Inclusion and Exclusion in the NHS:
Power, Innovation and Rejection in Nursing

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This thesis is dedicated to my parents Eric and Marjorie Musson who have always helped and encouraged me throughout my journeys.

Abstract

In this thesis, I investigate my professional practice as an independent health adviser in the UK National Health Service. Inclusion and exclusion, power, innovation and rejection in nursing are themes that have emerged from my work within a milieu where the dominant discourse is systems thinking. I have analysed why systems thinking predominates in UK healthcare services, and examine the benefits and limitations of this approach. Similarly, I have studied complex responsive processes theory and assessed the value and drawbacks of this way of thinking.

A key focus of this research has been to consider how innovation occurs in organisations. NHS policymakers include examples of good practice in a number of recent policy documents and encourage staff to emulate these examples to improve their services. This overlooks the unique setting in which staff work, and disregards their collective working styles and roles. Power relationships, local ideological perspectives, histories and pertinent environmental factors all render the adoption of established blueprints inadvisable. Nor do such policy documents consider potential unintended consequences of the innovation: for example, reducing the waiting times to access treatment in one area can have a detrimental effect on other services.

Using narrative accounts from my professional practice, I critically evaluate the concepts of power, innovation and systems thinking. I draw attention to a number of particular dissonances that I consider many nurses and health care workers to be experiencing as rejection within their work-based relationships. These challenges include a fear of job loss, the difficulty of managing national targets and local service delivery, a loss of consumer confidence in clinicians, the pressures of increased regulation, and tensions between clinical and managerial staff. These concerns led me to examine the nature of the employer–employee relationship.

The psychological contract is a way of describing the relationship between employers and employees in terms of optimistic reciprocal agreements and expectations. These positive assumptions tend to underplay or overlook the unpredictability of organisational life, such as financial constraints that might threaten job security. When disruption arises, employees may feel wary of their managers and distressed that their psychological contract has been violated. I argue that trust is a concept requiring continual renegotiation

through the ongoing patterning of relationships that emerge through the conversations between people as employees participate in the organisation's development.

My thesis departs from the traditional view of positing the psychological contract as a central feature of employment. Instead, I propose that the complex responsive processes perspective offers a legitimate and useful way of deepening our understanding of employer–employee relations.

I have used a reflexive research method, challenging Alvesson and Skoldberg's (2000, p. 250) reflexive interpretation framework for its individualistic approach. I demonstrate that my method is social and iterative, and extend the framework in order to illustrate the way in which I developed my reflexive approach. This framework presents a way of demonstrating the movement of interpretation based on the researchers' judgment and intuition that guides the research process (Alvesson and Skoldberg, 2000).

My original contribution to practice offers a different way of looking at healthcare organisations from that proposed by many healthcare consultants. I engage with staff to analyse their day-to-day relationships by reflecting on their micro-interactions with colleagues as we try to make sense of what is happening in their departments. I introduce the notion of interdependence, and encourage clients to engage in dialogue and seek to influence what occurs through their relationships with their colleagues. There is no blueprint for success: rather than focusing on supposed 'organisational systems', we concentrate on what is actually happening in their ongoing work relationships.

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CHAPTER 1
Synopsis

Introduction

This synopsis provides a précis of my four projects and reflects on the main themes examined by my thesis, *Inclusion and Exclusion in the NHS: Power, Innovation and Rejection in Nursing*. Here, I describe the work and conclude with my findings and contributions to theory and practice. The subsequent four chapters contain the four projects that were submitted over a three-year period.

I will describe how I chose the narratives as examples of the types of scenario that I encountered in my work.[1] I have reflected on these narratives as a way of conceptualising the dynamics that underpin organisational life and as a means of making sense of my work. Given the evolving nature of the enquiry, rather than attempting to prove or disprove a particular research hypothesis through in-depth analysis, I have undertaken a broad examination of the literature within the themes that have emerged from my professional practice. I have included a section on systems thinking to provide a more in-depth analysis of the context of the National Health Service in which my narratives are based.

I also describe my research method and propose a contribution to research theory. Later, I describe the notion of the psychological contract in relation to a complex responsive process way of thinking, and put forward a further contribution to theory. Finally, I propose that my work also represents an original contribution to professional practice.

A Brief Synopsis of Projects 1-4

In my first project, I describe the influences and experiences that had made an impression on my working life in organisations. I recognise the concept of power in my day-to-day relationships with my line managers, and observe how this influenced my behaviours. The second theme that emerges is associated with the creation of novelty. In my experience of the NHS, systems and processes are perceived to underpin every organisation. I question how, as a healthcare adviser, I can facilitate the emergence of

[1] To preserve anonymity, the names of individuals, departments and organisations have been replaced with fictitious names throughout this thesis.

novelty in an environment where unpredictable futures are not tolerated and management consultants are brought in to “fix it”.

In my second project, I examine what happens to the balance of creativity and control in a highly structured environment. This is considered in the context of my membership of a newly formed associate group called Giselle who are asked by a client to work with a well-established and eminent organisation that I identified as Queensborough (QB). The assignment involves creating a programme for nurse and allied health professional consultants. As the relationships between the client and the two consultancy groups increases in complexity, the different ideological stances that emerge become a feature of my ongoing work. I notice how my associate group underrate our clinical expertise, and I explore the notions of inclusion/exclusion and power, challenging my views on the nature of creativity.

My research in the third project focuses on the emergent question: How can I help clients make meaning of the conflict and power relationships that exist as part of human interaction, so that novelty and change can occur? I describe the conflict that arose during the first day of consultancy work in a children’s unit, and examine the diverse ideological perspectives of the various professional groups that influence staff behaviours. This provides the foundations for the theme rejection as I engage with a group of Senior Sisters whose Manager perceives their management practice to be ineffectual. I describe how the Senior Sisters’ efforts to avoid conflict results in institutionalised patterns of working. They had attempted to preserve a harmonious working milieu within an aggressive and antagonistic environment within which managers strive to create order through setting and measuring targets. I also study the concept of power and reflect on the potential conflict between my role as an experienced children’s nurse and my position as a healthcare adviser. Finally, I consider the use of action learning sets as a medium to reflect on the conflict and power relationships that underpin the day-to-day workings of the unit.

In the fourth project, I build on the theme of rejection in the context of involuntary workplace separation (redundancy). I pose the following research question: In making sense of my own experience of redundancy, how can I help others in similar situations “move on”? As a consultant, how do I support those at risk of redundancy who work in organisations where managers, primarily influenced by a systems way of thinking, make

others redundant? As I explore my experience of redundancy, I examine the prevailing redundancy literature concerning the impact of, and response to, individual job loss. I analyse my narrative from both systems thinking and complex responsive processes perspectives. I advise managers that poor HR practice might result in staff feeling like the victims of bullying, and provide examples of good practice. I highlight the implications for managers and policy-makers in the NHS, who lose loyal and committed employees because there was no formal way of redeploying staff at risk of redundancy.

In the next section, I will describe the Doctorate in Management (DMan.) programme and then describe my research approach in detail, using a reflexive interpretative framework to explain how my research projects unfolded.

Research Methodology

Introduction

As part of the research method of the DMan programme, I attended five residential programmes, involving a large group of peers and faculty members. I also participated in a learning set, which met nine times, and have written four projects. I wrote about work-based narratives, chosen because I found the incidents complex and confusing. I wanted to reflect on my work and understand my professional practice, while making sense of the experience within the wider traditions of thought. My assumptions and beliefs were regularly challenged as I shared my iterations with my learning set colleagues and supervisors within agreed timescales. This social, reflexive approach has enabled me to continually analyse my projects within a myriad of conversations with my co-researchers and through my engagement with the literature.

On one occasion, I received conflicting advice from my first and second supervisors that I could resolve only by considering their comments in light of my own insights and intuitive response. I then delineated the themes and insights that felt congruent with my personal experience. This has been an interdependent process encompassing complex responsive processes thinking, which implies a social and iterative approach to research, as the emerging themes were influenced by conversations with my supervisors and learning set colleagues. I have found the programme demanding, especially participating in the five large-group residential meetings and engaging with new literature and ways of thinking.

I recognised that the themes of power and conflict that emerged from my narratives are also reflected in my experience of the research method. The supervisors are perceived to have power, although the interdependency between my supervisors and myself ebbed and flowed. Their role is to challenge my interpretations and engagement with the literature, to examine my assumptions and writing style, in guiding me towards doctoral level. Equally, my achievements contribute to the continuing success of the programme. Sharing iterations with my learning set and supervisors has sometimes involved conflict, which has been fundamental in exploring difference and stimulating the movement of my thinking.

In the next section I will discuss quantitative and qualitative management research, examine a brief overview of management research, general research methods and design, and then critique the method used for my DMan studies. I conclude with a section on the generalisability and trustworthiness of my research approach.

Quantitative and Qualitative Research Perspectives

Historically, the social science approach to research was based on the positivistic paradigm used in the natural sciences. It was argued that social scientists could adopt the role of observers and remain distant when conducting their research, so that values and bias did not distort their objective views. Thus, logical reasoning is employed to analyse the data using objectivity, precision and rigour, with little regard for the subjective state of the individual.

Some social scientists argued against positivism (Collis and Hussey, 2003), contending that physical sciences dealt with objects that are outside of us, whereas social science cannot be unaffected by the process of research. They argued that it was not possible to separate what was being investigated from the investigator, as social scientists dealt with ‘action and behaviour which are generated from within the human mind’ (Collis and Hussey, 2003, p. 53). It was assumed therefore that social reality is ‘within’ us, and therefore the act of investigating reality has an effect on that reality. The phenomenological paradigm, developed from criticism of the detached observer approach of the quantitative paradigm, is concerned with understanding human behaviour from the participant’s own frame of reference. The researcher draws on a variety of methods in an endeavour to make sense of, or interpret, the phenomena being studied, acknowledging

and working with the subjective nature of human activity. I analyse the paradoxical nature of detached involvement further in the Research Method section.

In order to explicate my research method, I will begin this section by providing a brief critique of the prevailing management research methods. I will then consider the broader methodological context comparing quantitative and qualitative approaches to research, and the implications of researcher involvement and detachment. The Doctor of Management (DMan) programme endorses 'taking experience seriously' (University of Hertfordshire, 2004, p. 3) and, given this research focus, a qualitative research method was indicated to enable me to critique and scrutinise my professional practice within an academic context.

I had been drawn to the doctoral programme both by my interest in complex responsive processes and by the opportunity to develop theory out of a rigorous scrutiny of my own professional practice. I used a narrative inquiry to start the iterative, social and temporal approach indicated by complex responsive processes thinking.

A Brief Overview of Management Research

In locating my inquiry in the broader research canon, I begin by considering the prevailing management research, founded in a positivist approach drawn from the methods of the natural sciences. Managers often claim that researchers work in ivory towers far removed from practice and are often not relevant to the everyday work environment (Gill and Johnson, 2002; Maylor and Blackmon, 2005; Van de Ven and Johnson, 2006).

Gill and Johnson (2002) argue that:

> Research may be classified according to the broad approach taken to the problem. Such classifications are often placed on a continuum of increasing rigor; from laboratory experiments to what may be termed as field research using ethnographic methods built on single cases.
>
> (Ibid, p. 10)

They particularly challenge management researchers, whom they describe as an 'influential body of writers who all apparently believe that science is basically a way of

producing and validating knowledge which can be applied to managerial problems without too much difficulty' (ibid, p. 8). They echo the prevailing view that management research is rarely put into practice in organisational settings and that researchers are hence detached from the managers with whom it is assumed they are addressing their work.

Johnson and Duberley (2000, p. 45) argue that 'the focus of research from a positivist perspective is upon that which can easily be measured … and subjective aspects of a phenomenon are either ignored or considered to be mediating variables which explain any unexpected variance'. In adopting an iterative, social and reflexive approach, which I describe later in this section, measurement is not significant; as the researcher and subject, I am key to my research method and the focus of my research. By adopting a social and narrative inquiry, my theoretical understanding is consistently challenged in the context of organisational life.

Bryman (1989) argues that 'much organisational research exhibits the trappings of what is often taken to be a scientific approach to research – the emphasis on causes, variables, experiments, measurement and so on' (ibid, p. 5). He goes on to assert that 'quantitative research is claimed to be infused with positivism, an approach to the study of people which commends the application of the scientific method' (ibid, p. 6). According to Bryman (1989) and Maylor and Blackmon (2005), this positivist approach, based on scientific method or principles, is currently the primary method used in management research.

However, Collis and Hussey (2003) describe qualitative research as useful to management researchers in certain contexts, arguing that 'qualitative research is more subjective in nature and involves examining and reflecting on perceptions in order to gain an understanding of social and human activities' (ibid, p. 13). As my inquiry will show, my research evolved within the context of social and human activities and was constantly scrutinised within the context of both my professional life and my research community.

Denzin and Lincoln (2005) describe how qualitative research

> …involves the studied use and collection of a variety of empirical materials – case study; personal experience; introspection; life story; interviews; artefacts; cultural texts and productions; observational, historical, interactional, and visual

> texts – that describe routine and problematic moments and meanings in individuals' lives. Accordingly, qualitative researchers deploy a wide range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand.
>
> (ibid, p. 3)

Similarly, Miles and Huberman (1994, p. 5) argue that 'qualitative data, with their emphasis on people's "lived experience", are fundamentally well suited for locating the meanings people place on the events, processes, and structures of their lives'. Bryman (1989) highlights the importance of interpretation and context, pointing to the strong links between the researcher and the organisation. This is allied with researching my professional practice, whereby I am providing a body of narratives that may resonate with other practitioners. Hence, a qualitative methodology was apposite. Before detailing my own approach, I will briefly compare quantitative and qualitative approaches to research.

Table 1. Quantitative and qualitative approaches to research (adapted from Bryman and Bell, 2003, p. 302).

Quantitative	**Qualitative**
Numbers	Words
Point of view of researcher	Point of view of participants
Researcher distant	Researcher close
Theory testing	Theory emergent
Static	Process
Structured	Unstructured
Generalisation	Contextual understanding
Hard, reliable data	Rich, deep data
Macro	Micro
Behaviour	Meaning
Artificial settings	Natural settings

Although Table 1 is only a brief overview, it provides a useful distinction and framework to illuminate my choice of research method. My main reason for choosing this doctoral

programme was to provide me with the opportunity to rigorously examine my work. The approach that I have taken focuses on a qualitative paradigm of Table 1, where the researcher is part of what is researched. Thus, I intended throughout to be close to the research, which took place within my daily professional practice. Throughout, I engaged with participants analysing micro-interactions and engaging with the narratives in an iterative manner to provide rich deep accounts from which theory emerged and my own professional practice evolved.

Hence, a qualitative, theory-building research method was strongly indicated. As I continued to iterate my narratives, new themes have emerged, informing professional practice, which has been reflexively affected by my inquiry. Hence, through a number of iterations, scrutinised by fellow researchers, research themes continued to evolve; and there has been a continuous reflexive engagement where research and professional practice conjoin.

Research Method and Design

As already indicated, I chose this programme in order to research my own professional practice within organisational life. Given my growing understanding of complex responsive processes thinking, I was becoming increasingly aware of the importance of examining micro-interactions in order to elucidate how my research themes evolved. I chose to focus on my experience as a healthcare adviser through reflexive narrative inquiry.

Bryman (1989) describes five approaches to research; some contain aspects similar to my method, while others are very different. Nevertheless, they provide a landscape within which I can start to locate my own research method. These include experimental research, surveys, participative observation, unstructured and semi-structured interviews, and case studies.

Experimental research approaches organised research using the scientific method. It is usually underpinned by the researcher's hypothesis, and can be used to make strong claims about causality. In this approach, the researcher stands outside the research process and must adhere to rigorous standards of objective reporting, designed to overcome potential bias. This is an approach that has been used commonly in management research. According to Bryman (1989, p. 72), 'much organisational research

based on experiments can be construed as either laboratory or field experimentation'. Field experiments are conducted in real organisations and are often termed 'quasi-experiments'; this is because researchers are unable to fulfil all the requirements of an experimental study since, for example, they are unable to control the environment within an organisation as they would in a laboratory.

Surveys (including longitudinal survey design) where data is collected either by structured interview or by questionnaire are usually associated with a quantitative approach. Unlike in experimental research, the researcher does not intervene in the organisation but collects data on a number of variables, usually at the same point in time; the causal relationships are analysed, and form the basis for research outcomes. Further examination of the respondents takes the research into a longitudinal study. This approach focuses on a particular phenomenon of study where the researcher analyses data from the periphery of organisational life.

Neither of these quantitative approaches was apposite to my research as, through studying organisational life, I intended my inquiry to evolve from rigorous examination of my professional practice. As discussed, I had chosen a practice-based, professional doctorate. I was not an academic conducting a trial to prove or disprove a hypothesis, but a practitioner-researcher interested in elucidating theory from scrutinising day-to-day organisational life.

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The following three approaches identified by Bryman (1989) are situated in a qualitative research paradigm. They differ from a quantitative approach in that they are concerned with the priority given to the perspective of those being studied, rather than the prior concerns of the researcher. Emphasis is on individuals' interpretations of their context, environment and behaviours and stresses the subjective aspects of human activity by focusing on the meaning, rather than the measurement, of social phenomena (Collis and Hussey 2003). The paradigm encompasses many methods and approaches; Denzin and Lincoln (2005) refer to the term as a 'complex, interconnected family of terms, concepts and assumptions' (ibid, p. 2). They offer a generic definition: 'Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible' (ibid, p. 3). These phenomenological methodologies embrace many approaches such as participant observation, unstructured interviewing, semi-structured interviewing, action research, and case studies.

Indeed, a distinguishing assumption of qualitative research is theory that is considered to emerge from practice (Alvesson and Skoldberg, 2000; Bryman and Bell, 2003), unlike theoretically driven quantitative research. I would challenge this as somewhat of an oversimplification, given my interest in complex responsive processes thinking. However, my research is focused on developing new theory within an organisational context, thereby militating against the issue of the distance between management research and implementation in an organisational context (MacLean et al, 2002; Van de Ven and Johnson, 2006).

In participant observation, 'the researcher is fully involved in the participants and the phenomena being researched. The aim is to provide the means of obtaining a detailed understanding of values, motives and practices of those being observed' (Collis and Hussey, 2003, p. 171). Observational researchers traditionally have attempted to see events through the eyes of the people being studied. According to Angrosino (2005), this usually involves three procedures of increasing levels of specificity. The first level includes a broad descriptive observational approach, where the researcher attempts to eliminate all preconceptions and large amounts of data are gathered. The second level includes more focused data collection, which concentrates on material that is relevant to the inquiry; and the third level involves selective observation, where there is a greater focus on a specific area identified in the previous observations. A grid is then designed to enable the researcher to record the observations and analyse the data.

In unstructured interviewing, the aim is to elicit respondents' perceptions (Silverman, 2000, p. 35). To reduce researcher bias, the investigator 'will not design specific questions in advance, but encourage the participant to discuss various topics' (Collis and Hussey, 2003 p. 178). In semi-structured interviewing, the researcher has an interview schedule but 'recognises that departures will occur if interesting themes arise from what the respondents say' (Bryman, 1989, p. 147).

In the qualitative approaches examined above, the researcher using participative observation is usually a member of the organisation, but in interview-based studies is less likely to be employed. However, a combination of researcher as employee and independent researchers to obtain data might be used. These methods aim to understand the perspective of the participants rather than the researcher. This is different from my approach, as I focused on understanding the perspectives of both the researcher and the

participants as I researched every day organisational life and my professional practice. I examined organisations from a local perspective and from my experience within an organisational setting.

In participant observation, access may be a problem and 'reactivity may occur, implying that subjects' behaviour may be affected by the observer's presence' (Bryman, 1989, p. 145). Denzin and Lincoln (2005) argue that the effects of the observer's presence can never be erased. I was not working in organisations as a researcher *per se*, but as a practitioner-researcher who wrote retrospective narratives analysing my professional work. In this way my research differs fundamentally from a participant-observational approach, as the research focused on my own professional practice, which took account of and analysed my presence within the organisational setting in which I was working. Equally, interviews would have provided me with others' perspectives of their professional lives, whereas my approach allowed the scrutiny of micro-interactions between the client and myself.

Another qualitative approach is the case study method. A case study is defined by the interest in the individual case rather than the methods used (Stake, 2005), as there may be a number of quantitative and/or qualitative methods used to study the case. Case study research involves the detailed examination of one or more of a small number of cases. A case is usually a site, such as an organisation or a department within an organisation, and can sometimes be a person. The method used to collect data in a case study includes documentary analysis, interviews and observations (Stake, 2005; Collis and Hussey, 2003).

Stake (2005) argues that, in being reflective, the researcher is committed to ponder on his or her impressions as 'local meanings are important, fore-shadowed meanings are important, and readers' consequential meanings are important' (ibid, p. 450). There are similarities to case studies in my approach with regard to the importance of reflexivity, as I examined my narratives and considered the historical background, the environment and contexts such as the economic, political and aesthetic. However, a case study approach is based on examining the 'case', which has specific boundaries, and a 'unit of analysis' is agreed that 'involves gathering detailed information about the unit of analysis, often over a long period of time, with a view to obtaining in-depth knowledge' (Collis and Hussey, 2003, p. 68).

A research method that Bryman (1989) does not consider is action research. As my professional practice/research was enacted and developed within organisations, I discussed my research with colleagues, clients and fellow researchers; thus the research was co-created and others were engaged, to a greater or lesser extent, with my research process. Hence, it could be argued that I used an approach closer to action research, which I will now briefly consider.

Reason and Bradbury (2001) describes action research as researching one's own professional practice in order to improve both one's own and that of others. He also advocates this approach as emergent, worthwhile, and done both with and in collaboration with others. Though there are some fundamental differences, which I will discuss later, there are also similarities with the way in which I have researched my own professional practice.

Bryman (1989) argues that 'action research is an approach to social science research in which the action researcher and a client collaborate in the diagnosis of and solution for a problem' (ibid, p. 178). Reason and Bradbury (2001) argues that it 'seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people' (ibid, p. 1). There appear to be a number of different schools of action research that include cooperative inquiry, action science and action inquiry, appreciative inquiry, participative action research, and whole systems inquiry. Although the basic process might be approached in different ways, it is generally thought to involve a spiral of self-reflective cycles of the following:

- Planning a change
- Acting and observing the process and consequence of the change
- Reflecting on the processes
- Re-planning
- Acting and observing again
- Reflecting again, and so on…

(Kemmis and McTaggart, 2005, p. 563)

In reality, according to Kemmis and McTaggart (2005), the process is more likely to be 'open and fluid than is depicted in this list leading to a strong and authentic sense of

development in their practices, their understanding of their practices, and the situations in which they practice' (ibid, p. 563). Again, there are similarities to the approach that I have taken, in that the method is reflexive and social. However, my approach differs in that there is no predetermined cycle and 'emergent exploration does not prescribe how specific techniques can be used to engineer and improve this quality of knowing' (Parsley, 2004, p. 167). It also differs from action research in that – given the evolving nature of my inquiry – I cannot promise that it will be worthwhile, although I may hope for it to be so.

As I engaged with my narrative approach, I deepened my inquiry as I wrote about my everyday experience and then inquired more deeply into how I make sense of this. Although I have participated in a learning group where my work has been discussed, it was from these discussions that the themes from my enquiries emerged. I did not start by planning a change, agreeing to take any specific action in my working life and then reflecting on it.

In this section, I have reviewed a number of research designs and methods and described why I have not taken these approaches. In the next section, I will detail how I have chosen to research my professional practice.

My Research Method

The literature describing the DMan programme states that 'The research is undertaken from the perspective of a practitioner who takes his or her experience seriously and fundamentally questions ways of thinking in practice' (University of Hertfordshire, 2004, p. 3). Prior to the interview for the DMan programme, prospective participants are asked to write a reflective piece about an experience; this set the scene for the methodological approach for the whole programme. I had chosen the programme as it was a professional practice-based doctorate, which encouraged me to rigorously research and make sense of my work, which was based on four projects derived from several narratives.

According to Chase (2005), a narrative is a way of organising and understanding events and seeing the consequences of actions and behaviours over time by communicating the narrator's viewpoint, including why the narrative has been chosen. My narratives were descriptions of incidents, selected because of their impact on my thinking and way of working. Each of the narratives examined powerful experiences that I wished to explore

in greater depth. The qualities of these experiences, which made them significant, includes the intense emotional responses I experience when working with the QB group in Project 2, which leads me to examine the sphere of ideology. During the business meeting I describe in Project 3, I feel a strong avoidant reaction to the overt conflict that I witness. This led to a further inquiry into power relationships and conflict. In Project 4, I write about the way that I, and others, was treated as I study aspects of redundancy.

As each project was written, it was shared with my learning set and supervisors, with consistent feedback. Thus, an emergent, iterative, reflexive process was fundamental to my research. As I iteratively engaged with research colleagues, their research and relevant literature, new themes evolved that affected the narratives. Hence, this social reflective method is a rigorous research method in which I detail and critique my experiences, while being challenged by others in the research community. Each narrative was considered in the context of relevant prevailing literature and, as I reflected on my writing, I unpacked the impact of past experiences and assumptions and my social context; hence, the research method is both reflective and reflexive.

Through this narrative inquiry approach, I have used a descriptive account to describe an experience, using storytelling as the research medium. Referring to storytelling as a means of describing a case study, Stake (2005) asks, 'is the purpose to convey the storyteller's perception or to develop the researchers' perception of the case?' (ibid, p. 450). The fundamental difference between case studies and my approach relates to the paradoxical position of detached involvement. I am both storyteller and researcher, because I am researching my professional practice using a narrative approach. Therefore, my research reflects the subjective choices I make about what is studied:

> It follows that the research method is subjective, or rather, a paradox of *detached-involvement*. The term 'involvement' refers to the inevitable emotion that is aroused in the experience of interacting with others… Clearly, such thinking cannot qualify as research. However, if we can never completely avoid involvement it follows that it is impossible for any of us to achieve fully detached thinking about the action of engaging with others… By detached thinking, we mean purely rational thinking as is supposed by the classical, positivist scientific method.
>
> (Stacey and Griffin, 2005, p. 9).

Hence, the research is not undertaken in isolation, but as a participative social process. Throughout the iterative process, the choices and sense that I make are continually challenged by my co-researchers, and sometimes by other colleagues, as I am compelled to justify the perspectives that I have taken.

According to Chase (2005, p. 656), 'narrative is retrospective meaning making – the shaping or ordering of past experiences', and is a way of understanding one's own and others' actions. It includes expressing emotions, thoughts and interpretations. Through narrative inquiry, the narrator's voice is emphasised, and attention is drawn to the styles of communication and the context of the narrative from which the researcher speaks (Gubrium and Holstein, 2002).

Rather than the researcher focusing on the accuracy of the narrator's statement, he or she highlights the versions of self, reality and experience that the storyteller produces through the telling (Chase, 2005, p. 657). Therefore, through the use of narrative inquiry, the researcher develops theory from his or her material, whilst reflexively engaging with the work of others. Thus, through their research, researchers are enabled and constrained by the social resources and circumstances of their disciplines (Chase, 2005). This history and culture is explored and reflected upon in depth as part of the sense-making process. It also enables the researcher to engage with patterns that emerge through the examination of similarities and differences across narratives.

Through writing and rewriting the narratives, I considered differing themes and struggled with the implications of contradictory theories. In sharing many iterations of each project and constantly responding to the analysis of my work within my research community, my research developed and theory emerged. These dialogues stimulated a more rigorous and intense focus on the micro-interactions that took place, 'because it is in these that wider organizational patterns emerge' (Stacey and Griffin, 2005, p. 24).

This is underpinned by a complex responsive processes view of organisations, which 'invites us to stay in the movement of communicating, learning and organising' (Shaw, 2002, p. 20) within which patterns of behaviours emerge. As I wrote my synopsis, I re-engaged with the four projects and wrote a reflective piece at the end of each assignment, describing the connections, themes and movement in my thinking. This led to a new

cycle of reflexive research that enhanced my understanding of my original contribution. I also noticed how emerging themes continue to affect my professional practice.

As each theme evolved, I became more aware of and commented upon issues such as inclusion and exclusion, power, ideology, innovation and rejection, especially in relation to the employee–employer relationship. Thus, as I examined and reflected on my perceptions 'in order to gain an understanding of human and social activities' (Collis and Hussey, 2003, p. 13), the reflective process became part of my professional practice rather than an isolated theory that I attempted to relate to my work.

A Complex Responsive Processes Approach to Research

Complex responsive process thinking points towards a reflexive, iterative and social method. Given that I argue that an organisation is an evolving pattern of relations between people that emerges in local interaction, then no one is designing or controlling the patterns. This then leads to the importance of examining micro-interactions in order to evolve theory. In particular, the narratives allowed intense, social scrutiny and analysis of experiences significant to my evolving theory and professional practice.

There were an agreed number of projects, which had to be completed, and an iterative approach was required. We agreed time deadlines for work to be shared with my research community. Given the basis in complexity, the research was acknowledged to be emergent. My work evolved as I interacted with the challenges from my research colleagues and refined my understanding of my professional practice.

I will now describe how I adopted a reflexive approach to my research and elucidate the reflexive, iterative and social nature of my method.

Reflexive Methodology

Mason (1996) proposes that qualitative research should involve critical self-scrutiny by the researcher, which he describes as active reflexivity. Hence, the researcher should review his or her actions and 'their role in the research process' (ibid, p. 6). Whilst writing each of my projects, I scrutinised my work regularly in conversation with learning set colleagues and a wider research community at five residential meetings. I also discussed my work with clients and work colleagues, ensuring an in-depth critique of my context and conclusions.

Stacey and Griffin (2005) argue that there 'is no dualism between the individual and the social – both are aspects of the same phenomenon, namely human interdependence' (ibid, p. 10). Hence, in using a reflexive method, I am overtly exploring my assumptions and ideologies as I elucidate the meaning that I am making from the narrative inquiry. As part of my research process, I scrutinise my behaviours, preconceived ideas and examine my assumptions. My supervisor and learning set colleagues challenge my assumptions through the iterative process, causing me to reconsider more deeply my biases, prejudices and interpretations.

According to Alvesson and Skoldberg (2000), reflection means:

> …thinking about the conditions for what one is doing, investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched, often in ways difficult to become conscious of.
>
> (ibid, p. 245)

They note that researchers sometimes use the terms 'reflective' and 'reflexive' synonymously. They define *reflexive* as 'a particular, specified version of reflective research, involving reflection at several levels or directed at several themes' (ibid, p. 5). They emphasise the breadth and variety in reflexive work and argue that 'The whole idea of reflexivity, as we see it, is the very ability to break away from a frame of reference and to look at what it is *not* capable of saying' (ibid, p. 246). Their definition connects with the reflexive approach that I have utilised throughout my research. I will discuss these connections in the next section.

Cunliffe (2003) argues:

> Reflexive ethnographers suggest that the social world is not an object to be discovered and represented by dispassionate objective researchers, rather researchers actively constitute reality as we study it – we are constructing what we think an organisation is.
>
> (ibid, p. 993)

As a practitioner-researcher, I have used my experience to develop an original contribution to both theory and professional practice. Reflexivity has been an important

aspect of my research method and I have built upon Alvesson and Skoldberg's reflexive interpretation framework as part of the iterative process, which has included reflection and discourse with my research community. They claim that their framework is particularly useful 'for drawing attention to, and mediating between, various core dimensions of reflection, for initiating acts of reflection and maintaining movement between reflective themes' (2000, p. 250). This resonated with my approach, although I will highlight some differences as I have explicated their work through a temporal, iterative engagement with the framework as depicted in Table 2.

The first two columns are taken from the Levels of Interpretation table in Alvesson and Skoldberg, 2000 (p. 250). The first column shows the four levels or aspects of interpretation that they believe to be key to the reflexive process. They suggest that reflexivity arises when the different elements or levels are played off against each other; 'It is in these relations and in the interfaces that reflexivity occurs' (ibid, p. 249). They are emphasising that there is no hierarchy between the aspects/levels, nor any suggestion that one is more important than another: reflexivity might occur at all levels, both together and separately.

The second column outlines the focus of the aspects/levels described in the first column. I have added a third column to show the theoretical differences when adopting a social and iterative dimension when considered through a complex responsive processes approach. In the fourth column, I illuminate the framework, providing examples of my reflexive inquiry in Project 4.

Table 2. Levels of interpretation (Alvesson and Skoldberg, 2000, p. 250).

Aspect/level	*Focus*	*Considered through a complex responsive process approach*	*Development of Project 4 examples*
Interaction with empirical material	Accounts in interviews, observations of situations and other empirical materials	A narrative account detailing micro-interactions exploring how my thinking and feelings were evolving	• Narrative of the meeting with the Directors of Nursing (DoN), shared with co-researchers
Interpretation	Underlying meanings	• Reflexive approach to research through socially explicating the thinking behind the narrative interpretation • Development of emerging themes • Scrutiny and challenge by research colleagues	• Analysed why the DoN roles were vulnerable • Explored my experience of redundancy and of making someone redundant in discussion with research colleagues • Making sense of systems thinking as the context within which managers make choices • Clarified thinking, ongoing reflexivity halted by deadlines, necessary within the constraints of a doctoral programme
Critical interpretation	Ideology, power, social reproduction	• Location and critical appraisal of thinking within the wider traditions of thought and seminal literature e.g. Lukes, 2005; Clegg, 1989) • Extrapolated evolving themes, and responsively analysing my interpretations through nine iterations with learning set and supervisors.	• Shared iterations with research colleagues; considered detailed responses • Developed thinking in response to the questioning of my assumptions and pointers to different literature e.g. psychological contract theory

		New themes emerged through this social reflexivity • Triangulating through peer review and critique with research colleagues • Iterative process • Challenge of critical interpretations and assumptions	• Interpreted the differing ideologies of the DoN and CEOs in relation to the wider management and psycho-social literature (Luzio-Lockett, 1995; Hannabuss, 1998; Elias, 1994) • Reviewed the impact of systems thinking and a complex responsive way of thinking. Elucidated creativity/destruction and the potential for innovation to result in redundancy. • Drew conclusions for my practice and, with research colleagues, formulated my own contribution to theory
Reflection on text production and language use	Own text, claims to authority, selectivity of voices represented in the text	• Examine impact of past experiences on self and others • Review of interpretations of micro-interactions of the narrative • Continuing engagement with research and work colleagues through their and my work, leading to a social scrutiny of written forms of research	• My research question continues to evolve within my research community • Through iterative writing I make sense of the value of my redundancy experience • Reflected on challenges, assumptions and interpretations from research colleagues whilst challenging their assumptions and interpretations • New theory evolving with research community and DoN colleagues

Alvesson and Skoldberg's (2000) model is not a sequential or static structure; rather, they present it as a way of demonstrating the movement of interpretation based on the researcher's judgment and intuition that guide the research process. Although they acknowledge that research networks affect the researcher's interpretations, they nevertheless present the process as fundamentally individualistic. I have adapted this, given my view of human beings as fundamentally interdependent. My method is social and iterative, and was conducted within a research community that scrutinised and challenged my assumptions and interpretations throughout. However, I would agree with Alvesson and Skoldberg that this is not a sequential process.

