the medical profession had assumed a more powerful position, with less formalised responsibility, and more emphasis placed on the midwives in the clinical area to take on direct duties, with little room for manoeuvre. However, there was evidence of the midwifery staff fighting back through the ability to escalate to Trust management if they felt that care was not being appropriately managed. This subcultural conflict was presented to the organisation in the form of the operational policy.

Another example of organisational power dynamics was seen in the Learning and Sharing session. This took place at 8.00 on a weekday morning and was scheduled to last 30 minutes. This time was chosen after much deliberation to try and suit both doctors and midwives, whose working hours and patterns differed considerably. Generally, midwives started their shifts with handover some time between 7.30 and 8.00 and were beginning their duties at 8.00. They tended to work long days for only two or three days of the week; 12-13 hour shifts that finished in the evening, with staggered, protected rest breaks at varying times throughout that period. Doctors started their day with handover some time between 8.00 and 9.00 and clinical duties, such as clinics, elective operating lists and ward rounds, started around 9.00. Except for the doctor on call, the working day finished around 17.00 and, unless on night shifts, doctors worked five days a week. Lunchtime was flexible and tended to be a working

lunch, eaten together at a meeting or teaching session. The aim to make the Learning and Sharing session an integrated part of the work day ran into difficulties because of the differences in what work days looked like for the different professional groups who had clinical responsibilities and duties.

*“And for the teaching to take place the biggest constraint is that people who knew they had to try and take it...We expressed the idea to our other colleagues, where, you know substantive posts, and trainees and midwives, and everybody encouraged the idea but when we said we were going to have this daily teaching session and expect people to attend, the initial fear, or the initial reluctance people had, that they expressed it as difficulty with coming in the morning. And afternoon, even after 5, was all the more difficult... And we had...we decided to have a multidisciplinary format, you know not just the obstetricians attending it. And to have...huh...to get all the different categories of people attending it was difficult”* (Priya, consultant obstetrician).

Priya clearly categorised staff, as can be seen. However, one of her express strategies for encouraging integration was to bring breakfast with her to the Learning and Sharing session. She felt this would motivate attendance and foster a sense of team working. She directly encouraged everyone to help themselves to *“brain food”*, seeking to create a relaxed atmosphere.

*“We had doctors, we had midwives, everyone really enjoying it. I had brought breakfast and one of the HCAs made toast from the kitchen. Even though it was early morning everyone was happy to be there and, you know, like we were a team together”* (Priya, consultant obstetrician).

Just before the start, Priya directly asked the healthcare assistant attending if she could arrange a pot of tea and some toast. The healthcare assistant left to do this, without verbal or non-verbal protest, but as a result missed the opening few minutes of the session. This act marked her out as someone whose role was supportive, rather than central to learning and change. The fact that there was no apparent protest or offer of help indicates that the whole group saw this as part of her role and in keeping with the expected divisions of labour within the organisation. From an integration perspective this act can be seen as bringing the clinical team together over a shared meal. However, from

a fragmentation perspective, the act of one group member being singled out in a supportive role may have led to separation. A further source of tension and shifting power balance was seen approximately three quarters of the way through the session, when it was interrupted by the appearance of one of the departmental matrons requesting that all midwives return to “*the floor*”. This implication that the education session did not count as work led to a terse discussion between the matron and Priya, in front of the group, about what had been agreed beforehand. This altercation was quite clearly uncomfortable for several members of the group, especially midwives, who at no point were asked what they wanted to do. However, it resulted in them leaving before the end. Following this, Priya seemed noticeably deflated and as though she had lost her enthusiasm for the topic. The absence of midwives in the room also changed the discussion, with the doctors ascribing more blame directly to midwives for the errors discussed, and all other errors in the department. This incident was also used as evidence that the new system and proposed way of working would not be successful, with doctors voicing that midwives are not interested in learning new ways of working and just want to carry on the way they are. The narrative voiced positioned doctors as external and superior to the organisation with the midwives an integral part of the old, failing organisation. One junior doctor commented “*What do you expect in this place?*” shortly after the midwives were asked to leave, distancing himself from the organisational collective.

This episode highlighted issues with integration in the organisation. It brings out the difference between what was valued by staff looking to change from the bottom up, as evidenced by the feedback given to Priya by midwives, and the perceptions of leadership managing from the top down. Priya’s interpretation of this episode was that the matron was exerting her power over the doctors through her ability to control the midwives and prevent innovative and new ways of working together. The matron exerted her authority through the shared pull of ‘real’ clinical work with patients, rather than time spent on ‘abstract’ learning in a classroom. This affected how the collective engaged with the object of the activity and their relations with each other. I also had experience of this matron myself in the early stages of the research, when I

was seeking permission to undertake the study in maternity. As one of my identified gatekeepers, she had requested I come to see her to discuss the study face to face. However, she then repeatedly failed to come to arranged meetings without explanation and told me she could only meet either very early in the morning or very late in the evening. We eventually did meet and I sensed hostility towards me and mistrust of the research process, although she did finally consent to my presence. This episode made me question whether I was able to continue with the study and was one of my major setbacks at an early stage. I recognise that this may have affected both her actions in the Learning and Sharing session, where she knew I would be present, and my interpretation of them. This represents a clear example of when I, as a researcher, played an integral role in the activity system. Drawing on my personal experiences with her, I am disposed to view her as an individual who was hostile towards medical staff and suspicious of shared working. However, I endeavoured to keep an open mind in my interpretation and tried to ascertain what Priya thought of the interruption in the post-observation interview. Reflecting on the situation, Priya commented:

*“It’s...like, well I understand if it’s busy or if an emergency...or maybe if one or two have to leave and we do... but she didn’t want anyone there with us and...the midwives were so annoyed, angry. They said to me after they were enjoying it and learning relevant to work. I think I feel that it is personal to me but I also know it is personal to all doctors” (Priya, consultant obstetrician).*

One of the key informants also articulated this structural division between midwives and medical staff, expressing this as part of the rules and hierarchies of the organisation and how these governed the division of labour.

*“Well, like everyone...like...I don’t have any specific examples but it’s just sort of accepted that everyone has their own little area. The midwives, they have their rest area on the unit, they eat their lunch there together, the doctors never go in. The junior doctors have an office on the unit and they all gather there. The midwives knock at the door if they want to find them to get something done. There’s nowhere they go together, no shared work space, no shared social space. They don’t do a joint handover, it’s all separate. And the consultants all have their offices along the corridor outside and people*



*generally don't go there. The matrons have offices in their relevant bits and [the senior nurse's] office is right on labour ward, they're more in the action whereas the consultants are removed a bit. There's not really anywhere or any reason for everyone to do anything together, we all have the different aspects of our roles, different roles"* (Key informant C, Nursing).

Tracy, a senior midwife who had been present at the business meeting, was interviewed after the event. She commented on the behaviour of the two consultants who had argued at that meeting, voicing the perceived difference between consultants and midwives as employees of the organisation, subject to organisational rules, policies and procedures.

*"It's a bit like watching a bunch of 2 year olds throwing their toys out the pram sometimes. A couple in particular, erm, never seem to agree with each other and shout each other down and, erm, everyone just lets them. There doesn't ever seem to be any... fall out... from it... Well like even telling them that's not the way you behave professionally, erm, like making them see it's not all about their egos. I've worked in a lot of places and I have never seen behaviour like I've seen here and no-one seems to get performance managed. [One of the new matrons] has started trying to take some of the poorly performing midwives to account but it takes up all her time, the process is so slow and difficult. I can imagine it must be even harder with the consultants"* (Tracy, senior midwife).

Another key informant had voiced his opinion that the consultant medical staff saw themselves as the lynchpin of organisational practice, immune to the usual management procedures.

*"Certainly to a group of consultants who generally might, you know some of the more, erm, resistant to change consultants might, you know say 'well who cares who the Chief Executive is as long as I get paid and I turn up and I do my bit it doesn't matter.' Well actually if the official receiver comes in he might even tear up your contract mate!"* (Key informant A, Executive).

In summary, there was evidence within the department of a number of activity systems. Some of these formed around discrete goals and objects, such as

the project groups. Others formed around working relationships and clinical shared practice, such as wards or clinical areas. Despite the apparent integration, these activity systems were fluid and improvised, continually shifting as individual subjects and the wider collective experienced tensions and disturbances. Some of these disturbances were internally generated but some were externally imposed then interpreted by the collective, including tensions that had been internally generated elsewhere that then spread to encompass further activity systems. As a consequence power relations were formed and reformed. These affected horizontal integration across activity systems, as the shared motivations in one collective sometimes acted as a barrier to integration with other collectives. There was also evidence of wider institutional power dynamics that affected practice and learning within the activity systems. In particular, professional subcultures and dominant understandings of professional power played a part in affecting vertical integration. The medical profession appeared to be the dominant professional group, having an impact on integration one way with the managerial Board and the other way with midwives and nursing staff. These power dynamics and the complex social exchanges and institutional relationships affected the organising processes within the activity systems and how the collective and the object of activity were transformed.

#### **5.4 Constructing a shared object of cultural change**

As the activity systems formed and reformed, individual subjects and collectives consumed and interpreted the organisation's cultural manifestations. Mediation of activity by these cultural manifestations impacted on the construction of intermediate and shared objects of activity. Most often, activity systems had particular actions and motivations for change imposed on them by external agents. They then engaged with these actions and motivations and adapted them, resulting in the emergence of a more meaningful intermediate object of activity. This process was laden with negotiation, contradiction and tension. Through the construction of intermediate objects of activity there was evidence of activity systems working to construct shared objects of activity with other activity systems and the wider

organisation. While this sometimes led to learning and cultural change, at other times the object constructed acted as a barrier to cultural change. Boundaries between activity systems were again seen to be fluid and moveable as shared objects were constructed.

All three key informants talked of how the Trust Board and wider NHS managerial structures would attempt to communicate down to the organisation. This usually took place in the form of targets and the focus was on short term action to achieve the target rather than more long term activity.

*“They’re just worried about the target, and the number, and the patient...not the patient. And similarly they’re worried about getting all the discharges without, sort of, it being a self fulfilling prophecy because they’re managing, assessing and discharging patients in a high quality fashion...getting it right, getting them properly assessed, properly managed, properly treated, on the right pathways and safely home again. Then the discharges follow reflexly. But they’re so focused on getting 50 people out, getting 60 people out a day they’re going round trying to drag people out the hospital. It’s...there are lots of...so it’s trying...there is a bit of reframing that has to take place to get people back to basics”*(Key informant A, Executive).

The pressures placed on the organisation by external agencies were also seen as driving more short term actions that were disconnected from the larger picture of cultural change activity.

*“The focus recently has been very much on what the CQC said though, on the mandatory training element, making sure everyone has the basic skills. That has really been the driver for learning. And I can see that is necessary, and it’s what the Board are interested in. But it’s become a tick list exercise”*(Key informant B, Clinician).

*“To be honest, I spend so much time filling in the paperwork that is required by the CQC to show how we are achieving the targets they have set that I rarely get time any more to get out and see what is actually happening, what really needs doing”* (Key informant C, Nursing).

Targets were actively discussed at the departmental business meeting. However, the implication of these and the action required to achieve them appeared to be interpreted by the group in a way that may have been contrary to what the Board intended. The General Manager presented the performance of the department against the targets by passing round a set of graphs and tables to the group. These clearly hadn't been seen by anyone beforehand as some time was spent studying them, giving me the impression that the information in the documents was abstracted from the daily practice of the group. Soon afterwards, while the manager was explaining the data presented, one of the clinicians noted that the department had successfully achieved a key staffing target set by the CQC in one clinical area for the last few months. Immediately the other group members focused on this target and there was widespread congratulation. The discussion then seemed to focus on how to maintain this achievement and the other targets were dismissed as less of a priority. The achievement of this target provided consensus amongst the group and all members contributed views on how success had been achieved. There was also consensus around the dismissal of other targets as less important. However, while I perceived consensus and integration, a key informant who had attended similar business meetings described fragmentation as the usual pattern, with the role and function of the targets interpreted ambiguously by members of the group.

*“We discuss how we have failed to achieve the target, we make excuses for why that is, then we think of how we are going to make the figures look better next time. And there's always disagreement and it's usually over something very minor, like whether one patient should have been managed differently, or whether if one process was slightly different it could have changed one minor thing” (Key informant B, Clinician).*

Therefore, the group reworked the centrally imposed targets and constructed their own intermediate objects of activity around them, mediated by professional patterns of behaviour and organisational resources. Consensus at the level of the collective did not necessarily result in departmental or organisational consensus. Consensus was issue based only. Another interviewee, whose work was mainly in a different clinical area, pointed out the

effect focusing on a key target in one clinical area had on the wider department and other patients. By ensuring that staffing levels were always shown to be maintained in one area, patient access to that area was limited to prevent it becoming too busy. That had led to at least one clinical incident where a patient waited several hours in an inappropriate area with inadequate staffing levels and her condition had deteriorated.