Through considering this framework from a complex responsive processes approach, I have built upon their work. In doing so, I have developed their method of reflection, and enhanced their argument that this is a dynamic construct. In adopting a reflexive approach to my narrative, I have challenged my assumptions and behaviours. Hence, by taking a reflexive approach new themes have evolved in both my professional practice and research. Throughout my inquiry, inclusion and exclusion, power and rejection have emerged as fundamental themes, key to the organisational incidents that I analyse. Understanding these day-to-day aspects of organisational life has affected my professional practice, leading to my encouragement of staff to articulate and reflect on what is going on their workplace, especially from the perspective of inclusion/exclusion, power and rejection.

In making sense of my professional practice and examining the management, social psychology and philosophical literature, I have explored the broader contexts behind the phenomena I was examining. 'Social reflexivity requires the narrator to explicitly locate his or her ways of thinking about the story being told in the traditions of thought of his or her society, differentiating between these traditions in a critically aware manner', (Stacey and Griffin, 2005, p. 23). Therefore, part of the approach to my research method has been to draw upon a broad range of literature to understand some of the wider traditions of thought whilst engaging with, and making sense of, my narrative.

It has been argued that this methodology does have some potential pitfalls, such as isolation and insufficient challenge to the author's reflections (Alvesson and Skoldberg, 2000). Finley argues that reflexivity should be 'neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting' (Finley, 1998, p. 445).

However, the five residential programmes built into the DMan syllabus, together with the nine learning set meetings, ensured scrutiny and challenged any potential for 'emoting' through a community of researchers, thus enhancing the rigour of my research.

In the next section, I will discuss the assessment of research quality. Mason (1996) suggests that research must meet the academic criteria of generalisability and validity, and must be conducted ethically. What follows is a discussion of these issues within the context of my research.

Generalisability and the Trustworthiness of My Research

Johnson and Duberley (2000, p. 53) maintain that assessing research through measurement, generalisability and validity derives from a particular view of research drawn from the natural sciences. They argue that 'validity' may not be an appropriate term, as it suggests a concern for acceptance within a positivist definition of research rigour. Instead, they point to the relationship between researcher and research subject as separate; this is fundamental to the positivist paradigm. This differs fundamentally from my approach, where I am both researcher and a subject of research.

Bryman (1989) challenges the way in which empirical data are examined, which are 'often not definitive because they are capable of more than one interpretation' (ibid, p. 62). Throughout my research, I have illuminated the myriad interpretations, rather than assuming one.

Given my research process, and examination of different ways of thinking about organisations, I approach my work differently. As I consider the nature of evidence and knowledge, I discuss how my work contributes to knowledge and practice. Collingwood (1992) asserts that any interpretation of a past happening is subjective and historical, since it involves the researcher's own time-bound frames of reference and values. I acknowledge that my research approach is subjective; in fact, it is in the elucidation of this subjectivity that I analyse the interpretations that I have made. From this reflexive analysis, I increase the understanding of my relationships, which form the basis of my research approach.

Stacey and Griffin (2005) point out that, if research arises from the researcher's reflection on his or her micro-interactions in organisations, 'it follows that the research method is subjective, or rather, a paradox of detached involvement' (ibid, p. 9). They argue that 'involvement' refers to the emotional response encountered during interactions with others, and that it is not possible to be fully detached during these interactions. Through reflecting on experience or narratives in a detached-involved way; questioning my behaviours and values; and consulting a wide body of literature, propositional themes emerge for further reflection.

My supervisors have assessed my work and through the iterative process; it will also be assessed by external and internal assessors, in the course of which I will be asked to account for my work. My research has been scrutinised and challenged by a community of researchers. A valid contribution to knowledge and professional practice requires us to take a consensus view of what truth and knowledge are, through reflecting and interacting with others. I am not applying my findings from the analysis of my narratives to a sample of the population; rather, through an iterative and social research method, I highlight patterns and linkages that may resonate with people working in other organisations.

Stake (2005) maintains that experiential knowledge can be conveyed through 'narratives and situational descriptions of cases, personal relationship and group interpretations'. (ibid, p. 454). He describes this as 'vicarious experience' that feeds parallel processes of awareness and understanding, which he calls 'naturalistic generalisations'. Thus, in resonating with others, my research offers 'naturalistic' generalisability.

As Cunliffe argues:

> Reflexive inquiry can offer valuable insights into organisational studies and practice by stimulating a critical exploration of how we constitute knowledge and enact our own practices as researchers. In doing so, it raises possibilities for different forms of inquiry and new ways of understanding experience.
>
> (Cunliffe, 2003, p. 999)

As my research emerges, my professional practice continues to evolve, impacting upon colleagues and clients. As my chapter was read (Stacey, 2007), it provided a platform for discussion with fellow NHS practitioners. In this way my work is sustainable, in that it

leads others to engage with, and consider some of the more subtle and ambiguous aspects of practice in the NHS.

Gill and Johnson (2002) claim that research can be usefully evaluated according to its purpose. Hence, research may focus on an issue that can be widely generalised theoretically, but where application may be difficult in practical organisational situations. Conversely, research may focus on professional practice in a specific setting, solving a local problem with little application to a broader field.

Cunliffe (2003) argues that reflexivity can stimulate diverse perspectives and uncover taken-for-granted practices, relationships and 'forgotten voices' (ibid, p. 1000). Although narratives are context-specific, they contain insights into organisational life that are often unspoken, such as anxiety, ambiguity and hesitation. These are insights into the feelings and experiences of people's working lives that may be valuable to others and could therefore be considered generalisable. This is an important issue in relation to my research. Through my narratives I am revealing complex themes such as inclusion, exclusion, power and the unpredictable side of innovation – which, with notable exceptions (Shaw, 2002; MacLean and MacIntosh, 2004; Weick, 2001), are rarely discussed in accounts of organisational life, although frequently discussed theoretically.

I am not claiming objective validity; my research constitutes a subjective reflection on my personal experience. However, it needs to make sense to others, be persuasive and resonate with others' experiences (Stacey and Griffin, 2005). The value of the DMan programme is to take the practitioner's experience seriously. This is why the iterative process, involving regular repeated assessments from the supervisor and learning set, is essential to validating the progression of thought by challenging individual perspectives and assessing the content within the framework of established philosophies. This is similar to the process of peer review of journal articles for validity and generalisability as a way of assessing the quality and legitimacy of the research prior to publication.

In a learning set discussion regarding this issue, our supervisor suggested that we could consider whether our research is relevant, sustainable and timely, as well as worthy of peer-based review and publication in order to substantiate our research. Given that this is a professional doctorate, it is more appropriate to scrutinise rigorously organisational life than to rely on a positivist approach. Throughout the programme, we, as students, are

required to take our experience seriously; hence, it is apposite to inquire into my professional practice, and important that my inquiry should be as relevant to a fellow NHS practitioner as it is to the academic community.

Through undertaking the DMan, I was introduced to qualitative reflexive research; reading my research colleagues' work affected the way I developed my professional practice. This was not my experience of reading or pursuing most positivist research. Qualitative research stimulated my awareness and facilitated my understanding; the stories of other practitioners resonated with my experiences and inspired me to research my own professional practice further. In reading quantitative research, I felt like an outsider looking on; as I was interested in the insider's perspective, I was motivated to research my own work, as it seemed more relevant to my professional practice. I was encouraged to engage with and practice qualitative reflexive research. Thus, by inspiring others to continue the research, it could be argued that the research continues and is therefore sustainable.

In summary, then, I propose that the general quality of my work can be verified as follows:

- I highlight patterns and linkages through reflection on my narrative that might resonate with people working in other organisations.
- I reflect on context-specific micro-interactions that contain insights into aspects of organisational life, such as anxiety and ambiguity, which are rarely discussed; these insights may be of value to others.
- The questioning of my work within a body of literature led to the emergence of propositional themes, which brought to light the need for further reflection.
- My work has been continually questioned and assessed by a community of researchers.

The main limitation of this approach is that my reflections might not resonate with others. Furthermore, the positivist approach to management research is often favoured by many management researchers who value the objectivist method of research and criticise the more expressive and emotional dimensions that are inherent in reviewing the complexities of organisational existence.

However, as I write about and research my professional practice, I am conscious of the theoretical, cultural and political context of my narratives. Through the iterative process, theoretical themes such as novelty, power and conflict evolved from my analysis of my professional practice. The reflective approach has increased my understanding of my experience. I have explored how my shift in understanding, through the reflective process, has an impact on how I work. This medium of questioning my assumptions and interpretations has brought energy and challenge to my progression through the DMan programme and to my professional practice.

In the following section I consider the themes that have emerged from my thesis overall.

Emergent themes from Projects 1–4

I will now describe the impact of my work on myself, theory, and my professional practice and elaborate upon how this has evolved over the past three years. In this synopsis, I will continue with the reflexive process, indicating how, in revisiting my projects, my thinking continues to develop.

As I explained in the Methodology Section, I chose the narratives because they represented complex issues that I wanted to analyse to inform my professional practice. I struggled with the amount of time and effort required for the repeated written iterations. Over time, I came to realise that I needed to respond to the criticisms of my colleagues and supervisors by reviewing my conclusions against complex responsive processes thinking, organisational theory and other theories related to my themes. The themes that evolved through my work include systems thinking and performance management, power and inclusion/exclusion and innovation.

I will outline various dissonances in the relationships between nurses, doctors and managers, and the potential for a strained relationship between policymakers, government and the local service providers from the earlier themes. I then draw together some of these perceived tensions within the themes of innovation, power and performance management from systems thinking. I examine the nature of the relationship between employer and employee in light of these concerns and examine the construct of the psychological contract. Finally, I go beyond the traditional psychological contract formula to provide an alternative view.

As I have reflected on my projects, I notice that I have been critical of systems thinking throughout. In the next section, I will examine why targets and performance management are the dominant discourse within the NHS. I then appraise the benefits of a systems perspective, and raise concerns about the disadvantages of this concept. Finally, I have undertaken an analysis of the potential contribution and limitations of complex responsive processes theory in the context of organisational life.

Targets and performance management

A system approach to management has been an ongoing theme throughout my projects. In this section, I will critique how targets and performance management might be understood within the social structures and underlying rationales of healthcare policy and practice. I will show how targets aim to improve specific services in quantifiable ways, which enable government ministers and senior managers to demonstrate accountability to the public. There is evidence that this approach has been successful in some areas, but it can have unintended consequences.

I analyse how targets and performance management are the dominant discourses familiar to NHS managers. This common understanding of the logical and rational approach to managing organisations is embedded in frequently taken-for-granted assumptions of management practice. I also analyse why systems and cybernetics predominate within the NHS because of the perceived inefficiencies and dominance of professional groups.

I position the differing views of targets and performance management within the paradigm of structure and agency, a key concept in social theory (Harrington, 2005). The central debate focuses on whether the action of individuals is the prime social phenomenon, or whether social structures are the more important aspect of social activity (Harrington 2005). ‘Structure’ is a term widely used by sociologists to denote a social configuration that is more than just a collection of individuals or groups (Lawson and Garrod, 2003). Although there are many variations of structuralism, they operate from the premise that there are underlying rationales that can be conceptualised as rules and ideas, which are autonomous of individuals and both influence and restrict individual action within society.

‘Agency’ refers to the action of human individuals or groups of individuals and ‘social theorists generally argue that social structure is reproduced by the actions of individuals through the mediation of rules, roles and other resources broadly referred to as “culture”’ (Harrington, 2005, p. 215). In this sense, structure refers to social ideals that are independent of the individual but nonetheless determine and constrain human action. Conversely, individuals and groups are capable of choosing alternative courses of action even though their choices are restricted and shaped in various ways by structural realities. As I will illustrate, some change models are more focused on individual agency, whether at a local or top-team perspective. In several models, individuals are seen as an aspect of

the process rather than authors of the approach taken. Other methods are more cognisant of the social nature of the organisational life and recognise that conflict might arise, as staff feel threatened by changes in power relationships.

This split between agency and structure is similar to the split between the individual and the group or system in psychological-sociological terms. In this way of thinking human 'interactions produce systems we call groups, organisations and cultures and societies and individuals are part of the systems they form', (Stacey 2003a p.5). I will argue that from a complex responsive processes perspective, there is no split between structure and agency, or the individual and the system, as organisational life is formed as individuals and groups communicate on a day-by-day basis.

In Project 4, I describe in detail the principles underpinning a systems way of thinking. Briefly, this means that an organisation is seen as a whole system, which can be divided into interconnecting subsystems. The characteristics include being driven by goals or objectives, which are perceived as a 'given' and not questioned by practitioners. These objectives are reviewed and scrutinised by an individual, who applies rules or controls to the systems and draws conclusions as to what needs to be accomplished. The outcomes are compared to pre-existing goals, and any discrepancies are seen as negative feedback, which then influences the next actions to be taken with the aim of reducing the discrepancy gap. Prompt comparisons between the objective and actual performance are executed, and rapid corrective action (if necessary) is undertaken.

Finally, in a cybernetic way of thinking there is the need to achieve stability and maintain equilibrium. This type of learning is known as single-loop learning, where problems arise when there are changes in the system, and the negative feedback process attempts to maintain appropriate patterns of behaviour.

There has been a movement in thinking from a cybernetic approach, which has become known as an interpretive systems approach and is frequently referred to as 'soft systems thinking' (Jackson, 2000, p. 211), based on the work of Checkland (1978). The principles of soft systems thinking include a focus on people, or agency, rather than the organisation of the system, reviewing process and skills, and with a concentration on perceptions, values beliefs and interests. People are seen as having free will rather than being a mechanistic component within the system.

The principles of modern cybernetics, or soft systems thinking, provide a framework for thinking about the development of individual and organisational learning to detect and correct errors in operating norms (Morgan 2006). ‘This type of questioning ability underpins the activities of systems that are able to learn and self-organise’ (ibid, p. 84), and is identified as double-loop learning. This way of thinking acknowledges the importance of relationships and the co-constructed realities in which agents act (Stacey, 2007).

However, the reliance on thinking about the organisation as a system remains. The boundaries now include the broader social and political dimensions to achieving performance targets. In this more participatory approach, managers observe the wider socio-political aspects of the system from the outside, in order to improve their understanding of the problem.

From a social structure perspective, the foundations for this way of thinking are found in Parsons’ (1967) structural account of social order linking power with authority and the pursuit of collective goals. Social order, in this case the provision of health services for the population, is outlined in healthcare policy. It is then conceptualised as rules and ideas, which theoretically and tangibly determine and constrain individual action within healthcare. Individual and groups of managers act as agents to reproduce healthcare policy in practice. So performance management targets can be understood as a collection of specific goals that are measurable and can be managed. This paradigm is reassuring to managers who are trying to run very complex organisations. By focusing on explicit targets, managers engage by focusing on specific tasks, whose outcomes they believe they can influence.

In terms of how performance management targets might be engaged with, Williams asserts that ‘leaders are the local advocates of macro policies as they are the energisers of processes of control designed to ensure that others enact behaviours that are consistent and compliant with respect to the wider policy orientation of their service’ (Williams, 2005, p. 146). NHS managers are expected to be the persuasive implementers of healthcare policy, which is sometimes unpopular with colleagues at a local level. They are also constrained by the threat of sanction, which is legitimised through the institutionalisation of the authority of government and through the monitoring of performance by agencies such as the Healthcare Commission.

March (2007) argues that agents find it natural to interpret their choice behaviours on a presumption of human purpose and have invented terminologies associated with values, needs, objectives, goals, aspiration and drives. Targets and performance management are understood to be a cybernetic approach to managing the NHS. In this context, the human agency and purpose, as proposed by March, is 'specific improvements to services and the way we do business' (Department of Health (DH), 2007, para 2.1). Therefore, targets and performance management are engaged with through specialist terminologies such as, for example, tariffs, access targets and commissioning. The lexis embodies specific meanings and currency that are shared by healthcare managers. For example, in the NHS *Operating Framework Guidance* (DH, 2008), the specific business and financial arrangements for the NHS are outlined.

It states that 'there are a number of goals we have set ourselves as a system, both in terms of specific improvements to services but also the way we do business' (ibid, p.1). This document goes beyond a set of rules as it also sets out ideals that enable and constrain the behaviours and ways of working of healthcare managers. It is not just a set of instructions, but provides edicts that influence social norms, within a highly political environment.

This is exemplified by March (2007) who proposes that our theories of choice are deeply embedded in our culture and are based on three interrelated ideas: the pre-existence of purpose, the necessity of consistency, and the primacy of rationality. Applying these ideas to UK healthcare, the *NHS Plan* (DH 2000) summarises the underpinning principles of UK health services and the need for the consistent provision, which are values that are deeply embedded in the mores of free and accessible public sector healthcare.

The third idea, the primacy of rationality, is 'a procedure for deciding what is correct behaviour by relating consequences systematically to objectives', (ibid, p. 340). This suggests that what can be measured can be managed. These are the operating norms, which, in the NHS, are ostensibly achieved through the setting of healthcare standards, which are then monitored and evaluated. The government is therefore using a cybernetic approach to managing the NHS through the Operating Framework guidance (2008). This 'top-down' initiative for change includes reporting mechanisms, external scrutiny and information collection systems.

From this paradigm managers aim to determine the most effective ways of working by designing the most efficient way of undertaking tasks, and then select and train the best person to undertake the job. The worker's performance is then monitored to ensure that appropriate procedures are followed and appropriate results achieved, (Morgan, 2006). This way of thinking is often ingrained in our way of thinking about organisations and the way in which we evaluate organisational practice. Morgan (2006) also draws attention to how understanding organisations as a rational, technical process underplays the human aspect of organisations, as the tasks facing organisations may be more complex, uncertain, and difficult than those that can be performed at a more mechanistic level.

A recent example of how managers are expected to engage with performance is illustrated in the Department of Health's tool kits to support the implementation of targets. The guidance aims to promote innovation in commissioning (NHS Institute for Innovation and Improvement, 2008). The process of assessing the viability of new ideas is aligned with seven dimensions of performance: effectiveness, efficiency, safety, timeliness, equity, co-ordination and people-centeredness. It states that if innovators are 'unable to describe how the idea makes a difference in at least one of the seven categories, then it would be difficult to consider it an improvement or innovation' (ibid, p. 19).

This example concurs with Morgan's (2006) concerns about rational and technical approaches that can inhibit more innovative ways of achieving performance management targets. It also underplays the human aspect of organisations, such as the power dynamics within relationships, which will be studied in a later section. I will also argue against a prescriptive type of approach to innovation, which advises the agent to gather as much measurable evidence as possible before engaging with colleagues or service users in dialogue about the viability of the changes. I will also contend that innovation is emergent and occurs in the known and unknown qualities of the social patternings of interaction between people, rather than from a predetermined blueprint.

In this section I have examined how performance management targets are written directives through which government policy makers aim to implement changes in the delivery of healthcare. Managers are the local implementers of the macro policies as they design systems and processes to control the execution of the strategies. They are expected

to ensure that others enact behaviours that are consistent and compliant with the wider policy orientation of their services. I will now consider why systems approaches predominate within UK health services.

For the last 20 years, the model of governance for public sector organisations has become increasingly centralised. Historically the role of central government was to generate healthcare policy, ensure that there was adequate provision of healthcare through allocated funding, and co-ordinate the activities of the Health Authorities (Stacey and Griffin, 2006). Income was given to local funding bodies or Health Authorities, which invested in relatively autonomous local healthcare institutions that were accountable to the Health Authority for how they used their funding.

According to Gregory (2007), this changed when the Conservative government of 1979 set out to restructure public services based upon freedom, choice, enterprise, self-reliance and responsibility. Dawson and Dargie (1999) assert that at this time the public sector was thought to be inefficient and often ineffective, so that if left unchecked it would lead to unacceptable growth in taxation. Based on these beliefs, cost containment, public support and performance management emerged as the central drivers for reform.

To deal with these problems, politicians and their advisers turned to the private sector, believing that the private and public sector could be organised and managed, fundamentally, in the same ways, (Dawson and Dargie, 1999). Not only were systems and processes imported from the private sector, but also there was an attempt to construct market mechanisms so that competition through the mechanism of contracting, rather than hierarchies, could become the dominant means of control.

A market economy is an economic system in which the production and distribution of goods and services takes place through the mechanism of free markets, guided by a free price system. In a market economy, business and consumers decide of their own volition what they will purchase and produce and resources are allocated without government intervention (Hofer et al, 2007). Market economies ‘rest on the fundamental principles of individual freedom: freedom as a consumer to choose among competing products and services; freedom as a producer to start or expand a business and share its risks and rewards’ (Watts, 1998). Watts claims that in this system of economic individualism, producers and consumers are in a better position to know what they want and what is

happening to market prices for the products they buy and sell, than in a centralised configuration. In a decentralised system of private markets, resources are efficiently allocated to satisfy customer demands (Watts, 1998).

Decentralisation has been a key element in improving healthcare services (DH, 2003: DH 2004). Financial saving is to be achieved by following the incentives of a competitive environment, and fostering innovation and creativity in public sector management (Peckham et al, 2008). However, the recent government reaction to NHS deficits and to the lack of financial balance has led to increased central intervention and more focused targets. NHS trusts have experienced job cuts, and mergers have been imposed on Primary Care Trusts (PCTs), (Peckham et al 2008).

Gregory (2007) contends that managerialism is contemporaneous with marketisation; if the public sector is perceived to act like a private company with a focus on consumer choice, then it is logical to import managerial practices from the private sector. A key feature of the managerial transformation was the introduction of what was seen to be more ‘business-like’ management practices such as goal setting and targets, individual appraisal and the appointment of senior managers from the private sector (Dawson and Dargie 1999). They draw attention to the private sector management gurus who extolled the virtues of creating strong core values to unite employers and employees in order to achieve improvements beyond financial and contractual incentives. Management could achieve more if there was a sense of shared mission built around common values and mutual trust.

Health services had traditionally been delivered by institutions that were internally governed in a highly collegial manner (Stacey and Griffin, 2006). At that time, the ‘bonding’ between the employee and employer through shared values was virtually nonexistent. Management practices were seen to be weak and lacked the capacity to manage clinical professional groups. Traditionally, public services had a poor reputation in terms of controlling costs, improving quality, or meeting the standards expected by the public; they were organised to meet the needs of professionals (Dawson and Dargie, 1999).

The construction of a market mechanism aimed to control the provision of healthcare through contracts rather than hierarchies. Though significant changes had been made to

healthcare policy during the 1980s and 1990s, implementation of the new policies was slow. Many clinical professionals have been reluctant to accept managerialist practice. In Project 3, I consider the tensions between managers and clinical practitioners. I describe the low status of managers in the NHS (Dopson, 1994; Bolton, 2003; Thorne, 1997) as a contributory factor to the reluctance on the part of many clinical staff to participate in management.

Thorne (1997) suggests that managerialism is an ideology based on rationality, hierarchy, and a belief that managers should be free to manage and control. She postulates that doctors believe they have the right to control their own work and exercise clinical judgement. They do not expect to be managed, and work within a peer group of networks and pecking orders. Concern about professional accountability, inefficient healthcare, lack of innovation and poor accountability for the quality of care delivery has continued to fuel healthcare reforms (Stacey and Griffin, 2006).

This was exemplified in the inquiry into paediatric cardiac surgery deaths at Bristol Royal Infirmary Inquiry (DH, 2001, para. 8). The investigators found that the flaws in organisation and culture reflected wider failures of the NHS. They found a 'club culture': an imbalance of power, with too much control in the hands of a few individuals. The investigators observed that the consultants' job-for-life culture made it difficult to bring about change, especially as the CEO of that particular institution was himself a doctor. This is an example of how public sector governance had been sustained by particular social power structures that gave individual professionals and professional groups' freedom to act in ways that maintained their autonomy and freedom from wider accountability.

Other notable inquires helped to fuel a loss of confidence in healthcare professionals. In Project 1, I describe working in the ward where a nurse had been convicted of murder and attempted murder of children in hospital (Clothier Inquiry, 1991). Jenkinson, a nurse, was convicted of grievous bodily harm of an intensive care patient (Bullock, 1997); Shipman, a GP, was convicted of murdering 15 patients, (Smith, 2005); Neale, a gynaecologist, was found guilty of poor practice; Kerr and Haslam were psychiatrists convicted of indecent assault (DH, 2004); and Ayling, a GP, was convicted of indecent assault (DH, 2005). The trust of the public trust was also compromised when Alder Hay Children's Hospital was accused of serious mishandling of the removal, retention and

disposal of human tissue (Redfern et al, 2001). Since the Maidstone and Tunbridge Wells Inquiry (Commission for Healthcare Audit and Inspection 2007), the image of nursing has deteriorated, as poor nursing practice was cited as the reason for a number of deaths in the hospital.

These exceptionally grave incidents fuelled the discontent and concern that general government policies were inadequately policing professional groups. In light of this, a White Paper has been published (DH, 2007) explaining that healthcare professionals will be required to provide evidence of revalidation as part of staff management and clinical governance systems, with employers providing recommendations to the professional regulators. This has the potential to deal with poorly performing clinical professionals, and is an example of how managerialist practice is being used to bring increasing accountability to professional practice. This will be dealt with further in the section on rejection.

The focus on efficiency, accountability and innovation has been continued by the current Labour government, whose vision is set out in the *NHS Plan* (DH, 2000). In a more recent publication, the vision for 'World Class Commissioning' (DH/Commissioning, 2007) is outlined. Commissioners are PCT managers, who hold the majority of the NHS budget and commission services from provider services such as hospitals and GPs. Commissioning services are focused on outputs; and the means by which targets are achieved is based on a strong belief in competition and consumer choice (Dunleavy and Hood, 1994). Patients are seen as consumers of healthcare, and as such are entitled to have more choice; and funds should follow demand (DH, 2000).

According to the World Class Commissioning guidance, 'equipped with a clear understanding of current and future needs, world class commissioners will use outstanding negotiating, contracting, financial, and performance management skills to shape local services and drive continuous improvement in quality, safety and choice' (DH/Commissioning, 2007). To reach this vision of the future, the document outlines the characteristics they think will enable commissioners to gain the characteristics of a world-class organisation: they will be credible leaders, respected by local community and business partners, and are responsible for stimulating the market. The NHS Institute for Innovation and Improvement has produced best practice guidelines to support the

implementation of World Class Commissioning (DH/Commissioning, 2007) and frequently refers to ‘markets’ and ‘marketplace developments’.

This recent guidance demonstrates that the NHS is becoming even more overtly linked to managerialism and markets, as commissioners are instructed to stimulate the market by ensuring that there is a competition within their purchasing strategies. The World Class Commissioning document is a statement of intent, and outlines core organisational competencies required to achieve the vision. It demonstrates the highly centralised form of governance that is policed by the Audit Commission, the Healthcare Commission and Monitor (the regulator for NHS foundation trusts). This has changed the power dynamics from service delivery institutions to the inspection agencies of central government. Similarly, the power relationships between clinical professionals and managers have changed as managerialism dominates the structure and organisation of care delivery.

However, as Dawson and Dargie (1999) point out, health cannot be seen as a standardised commodity. Health care is a labour intensive activity requiring a large number of different professional groups to provide health care for the sick and advice on how to maintain good health. Dawson and Dargie conclude that the strength and diversity of professional groups, and their ability to work together, adds considerable complexity to healthcare systems. The recent appointment of Lord Darzi, a surgeon, as Parliamentary Undersecretary of State for Health is an attempt to re-engage with clinical professionals. He has collaborated with over 2000 clinicians to set a new vision for quality of care, and has outlined a number of proposals to re-engage clinical staff and raise standards (DH, 2008). This suggests that government accept that clinicians have an important role to play in the improvement of healthcare services.

In this section, I have outlined how targets and performance management might be understood within the social structures and underlying rationales of healthcare policy and practice. I have shown how targets aim to improve specific services in quantifiable ways, which enable ministers, clinicians and senior managers to demonstrate accountability to the public. Managers are expected to engage with performance targets by designing effecting systems and processes and through employing and training their workforce.

Performance is then monitored at an individual and systems level to ensure that appropriate procedures are followed and apposite results are achieved. Engagement with

targets allows managers to feel more in control, as the focus on quantifiable goals suggests that they can manage processes to improve the outcomes. As described earlier, targets and performance management are a way of working that has become familiar to managers in the NHS, where familiar terminologies associated with values, needs, objectives, goals, and aspirations are known and understood.

I have also analysed how systems and cybernetics came to predominate within the NHS because of the perceived inefficiencies and dominance of professional groups. This prompted a significant change to healthcare organisation, as managerialist market-driven practices from the private sector were imported into public sector organisations. The private sector approach to management is based on systems theory of setting targets, planning and monitoring, and is thought by government to be the means by which the health service will become more consumer-orientated and efficient. It was perceived that this was a more efficient and cost-effective way to govern healthcare services, which will therefore produce a more financially viable and quality-driven service.

The benefits of targets and performance management

I have described cybernetic systems thinking earlier, and have illustrated how this way of thinking is promoted by politicians, since government needs to demonstrate to constituents, in a tangible way, that it is improving healthcare. Performance management systems attempt to bring accountability to healthcare providers for quality of care (DH, 2000).

This approach to management attempts to bring about standardisation (Morgan, 2006), which is also important in healthcare. Standardisation is achieved through national policy initiatives, which provide a 'practical framework for the expression of political messages and the achievement of social goals' (Hodgson and Irving, 2007, p. 1). This standardisation was one of the statements of intent within the *NHS Plan* (DH, 2000), which aimed to bring services up to the level of the best-performing healthcare organisations.

As I illustrated earlier, health services were traditionally delivered by institutions, within which professional groups exerted a great deal of uncontrolled power and influenced. A managerialist approach has brought in systems and processes, which have reduced the

‘club culture’ found in many healthcare organisations dominated by professional groups (DH, 2001, para. 8). There has also been a shift in the power relationship between doctors and patients. The introduction of managerialism and market forces focuses on consumer choice (Gregory, 2007), so that patients are now able to choose not only their GP, but also which hospitals they go to for care for example.

From a market perspective, business agency is achieved through its command over resources (Farnsworth, 2006). Governance of the NHS has been increased through strict accountability frameworks. The NHS *Operating Framework* (DH, 2007) provides systematised arrangements for the allocation of resources, which brings accountability for the way in which public funds are spent. Chief Executives and Trust Boards are threatened with sanctions if they fail in their responsibilities to meet their financial targets. The severity of the punishment has made financial accountability a top priority for healthcare Trust Boards (Windmill, 2007).

Targets that aim to improve quantifiable aspects of service delivery, such as waiting times to access treatment, appear to have been successful. Changing systems and processes to meet access to hospital waiting-time targets, access to care and to GP appointments, have significantly shortened access time to healthcare (King’s Fund, 2005 and 2007). This shows that focusing on targets does bring about improvement in those areas where processes can be changed to meet the targets. It also highlighted hidden waiting times for treatments such as diagnostic interventions, which now have performance targets attached to improve access (King’s Fund 2005). This target-driven approach indicates to the public that there have been demonstrable improvements in healthcare through the collection and monitoring of qualitative data. This is important politically, as public confidence is gained as services improve. The move to a more market-driven approach is justified, as government can demonstrate that it listens to and acts on complaints and considers consumer choice.

Spence (2008) argues that popular medical logic infers that patients are to blame for their dependency on health services. He maintains that it is doctors, and their way of managing their systems, who dictate how patients consume services. This is pertinent to GP’s who have more autonomy as to how the budget is utilised as they are more independent practitioners. Hospital doctors have less control over the budget and in the way in which services are managed. This is important, as the quality of clinical practice, and the

allocation of resources, must be informed by clinical practitioners. According to the recent Dazi review (DH, 2008), if the quality of patient care is more than just improved access to services, then clinicians must be able to influence the resource base and organisation of healthcare.

Managerialism has brought consumer choice up the government agenda of priorities as it tries to organise services to provide customer alternatives. This is currently at a rudimentary level, as the choices about where patients are seen are limited. As not every hospital has access to specialist services such as cancer care, paediatrics and neurology, for example, the choice is rather limited for many patients. As described earlier, this scientific approach to management is the dominant discourse that is familiar to managers. It enables them to have a shared language and understanding of taken-for-granted assumptions of a logical and rational approach to managing organisations.

This way of managing also helps to reduce anxiety, as rational planning gives the manager a sense of control. This is important in an environment that stresses personal accountability for improvements in poor care. Performance league tables are published, and there is considerable media coverage of hospitals that miss targets, resulting in the sacking of management boards. This shows how the power dynamics within the NHS have changed from traditional hierarchies to an attempt to construct market-led systems led by managerialist practices.

In this section, I have shown the benefits of systems thinking in the following areas:

- Targets can focus agency on quantifiable aspects of the service and bring about tangible improvements.
- Setting the same national standards brings about standardisation of certain aspects of care across the whole population, reducing ‘postcode lotteries’.
- Public confidence is enhanced when they experience or hear about healthcare improvement and adept governance.
- Competition in the market has the potential to reduce costs.
- Performance management of resources provides a better command over budget spending, particularly when accompanied by sanctions.
- Consumer choice is acknowledged and potentially acted upon.

- The dominant discourse of performance management provides a consistent way of tackling service improvement, providing a common language that is familiar to managers.
- Power and control have shifted from clinical professionals to managers.
- Performance objectives enable managers to feel more in control as they measure targets and then manage the results to improve healthcare systems.
- Performance management systems attempt to bring accountability to providers of healthcare for the provision of that care.

I have described the benefits of targets and performance management in this section, and highlighted the high priority that healthcare is given by government. There are, however, a number of limitations to systems thinking, which will be evaluated in the next section.

The limitations of targets and performance management

I have illustrated above the benefits of systems thinking, but there are a number of unintended consequences to this approach. There are drawbacks to a performance- and target-driven culture, as it is often difficult to define clear objectives; people are potentially seen as mechanistic contributors to the system; issues that are not open to quantification are given less attention; and conflict and challenge are discouraged by using complex mathematical formulisation, which deters contribution and novelty (Jackson, 2000). In their study of a public sector organisation, Betts and Holden (2003) noted the tension between the need to deliver specific improvements and the desire to encourage innovation in a less mechanistic manner.

Although soft systems theory acknowledges the importance of interaction and engagement, as I have shown earlier, the recent guidance on increasing innovation in commissioning (NHS Institute for Innovation and Improvement, 2008) is focused, in the main, on measurement and modelling. This promotes a particular approach to changing the system through logic and rationality. There are structural norms to which people are expected to adhere. These are not structures in terms of specific models, but acceptable approaches to managing targets. This is thought about in a rational and systematic manner, which does not account for the existing tensions in the local power relationships between clinicians and staff.

Enthoven (2001) is concerned that the drive to implement 'best practice' from 'top-down' initiatives will also inhibit local creativity and innovation. He is concerned that the monitoring agencies are so concerned with what they perceive as good practice that local innovation, which is tailored to the needs of a particular group, might be dismissed because it does not meet particular principles outlined in the inspectorates' monitoring frameworks. Equally, Morgan (2006) alludes to the limitation of learning opportunities, as the system is controlled by the operating norms that guide it. He is suggesting that the structural norms and the underlying rationales, which can be conceptualised as rules and ideas, provide unspoken but generally accepted ways of working and communicating. Models of goal-setting and monitoring prevail in the NHS; these promote single-loop learning and limit the opportunities for thinking in a less rigid manner.

In addition, questions have remained about productivity and the value for money the public were getting for their investment (Audit Commission, 2003; King's Fund, 2005 and 2007; Healthcare Commission, 2007). The government has doubled its investment to improve patient care, but was unable to predict other significant factors. The increase in clinical negligence payments, the rising drug budgets, and local interpretations of the change in staff grading structures have taken funds away from direct patient care (King's Fund, 2007). This does not imply that the increase in capital was not aimed at service improvement, but demonstrates that predicting long-term improvements through target-orientated systems can be undermined by unforeseen circumstances.

There is evidence that targets and performance management have brought about service improvement to certain areas that are quantifiable, such as waiting times for treatment, access to emergency care, access to GP services, and changes from inpatient to day-care treatments. However, there have been unintended consequences of some of these initiatives. For example, meeting the key target that patients should be able to see their GP in two days has resulted in some GP practices refusing to book any appointments further than two days in advance (*The Economist*, 2005).

Another knock-on effect of changing access to see a GP has been an increase in the number of patients attending Accident and Emergency Department (A/E). It is not clear why there has been a 35% increase in the number of emergency admissions, but changes such as the four-hour A/E target (it is quicker to admit a patient than arrange for discharge into community care), and changes in access to GPs' out-of-hours services, are

thought to have contributed (King's Fund, 2007). These consequences were unforeseen, and could not have been planned for in advance. Managers have focused on the targets that the government chose to measure, and then have to deal with the unforeseen consequences of these initiatives.

Bevan and Hood (2006) argue that the use of targets results in gaming. They cite the example of the implementation of the target for inpatient waiting times, where one hospital met the target by cancelling and delaying follow-up ophthalmology outpatient appointments (which had no target) to provide the capacity to meet the first appointment target. This resulted in at least 25 patients losing their sight over two years (Public Administration Committee, 2003). This particular example is extreme, but demonstrates the anxiety experienced by managers who fear that failure to meet targets might result in their job loss.

Unfortunately, performance management targets are less successful when aimed at changing peoples' behaviour to promote healthier diets or healthier living (King's Fund, 2005, 2007). Progress on preventative measures, such as reducing smoking and improving diet, were less favourable. This suggests that it becomes more difficult to implement change in lifestyle areas of healthcare, which necessitate a change in behaviours. This is not to say that resources should not be focused on healthy living, but healthcare managers cannot be held accountable for the choices individuals make over which they have no control.

An underpinning value of healthcare marketisation is consumer choice. The Department of Health maintains that patients who have been able to choose are highly satisfied (Healthcare Audit and Inspection 2007). The guidance proposes that healthcare services needs to maintain public confidence, to a degree that matches the high satisfaction levels of any other service. This is a laudable intent, but raises complex questions. Cole (2007) cites a recent survey on the DH website, which was later removed as it was claimed that it did not reflect the views of the DH. The survey claimed that there is no evidence that patients' ability to choose where they are treated improves the quality of care. He fears that inequality might increase because the views of the more articulate and affluent patients might be favoured.

Anya (2006) is concerned that public reassurances that changes in healthcare are solely driven to provide better choice, by implication, suggest that they are accessing better services. He is concerned that patients then cannot understand why they are unable to choose to access emergency services in their neighbourhood. This is an important issue, as decisions to locate services such as A/E are premised on complex factors such as clinical competence and expertise, the ability to maintain clinical skills with a small volume of patients, and the financial viability of providing specialist services. Treating the NHS as a market and promoting consumer choice raises expectations that the NHS might not be able to meet from the public purse.

There are various concerns about running healthcare as though it were a market. These include the difficulty of demand due to the unpredictable nature of healthcare, as illness and accidents strike in a random way (Hall, 2001). In addition, 'consumers lack expert knowledge to be able to translate their demand for health into their demand for healthcare. Hence, they rely on the advice of experts', (ibid, p. 320). Furthermore, health and welfare consumption (e.g. immunisation against infectious diseases) depends on others, a situation that is unique to healthcare.

Equally, there are also a number of specific factors that limit the scope and impact of competition (Smee 2000). These include: commissioning expertise to redress the imbalance of information in favour of the provider; historical local monopolies, and the distance to travel to find alternatives; an emphasis on regulation, to restrict or prevent risky behaviour rather than promote innovation; a lack of knowledge at DH level about marketisation in other areas of the economy; and the reluctance of politicians to allow market principles to prevail (Smee 2000). It is politically unfeasible to let go of major local resource allocation decisions, as this could result in unpopular hospital reconfigurations and closures.

Finally, in addition to changes in financial management practice, contracting, performance measures, and the introduction of markets and competition, public confidence in the integrity of healthcare professionals changed (Dawson and Dargie, 1999). As I have shown earlier, the control and power afforded to professional groups became unacceptable, particularly in light of the implications of inquiries such as that into the deaths at Bristol Royal Infirmary (DH, 2001). Professionals also lost influence or position in public management because of changes from administration to professional

management that were imposed. Their ability to influence health care was also diminished, as specialist managerialist language was unfamiliar to clinicians.

In conclusion, the government is committed to the improvement of healthcare through a target-driven approach to performance management. There is evidence that this approach is successful in some areas: the reduction in waiting times and access to day care are examples of significant improvement. However, I have raised concerns that the unintended consequences of this approach are significant, and can affect the quality of patient care. There is little evidence to suggest that government acknowledges that there are side effects to their market performance and target-driven approaches. I have argued in this section, that change models aimed at meeting targets have the potential to stifle local innovation. This also results in a lack of capacity to solve local problems, as energy is focused on 'must-do' nationally set targets. The penalty of missing targets is likely to result in disciplinary proceedings for senior managers, which in turn has the potential to encourage gaming as statistics are manipulated and services are managed to meet targets rather than improving the quality care. I have also highlighted the difficulty of treating a centrally funded service as a market when fundamental market principles cannot apply, as it is politically unfeasible for services to fail.

I have also drawn attention to how the focus on markets and managerialism has changed the power dynamics from service delivery institutions to the inspection agencies of central government. Similarly, the power relationships between clinical professionals and managers have changed as managerialism dominates the structure and organisation of care delivery.

Finally, I have raised concerns about how rational and technical approaches conceptualised as rules and ideas underplay human agency and the relational aspects of organisational life, such as the power and control dynamics of relationships. This will be considered in more depth in a later section.

The potential contribution of a complex responsive processes perspective

A radically different way of looking at organisations is from a complex responsive processes way of relating. This theory informed the basis of enquiry within my four projects. In Project 4, I detail the elements of complex responsive processes organisational dynamics in detail, and provide a brief overview here. From this

viewpoint, organisations are seen as myriad self-organising interactions from which emerge population-wide patterns that are stable and unstable at the same time.

Communicative interaction is based on Mead's (1934) work, where human activity is seen as a process of gesture and response, which is taken as a single social action from which meaning emerges. All human interaction involves the movement of identity, power relating and processes of inclusion and exclusion that arise from human choices made on the basis of ideology (Elias, 1978).

Rather than thinking about organisations as though they were systems, a complex responsive way of thinking explores organisations as 'temporal processes' (Stacey, 2003, p. 291). In this context, processes are not associated with parts of the system; rather, they refer to the interaction between people, which in turn produces more interaction.

Stacey and Griffin (2006) contend that it is through the everyday processes of relating that people in (not outside) the organisation, cope with the complexity and uncertainty of organisational life. As this occurs, people 'perpetually construct their future together as the present' (Stacey and Griffin, 2006, p. 4). This is a different way of thinking from that of perceiving people as contributing to the construction of, or as victims of, the 'system'. It is more concerned with how we might think about what is already happening in organisations.

People do not exist in isolation, but in relationship. Within these relationships, there are ways of relating that both enable and constrain; and this immediately establishes power relations between people. Local interactions between people are seen as conversational in nature. Meaningful themes emerge out of conversation, which organises the way that people get on together and how they get things done. However, conversational themes may take stable forms of repetition in which people are stuck, or they may be free flowing and dynamic.

Stacey (2007) describes legitimate and shadow themes that organise the patterning of conversation. The official ideological themes determine what is legitimate to talk about in an organisation. In the NHS, for example, a legitimate theme might be improving patient care through performance measures. A shadow theme might emerge if staff behave in ways that are inconsistent with the official ideologies; for example, they might pay lip

service to certain performance targets, but in reality focus on issues that are more pressing to themselves and their work colleagues.

Given that the NHS is committed to a target-driven performance ethos, managers are obliged to cooperate in the implementation of performance targets if they wish to retain their jobs. The contribution that complex responsive processes can offer is a way of thinking about what people in organisations are already doing in their ordinary everyday activities.

I identified earlier that managers are expected to engage with performance targets by focusing on what staff ought to be doing. They are expected to design and monitor the most effective and efficient ways of undertaking tasks, then engage, and train their workforce. By contrast, a complex responsive processes perspective focuses on what is actually happening in organisations, rather than on what members of the organisation should be doing. Paying attention to the quality of one's own experience of relating and managing brings a different perspective to organisational life. This reflective experience brings more focus to our own behaviours and the contributions that we make to organisational life at a local level. This has the potential to initiate change or adapt behaviours for the good of the individual, and potentially for those that we are in relationship with (Stacey, 2007).

Rather than standing outside the organisation as an observer, managers take notice of the thematic patterning of conversations, which provides the social structures in which people find familiarity and ways of relating. These patternings are unique to specific groups of individuals and are reflected in the ideologies and power relations within the group. This provides a way of understanding how knowledge emerges within the mores of a specific group of people and how they use systems and processes to improve their day-to-day working processes. Managers might use opportunities in their everyday conversations to influence, lobby and cajole their colleagues, persuading them to take certain actions and think in certain ways. However, they are never in control of the interactions, and cannot predict how meaning emerges or what that meaning might be.

This is a very different way of thinking about the use of systems and processes. Rather than invoking a model or blueprint to design a change, the onus is on the manager to reflect on how people utilise their tools and technologies, as well as with whom they

interact with and who is excluded. This provides valuable information about where the blocks to change are occurring, and leads to an examination of the local power dynamics that are manifesting.

Although the concept of managerialism was introduced into the NHS over 20 years ago, the concept of marketisation is less well established. This is slowly changing as policy directives are introducing more competitive criteria within the commissioning directives. Stacey (2007) draws attention to how managers make meaning from the notion of market economies in their day-to-day organisational lives. Complex responsive processes theory accentuates the need to make sense of the market and recognise that managers do not engage with the 'market', but with people in other organisations. In healthcare, these conversations might be, for example, between commissioners' policymakers and inspectors. All of these very different people make up the notion of the 'market'.

Mead saw the market as an example of a social object. A social object is not a physical entity, but myriad social acts wherein people interact in a generalised way and where there are social norms that enable people to know how to behave. Therefore, people take up the attitude of the other in their interactions, which are unique to a certain moment in time and are the sum of many particular interactions. Different groups of staff develop separate identities 'who develop generalised tendencies to act in similar ways… in similar situations' (Stacey, 2007, p. 348). Rather than managers measuring the market and monitoring the changes, complex responsive processes theory encourages managers to enquire about issues such as what generalisations are being made, what the power relationships are, and how people are making sense of their relationships.

Targets are usually the outcome of specific government policies based on a new initiative or building on existing guidance at a macro level. Policymakers then expect policies to be implemented at a local level. However, the NHS is made up of many groups of staff who generate their generalised tendencies to act, which makes implementation complex. These groups might or might not take up the new policies within their own organising patterns of interaction. Therefore, the issuing of a policy generates a reaction and is dependent on how the myriad different groups react to the initiative at a micro or local level.

I identified earlier in this section how performance management objectives might be engaged with. I postulated that managers found that targets provided opportunities to formulate models and frameworks, which helped them to manage change. Although this had the potential to reduce their anxiety by providing a way of managing and controlling the system, this is difficult, as predicting the future is problematic. Although logical and rational processes might be employed to achieve the goal, the behaviour of others cannot necessarily be predicted or controlled. Streatfield (2001) argues that thinking about control as an entity that is either present or absent is unhelpful. He maintains that it is more helpful to think in terms of the paradox of being in control and not in control at the same time. In my coaching of senior managers, I have used this thinking on a number of occasions. It is a concept that many have found useful, as they identify with the underlying anxiety associated with the notion of control.

Patterns of meaning emerge as managers interact with colleagues on an ongoing basis, where stable patterns of meaning arise. Understanding arises from these ongoing conversations and power relating, and 'it is this meaning that creates a felt sense of order, coherence, pattern or control' (Streatfield, 2001 p. 136). It is from these numerous conversations that deliberate goal-orientated agency emerge as a result of the patternings of local conversations. Rather than using models or blueprints to logically direct a course of action, it is from day-to-day conversations that meaning and direction emerges. Tools and techniques might then be utilised to implement the course of action, which will then be continually negotiated within ongoing conversations.

In Project 3, I describe the tense relationships between the manager and a group of Senior Sisters. I argue that if staff were able to discuss hidden conflicts and recognise the constraining and enabling patterns of relationships, they might be better able to contain the anxiety that working life often generates. In this project, I also discuss the meaning and implications of the waiting times initiatives within a children's unit. The managers see these targets as ways of increasing the number of children treated for specific surgical interventions. The unintended consequences are that there was a lack of beds for non-surgical patients. The conversation becomes stuck as the Senior Sisters blame the targets for causing the tensions they experience on a day-by-day basis because of the bed shortages. I encourage the Senior Sisters to think about what the targets were aiming to achieve, work through a number of options, and discuss a more organised, methodical way of working.

Earlier, I raised concerns about the unintended consequences of target-setting models. Thinking about organisations in terms of complex responsive processes does not militate against this, as unintended consequences can fall out of any interaction. However, from this perspective, managers are more likely to be aware of this potential effect and be willing to continually renegotiate their ways of working to accommodate the difficulties, in the knowledge that it is not possible to control all the unintended outcomes.

In Project 4, I point to how complex responsive processes theory has influenced my professional practice. Staff who are facing a change in role or redundancy often blame 'the system'. The job stability that many staff have experienced throughout their careers has been questioned. I draw attention to the way that systems are used as a vehicle to organise their day-to-day working processes. The system does not have a life of its own, but is dependent on the choices that managers make about how to change working arrangements. We then consider the reasons why the decisions have been made and their options to lobby and influence to find other work. This is not merely semantics: it has the potential to shift attention from an inanimate object, such as a system, to individual agency, where we are able to discuss choices and opportunities. Neither is it a prescription for success and cannot resolve the hurt and anguish that many experience. It can, however, provide the potential for a different way of thinking. This might help staff move from feeling impotent to a position where they are able to take responsibility for influencing their futures.

In this section, I have provided a brief summary of complex responsive processes theory. I have then identified how this theory might contribute to the understanding of and engagement with targets and performance management. In complex responsive processes theory, managers are encouraged to pay attention to the quality of their experiences of relating and managing in their interactions with others. From this premise of reflection, I have summarised the contribution of this way of thinking in the following bullet points.

Managers are encouraged to:

- Focus on what is already happening in their departments and build on how people get things done on a day-to-day basis
- Focus on what is actually happening, rather than what should be occurring
- Reflect on how individuals and groups use tools and techniques, including how they interact locally

- Be part of what is occurring, rather than outside observers of the system
- Recognise the power relationships that occur in day-to-day conversations, who is excluded, and where the blocks are occurring
- Notice how knowledge is emerging through the organisational themes that emerge through the patterning of relationships
- Discern how patternings of conversations can be influenced and lobbied
- Identify the importance of everyday conversations and how meaning arises from these interactions
- Recognise that markets do not exist as an entity, but are social objects made up of groups of people who act in a generalised way
- Understand that groups might or might not take up the implementation of new policies, depending on their tendencies to act
- Accept that being a manager means being paradoxically in control and not in control at the same time.

I am not arguing that complex responsive processes thinking is a solution to the multifaceted problems of running the NHS and I will now consider some of the confines of this way of thinking.

Potential limitations to a complex responsive processes perspective

I have maintained throughout my projects that complex responsive processes are not a blueprint to success; neither is it a management technique. It is simply a way of thinking about what is already happening in organisations.

Although the manager might influence the patternings of conversation by influencing the way in which knowledge is understood, there is no guarantee of success. Neither is there a guarantee of success in the performance management model, but this more tangible, logical process provides some degree of reassurance in terms of agency. Policymakers, who issue directives, expecting managers to implement their targets, want to see hard evidence that change models have been evoked. It is unlikely that healthcare inspectors will concede that staff have a choice either to cooperate or feel that there are more pressing issues in their work environment that require their attention.

The manager is paradoxically in control and not in control at the same time. The challenge is to cope with this paradox. Our actions shape and are shaped by the ongoing

patterns of relationships, and managers are merely a part of this evolving pattern. This is not an acceptable message for many managers who have been brought up to believe the prevailing management theory, based on prediction, organisation and control. Also, the language used to describe human relating, such as Mead's 'calling forth responses' and the theoretical aspects of the teleology of cause and effect, are not terminologies that many people can relate to easily.

Most NHS managers are focused on trying to meet performance targets on the one hand, while on the other dealing with the unpredictable problems of day-to-day organisational life. Taking time to reflect on the local micro-interactions of their day-to-day conversations, and analysing their enabling and constraining power relationships, demands a very different way of perceiving organisational life.

Zhu (2006) criticises complex responsive processes thinking for abandoning systems thinking. He argues that Stacey insists that he is suggesting a different way of thinking, yet managers should continue to do what they are already doing. He accuses Stacey of pursuing theoretical concerns rather than addressing managers' practical concerns. I think that in more recent publications, Stacey is more practical and is clearer that systems and processes are acceptable tools to implement change. Stacey maintains that understanding how sense making is emerging at a local level needs to precede the implementation of goal setting. This is using models as tools to help sense making, rather than as blueprints to introduce service improvements.

Zhu (2006) also proposes that managers need to step outside of the system to be able to 'exercise freedom while none else does' (ibid, p. 7). Stacey is criticised for no longer seeing systems thinking as a conceptual tool, but for choosing to see systems as something 'real' in which we are (or are not) producing or mirroring. Zhu (2006) concludes that, as long as systems are seen as conceptual tools for making decisions, and not as a representation of a real thing, there is no point in disparaging them. He does concede that the systems concept is problematic, as there is a lack of consensus within the systems community.

I have shown that there are a number of benefits to systems thinking, as well as a number of drawbacks. What complex responsive processes thinking does is offer another way of thinking about organisations. It acknowledges the complexities of organisational life,

such as anxiety and control, which are rarely articulated in the workplace. However, I agree with Zhu that the concept is highly theoretical and offers managers reflection and reflexivity as a means of understanding their organisation and their part in its development. Stacey (2007) recognises that reflexive practice is difficult and not easy to sustain. The ability to articulate fluid conversations, taking responsibility for one's own behaviours and understanding group dynamics, are skills that complexity theory requires of managers. These competencies come naturally to some, but could be a challenge for others to acquire. Some managers might argue that this degree of reflection takes too much time, as they are constantly dealing with problems as they arise.

In summary the limitations of complex responsive processes thinking are

- The premise that staff might or might not take up initiative is unacceptable to senior managers and inspection agencies
- Complex responsive processes language is complex and difficult to understand
- Senior executives expect managers to be in control of the systems and processes
- Managers work in an environment where the accepted discourse is that the organisation is a system which can be designed
- The argument that it is conceptually possible to step out of the system and analyse how effective the system is working
- Some managers struggle with the concept of reflection
- The difficulty of sustaining a reflexive approach
- A misunderstanding about the time required for reflection.

In this section, I have analysed how performance management targets might be understood and engaged with, and included the reasons why cybernetic systems predominate, along with the benefits and limitations of this. I have analysed a complex responsive processes perspective and critiqued the advantages and limitations of this approach. I will utilise both systems thinking and complex responsive processes theory in the section on the psychological contract as I examine the employer–employee relationship.

In the next section, I will examine the notion of power. In my projects, power is an on-going theme and I will now examine some of the established literature associated with the concept.

Power

In this section, I have mainly drawn on literature from the social and political sciences rather than the economic theories related to the understanding of power. Clegg (1989) argues that there is no single all-embracing definition of power, but describes a number of 'family relationships between some closely related but nevertheless differentiated concepts' (ibid, p. xv). Wittgenstein (1967) argues that when we use the concept in different contexts, its meaning changes, so that there is no single definition of power that covers all usages. Each usage takes place within local, tacit or explicit theoretical systems that we construct or take for granted (Haugaard, 2002).

I intend to illustrate the distinctions between the different views of power, indicating the contributions of writers from the last 50 years within the context of the structure and agency debate within the social sciences. I will identify how the distinctions between these different views led to different ways of understanding and interpreting the phenomenon.

I will continue to locate the differing views of power within the paradigm of structure and agency. Agency is the dominant paradigm of American writers such as Hunter (1953) and Mills (1956). They focused on the processes by which political communities were constructed, arguing that social order required explicit planning and organisation. This required agency by an elite group to plan, organise and oversee its implementation. Their command 'of this rational apparatus produced both order and the concentration of power in their hands' (Clegg, 1989 p. 47). Hunter (1953) focused on elite power in local communities characterising power at this level as a relationship shared between governmental and economic groups. This school of thought was known as the 'elitists' (Haugaard, 2002), which assumed that the ruling elite would have power by virtue of their visible position in society. In this context, social structure is developed through the agency of elite individuals who determine the rules of social order.

These writers operated within a rather imprecise notion of what constitutes power, according to Dahl (1957), who attempted to study a more situational and relational concept of power. Dahl equated power as something held by people (rather than, for example, an organisation), and studied power and decision-making in the city of New Haven in the 1950s. He was disparaging of his contemporary authors, who proposed that the elite dominated powerless populations. He brought a behavioural science approach

and proposed a methodology whereby power could be measured by studying its exercise. As Dahl studied the frequency of who prevailed in decision-making situations, power was revealed as intentional and active.

The 'situations' studied involved the conflict between interests or preferences, and the outcome was measured through the responses. 'Responses were taken as the indicant of the power which stood as the cause of the measured reaction' (Clegg, 1989, p. 8). Within Dahl's framework, A has power over B to the extent to which A can get B to do something that B would not otherwise do. Therefore, the power of A could be measured through the reactions of B. An individual could exercise power to prevent another from doing something that they would have preferred to have done.

This mechanical and behaviourist approach focused on a very specific meaning for ensuring equality of decision-making. It centres on the agency of individuals within political decision-making, which is significant in the running of the state political structures. Dahl (1957) concluded that there was no ruling elite, as there were a myriad different people and interest groups involved in a multitude of different issues. Although this model was felt to be limited, it challenged the previously less rigorous research approaches proposed by the elitist researchers.

Bachrach and Baratz (1962) built on Dahl's work by identifying a second dimension. They retained the focus on agency and the view that power had to be analysed at a behavioural level. They criticised the Dahl model, arguing that, by measuring power *only* through observable acts of decision-making, it ignored the behaviours and actions that prevented things from being done. Bachrach and Baratz (1962) referred to this as 'non-decision-making', as A might also exercise power over B by limiting the scope of the political process to issues that are relatively innocuous. This argument was not universally accepted (Clegg 1989), as 'some doubted that any hidden or obscured phenomenon lurked in the dark, outside the empiricist gaze' (ibid, p. 12), insisting that if this second dimension could not be seen, there was no proof that it existed.

Although Lukes (2005) acknowledges the Bachrach and Baratz (1962) second dimension was a major advancement from the one dimensional view, he purports that both dimensions are based in a behaviourist model of actual, observable conflict. However, Lukes also illustrates his ideas through the rather mechanistic activities of 'A' and 'B'

type exercises of social action. Nevertheless, he endeavours to focus on meaningful social action rather than on simply observable behaviour of the one-dimensional more behaviourist model of Dahl (1957).

Lukes (2005) contends that 'non-decision-making power' exists only where there are grievances that are prevented from being heard by those perceived to exert power. This suggests that 'actual' conflict is necessary for power to be exerted. However, this is to ignore the crucial point that the 'most effective and insidious use of power is to prevent such conflict from arising in the first place' (Lukes, 2005, p. 27). It could be argued that if the observer cannot uncover a grievance, then no one is harmed by the use of power. Luke goes on to contest that the insidious exercise of power prevents people from having grievances, by shaping perceptions and preferences in such a way that people accept the existing order of things.

Lukes (2005) took the argument further by introducing a third dimension. The first element of this dimension relates to the argument that partiality is not derived from an individual's overt actions or from 'non-decision-making', but is inherited from the past in the form of culturally patterned behaviour of groups. The second aspect involves 'false consciousness', whereby the less powerful are not aware of their 'real interest'; this suggests that domination is sustained by the social knowledge that individuals use in order to shape their preferences. In this way, power is seen to warp the truth in a direction that benefits the interests of dominant individuals or groups.

The notion of false consciousness is criticised by writers who make the case that this concept potentially lends itself to conspiracy theories, mind control and brainwashing (Clegg, 1989; Haugaard, 2002). Whilst Lukes' work is important in highlighting the links between social knowledge and hegemony, power is conceptualised as an entity involving 'possession, sovereignty and control' (Flyvbjerg, 2001, p. 116).

Clegg (1989) argues that at the heart of Lukes' work lies a commitment to individual agency. Agency is conceptualised in terms of moral responsibility in which individuals choose their actions in more or less autonomous conditions. Their responsibility is to choose whether to act in the furtherance of self-interest, or for the good of wider segments of society as a whole. The limitation of his argument lies in the conundrum of who makes the decision as to what is meaningful social action. Judgments made by an

observer, for example, will either have standards by which they assess what is self-interest or in the interest of society, or will be made capriciously. If a subject involved in an analysis of a specific situation makes the judgment, it is difficult to differentiate between the motivations of a subject who feels *devoid* of power and someone making a judgment from a position of arguing against the *constraints* of power.

Another limitation of Lukes' work is the confusion between agency and structure. On the one hand, Lukes argues that the

> …bias of the system is not sustained simply by a series of individually chosen acts, but also, most importantly by the socially structured and culturally patterned behaviour of groups, and practices of institutions, which may indeed be manifested by individuals' inaction.
>
> (Lukes, 2005, p. 26)

Later, he contradicts this argument by asserting that power exists when human agents can be shown to have acted differently, arguing against any 'conceptual assimilation of power to structural determination' (Luke, 2005, p. 57). It appears that, in Lukes' view, structural determinism precludes moral responsibility, which is influenced by the individual. He argues that 'within a system characterised by total structural determinism, there would be no place for power' (ibid, p. 57). This creates a level of incoherence, in that he acknowledges the importance of social structures and later defines power only in terms of agency.

In spite of these inconsistencies, Lukes' categories, for the most part, focus on one person's power 'over' another. Arendt (1970) holds a different view, claiming that 'power is never the property of an individual; it belongs to a group and remains in existence only as long as the group keeps together' (ibid, p. 44). She argued that power in government survives only as long as people support it. Arendt draws a distinction between power and violence, maintaining that power and violence are opposites, and where violence governs then power disappears.

The facilitative conception of power was exemplified in the work of Parsons (1967), Foucault (1979) and Arendt (1970). Parsons defines power as a

> …generalised capacity to secure the performance of binding obligations by units in a system of collective organization when the obligations are legitimized with reference to their bearing on collective goals and where in case of recalcitrance there is a presumption of enforcement by negative situational sanctions – whatever the actual agency of that enforcement.
>
> (Parsons, 1967, p. 306)

Parsons' (1967) structural account of social order links power with authority and the pursuit of collective goals. Although there is the threat of sanction, this is legitimised through the institutionalisation of authority. Parsons' view is important because it draws attention to aspects of social power that were ignored by conflictual theorists such as Dahl (1957), Bachrach and Baratz (1962) and Lukes (2005). Parsons' view of power was conceptualised as 'a facility for the performance of function in and on behalf of society as a system (Parsons, 1967, p. 139). Hence, Parsons legitimises the use of power as an inanimate communal decision-making entity that takes 'decisions in the interest of the effectiveness of the collective operation as a whole' (ibid, p. 318).

Parsons perceives power as a contributory factor to the realization of a stable and civil society. He developed a theory of social action that separated the social system from agency based on cybernetic systems thinking. So there is a duality of realities as, on the one hand, the individual is seen to be acting autonomously from the system but, on the other hand, is part of the system.

Arendt (1970) differentiates power as separate from domination; requiring consensus, as 'power springs up whenever people get together and act in concert, but it drives its legitimacy from the initial getting together rather than from any action that then may follow' (Arendt, 1970, p. 52). Parsons and Arendt focus on the exercise of 'power to' rather than 'power over', implying that it is a capacity or ability rather than a relationship (Haugaard, 2002; Flyvbjerg, 2001).

In contrast, Foucault (1979) argues against the view of power as an outcome or the localisation of power, and sees power not as a possession or an institution, entity or structure but as part of an ongoing relationship. His work was influential in raising new questions about the historical character of the categories of social experience. He claimed to refute the structuralist view that society can be reduced to underlying generalisations,

conceptualised as rules and ideas. Foucault saw the relationship between power and knowledge, not as authors such as Lukes describe wherein power distorts knowledge, but as mutually constitutive (Haugaard, 2002).

Foucault argues:

> ‘If power were never anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it transverses and produces things, it induces pleasure, forms knowledge, produces discourse.
>
> (Foucault, cited in Rabinow, 1984, p. 61)

Similarly, rather than conceptualising power as the ability of individuals and groups to have ‘power to’ or ‘power over’, Elias (1998) also describes power differently. He argues that the figuration or patterning of competitive and cooperative relationships reflects the interdependencies between individuals and groups, and describes the way that people often unconsciously measure their strength against each other (Elias, 1978). Rather than conceptualising power as an object owned by one person, he sees it as a dynamic concept that points to the ebb and flow of dependency. This implies that any relationship is both enabling and constraining; for example, the positive relationship I had with my CEO line manager in Project 1 was constrained by his relationship with his personal assistant. If I became too valuable an asset to him, she became jealous and used gossip to relegate me to the position of an outsider to her intimate inner relationship with the CEO.

In this section, I have provided distinctions between different views of power from a variety of seminal works in which power is portrayed in a number of ways. Though there are some similarities, they are far from the same; it is not possible to reduce the concept into a single definition. Haugaard (2002) notes that ‘social theorists construct empirical models of how society works and, depending upon their theory, define power in a manner which best suits their model. This suggests that their concept of power is highly specific’ (ibid, p. 3).

In my analysis, I have drawn attention to certain generalisations, outlined in the following bullet points:

- Power seen as ascendancy, which is ‘owned by’ particular groups as proposed by the elitists.
- Power as an observable phenomenon, where there are conflicts of interest exerted by preventing others from entering into conflict and by shaping preferences, as described by Bachrach and Baratz (1962), Dahl (1957), and Lukes (2005).
- Parsons’ theory is based on a consensual model, linking power with authority in the best interests of society.
- Arendt (1970) builds a model made for a highly specific task of how society should be constituted, based on her observations of tyranny.
- Authors such as Foucault (1979) and Elias (1978) argue that power is an emergent characteristic of all relationships. Foucalt is particularly critical of social scientists that focus on social models, arguing that studying how power actually functions is more likely to increase our understanding of the phenomenon.

The distinctions between these differing views lead to different ways of understanding and interpreting power. I have shown that there are some generalised perceptions of power that seem to dominate. The behaviourist milieu, which encompasses power ‘over’, entails the ability of one person to prevail over another despite resistance. Power ‘to’ is power as a generalised capacity (as in A has the power to make X happen), linking causal capacities to the concept. Relations of domination are sustained by the social knowledge that prevailing individuals use in order to direct interaction and shape others’ preferences. This analysis of power is often identified with elites and leadership, in which power is allocated to different social and often political strata.