*“So people were being sent from one area to another and jobs weren’t completed and that contributed to the incidents. Even in my project, it was the first thing I saw that there was a lack of continuity, everybody did a little bit and just closed their eyes and moved the patient on. And when you move the patient on you know the patient will be waiting for hours. But they didn’t focus on that”* (Ranita, project midwife).

This appeared to be part of a more widespread institutional pattern, as discussed by another key informant who spoke of other departments and how they reworked targets to the detriment of effective patient care while ostensibly providing a better service in dedicated areas.

*“It’ll be...what you’ll normally have done is, it will be a work around. The classic work around for the early [emergency department] target was the original MAUs, or whatever, were just holding bays for people who stayed in the hospital more than 4 hours. So there is an argument that they now may have become holding bays, just as well, but we now pretend to do something with them, when in fact we should be sending them home”* (Key informant A, Executive).

In both these cases, the reworking of the targets led to new patterns of activity. The intermediate object of this activity was a new patient pathway and the shared object of the activity was a cultural change that was learned by staff and that advocated managing patients within a series of holding areas. However, the outcome of this activity was not an improvement in quality for patients, despite it still meaning hard work and time spent on patient care for staff. Instead, a story emerged during the study of a poor quality outcome for some patients and extended lengths of stay in hospital with added complications.

Other activity systems took externally imposed actions and targets and reworked them to make them more meaningful, but with more positive effects on quality. Tracy was a senior midwife who was interviewed after the business meeting and clinical governance event. She had been working as part of a project team moving services from the hospital into the community. She viewed this project as “*one of the good projects*” and felt it had achieved significant successes that were felt by multiple professional groups and by patients. She had presented the results of some of this work at the clinical governance meeting where it was seen as an opportunity to learn from successful practice. The driver for the project originally came from Trust management and the Health Authority, who planned to close services at Gold Hospital and centralise all services to Olympic. Tracy reported being told to “*look within the area and see what we thought we could work on*”. Therefore, although the drivers were central, she was given some autonomy to draw on her professional experience. There was much local opposition to this change and it was perceived as a removal of care. This feeling was originally echoed by many of the staff throughout the Trust, who set themselves up in two opposing camps, as explained to me by one of the key informants.

*“It’s been on the cards for some time, the reconfiguration, since around the time I joined. But...originally everyone was very against it. There had been so much publicity at [Olympic], erm, so much bad publicity. No-one could understand why they were insisting on it. It was always seen as [Olympic’s] problem though. Midwives at [Gold] talk about how all the problems happen at [Olympic] and it must be the midwives there as the doctors all work across site. The midwives at [Olympic] think that [Gold] is having an easy time of it and all the difficult patients come to [Olympic]”* (Key informant C, Nursing).

As the project progressed, however, these external motivations and contradictions were reworked by individuals and by the collective. Tracy described this transition period as a time full of “*stumbling blocks*” the project team had to “*get over*”. She felt that the key element in the project’s success was the involvement of an internal midwife who had worked in the community and who was able to communicate across perceived boundaries and divisions. Through the experiences of this team member, the group was able to redefine

the externally imposed goals and construct an intermediate object of activity; a new process of working.

*“In that one it was an internal [project team member], it was really good, she actually worked in the community so, erm, she knew what areas needed to be addressed. So it was from her experiences working in the community that this was highlighted. And then we had a mentor who was a community matron and she supported us, ‘cause obviously it was her area and, erm, she knew that this has really improved the community and clinics. So she has support from management and from her team, the fellow community midwives, which I think helps her succeed”* (Tracy, senior midwife).

The new process involved moving tasks originally done by doctors and hospital based midwives into the community to be performed by a team of community midwives at their planned contacts with patients. These midwives would then be responsible not only for the discrete tasks, but also for the ongoing management and decision making for patients. At the start of the project, the work was very task oriented and the goals were cast in terms of skills training. However, as the project progressed the object of the activity was redefined and the midwives began to feel empowered to take responsibility for patient care while still feeling supported. The medical staff were pleased with this as it freed up their time to work elsewhere, so they supported the change in role. From an integration perspective, the new process can be seen to unite all staff around the common goal of improved patient experience and allow them to construct a shared object which leads to cultural change. However, from a differentiation perspective one of the reasons this project was successful was that it allowed the community midwives to function as an autonomous professional subculture, in contrast to Ranita’s project which was dependent on achieving shared medical and midwifery cover in a common clinical area.

Over the lifetime of the community project the midwives took the externally imposed motivation and time targets and reworked them to suit their perceived needs. Initially this involved a focus on skills training and the pathway of care was not complete. However, as the project progressed the object of activity

was reworked to become midwife-led patient care. This overlapped with objects of activity from other activity systems; the other change project, the labour ward and the senior medical staff clinics; and resulted in a shared object of culture change.

*“Although at the beginning I did feel like perhaps the midwives didn’t want to change. But I do feel that they are willing to change, they do want change, it’s just that they’ve had so many people come in and tell them ...try to change things and then not change, it disheartens a bit.... Erm, but it’s been a success. So we were able to close down the clinic in [Olympic]... Erm, I was speaking on the training this week, I was speaking to the community midwives and they say that more and more they’re hearing positive feedback about the labour ward and about the 1-1 care that they do receive” (Tracy, senior midwife).*

This perception of success and positive feedback mediated future professional practice; allowing midwives in other locations, the labour ward, to accept professional responsibility for patients and provide improved care and, in turn, make the community midwives feel part of a successful team.

Therefore, the boundaries between activity systems appeared to shift as external influences and contradictions were reworked and renegotiated, resulting in overlap and consensus in some instances but also fragmentation and dispute in others. Through this fluidity within the activity systems, shared objects were constructed which allowed a move towards cultural change.



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**CHAPTER SIX:****EXPLORING POSSIBILITIES FOR TRANSFORMATIVE CHANGE**

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My second approach to data analysis and interpretation explores the form of the data to hear the organisational voices and meanings that were constructed during the course of the study. In the preceding chapter I have begun to explore the object of activity of the activity networks at Olympic. However, as Engeström and Sannino (2010) remind us, the object is ambiguous, open to interpretation, personal sense making and societal transformation. To explore this sense making, I will explore some of the organisational stories that were told, how their meanings were interpreted and what this tells us about the organisation and the possibilities for transformative change.

Organisational stories communicate cultural beliefs and values, indicate acceptable behaviours and attitudes and provide examples of general themes or ideas. However, they can also be dynamic; challenged, reinterpreted and revised by their audience; as part of sense making (Boje, 1991).

Transformative change happens slowly, over time, as discussed in chapter three. Stories allow access to a wide timescale; past, present and future; through their telling and retelling. By exploring stories from the three perspectives of integration, differentiation and fragmentation I can consider the rich variety of meanings that are made within the organisation. Three main types of story were identified through content analysis in the different stages of the study: conflict stories; atrocity stories and phoenix stories. These are outlined and discussed in this chapter.

**6.1 Conflict and resolution**

In addition to the conflicts directly observed during the observation stage of the study, a number of stories of conflict arose during interviews with participants. There were differences in how participants viewed conflict and the function they ascribed to it in terms of individual and organisational learning and

change. However, there were also commonalities in the outcomes of conflict on the activity systems and learning.

One of the common stories told was that of verbally aggressive clashes between consultant obstetricians, being repeated in one form or another to me by four different interviewees. In this tale, individual consultants, or small factions of consultants, set themselves up against other consultants; leader against leader. This led to disagreement and argument over a number of matters; from the care of patients, to the agreement of departmental policy, to the training of junior staff. The different consultants used a combination of factors, such as their clinical experience, their experience elsewhere or their external leadership roles, to assert their opinion over the wider department and draw them into the conflict. This led to work carrying on in the same way it always had and the department learned to cope with and manage the disruption rather than learning to change it. Individual staff in the department tried to achieve resolution with the individual consultants in order to make working life easier and more manageable.

An example was given by one of the key informants, who had been tasked by the Board with improving patient flow. She spoke of how two of the consultants disagreed on the responsibilities of the consultant in discharging patients and how this led to a complete refusal to agree a new pathway of care and to a number of heated arguments in meetings. This conflict led to continued delays and the failure to implement any change. The conflict was widely recognised by midwifery staff and junior doctors, but many expressed to her that they found it easier to adapt their day to day practice depending on the consultant, rather than conform to a shared way of working.

*“ When [Dr A] is on, she just won't even go there, you know. She just says it isn't in her job plan, her clinical priority is the sickest patients on antenatal ward. The midwives, when it's her on, they know that there will be delays so, so they tell me they can't get anything done and the discharge is delayed so they let labour ward know to reduce patients as they can't get women up. [Dr B] has fought with her over this so many times, so many...she's totally different, she's worked in [other hospital] and has seen that it can work the*

*way we want and ...she tells [Dr A] this but it's like she's banging her head against a brick wall sometimes. She has tried taking it to the different meetings, trying to get other people on side, but they just end up all shouting at each other and we get nowhere going forward as the consultants can't agree" (Key informant C, Nursing).*

This story seems to be one of fragmentation, with different interpretation of clinical priorities by different team members and resulting ambiguity and confusion. Staff views changed as the tasks and leadership changed, leading to co-existing practices and beliefs but no agreed change. However, when examined from a differentiation perspective this story can also be seen in terms of power. The consultants are positioned powerfully and this places other members in a different, lower, subculture where they share values based on their status. Integration was apparent at a subcultural level, as more junior team members adapted their work patterns to manage the change in leadership moment to moment. Through this subcultural working, the power of the consultants was reinforced and organisational members learned through their practice that the culture is hierarchical and divided. From an integration perspective, the key informant can be seen striving for consensus in order to achieve cultural change. She is clearly aligning herself with one side through her narrative, talking of *"the way we want"* and *"we get nowhere"*. In her story telling to me, she makes clear what she sees as the integrated and effective way of working and paints the other consultant as a barrier to this. Her sense of this situation is that consensus has to be achieved. Without this, no shift in policy or practice can happen and organisational change is not possible. For her, the conflict is a barrier and learning is not possible while the conflict continues. However, my interpretation is that organisational learning is taking place and that cultural change is occurring, but in a way that reinforces dominant beliefs about hierarchy and power and furthers subcultural division.

Priya, a consultant obstetrician, told a number of stories of difficult working relationships with her colleagues. These experiences contributed to her learning about both herself and others. In the story below she stepped in to break up a conflict between colleagues.

*“Two days ago we had this situation where we wanted good teamwork and we had hugely complicated cases around. And each one didn’t want to listen to each other and, you know, the attitude was different, the behaviour was different and a few of them, you know, it can affect the whole team. But it, kind of, works as a team. For example elective sections that are complicated ones, you need midwives, you need theatre staff, you need anaesthetists, obstetricians to work together...and we had a cardiac patient as well, so...the...cardiologist input. But I saw that, that day, everything fell apart and they...it was chaos and emotions went up and up, they couldn’t get...errr....oh my god, everyone got really upset. We really tried to get the other person to talk and what had upset them and I was open and I was trying to understand and I said, ‘Yes but does it work? For that moment you’re showing a stern face and it plays with people’s emotions and you want a team work, you don’t want at that time just the work being done’. Ermm...I think...you know, I think it doesn’t work in this one, I think you need to keep talking and building up the relationship . But I realised that myself and the CD at that moment, we came in to help the situation. I volunteered, and he was called as the CD, and we had help from the management and we went and spoke to the people and gently calmed the situation” (Priya, consultant obstetrician).*

From an integration perspective, in this story Priya constructs herself as a voice of calm and reason in the midst of a sea of chaos, aiming to unite through “*teamwork*” and achieve the organisation’s overarching goal. She speaks of how “*we*” wanted good team working but it is not clear who ‘we’ are. She sees the conflicting behaviour of a few individuals as affecting overall integration and excludes them from the team. My impression was that this was partly done for my benefit and that she saw me as a similarly rational person, the researcher, who would understand her desire for calm. However, from a fragmentation perspective, the complexity of the work and the different roles and views of team members leads to dissent. In achieving successful practice, these conflicting views and systems of meaning had to be acknowledged as the situation was calmed down. Therefore, change was only possible through an active effort to confront and accept apparently irreconcilable differences. Priya viewed the conflict as cathartic, and once it had been confronted and acknowledged, everyone could learn to carry on. It is interesting, though, that Priya resorts to hierarchical understandings of how conflict should be

managed, noting that the Clinical Director was called due to his role and how the two consultants resolved the matter “*with help from the management*”. This more subcultural understanding again reinforces dominant beliefs around power and status.