Conflictual and consensual power mirrors the power ‘to’ and power ‘over’ concepts, but is used by modern social theorists to characterise social life. Barnes (2002) describes social power as the capacity for action possessed by a ‘controlling agent’. A controlling agent is someone who ‘gains discretion in the direction of capacity for action and discretion in the use of power’ (Barnes, 2002, p. 124). Therefore, according to Barnes, a hierarchy develops in that some people direct others in the workplace, for example, and thus have social power over others. Morriss (2002) contends that the abstraction of conceptualising that A has power, in that A is able to affect (usually in negative ways), ‘scarcely encompasses everything we understand as power in social contexts’ (Morriss, 2002, p. 299). He argues against power as a relational phenomenon, and sees power as a capacity that can be described via the outcomes that we are capable of effecting. This

view, though rationally defensible, does not consider power as a co-creation but as ability, which returns to the problem of how to make a judgment about the outcome.

Authors who take a structuralist view, such as Parsons, construct empirical models of how society works in which power is consensual and decisions are made in the best interest of community. This way of thinking brings legitimacy to the concept of performance management goals in the NHS, where there are many examples of standards being set that result in positive outcomes such as reduced inpatient waiting times for treatments, or access to care for serious diseases such as cancer. An unintended consequence might be the threat of sanction being so great that managers fear for their jobs at times, and there are examples of where statistics have been falsified (Windmill 2007). As indicated earlier, for Parsons there is a duality between individual freedoms and the demands of the system.

By contrast, from Elias' (1978) perspective there is no such duality. Power is not a 'thing' or an object that is owned (Foucault, 1979; Elias, 1978; Clegg, 1989), but is part of an ongoing relationship. Elias (1978) does not separate structure from agency, but conceptualises large social configurations or networks, explaining the emergence and function of large societal structures without neglecting the aspects of individual agency. In fact, structure and agency are paradoxically formed at the same time, as individuals continually negotiate their relationships through sustained spontaneous interactions. Within these groups, individuals form the social structure and are formed by it through the self-organisation of interdependent people, rather than through cultural systems or social forces.

I will later show how the distinctions between the ways in which power is conceived affect the way we think about the employer–employee relationship, as the employer is often viewed as 'owning' power and is thus the more dominant character. By acceding to this conceptualisation, I will argue that this leads to a reification of the psychological contract as a structure. This then negates the ongoing relationship in which the employer and employee negotiate their relationships through sustained spontaneous interactions.

I will now build on the different theories that I have illuminated above, within the context of structure and agency, by analysing power in organisational life.

Power in Organisations

According to Clegg (1989), power in organisations must concern the power of hierarchical structures of officers and their relation to each other (ibid, p. 189). Clegg also maintains that, in certain circumstances, agency may have a more collective form, as not all agents are human actors: 'power may be vested in non-human entities as diverse as machines, germs, animals and natural disasters' (ibid, p. 188). It is not clear how these inanimate objects can exercise agency, but Clegg is making the point that, in his view, agency is not just about the actions of individuals.

In a similar way, Ham (2005) refers to power and regulation as a collective form within the NHS. He argues that the health service is experiencing a combination of controls – some hierarchical and some regulatory – that together will restrain the power of local organisations. There is a tension between desires to devolve power to local organisations in conjunction with politically set national targets. Ham (2005) argues that the challenge is to

> …create a framework in which central controls and national targets are limited to high priority areas and inspectors and regulators intervene in a way that is proportionate to the performance of NHS organisations. Only in this way will the enterprise of managers and clinicians at a local level be released to deliver the improvements in performance set out in the new planning framework.
>
> (ibid, p. 107)

Ham (2005) is concerned that the conflicting messages from government inhibit managers and clinicians from delivering quality healthcare. Staff invested time and resources in attempting to negotiate the extent of their influence and authority at a local service delivery level, to comply with national targets and satisfy local and national regulators.

Some authors (Mintzberg, 1983; Weber; 1978) stress the connection between obedience as a central tenet to the analysis of power in organisations. Mintzberg (1983) also uses the terms 'influencing' and 'controlling', exploring structures that hold potential power. Pfeffer (1992) depicts power as political battlefields where opposing power structures compete and contribute to the development of the organisation. In this way, power is seen as a '"capacity" premised on resources control' (Clegg, 1989, p. 190). This is illustrated

earlier as power as an observable phenomenon, as described by Bachrach and Baratz (1962), Dahl (1957) and Lukes (2005).

Assad (1987) research stresses the relationship between discipline and organisational virtue, or achievement. The mechanism for this achievement, argues Clegg (1989), has come to be termed ‘disciplinary practice’. For example, a system’s approach to measuring performance data, supervision, policymaking, and appraisal could be seen as a way of controlling the behaviour of the individual. I will consider the implications of regulation and control of professionals in the section on rejection later in this report. This also characterises power in the context of Parsons, a theory that is based on a consensual model linking power with authority in the best interests of society.

Clegg (1989) argues that this control, necessary to secure the best interests of society, is further secured through contract exchanges where the cooperation of the employee is secured. These contracts are ‘rarely reciprocal, conflict-free and equal exchanges’ (ibid, p. 193). He does not make explicit whether these contracts are written or psychological, but points to the resources that empower the employee (their skill, knowledge and physical attributes) being weighted against the resources that empower the employer (ownership of the means and production, state and legal support and managerial sanction). Clegg (1989) sees this as an issue of control, as the rational employer tries to govern the relationship and the production of meaning. He argues that contract exchanges are unrealistic and misguided. This theme will be taken up in the section on psychological contracts.

Morgan (2006) claims that most organisational theorists take the view of Dahl (1957), who purports that power involves getting another person to do something that they would otherwise not do. Some organisational theorists study which groups become dependent on each other, while others study the historical forces that ‘shape the stage of action on which contemporary power relations are set’ (Morgan, 2006, p. 166). They are basing their theories on agency and the ‘power to’ or ‘power over’.

However, Morgan (2006) then examines a broader church, looking at sources of power that are used to shape the dynamics of organisational life. Formal authority, he claims, is authority that legitimises power through social approval as people accept that a person has a right to rule and it is their duty to obey. Control over resources is another form of

power, as is control over knowledge and information. The use of organisational structures, rules, regulations and procedures, viewed as rational instruments, are seen as reflections of a struggle for political control. Morgan (2006) is thus using both agency and structure to define the use of power in organisations.

Clegg proposes that power can be seen through three distinct circuits of power, which he describes as episodic, dispositional and facilitative power. Central to each circuit is, he argues, effective organisation. Episodic power is the most visible circuit of power, where periodically A has power over B; for example, when a police officer directs traffic, exercising power over car drivers. However, at a deeper level, there is a system of meaning in which the authority of the police officer 'exists'.

This deeper meaning lies in the idiom of the second circuit, dispositional power, providing the context for episodic power. Dispositional power is a system of meaning and being-in-the-world. It works through the creation of specific meaning tied to rules that are followed in the workplace. As dispositional rules and meanings are reproduced, membership to the system is re-created, thus establishing social integration. This is a structuralist approach that is likely to be resisted through individual agency. Therefore, dispositional power has to be reinforced and fought for. Adherence to the rules brings about a disciplined worker who accepts a particular form of relational domination.

The third circuit of power, termed facilitative power, is based on Parsons' notion of power. It is a transformational concept, which lies in the ability to achieve goals and get things done. Clegg is aiming to provide an insight into different notions of power and, on this basis, claims that power can be understood analytically as moving through three circuits 'carried always by the organisation of agencies' (Clegg, 1989, p. 239).

Clegg (1989) is attempting to bring together the notion of power as a capacity, as a structural concept, and as a facilitative concept within an underpinning framework of the organisation. In his framework, he is arguing that, by following and understanding an apposite system of rules within a facilitative structure, organisations seek to be sufficiently robust to outflank competitors.

Mann (1993) has written extensively about the sources of power over periods of history. He maintains that the choices available at a moment in time are situated in complex

overlapping networks of power that are continually negotiated in novel ways and, in the process, transformed. Similarly Elias' ([1939] 2000) analysis of Western culture reaches a similar conclusion: the constraints imposed by others were converted to self-restraint over time. Elias argues that individuals and groups interact in their local situations in an intentional and planned style, but need to be taken in conjunction with other groups that are behaving in the same way. Patterns emerge from the interplay of this population-wide interaction, but the consequences of how these activities, plans and intentions will emerge cannot be predicted. What Elias is describing here has been taken up by complexity scientists as self-organisation and emergence (Stacey, 2007).

Earlier, I described Elias' understanding of power as a characteristic of all human relating, by which people are interdependent; have different levels of dependency, based on their need of the other; and constrain and enable each other's actions within the relationship. Organisations are not structures, nor are they the blueprints of individual or group design. It is through the simultaneous conflicting–competitive and cooperative–consensual relationships in organisations that everything happens. This is underpinned by relations of power as people interact in their day-to-day experiences within organisations. The social structures are continually negotiated within the relationship, since there is no duality between structure and agency as agents are ceaselessly negotiating their social norms on an ongoing basis.

As can be seen, different concepts of power in the more organisationally orientated literature reflect many of the debates in my earlier analysis on the concept of power. Morgan (2006) acknowledges the lack of consistency between theorists. Some claim that agents might be non-human entities; others focus on the virtues of disciplinary practice through domination; and others, for example, through 'circuits of power', suggest a combination of a number of concepts.

An ongoing theme throughout my inquiry has been how the notion of power moves or changes based on need or dependency, and how shifts in power relationships affect the patterning of who is included and excluded. Thus, the role of power as an enabling/constraining aspect of any relationship has become increasingly significant in understanding my professional practice. This way of thinking leads to the perception of power as part of a relationship, which is co-created by individuals and groups, rather than as a capacity that is owned and controlled by an individual. This provides a more fluid

quality to the concept in which the scope is, paradoxically, constraining and enabling, inclusive and exclusive, conflictual and harmonious at the same time.

I will now consider the implications of the power literature on my narratives. The notion of power was an implicit theme in Project 1, where I discuss the 'authoritarian ward sister' and the petulant CEO. At this point, I was moving from a perception of the power relationships from an elitist stance to a more relational position. I developed this theme further in the following two projects, exploring power as a characteristic of relationships.

In Project 2, I reflect on the power relations ebbing and flowing between the two consultancy companies. The power balance initially appears to be in favour of Queensborough (QB): I perceive that they had 'power over' our small and unproven organisation, since they were the nationally recognised healthcare consultancy. This affects the development of the programme, and I reflect on how my associate group spent too much time examining the power dynamics rather than focusing on how we could influence the relationships to develop an innovative programme. I also learn that, by feeling vulnerable, we accepted the belief that we were an inexperienced group, and thus feel excluded.

My thinking has shifted since I wrote this project and, rather than seeing power as a struggle between obedient employees and a controlling employer (Mintzberg, 1983; Weber, 1978), I now see how the interdependencies between the two companies and the client ebbed and flowed as a number of power scenarios were played out. Although I focus on the power relations between the two companies, I am less aware of how the client's frustration with Gloria, the QB leader, enhanced the power ratio in favour of Giselle. In Elias' terms, the relative strength (or power balance) lies unwittingly with Giselle, because we accept the terms of the contract requiring us to work with QB. Gloria, however, continually challenges the client to change the contract in favour of one provider. Because of this, Gloria becomes more excluded as her attitude ultimately leads to her dismissal from the project and reduces the credibility of the QB Company.

In my fourth project, I reflect on the power relationships between the CEOs and their Directors of Nursing (DoNs). In line with my earlier understanding of the organisation as a cybernetic system, which I reified as an entity in possession of power, the DoN and I experience feelings of considerable vulnerability. The CEOs' power could not be

absolute: their authority depended on the DoNs acceptance that they are less powerful or more dependent. Although many appear to have been treated unfairly, they had sustained the power dynamic through the collusion with their CEOs. Nevertheless, I point to the element of choice that negates the assumption that staff are the victim of their managers' behaviour. The DoNs could have taken their CEOs to employment tribunals, published their experiences and sought press coverage. This would require considerable courage, as the social norms of the NHS would not endorse this degree of confrontation.

The concept of power is crucial to my work as a management consultant with the nursing profession. I am arguing that the notion of power is premised on relationships in which people are dependent on each other and where the degree of dependency changes according to the degree of need. In the NHS, the fluctuation of power relationships is rarely articulated. Rather, there is a simple bifurcation between those with and those without power. Throughout my work I am challenging this notion, showing that emergent power relations are an inherent part of human relating.

Understanding the theory of power as a relational paradigm, rather than an object owned by another person or 'organisation', has fundamentally influenced my professional practice by reducing my sense of powerlessness and providing the prerequisite for personal responsibility and choice. Taking a reflexive approach to my work has enabled me to offer insights into the power relationships between the clinical and managerial factions when helping clients and colleagues make sense of their relationships.

An example of this occurred in my current role as a Regional Director for the Royal College of Nursing (RCN). Claire, one of the senior Regional Officers, contacted me about a local employment dispute. I was initially concerned about my lack of experience in employment relations. However, she described how the staff side (containing all the unions within an NHS Trust) had gone into dispute over the downgrading and possible redundancies of a large number of nurses. Claire described how a local director of one of the other trade unions had used a television interview to 'show their power' by ridiculing the hospital. This director had said they would 'fight to the death and stop the hospital's plans, which would ultimately bring the labour government down'. We had a conversation about what she meant by 'a show of power'. She felt that RCN members might be enticed by the rhetoric to join the other trade union, as they appeared to express members' anger in an overt and 'powerful' manner.

I suggested that the power relationship between the College, the other union and the Trust HR director was in an interdependent one, that they were all pitting their strengths against each other, and that their power ratios would rise and fall as the dispute progressed. I said that the other trade union 'would only be as powerful as we let them be, as no one could own power'. She became thoughtful and then realised that her power relationship with the Trust had changed since the other union undertook the television interview. The previously positive relationship with the Trust was enhanced, as she had not taken the aggressive stance of the other trade union and her professional approach was recognised.

We decided that we needed to build on this relationship, but also reassure our members that the College had authority in the situation. We agreed that she would issue a press statement outlining the College's disappointment at the Trust's action that had resulted in a dispute, and stating that it was seeking to work with the Trust to reconcile the position. Claire then wrote to each member to inform them of the College's position and reassure them that the College was working hard on their behalf to reconcile the situation.

Although this is a brief outline of the long and in-depth conversation I had with Claire, it illustrates how I used my understanding of the theory to inform my professional practice to analyse the power relationships and think through, with Claire, how to deal with the situation. Although I was not experienced in industrial relations, this narrative shows how my observations about the nature and 'ownership' of power helped Claire to recognise that her trade union colleague's rhetoric had not intimidated the HR director. Through our conversation, she realised that she could build on her positive relationship with the HR director to her advantage and also find a way of asserting her independence and authority to placate the members she represented.

In summary, I have argued that power is a central aspect of human relating, rather than an organisational artefact that has the ability to exercise domination and control, or a structure dominated by rules and procedures. Rather than thinking about power as linking social knowledge and hegemony, or facilitative institutionalised authority, a more useful way of thinking about power is through the enabling constraints of the interdependence between people and groups.

Inclusion/Exclusion and Power

In this section, I will exemplify the way that I have conceptualised power and inclusion/exclusion. I will then amass the staff dissonances that I have drawn attention to in the earlier sections of this synopsis, leading to an analysis of the employer–employee relationship.

The emotions associated within power relations are experienced through feelings of inclusion and exclusion within social groups; 'power is thus felt as the dynamic of inclusion and exclusion' (Stacey et al 2000 p. 353). In managing this anxiety, Stacey (2003b) asserts that 'when the patterning of relationships can contain the anxiety "in a good enough" manner, then there is the possibility of change' (p. 353). Walker (2005) argues that 'demands and pressures can be more easily managed and quality services developed if the experience of anxiety in the present moment is attended to' (ibid p.3). A practical example is illustrated in Project 3, where the action learning sets forum provides staff with the opportunity to articulate and reflect on their relationships, their concept of power and related behaviours, and consider different ways of working.

I am conceptualising power as a function of dependency that ebbs and flows as people are included and excluded from the established group. I illustrate how the inclusion/exclusion dynamic is felt by the Giselle group as they feel excluded by the well-established and nationally recognised QB healthcare consultancy. In Elias' terms, the relative strength (or power balance) is in Giselle's favour, as the client approves of our clinically competency group but we are unable to see this at the time and behaved in a defensive manner, blaming QB for making us feel excluded. In this way the power relations evolved and, because of our sense of exclusion from what we perceived to be the established group. I think we took fewer risks and thus diluted the strength of our contribution.

This work is also informed by the Elias and Scotson (1994) study on life in Winston Parva, a Leicestershire suburb, to illustrate this phenomenon. They describe a clear distinction between those who had lived in the village for several generations and those who were new to the area. Although there were no obvious differences between the two groups, Elias and Scotson highlight the consequences of the cohesion that developed among the established residents, who cultivated a 'we' identity as a group with common

attributes that had emerged over their years together as a community. The newcomers had no history of being together, so, in this context, they became outsiders.

Professional groups come to think of themselves as a ‘we’ group with different norms and values leading to the exclusion of others. The theme of inclusion/exclusion is sustained by the notion of values that bind one group together while excluding others. Values are ‘fundamental aspects of self, giving meaning to life’ (Stacey, 2005, p. 10). I illustrate, in my third project, how the Senior Sisters feel like marginalised ‘outsiders’ as they are taken to task for their poor performance.

I now propose that they became an inclusive group that excluded and rejected general managers, seeing themselves in some ways as a group of higher value: they felt that providing equity of care to all children was more important than the performance management ideologies advocated by managers. In doing this, they ignored the managerial aspects of their role by returning to the comfort of their clinical experience. They also ignored their responsibilities to challenge junior colleagues to co-ordinate adequate staffing levels to ensure that the skills were available to provide the high-quality childcare that they said they valued.

In Project 4, I describe the sense of shame and exclusion that I feel through being made redundant. Like many of the DoNs in the narrative, I feel excluded and victimised by a perpetrator called ‘the organisation’. My supervisor challenged me about this and, as I reflected on the experience, I realised that I was not made redundant because of a systems approach to management. I could equally have been made redundant by staff who embraced complex responsive processes thinking about organisations. I describe how I was employed by a CEO who valued organisational development. When he left, the patterning of the local conversations changed to one where cost-savings and performance targets became central. The impact of the change of my line manager affects my employee–employer relationship so significantly that it ultimately leads to my redundancy.

The notion of inclusion/exclusion is an important aspect of my professional practice. Introducing the concepts of inclusion/exclusion and highlighting patterns of blame and gossip will often move the conversation from a stuck to a more free-flowing conversation (Shaw, 2002). I work with the Senior Sisters in Project 3 on different ways of providing

impartial care. We discuss how a target-driven environment might be perceived as favouring the access to particular care groups. I challenge their concept of management as a secondary value to clinical care and they concede that, by excluding themselves from these responsibilities, there might be a detrimental effect on the care of children.

I also work with DoNs to examine the relationships with their peers and CEOs, encouraging them to innovatively contribute to the wider remit of their executive director roles. We focus on developing relationships that will ensure their work is included and valued in the boardroom, thus aiming to secure their position at that level. In reflecting on power as the 'felt' response to inclusion/exclusion, I have become increasingly cognisant of this with regard to the employer–employee relationship, which will be examined later.

While acknowledging the interdependence of doctors' nurses and managers, as their power relationships ebb and flow, it is important to recognise that they are continually renegotiating their enabling and constraining relationships within their interactions. Within these relationships, they are included at certain times and excluded at others, depending on the changing dynamics of the relationship. In detailing such micro-interactions throughout my four projects, I illustrate how policymakers and managers are assuming that professional managers take up and implement new policies from their systems perspective, whereas I have analysed how this occurs within daily interaction.

In summary, I have revealed how the different interpretations of power have led to different ways of understanding and interpreting the phenomenon. I concur with the view that power evolves, rather than being owned by individuals: power is not a function of role or managerial status, but rather a pattern of relating co-created in the interdependent relationships between staff, upon which the local implementation of any central policy directive is contingent. It is within this fulcrum of local interactions that central policy directives and performance objectives are functionalised.

In the next section, I will examine the concept of novelty and innovation, which emerged from the analysis of my four projects. I did not address this concept in depth within my earlier work. I now begin with a definition of novelty and innovation and then review a range of traditional theoretical and empirical literature on innovation, much of which uses systems approaches, to provide different ways of understanding and interpreting innovation.

Novelty and Innovation

I will now examine what is meant by the concept of novelty. The dictionaries provide a number of definitions: the Collins Thesaurus (1995) defines novelty as freshness, innovation, newness, oddity, originality, strangeness, surprise, unfamiliarity and uniqueness. Chambers (1998) describe it as newness*;* unusual appearance, anything new, strange or different from what was known or usual before. It is a term often used in the natural sciences, where novelty is associated with evolution and emergent order (www.yourdictionary.com). I am using the term to mean something new and creative.

Innovation originates 'from the Latin word *in* and *novare* – to make something new, to change' (Bessant and Tidd, 2007, p. 12). The Department of Trade and Industry (DTI) in the UK defines innovation as the 'the successful exploitation of new ideas' (DTI, 2004 p.2). Van de Ven et al (2008), however, argue that 'invention is the creation of a new idea; innovation is more encompassing and includes the process of developing a new idea', (ibid, p. 9). Hence, innovation involves change, new ideas and the processes involved in implementing the new idea.

I will continue to position the differing views of novelty and innovation within the paradigm of structure and agency. There are numerous theoretical models and examples of empirical research that demonstrate different ways of analysing and implementing change, novelty and innovation. Rather than emphasising organisation-wide models, Perry-Smith and Shalley (2003) view innovation from a personal or individual-agency perspective, defining creativity at work as

> an individual-level construct – as an approach to work that leads to the generation of novel and appropriate ideas, processes, or solutions… Individuals can be creative in their jobs by generating new ways to perform their work, by coming up with novel procedures or innovative ideas, and by reconfiguring known approaches into new approaches' (ibid, p. 90).

Similarly, Bessant and Tidd (2007) assert that creativity at work is related to individual agency and the choice between the routine and novel. They argue that the individual's personality, the process of creative thinking and environmental factors inhibit or facilitate creative performance. In this context, creativity is seen as a continuum where the individual generation of new ideas is then shared with others and, through interaction

with individuals and the environment, their ideas and concepts have the potential to be translated into new products, services and businesses.

The concept of innovation is characterised by Bessant and Tidd ((2007) within three core themes: generating new ideas, selecting the good initiatives and implementing them. They acknowledge that this is fraught with uncertainty, relying on trial and error to find out whether an idea is good. They maintain that even if project managing the resources and budget to produce a new product or service is successful, there is no guarantee that people will people will adopt it and it will diffuse widely. However 'innovation is a not a simple flash of inspiration but an extended and organised process of turning bright ideas into successful realities' (ibid p. 298). Innovation, they maintain, is an output a new product or service and the process of making it happen.

Focusing on how innovation is perceived in organisations, some writers argue that novelty and creativity can be seen as a continuum (Amabile, 1996; Mumford, 1995; Rothwell and Gardiner, 1985; Van de Ven et al, 2008). At one end of the spectrum are minor adaptations to existing ideas and, at the other end of the continuum, are major breakthroughs that represent new and radical ideas. So novelty should not be seen only as major changes to working practice or groundbreaking new inventions: it can also be minor changes.

The innovation and change field is dominated by literature promoting logical and rational models. Poole and Van de Ven (2004) see innovation as an important partner to change, which is 'both a product and facilitator of the free exchange of ideas that is the lifeblood of progress' (ibid, p. xi). They define organisational change in terms of difference in form, quality and state over time, which can be measured. Poole and Van de Ven (2004) contend that much of the literature on innovation and organisational change focuses on these differences, what produced them, and the resulting consequences.

So novelty and innovation can be understood as

- the creation of a new idea
- the process of developing a new idea
- an individual approach to work that generates new working practices that are taken up by others and evolve into new practices
- an extended organisational process or rational change model

- a small organisational change or a revolutionary new concept, product or system
- a change in a product or process where the differences can be measured

The management of novelty, innovation and change

In the next section, I will further consider what is meant by the concept of novelty innovation and change by examining some of the traditional approaches to the concept, drawing on the structure-agency construct. I will focus on the management and implementation of the innovation process because the focus of my projects is on how innovation occurs in organisations from a professional practice-based perspective.

Garside (1998) assets that managers involved in changing health services at a systems and processes level must recognise that change has to be led and managed. She argues that managers can 'draw on the lessons from the field of organisational development and organisational change' (Garside 1998 p. S9). In a study of a number of different change models, Seo et al (2004) reviewed the literature on the phases of organisational development (OD) that took place over the late 20th century and continue to influence innovation today. I will use their dimensions to examine the implementation of novelty and innovation in organisations. I will review these phases of organisational development in greater detail later, but briefly, the dimensions are described as:

- First-generation OD, where practitioners focused on innovation and change within a local incremental and sequential approach
- Second-generation OD, which centres on a whole system's alignment of the organisation to its environment
- Third-generation OD, which is identified as learning organisations wherein innovation and change are focused on individual and group learning.

The first dimension of the Seo et al (2004) model is related to Lewin's (1951) three-step framework of unfreezing an undesirable present state, moving or taking action, and then refreezing the desired state of effectiveness. First-generation OD practitioners focused on developing and improving human agency in an incremental and sequential approach, and many of the OD frameworks at this time are encapsulated to a greater or lesser degree in Lewin's (1951) framework.

Organisational members define the problems and solutions inside the system and are considered to be the primary agents of change, advised by OD facilitators. This approach assumed that the organisation could collectively envision what the desired future state would look like. The organisation is viewed as being at equilibrium or in a balanced state, by equal and opposing forces and is the OD practitioner's role to identify these significant forces (Seo et al 2004). This is followed by planning a cycle of goal formulation, implementation, evaluation and modification, in the belief that this would lead to improvement. Then the organisation would re-stabilise into a new state of equilibrium.

According to Garside (1998), although the Lewin model remains a helpful concept, it requires the whole organisation to concur with the new vision, disengage from the past and recognise that old ways of doing things are no longer acceptable. Seo et al (2004) argue that one of the problems with Lewin's (1951) approach is that innovation is fragmented rather than being part of an overall change strategy. Garside (1998) comments that the model has much to teach current managers: she observes that the Lewin model does not consider detailed change process issues and prescriptions for managers to action.

Second-generation (Seo et al, 2004) OD centres on the alignment of organisations to their environment. Interventionists focus on major organisational transformations led by the Chief Executive Officer (CEO) to help organisations develop and attain future visions. Rather than focusing on individuals or groups, multiple interventions are generated to transform the entire system, which will take the organisation towards to a desired future. This involves large-scale interventions at an agency level, emphasising the role of the senior executive as the agent to provide the new vision and organisational logic (Keck and Tushman, 1993).

At a structural level 'transformation works through bending organisational frames and altering the architecture and infrastructure of the organisation' (ibid, p. 90). So in this approach both structure and agency were targeted as foundations for change, but the focus of second-order OD relies on the top management team providing direction. It centres on discarding old practices and focusing on new, specific, organisational strategic goals within a given time frame and space. The OD facilitator is involved in the planning and directing of the change process. Like first-order OD, the change is episodic, but here it is more rapid and radical.

Smith and Tushman (2005) looked at how leaders balance exploratory and exploitative activities in developing innovation and sustaining the existing product. They proposed that too much exploitative activity resulted in inertia and conservatism, while too much exploration drove out efficiency, learning and innovation. They concluded that sustained performance occurs by attending to and dealing with the strategic contraindications of short-term performance and long-term adaptability, exploration and exploitation. Garside (1998) draws attention to the pace of change within the NHS and the need to focus on immediate short-term solutions rather than develop longer-term change strategies.

Instead of focusing primarily on processes, Pettigrew et al (1992) argue that the context, the 'why' and 'when' of innovation and change, is significant. The historical, cultural and political elements ought to be considered. As in second-generation OD, they differentiate between the outer context of prevailing economic markets, social and political environments and the inner influences, such as resources, capabilities, structure, culture and politics. Pettigrew et al (1992) draw attention to the complexities of organisational life and (unlike the Lewin model, for example) considers the features of the internal and external environment.

Garside (1998) points to the resisters to change and suggests that innovation and change often generate anxiety about the changing power dynamics between staff, loss of job security and potential loss of income. This might be particularly problematic if staff feel that the changes are imposed. Losses of position or access to information in the organisation, and fear of being prevented from acquiring new skills, are other resisters to change. These factors centre on individual agency as the structure of the organisation alters. However, group resistance frequently occurs if teams are concerned about changes in their working processes, power relationships and their social norms.

Hargreaves and Van de Ven (2006) point out that innovation scholars have examined staff resistance within organisations that are mandated to implement externally developed technical or institutional innovations. This is particularly relevant to healthcare, where the sharing and spreading of good practice is encouraged as I describe in Project 4. Hargreaves and Van de Ven (2006) argue that the innovation needs 'reinvention' to be owned by the new organisation. There must be enough autonomy given to the adopting unit to identify with, and internalise, the innovation, which is particularly difficult if multiple interventions are imposed to change the entire system. However, if innovation is imposed, then resistance to the changes will increase.

However, Smith and Tushman (2005) suggest that understanding how organisations effectively manage contradictions is an important question in the management of innovation. They conclude that balancing contradictions in decision-making is rooted in cognitive frames and processes, which means that the senior management team is encouraged to effectively embrace rather than avoid contradictions. Based on the assumption that the existing product and the new innovation must succeed, managers confront the differences and similarities between the new and the old and manage the contraindications through cognitive frames.

This contradicts Schumpeter's (1934) 'winds of creative destruction', where new innovation destroys old ways of working. In the Smith and Tushman (2005) model, managers are responsible for reconciling the simultaneously creative and destructive elements of change. Though the focus of their research had taken place with top management teams, in my own research I found that staff at all levels of the organisation are working with this paradox. For example, in Project 3, the Manager tries to find innovative working patterns and maintain clinical care, while retaining quality and effectiveness. The Senior Sisters see the changes in practice as a threat and do not want to lose their everyday ways of working. They see innovation as destroying their customary routines.

Rather than thinking about innovation as being restricted to an individual or top team, Schumpeter (1934) describes innovation as both social/organisational and individual. Thus, he viewed innovation in terms of both structure and agency. He contends that economic growth had to be explained in terms of the dynamics of scientific and technological innovation. The agent as innovator was separate from the innovation or advancements, which were seen as part of a systemic outcome of change within the organisation. He saw organisations as systems with characteristics that enabled people to innovate. This way of thinking about systems was analysedearlier; but, in the context of innovation, Schumpeter (1934) argued that the role of innovator was not confined to one person but could be shared by many.

Similarly, Van de Ven et al (2008) claimed that, rather than innovation being led by an entrepreneur working with an implementation team, they observed that many different staff groups engaged with and disengaged from the innovation process over time, as their

interest in being included ebbed and flowed. They centre on the importance of staff relationships rather than leadership and process implementation.

The third generation identified by Seo et al (1994) are Learning Organisations, where change is focused on individual and group learning. Sharing and utilising knowledge through an ongoing and cumulative process is favoured, rather than focusing on problem solving. Individuals and groups are reconfigured into learning systems at an organisational level, united through collective visions. Change is seen as structural, dependent on the sharing of visions and ideas. It is also specific to individual agents and groups, as organisational learning is enhanced through members developing their ability to examine thought processes and scrutinise their practice through mental models. When these sequential stages involve the development, implementation, and then the questioning of the appropriateness of the operating norms, this is known as double-loop learning, Seo et al (2004).

Thus, the phases of the process can be assessed during the journey and people are thought to learn by trial and error: they do more things that achieve positive results, and less of what leads to unsuccessful outcomes. This is conceptually appealing, as it offers reassurance to the innovators by providing a coherent framework in which ‘people can gain intelligence during their innovation journey by reducing uncertainties between action and outcomes during each stage of the process’ (Van de Ven et al, 2008, p. 4). Rather than centre on external drivers for change, as in the second OD dimension, the primary emphasis is building on the internal positive aspects of the organisation.

Betts and Holden (2003) studied the development of organisational learning in a public sector organisation. Managers engaged in the development programme experienced tensions between opportunities for individual growth and the constraints of traditional value systems. Individual agents developed new skills; but they found that the existing structures, the rules and ideas that emerged within local power relationships, inhibited the application of new knowledge in the workplace.

This approach also assumes that individual or group reflection will create applicable learning. In the Betts and Holden (2003) study, they observed that there was a failure to connect individual, social and organisational learning. It became clear that senior managers were attracted to learning that could increase the achievement of targets, rather

than the less easily definable enhancements of individual learning and development. They concluded that, for organisational learning to take place, learning must be collective, processual and, above all, cognisant of organisational power patterns. However, members learn in different ways and within differing timescales and some staff might be more open than others to more reflexive learning models. Betts and Holden (2003) do not make it clear how being cognisant of power relationships, in particular, enhances organisational learning.

There are aspects of both the second and third dimension of the Seo et al (2004) model in Bessant and Tidd's (2007) description of a systematic framework of outputs and processes. Here they separate out individual agency from other types of innovation. They single out four dimensions of innovation:

- **Product** innovation – changes in the things (products/services) which an organisation offers; *resembling Seo et al's second-generation OD*
- **Process** innovation – changes in the way that things (products/services) are introduced; *resembling Seo et al's first-generation OD*
- **Position** innovation – changes in the context in which the products/services are introduced; *resembling Seo et al's second-generation OD*
- **Paradigm** innovation – changes in the underlying mental models which frame what the organisation does; *resembling Seo et al's third-generation OD*

(Bessant and Tidd, 2007, p. 13: Italics added by the author)

The first three bullet points refer to changes in the outputs, processes and the environment. Human action is required to change these aspects of innovation; but Bessant and Tidd (2007) appear to be drawing attention to a specific model of human action, which they call paradigm innovation. This reflects Seo et al's (2004) third generation of OD. Mental models are based in cognitive psychology, made popular in organisational theory by Senge (1990) and his work on learning organisations. Individuals are challenged to carefully examine their mental models, to gain mastery of their deeply ingrained assumptions and learn from them.