## **6.2 Atrocity as a strategy for change**

A key strategy to encourage change at many levels of the organisation was the telling and hearing of atrocity stories. These tales of horrific clinical events, that were portrayed and interpreted as beyond the normal boundaries of quality health care, were told in meetings from Board to departmental level, in departmental education events and by staff in all sectors. In some cases they referred to specific recent patients, known to many members of staff. In others, the patient was more abstract and the stories referred to ‘a time when’ rather than a specific, recognisable event. During my time in the department I heard a number of different atrocity stories, both during formal data collection and informal discussions with staff.

A key atrocity story that recurred during my time in the organisation was one where a serious clinical error had resulted in the death of a young patient. The story began with a dispute between different clinical specialties in the organisation about who was responsible for the patient’s care, led to an inexperienced and poorly supervised doctor carrying out a procedure when he did not feel adequately prepared, and ended with a failure of either specialty to follow up on unexpected results. The tale as a whole was told in both the clinical governance meeting, where it was presented to the whole department as a learning opportunity, and in the business meeting, where it was presented to senior staff as a problem to be solved. It was also recounted to me by a key informant at the start of the study, who presented it as an example of the difficulties the department faced in achieving cultural change.

*“I don’t really know how we are going to move forward from that case. Obviously there has been disciplinary action but the thing is I can see something like that happening again...nothing has really changed. We’re all*

*still arguing over what went wrong and whose fault it was and nothing is changing” (Key informant B, Clinician).*

The telling and hearing of this story seemed to serve a multitude of functions. In one sense the story served to unite the department around a common theme and this appeared to be the thinking behind its use in the clinical governance meeting. By hearing and sharing the story, staff could share in the solution, learn ways to avoid error and feel motivation for change. However, subcultural differentiation was evident in the inconsistent interpretations of the story by professional groups. The discussion that arose during the clinical governance meeting positioned midwives as external to the story. The midwives present recognised and shared in the horror of the tale but articulated that it was the fault of medical staff at each stage of the process, abdicating any responsibility for midwives in preventing similar problems in the future. At each point they were brought into the discussion they deflected it back to the medical staff; with one at one point saying *“We wouldn’t really know about any of this as it’s the doctors”*. There appeared to be a protective aspect to their interpretation, central to how they viewed their professional identity and role. This was, however, noticed by the doctors present, who appeared to be offended by this and turned against it, actively vocalising the need for a shared understanding of the errors. As one junior doctor commented to me directly after the meeting, talking about a senior midwife present, *“She doesn’t want midwives blamed for these errors and if they learn about them then they are to blame”*. From a fragmentation perspective, this story highlights a number of ambiguities and complexities in the organisational culture. The same patient’s needs were interpreted differently by different clinical teams but also by different members of the same team, leading to an unsuitable practitioner performing a major procedure. This practitioner had to reconcile their desire to act in the best interests of the patient with their desire to act on instructions from a senior and their subordinate role as a junior medical staff member. Contrasting beliefs about lines of responsibility after the procedure meant that no-one felt accountable to act on the results of tests.

Learning from this case appeared to happen in a number of ways, not all of which seemed to be expected. The use of the case as a form of inverse

propaganda, both in structured contexts and by individuals privately, led to a shared reflection and acted as a mediating artifact for transformative change. However, subcultural groups constructed and reinforced their own identities through the language used in the discussion of the case. Again, a drive for total consensus and a failure to acknowledge ambiguity and shifting views may have inhibited transformation.

### **6.3 Rising from the ashes**

The third genre of story told during the course of the study was the phoenix story; a tale of overcoming adversity and failure to rise from the ashes stronger than before. This type of story was predominant with speaking to Desmond, the external project manager, and also on analysing the Trust's outward facing documents. It, therefore, seemed to be a dominant theme of the quality improvement strategy of the Trust.

Desmond was employed for a fixed period in the Trust to co-ordinate a programme of quality improvement and provide project management support to particular projects. There were a number of external management consultancies and project managers in the Trust throughout the study period but Desmond worked as an independent contractor rather than for a consultancy firm. He had fixed responsibilities on which he had to deliver, but also a floating role within maternity scoping and supporting change. He came from a business background but had built up expertise in healthcare in the last several years and had worked on a number of successful turnaround projects in NHS Trusts. It was on the basis of these successes that he had been invited to work at Olympic.

From the start of our interview, which occurred after the change project meeting, Desmond portrayed himself to me in a language of triumph over adversity; from detailing his route to personal qualifications through to the successes achieved in previous employments and the networks he had forged. Even when talking about aspects of the role that frustrated him, Desmond was liable to focus on his personal accomplishments. As a reflexive researcher, I

can acknowledge that Desmond's identity construction and my interpretation of it were influenced by aspects of his background and their relation to me as a white, female, professional researcher. Desmond also told tales of Olympic Trust and how it had overcome adversity to reveal new organisational forms. One of these was the story of how restrictions on the maternity unit had been lifted through the concerted efforts of staff to ensure standards were consistently met. Desmond seemed to view contradiction and tension as troublesome rather than productive and saw consensus and integration as markers of a successful culture. His narrative emphasised staff pulling together across all levels, agreeing change and the emergence of new organisational forms; a classic story of integration where the organisational culture functioned to remove ambiguity and unite values.

*“Well, [the CEO] spent a lot of time with me in maternity and really being hands on, walking the shop floor and speaking to staff and patients. Errr, we closed beds for a while to help maintain the staffing ratios but even after the beds have reopened we have managed to maintain the 1 to1 care and high patient satisfaction. But, you know, since the beds reopened everyone has been working in a much more efficient way. The leadership is visible, and there, and it keeps everyone focused on achieving the best care, the safest care” (Desmond, project manager).*

However, as highlighted in the previous chapter, these successes were interpreted ambiguously by other participants, who acknowledged the adverse effects the achievement of the targets had on other areas of the department. From a differentiation perspective, the visit of the Chief Executive to the department and their interest in staff and patient care could be interpreted as reinforcing hierarchy and divisions between Board and clinical staff. Desmond glosses over the closing of beds as a managerial step in the journey towards rising from the ashes, but this act may have had more significant consequences on clinical staff who had to manage patient flow and expectations and may have interpreted bed closures punitively.

For some, this new, more private sector and business like, organisational form was positive and allowed people to unlearn past behaviours and learn new



ones. In this case, Desmond was seen as expert and influential within the wider organisation, bringing in new ideas and ways of working.

*“So the advice from the external consultant...he knew what would persuade my colleagues. And because he was external he didn't have to please in the same way as others did...[He] was more kind of aware, knew what was needed in the team. You know I was sceptical and he said he would go along with me to the meeting happily” (Ranita, project midwife).*

However, for others it generated mistrust and a change in perspective from the more familiar and traditional ways of working.

*“Erm...I think it was difficult at the beginning 'cause we didn't have an office, we didn't have computers, so, erm, two of us went out and bought laptops. So when you are brought into an organisation and you're not supplied with computers, that's when we found it hard, like we weren't valued. Especially as there were all these project managers in using up the budget and we don't really understand what it is they're meant to be doing... It would have been helpful for people to know exactly what was going on. We felt like people just heard, through the grapevine, this project and that project, you know.” (Tracy, senior midwife).*

During the study period the Trust redeveloped its website and rebranded itself as a leading provider of maternity care, based on its CQC successes. The home page spoke of the investments that had been made to update facilities. Women were assured of highly trained staff and the high volume of patients was given a positive spin as experience. This seems to be in contrast to the negative spin placed on it by staff, who saw size as a key factor in causing errors, but also in contrast to the Chief Executive's view of the Emergency Department, which was too busy to provide high quality care. The image portrayed to external stakeholders was one of transformation. According to Desmond, this had been a conscious decision of the Board, who wanted to portray an organisation with a culture of care and compassion and focus attention on unifying values and assumptions.

*“Working on the image and reputation is a key work stream of the Board right now. Yeah...they have to be sure of painting the right picture, you know,*

*making sure stakeholders and patients know that we are all focused on the same goals and want the same thing” (Desmond, project manager).*

Therefore, the phoenix story can be viewed primarily from an integration perspective as a manipulation of symbols and signs by leadership that unites staff around a shared success. This appears to be the goal in its telling to an audience. However, it may be interpreted more ambiguously by clinical staff, who are able to see it in its wider context. While some aspects of the story may be used positively and some values may be shared, a change in organisational form can also generate mistrust as it comes up against traditional ways of working. This ambiguity affects the meanings made by individuals within the organisation.

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**CHAPTER SEVEN:**  
**DISCUSSION**

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**7.1 Summarising networks of change activity**

Drawing together my analysis on the role of subjects, collectives and objects of activity I can now begin to map out the networks of activity in the organisation and explore how activity systems are interlinked and how activity leads to change. Activity systems appeared to form around professional groups, management groups, clinical work teams and project teams. They cannot be clearly separated into 'work' or 'management' due to the complexity of work activity and the nature of interprofessional involvement. Many individuals had roles in more than one of these and activity systems shared rules and divisions of labour, so boundaries between them appeared fluid. Motivations for activity were often imposed externally and then reworked by individuals and the collective, drawing on organisational artifacts to construct the object of activity. A number of intermediate objects led to the construction of shared objects between activity systems. The outcome of this was individual and collective learning about the organisation and its culture, and a move towards a shared object of cultural change, as individuals engaged with the object through mediated practice. However, this was a dynamic and evolving process which in turn fed back on the activity systems which made use of organisational cultural artifacts.

Analysis of the organisational stories told to me during the study from the three perspectives of integration, differentiation and fragmentation has revealed something about the organisation's journey towards transformative change. Although healthcare organisations are relatively stable settings in the sense of physical location and outcomes, the interprofessional collaboration and expertise required for cultural change was negotiated, constituted and contested through practice. Transformation happened in small, multidirectional steps and different individuals and collectives took steps in different directions at the same time. However, the day to day changes were small. Attempts to reconcile ambiguity and to construct and interpret identities led to a process of

meaning making for those involved. One of the main barriers to transformative change was the persistence of traditional rules and divisions of labour within the organisation and the wider system. This emphasised medical hierarchies and the dominance of the clinical consultant. Attempts at cultural integration were hampered by differences in values and beliefs amongst these dominantly positioned leaders. At a lower subcultural level, this may have encouraged some cultural integration as staff united around working to the drum beat of different leaders. However, it also encouraged ambiguity, dissent and confusion at a more senior level. A continued focus on the achievement of consensus is likely to lead to further irreconcilable differences, although staff can, and do, change their views and beliefs over time as practice and priorities shift. The effect of change was further knock on change, and the complexity of the system means that new pathways of change were opened up at each juncture. Some of these paradoxically reinforced traditional values and beliefs, although new innovative organisational forms and ways of working were also revealed. Specifically addressing the question of change, through exploration of organisational successes and failures, was not guaranteed to lead to change. Individuals made their own interpretations of organisational stories, mediated by a number of experiences, and used these understandings in the construction of their own professional identities and in their daily practice.

## **7.2 Exploring the object of activity to explore cultural change**

Activity theory is a theory of object driven activity (Engeström, 2009b). It takes the object of activity as a crucial analytical tool which gives meaning to various phenomena (Kaptelinin, 2005). In his study of interprofessional learning for interagency work with young people, Daniels (2004) considers that research that focuses on actors is flawed, as actors become dispersed and replaceable. Rather researchers should follow the object of activity. My findings would seem to fit with this. One way to explore my findings further is to consider the notion of epistemic objects; “open-ended projections oriented to something that does not yet exist, or to what we do not yet know for sure” (Miettinen and Virkkunen, 2005 p438). This idea was developed in the study of natural sciences but Miettinen and Virkkunen suggest that it is relevant to analysis of

organisations as well, especially when considering the need for innovation and change. They critique the concept of organisational routines to demonstrate this idea through empirical analysis of an intervention project in an organisation whose established routines had become ill suited to its developing priorities and which needed to create a new form of practice. My findings support the notion of culture change as an epistemic object. Organisational routines and occurrences at Olympic acted as a focus for the formation of activity systems and as a source of reflection and development for subjects. Norms of action and cognition were used to create artifacts that mediated the activity. Often the object of activity was not permanent or repeatable but rather evolved and developed through activity, acting as a source of reorientation to, and reflection on, practice. Lektorsky (2009) considers reflection as a form of re-mediation that is necessary for changing activity and constructing something new. Reflection allows individuals a way of understanding contradictions and the possibilities of changing activity, while taking into account the history of the system, its norms and values. This process then acts to re-mediate the activity. Organisational events and stories at Olympic acted as triggers to reflection, both individual and collective, that then acted to re-mediate the object. Considering cultural change as something undefined and unstable, an epistemic object, helps to bridge the gap between stable organisational routines or shared values and the emergence of new practices through ambiguity and contradiction.