The process of learning involves identifying similar patterns and characteristics in one problem, which triggers the use of previous mental models that are amended to meet the new challenges. Although Bessant and Tidd (2007) are clear that there is movement between the paradigms, they separate out mental models as a separate entity from

products/services, their introduction and context. Later in this section, I show that, rather than separating out the individual and group mindsets, change and innovation are part of ongoing relationships that drive the continuous transforming of the organisation.

In outlining the Seo et al (2004) dimensions, I have shown how a number of different models attempt to describe and develop organisational innovation models. I have summarised the main points as follows:

- **In first-order OD**, innovation is described in terms of individual agency
    - Models focus on managing innovation at a local problem-solving level
    - Change is episodic, bringing slow and incremental change
    - Problems are identified and solutions developed through a planned, systematic approach to the implementation of the locally agreed vision or future state
    - There is a tension between changes at a local level and organisational direction
- **Second-order OD** focuses on whole system change
    - Models are more detailed and prescriptive, and focus on multiple interventions
    - Leaders are identified as individual agents who share their compelling visions of organisation-wide improvements
    - In a whole-scale organisational approach, the human aspect is downplayed as the shift to strategic and economic systems takes precedence
    - The focus of whole-scale organisational change appears to privilege the top management team over the individual entrepreneur
    - Change is episodic but more rapid than first-dimensional OD
- **Both** dimensions rely on systems planning, interventions, monitoring, evaluating and modifying performance to achieve the goal; this is known as single-loop learning
- **Both** dimensions assume that the entrepreneur or innovation team is able to stand outside the process and control the stability and equilibrium and disequilibrium of the organisation by their interventions
- **In third-dimension OD,** organisational members develop their ability to examine their thought processes and scrutinise their systems and processes practice through mental models; double-loop learning occurs as

- Learning organisation appears to bring together a shared vision alongside individual reflection and shared knowledge and learning
- Change is continuous, so that when unpredictable organisational problems occur, members are likely to be better prepared
- Resistance and power relationships can interfere with the focus on learning.

I have shown through the models outlined above that planned organisational change can be packaged in a number of ways. However, there are various tensions attached to these approaches. Some models focus on managing innovation as a local problem-solving, episodic process that brings a slow and incremental change to the structure of the organisation. Fundamental to this approach is the identification of problems, moving through a planned systematic approach to the implementation of the locally agreed vision or future state. Focusing on individual creativity or problem solving ignores the tension between changes at a local level and the direction in which the whole organisation may be moving.

Other models are more detailed and prescriptive, and focus on multiple interventions aimed at achieving the organisational vision by changing the entire system. Leaders are identified as individual agents who share their compelling visions of organisation-wide improvements. In a whole-scale organisational approach, the human aspect is downplayed as the shift to strategic and economic systems takes precedence. The focus of whole-scale organisational change appears to privilege the top management team over the individual entrepreneur.

Finally, in the learning organisation model, the facilitation of a shared vision is accompanied by individual reflection and shared knowledge and learning. Rather than seeing change as an episodic and erratic approach, the learning organisation sees change as an ongoing continuum. However, the concept of organisation-wide learning is problematic. Some members will resist, and power relationships can interfere with learning. Nevertheless, this is conceptually a continuous, rather than episodic, approach: when unpredictable organisational problems occur, members are thought to be better prepared because of their ability to scrutinise their own practice.

Van de Ven et al (2008) assert that we know relatively little about the emergence of creativity and novelty, nor about the generative process by which innovation develops. They concur with the earlier analysis that the focus has been on the use of models, and reference the traditional methods of illustrating the process by which innovation emerges through a staged, sequential, cybernetic approach. Van de Ven et al (2008) undertook a ten-year longitudinal study of innovation within one organisation. They bring together many of the models portrayed in the Seo et al (2004) dimensions. They describe a cyclical model in which one-half of the cycle is identified as a series of *divergent* behaviours that are triggered by the infusion of resources (attention, time and money) beyond the system's normal sustenance. This increases the dimensions and complexity of the system, which tends to be a random and chaotic process in which new ideas and directions are explored. Learning by discovery, the encouragement and balancing of diverse views, and building relationships and networks are also identified as divergent behaviours within this half of the cycle.

In the other half of the cycle, *convergent* behaviour is described as an integrating and refining process that focuses on testing and exploiting a given direction. They claim that, in this half of the cycle, the complexity is reduced and moves the organisation into quasi-equilibrium. External constraints such as institutional structures, rules and mandates narrow the boundaries of action. In this cyclical process, innovation is enabled by the injection of resources and constrained by the structure of rules and the outcome of testing the new ways of working. They concluded that managers could manoeuvre the innovation journey but could not control it, especially in divergent conditions. Their research acknowledges, in greater depth, the agency aspects of organisational life. They also argued that, in divergent periods, familiar principles of rational management techniques such as goal-setting, trial-and-error learning and unitary leadership were appropriate.

Complex responsive processes and novelty, innovation and change

Moving from mainstream literature to a more human-centred approach, I will now study novelty and innovation as an emergent characteristic of complex responsive processes. I will define how a complex responsive processes approach may add to an understanding of how the dynamics of social processes promotes novelty and innovation. From this view, organisations are seen as patterns of relationships between people. Self-

organisation means that ‘agents interact locally with each other according to their own local principle of interaction’ (Stacey, 2007, p. 321).

Within these self-organising processes, the patterning of communication varies in erratic ways. Relationships are formed by the ebbing and flowing of the power relationships as they are negotiated between individuals and groups. Individuals form, and are formed by, individual agents and groups and by the social structures (the rules and ideas) that determine and constrain individual action within society. There is no split between structure and agency, as structure is formed as individuals and groups communicate on a day-by-day basis.

Mead’s (1938) work is one of the underpinning elements of complex responsive processes thinking. For Mead, novelty emerges in the interaction between people rather than through following rules that can be decided in advance. Mead (1934) argues that mind, self and society evolve socially. Fundamental to being human is our ability to reflect on ourselves as objects to ourselves. To do this, an individual takes up the attitude of the group through an internal silent conversation that involves a ‘me’, that is, the attitude of the group towards oneself. The individual’s response to the ‘me’ he calls the ‘I’. This is the individual’s response to the community or social view of him/herself. Mead argues that the ‘I’ response is potentially novel, and hence unpredictable. However, there is no split between the ‘I’ and the ‘me’; they are aspects of the same phenomenon.

This private, silent conversation is the same process as vocal, public conversations between people. This suggests that the individual and the social focus on one level of analysis, not two. Meaning does not occur in the mind of an individual who then takes action; it continually takes place in response to gestures within social relationships. Ongoing communication takes the form of words that embody meaning, which is understood within ordinary, routine conversations where individuals account to each other for their actions (Shotter 1993). It is in these interactions that patterns of conversations arise which, paradoxically, reveals both continuity and transformation, as there is the potential for new ideas to emerge.

In Mead’s (1934) way of thinking, there is no one person or group controlling or driving forward the development of novelty, as individuals are formed and being formed at the same time. There is a known/unknown quality to the interaction, in that there could be a

pattern of communication that may be repetitive of previous encounters or may generate transformative possibilities within the interaction. Joas (1996) considers the impact of evolving intentions on the conventional concept of planning, proposing that this could also be an emergent phenomenon, rather than seeing these as pre-planned, independent schemes that are decided before action is initiated. However, I would consider them to be useful artefacts around which conversations evolve, hence opening the way for innovation to evolve.

Sacks (1992), a conversations analyst, found from recording ordinary dialogue that he could build up an impression of the patterns of conversations between individuals as they took turns to speak. On a largely unconscious basis, each person brought his or her own life histories, skill and expertise into the conversation. They categorised or ordered this experience in relation to the group context and time in which they were interacting to ensure that they were understood. As they took turns to speak, they took up cues from others within the conversations; thus, as the conversation evolved, they could not be seen as acting solely as individual agents.

As shown earlier, Mead (1934) describes how individuals respond to, and take up, the gestures of others so no one person can control or direct the conversation. Therefore, there is the potential for an emergent spontaneity and improvisational quality to the conversation that cannot be organised or planned for. However, there is also repetition and familiarity within the style of interaction, which is recognisable to the individuals or groups and provides stability within the social structure.

Organisations can thus be seen as repetitive, interactive processes of communication that emerge and form patterns in the present moment. From these patterns, themes are continually reproduced that have the capacity to trigger transformation. It is in this potential for transformation that innovation occurs, through ‘the possibility that small differences, variations in the reproduction of habits, will be amplified into new action with new meaning’ (Fonseca, 2002, p. 9). Therefore, change is not seen entirely within a local dimension, as it is possible that the significance of the change has broader implications.

Shaw (2002) stresses the importance of ordinary, everyday conversations in organisations as the means by which change occurs. Rather than thinking about change within plans,

models or frameworks, she argues that theses vehicles often kill the potential for spontaneity within conversations from which new meaning can emerge. Instead of designing change in a pre-planned orderly fashion, Shaw (2002) draws attention to features or aspects of change that are excluded from systematic accounts of change initiatives. Rather than seeing change as something that needs to be managed, it is the themes that emerge from the patterning of ordinary conversation that direct what, and how, things get things done.

It is important to stress that these interactive processes of communication or conversations are both repetitive and potentially transformational at the same time. When the themes take a highly repetitive pattern, the conversations can lose their lively, spontaneous qualities and become stuck, and the emergence of new forms of behaviour is blocked. However, this is not to say that interaction is *either* repetitive *or* transformational. All conversation needs to be repetitive, to provide the continuity and structure that are required for social life, enabling people to get on with each other (Stacey, 2007). Paradoxically, for innovation to occur, conversations need to be both repetitive and spontaneously transformative.

The repetitive nature of conversation brings security, and people do not necessarily seek change intentionally (Fonseca, 2002). People become used to the stability and security of habitual ways of talking and feel threatened, even aggressive, when atypical discourses are introduced. As the patterning of conversations changes, so do the patterns of inclusion and exclusion, resulting in the reconfiguration of power relationships, which are often resisted. According to Stacey, (2007), ‘organisations display the internal capacity to change spontaneously only when they are characterised by diversity’ (ibid, p. 446). Relationships impose constraints on what it is acceptable to say, leading to unofficial ideologies that often undermine existing power relations through conversations organised by shadow themes.

As described in the Performance Management Section there is a tension between legitimate and shadow themes that organise the patterning of conversation. Legitimate themes organise what it is permissible to discuss openly and freely in terms of the official ideology of the organisations. Where people feel less able to speak openly, shadow themes organise informal conversations, with participants carefully selecting whom to confide in and challenging the official ideology.

Elias ([1965] 1994) shows how praise-gossip and blame-gossip, within ordinary conversations, sustains who is included and who is excluded within social groups. From the patterning themes that emerge from conversations, power relationships are sustained and potentially transformed through including and excluding groups of people. Gossip is a potent shadow theme, particularly among close-knit groups, who might feel threatened by the potential change in power relationships and wish to undermine those attempting to implement innovative changes in practice.

It is in the patternings of inclusion and exclusion that Stacey (2007) claims that a condition for creativity is the tension between shadow and legitimate themes organising the experience of relating. Fonseca (2002) argues that legitimate and shadow themes and the ambiguity, which emerges from ordinary conversations, characterise diversity. It is in this diversity that innovation and creativity emerge.

New meaning emerges from self-organising conversations characterised by legitimate and shadow themes shaped by power relationships. Different patterns of conversations continually merge, increasing the potential for misinterpretations. These patternings take the conversations into disequilibrium at times as people try to clarify meaning. It is in this negotiation of meaning that new novelty and innovation emerge. No one person can control the flow of conversation or the meaning that develops. A crucial characteristic of complex responsive processes thinking is the joint abilities of contributors to a conversation to negotiate a way through the diversities and misunderstandings to reach an understanding where new meaning can emerge.

The formal, legitimate conversations that take place in organisations form the stability and structure that people seek to take action and get on with their day-to-day work (Fonseca, 2002). However, within these legitimate conversations are shadow themes and misunderstandings that occur at the same time. New meaning is initiated as people attempt to negotiate these concerns and misunderstandings. This is a cyclical process, as organisations function in stable and unstable environments that are predictable and unpredictable at the same time.

Understanding the ambiguity of innovation and change in this way provides a very different way of thinking about the concept, as it acknowledges the disruptive elements of shadow themes and misunderstandings, and the ebbing and flowing of power

relationships that result in resistant behaviours. This is a way of viewing the manner in which innovation emerges. It does not represent a model or framework from which to plan change, but demonstrates that innovation is part of the everyday fabric of organisations. Leaders may wish to bring about changes in their organisations but as Shaw (2002) has shown in her work in organisations, it is in the ongoing meaning making between individuals and groups, rather than in plans and designs, that novelty and innovation occur.

The dynamics of the social process that promote novelty and innovation from a complex responsive processes perspective are as follows:

- Fundamental to being human is our ability to reflect on ourselves as objects to ourselves. To do this, an individual takes up the attitude of the group through an internal, silent conversation. This private, silent conversation is the same process as verbal, public conversations between people (Mead, 1934).
- Ongoing communication takes the form of words that embody meaning which is understood within ordinary, routine conversations where individuals account to each other for their actions (Shotter, 1993).
- There is a known/unknown quality of each interaction, in that there could be a pattern of communication that may be repetitive of previous encounters, or may generate transformative possibilities within the interaction.
- There is spontaneity and improvisation within the conversation that cannot be organised or planned for, as it emerges within the interaction (Shaw 2002).
- The patterning of conversations is organised by legitimate themes, which structure what it is permissible to discuss openly, and shadow themes where participants carefully select whom to confide in before challenging the official ideology (Stacey 2007).
- When the themes take a highly repetitive pattern, the conversations can lose their lively, spontaneous qualities and become stuck, and the emergence of new forms of behaviour can be blocked.
- The formal, legitimate conversations that take place in organisations form the stability and structure that people seek to take action and get on with their day-to-day work (Fonseca 2002).
- This is a way of viewing the manner in which innovation emerges. It does not represent a model or framework from which to plan change, but demonstrates that innovation is part of the everyday fabric of organisations.

An analysis of the different perspectives

I will now distinguish between the different views of innovation. Some innovative approaches focus on major innovation, which aims to change the whole organisational system. For others, changing the people and culture is thought to then lead to change. Several authors describe a continuum of innovation, where minor adaptations to existing ideas at one end are distinguished from major breakthroughs that represent new, radical ideas at the other. What is less explicit is the potential for minor changes, as identified in complex responsive processes thinking, to result in major transformations.

Innovation is seen as a system or process to be managed that focuses on the notion of a shared vision. Models of change are then designed to achieve the goals outlined in the initiative. The understanding of existing systems and processes and cultural norms are explored and later reviewed and adapted. The importance of individual and collective agency is also stressed in terms of engaging the workforce in a learning environment. I agree with Fonseca (2002) that it is meaningless to describe organisations as 'learning organisations' or to discuss whether people in organisations learn because it is the same process.

An example of the difficulties of planning organisational change was seen in the Betts and Holden (2003) evaluation of the learning organisation cited earlier. The change was planned in incremental steps as different groups undertook the programme. The authors referred to the power relationships that affected the ability of members to share their learning. Those who had undertaken the training were seen as outsiders, as they were challenging the structural norms of the organisation. Within these power relationships, an insider and an outsider group was developed. Rather than thinking about phased approaches, innovation is the emergence of new meaning that materialises within the power relationships within ordinary, everyday conversations.

Aspects of these models also include the need for a supportive environment for innovation to flourish, and the confrontation of core beliefs through the challenging of mental models. Change as patterns of ordinary conversations means that organisations change only as far as their conversational life evolves (Stacey, 2007). Creativity and novelty may or may not emerge from within these conversations; however, there is no division between agency, structure and organisation. Nor is there any focus on changing

the people first and then changing the organisation, since organisations and their individual members change together.

A complex responsive processes perspective reduces the problems outlined in the review of the traditional models, by not:

- attempting to predict the future and identify plans and solutions for a vision that may not necessarily be taken up
- attempting to change a whole system at once
- downplaying the human aspect to an element of a model within a strategic or economic system
- viewing change as an episodic unit
- assuming that the entrepreneur or innovation team is able to stand outside the process and control the stability and equilibrium and disequilibrium of the organisation by their interventions
- focusing on wholesale organisational change that appears to privilege the top management team over the individual entrepreneur.

From the dominant discourses, innovation and change are seen as making changes to procedures, setting targets or changing mental models rather than understanding that change occurs in the spontaneity and improvisational aspects of ordinary conversation. Traditional approaches are premised on the belief that innovation can be managed by moving the organisations from a stable environment, through a period of instability within a change programme, and return back to stability. There is a certain degree of logicality and calculation in this way of thinking, based on the premise that movement of the organisation into the future can be planned for. Stacey et al (2000) call this ‘rationalist teleology’, where organisations are perceived to be designed from organisational visions and goals from which novelty can be constructed.

However, Schumpeter (1934) argues that chance innovations were unpredictable, requiring organisations and individuals to adapt in the present to survive. Growth was seen in terms of a continuous disturbed equilibrium rather than moving from equilibrium to disequilibrium. This is known as ‘adaptionist teleology’, as survival relates to movement into unknown futures that are driven by chance and competition. Complex responsive processes are understood within a causal framework of transformative teleology, a way of thinking in which the future is understood to be under perpetual

construction. The emergence of novelty is seen in terms of local self-organising agents in the present.

In terms of the dimensions described by Seo et al (2004), the OD facilitators planned their courses to meet their visions and goals. In this rationalist teleological approach, it is assumed that humans can stand outside of the system and decide what course of action is to be chosen. Individuals or groups are understood to choose the future in an entirely innovative and independent way. A system of human activities and behaviours can be designed to create that future through selecting logical choices. This suggests that the individuals working in this system have no individual freedom and are merely complying with the designs of the system's creator.

In complex responsive process thinking, innovation is not part of a process and there is no external creator who designs or manages the emergence of innovation. It is in the observance of the detailed interactions that people increase their awareness of how change emerges in their organisations. This is not a completely anarchic process, as individuals perpetually and unpredictably constrain and enable each other within the social norms of the local structures. Within these relationships, people attempt to influence, lobby, coax and persuade.

Fonseca (2002) notices that as new themes emerge from conversations, people start to act in a more sequential manner. As the new ideas are shared with others, the meaning is further altered and refined within conversations. This is not to say that organising ways of implementing change does not require reviewing systems and processes in a systematic way, but it is driven by the patterning of conversation in which meaning is continually negotiated, rather than conforming to a preconceived prescriptive framework. This echoes a more realistic explanation of what happens in organisations as managers and innovators try to impose systems and structure to reorganise institutional wholes.

Thinking about the ongoing communication is a significant factor in many of the traditional models, but tends to be considered within an overarching framework. Communication is often seen as a contributory factor in the implementation of organisational change frameworks. In complex responsive processes, it is the central tenet to how innovation emerges in organisations. Rather than separating out agency from the environment and tools to implement change initiatives, this way of thinking brings

together the mind, the individual and society. It is not claiming to be a management technique, but offers an explanation for what happens in organisations. Rather than identifying change as a project, innovation is seen as an ongoing aspect of daily life.

As I argue earlier, organisational change models have the potential to provide defences against anxiety through the organisation of rational tasks. Traditional models focus on what the future will look like and the journey to get there. Schumpeter (1934) focused attention on the actuality that, for innovation to arise, other ways of working is destroyed, which can generate enormous anxiety. The challenge for managers is to find ways of building trust and managing the anxiety that often accompanies the process of change. Complex responsive processes theory draws attention to the importance of fluid conversation; Stacey (2007) and Fonseca (2002) stress the importance of trust within relationships, so that there is the potential for difficult conversations such as the factors that might be developing or destroying that trust.

In this section, I have illustrated the distinctions between the different views of innovation. I have shown how traditional theories – which imply that innovators design, in advance, the conditions in which novelty and innovation will occur – contrast with more recent interpretations, in which shadow themes and misunderstandings provide diversity within ordinary conversations from which change has the potential to emerge. Rather than thinking about ways of identifying resisters as part of a model, I am arguing that resistance occurs from anxiety about loss of control and power within the ordinary, day-to-day relationships that occur in organisations, as change is continuous, not an episodic occurrence. It is often in this resistance that the potential for change arises.

Different ways of understanding novelty, innovation and change in practice.

In the next section, I will identify how these distinctions lead to different ways of understanding innovation in practice. Innovation is not necessarily a whole organisational change, but on the one hand can be seen as minor adaptations to existing ideas, such as building on nursing documentation to make it more children-friendly, as I describe in Project 1. On the other hand would be major breakthroughs that represent new, radical ideas. The introduction of nurse consultants, nurse-led clinics, nurse prescribing, nurse-led minor surgery and telephone advice lines (NHS Direct) are examples of more radical, innovative practice. These changes have occurred because of the need for nurses to take on ‘work traditionally done by junior doctors’ (Bolger, 2007, p. 26). These examples

support Amabile's (1996) claim that creativity is usually determined within the bounds of social structures and cultural and historical precedents. Although the innovations might be radical, they are based within the context of a National Health Service.

Innovation is a theme that has run throughout my projects. In Project 1, I reflect on the influence of my employer in relation to innovation. I argue that my innovative line-manager gave me permission to be creative, as though innovation was a gift that she could bestow. I now recognise that she encouraged free-flowing conversations within which we negotiated new ways of working. Trust developed through taking risks, as failure was discussed and new ways of sense making were encouraged.

In Project 2, the client likes the creative tender produced by the Giselle group, but wants the stability of a known company to underpin our work. This leads to difficult conversations that are repetitive at times, free flowing and productive at others. In the third project, I work with a group of staff whose conversation is 'stuck', and their patterns of behaviour are repetitive. There is a lack of creativity and a propensity to blame their manager. I describe how Beth has recently been promoted to a Senior Sister post, but has worked in the environment for most of her career. She acknowledges that she has taken up the predominantly negative views of her peers at times, but now recognises that she has choices. There had been earlier occasions where Beth had introduced a different way of thinking, which had not been really accepted by the Senior Sister group.

During one conversation, we discuss different styles of working and Beth said, in a very quiet and placid manner, that she feels like an outsider within the group. She also feels that the innovations she has introduced and her atypical management style are treated with suspicion by her colleagues. Initially, the Senior Sisters say that she is a valued member of the group but as this awkward conversation progresses, they take up the cues from her brave gesture and admit that, initially, they disliked Beth's candid style and the way in which she had focused on bringing about changes to her service.

There was honesty in the conversation that was different from their usual avoidance of diversity. The organising theme that normally dominated the conversation was one of ambiguity, but this changed. During the interaction, they realise that her management style exemplifies what they are employed to do. Although this might not sound

particularly significant, it begins a series of conversations in which the Senior Sisters consider their roles as innovators. Eventually, two of them return to purely clinical work, as they find the role difficult; ultimately, the whole senior nursing structure is altered.

Beth did not meet with her colleagues with the intention of sharing how she feels; the issue emerges spontaneously during the conversation. This changes the dynamics within this team, illustrating Mead's (1934) notion of forming and simultaneously being formed within the social group as new ways of understanding each other emerged. Rather than the change being part of a formal change programme, the Senior Sisters initiated the transformation of their roles. This is an example of how change occurs from within the ongoing conversations within organisational life.

In Project 4, I describe how my employer outsources my department to another area, which could be considered as an innovative change. New initiatives result in changes of practice, where other ways of working are inevitably destroyed. Foster and Kaplan (2001) argue that many companies strive to maintain continuity and stifle their need to change. They base their argument on Schumpeter's (1934) assertion that, unless companies change at the pace of the market and 'manage the process of creative destruction' (Foster and Kaplan, 2001, p. 10), they will fail.

Corporations, they insist, are built on the assumptions of continuity, focusing on operations, while the market is built on discontinuity, which centres on creation and destruction. This encourages rapid development and creativity, but is less tolerant of companies where there is long-term underperformance. On reflection, my department was a new creation and was still being established; but, in relation to market principles, the output of my organisational development department was difficult to monitor and measure. The lack of understanding of the potential benefits coupled with the need to demonstrate immediate outputs were contributory factors in the abolition of the department.

I have exemplified how, for new behaviours or systems and processes to emerge, old methods or people must be replaced, as the two could not co-exist. Without diminishing the emotional impact of redundancy as rejection, redundancy can be seen as an inherent by-product of creativity and innovation.

In Project 4, I have numerous conversations with my line manager and many others, and remain convinced that the accepted structural norms of the NHS, at the time, means that nurses will not be made redundant. The organising themes that structured my conversations with my boss are based on financial management and, over time, I realise that the cultural norms are changing within the innovative plans that my line manager wishes to implement. This is an important feature in my consultancy, as I work with staff that fear redundancy or are currently being made redundant. I offer reflective time to unpick the experience and help others, if they are willing, to make meaning from and attempt to move on from the incident.

As I argue earlier, the manifestation of change is unpredictable because it emerges in everyday conversations rather than being controlled by an external innovator, and is therefore difficult to control and manage. In the dominant discourse, innovation is usually portrayed as a constructive phenomenon. This does not take account of the positive things that might be destroyed, nor does it acknowledge that the changes may result in unplanned – even unpredictable – consequences.

NHS policy documents tend to give examples of innovation that demonstrate good practice, without mentioning any potential for unintended consequences. It is important to recognise that good practice is not always transferable, as it does not take account of local power relationships and social norms. As nurses develop innovative roles, for example, this will render other ways of working obsolete, which ultimately may result in staff redundancies.

I conclude that the idea that innovation can be managed is limited, because we appear to know little about how innovation occurs. Choosing goals and implementing agreed sequential steps have the potential to provide managers with reassurance and a sense of control. I contend that innovation is more complex and uncertain than this logical approach suggests, but this is generally unacknowledged or underestimated in the mainstream innovation literature. There is a known/unknown quality to each social interaction, where patterns of communication might be repetitive of previous encounters yet also generate transformative possibilities within the interaction.
I am arguing that innovation is emergent, occurring in the known and unknown qualities of the social patternings of interaction between people rather than from a predetermined blueprint. Within the social patternings, power relationships, social norms and associated

values contribute to the emergence of innovation. As new themes emerge from conversations, people start to act in a more deliberately sequential or systematic way, to put their ideas into practice, as they work together to create meaning from the actions that have been taken, but these actions are continually renegotiated in a cyclical manner.

I am not suggesting that the review of routines and processes is to be avoided; as new themes emerge from conversations, people implement change in a logical and systematic manner. Nevertheless, this is driven through the patterning of conversation, in which meaning is continually negotiated, rather than conforming to a preconceived prescriptive framework.

However, the complex responsive processes perspective does pose some difficulties for NHS managers, who are accountable for the implementation of targets. I have shown that innovation arises through the thematic patterning of conversational themes where innovation may or may not occur. The result of creative endeavours might be positive, or it might be stuck in repetitive conversation; and there is no guarantee that ideas will result in successful outcomes.

As I described earlier, this is problematic, as managers are expected to control the development of new ways of working in response to new policy directives, and failure might result in job loss. Traditional change models, based on traditional systems thinking, are the dominant discourse in the NHS. Nevertheless, I contend that, within pre-planned change programmes, individuals and groups select and spurn new ways of working on the grounds of whether they can see the potential benefits, whether the changes resolve local problems, and how the changes impact on individual or group power relationships.

In my professional practice, I encourage managers to focus on change and innovation at a local level through observing the detailed interactions between individual agents and groups. I urge them to think about how they influence, lobby, coax and persuade their colleagues as a way of understanding how they perpetually and unpredictably constrain and enable each other. I am not suggesting that managers should stand outside their relationships as observers, but encourage them to reflect on their real-life interactions to understand how meaning is renegotiated, altered and refined through the patterning of their conversations.

As I have revealed, meaning does not occur in the mind of an individual who then takes action. It continually takes place in response to gestures within social relationships. It is in the ongoing routine conversations, in which words embody meaning, that individuals are answerable to each other for their actions. This is important when considering the employer–employee relationship, conceptualised as a psychological contract.

When the psychological contract is perceived to have been violated, the employee is less likely to take risks in pursuit of innovation, as there is a breakdown of trust in the relationship. This phenomenon will be examined further in the section on the psychological contract.

In the next section I draw together some of the dissonances and perceived tensions experienced by staff from the earlier themes outlined in this synopsis. I will then review how employers and employees attempt to make sense of their relationships within the construct of the psychological contract.

Staff dissonances leading to feelings of rejection

In this section I will draw together some of the perceived tensions from earlier sections on innovation and novelty, performance management and power. I will summarise a number of dissonances in the relationships between nurses, doctors and managers, and the potential for a strained relationship between policymakers, government and the local service providers.

Innovation

In the body of my study of innovation I have evaluated a number of different models and examples of empirical research that demonstrate different ways of analysing and implementing change, novelty and innovation. I have identified how organisations are often built on the assumptions of continuity, focusing on operations, while the market is built on discontinuity, which centres on creation and destruction. I have explained how my employer decided that outsourcing my department to another area was an innovative change, and as a result, former ways of working were replaced.

I have discussed how NHS policy documents tend to give examples of innovation that demonstrate good practice, without mentioning any potential for unintended

consequences. As nurses develop innovative practices, this changes working patterns that ultimately may result in the rejection of staff, leading to redundancies. This is a newer phenomenon than in the private sector, where there is less expectation of job security, whereas in the NHS there has traditionally been an expectation of job protection (Skinner et al, 2004).

There appears to be an expectation within many of the change models that staff will embrace the new visions and adopt new ways of working. As I have illustrated earlier, this brings particular difficulties for managers and clinicians, who as individuals or in local groups, may not hold to the same value set as the organisation. Although they are unlikely to disagree with values, such as, 'putting patients' first' or 'improving patients' access', it is in the functionalising of these values that dissonance occurs. Clinicians are interested in innovative practice that will improve the care of their patients. Shortening waiting-list times for planned treatment is of no interest, for example, to physicians who treat patients with chronic conditions who deteriorate and require emergency admission.

This can lead to clinical staff feeling rejected by hospital managers if their desire to be innovative in the care of specific groups of patients is interpreted as selfish and narcissistic by employers. This is especially difficult if clinicians appear to ignore, or even challenge, the pursuit of patient care that is targeted by policy initiatives.

Many of the traditional models focus on what the future will look like and the journey to get there. I have asserted that these organisational change models have the potential to provide defences against anxiety through the organisation of rational tasks. Nonetheless, managers also have to manage the anxiety that arises from the resistance to change and innovation as power relationships are threatened. They need to be mindful of the tension between shadow and legitimate themes, which emerges from ordinary conversations, as it is in this diversity that innovation and creativity emerge. However, there is no assurance that their influencing and persuading approaches will be successful, as the conversation sometimes becomes repetitive and unproductive. When there is a breakdown of trust in the employer/employee relationship, the employee is less likely to take risks in pursuit of innovation. In the next section, I will examine the difficulties that staff can encounter in the current managerialist culture.

Performance management and managerialism

I described earlier how the central management of the NHS was traditionally rather weak and often had problems in employing much influence over professional groups. Public services did not effectively control costs, improve quality, or meet the standards expected by the public, and were perceived as being organised to meet the needs of professionals. In the past, medical staff did not expect to be managed, and worked within a peer group of networks and pecking orders. Concern about professional accountability, inefficient healthcare, lack of innovation and poor accountability for the quality of care delivery has stimulated the need for healthcare reforms.

The earlier accounts of how managerialism has been adopted by the NHS described the tensions that managers experience when trying to organise care at a local level alongside politically set national targets. This can create tension and anxiety, and there are examples of staff falsifying targets to meet performance targets as sanctions are applied to managers who do not meet targets, which can result in job loss.

Managers are expected to be in control and manage the systems and processes to improve care. This poses clear difficulties when attempting to improve services that rely on the cooperation of autonomous clinical staff that they do not manage. This was exemplified in the meeting I describe in Project 3 where the clinical and managerial staff cannot agree on how the allocation of operating theatre time can be managed more efficiently. No one is willing to negotiate a change in working practices with the surgeons, because they are perceived to be too powerful a group.

Unfortunately, there has been a considerable loss of confidence in healthcare professionals. Earlier, in the Performance Management section of this report, I described a number of serious transgressions by clinical staff including murder, sexual assault and gross misconduct, inferior care leading to a number of deaths, and the serious mishandling of the removal, retention and disposal of human tissue.

These incidents are particularly significant in light of the endorsement of consumerism in the NHS, which has fuelled public concerns that the government has been inadequately policing professional healthcare groups. Consequently, healthcare professionals will be required to provide evidence of revalidation as part of staff management and clinical governance systems. This is an example of how managerialist practice is being used to

bring increasing accountability to clinical practice. This is exemplified in my third narrative where the manager attempts to emphasise the managerial duties that the Senior Sisters' are avoiding. Although there are no concerns about malevolent practices, managers are, rightfully, attempting to bring the Senior Sisters to account for not fulfilling the managerial roles for which they are being remunerated.

The new regulatory legislation for clinicians also extends the role of the employer in providing recommendations to the regulatory bodies about individual performance. Both the Royal College of Nursing (RCN, 2007) and the British Medical Association (BMA, 2008) are concerned about the percentage of employer involvement, the extent of which is not clear from the White Paper. This shows how the government are trying to bring the clinical professions to account for their behaviours by recognising the role of the employer through managerialist methods of performance management appraisals.

The RCN are cautiously welcoming the changes, but the BMA are rejecting the proposal that medical members are elected by the Privy Council rather than by the medical fraternity. They are also arguing that it is imperative that there is a medical predominance, rather than lay member majority, on their regulatory council, to maintain medical confidence in its regulator. The traditional autonomy of the medical profession in particular is jeopardised by the behaviour of a few of its members but it is unlikely that there will be public support for the BMA's concerns.

The BMA are trying to plicate their members concerns about autonomy, in an environment where the government want to protect the public against the actions of rogue clinicians. This coupled with the desire to run the NHS along more market-driven, and thus consumer-orientated, lines increases the governments imperative to bring more accountability into the management of clinical professionals. They need to prove to the public that their concerns are being taken seriously, and maintain the confidence of the electorate. The consequences of these dynamics alter the power relationship between the employer and clinician in an unprecedented way, and will be considered in the next section

Power

I have illustrated how the principle means of control in the NHS now lies, increasingly, with staff working in commissioning, contracting and the inspection agencies of central

government. The power relationships between clinical professionals and managers have changed as managerialism has come to dominate the structure and organisation of care delivery.

Earlier in this synopsis, I have illustrated how power can be described as the ‘felt’ dynamic of inclusion and exclusion. This is exemplified in how professional groups come to think of themselves as a ‘we’ group with its own norms and values, leading to the exclusion and rejection of others. The resultant feelings of inclusion/exclusion are sustained by the notion of values that bind one group together while excluding others. I describe the different values and low status of managers in the NHS in Project 3 as being a contributory factor in the reluctance of clinical staff to participate in management. These differences sustain the exclusion of managers from clinical groups.

I have illustrated how performance management and measuring, supervision and appraisal has emphasised the relationship between discipline and organisational achievement as a means of securing and controlling staff behaviours. I have alluded to ways of securing this control further through contract exchanges where the cooperation of the employee is secured. This can be understood as an issue of control, as the rational employer tries to govern the relationship and the production of meaning; it is particularly significant in considering the employer–employee relationship.

Employers might judge as recalcitrant and self-interested those healthcare professionals who hold different value systems from those sanctioned by the executive management vision. If regulation is aiming to include the judgments of employers about individual performance, this is a significant challenge to these power relationships and has the potential to inflame antagonism between the two groups.

In this section, I have pointed to a number of conflicts that I propose are particular dissonances that many nurses and healthcare workers are experiencing as rejection within the day-to-day working environment. These include:

- Potential job loss due to the introduction of new ways of working as a result of innovation and change
- The difficulty of getting individuals to commit themselves to organisational visions because the ideals do not necessarily fit with their personal values.

- The potential for discrimination against staff who do not appear to share the value systems within the prevailing organisational vision
- The anxiety generated from the expectation that managers will control and administer the implementations of targets and innovation
- The difficulties that managers experience when trying to balance the implementation of central targets against the specific needs of local healthcare institutions
- Changes in the power dynamics between staff who work in commissioning and contracting with those providing healthcare services
- Consumer confidence in clinical professionals having been compromised through the acts of malevolent nurses and doctors
- The resultant reduction of clinical autonomy of doctors and nurses and the increased regulation of professionals
- An apparent loss of clinical professional power in favour of managerialist approaches to healthcare organisation.

However, health promotion and combating illness are labour-intensive, agency driven activities that rely on a range of different professional groups. Their potency and diversity, and their ability to work together, adds considerable complexity to the management of healthcare systems. I have studied many of the dissonances highlighted in this section within my projects. In my first project, I describe the influences my employers had exerted over my professional life and Projects 3 and 4 centre on difficult employer-employee relationships. These concerns have led me to examine the nature of the relationship between employer and employee. The construct used to describe the employer–employee relationship in the human resource literature is called the ‘psychological contract’, and this will be considered in the next section.

The psychological contract

The psychological contract is a popular concept with human resource managers, who use the theory to construct ways of understanding the relationships between the employer and employee. In this section, I describe the nature of the psychological contract; illustrate what happens when the contract appears to be broken and then account for the purpose of the construct. I then go beyond the traditional psychological contract formula to provide an alternative view.

The psychological contract is different from the traditional employment contract, which is a written agreement, usually signed by the employee and manager, outlining the formal terms and conditions of service such as wages, working hours and shift patterns, holiday and notice entitlements.

I will now analyse how psychological contract writers define the concept, and then examine the purpose of describing the employer–employee relationship in this way. Anderson and Schalk (1998), state that 'in the relationships between employer and employee, mutual obligations are the central issue. These mutual obligations are partly put on record in the formal contract of employment, but are for the most part implicit, covertly held and only infrequently discussed' (ibid, p. 637).

Similarly, Skinner et al (2004) propose that employment relations are founded on a set of shared expectations, which are conceptualised as the psychological contract. This is a set of unwritten, often unarticulated, reciprocal expectations and assumptions between an individual employee and the organisation.

According to Herriott and colleagues, the 'the psychological contract refers to the perceptions of mutual obligations to each, held by the two parties in the employment relationship, the organisation and the employee' (Herriott et al, 1997, p. 151). Rousseau and Schalk (2000) share this notion of obligation, defining the psychological contract as

> 'the belief system of individuals and employers regarding their mutual obligations. These obligations grow from the promises made as employment arrangements are started and sustained' (ibid, p. 1).

Similarly, Schein (1978) describes the psychological contract as a set of unwritten reciprocal expectations between an individual employee and the organisation. Herriott and Pemberton (1995) contend that it is the perception of both parties in the employment relationship (that is, the organisation and the individual) of the obligations implied within that relationship. They contend that the 'psychological contracting is the process whereby those perceptions are arrived at' (ibid, p. 21). It is unclear as to how one knows when the psychological contract has been 'arrived at' if the process is unwritten and unspoken about.

Schermerhorn et al (1991) focus on the more structural aspects of the psychological contract in terms of values, and contend that:

> When the exchange of values in the psychological contract is felt to be fair, a state of inducements–contributions balance exists. In this ideal condition, the individual can be expected to feel good about his or her work and have a positive relationship with the organisation. When the exchange of values is perceived to be unfair, however, people may develop bad attitudes, lose their desire to work hard, and/or even quit to take 'better' jobs elsewhere.
>
> (ibid, p. 40)

This suggests a rather cognitivist approach, suggesting that individuals weigh up the merits of the organisational values with their evaluation of the worth of their contributions. In the Performance Management section, I raised concerns about the potential for staff discrimination when members do not share the value systems set out in the prevailing organisational vision, but this issue is not considered within the psychological contract literature. However, it is a significant issue as non-compliant staff could be seen as breaching the unarticulated, reciprocal expectations because it is assumed that staff will concur with organisational visions.

Also, the proposed 'exchange of values' exemplifies the concerns I raise in Projects 3 and 4 about cult values, such as the importance of 'valuing staff' and 'patient-centred care'. When functionalising or implementing these values, the Senior Sisters in Project 3, for example, do not feel valued by their managers for their clinical or managerial skills. These are not the values of individuals taken in isolation; they are based in the context of group norms set in a specific hospital environment where the values and norms are constantly negotiated at an individual and group level.

From the above definitions, the psychological contract is described as perceptions, expectations, beliefs, promises and obligations, suggesting that the delineation of the concept is somewhat imprecise. When comparing these definitions, Guest (1998) observed that failure to meet expectations is of a different order to failure to meet obligations. The idea that nurses always smile at their patients might be an expectation, but is unlikely to be realised consistently in practice. However, the nurse would be under an obligation to provide safe patient care and would lose public confidence, and be

disciplined, if this was not fulfilled. This suggests that there are various levels and qualities inherent within the construct of the psychological contract.

Many of the psychological contract writers describe employees as having a relationship with an organisation. This raises the difficulty of defining what is meant by the term ‘organisation’. Kotter (1973) argues against the reification of the term, insisting that it cannot be the organisation itself that has perceptions, but only individuals within it. The collective use of the term ‘employer’ is equally problematic when considering who represents the organisation. Many people take on the role of employer within their posts and are also employees. They will not share a uniform set of expectations, beliefs or obligations, yet are nevertheless collectively known as employers in this context.

Rousseau et al (1998) introduced a narrower definition, viewing the psychological contract ‘as an individual’s belief in mutual obligations between that person and another party such as an employer (either a firm or another person)’ (ibid, p. 679). This shifts the perception from the mutual relationship of two parties to the single-level belief system of the individual agent, implying that the relationship is not necessarily mutual.

The psychological contract is linked to systems thinking, wherein the individual agent is seen to be separate from the social system. This assumes that the individual exists in a day-to-day reality that is separate from the social system or organisation. The idea that an individual can have a relationship with an organisation suggests that an individual is separate from the system in which they find themselves. Guest (1998) argues that the market philosophy, which has dominated the economic policy for a number of years, views the employee as an independent individual offering skills and knowledge. He assets that “contracting in all its guises, suddenly becomes an important focus of study and the value of the psychological contract lies in drawing attention to the range and complexity of contracts in organisations” (Guest 1998 p. 659).

From a structure/agency perspective, the psychological contract construct appears to focus on individual agents and their relationship with another agent or with the organisation. It appears to underplay the structural norms that influence the individual agent’s behaviours as part of a group, and tends to neglect the significance of the emotional dimension for human action and social structure (Shilling, 1999).

This suggests a rather disembodied view of the agent that overemphasises cognition and ignores the emotional dimensions of interaction. Individuals are seen as separate from the parts of the social system, making it difficult to examine the interplay of actor and setting. This also implies that the individual acts autonomously, as though able to rationally weigh up the implications and consequences of the unwritten, often unarticulated, reciprocal expectations, values and assumptions of the employer or the organisation. There is also an implication that the individual agent and the employer assess and reflect on the expectations and assumptions of both parties, and then take action.

I consider the psychological contract to be a term for describing the way that people feel about the place in which they work, and it provides a genre for describing and rationalising the employer–employee relationship. However, some human resource writers (Mumford, 1995; Stuart and Lucia, 2000; Whitener et al, 1998) refer to the psychological contract as though it existed as an entity. For example, according to Mumford, ‘the psychological contract seems to be experiencing considerable negative distortion and to have considerable contradictions located in it’, (Mumford, 1995, p. 60).

This is a reification of the concept, as it idealises the notion of the employer–employee relationship into a cult value. It is treated ‘as if’ it existed and had overriding motives or values. The notion of a psychological contract is popular with HR authors because understanding employment relationships is complex. However, the psychological contract is a concept that offers an account of how people construct their worlds in the context of their working relationships.

According to Anderson and Schalk (1998), the psychological contract is individual; it will change over time; and the premise of mutual obligations will result in a positive outcome for both groups. In practice, many of the prevailing psychological contract writers describe unequal outcomes. I am concerned that this way of thinking reduces crucial issues, such as what motivates people, to a static ‘cause’ (job security) and ‘effect’ (loyalty and commitment) link, without taking into account other factors such as how values, vocation, power and ideologies, purpose and ambitions arise.

I have demonstrated the difficulties in defining the characteristics of the psychological contract and the lack of clarity about what constitutes an organisation or an employer.

This agency-based model focuses on the individual, and there is little mention of any psychological contracts that employees might have with their co-workers, for example. Although many psychological contract writers point to reciprocity between employer and employee, the employees' perspective tends to dominate the literature. In addition, there is no mention that the employer has a dual role, as an employer is also an employee. This adds to the concern that the role of the employer or organisation is an ill-defined concept.

I will now consider the purpose of the psychological contract. I have so far explained it as a means of describing the employer employee relationship. McFarlane-Shore and Tetrick (1994) argue that the first function of the psychological contract is to reduce insecurity, as not all aspects of employment relations can be written into formal employment contracts; the psychological contract fills this gap in the relationship. This suggests that the psychological contract is based on a positive relationship and that the employee is in a secure relationship with the employer.

They also argue that the psychological contract shapes employee behaviour. The employee weighs their obligations towards the organisation against how they perceive that the obligations of the organisation towards them are being realised. This suggests that there is a static rather than dynamic relationship between the employer and employee.

Applying this way of thinking to an example from the earlier staff dissonances section, regarding autonomous clinical freedom, at some point clinicians will have 'weighed up' that ignoring other hospital's quality measurement data and patient outcome statistics was acceptable behaviour. Viewing the relationship from this rational perspective, it is not clear how the clinicians could be expected to know when the expectations and assumptions on the employer side had changed. Within the psychological contract literature, there is an acknowledgment that the contract will change over time (Anderson and Shalk, 1998). However, there is no sense of ongoing negotiation, as the psychological contract appears to have a certain latent quality, rather than showing signs of continual renewal.

Finally, McFarlane-Shore and Tetrick (1994) argue that the psychological contract gives the employee a feeling of influence over what happens to them in the organisation. Again, this posits the psychological contract as a positive phenomenon from which the

employee gains a sense of well-being. As noted earlier, Clegg (1989) is far less positive, drawing attention to the imbalance of power in employer–employee relationships. He argues that contracts are rarely reciprocal or conflict-free, as the assets and resources within the relationship are weighted in favour of the employer.

Many of the psychological contract writers describe the psychological contract in terms of reciprocity, shared expectations and mutuality between employer and employee; this reciprocity assists in providing organisational stability. In this context, I am making a connection between the between the psychological contract and Parsons' (1967) consensual model, which links power and authority with the best interests of society. The cooperation of employees is secured through the exchange of contracts. Although Parsons does not refer to psychological contracts, there is a similar thread in his description of the employee bringing skill and knowledge to the organisation and is rewarded with job security and protection. It is perceived that this reciprocal arrangement works in the best interests of both employee and employer. The employee accepts the power and authority of the employer in exchange for a regular income.

However, in Parsons' model, those with power and authority can invoke sanctions to maintain the stability of the organisation or society. When the employer needs to make changes to their organisational structures that appear detrimental to individual employees, there is a breakdown of the psychological contract, which I will analyse in the next section.

I have distinguished between the various interpretations of the psychological contract and identified the positive assumptions on which it is premised. It is perceived to be a useful conceptual framework in which to think about the employer–employee relationship. The psychological contract provides security, influences behaviours and maintains organisational stability.

I will now analyse what happens when the psychological contract appears to be breached. Earlier I have argued that by thinking about organisations as systems, managers emphasise the importance of predicting the future, choosing strategies, measuring performance and controlling the outcomes. Psychological contract theory is rooted in systems thinking, where the employer and employee are able to determine, in advance,

what their future needs will be. Based within these anticipated requirements, the unwritten and often unarticulated psychological contract is fashioned.

However, organisations cannot be viewed as static entities, as they frequently go through periods of flux as markets change, clinical priorities alter, and performance targets are amended; this is one of the concerns outlined in the earlier section on staff dissonances. Sometimes difficult decisions need to be made about the viability of an organisation. This affects employment relations and changes are made to an individual's contract, at times without the employees knowledge or consent, which impacts on whatever trust has become established between employer and employee.

Mumford (1995) points out that the employee is expected to be loyal and highly motivated despite the erosion of longer-term employment prospects and the threat of imminent redundancy. Skinner et al (2004) conclude that in the NHS, expectations of employment security have been undermined and established norms overturned, while the emphasis on short-term goals has challenged existing psychological contracts on all levels.

This reflects how I regarded my relationship with my employer at the time of my redundancy. I had believed that in some way the commitment that I had made to working for the NHS would be rewarded by job security; in disillusioning me on this score, my employer seemed to personify the broken promises between the NHS 'organisation' and myself.

Sometimes when job security is under threat, employers increase their demand for employees to be more flexible and contribute more than is required by their job descriptions (Anderson and Schalk, 1998). Mumford (1995) argues that motivation, recognition, responsibility, advancement and a sense of achievement seem to have been removed from many work situations; they have been replaced by the fear of job loss.

Herriott et al (1997) note that the psychological contract has become a popular addition to human resource managerial textbooks, as it offers an account of 'the reasons for the difficulties in the employment relations currently being experienced by many organisations, particularly in the UK' (ibid, p. 152). In this context, I contend that perceiving the employer–employee relationship as a reciprocal entity inadvertently

creates additional distress to employees who had trusted that employers would work in their individual best interests.

There is no mention in the psychological contract literature of the ethics involved in employers/organisations not keeping their side of the agreement. Within a construct where the contract is often unarticulated, based merely on reciprocal expectations and assumptions, there can be no evidence that the employer or the organisation has breached a contract of any kind. I argue that this is not a very helpful construct, as it appears to raise individual expectations of a positive exchange of mutual obligations. However, the penalty for not fulfilling the employer's expectations could result in the termination of the employee's contract. There are no such sanctions applied to the employer, which diminishes the sense of mutuality.

Conversely, a situation where the employer feels that their psychological contract with the employee has been violated is not mentioned in the literature. Although the employer might have greater access to redress, in situations where professional performance is only mediocre, for example, the employer might feels that their psychological contract is not being reciprocated. This is difficult to deal with due to the nature of the unwritten and unarticulated agreement.

The ways in which power is understood affects the way that the employer–employee relationship is perceived. Guest (1998) draws attention to the inequality of power relationships between unrepresented individual and the sometimes-monolithic organisation, as an increasing proportion of workers do not have the protection and representation of a trade union. The employer is often viewed as 'owning' power, and is thus the more dominant character. Acceding to this conceptualisation, I propose that this leads to a reification of the psychological contract as a structure. This in turn negates the ongoing relationship in which the employer and employee negotiate their relationships through sustained spontaneous interactions. As noted earlier the employer appears to be able to evoke a disproportionate degree of power because of their capacity to access greater resources and make crucial decisions.

In summary, I have analysed what happens when organisations need to make changes, which results in a departure from the assumptions within the established psychological contract. The unequal status of employer and employee can also mean unequal access to

resources when things go wrong. In circumstances where the employee feels the psychological contract to have been breached, feelings of mistrust and disappointment can be experienced as a sense of violation.

I am now proposing a very different way of thinking about the employer–employee relationship. I have argued earlier that it is through the everyday processes of relating that people within the organisation cope with the complexity and uncertainty of organisational life. It is in their ongoing interactions that the values and norms of individuals and groups form, as they continuously construct their future together in the present moment. I am arguing that the relationship between the line-manager and employee is a perpetually evolving interaction that arises between the two, in which mutual identity and patterns of relating are continually shaped and renegotiated as an ongoing process of co-creation.

Elias (1978) describes the figuration or patterning of competitive and cooperative relationships that reflect the interdependencies between individuals and groups. If relating constrains and enables, it establishes power relations between people, and it 'places power, politics and conflict at the centre of the cooperative social process through which joint action is taken' (Stacey et al, 2000, p. 124). The 'organisation' is about people relating together in a self-organising way. This means that 'agents act locally with each other according to their own local principles of interaction, where those local principles have a life history' (Stacey, 2007, p. 321).

Therefore, staff enable and constrain each other in particular ways according to their histories of interacting with each other. Rather than constantly changing behaviour in response to how the employer is judged to be delivering their obligations, as proposed by McFarlane-Shore and Tetrick (1994), it is in their ongoing relationships that staff come to establish an agreed definition of acceptable and unacceptable behaviours.

Lee (2005) notes that 'movements in patterns of power relating are experienced as sensations of inclusion and exclusion that configure as socially created identity… a movement in these patterns therefore alters our experience of being included or excluded, which may be seen as the movement of identity' (ibid, p. 167). In the psychological contract, the relationship appears to be rationalised into groupings of mutual obligations. The focus is on the employee aspect of the relationship, and what constitutes the employer and/or organisation is unclear especially, as I noted earlier, the employer is also

an employee. I am arguing that it is in the interdependence of the line manager–employee that themes such as their power relations organise the patternings of their interactions.

It seems to me that psychological contract writers tend to highlight the cooperative aspects of the employer–employee relationship, using terminology such as ‘reciprocity’ and ‘exchange’ to imply equality and fairness: the employer provides financial recompense for labour and expects loyalty and commitment to the job, while employees expect an income, and certain opportunities such as promotion. Clearly, staff have different roles in the organisation; for example, the power distribution will lean towards those who have more understanding and knowledge. However, the split between employee and manager – so evident in the psychological contract – becomes less apparent in a complex responsive processes way of thinking. Here the line-manager is involved in an interdependent relationship with employees, and cannot control the future; there can be no guarantees that the relationship will be either positive or reciprocal.

By assuming that the concept of the employer–employee relationship is based on a construct called the psychological contract, a sender–receiver style of communication is implied, which diminishes the opportunity for innovation. Perceiving that the relationship is based on reciprocal exchanges of expectations suggests that the future is predictable and that staff will work within the expectations of the employer in exchange for job security.

There is little reference to innovation in the psychological contract literature, as the writers do not appear to deal with the emergence of innovation. Neither do they acknowledge the constraining nature of relationships in any depth. Employers are unable to guarantee job security; staff then blame them and feel rejected when the unwritten – and often unarticulated – reciprocal expectations and assumptions of job security are not realised.

I started to consider the concept of the psychological contract when I was writing Project 4. At that time, I found the concept helpful as a way of blaming my employer for my unreciprocated expectations; I later changed my perspective. In Table 3, I have analysed how the prevailing psychological contract writers deal with the themes from my projects, contrasting these in the third column with a complex responsive way of thinking. The fourth column gives examples from my research of how I have changed from a

psychological contract way of thinking to a more complex responsive processes perspective.

Table 3. My themes in relation to the psychological contract and complex responsive process thinking.

	Assumptions underpinning the psychological contract	*A complex responsive process perspective*	*Evidence from my research*
Inclusion and exclusion	The employee and employer have different ideologies, potentially creating a tension between the two groups • Employees expect NHS job security, training, equity and involvement • Employer expects competence, effort compliance (Armstrong, 2000, p. 27)	Elias (1978) describes the figuration or patterning of competitive and cooperative relationships that reflect the interdependencies between individuals and groups. 'A movement in these patterns ….alters our experience of being included or excluded, which may be seen as the movement of identity' (Lee, 2005, p. 167) Participation in relationships is the direct interactions of people working together as processes of perpetual negotiation (Griffin, 2002)	In Project 3, the Senior Sisters have a different ideology from the managers. The relationship, viewed from a PC perspective, lacks reciprocity. Though not directly involved in managerial developments, they feel that unless they conform with the PC they will be excluded (or they might exclude themselves by leaving) From a CRP perspective, both groups were continually renegotiating their interdependent relationships
Power	There is an inequality in power in the relationship between the unrepresented individual and the sometimes monolithic organisation	All relationships are based on interdependent enabling and constraining power relationships. (Elias,	In Project 4, I identify with the PC assertion of violation of relational reciprocity. The DoNs and I had been committed to the NHS

	(Guest, 1998a, p. 660)	1978) Since relating immediately constrains, it immediately establishes power relations between people (Stacey, 2003, p. 383)	and felt like rejected, powerless victims. I later realise I had choices and had colluded to sustain the power differential with my employer
Innovation	There is little reference, as the liaison is seen as a static 'reciprocal exchange of employees and employer expectations. (Armstrong, 2000, p. 27). When the PC is broken staff are less willing to 'take risks in pursuit of innovation' (Herriott et al, 1997, p. 152)	'Novelty means a coherent pattern that has never existed before, not some hidden form that already exists but has not been revealed. Diversity and conflicting constraints (that is, power relations) are all essential to the emergence of novelty' (Stacey et al, 2000, p. 155)	In Project 1, I question the ability to be innovative in a systems way of thinking, where the future is thought to be predictable In Project 2, the diversity of conflicting constraints results in an innovative development programme that was very different from the original plan.
Rejection	The PC is seen to be changing in favour of the employer; writers report that there are many cases where the contract has been violated	Part of organisational life; for creativity to occur, other things are destroyed as power relationships ebb and flow	Initially, I felt that my contract had been violated. I now see that the patterning of the conversation and values changed as my boss left, and my role was no longer required

PC = psychological contract; CRP = complex responsive process.

In Table 3, I illustrate that within the construct of the psychological contract employees and employer have different needs, creating an artificial boundary, which sustains the power relationship. This inclusive/exclusive element demarcates the differing expectations of their relationships. This suggests that each group works within differing ideologies, as their expectations are diverse. Elias (1978) points to how groups maintain

their power by emphasising difference, and how this difference is used to arouse the antagonism necessary to preserve the difference. The psychological contract could be seen as a way of preserving the differences between employer and employee. When the employee does not receive what they expect, they feel ‘violated by the employer’. This results in feelings of inclusion and exclusion, an ‘us and them’ scenario, even though some writers suggest that there need to be shared values.

As I have shown, the social context is an important aspect of innovation, giving rise to a known and unknown quality of interaction in which creativity may or may not arise. Within the sender–receiver model, the employees expect job security, training, and involvement and the employer expects competence, effort and compliance. The illusion of reciprocity could be interpreted as a guarantee of protection wherein safety is secured through collusion, but there is a danger that employee creativity becomes stifled. This way of thinking ignores the emergent qualities of the relationship, which are both familiar and unknown, wherein innovation arises as the social patternings of interaction between people evolve in the moment, rather than from a predetermined blueprint of job security in exchange for effort and compliance.

There is also a connection between employee redundancy and innovation that I had not previously considered. Joas (1996) describes how intentions and creativity emerge as a result of a moment of interruption to habitual behaviour and pre-reflective aspirations, that is, needs that have been present for some time and of which we are unaware. Although the DoNs and I were unhappy about our experiences, we all moved into other jobs; many of us were working in new ways and had found freedom in portfolio working. The experience of redundancy interrupted our ‘habitual behaviour’ and provided opportunities in which novelty could arise. Some of us had redefined our approach to the employer–employee relationship through running our own businesses, creating a new and different type of employer–employee relationship with our clients.

I will now consider the tensions I described at the beginning of this section in relation to complex responsive process thinking. I am not suggesting that these dissonances will be reconciled by thinking about the employer–employee relationship from a complex responsive processes perspective. Rather, I consider that it is possible to look differently at the issues, as outlined in the earlier sections on innovation, power and performance

targets. One of the appealing aspects of the psychological contract is an implicit belief that part of the employers' responsibilities is to provide employment.

When organisations have to reduce the workforce numbers, I am contending that employees experience greater disappointment because of their expectation that the employer will honour their obligations. However, in complex responsive processes theory, there is no expectation that the employer has an obligation to provide job protection as the employer is unable to predict the future and is therefore unable to guarantee employment security.

Similarly, rather than considering the implementation of the collective vision, the ownership of the shared vision is focused at a local level as the future is perpetually under construction within the ongoing day-to-day work relationships. This is not to say that groups of staff will not aspire to reach national and local aspirations and establish systems and processes to realise these goals; but this is a different way of thinking about the use of systems and processes.

Rather than invoking a vision or model, the onus is on both the manager and employee to reflect on how they utilise their skills and technologies, whom they interact with, and who is excluded. This provides valuable information about where the blocks to change are occurring and leads to an examination of the local power dynamics between staff.

Through the constraining and enabling relationships, poor practice may either be dealt with or ignored, depending on whether the power balance between clinicians and others prevents or enables staff to take action. There is a known/unknown quality to each interaction, in that there may be a pattern of communication that could be repetitive of previous encounters, or may generate transformative possibilities within the interaction. Similarly, the perceived reduction in clinical autonomy will be variable, and must be seen within the context of local social norms and values that will have different characteristics, influenced by the power dynamics that are acted out in individual departments.
Given that the NHS is committed to a target-driven performance ethos, managers are obliged to cooperate in the implementation of performance targets if they wish to retain their jobs. I have shown how complex responsive processes theory offers a way of focusing on what people in organisations are already doing in their ordinary everyday activities. Rather than focussing on systems and processes, this means noticing what is

actually happening in the relationship between the manager and employee in relation to the realisation of their performance goals. This brings more focus to reflecting on both manager and employee behaviours and the contributions that both make to organisational life at a local level.

The loss of professional power of clinicians can be seen within the context of how power relationships move or change on the basis of need or dependency, and how shifts in power relationships affect the patterning of who is included and excluded. Clinicians have traditionally been dominant in the organisational administration of healthcare, to the exclusion of other professional groups. Since the development of a more market-driven and managerialistic approach to healthcare, the power of managers has increased, while that of the clinician has diminished. An erosion of confidence in clinicians has changed the social norms and ideologies previously associated with the professionals, as consumers have greater power and influence on how healthcare is regulated.

In considering the concept of the psychological contract, I have identified a number of definitions, the purpose, and the impact of breaches to the construct. The psychological contract represents a way of interpreting the feelings that staff have about their relationship with their employers. I understand why the concept has developed over the past few years, as managers and HR staff have tried to make sense of the changing landscape of the employer–employee relationship. However, I have explicated how complex responsive processes theory leads to a different way of understanding and interpreting the phenomenon. I am suggesting that the psychological contract is an unhelpful construct, as it sets up expectations that cannot be guaranteed; but there is no acknowledgment of this significant limitation of the construct in the psychological contract literature.

My original contribution to theory and professional practice

As I have discussed throughout my inquiry, the current climate of change in the NHS has led to dissonances for some staff. In my synopsis, I elucidated the overarching theme throughout my research, which concerned the seemingly dichotomised relationship between managers and staff. In Project 2, I analyse the impact of employing two competing organisations to undertake an assignment, pointing to the way that the power relationships ebb and flow between the client and the two organisations. In Project 3, I notice the tense relationships between managers and clinicians at a directorate meeting,

illuminating how the differing ideologies between the managers and clinicians shape their behaviours. In Project 4, I make sense of my experience whilst encountering Directors of Nursing who had been made redundant by their line-managers. I postulate on how the prevailing values and norms, and sense of shame and exclusion, prevent the Directors of Nursing from challenging their CEO's. In the synopsis, I have described a number of dissonances, which some staff are experiencing and elucidate on how the psychological contract is a way of describing the relationship between employers and employees. I have proposed that complex responsive processes theory offers a legitimate and useful way of deepening our understanding of employer–employee relations.

Through my research, I have highlighted the broader political factors such as the loss of consumer confidence in clinicians and increasing endeavours to regulate their practice. Many clinicians are concerned that local managers have additional powers to influence and sanction the outcome of ongoing individual professional regulation applications. I have also demonstrated how factors, such as, managers being expected to be in control of the implementation of targets and change, plus the current climate of potential job losses, gives rise to anxiety.

I have concluded that conceptualising the employer/employee relationship within the ideological principles of a stand-alone psychological contract, offers a limited theoretical construct. Psychological contract writers highlight the cooperative stance of the relationship, using terminology, such as, 'reciprocity' and 'exchange' to imply equality and fairness in the employer–employee relationship. However, the employer and employee are not able to discern, in advance, what their future workforce requirements will be. The potential for a loss of trust within this way of thinking is high. My research shows that the relationship between the employee and their line manager is interdependent wherein they both have opportunities to influence the dialogue. The power relationships will vary depending on the degree of need.

The reciprocal aspect of the psychological contract, generally, does not account for the different power dynamics between the employer and employee until there is a breakdown in the perceived psychological contract. Then employees are perceived to be more dependent as the employer has a greater capacity to access resources and make crucial decisions. There are fewer options available to the employee, and if they encounter

incongruities between the fulfilments of the obligations they perceived had been made by 'the organisation', and what they experience in practice, they might feel like victims.

However, this assumes that the employee is always in a less powerful position. For example, employees may use their employers to gain specific skills and then leave the organisation. If the employer is dependent on these highly trained staff, the manager will have difficulty in providing a viable healthcare service. I am arguing from an Elysian perspective, elucidating the enabling and constraining nature of relationships. I have shown that power, as a function of dependence, ebbs and flows within all relationships regardless of the position of staff in the organisation. Thereby in considering these relationships as interdependent, I encourage staff to notice these patterns of shifting power relations elucidating how, by influencing those moment-by-moment interactions, different outcomes may emerge.

I have detailed how micro –interactions within relationships evolve and develop; also picking up on times when they stagnate. Although this reflexive perspective cannot guarantee success, it does provide an opportunity to influence the dialogue, and reduce the feelings of helplessness and exclusion. Hence, my research highlights the importance of conversation in influencing, by focusing on who is included and excluded in the conversation, the blocks that prevent change, and the way in which staff can attempt to shape the dialogue.

From the prevailing literature on the psychological contract, the term employer or organisation is often treated as if it is 'a thing' or an object. This is further confused by the anomaly that executives and managers are also employees. There is a failure in the literature to acknowledge this dichotomy, as the focus of the construct lies with the individual agent and an anonymous entity known as the employer or organisation.

From a structure/agency perspective, not only is the focus on individual agents and their relationship with an ill defined other, the structural norms that influence the individual agent's behaviours as part of a group, tends to be underplayed. I have made sense of organisations as social networks, in which paradoxically, individuals form the social structure and are formed by it at the same time; therefore, there is no split between agency and structure. In addition, the significance of the emotional dimension of human

relationships appears to be neglected in relationships where the participants weigh up the value of each other's contributions.

Through my work, I have challenged the oversimplification of accounting for the employer –employee relationship as a psychological contract whereby

- The relationship between the manager and employee is a perpetually evolving interaction that arises between the two wherein continuity and change are continually negotiated
- The manager operates from a state of knowing and not knowing at the same time
- It is through the everyday processes of relating that people within organisations cope with these complexities and uncertainties.
- The manager cannot guarantee job security and is unable to accurately predict the future workforce requirements. This has the potential to raise anxieties that cannot be assuaged through the notion of a psychological contract, but is a characteristic of organisational life.
- I have emphasised the movement away from the simple dichotomy between the employer and employees expectations, and focused on the influencing, lobbying and cajoling characteristics of every-day types of conversations.
- My research highlights the oversimplified duality whereby the manager/employee relationship is centred on a reciprocal relational exchange based on equality or fairness.
- Rather than relying on unwritten and unspoken agreements, it is in their ongoing interaction that values and norms emerge.
- The expectation that the employer has a responsibility to provide employment in exchange for skills, loyalty and commitment is tenuous.
- Managers are not in a position to commit to this type of relationship; it is unreasonable to raise employee expectations that they can expect this degree of mutuality, which is often undeliverable.
- The employer is also an employee and there is the potential to experience dissonance and vulnerability in both roles.
- The psychological contract is based on unrealistic expectations that are often undeliverable.

When working with clients and other colleagues I draw on my theoretical understanding of innovation, power and the embodied feelings of inclusion/exclusion. Rather than

considering theory as a separate aspect to my professional practice, they are both different aspects of my experience. An example of this phenomenon arose from my narrative account of my experience of redundancy in Project 4. As I examined the theoretical concepts relating to redundancy, I studied the notion of the psychological contract. From this, I have developed a new way of considering the employer – employee relationship based on complex responsive processes theory, which I discuss with clients. This is an original contribution to theory and professional practice.