In considering cultural change as an epistemic object I need to consider further how the object is developed by the collective. Activity theory considers objects of activity as the true carriers of motives of collective activity. Miettinen (2005), drawing on the early work of Leont'ev, considers that the sources of motives are found in activity and its emerging contradictions, rather than arising solely within individuals. Discontent with present activity meets an object and is transformed through collective artifact mediated activity. In this way, objects are increasingly complex, a "contradictory assembly of heterogeneous materials embedded in social and economic relationships" (ibid p53). Engeström and Blackler (2005) remind us that objects are not just given but rather are constructed by actors as they make sense of their actions and

activities. They have histories and built in affordances and resistance. They suggest that work organisations are built and maintained around partially shared, partially fragmented and partially disputed objects. This study, using a three perspectives framework to analyse organisational culture, takes this idea further by exploring in what ways objects are shared, disputed and fragmented. I have found that the imposition of external political motivations in the form of targets is a major source of fragmentation and dispute, but that these can be reworked through collective activity to become a partially shared object. However, this often happens in unintended ways which can lead to further fragmentation. This finding is similar to other studies that have used a three perspectives approach to analyse organisational change. In their analysis of a software development company's management practices, Dube and Robey (1999) found that management practices, such as team reorganisation, were interpreted by members of the organisation and collectively redefined, often rendering them ineffective or problematic.

In their study of alcoholic liver disease, Law and Singleton (2005) theorise the nature of objects using various images, including fluid and fire, to account for the complexity they found during their research. My findings would agree with the nature of the object as fluid. The shared object of cultural change is continually in ebb and flow and, if not maintained, it starts to seep away. However, as it is maintained it shifts and may gently change shape, while maintaining its inherent sameness. It also flows back to mediate further activity and introduce new contradictions into the system through the creation of cultural artifacts.

### **7.3 Considering the collective subject as the agent of change**

Part of the complexity in the networks in my study was introduced through the sharing of individual subjects, who moved between activity systems and adopted different roles. Miettinen (2005), in a study of a biotechnology laboratory where enzymes produced for research contributed to better commercial production of ethanol, showed how intermediate objects of activity and their connected expertise can be used as elements in other activity

systems. As the object evolved, so did the motives and capabilities of individuals. However, in this study he saw individual subjects as being part of single activity systems functioning in interconnected networks. He suggested that further research was needed to understand the dynamics and complexities of the involvement of individuals in collective activities and their contribution to transformation. Without the activity of individuals, collective activity is impossible. However, an individual can influence collective activity only by participating in it (R.Engeström, 2009a). Individuals cannot have norms and rules that are only theirs; these will always be shared with others (Lektorsky, 2009).

I have, therefore, tried to look at the way in which interprofessional relationships are mediated within the activity system and how this affects the way in which professionals engage with the object of activity. Guile (2011) considers ideas of restructuring, repositioning and recontextualising to explore how project team members from multiple backgrounds explain their reasoning, learn from other sources of expertise and agree on courses of action in the design of a novel product. The community project at Olympic began with the retraining of individual midwives, focusing on skills and competences that they did not traditionally possess. However, more was needed to achieve change. Over the course of the project, engagement with the wider project team encouraged them to engage with these new practices and rethink their role as midwives. The project achieved success and a change in practice only when both midwives and doctors participated in it, created a new normative context, and the hospital clinic could close. Throughout the lifetime of the project, different professional groups engaged with the object of activity in different ways, before negotiating and constructing a shared object. There was a range of responses to the object, mediated by past experience, professional subcultural belonging and political agendas. This is somewhat different from Engeström's (2001) notion of knotworking, which appears as a transient process of co-configuration, which relies on collaboration that occurs without set rules or hierarchies of authority (Engeström, 2005). My data suggests that culturally determined patterns of professional behaviour, rules and hierarchies are central in the process of constructing a new object. While professionals

are capable of working together collaboratively and in innovative ways, the permanence of the object is mediated by more traditional patterns of working.

I draw on Stetsenko and Arieviditch's (2004) conception of the self as a leading activity to explore this issue further. This emphasises that neither individual agency nor collective social exchanges are subordinate to one another in the production of human subjectivity, seeing the self and society as transformations of the same reality. In this way, there is "a process of real-life activity that most explicitly positions individuals to meaningfully contribute to the ongoing social collaborative practices in the world" (ibid, p493). I have demonstrated how, through practice and engagement with the organisation and its culture, individual actors developed in their organisational roles and enacted their selves, but also simultaneously developed the collective and transformed the social world. In some cases, such as in the case of the Chair of the business meeting, this process was highly individual. His influence on the activity network took place largely through the organisational importance attached to his role as he played a part in more than one activity system. However, in other cases, such as in the community midwifery project, there was evidence of the activity of collective subjects, who shared a common identity as midwives and who developed collectively, thereby transforming the activity network through influence on all activity systems in which midwives played a part.

From an organisational development perspective, the organisation can be considered in terms of the primary function of its performance (Gallos, 2006). However, in the NHS the primary function can be elusive and no 'product' as such is produced. While it can be argued that the outcome of all activity should be patient care, my study of activity at Olympic showed that this can get lost in the day to day tasks, actions and intersubjective relationships in the complex cultural system. Bedny and Karwowski (2005) critique Engeström's (2000) study of children's healthcare by challenging the notions of task and action when applied to the study of physician's work. They highlight how a purely individual approach to the study of activity can mask certain crucial elements, such as the subjective role of patients, the hierarchies of medical



care and the balance between service and training of junior doctors. Engeström (2009b) takes this idea forward when he considers the role of boundary crossing in development, recognising that human beings are involved in multiple activities. As Akkerman and Bakker (2011) discuss, sociocultural learning theories stress that boundaries carry potential for learning. Through use of the concept of boundaries and boundary crossing, we can begin to see not only the cultural differences and difficulties of interactions, but also the potentials for collaborations and communication between activity systems. Learning at the boundary is ambiguous and is a matter of identification, co-ordination, reflection and transformation, with dialogue between different perspectives (ibid). Edwards (2009) uses an activity theoretical study of interprofessional learning to discuss how new conceptual tools are needed to mediate professional relationships at the boundary. In particular, 'know how' becomes secondary to 'know who'; the knowledge of who knows how to do what in the complex network of professional activity. Using a three perspectives approach to focus in on cultural activity at the boundary between activity systems at Olympic, we can see how subjects, both individual and collective, continually developed in their roles. As new relationships were formed through work activity, individuals constructed organisational identities and created new understandings of practice and culture which affected the boundaries between activity systems. Some of these led to new shared ways of working but others created new ambiguities, particularly when subject to political processes, and reinforced hierarchies. Therefore, although it is individuals who interact at the boundary, collective learning takes place through the effect of these individuals on collective practice, their negotiated organisational roles and the power relations these generate. This again is quite different from Engeström's notion of knotworking. Maternity consultants often worked at the boundary; between clinical work and management, between different clinical areas, between service requirements and training needs of juniors. The ways in which some of them engaged with change altered the rules and divisions of labour in the activity system. The resistance of some of the consultant body to new patient pathways across maternity led to ambiguities in patient flow. Beds were protected in one clinical area resulting in delays in discharging or admitting

patients in other areas. The work of different groups was presented ambiguously so staff learnt to modify their way of working day to day, depending on which consultant was in charge. Hierarchies were reinforced and political pressures ascribed new meaning, with a resultant effect on both patient care and cultural change.

#### **7.4 The productive nature of contradiction**

The idea of contradiction is central to activity theory and the theory of expansive learning. Engeström has studied contradiction in the field of healthcare in Finland and used this to theorise levels of contradiction based on the phases of expansive change in activity systems (Engeström, 2001; Engeström, 2005). However, as Miettinen (2009) points out, the analysis of contradiction in Engeström's studies of healthcare neglects to consider fully the role of the community or the wider role of capitalist society. In my study, the intra-subjective and inter-subjective contradictions and tensions that evolved during practice shaped the object of activity and, through the shared object of cultural change, shaped the activity network. By exploring these processes using a three perspectives theory, I have been able to show how these contradictions and tensions manifest and explore some of their shaping forces.

Professional power is the dominant shaping force in how individuals and collectives experience and interpret contradiction. Other studies in healthcare that have explored culture using three perspectives have found similar. Rivard et al (2011) looked at the difficulties implementing a new clinical information system in a hospital. They found that while shared emphasis on quality of care and clinical efficiency were important in implementation, challenges to medical professional dominance and professional power by the new system led to conflict between subcultures and hindered the implementation process. Morgan and Ogbonna (2008) also highlight hierarchies within subcultures and high levels of uncertainty within and between subcultures that affects the rules of the organisation and the divisions of labour. Within my study, I found that when object-motive aligns with conceptions of professional power a project

can achieve success and lead to shared understandings, even if it challenges traditional patterns of working. However, when it disrupts professional status and hierarchy, fragmentation dominates. These forces have impact on the activity system as motive is not only affected by, but also has an effect on, power relations (Miettinen, 2005). The community project succeeded, despite radically altering the way care was delivered, because the midwives functioned as an autonomous subculture in a way that removed their work from the work of the medical profession. The 'normality' of the patients, who did not need to come to hospital for clinical expertise, was highlighted, freeing up medical staff to work with more 'complex' patients in keeping with their professional perceptions and, thereby, allowing the midwives to develop their own service. By contrast, the project within the hospital had more difficulties because doctors and midwives were being asked to work alongside one another in a way where neither profession had a higher status. This led to a power struggle which affected wider working relationships and divisions of labour. As changes in culture result in changes in collective practice they also result in changes in norms and values, which are reproduced through the rules and divisions of labour in the activity network.

Taylor (2009) argues that authority is foundational for the sustained existence of a community and that activity theory fails to treat authority in depth. However, Engeström (2009b) argues that the achievement of coordination through transformative negotiation is a central manifestation of authority in social production. He considers that negotiation processes transform the dispute as well as the outcome, thereby transforming individuals and allowing opportunities to create new social realities. Exploration of organisational stories at Olympic highlighted how this process happened on a daily basis: as the organisation tried to construct a narrative of success and encourage shared learning from error, the staff were faced with an object that required constant questioning and reconfiguration of the boundaries, the rules and the division of labour. This required renegotiation of the order of things to allow the pursuit of intersecting activities. Conflict was common and understood differently as individuals changed their interpretations of their practice and that of others. This led to transformation happening in multiple ways, rather than

the unidirectional way the organisation seemed to intend. While conflict can be seen as a short term action, contradiction developmentally affects the object of activity and may arise from conflict (Engeström and Sannino, 2010). A major source of contradiction in this study was external political pressure, what Engeström would call a quaternary contradiction (ibid). However, in their critique of Engeström's activity theory, Langemeyer and Roth (2006) highlight how Engeström tends to psychologise contradictions and play down the societal plane of contradiction. In this study, the societal plane, with its capitalist market forces, political processes and constellation of power relations, emerged as vitally important and a source of major contradiction that drove cultural change but also narrowed the scope for development. By using a three perspectives approach, I have been able to see how subjects take these external contradictions and rework them to make them meaningful to practice. This can lead to unintended consequences, such as when patients are managed in inappropriate areas in order to maintain centrally imposed time or staffing targets. It can also lead to cultural change through innovative ways of working that disrupt traditional roles in order to meet demands for services or encourage learning in interprofessional networks.

### **7.5 Revealing aspects of change**

While an organisational development perspective on this case study might analyse findings in terms of purpose, structure, process, authority and defined relationships, an activity theoretical approach considers the data differently. Rather than purpose I have considered the object of collective activity, which is fluid, dynamic and uncertain. Rather than structures and processes, I consider boundaries and their potential for change. Agency and collective subjectivity, with their negotiations, conflicts and contradictions, are seen as central to understanding relationships and authority.

Analysis of the organisational stories and meanings made at Olympic using an activity theoretical lens, augmented by a three perspectives analysis of culture, has allowed me to reveal the mediated aspects of the relationship between practice and learning. Other studies in healthcare have used a communities of

practice approach to study interprofessional working in quality and safety improvement (for example White et al., 2008). However, this analysis very much focuses on achievement of consensus, as communities move towards full integration. Learning is seen as learning for practice, with a focus on learning new styles of effective communication to enable more effective practice. Culture is also viewed simply as the context which binds interprofessional team members working towards an agreed end point. My analysis, by contrast, allows recognition of mediated aspects of practice and learning by viewing culture as disputed, contested and consumed differently by different team members. Through analysis of contradictions and tensions as productive, rather than simply as barriers to learning, I have been able to explore how individuals and collectives create and agree the collective meaning of a new object and how the new object mediates individual and collective practice. This analysis explores how individuals are repositioned (Guile, 2011) in different ways in relation to the object of their activity and recontextualise (ibid) their understanding of practice, learning and change. An analysis of the differences as well as the commonalities between interprofessional groups has led to recognition that meanings are made in a number of different ways.

### **8.1 Introduction**

In this thesis I set out to explore the relationship between organisational culture, learning and change in NHS healthcare organisations in an attempt to untangle some of the culture confusion inherent in NHS managerial discourse. My central argument has been that the NHS has approached the question of organisational culture from a neopositivist, organisational development standpoint and that this has coloured much of the policy and research of the last 30 years. Culture is conceived of as a homogenous attribute that can be manipulated through top down structural and process changes. However, despite a continued focus on the variable of culture throughout the managerial and healthcare literatures, there has been little meaningful insight into how, or indeed if, cultural change can, or should, be achieved. In the current complex and fragmented NHS there is an urgent need to better understand organisational culture change and its effects on both the individual and the collective.

Starting from a social constructivist perspective in this enquiry allowed me to conceive of organisational culture as socially and discursively constructed and consumed by cultural members. Rather than a variable to be manipulated by management, I questioned instead how organisations might learn about culture and change. By taking a sociocultural perspective on learning I moved to try and understand the relationship between the individual and the collective in learning about culture and how this might affect cultural change. I conceptualised learning as a dynamic process of interpretation and response, rooted in mediated professional practice, where there is a reciprocal relationship between the individual and the collective. My conception of the healthcare organisation as a complex cultural system draws on two broadly interpretive theoretical frameworks; Martin's three perspectives framework for analysing organisational culture and Engeström's third generation activity

theory and theory of expansive learning. These approaches were used to design an interpretive case study to answer the following research questions:

1. What is the interplay between organisational culture and organisational learning for cultural change in an NHS organisation?
2. What is the relationship between individual and collective learning within the organisation and how does this manifest?
3. How and why does cultural change take place, or not take place, in NHS organisations?

## **8.2 Report of main findings**

In this empirical research I used methods to study the learning that takes place during professional participation in activity that aims to improve service and quality of care and, through this, change organisational culture. Activity theory has been used as a lens through which to examine the change journey and analyse how professionals engage with change. My thinking draws heavily on the work of Yrjö Engeström; his conceptualisation of activity theory, his ideas on interprofessional learning at work, and the central role he affords contradictions in developing the object of activity. However, I have broadened Engeström's approach in order to study an organisational context where the object of activity is not stable or well defined and where the interprofessional practice and learning are mediated by a wide range of factors from within and without the complex cultural system. In particular, I expand upon ideas of disputed objects, mediated practice and learning, and professional power and authority.

My findings suggest that cultural change is far from a static phenomenon, with a linear cause and effect. It can instead be considered an epistemic object, anticipated but not yet known with certainty, a process of continual learning and transformation at the boundary of the unknown, rooted in practice. In the same way that the object is uncertain, networks of practice are themselves continually forming and reforming, both contributing to and influenced by cultural change. Through practice, individual actors and collectives of actors

learn about the organisation and their roles within it. This learning activity is mediated by a number of internally generated and externally imposed motivations. Internally generated motivations may arise from events that happen in practice, such as conflicts or errors. However, these same events can also be presented as externally imposed motivations from other activity systems. In this case they are reworked by individuals and the collective to produce more collectively meaningful motivations and short term actions, which then affect the object of the activity.

The role of individual subjects within the organisation cannot be rigidly bound within specific groups or subcultures, as organisational members increasingly have diversified roles and responsibilities and function at the boundary of activity systems, experiencing tension and contradiction but also collaboration and communication. Subjective change is dynamically constructed over time through activity and practice, as individuals engage with the collective in ways influenced by their own histories and professional voices. Individuals redefine their understandings of the organisation and its culture as they continually reinterpret their role, the activity of the collective and its goals, in order to make meaning. Any consensus achieved is momentary or issue based and likely to change multiple times. Through the learning of individuals the collective is also changed, as roles and goals are reworked and refashioned. A major influence on this is the emergence of professional subcultures and dominant understandings of professional power. This can, at times, act as a force for integration and bring shared understandings. However, it can also cause fragmentation as traditional rules and divisions of labour are reinforced but also challenged through shared activity. The individual and the collective are bound together as learning leads to cultural change, which in turn feeds back on the activity system, individual subjects, the wider collective and the object of activity, resulting in further cultural change.

Cultural change takes place in a series of small, multidirectional steps as both individuals and collectives work to resolve tensions and contradictions that arise through shared practice. Many of these contradictions will be externally imposed and the complexity of the network means that the renegotiation and



reinterpretation of these may have unintended consequences for cultural change. Change leads to more change, through a continual process of feedback, and it is not always possible to predict what the outcomes will be. However, some changes act to reinforce traditional values and beliefs, particularly around professional power and conventional ways of working. This can act as a barrier to the development of new organisational forms, even if a narrative of consensus is constructed within the organisation. Transformative change, therefore, happens slowly, over time, and often in unexpected directions.

Through this work, I have shown activity theory to be a useful theoretical framework for analysing learning and cultural change in healthcare organisations. It allows for exploration of contradiction, transformation and engagement between individuals and the collective, with emphasis on the dialectical relationship between knowing and doing (Engeström, 2007). However, critics of activity theory point to several unresolved questions that were addressed in my conceptualisation of activity theory for this research.

Blackler, Crump and Macdonald (2000) highlight how, in the modern, complex world of work, objects of activity and patterns of collaboration tend to be difficult to see and represent. Engeström (2001) has attempted to explore collaborative working across boundaries within healthcare, suggesting that loosely connected individuals can knotwork together in a continually changing pattern to achieve new ways of working. My addition to this theory would be to suggest that in complex healthcare organisations the boundaries themselves are subject to external interference. Boundaries shift as individuals and the collective experience tensions and disturbances generated by power relations and political pressures, which are worked and reworked. The object of activity is fluid. It is partially through this fluidity that shared objects are constructed and the journey is started towards cultural change.

Langemeyer and Roth (2006) question the role of contradiction as a force for change within activity systems, arguing that Engeström tends to dichotomise individual and social contradictions. A central question similarly remains on

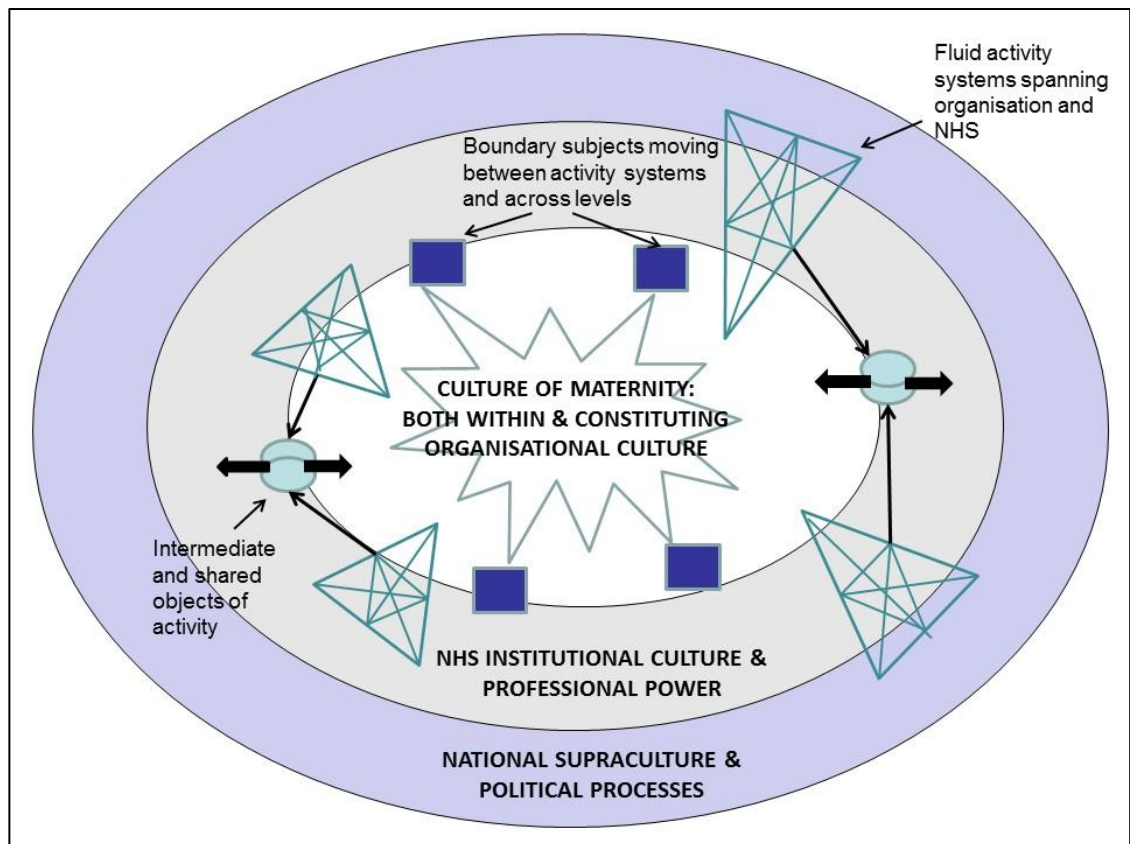
the role of the self and the forms of agency involved in expansive learning (Engeström and Sannino, 2010). Through my empirical data I have begun to show that motivations and contradictions can be both internally generated or externally imposed. However, they are consumed and reworked at both an individual and a collective level through practice and object related activity. By applying Martin's three perspectives framework to look at the lived experiences of actors within the activity system, I have shown how tensions are often affected by subcultural dynamics and power relationships, especially around the issue of professional power. These power dynamics shape the collective and the object of activity through the rules and divisions of labour in the activity system. Individual actors in complex healthcare systems may have roles in more than one activity system. Their engagement with these roles, and the contradiction this generates through challenges to subcultural stability, leads to ambiguity and flux, with a continual reworking of the self and the collective as consensus and dissent coexist and are challenged.

My final conceptual conclusion concerns the notion of transformative change. I questioned the validity of Engeström's claim of transformative change in healthcare systems when his empirical methodology abstracted change from the practice setting. Other authors have also questioned whether changes achieved through expansive learning can be more than superficial (Avis, 2007). Through the application of a case study methodology, I have been able to explore cultural change from a number of perspectives. I propose that cultural change can be seen as a shared object of activity, arising through the construction of intermediate shared objects between activity systems. This in turn feeds back on the activity system as cultural artifacts are used to mediate activity. Therefore, the process of change is ongoing, multidirectional and may occur in unexpected ways.

Returning to the conceptual framework I developed at the start of the study, I can now modify my conceptual understandings of the complex cultural system of the healthcare organisation, as shown in Figure 6. This recognises that individual departments both lie within, but also constitute, the wider culture of the organisation through their subcultures, their negotiated activity and the

practice of their boundary subjects. These subjects move, through their practice, between activity systems and also across the cultural layers of the wider NHS, influencing interprofessional relationships and mediating practice through their engagement with the collective and the network. The intermediate and shared objects of activity constructed within the network act to feed back on organisational and institutional culture and power, introducing further contradiction into the network.

*Figure 6: Modified conceptualisation of cultural activity in NHS organisations*



The strength of this thesis lies in its novel contribution to both the healthcare organisational culture discourse and the theoretical field of activity theory. By adopting an interpretive approach to my research, I have been able to challenge the dominant discourse and create new understandings of organisational culture, learning and change in NHS settings. By applying Martin's three perspectives framework to empirically explore the lived experiences of actors within activity systems, I have been able to use activity theory in an original way and offer some contribution to the ongoing debate.