Studying the employer-employee relationship has influenced my work in employment relations. I illustrated earlier the way in which I focused, and commented upon, how power relations evolved and patterned conversations, in the dispute between different trade union groups and a Human Resource Director. I also draw attention to the way in which my trade unionist colleagues refer to 'management' as an all encompassing term, as if it existed as a real and tangible object, rather then noticing the patternings of conversation and ways of influencing the direction of travel.

In Projects 1 and 4, and in my synopsis, I draw attention to the tensions that arises within legitimate and shadow conversations, where gossip and misunderstandings generates disquiet. Resistance to change often occurs from anxiety about loss of control and power within the ordinary, day-to-day relationships that occur in organisations. Although it is often in this resistance that the potential for change arises, the potential anxiety generated is often difficult for staff to deal with. These concerns are often unacknowledged but are significant aspects of organisational life, which I reflect on with clients and colleagues. I use my theoretical knowledge of concepts, such as interdependent power relationships, and the paradox of being in control and not in control at the same time. We work together in making sense of their local relationships and ways of managing their anxiety.

It is through these ongoing conversations that meaning emerges, and there is the potential for anxiety to be contained as a felt sense of order, coherence, pattern or control is created, (Streatfield 2001). As patterns of meaning become clear, often deliberate goal-orientated agency then evolves. These tools and techniques are then continually renegotiated, instead of using models or blueprints to logically direct a course of action.

The tension I describe between the clinical staff and the Manager, in Project 3, typifies many of the dissonances I have described earlier. My work with this group exemplifies

how I encourage staff to reflect on their capacities rather than focus on their feelings of rejection, by observe the detailed interactions with those they converse with. We consider together ways of affecting their day-to-day relationships.

Many of the staff I work with, especially those who have experienced redundancy, perceive power as something that is owned or held by other people, or as the organisation 'controlling' their relationships and how they work. Through my review of the literature and inquiry into the nature and interpretation of power, and through my experience, I now offer a different view. From my work I have illustrated how I initiate discussions with clients who fear, or have experienced, redundancy and draw attention to their relationships as interdependent within which they had potential choices.

Through reflecting on my experiences of developing a creative development programme, I study the notion of innovation in Project 2. I now recognise that, as I articulated my concerns about the diversity between the two consultancy groups, a different conversation emerged, which enabled me to understand the anxieties that were driving my colleague's behaviour. As we begin to make sense of the power dynamics, and the emergence of novelty, we are able to negotiate the development of an innovative programme. Again, my understanding of how novelty emerges influences my approach to the implementation of new ideas.

When I commenced the DMan programme, my thinking was underpinned implicitly by systems thinking; the dominant discourse in the NHS. I have studied the benefits and limitations of this construct over the past three years, attaining a greater theoretical understanding. I discuss my theoretical and professional practice experiences with others working in nursing and other healthcare professions. Rather than focus on outcomes, as no one can predict the future, I encourage clients and colleagues to be aware and comment upon the patterns that evolve from local conversations to inform business planning. There is no is no guarantee of success but it provides the potential for staff influence the direction of their department and negotiate appropriate systems and processes.

In my future professional practice, I look forward to continuing my inquiry into the nature of employer-employee relationships. I will emphasise how the expectations that the employer has a responsibility to provide employment in exchange for skills, loyalty and commitment is untenable. The manager is unable to guarantee job security and is unable

predict the future workforce requirements. I will stress how the relationship between the manager and employee is a perpetually evolving interaction that arises between the two, wherein continuity and change are continually negotiated. Rather than relying on unwritten and unspoken agreements, it is in their ongoing interaction that values and norms emerge. It is within the everyday processes of relating that people within organisations cope with these complexities and uncertainties.

A valid contribution to knowledge and professional practice requires us to take a consensus view of what truth and knowledge are, through reflecting and interacting with others. I am not applying my findings from the analysis of my narratives to a sample of the population. Rather, through an iterative and social research method, I hope that some of my insights and new practices will be taken up by others.

Concluding remarks

There are insights in this thesis that I believe will be of general value to staff working in healthcare organisations. I have established a variety of reasons why NHS nurses and other professional groups are feeling disheartened. I have offered a different way of making sense of the working environment in UK health care.

The Personal Development Framework developed in Project 4 was developed to help staff at risk of redundancy. Unfortunately, this work is only available on nursing websites, though it is applicable to other professional groups. Further work is needed to negotiate with other trade unions to use the tool in supporting other staff groups. I also plan to evaluate the usefulness of the framework and adapt it accordingly.

The Hertfordshire Complexity and Management Centre promote a reflexive research approach, supported by what appears to be a unique supervisory arrangement, which includes learning sets, large group meetings as well as individual supervision from faculty members. Additional research into the value of different paradigms of using research communities to advance the social nature of reflexivity is also required.

My thesis is based on the following four projects from which the themes of *Inclusion and Exclusion in the NHS: Power, Innovation and Rejection* emerged.

CHAPTER 2
Project 1

The influences and experiences that have made an impression on my working life

I have endeavoured to weave together the influences and experiences that have made an impression on my working life in organisations. As the themes have become clearer to me I have become aware of the 'powerful' individuals have influenced my professional practice. The thread runs from working with an authoritarian ward sister to a petulant CEO and concludes with redundancy.

The second theme that has emerged concerns the creation of novelty. In my experience of the NHS, systems and processes are perceived to be the underpinning constructs that form the foundations or each organisation. Managers aim to shape the future from business plans, targets and objectives and conceptualise themselves as working within a system. I am interested how as a consultant, I can facilitate the emergence of novelty given my embryonic understanding of complex responsive process theory, in an environment where unpredictable futures are an not tolerated and management consultants are brought in to "fix it".

Becoming a nurse

My decision to become a nurse was influenced by my strict Christian evangelical upbringing, in relation to working for God and helping people, with a longer-term desire to undertake missionary type work in the third world. It was not long before I experienced the difficult and harrowing experiences of hospital life and death and decided that the existence of an external life force was questionable.

Having lost the zeal to undertake a missionary "career", I moved back to my hometown in the late 1970s, married and became a staff nurse in a Children's Accident and Emergency department within the local university teaching hospital. I loved the unpredictability of the work and felt that gaining competence as an emergency nurse, would give me the confidence to work in any area of child health. Sister Yakof, the Senior Sister in the department was a redoubtable woman who wore her blond hair in a

striking “beehive” style, and ruled the department with a rod of iron. The standard of care was extremely high but the atmosphere within the department was dominated by her authoritarian style of management, which generated fear and anxiety amongst staff. I assessed the mood of each shift by interpreting Sister Yakof’s gestures; for example, the way she crossed her arms over her ample bosom as she left the office at the beginning of the day would indicate the nature of her disposition. I would then decide whether she was open to social discussions or whether it would be better to protect myself from her wrath, by checking and cleaning the equipment. Although staff knew the standards of care that were expected, introducing new ideas was difficult. There was a stifling of creativity and we learned to introduce innovation carefully sensing that the generation of novelty was more likely to be successful if we convinced Sister Yakof that that she was the innovator of the ideas. As I reflect on this period, I notice the erratic qualities of accident and emergency work and the need to be innovative enough to respond to the unpredictable. In contrast, the environment was dominated by the inescapable rules and protocols and a rigid style of management generated by our Senior Sister. It was important to me to be accepted by my new colleagues and in particular, Sister Yakof. She shaped my thinking about how things were to be done and I mirrored her management style.

At the beginning of the 1980s, I was promoted to a sister post within the A/E department and my management style continued to reflect the example set by the Senior Sister. I remember having coffee with a group of colleagues and a staff nurse saying to me “I can always tell when I have done something wrong by the way that Sister Marriott looks at me”. This caused some amusement within the group but I felt uncomfortable about contributing to the culture of fear within the department. I recently visited an old friend who had worked with me during this period and was describing this section of my Project 1. She became very animated as I recalled this story, and described me as a “formidable woman”. We had a lively exchange as we explored what she meant by the term formidable – (not a term I would use in describing myself). As we explored the negative and positive connotations of the term, we reminisced about our different and similar memories of working within a complex and stressful environment.

As I reflect on this interaction with my friend, I became aware of how differently and yet how similarly we recalled these shared episodes. When trying to make sense of the influences and experiences of this period in my career, I read Stacey’s (2003 p.7) chapter on “Making Sense of the Phenomena”, noting his comments that there is no agreement

about which model of sense making is the most useful. I want to reflect on the different ways of making sense of the situation I described above using Stacey's analysis of the realist. From this perspective, the world exists external to the human being who tries to interpret and stand outside of the situation. Translating this to the situation I have described, as an observer outside of the situation I perceive my way of behaving as driven by the departmental rules and regulations and Sister Yakof's mood. My management style was influenced by "the way we do things around here". Thinking about this from a postmodernist perspective however, the labels or categories I use to make sense of what was happening (like "authoritarian management styles) were categories constructed in my mind, projections I made in my internal world, but did not exist in reality. Authoritarian management did not exist as an "entity" but rather a construct, a way of thinking.

As I have rewritten my project, I am more aware of the way that I was influenced by the management style of my bosses. As I became more confident, I learnt to manage the anxiety that challenging Sister Yakof generated but was unable to challenge her behaviours. I was not comfortable with the stifling work environment of A/E and decided to leave.

The philosophy of child-centred care

I became the sister of a children's medical ward – a post I really relished, and stayed until the late 1980s. I was appointed by a new manager – the DoN for Children's Services, a highly creative woman who quickly gained a national profile within child health nursing, and have been an ongoing influence over much of my career. She transformed the department and drove forward the philosophy of child centred care, an ill-defined concept in the literature (Campbell 1993). The principles included allowing the family 24-hour access and good communication.

This approach to caring for children was driven forward by our new boss who regularly published and spoke at conferences about the work that we were doing. Articles were published in nursing journals congratulating the unit on winning the Daily Telegraph's prestigious parent friendly Campaign Award, suggesting that the unit was the envy of paediatric nurses throughout the country, (Mason, 1993). The article paints a glowing report of the care we were giving, and in retrospect, it shows the pioneering approach to child-care that we were trying to achieve.

Although I greatly respected my manager, I remember saying to her that the innovations she wrote and spoke about were not consistently implemented within the unit. I was worried that she did not know what happened in practice and felt a responsibility to tell her, feeling uncomfortable about the glowing press reports we received. This conversation must have made an impact on her also, as I recently read an article she had written recalling the influences of her career (Fradd, 2003). It mentioned a conversation with a colleague who informed her that there was a gap between theory and practice and how useful the conversation had been.

I identify with White's (1999) observation that

> The initial steps on the path of courageous speech ... are the first tentative steps into the parts of us that cannot speak. Entering their shadowy previously hidden abodes we discover an interior soul energy that has not seen the light of day in a long time. (White, 1999, p.103)

I felt that I was being bold in speaking to my manager but I knew that she was unlikely to be punitive. I felt energised by working for her and appreciated her drive, vigour and the permission she gave to be creative.

At this time, I undertook an Open University (OU) course in management and learnt about theory. According to Drucker (1964), Management by Objective involves spelling out what is meant by managing a business by breaking the components into objectives, and examining the outcomes over time. He suggests that by setting objectives, managers plan what the business is aiming for and work out ways of effectively achieving the aims. This is a systems way of thinking, – by choosing a number of organisational goals and designing a system of rules and procedures to implement and achieve them, followed by evaluating the results by measuring the outcomes against the chosen goals.

I was very excited by the concept of planning and goal setting and developed a set of objectives for my ward. I was very disappointed that the objectives remained pieces of paper stuck to my office wall and made no difference to clinical care. There was a gap between the notion of what we intended to do and what happened in reality. As I indicated earlier, I also recognised that there was a gap between what my manager thought was happening and the innovations that were implemented in practice. I did not see the correlation between this and my new Management by Objectives concept – the

gap between what we espoused to do and what happened in reality. I had written a sequence of goals and outcomes, decided on the series of sequential steps to achieve the stated outcomes and measured the outcomes against the objectives. In my experience this systematic approach remains the way that the NHS attempts to manage new innovation and change. I remember reading the "Getting things done anyway" chapter in the Complexity and Management book (Stacey et al, 2000, p. 3) last year and wondered how the authors had manage to capture such an accurate description of my experience of organisational life.

We evolved our own nursing model of care that included accounts of the care that parents agreed to undertake, and parents were encouraged to write in the nursing records. This was innovative practice at the time and was evidence of the desire to evolve a way of working which was centred on the child and family rather than the needs of health care professionals. Unfortunately the amount of paper work involved meant that the records were never properly completed, and was one of the examples I used when explaining the gaps between theory and practice to my DoN. However the ability to be creative within the nursing process system was available and the following story illustrates how we were able to adapt our care and nursing documentation to meet the needs of an individual child.

A tiny one-year old child who had a serious cardiac condition was admitted to my ward. His mother was French and spoke to him in her native tongue. She was not able to be with him all the time as she had another young child at home. I discussed my concerns about how fretful Guillan became when his mother left. She said that part of the problem was that he did not understand English. Not only was the child missing his mother, he could not understand any words of comfort from the nurses. I had a friend who spoke excellent French who wrote a list of phrases like "what a beautiful boy" etc with a phonetic translation for staff not use to speaking French, and I placed the card over his bed. The night nurse said she thought I was taking this notion of individualised care to the extreme. The next morning she reported that she had never been able to evoke a smile from Guillan before using the comforting phrases in French.

I want to reflect on this story using the notion of Creative Action (MacLean and MacIntosh, 2004), to help me make sense of the experience. In describing this notion the writers refer to emergent outcomes, the interplay of different aspirations and capabilities,

and the process of interacting as features of creative action. So the capabilities or strategy behind the nursing models that we used, did not offer an option for children whose language was not English, and we did not realise that Guillan was only used to being addressed in French. My distress at seeing a child so upset, coupled with the aspiration to sooth him, led to the discussion with his mother. MacLean and MacIntosh note, “patterns of interaction shift in moments of creative breakthrough and these shifts lie beyond the realm of prediction or control” (p.26). I did not recount this conversation at home with a friend because I was looking for a way of helping Guillan even though I knew that she spoke French. However through our conversation she used her language skills to come up with a creative approach to communicating with Guillan. Although creating a list of phonetic phrases seems like an obvious solution on reflection, we had never used this form of communicating with children from backgrounds where English was not their first language before.

I have described the experience with Guillan because I was affected by the degree of creativity that materialised within a highly structured documentation framework. Although the system was unwieldy, it was flexible enough to enable us to be receptive to the individual needs of children (for example non English speakers). We knew that good record keeping was necessary but had the encouragement of our manager to be inventive in responsive to individual needs.

Again as I rewrite my project it occurs to me that the DoN gave permissions to be innovative, and my management style had become more relaxed and less authoritarian within this environment. I felt excited and liberated during this period even though some of the ideas we tried to implement were more successful than others. As I have rewritten this project over the past three months I have become interested in the circumstances in which novelty can emerge from within a structured or systems approach to the organisation of care

Professional development nursing

One of the most difficult career decisions I made was to leave clinical work. Although I felt I needed to do something different, I gained a great deal of job satisfaction from clinical nursing. I chose a compromise by obtaining a professional development nurse post within the same unit. This post involved developing nursing practice with ward

sisters, helping them turn innovative nursing theory into practice. I did not loose patient contact but had time to work with staff in a role that was uninterrupted by the day-to-day distractions brought by operational management. After 18 months in post my role changed in a way that I could have never anticipated.

In the early 1990s at a District General Hospital in a small market town, thirty miles away, a nurse was accused of murdering babies within her care. The children's unit in which I worked was asked to take over the management of the children's ward and outpatients department. My role was to work with the nursing staff to implement up to date child-care practice. The staff were extremely demoralised. Historically the ward would have had approximately one child requiring resuscitation per year. Over a few months nine babies and children had required resuscitating and three had died. The staff had just finished giving evidence in court and were trying to come to terms with what had occurred and the part they had played in the tragedy.

I have a very clear memory of my first day on the ward, standing in the kitchen having a cup of tea and chatting with many different grades of staff. As the conversation evolved I realised that having tea with a senior member of staff in the kitchen was an unusual event. Towards the end of the discussion I was asked how they were to address me. Would I be called Mrs Marriott or Sheila? I was not used to the formality that pervaded this hospital and noted that my style and informal way of working with staff was a contrast to their concepts of how managers behave. I said Sheila would be fine. This set the scene for many important conversations that were held in that dim and dingy, disinfectant smelling kitchen.

Although I set up numerous working groups and implemented new practices, looking back I think that many of the changes came about through the conversations I had with staff as we worked together. I recall checking medication in the ward treatment room with staff nurses who relived incidents they had witnessed in that very room after the perpetrator had attempted to kill a child. The disbelief that they had not suspected that she had just injected a child with an unknown substance, meant to injure and kill, often resulted in anguish and grief. I felt impotent at times and constantly reiterated that very few people had ever worked with a nurse who was killing children.

The conversations ranged from anger and regret to elated animated discussions as new and exciting ideas were sparked backwards and forwards about how to improve practice. Shaw (2002) talks about the patterning of conversations creating continuity "and yet, at the same time, the possibility for unexpected outcomes to occur and this changes what becomes possible" (p.27). I am struck by the unexpected outcomes that led to change, as new friendships and alliances were made through those free flowing conversations. Staff formed small groups to explore new ideas -staff coupled up to shadow other services together, others decided to write to (and obtained) additional funding from local charities. Sometimes staff would wander into the room to join the conversation; new ideas would form in an unstructured manner. On reflection I was working in a very different way during this time. Although there were structured meetings, things often changed through the types of conversations I have outlined above.

As I reflect on this episode and what made the experience so different, I have been thinking about how I became interested in this doctorate programme. I read about Complex Responsive Processes of relating, through a friend who was participating in the Hertfordshire DMan programme. The notion of thinking about an organisation as "highly complex ongoing processes of people relating to each other" (Stacey et al, 2000) appealed. Under the influence of Management by Objectives, I had always viewed the management of work as a system dictated by the organisation but had never thought about what I meant by the term "organisation". Although the notion of putting a framework or system around the things that I needed to achieve was helpful, the outcomes were often not what I had anticipated, often because colleagues did not behave as I had anticipated.

Becoming a Director of Nursing

I became more initiated into the management side of organisational life when I became a nurse manager in the early 1990s. Later I was appointed as the Executive Director of Nursing in a Children's Hospital Trust, fifty miles from home. In this role I was an executive member of the Trust Board and provided nursing advice to the executive and non-executive members of the Trust board. The CEO, Paul, was a cautious man who had been in post for a year before I was appointed. I learnt over time, to treat him with vigilance and, where possible, gauge his mood before entering into a discussion with him. He had a strong bond with Anna, his personal assistant, who was intensely loyal to him

but often fed his paranoia. A number of staff were sacked or demoted because they had upset Anna. They regularly socialised in the local pub with other directors and there were rumours that their relationship was beyond the professional.
The atmosphere was tense at times and Paul's behaviour could be unpredictable. Kets de Vries (1989) describes the neurotic leadership style, where personal weakness is denied and personal blame is not accepted. The style of behaviour between the leader and the followers determines how the behaviours unfold. Paul seemed to display a high degree of paranoia, and on reflection I realise that the way that the executive and Paul interacted, co-created the power relationship within the group. The CEO, could not impose his will on to the group (although it felt like it at times), just as the Senior Sister in A/E could not "make" the staff behave in a particular way against their will.

Returning to my reflections on my career at the children's hospital as the new Nursing Director it was agreed that I would establish nurse manager roles into the directorates (or management teams). During the next four years the role changed annually from nurse manager to part nurse, part business manager, to business manager only – the structure reflected the anxiety levels of the CEO regarding financial control. At times I believed that I had let the nursing profession down and felt distraught. It seems rather grandiose now to think that I might have had the power to change the course of events. One of the things that has been of great importance to me is the notion of taking responsibility for what happens, and reflecting on the part I have played in the incident. The learning I took from the repeated modifying of the nurse manager roles is illustrated in the adage that "what goes around comes around". I recognise that I became increasingly cynical and ambivalent, about work life at this time, seeking roles and responsibilities at senior levels external to the Trust, because I could not make sense out of what was happening.

As I read Stacey et al (2000 p.5) describing groups of managers revisiting business models that did not work, feeling demoralised and agreeing to do better next year, it felt like a recreation of my story. As I consider the concept of systems thinking and try to make sense of my experiences in a different way, I note a reduction in my ambivalence to this period of working life. The executive group constantly looked at the "system" to try and achieve the type of changes we desired. I was unaware of the management theory which underpinned our approach to business modelling, but the prevailing orthodoxy involved setting objectives from our strategy and sending an annual evaluation of these objectives to the Regional Health Authority.

Nevertheless in my experience, most managers in the NHS have a set of beliefs about organisational direction, with accompanying aims and objectives and implementation plans to drive forward the organisation. These are the comfort blankets that help to reduce managers' anxieties. Suggesting that frameworks and models do not result in the desired outcome, defies many of the foundations of NHS management ideology. Although many colleagues may share my frustration about the long term futures planning, which bear little relationships to the reality of day-to-day organisational life, the prospect seems preferable to working in an organisation of unknowable futures.

The Influence of Psychotherapy

Earlier in this project I mentioned the importance of personal responsibility and reflection. Perhaps this is a manifestation of my Christian upbringing and the notion of being responsible to God for my actions. However, since I had moved away from accountability to an "outside force", in 1995 I decided to take a course in Transactional Analysis (TA) psychotherapy to help me make sense of my life and the way I lived it. Unfortunately the course tutor died from cancer during the course and this resulted in a very elongated study period.

TA is a form of psychotherapy and is focused on the central tenant of humanistic psychotherapy, – that individuals are motivated by self-realisation, or self-actualisation (Stacey, 2003 p.330). Stewart and Joines (1994 p.1) describe TA as "a theory of personality and a systemic psychotherapy for personal growth and personal change". It uses a three-part model known as the Parent Adult Child ego-state model, to help people understand how individuals function and express their personalities in terms of behaviour. According to this model when people behave, think and feel as they did as a child they are said to be in the Child ego-state. The Parent ego-state is described as behaviour copied from parents or parent-figures. When people are behaving, thinking and feeling in ways that are direct responses to the present or the here-and –now, they are said to be in their Adult ego-state. I found this model useful when reflecting on organisational life, for example the temper tantrums of the chief executive and the child like position that I, and the rest of the executive took.

However, I find the chapter on "the Nature of Human Beings" and analysis of humanistic psychotherapy by Stacey (2003 p.77) quite a challenge to my thinking. The notion of the

individual trying to interpret their early experiences of life into some kind of construct to help to understand current feelings and behaviours, has been part of the foundations of my personal growth during the last 10 years. Although I have participated in a number of therapy groups in the past, I have perceived that the group functions as a group of individuals who interact and affect each other particularly in the constructed group process session. Mead's (1934) thinking on the social rather than the individual, the stimulus and response of an interaction combined bringing meaning lying in the response, challenges the way that I have perceived human relationships. However as I relate this to making sense of the conversations I recalled earlier in this project when working with the traumatised staff in the district general hospital, I realise that I am beginning to be able to relate these concepts to my past experience.

Stacey (2003) suggests that human relationship are not about one subject affecting the other but are subjects which interact with each other and "in their interaction they form the experience of each other" (p.330) This complex responsive process suggests that the private conversations people have in their minds, hidden from the other, arises in the relationship and are a felt experience.

The path of courageous speech

Returning to my relationship with Paul, I recall the situation where I felt unable to continue to collude with his intimidating behaviours. Helena, the chair, became increasingly concerned about the power and influence that Anna apparently had within the executive team, particularly within her relationship with Paul. She asked Paul to interview all the executive directors and ask how they felt about Anna and her role. I think that Helena thought that this would give her ammunition to challenge the unhealthy relationship between Paul and Anna. At my individual interview, Paul was very parental in style, making it clear that the only reason we were having the conversation was because of the chair's request, and as far as he was concerned there was not a problem with Anna and her role. He sat forward in his chair, hands clasped in front of him on the desk. I felt very tense, my mouth was dry and I had "butterfly" feelings in my stomach, my intuition told me that I was in dangerous territory.

Nevertheless, I decided that I had an opportunity to say what I thought and in TA terms speak from my Adult (even though the frightened Child inside of me was screaming "don't do it!"). I spoke of my concern about the number of staff who had fallen out with

Anna and had subsequently left the organisation. I remember sitting right back in my chair almost as though I was ducking an imaginary swipe, as Paul's facial expression and body language gave me unspoken clues about how he was receiving the words I articulated. I had felt intimidated by Paul on many previous occasions but there was a new pattern of behaviour emerging where I felt even more intimidated by both his gestures and the spoken conversation between us. I imagine that my anxiety was very clear to Paul but there was a silent conversation going on in my mind telling me to stand up to the postulating and express the concerns that I had never articulated before. A new meaning emerged. I recognised that I was challenging the power relationship between us.

Paul looked angry and I knew that he was required to convey my comments back to the chair. I saw this as an issue of personal integrity and I had to be honest about my concerns, even though I knew that the consequences would affect my relationship with both Paul and Anna in the future. My executive colleagues had shared my frustrations and had their own stories to tell about Anna's behaviour over the years but chose not to recall them to Paul. I felt isolated and excluded from Paul and the executive group and Anna refused to speak to me for the following six months.

This experience was a particular watershed for me and I have described this incident to try and make sense of what happened. I was given an opportunity to say what I thought and was unable to lie about my experience to preserve my relationship with him. The theme of the shadow side of organisations remains prominent as I reflect on this experience. Stacey (2003 p.363) argues that "shadow themes that organise relationships in organisations". By the shadow side I mean the ability to speak the unspeakable and survive the consequences. I was unable to stand up to Sister Yakof but was able to tell my boss later in my career of my concerns about the theory of child centred care and what happened in practice. Finally I had come to a situation where I felt bullied by Paul but was able to stand up to him and be honest – to speak the unspeakable.

Eventually the chair asked Paul and Anna to leave and the following year under the leadership of an acting CEO, I began to accomplish many of the aspirations I had set out to achieve in the previous 6 years. I obtained funding for a number of posts that I believed would help to implement the philosophy of child centred care, like a lead for adolescent care and a patient advocacy post. I then became confident enough to apply for

a very senior post. Again I note how much better I thrive within an environment free from repression and persecution.

The National Health Service Reorganisation 2000

I took a one-year secondment as the West Midlands Regional Office as the Regional DoN. This was within the context of a new Health Service directive called "Shifting the Balance of Power". The aim of this change was to reduce the power and influence from central government to four regional Directorates of Health and Social Care. These directorates were responsible for the performance of 28 Strategic Health Authorities, (SHA). The SHA were responsible for monitoring local health care. The other significant change involved the commissioning of local services that would be undertaken by Primary Care Trusts – organisations based in the community comprising of groups of General Practitioners (local community based doctors). Under this new system the majority of money allocated to the NHS would be given to Primary Care Trusts to purchase health care on behalf of the local population (DH 2000). This was a very turbulent time to be working in the NHS. About ten months after the changes were initiated Health Service it was decided that the Directorate of Health and Social Care was unnecessary and abandoned this level of bureaucracy, leaving the 28 SHA to monitor local performance.

After the secondment I was appointed as the Director of Organisational Development and Learning at the newly formed Strategic Health Authority. This was to be the greatest challenge of my career. Shaw (2002 p.125) suggests that organisational development brings a certain rational inquiry into improving human communication and organisation. By examining the organisational processes, organisational development practitioners try to bring understanding and change to human systems and processes, targeting different levels of the organisation.

The CEO was not really clear what he wanted from this post (and neither was I) and we agreed that we would develop the post together. He felt that the Trusts were in good financial shape and the Health Authority could afford to do something more creative. In some ways it seems strange that I had worked in a hospital which had had little such a lack of organisational stability and went into a job about organisational development.

Seven months after I had been appointed the CEO left and the acting CEO had to deal with the poor performance of the Workforce Development Confederation (WDC) CEO. He decided to change the management arrangements for my OD team and transfer the department to the WDC. I was invited to compete with the WDC CEO for the leadership role of the WDC. I was not interested in this post and was made redundant.
This was a tremendous blow to my self-esteem and I realise now how difficult I had found organisational life. The ongoing relentless workload was always problematic for me, but as I think back I always found my role as an executive difficult and frustrating.

The areas of development I had always been involved in came second to the performance targets and finance. I had always felt like an add-on because the thrust of performance did not appear to concentrate on improving patient care, but focused on improving the measurements of certain parts of "the system". I wanted focus on people, their relationships and the provision of networks of good practice across the SHA boundaries and provide a health economy wide development programme. I was still working with the Human Resource Directors, trying to make sense of the term organisational development, when I was made redundant. No further work has been undertaken within this field in this Strategic Health Authority since I left.

I have been working for myself for the last ten months and reflect on the term working for myself. This "working for myself" terminology bears significance for me where as the term "set up my own company" feels too grandiose. Colleagues regularly send me details of jobs in organisations and my immediate reaction is to disregard the jobs because they are part of an "establishment". I do not have any desire to work for an institution at the moment. This may be a defensive reaction because of the hurt I experienced last year. However when looking at the narrative so far I realise that I never felt comfortable with organisational life particularly as a director. I was unable to understand why I was so frustrated with the way that organisations were managed, the separation between the care that patients received and the priorities that concerned the leaders.

Summary

I have endeavoured to weave together the influences and experiences that have informed my practice in organisations. As the themes have become clearer to me, I am aware of the way that individuals have influenced my practice. The thread runs from working with an

authoritarian ward sister to a petulant CEO and concludes with a complex consultancy assignment. I am wondering what gives people the courage to speak the unspeakable and stand up to the prevailing attitude and authority. This notion of the shadow side of organisations is a theme that I am particularly interested in researching further.

Systems and processes are often seen as the underpinning constructs that form the foundations of the NHS. Managers aim to shape the future from developing business plans, targets and objectives and conceptualise themselves as working within a system. The research question I wish to explore involves, how as a consultant, can I facilitate the emergence of novelty (given my embryonic understanding of complex responsive process theory), where unpredictable futures are not tolerated and management consultants are brought in to “fix it”?

Reflections on Project 1

In Project 1, I was concerned with how staff could be innovative in an organisation where the dominant discourse reflected systems thinking. I thought that it would be difficult for novelty to emerge in an organisation which was managed according to an inflexible systems approach. I now see more clearly that systems thinking is a construct or a way of thinking about organisational life that has benefits and limitations. In this project I described my use of management by objectives as an example of an experience where change did not occur (page 127). At the time I thought that if I set a vision for the ward with associated goals we would become a more successful ward. I now realise that I blamed the model for the disappointing results, rather than recognising that I could not achieve the results I required in isolation from my ward colleagues who I had not consulted.

In this project, I can now see how I initially regarded complex responsive processes theory as a panacea to remedy the frustrations I had experienced with the way that the NHS was governed. I uncritically took a cybernetic systems approach to management to be the cause of the frustration I experienced and wanted to take a complex responsive processes approach to management as a superior alternative. This was challenged by my supervisors and led to my undertaking an analysis of complex responsive processes thinking in later projects and in the synopsis.

In Project 1, I refer to a nursing model framework that was developed by staff to document the innovative approaches to child healthcare. A model was required to record care in a systematic way, and this was managed through a systems approach to patient care; but I did not make the connection at the time of writing. The significant feature for me now is that the systems approach was developed by staff who used the documentation as a vehicle to implement their values from their philosophy of child-centred care. We were committed to using it because we had developed the system; therefore there was ownership of the model. This is different from developing a way of working in response to centralised policy directives, which may or may not be relevant to day-to-day-work. A review of systems thinking is developed in the third and fourth projects and a further critical analysis is undertaken in the synopsis.

Although the nursing model was unwieldy, it was flexible enough to accommodate new and innovative practice. In the narrative account of finding a way of communicating with a small French child, I use MacLean and MacIntosh's work to demonstrate how the interplay of aspirations and capabilities could explain how an innovative approach benefited the well-being of the child. On further reflection, I now see that I had not considered the power relationships between myself as the ward sister and the ward staff. I recognise that I did not negotiate the introduction and implementation of a different way of working, but initiated new practice with little consultation. I am now more aware of the connection between power and innovation, which I study further in my synopsis.

I express my frustration in the phrase 'what goes around comes around' as I considered the constant reorganisation within the health service. This concern about the ongoing changes in the NHS is a recurring theme in my work, and is studied in more depth in Project 4 and in the synopsis.

This was the beginning of my journey into understanding a complex responsive processes way of thinking and I acknowledge that, at times, I saw it as an antidote to systems thinking. As I have studied the theory further, I have realised that it is a construct; a different way of understanding organisational life. I have developed my thinking further and critically analysed the theory in the synopsis.

In my next project, I explore the emergence of novelty further, and consider the notion of differing values and norms leading to a clash of ideologies, as I work with an associate group of staff rather than as an independent consultant.

CHAPTER 3

Project 2

Introduction

In Project 2 I have explored what happens to the balance of creativity and control in a highly structured environment. This has been considered in the context of a newly formed group working with a well established and eminent organisation who was asked by a client to jointly produce a programme for nurse and Allied Health Professional (AHP) consultants. I explored the difficulty of working with colleagues used to a centralised, controlling environment, when attempting to work from the perspective of complex responsive processes.

I realised that my desire to work with these concepts was my ideology and did not readily translate into working with an “associate” group of colleagues used to a rationalist approach to organisational development. Although many of our values and norms were similar the significance of this difference became apparent when attempting to design the joint programme. My colleagues accepted the rationalistic approach fostered by our partner organisation and did not share the frustration I experienced about wanting to work in a different way.

I have drawn extensively on the work of Elias (1978) and Elias and Scotson, (1994) to explore the concepts of power and ideology, which influenced the way that the two groups functioned. The notion of rationalist cybernetics, power relationships and differences in professional backgrounds are considered as I explore the experience of a “shotgun wedding” between the two “organisations.”