My methodological approach allowed me to remain rooted in practice, although the inductive nature of the research limits the generalisability of my findings. However, all research has limitations. It needs to be reiterated that this study represents insider research and, as such, consideration needs to be given by the reader as to the extent to which this influenced the research process and the understandings generated. While I have aimed to be transparent in my decision making, the ethnographic and iterative nature of the research process means that much will remain hidden, perhaps even to me. There are specific limitations to the data collection. In particular, I was unable to interview as full a range of participants as I would have liked due to practical constraints. Therefore, I may not have been able to fully represent the department in the research, especially the junior doctors, general managers and support staff. I was also limited to a single department in the study, with just glimpses of how this reached out into the wider organisation or institution. An alternative approach to data collection may have overcome this. A more detailed ethnography would have allowed more time to be spent with more members. However, I continued to work as a practitioner during my research and the time required for full immersion in the field would not have been practical. A survey based approach would have similarly allowed access to a greater variety of participants, but is unlikely to have allowed for the iterative nature of data collection I found so helpful. All research involves choices, and I aim for this research to be read and interpreted with the choices I made in mind, in keeping with my interpretive epistemology.

### **8.3 Implications for policy, research and practice**

I began this thesis by critiquing expressions of organisational culture in NHS policy. Therefore, I would like to consider the effects my research findings might have on policy; government policy, local healthcare provider policy and educational policy; as well as on professional practice. The NHS has lately undergone several prominent policy changes and the recent publication of the Francis report (Francis, 2013) is likely to lead to more. While Francis quite rightly recognises the complexity of the NHS and the need to address culture at all levels, an integration perspective is apparent throughout the report in the

language used, the values espoused and the recommendations made. This study, in line with the position advocated by Martin (1992), would suggest that organisational culture needs to be considered more deeply than this in order to offer a wider range of insights.

I would, therefore, recommend that future policy makers recognise that the imposition of consensus is not the ultimate aim of a 'new and improved' NHS culture. Culture cannot be manipulated in a linear and predictable way through creation of the right process or system from the top down. Rather, policy should focus on how organisations can be supported to recognise and work through issues of subcultural power and to probe contradictory and dynamic systems of meaning making. At a government level, this will include a more detailed analysis of the effects of central targets on local healthcare providers, recognising that these targets are reworked locally in ways that often produce unexpected and unintended results. At a local healthcare provider level, this will include more direct support for practitioners with dual roles, allowing them to engage with these roles and make use of the contradictions the duality generates to drive transformative change. Organisational leadership needs to acknowledge differences rather than try to smooth over them. Successful change appears to happen when practitioners are given time and means to engage with organisational challenges at the boundary and rework them collectively. However, organisations also need to recognise that traditional patterns of work and professional power may prove a barrier to change and take steps to challenge this. At an educational policy level, I would argue that students and practitioners at all levels should be encouraged to engage with a critique of NHS culture. Cultural change is dependent on all within the complex cultural system, as activity systems simultaneously influence and are influenced by cultural change. A sociocultural view of learning emphasises the importance of context and community and this study would suggest that cultural change occurs through 'knowing in practice'. Being a practitioner in the contemporary NHS calls for more than the acquisition of clinical knowledge and skill. It is time for educational policy makers to engage with the debate on organisational culture within the healthcare system and consider their role in it.

The study suggests implications for professional practice for clinicians at all levels. Clinical leaders will have a vital role in the balance between authority and collaboration and should be encouraged to disrupt and question traditional rules and hierarchies through their own practice in positions of authority. They should support the asking of difficult questions from staff and facilitate the learning that can occur from the contradictions caused by these. I would encourage senior clinicians to promote and foster innovation amongst junior staff, even if this takes them away from traditional roles or does not have clear end points or outcomes. They also need to make more use of their own dual roles, without feeling the need to sit in one camp or the other, as these offer the greatest opportunity to reach across boundaries. Senior clinicians are ideally placed to mediate the effects of political interferences in the activity system and need to have greater recognition of how staff rework and redefine externally imposed motivations. Without this understanding, unexpected outcomes can occur. On the clinical front line, professionals need to reflect on the importance that learning about their own role has on the service provided to their patients. Recognition of professional hierarchies and traditional patterns of working, and the effect these can have on patient care, is vital. In modern, complex NHS organisations traditional, role based learning is not enough to function effectively as a professional. Practitioners need to arm themselves with contextual 'know who' as well as 'know how' in order to deliver quality care. In order to learn cultural change, practitioners need to practice, question, challenge and reflect, rather than be told or taught. Cultural change happens from the bottom up as well as from the top down, and practitioners play a key role in this.

To guide practice further there is a need for additional research in a number of key areas. Firstly, the ability of this study to generalise is limited as its main purpose has been to refine a conceptual framework for the study of organisational learning and cultural change. Therefore, the application of this framework to further case studies will be helpful. In particular, I would have liked to explore the links between the organisational collective and the institutional collective in more detail to understand how individual actors move between roles in these and how institutional culture shapes and is shaped by

local practice. More 'outsider' research will have great benefit here as there are significant implications to research of this nature being carried out in institutional settings. I also feel that there is a need to explore power within the networks of activity in more detail, to further understand processes that support or inhibit cultural change. As a feminist researcher, one obvious self critique is that I have failed to explore power and hierarchy as gendered. A re-exploration of power relations as relations between mostly male medical professionals and mostly female midwives would have offered an alternative analysis. Finally, one of the key messages of the Francis report, and indeed much of the policy literature of the last 20 years, has been that patients should be at the heart of the NHS. Expanding this conceptual framework to include exploration of patient experience would be possible and would provide exciting further avenues for understanding cultural change in the wider system.

On a personal note, the findings of this study will have implications for my own practice as a clinician, a healthcare leader and an educator. I am continuously striving to improve my own clinical practice and the service I work in. As my understandings of the NHS and its culture have changed through this thesis, so has the way in which I approach the care of patients in the organisation I work in. I can begin to see myself as someone with diverse roles, learning at the boundary and making a difference to the wider collective through my personal practice. However, I am more open to the possibility of ambiguity as well as consensus around that practice. As an educational supervisor for trainee doctors, I have been able to offer them new insights into their role and responsibilities and encourage reflection on how their practice and learning impacts on the wider system. Recognition of the impact and challenges of initiatives developed from the bottom up has allowed me, as a leader, to encourage wider involvement in service improvement and accept and promote differences and conflicts as productive rather than destructive. I am increasingly aware of the power dynamics in the system I am part of, and more empowered to challenge those through my practice and influence.

I aim to disseminate this study in both professional and policy making arenas, as well as for academic peer review. Firstly, by submitting this thesis for

presentation at local and national leadership and development conferences, such as that organised by the King's Fund ([www.kingsfund.org.uk/eventskingsfund-annual-conference-2013](http://www.kingsfund.org.uk/eventskingsfund-annual-conference-2013)). In this way, I hope to offer clinical leaders interested in culture change an alternative way of thinking about the issues. Secondly, I plan to submit my reconceptualisation of organisational culture and learning, and my research findings, for publication in clinical and medical education journals. In this way, I hope to reach a broader range of professionals working in healthcare and medical education, who form the community of the activity system. Finally, by offering my rethinking of activity theory for publication in academic sociocultural journals, I hope to be able to contribute to the current debates in activity theory as a framework for developmental work research.

#### **8.4 Conclusions**

The trouble with culture in the 21<sup>st</sup> century NHS shows no sign of diminishing, despite countless policies and mandates to affect cultural change. While the dominant discourse in NHS cultural research and policy is one of managerialism, the focus of cultural change strategies will continue to be new structures, processes and targets. However, a reconceptualisation of organisational cultural change as a process of transformative learning, with individuals and collectives engaging with culture through practice, allows for a rethinking of how change occurs. Culture is no longer seen only as consensus, but can also encompass inconsistency, ambiguity and dissent in varying degrees. There is recognition that boundaries are fluid and changing and that tension can be both productive and obstructive as individuals and collectives interpret and negotiate motivations and contradictions. The journey is not one way and has no end, as changes in culture are taken up by the system and used again to mediate further activity. A rethinking of organisational culture change strategies is then necessitated, and it is this challenge which waits to be taken up by today's NHS.



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## APPENDICES

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### APPENDIX 1

#### Interview schedule

Interviewee role..... Date:.....

Intro to study

Purpose

Check consent

(Post obs interviews: I came along to ..... Can you tell me about that event?)

Tell me about your current role

What's it like working at XXX?

What have you learnt about the organisation while you've been here?

Tell me about an improvement project you have been involved in

- Experience
- Background
- Results
- Contradictions
- Key players
- Learnin

## APPENDIX 2

### Observation matrix

	Activity system	Voices	Historicity	Contradictions	Transformation
Who learns?					
What do they learn?					
Why do they learn?					
How do they learn?					



## APPENDIX 3

### Worked examples of data analysis: L&S event

	Activity system	Voices	Historicity	Contradictions	Transformation
<b>Who learns?</b>	Seating along professional lines (D)	Different groups present: SHOs, regs, one consultant only (Priya, teacher), midwives Ask different questions – different priorities Sometimes come together (F)	New event created from background of SUIs	Midwives called out by matron – pressures of work. Uncomfortable atmosphere (D) Priya expresses disappointment to matron – leads to disagreement in front of audience (D)	Negative transformation when midwives asked to leave – disruptive to group learning, altercation between Priya and matron around importance of event(F)
<b>What do they learn?</b>	Learning about shared roles in working towards transformative change (I) Reinforcement of differences in roles through discussion (F)	Different learning priorities for different groups – Midwives r/o good, docs r/o bad (D) Unite about senior review (I/D) Presence of matron half way disruptive voice (F)	Learning from error – why mistakes were made in past Questioning of how mistakes happened (F)	Competing priorities in interpretation – sets groups at odds (D) “What do you expect in this place” – strikes out progress (F)	Learn how to use CTGs safely (I) Focus on patient safety bringing groups back together (I)
<b>Why do they learn?</b>	Interacting systems – patient safety shared object of activity(I)	Dominant voice of doctors at start and after midwives left (D)	Focus on past errors leads to defensive behaviour from some individuals (F)	Contradiction between need to improve and defend past actions (F)	Move away from task oriented to goal oriented behaviour – expressed shared understanding (I)
<b>How do they learn?</b>	Intermediate objects of activity – learning about elements of CTGs, through this create shared object (I)	Midwives less vocal ?feel able to speak up (D) Assertion of regs – excusing of past behaviour (F) Discussion between docs ?different perceptions between groups (D) Priya dominant voice(D)	Dismissal of IT systems, let down by past failures, sense that nothing will help (F)	Discussion allowing space to voice uncertainty (I) Breakfast allows informality (I) Odds between what said and what seen (F)	Creation of shared object led to common ground and way to move forward (I) Encouragement by Priya to get groups thinking and working together (I)

I = integration D = differentiation F = fragmentation

**Participant interview  
Consultant O&G 'Priya'**

LE	So what I wanted to try and find out about today was a bit more about the learning events you organised and your experiences of those. As you know I came along to observe one a few weeks ago. I wondered if we could talk a little bit more about those?	
I	So those that were focused on learning and sharing?	
LE	Yes	
I	Yes...so you know this idea just came up...so...as part of my project looking at quality and safety of patients. And so...errrr...apart from my project which was aimed at risk, by the time we got the machine I thought it's not going to make much improvement. It takes staff as well.	Practitioner developed idea, learning from practice within system CONTEXT
LE	Yes	
I	And...errr...with the background it was more an urgent agenda.	
LE	Yeah	
I	Erm...I didn't feel, you know, it was just the idea came up and then I felt, to carry on, and that risk was very...I expressed this to my other colleagues, who had similar ideas, and we...everybody was very, very happy to do that, especially the other consultants and a few interested people. So 4 of us sat there and we decided how we were going to do it, and that's why it was launched. We decided the timings, the days, and what...who was going to teach, what topics we were going to be discussing.	Develops idea through discussion with colleagues Collective practice Power dynamics – consultant input deciding factor COLLECTIVE RELATIONSHIPS & POWER
LE	Yeah	
I	So it was launched on [date]. Erm, basically what I thought is we...because for me it is a new idea, erm, I didn't actually, we just planned it. The setting, the place, the biggest constraint is the hospital timing, you know,	
LE	Yeah	
I	And for the teaching to take place the biggest constraint is that people who knew they had to try and take it, and, erm, you know, we have a very busy unit, they hardly have time, you know there were loads of constraints...2 sites, people on call, people who were unable to attend. And the bigger the things we have the more this happens, yeah, that's one thing. And the second thing is, we expressed the idea to our other colleagues, where, you know substantive posts, and trainees and midwives, and everybody encouraged the idea but when we said we were going to have this daily teaching session and expect people to attend, the initial fear, or the initial reluctance people had, that they expressed it as difficulty with coming in the morning. And afternoon, even after 5 was all the more difficult.	Constraints as influencing factors Collective Power dynamics – rules and divisions of labour, unchangeable nature COLLECTIVE RELATIONSHIPS & POWER
LE	Yeah	
I	Erm, and second thing, having a dedicated time, whether to make it mandatory or, erm, just people if they want to come along for the	Acceptance that mandatory not

	<p>morning time. Then we couldn't make it mandatory of course, that's a huge organisation, and you have to have the time, and that's not possible.</p>	<p>possible, not done thing  Collective – power dynamics – traditional rules and practices  Collective – structure – constraint  <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b></p>
LE	Yeah	
I	<p>And we had...we decided to have a multidisciplinary format, you know not just the obstetricians attending it. And to have...huh...to get all the different categories of people attending it was difficult because...Erm, anyway, we start off and half of them...we had some supporters but we had a few, erm, where they didn't stay and it wasn't sure whether we could continue or not. But we had a few. So we started off and all 4 dedicated presenters thought well we have time so we'll start off and see how it goes. And so we sent out info to the trainees and well we didn't get much support from the senior level. Erm, they couldn't commit to having a dedicated time for the trainees. So, well everyone is already at work but we realised there were some issues with different patients in different areas...</p>	<p>Categorising staff by role – traditional power and identity  <b>SUBJECTIVITY</b></p> <p>Traditional work practices seen as constraint  <b>CONTRADICTIONS</b></p>
LE	Yeah	
I	<p>So...erm...so when we started, initially there was teething problems, people were not aware. Communication was a big...errr....a big...I did not have the midwives, all their emails. The support from, well, the [senior midwife], you're aware of that.</p>	<p>Subcultural differences in communication – set up as constraint  Collective – relationships and communication  <b>CONTRADICTIONS</b>  <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b></p>
LE	Hmmm	
I	<p>Not at all, nothing much at all. The session you came...it was one of the early ones and we decided we should look at CTGs as that is what goes wrong so much. We had doctors, we had midwives, everyone really enjoying it. I had brought breakfast and one of the HCAs made toast from the kitchen. Even though it was early morning everyone was happy to be there and, you know, like we were a team together, it wasn't that busy, patients could wait half an hour, nothing urgent. [Matron] knew it was on as I had told her and emailed like all the others and she agreed.</p>	<p>Staff together sharing common goal, informality  Collective – integration  <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b>  told her' – power of clinical role  Seek to achieve consensus, disappointment when not apparent  <b>CONTRADICTIONS</b></p>
LE	How did you feel when she came in and told the midwives they had	

	to leave?	
I	It's...like, well I understand if it's busy or if an emergency...or maybe if one or two have to leave and we do... But she didn't want anyone there with us and... <b>The midwives were so annoyed...angry...they said to me after they were enjoying it and learning relevant to work.</b> I think I feel that it is personal to me but I also know it <b>is personal to all doctors.</b>	Integration through shared dispute with matron <b>CONTRADICTIONS</b> Collective – power dynamics – prof identity and subcultural conflict and contradiction <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b>
LE	So what approach did you take after that session then, to address what had happened?	
I	<b>So I had to look into, look and ask people whether we could get the midwives away from the women.</b> So I emailed some others and I was looking for specific info on details of midwives and to drum up interest and suddenly, you know I got one and I took that as a send off and then, you know people started responding and we had a good response from midwives. And then the trainees were new, you know, from [date] they all started attending. I feel very pleased with the response. So...erm...even though there were constraints with the timing, you know, the venue we thought well staff could come and have their breakfast but people were so keen they didn't bother about that, you know. We just had to get people interested and then if enough want to come it happens.	Fighting back against power dynamics Collective – structure – need for physical presence of staff <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b>
LE	Yeah	
I	So they started coming, and they started coming and people were looking at it...erm...they weren't sure but then it was really successful and it went on after the first week and people said...But some of the seniors started saying "oh it's not sustainable, and you can't do it every day" and all these kinds of comments because it's multidisciplinary and all people can't come every day.	
LE	Yeah	
I	Erm...and then we thought we'll make it available, it's only 30 minutes and unless we do that then it's difficult. <b>So we'll start off with 3 days and the morning session and, err, and we'll start with the cases we already have and the incidents reported and the SUIs, cases and go from there.</b> So we had a good response with them and after that we had a lot of volunteers wanting to come and teach in the sessions. We were still helping people find topics. <b>And some of my colleagues were saying they couldn't do it unless they were being paid or it was in their job plan, so that needed to change and they needed an extra SPA. The others were happy, so we continued with people who were happy to contribute.</b>	Evolving learning about what works and doesn't Object evolving as collective learns and works <b>COLLECTIVE RELATIONSHIPS &amp; POWER</b> Setting up contradiction within AS between staff – those in support and those not – fragmentation <b>CONTRADICTIONS</b>
LE	Yeah	

I	And initially it was, you know, very well structured, one to two days for patient safety, one day for cancer, one day for trainees and one day for consultants, you know a consultant teaching session. But because of maternity's unique situation, the timings and working with different sites, the on calls, the rota issues...was not sorted out, I couldn't continue with the teaching session which was more dedicated to trainees, to their needs and to the higher level formal teaching	
LE	Yeah	
I	So while it was planned to have a teaching session along with a learning and sharing session over the whole team, because of these constraints the trainees spoke to us and said for their teaching they wanted picking a topic and doing it formally, with experts and a screen, and this isn't what happened.	Defaulting to traditional 'learning' – classroom based and didactic Subcultural – novelty of shared learning contrasts with prof understandings of learning <b>CONTRADICTIONS</b>
LE	Such a shame	
I	And I then tried with available spaces as well but I couldn't get any support, or anything at all, from the in charge people as well, the in charge people internally.	
LE	So are you still doing it or have you stopped it now?	
I	Oh yeah, yeah, so we just continued. We were like, ok fine...so I just did it, I continued like, ok fine, 3 days, then I decided if I was going to do, you know it depends on the capacity and the knowledge as to how we are going to do it as well. So I dedicated, after discussing with different people, then I got the quality and safety manager doing it, she as well, she was very happy to do regularly Thursdays. She brings some cases and she has a systematic way of looking at the notes, starting from, you know, the documentation when they come in, the communication, the team working and the outcome...errr...something form every level, from the midwives, the trainees, the consultants and other multidisciplinary input and complete the outcome of the patient and their experience and complaints and claims and things. She'll make the whole journey.	Contradiction – challenging shared conception of colleagues results in activity which mediates object <b>CONTRADICTIONS</b> Innovative way of working and learning, encouraging integration and collective practice and learning <b>COLLECTIVE RELATIONSHIPS</b>
LE	And how are people taking that? How are the people who attend taking that?	
I	Oh that one...well because she's the quality and safety manager she doesn't blame anybody	
LE	Yeah	
I	She doesn't reveal people's identity. She's more coming from the care, patient's care and how it should be more...are we following the standards, that kind of way. She just goes through it the usual standard way. She uses we, we rather than this person, that person, blaming each other. She's very open and people know it and they ...you know we always have a house full. That room can only hold about 10, Thursdays we still have 20 or more than 20, 15	Integration around standards – little room for contradiction? <b>CONTRADICTIONS</b>

	to 20 people attending	
LE	Oh wow, that's really good	
I	So far the sessions are a dedicated session and she is also a dedicated person, she does her homework and she talks and she goes through it with them...erm...so I don't have any issue with Thursdays. <b>And on Fridays the CNST manager is very happy with me,</b> and the quality and safety manager as well, she has now taken that day. So she's dedicated, she's trying to achieve, we're on CNST level 1 and we have to go to CNST level 2	Personal achievement Subjectivity – developing roles – shaped by the process of contradiction <b>SUBJECTIVITY</b>
LE	Yeah	
I	So now she wants to talk about the standards to the trainees and the midwives, how to take us to that level. They think this is a good platform and they sometimes, well they need something every week and so she's taken one day for that. So I don't have any problem on those 2 days.	
LE	And how are the trainees and the midwives taking that, learning about that sort of thing? Are they receptive to that?	
I	There's a lot...they... <b>I haven't collected a formal feedback because it's still in a learning, you know it's still in a growing stage, because you know there were some teething problems, but I'm getting the verbal feedback from them and this is what they say. It's very, very different what they've learned. It's helping them to improve their changes and talk openly about it and they've, er, it's also improving the way they're documenting and remembering, they don't need this kind of, er, they are self aware and they have started doing that well.</b> And I can see the juniors, when I work with them, if I tell them this is the way it has to be done I can see they know why they have to do it and they are all falling in line. <b>The midwives, though, that has been the biggest area where I've had the huge positive response from them.</b> Nobody else has taken the initiative, err, calling them, teaching them, keeping up to date. <b>It's a combined them, developing the relationship between them and us.</b> Some days it's difficult to come in the early morning and, but they do try, and again with the constraints it's because of their rota and on call. But when they attend it's really useful, and especially in particular the sessions with the speakers.	Midwives also developing through the achievement Subjectivity – developing roles <b>DIVISIONS LABOUR</b>  Contrast with development of midwives Midwives develop, juniors learn to be like her 'fall in line' Subjectivity – developing roles <b>COLLECTIVE RELATIONSHIPS</b> Integrated team working, shared learning and impacts on wider work practices Collective – power dynamics – prof identities
LE	Yeah	
I	And now they say they have a good working understanding and that relationship is there when they work in teams there's a good understanding there.	
LE	Brilliant. And can I also ask you about some of your, kind of, other experiences of working towards change, so thinking about things like your consultant meetings, business meetings and things like that. So your experiences of working towards change in the department. What's that been like?	

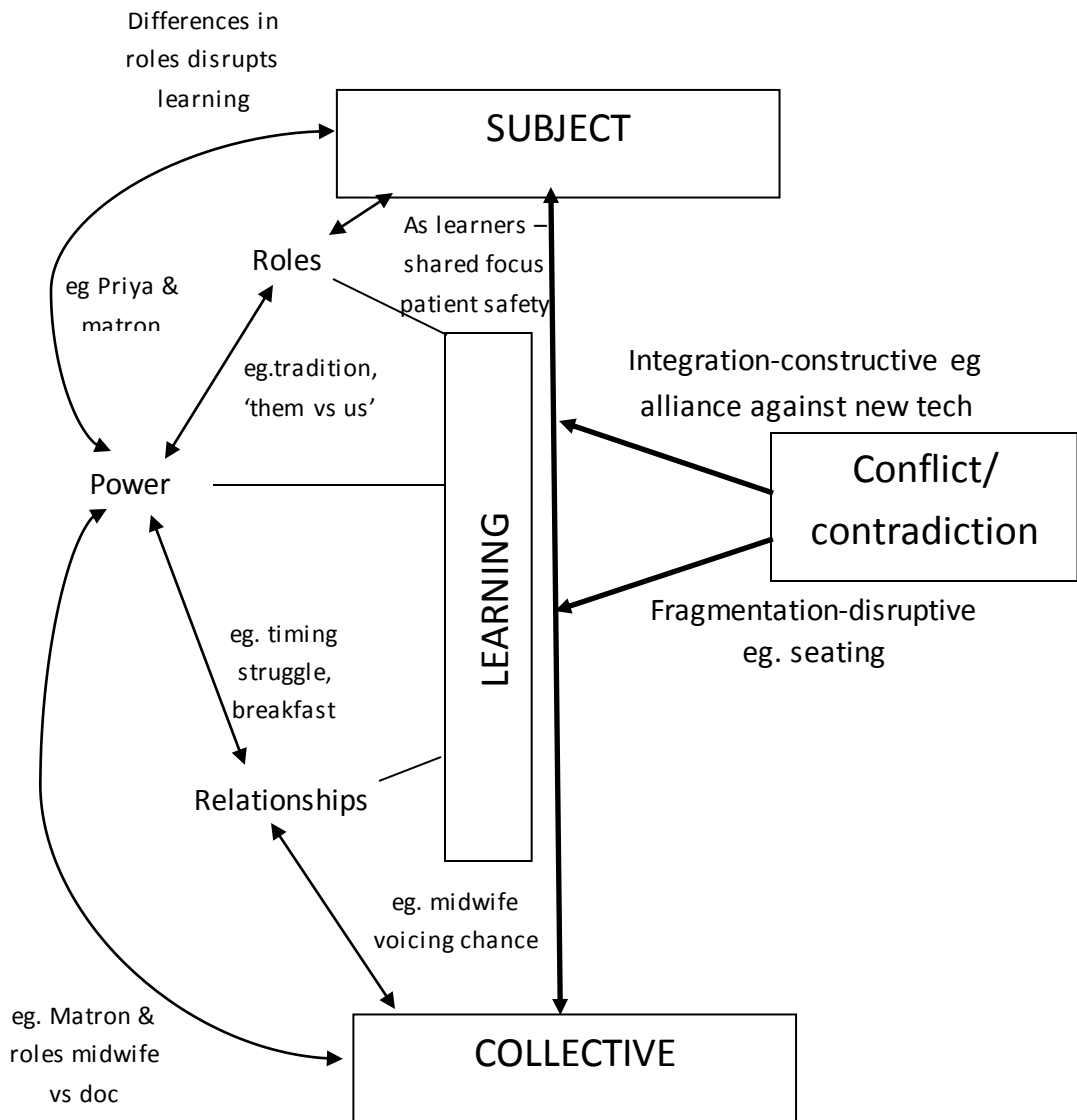
I	So this is also something where I expect people to come in...it's mainly patient safety and quality. The tension there has been it's because they are being asked to look into their...err....usual practice and how things come about. As usual it depends on, you know, people say...I never blame people there, it's how we communicate and how we say how can we make it better. When I interact with people I'm careful and I'm seeing how their attitude is and I observe how people are working together. They have their own agendas, especially my consultants, my colleagues, they have their own egos...err	Learning through contradiction – expressed as uncomfortable for people – conflict as a developing force for the self and the team <b>CONTRADICTIONS</b>
L	Yeah	
I	Two days ago we had this situation where we wanted good teamwork and we had hugely complicated cases around and each one didn't want to listen to each other and, you know, the attitude was different, the behaviour was different and a few of them, you know, it can affect the whole team	Conflict leading to change in practice – differentiation and fragmentation Learning from conflict and contradiction <b>CONTRADICTIONS</b>
LE	Yeah	
I	I think it's mainly, you know they think they are right and others, err, nobody, you know they have to follow what they say whether it's right or wrong and they don't like to be questioned. That is the biggest constraint and it's still existing.	Fragmentation as standard practice Collective – power dynamics – traditional roles <b>COLLECTIVE RELATIONSHIPS</b>
LE	And when you say it affects the whole team, do you mean midwives and, and other staff as well as doctors?	
I	Yeah, like we had the other day...initially you know we are all fire fighting, all busy, you know we don't want other people to come and tell us...but you know because my project was positive and more beneficial to them they were more positive to me. But if it's not beneficial or, like, to one colleague then she demands they have to change the way they are working, demands more time and work from them. So they became more defensive and they consider that what she says is not going to work and we don't believe in that and all kind of negative responses.	Intrusion of 'telling' as learning in busy practice Friction and conflict – how she sees colleagues approach compared with hers. <b>CONTRADICTIONS</b> Effect on collective relationships? Contrast with expressions of falling in line earlier Collective – subjective – role development <b>COLLECTIVE RELATIONSHIPS</b>
LE	Yeah	
I	But it kind of works as a team, for example elective sections that are complicated ones, you need midwives, you need theatre staff, you need anaesthetists, obstetricians to work together...and we had a cardiac patient as well, so...the...cardiologist input. But I saw that, that day, everything fell apart and they, it was chaos and	Fragmentation effect of busy work <b>CONTRADICTIONS</b>

	emotions went up and up, they couldn't get...errr...oh my god everyone got really upset. But it's previously happened and they bring in the leadership thing and...well the person who behaved like that is a person who has come in for that, was enrolled in the programme, but not fully, just partially...and when they come, they aren't fully part of the sessions they haven't understood how to...conduct, how to...it's a completely different thing for those of us who do the full thing...	
LE	Yeah	
I	And I thought sometimes it's difficult but you have to change people's personalities	
LE	So you think personality plays a part? You think it's a personality clash?	
I	Oh for sure. They're huge, the personalities are huge	
LE	So do you think personality is stopping the department learning and changing?	
I	Yeah definitely. It's not only stopping...erm...it's also affects other people to challenge them, question them. Especially if you have them in a substantive post. You know I witnessed that 3 days ago and I can't believe, you know even I couldn't open my mouth and say anything. But you know that one was more reactive, it could just be reactive...	Effect on subjectivities on collective and shared practice <b>SUBJECTIVITY</b>
LE	And do you, do you think that's...erm...one individuals personality or do you think that's something about the wider culture of the department? Or both?	
I	Erm...normally when there's no challenges or...erm...when it's in the acute situation people are behaving differently. Because the same person when I speak to them, when there's nothing, it seems they are normal	
LE	Yeah	
I	But when they are stressed, in the acute situation, then really they have to bring on their full character, you know, then you can feel the full personality being exerted there, the total opposite. But you know it's not just one person, I feel there's quite a few people from every level	
LE	Do you think anything positive ever comes out of that sort of contradiction and clashing? Does any positive change happen?	
I	Yeah because...in between those things, because I was , I was involved in this [change development programme] and, err, the clinical director was also involved and we were having similar, ok, we were able to understand what's the problem, what is happening there and...errr...we really tried to get the other person to talk and what had upset them and I was open and I was trying to understand and I said, yes but does it work, for that moment you're showing a stern face and it plays with people's emotions and you want a team work, you don't want at that time just the work being done	Work to develop improvement from contradiction <b>CONTRADICTIONS</b>
LE	Yeah	



I	<p>Erm...I think...you know, I think it doesn't work in this one, I think you need to keep talking and building up the relationship . But I realised that myself and the CD at that moment, we came in to help the situation ...I volunteered and he was called as the CD and we had help from the management and we went and spoke to the people and gently calmed the situation. And you know I have no idea if it will work, but again I'm talking about team working and it depends on the other people. What I realised was, the programme that we did, it was more focussed to us and we were never ever...so we had teaching and stuff how we were going to take it to the department , to the other team members and staff , how are we going to...that was not formalised or structured. You know [change development programme] it was our personal choice, it was not an active choice of anyone there.</p>	<p>Seeing herself in a leadership role  <b>SUBJECTIVITY</b>  Hierarchical – CD, management  Collective – power dynamics – managerial importance &amp; prof identities  ?influence of me?  <b>COLLECTIVE RELATIONSHIPS</b></p>
LE	<p>I mean do you think there's anything in the trust that addresses that as a team? Or do you think it's all very individual?</p>	
I	<p>I think, you know, you have a group, a small pocket of people going through this programme, the [change development programme], and you have the senior most people there. They have to have achieved these targets, the CQC targets and made all these changes...although the people going have to make the actual changes, the organised team is another group of people as well as managers at a Trust level. You could see that once the people were settling and new people replacing the old ones, they formed themselves into a team and they worked as a team and had good understanding. And then from us here we were able to bring in a bit of change. But the vast majority of staff they were not aware of what was going on and how to bring in changes so they couldn't work as a team. Erm...I don't know because as I was reflecting on it I think it has to continue but who's going to take that initiative I don't know. It probably has to be the Clinical directors.</p>	<p>Imposition of political processes into system and the effect on practice and object  Conflict – contradiction as shaping force  <b>CONTRADICTIONS</b>  Activity system    Fragmentation – project groups and rest of staff  <b>COLLECTIVE RELATIONSHIPS</b></p>
LE	<p>Watch this space! Thanks very much for talking to me</p>	

**'Mind Map' of coding links made during analysis**



## APPENDIX 4

### Exemption from NHS Research Ethics Committee Approval

Thank you for your email and summary seeking clarity on whether your project should be classified as research requiring ethical review. As you will be aware, the new harmonised UK-wide edition of the [Governance Arrangements for Research Ethics Committees \(GfREC\)](#) came into effect on 01 September 2011; detailed changes in the harmonised GfREC can be found [here](#) on the NRES website.

There two key elements are whether:

- i. your project is research? (The leaflet, "[Defining Research](#)", will help you to distinguish between research, audit or service evaluation and public health surveillance.) OR
- ii. your project is research requiring ethical review? The algorithm, "[Does my project require review by a Research Ethics Committee?](#)", is designed to assist researchers, sponsors and R&D offices in determining whether a project requires ethical review by a Research Ethics Committee under the UK Health Departments. It encompasses the requirements for ethical review under both the policy of the UK Health Departments and legislation applying to the UK as a whole, or to particular countries of the UK.

The **Supplementary notes** section, in particular, outlines the types of research that do not normally require review by a REC within the UK Health Departments' Research Ethics Service.

#### *Advisor's Comments:*

Research involving staff does not require REC review.

However, if you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may also be available from the clinical governance office.

Where the Research Governance Framework for Health and Social Care applies, the research will continue to require management permission from host care organisations ("R&D approval"). Within the Integrated Research Application System ([IRAS](#)), it is possible to indicate in the Filter that a research project requires review by NHS R&D only. Where a project raises potential ethical concerns, NHS organisations may require ethical review and, exceptionally, NRES would be willing to undertake this review. For student research, most universities will require such a review as part of their normal institutional processes.

All types of study involving human participants should, however, be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. Also, in processing identifiable data there are legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation.

This response should not be interpreted as giving a form of ethical approval or any endorsement to your project, but it may be provided to a journal or other body as evidence that ethical approval is not a requirement.

Regards  
NRES Queries Line  
REF 04/50

# ORGANISATIONAL CULTURE AND ORGANISATIONAL LEARNING IN HEALTHCARE



## RESEARCH PROJECT TAKING PLACE

Luci Etheridge will be in maternity from November 2012  
observing the team at work.

Please see the study information sheet or email  
[lucitheridge@gmail.com](mailto:lucitheridge@gmail.com) for more details, including  
how you will be asked to take part.

## STUDY INFORMATION SHEET

### ORGANISATIONAL CULTURE AND LEARNING IN HEALTHCARE

Luci Etheridge

#### **Why are you doing this study?**

I am doing this study as part of my doctorate in medical education. I am hoping to explore how organisational culture and learning are linked in the NHS and the impacts of learning on culture change.

#### **What will I have to do?**

This is a qualitative study, which means I am interested in people; their lives, work and thoughts. I will be conducting interviews one- on-one with some people and observing some team processes.

#### **Who will be asked to take part?**

Everyone working in maternity will be asked to take part. Particularly when I am observing the team at work, I could be observing anyone. This includes nurses, midwives, doctors, administrative staff and managers. Individual people may also be invited to take part in interviews.

#### **What happens to the information you get?**

I will be taking written notes and tape recording interviews. I will never use anyone's real name or detailed job title in either my written notes or on tape. For interviews I will use pseudonyms and will not identify job titles in any way.

All information I get will be stored securely, in line with the Data Protection Act. The information will be used to produce the thesis for my research and may be used later for presentations or publications, but neither the Trust nor individuals in it will be identified by name.

This research is NOT being done for the Trust, its Board or management, and I will not share data from the study with them in any way. It is an academic research project only. The only way anyone in the Trust, including you, will be able to read it is if it is published. Although I will never be able to guarantee that you can't be recognised in a written publication, especially by people you know well, I will do everything possible to ensure confidentiality.

#### **What do I do if I don't want to be involved?**

It is absolutely fine to say you don't want to be involved in the study. You don't have to give a reason and there will be no penalty. You will still see me around collecting data, for example at meetings, but if you identify yourself to me I will not include anything that involves you directly, even if this means that I collect no information at all on that occasion. I will always announce my presence so you know I am there.

**What do I do if I have any questions?**

I am happy to answer any questions at all about how I am collecting data and what it will involve for you, or address any concerns you have about how it will be used. Feel free to talk to me in person or email me at [lucitheridge@gmail.com](mailto:lucitheridge@gmail.com).

I won't be able to discuss my own thoughts on the theories of organisational culture and learning or what I think about the data I have, as this would affect the study and other people's confidentiality.

**Do you have ethical approval for this study?**

Ethical approval has been given by the Institute of Education research ethics committee.

**What are the benefits and risks for me?**

There is no direct benefit for you from taking part. There are no direct risks to you from taking part. If however you feel you may be at risk in any way then please let me know straight away.

**Can I change my mind once I have agreed to take part?**

You can withdraw from the study at ANY point by contacting me on the email address on this sheet. There will be no penalty, you do not have to give me a reason and I will destroy all data I have on you.

Luci Etheridge

[lucitheridge@gmail.com](mailto:lucitheridge@gmail.com)

**CONSENT FORM: INTERVIEW**

**ORGANISATIONAL CULTURE AND ORGANISATIONAL LEARNING IN HEALTHCARE**

**PRINCIPAL INVESTIGATOR: Dr Luci Etheridge**

I understand that by taking part in this study I agree to:

- My interview being audio recorded and transcribed, using a pseudonym
- My interview data and my contact details being stored securely
- My anonymised interview data being used in the preparation of a formal report for the Institute of Education, for publication in peer reviewed journals and for presentation at conferences

I understand that I am free to withdraw at any time by informing the principal investigator, I do not have to give a reason for this and there will be no penalty.

**Signed:**

Participant..... date.....

Investigator..... date.....

1 x copy for participant

1 x copy for investigator