I think that it is difficult for new organisations to gain tenders without the backing of a large organisation to reassure the client that the company is viable. The proposal for a small organisation to work in partnership is a solution to this problem. However I have explored how the difference in ideology and the power differentials affect the notion of partnership working. If these issues are too diverse the relationship is unlikely to work.

A new opportunity

I had been working independently for about a year. Much of my work had been with clinical staff and managers. This was an area of work that I enjoyed and was delighted when I was contacted by Bridie, a colleague who I had worked with previously, about collaborating on a new piece of work. She had seen a journal advertisement calling for tenders to run a development programme.

The client was a Workforce Development Confederation (WDC). WDC's are organisations that hold large budgets for healthcare education and training. The course was aimed at developing nurses and Allied Health Professionals (AHP's – physiotherapists' speech therapists, occupational therapists and clinical scientists etc) to become nurse and AHP consultants in the NHS.

The development of nurse or AHP consultants was taken from the NHS Nursing strategy (Department of Health 1999) and was seen as a way of developing senior clinical roles in the NHS and motivated by issues such as the shortage of doctors, and a desire to keep practitioners in the field. The new role was intended to improve better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwives and health visitors in practice. Posts can be established in any service or speciality where it is clear that doing so meets these objectives. (sic) (1999 Department of Health para B5)

It had been recognised that staff, other than doctors, could work autonomously and the new consultants would work at a "higher level of practice", meaning they could assume more complex medical interventions than nurses or AHP's would traditionally undertake. For example, nurses working in Accident and Emergency would be able to see, treat and discharge patients with minor injuries for example, without the need to see a doctor. By offering senior clinical roles with appropriated financial recognition, it was hoped to keep staff in practice rather than losing them to managerial roles. The purpose of the development programme was to provide an opportunity for senior skilled practitioners to develop their political and managerial skills to prepare them for working at a consultant level.

I called the chair (Paul) – to discuss their requirements further. I had known Paul for a number of years and had great respect for his integrity. We had met on a development programme 10 years before and had met periodically over the years. He was looking for a creative programme which would develop participants politically – to both help them understand how the NHS works as an organisation and increase their influencing skill.

Creativity

After the discussion with Paul, I felt excited at the prospect of designing a creative programme. According to the Thesaurus, creativity means originality, imagination, inspiration and inventiveness (Collins 1993). These definitions embody exactly the type of programme I wanted to create with my colleagues –a programme that would allow participants to explore original and inspirational approaches to their development, encouraging them to use their imagination and inventiveness. Joas (1996) suggests that there is "antagonism between rationality and creativity".

> The general fear…is that any emphasis on creativity may open a Pandora's box which, for the sake of rationalism and Enlightenment, would be best left closed. (Joas, 1996, p.73)

This quote is particularly pertinent in relation to how the tendering for this piece of work progressed as I will describe later.

My colleagues and I had not worked together before and called ourselves Giselle. Lisa, Bridie and I found a fourth member to join the group called Jean. She had a physiotherapist background and was recommended to us as someone who would work well with our group.

I had a lot of input into the tender and included many approaches from the DMan programme such as theatre, story telling and understanding organisations as complex responsive process, along with more traditional approaches to understanding the way that organisation work.

Stacey states that

> … the central argument of the complex responsive process perspective is that strategy is the evolving pattern of collective and individual identities emerging in the ordinary everyday local interactions between people. As they continually

> interact, people form and are simultaneously being formed by narrative propositional themes that emerge as continuity and potential transformation at the same time. (Stacey, 2003, p. 358)

Rather than thinking organisations as systems, complex responsive process posits that the experience of interaction produces further interaction. It is the ongoing processes of people relating in which they shape the patterning of the conversation, and are concurrently shaped by the patterning of the conversation that brings about novelty in organisations. I had worked in organisations where I had seen change occur in small departments, independent of the Trust's strategic directions where groups of staff had come together to improve the care of their patients. I had found their lack of corporate thinking irritating at the time. Since exploring the concepts further and commencing the DMan programme, I was keen to challenge my thinking further by including the concepts in a module that I would run.

We found we had a wealth of networks and contacts to call upon and became very excited about introducing innovative ways of providing an experiential programme for the participants. Weick (2001) uses the word bricolage which means using whatever resources and repertoire you have in order to perform whatever task you face. This describes the approach we took as we reviewed national guidance on the role of nursing and the AHP consultants. Weick (2001) also suggests:

> … what makes for skilled bricolage is intimate knowledge of resources, careful observation, trust in one's intuitions, listening, and confidence that any enacted structures can be self-correcting if one's ego is not invested too heavily in it. (Weick, 2001, p. 63)

We found we had an intimate knowledge of resources from our networks, were confident about taking risks based on our intuition, and felt sure that we knew each other enough to confront conflicts that may arise between us. Through the combination of utilising our diverse network of contacts and exploring the concepts embedded in the notion of complex responsive processes, we developed what we considered to be a creative and challenging programme.

The tendering process

We had discussed the fact that we had no track record of delivering such a programme and were delighted to be short-listed for the work. We became less confident when we heard that we would be in competition with a company I will call Queensborough (QB).

QB is a private company with a national reputation for health care improvement through health care policy development, staff development, coaching, research and publications. Much of their recent work came from the policies outlined in The NHS Plan (Department of Health 2000) a policy document, which outlines a set of core principles to guide the National Health Service (NHS) including the need to modernise the NHS. This means redesigning the way that services are delivered around the needs of patients. The NHS Plan focuses on the role of managers and clinicians to control the redesigning of their services and move their organisations towards meeting the centrally set targets.

Much of QB's work came from redesigning services and helping Trusts improve their ability to meet the Department of Health performance targets, which were introduced to monitor progress. QB has a reputation for providing development for managers and clinicians, and their programmes had credibility within the field. When contemplating on the niche that QB has carved out over a period of many years, I started to think about why I had found their programmes useful. I liked their empirical approaches to understanding the NHS, by helping participants understand organisational theory. I had wanted to try and understand the connections between the "theory" and the rationale behind what the NHS leaders were trying to achieve, e.g. the relationship between strategic planning and implementation. I remember thinking how useful I found the theory surrounding rational frameworks in managing organisations and I had a sense of personal confidence when I left a QB course. I will discuss rationality and the QB organisation in greater detail later.

I was unable to attend the interviews for the tender as I was on holiday; however there were four organisations short-listed. The Workforce Development Confederation (WDC) panel consisted of four members. I knew the two nurses from working in the geographical area in the past. Paul was a Nurse Director of a large acute Trust and the chair of the panel. Libby was a nurse by background, and was employed by three Strategic Health Authorities to take forward leadership development for all professional

groups. There was an allied health professional manager, Mary (a physiotherapist by background) and the Workforce Development finance director, Andrew. We later found out that this panel could not reach a consensus. The two nurses were keen to employ us; the AHP and Andrew from finance, preferred QB. This spit in the team is an issue that I will return to later. They explained to Giselle and QB that they liked the infrastructure, status and credibility of QB, and the creative approach of Giselle.

The programmes

At a later meeting we discovered that the QB tender was not written or presented in much detail. The two nurses on the panel, Paul and Libby were familiar with QB programmes. They felt that their proposal reflected the QB blueprint of programme delivery, duplicating similar material which they used in other QB courses. Andrew and Mary the AHP manager preferred the kudos, infrastructure and security that they perceived QB would bring, even though the programme lacked detail.

Paul and Libby liked the degree of detail we had submitted which outlined a different way of working, such as story telling, forum theatre, time to reflect and make sense/meaning of the participants experiences. They were keen to promote a tender, which showed a commitment to encouraging reflection and personal change. Paul and Libby were also impressed with the enthusiasm, commitment and knowledge of clinical practice that Giselle had demonstrated within their tender and at interview. However at interview this type of approach had been received sceptically by Andrew, who was more orientated towards what the “outcomes” of such an approach would be, i.e. how could we measure whether the participants had changed? I suspect that the request for the two organisations to work together to produce a joint programme resolved the conflicting views of the panel. It was hoped that the joint programme would reflect the collective strengths of the two organisations.

The client contacted us by letter regarding the elements of the programme which they considered needed modification. One of the criticisms included the lack of organisational development, strategy and planning. I had designed this deliberately, as I believed that these were issues that the participants needed to be aware of, but wanted to provide a forum where these concepts would emerge rather than plan a “chalk and talk” session. On reflection perhaps I had been naïve, or maybe I had attempted to be vague about these

areas because I had difficulty in articulating why and how I wanted to approach these topics in a different way.

We were delighted to work with QB and thought that it was a good opportunity to work within an established organisation. The Giselle associates had all functioned at director level in organisations previously and had diverse experiences to contribute. Although Giselle did not articulate the notion of apprenticeship there was agreement that we could learn from working with QB.

Three members of the Giselle group met to prepare for the meeting. My anxiety about working with QB was twofold. Firstly I had entered into the Giselle associate group because I was happy to work with a small group of colleagues, but I also noticed my anxiety about working with a prestigious institution. This was born from being made redundant eighteen months before and I knew that I felt a distrust of organisational life and being "done to". Secondly I had been on QB programmes before and I imagined that their approach would be very different to the complex responsive process thinking about organisational development that was beginning to influence the way that I worked. I was interested in the notion of how local interaction could shape strategy through the ongoing processes of people relating in which they shape the patterning of the conversation and are concurrently shaped by the patterning of the conversation, which brings about change in organisations. (Stacey 2005). I imagined that this was different to the way that QB viewed organisational life.

We met at the smart QB offices to discuss the joint working in a tiny hot room. I had a streaming cold and felt very tired, and did not want to be at the meeting. Both QB and Giselle organisations had received letters outlining the strengths and weaknesses of our tenders. We had shared our letter and our tender with QB in advance but had seen neither their letter nor a copy of the tender, which QB had submitted.

There were three members of QB at the meeting. Gloria had been appointed to lead the QB element of the partnership and they suggested that Gloria chaired the meeting. Although it felt unnecessary to quibble, I noticed their desire to control the meeting. Gloria was a nurse by background but had spent most of her career in university education prior to joining the QB consultancy. Teresa was an ex-chief executive with a general management background and the third QB member, Jim, was a management

consultant who had worked with health care staff for much of his career but was not a clinician.

Giselle said that that we were delighted to be working with them but had concerns about being consumed by their organisation. The QB group did not respond to this comment initially and said that they felt that the programmes were not that dissimilar. We were unable to comment as we had not seen their proposal. They said that they had arranged many similar programmes in the past and were surprised to be asked to work in partnership with another company. They appeared very confident and I gained the impression that they felt perfectly capable of delivering the programme alone. This was not said outright at this time but I felt that this issue was in the shadows. As we considered the joint strengths and weaknesses, I later noticed that the conversation had focused on our weaknesses, and we had gained little insight into the QB proposal.

Elias and Scotson (1994) describe life in Winston Parva, a Leicestershire suburb. There was a clear distinction between those who had lived there for several generations (inhabiting Zones A and B), and those who were new to the area, (living in Zone C). There were little apparent differences between Zone A and B – the "village", and Zone C the "estate". Newcomers were perceived to be a threat and were seen to reduce the status of the old villages, impairing the prestige of their neighbourhood. They noticed much in the behaviour of the newcomers, which they found offensive. The newcomers' behaviours were judged in terms of their morals and manners, which were used as symbols of the old inhabitants. The old residents had developed a specific social order, which left little scope for uncertainty and had a distinguishing way of behaving which they all had in common. The new residents did not know what behaviours were acceptable or not, as the knowledge was excluded from them. This gave the old residents the ability to exercise power in relation to the newcomers. No one could enter the circle of monopoly holders without the consent of the old families.

Although the associates within Giselle had some experience of commissioning and running development courses, we felt like the new residents. QB had their own way of working and had run many development programmes in the past. Their symbols were the "old programmes" that they had been running over many years. Giselle had no reputation for producing development programmes as a company. The power dynamics between the two groups will be examined later.

I began to feel that this first meeting with QB did not feel like a partnership, I felt that we were being interviewed again. My fears were not allayed when Teresa, one of the QB team, (an ex hospital CEO) asked what we thought we could contribute to the joint approach to the programme. Lisa enthusiastically described how three of the Giselle group had previously worked in the geographical area and knew many of the senior staff in the patch. She also spoke of our commitment to the development of clinical staff, which was met with further questioning.

QB had developed their own high standards of working and was probably concerned that working with Giselle may marginalise their standards. They appeared to use this meeting to interview Giselle, to postulate that their ways of working were successful and that their standards must be maintained. Because of their reputation I think Giselle felt intimidated. We did not know what "standards" we were being measured against; we were in the QB smart office environment and had not anticipated or prepared for a second interview.

Power

As I reflect on this first meeting I am aware of how the power dynamics between QB and Giselle changed during the course of the narrative. When we were asked by Teresa at the beginning of the meeting what we could contribute to the programme, the difference in backgrounds and passion about the development of clinicians became apparent. As she recognised our strengths and the differences in our ideologies I think we possibly become more of a threat. Elias (1978) describes the figuration or patterning of competitive and co-operative relationships which reflect the interdependencies between individuals and groups. Power ratios are created within the relationships, not by one person exercising their will over another. At the time it felt as though Gloria and Teresa were exercising their will over the group.

Elias ([1970] 1978) described a series of models as a kind of mental experiment to demonstrate the relational characteristics of power. I am interested in his description of "how the web of human relations change when the distribution of power changes" (p. 80). This is why I found Elias's games model, which I explain later, so useful when reflecting on my/our relationship particularly with Gloria.

Elias also suggests that people suppress their awareness of this contest when reflecting on human relations but after a while, find a balance of power that (depending on the circumstances) may or may not be stable. As will be seen from the games models, he emphasises how the self organising patterns of behaviour emerge in the interdependence between individuals and groups. People constrain and enable each other through relating, as all human relating is power relating, according to Elias.

As I think of the power differences between the groups I am drawn to the notion of ideology. In the next section I will consider the ideologies which influenced the behaviours of the two groups, and the differences which contributed to the difficult working relationship.

Elias and Scotson (1994) suggest that power differentials are preserved through the "weapon of ideology" (ibid., p.18). They also suggest that the social badge, the adherence to the common code of behaviours, strengthened the old villages' sense of group belonging together, in relation to the "inferiors" who were less restrained and tended to break taboos. This was a sign of social inferiority, which offended the superior's sense of good taste or morals and values. The old residents made a *choice* to close their ranks against the newcomers:

> They developed an ideology, a system of attitudes and beliefs which stressed and justified their own superiority and which stamped the people of the Estate as people of an inferior kind. (Elias and Scotson, 1994, p.18)

When considering the concept of humans making choices between one action and another Stacey (2005) suggests:

> The choices may be made on the basis of conscious desires and intentions, or unconscious desires and choices, for example, those that are habitual, impulsive, obsessive, compulsive, compelling or inspiring. In other words, human action is always evaluative, sometimes consciously and at other times unconsciously. The criteria for evaluating these choices of values and norms, together constituting ideology. (Stacey, 2005, p. 9)

According to Stacey (2005) norms are evaluative criteria which emerge over time and set the boundaries of social behaviours. These norms are adapted in our day-to-day relationships and affect the actions we take. Values are "fundamental aspects of self

giving meaning to life, opening up opportunities for action". (Stacey 2005 p.10). They are intense experiences which evoke feelings of commitment and when combined with the boundaries set by norms become ideology. So ideology is a system of attitudes and beliefs based on the values and norms chosen by the group.

Systems thinking and ideology

As I consider the QB ideology I will explore the influences of rationality and cybernetics that contributed to their style of working.

Gloria, Teresa and Jim had worked on many programmes together for a number of years. They had made choices about how to work together, the content of their programmes, implemented their plans and evaluated their work as a group. The group norms had evolved over time and they knew each others values, which was characterised within the joint programmes they ran. They had developed their ideology, their system of attitudes and beliefs from working together, and also from the more overarching ideology of the QB organisation.

An extract from in the QB 2005 report suggests that

> Our core businesses are policy development, service development and people development but to achieve in each area we need to be focused on outcomes, with more clarity on what we are trying to achieve, with whom we are trying to achieve it and how to maximise the impact we make. This is not just about improving communications, it should be about having a strategy for influence built into each area of policy and development work as well as clear performance goals. (Corporate Plan, 2005, p. 5)

So the ideology of the organisation was based on a rationalist systems thinking approach. The system is called rational because

> the means are expressly designed to achieve certain specific goals (i.e. the organisation is like a well designed machine with a certain function to perform and every part of that machine contributes to the attainment of maximum performance of that function) [sic]. (Pugh and Hickson, 1989, p. 7)

The initial development of systems thinking developed in the 1950s was set around the thinking that the whole organisation is thought of as a system, and the parts of the organisations are subsystems within it. The interaction between the parts is significant, as the subsystems interact to form a system. A number of systems then form a suprasystem. So the parts were seen to affect each other rather than being considered in isolation, and thus the whole system was thought to be greater than the sum of the parts.

So applying this analogy to the QB organisation, Gloria, Teresa and Jim are individuals who are subsystems who work together to form a group, which is a system. This in turn forms an organisation, (QB) which is thought of as a suprasubsytem. From systems thinking the notion of cybernetics developed (Ashby (1956) Wiener 1948). In cybernetics systems, goals are set with performance targets that are fixed for sometime in the future. The goal outcomes are then measured against the targets, and action is taken to self regulate the system by taking steps to reduce any outcome variance from the set target. So in the case of the health service, goals are set by government, who then measure the hospitals performance against their preset goals. It is the function of the regulator (or hospital organisations) to monitor and control the environment to reduce instability and ensure that action is taken to reduce any variance in performance from the set targets.

As the QB corporate plan makes clear, the organisation focus's on outcomes from policy development, service and people development. To be a more effective organisation, QB also requires that each area of policy or development work, have a strategy for influence as well as clear performance goals. There is a suggestion in other areas of the QB Corporate Plan that one of their tasks is to provide objective analysis to health and social care providers and "help them make sense of what is going on and where possible help them take control" (p.8). Although I share the notion of helping organisations make sense of the way that they work I was interested in working from a more complex responsive perspective. I make the assumption that their corporate ideology typifies the way that they work with their clients in their organisations. This assumption is also supported by the courses which I have taken with QB in the past as I earlier recalled. I noticed that there were some similarities between the ideologies of the two groups. The Giselle group members had been socialised into the norms of the NHS, we knew the culture and had worked within the cybernetic rationalistic approach as described earlier.

Reflecting on the Giselle ideology as a series of values and norms, (Stacey 2005) our values were rooted in a commitment to staff who worked in clinical care. We believed that this group of staff were of paramount importance to the provision of good patient care, another value which we all shared. The freedom to work independently and the desire to retain that freedom was also a shared value. We had a common experience of the NHS norms which bound us together and influenced our behaviour. This was the first time we had worked together, and our group norms were being further established as we endeavoured to develop the programme and work with QB.

Our development programme was based on these values. We chose to share our experiences as senior clinical/managerial staff who had worked in the NHS. We felt inspired by the programme we had put together and there was a compulsion to share our experience with the participants.

When considering the differences between the two ideologies I contend that QB used a blueprint, by adapting programmes that they had used before based on a systems way of working, and their approaches had to reflect their corporate plan. Giselle were more interested in working in new ways to provide opportunities for the programme participants to reflect and make meaning from their experiences. We had no blueprint or corporate plan.

We worked independently and had come together to undertake a particular piece of work. We were challenging traditional ways of presenting courses and introduced different ways of working. One of the reasons QB gave for wanting to work with us was related to our clinical expertise, yet this appeared to be threatening. I suspect that Gloria was particularly affronted by the notion of partnership working as she felt akin to clinical nursing staff. Even though she had worked mainly in an academic environment before joining QB, I suspect that she did not recognise or value our expertise.

Inclusion and exclusion

Although there were no obvious differences between the two Winston Parva groups, Elias and Scotson highlight the consequence of the cohesion that had developed between the old residents. They had developed an identity and had come to think of themselves as a “we” group with common attributes that had emerged because they had been together over a period of time. The newcomers had no history of being together and this made

them vulnerable. Similarly Giselle had no history or reputation and I remember feeling rather vulnerable as I sat in the QB offices in a meeting chaired by QB.
In time we found that there were close similarities in the type of programme QB and Giselle wanted to deliver. However there were differences in the reputations of the organisations, and in the backgrounds of the members of the two groups. Giselle had been managers who had retained close relationships with clinical practice staff.

The analogy of the insider and outsider is useful when thinking about clinician manager relationships. The low status of managers (Dopson 1994: Bolton 2003: Thorne 1997) is one reason that clinical staff are reluctant to participate in management. Thorne suggests that managerialism is an ideology based on rationality, hierarchy and a view that managers should be free to manage and control. She postulates that Doctors believe they have the right to control their own work and exercise clinical judgement, they do not expect to be managed and work within a peer group with networks and pecking orders. The two groups have different ideological outlooks.

Beil-Hildebrand (2002) argues:

> At the present time, the primary orientation of management is towards the enhancement of corporate control and the objectives of more efficient, flexible and innovative healthcare services. In doing so they inevitably enter into conflict or form a coalition of interest with healthcare professionals who are seeking to protect and extend their own interests in healthcare work. (ibid., p. 268)

She also argues that clinicians have their own ideologies, born from their professional lineage, which may or may not align with the organisations corporate objectives. There are tensions between managers and clinicians about improving patient care, which Doctors want to progress without the approval of management. The nurse consultant roles are based in clinical care with a strategic and service planning component to their role. They may share similar values to doctors about the importance of maintaining clinical autonomy. However nurses are more used to working in a hierarchy and are more able to straddle the clinical-managerial divide.

Bolton (2003) argues that although many nurses are effective managers,

> the influence of nurses' attachment to their professional role becomes clear in the way that they reinterpret senior management directives, manipulating and

> moulding policy initiatives into their own frame of reference. (ibid., p. 127)

Bolton is suggesting here that, rather than rebel, the nurse managers moulded the initiatives to reflect their values and norms. I wonder if QB was wary of Giselle because they were not quite clinicians and not quite managers, manipulating the consultant development programme to meet the ideology of our group.

Hallier and Forbes (2004) comment that the managerial policy agenda has fostered the formal socialisation of doctors to increase their acceptance of managerial roles. They suggest that "the assumption has been that traditional 'them' and 'us' attitudes exist between doctors and managers should be reduced by training in management ideas, practices and objectives" (Hallier and Forbes 2004 p.1382)

To try and reduce the "them" and "us" in healthcare – the notion of the insider and outsider, there has been a drive to introduce management training for doctors, nurses and AHP's. QB has undertaken this type of training for a number of years but there was no acknowledgment of the traditional conflicts that may have influenced the QB and Giselle relationship. Similarly, I did not take seriously the manager–clinician conflict between QB and Giselle at the time, yet this is an issue which we had all experienced over the years and is an inherent issue between managers and clinicians within the NHS.

As I reflect on this section I am not suggesting that managers do not care about patients but there is often a different ideology. Managers have to function within a framework of performance and many have never looked after patients. Although their values and norms are different, but many nurses have straddled the manager/clinician divide successfully. The WDC programme was about working with nurse and AHP consultants and QB may have felt that we had more credibility with the participants and the WDC, and they would be seen as the outsiders.

Renegotiations

After an hour Giselle asked for a break so that each organisation could have a private discussion about whether we wanted to work with each other. I knew that my colleagues from Giselle were annoyed, but we went for a cup of tea I realised that I had

underestimated their anger. They felt interrogated and patronised by Teresa; they also felt that Gloria had an inquisitorial style of behaving with which they could not work. Lisa and Bridie had felt particularly constrained by the power differential between the two groups, which was not conducive to working together in the future. We decided that the union was not going to work for us and, as I was the least angry, I agreed to feed back.

The meeting regrouped and QB said that they definitely wished to continue. They thought that there was a lot for us to contribute together even though they would have preferred to work individually. However they accepted that the WDC had requested that the organisations work in partnership and wished to progress a joint programme. This was a great surprise to us and not what we were expecting.

Mead's (1934) describes the meaning of human interactions, which

> arises and lies within the field of the relation between the gesture of a given human organism and the subsequent behaviour of this organism as indicated to another human organism by that gesture. (Mead, 1934, pp. 75-76)

So meaning does not arise just from the gesture, it arises from within the interaction between the participants. It is not that one individual is transmitting the meaning to the other person. Each gesture calls forth a response from the other and together gesture and response constitutes a social act. The social act has meaning to those involved in the gesturing and responding and so the meaning cannot be know in advance.

According to Mead (1934), self-consciousness is a function of our ability to see ourselves as an object – from our view of how others see us. Within this silent conversation we consider and take the attitude of our community towards ourselves. In this way individuals are fundamentally social and are forming, and being formed, by the group.

The meaning of the meeting I have described evolved within a pattern of communication formed by gesture and response. We had planned to go into the meeting to say that the partnership would not work. In other words we had assumed a transmission, pre-planned view of interaction. We ignored the fundamentally emergent nature of conversation, what happened was an interaction that evolved between QB and Giselle, moment-by-moment.

As we co-created the meeting we were simultaneously being changed and changing within the conversation.

Similarly I have reflected on my earlier references to Elias as he emphasises how the self organising patterns of behaviour emerge in the interdependence between individuals and groups, which no one group could control. We put constraints on each other and could not predict the response to each other and had not predicted QB's positive response to working with us which changed the conclusions that we had planned. Although I have been aware of power relationships in the past this episode graphically illustrated for me how, through the conversations the individuals both changed and were being changed by their interactions in the moment, rather than following through their previously agreed position.

Before the end of the meeting Gloria said that she had found our comments about losing our identity by working with QB difficult. She took exception to being labelled as QB. "I am an individual you will be working with me, not QB". I was pleased that she had voiced her disquiet but felt that she had not understood our concerns. We said we had no intension to be offensive, and reiterated our concerns about being a small group working with a large company.

On reflection, I wonder if Gloria was feeling like an outsider within her organisation. Thinking of Elias's work, I wonder if the values and norms which contribute to the ideology of QB may have been a challenge to her, and she felt she needed to clarify her position within the two groups by declaring that she was an outsider. Perhaps she was content to work within the norms of the organisation but was challenging the values. However there were internal conflicts between Gloria and QB that we were unaware of, which became clearer later on.

In this section I have reflected on the power dynamics and ideologies between the two groups. QB saw us as outsiders in the world of organisational development but was threatened by our potential power as clinicians. Our credibility with the WDC took us into the realms of insiders and had the potential to change the patterning of the power dynamics between the groups – an opportunity that I/Giselle failed to take seriously.

Bridie from Giselle agreed to return to QB the next morning and write a joint letter with Gloria based on the discussions from the meeting, and requesting a meeting with the WDC to clarify the proposal. Gloria however had changed her mind over night and suggested that they wrote to the WDC saying that the partnership would not work and request that the two groups submit individual proposals again. Bridie said that was not what the meeting had agreed and she did not have the authority or inclination to change that decision. Bridie and I were concerned by the lack of consistency, and the perception that Gloria could alter the agreed decision and write a different letter.

On reflection this brings me back to the Elias and Scotson (1994) study, in relation to the confidence of the old families and their belief in their power and superiority. Giselle never considered putting in a separate bid when asked to work in partnership by the client, and was surprised that QB were considering putting a single proposal to the client. After assenting to the notion of working in partnership, QB later appeared unhappy about working with a new group. Elias and Scotson (1994) suggested that no one could enter the circle of monopoly holders (the old families) without their consent. It appeared that we did not have the consent of QB to enter the world of partnership working.

Meeting the client

The differences in ideologies between QB and Giselle were replicated by the differences in ideologies within the WDC. Paul and Libby, the two nurses, wanted a programme which would provide the opportunity for reflection, and challenge their thinking. Andrew the finance director had a different perspective of wanting value for money, outcomes and evaluation; a more rationalistic approach.

Paul chaired a subsequent meeting between Gisele, QB and the client. He outlined the proposal for the two organisations to work in partnership to produce a new programme. The meeting was tense and I remember cringing as Gloria asked the client if they wished to pursue a single tender. Lisa from Giselle became agitated at this comment and asked the panel to reiterate exactly what they were proposing. Libby the other nurse on the panel was very direct. She told Gloria that this was not an option. She said that the QB tender was not innovative and creative enough, and lacked detail. She liked the innovative proposal from Giselle and mentioned the fact that we had close associations with clinical staff and felt sure that, between the two organisations, we could produce an

excellent programme. She wanted QB to underpin the programme utilising their experience of running courses and organisational infrastructure.

This was an uncomfortable exchange and I noticed that Jim (Gloria's colleague) took the lead for QB during the rest of the meeting. Lisa used the analogy of a shotgun wedding, pointing out that the partnership was like an arranged marriage and it would take time to adjust to the new arrangements, as we needed to get to know each other in circumstances that had been orchestrated by the client and not chosen by the two companies. The analogy of the shot gun wedding raised a smile and reduced the tension within the meeting.

Gloria was reproached by the WDC at the meeting for her request for a second tender – she contravened the convention. This put Giselle in a more powerful position, as the WDC saw each organisation as equal partners. Unfortunately Giselle did not pick up the cues and recognise the power shift in a way that changed their confidence or assertiveness levels. We remained uncertain as to how a joint programme would be progressed given the controlling nature of Gloria.

I have reflected in this section how the WDC decision making appeared to be based in a rationalistic systems approach where the mechanics (the WDC) attempt to move two parts of the machinery to perform another function. Suddenly two competing organisations were expected to set aside their differences and become partners. There appeared to be little regard for the complexities of the situation, the power relationships or the size and culture of the organisations. The WDC came to a decision which appeared to plicate the different preferences of the panel members but did not appear to acknowledge or take responsibility for the potential for conflict.

Negotiating the joint programme

Bridie, Janet and I met QB to develop a joint programme the following week. Lisa could not attend but had pulled together some ideas from the programmes that Giselle and QB had originally submitted. Gloria was the only QB member present. We had had discussions before the meeting and recognised the need to take account of appearing intimidating, as there were three members present from Giselle. Again we were at the QB office and, without discussion Gloria led the meeting. We said that we had looked at the

two programmes and pulled out the key themes from both to provide a starting point. Gloria said that she preferred to plan the programme together. In hind sight it may have been indiscreet to bring earlier work, but there appeared to be no negotiation with Gloria. I took a deep breath and tried to contribute positively to the discussion.

As I reflect on what the two organisations were trying to do, I am drawn to the work of Weick (2001), who writes about organisational redesign. The two organisations had clear ideas about how to design the programme, as we had both had one attempt and were now working together to design something new. We were also designing a way of working together. Weick (2001) uses the metaphor of improvisational theatre suggesting that "improvisation is about process and about designs that are continuously reconstructed" (ibid., p. 61).

I was concerned that QB had a design, which they used for all of their programmes like a recipe or blueprint. I think if we had discussed what we were trying to do, both organisations would have said that they wanted to start from scratch, and let a new programme emerge from our discussions. Weick (2001) also suggests that

> designs viewed from the perspective of improvisation, are more emergent, more continuous, more filled with surprise, more difficult to control, more tied to the content of action and more affected by what people pay attention to, than are the designs implied by architecture. Even though improvisation may involve more uncertainty, it does not therefore become any less effective. (Weick, 2001, p. 61)

Gloria stood up in the tiny room to lead the session and record our ideas on the flip chart. I felt increasingly annoyed by the manner in which she challenged the creative, improvisational approach. I sensed that Gloria was trying to strangle my attempts at creativity rather than promote emergence. "Why do you want to do story telling as a whole group activity, surely it will take too long?" I was asked by Gloria, and I noticed my difficulty in articulating why I wanted to give the whole group the opportunity to share their stories, get to know each other and learn from each others experiences. It was not that I minded her asking the question, but I found her style confrontational.

We ended up with much more "taught" material than I wanted to be included in the programme. Reflecting back on this episode I have found the Weick (2001) differentiation between blueprints and emergent approaches to design helpful. I was

rebelling against the QB blueprints but my inability to articulate a more complex responsive way of working, coupled with a desire to co-operate and contain confrontation, culminated in a less than innovative programme.

By lunchtime I was feeling angry and dejected, and became distant from the group by taking much longer at the salad bar than necessary to regain my composure. After lunch I said to Gloria that I was finding her bossy approach over whelming and did not know how to manage it. She became quiet and changed the subject. I felt rather lost by her lack of response as we returned to our tiny room. At one point later in the afternoon, she lent across the table and wagged her pen at me during a discussion about organisational development. I felt angry and responded by saying "Gloria, please don't point your pen at me in that way. This is what I mean by you being 'bossy'". She said that she had felt animated by the work we were doing and did not mean to be bossy.

As I have rewritten the narrative, I am aware of the lack of support from my Giselle colleagues. Bridie and Jane told me later that they were amazed by my honesty, and agreed that they too had found Gloria's behaviour difficult. They were less upset by the "final" programme. Perhaps my understanding of what under pinned Giselle's creative programme was different to my colleagues. I think there was less cohesion within the Giselle group than I had realised at the time. The different notions of creativity within the Giselle group and their collaboration with Gloria's rationalist way of working have become clearer to me as I have reflected on this experience.

I decided to take action to reduce my anger and disquiet and arranged to meet Gloria the following week alone. I called her to say that I was travelling through town and wanted to speak to her about the previous week's meeting. She agreed, but I later found out, contacted Bridie to ask why I was going to see her. Bridie said that she would leave it to me to discuss what was on my mind. Gloria and I met for lunch. I opened the conversation by saying that I had found the day-long meeting very difficult and recognise that she may feel offended by my comments about her bossy behaviour. I had not intended to be rude and wished to apologise if she was offended by my comments. I also said that I wanted us to explore how we were going to continue to work together because I was experiencing problems with her style of behaviour, particularly in relation to the way that she challenged new ideas.

Gloria said:

> I kind of have this framework of behaviour in my head. When I hear a new idea, I always reword it and reflect back what I think I have heard, to see if I have gained the meaning. I then ask questions to try to look at the pros and cons of what has been said to expand on the meaning and make sure I have understood.

I immediately recognised that I had seen her constantly communicate in this way and felt amazed at this systematic approach to communication as though she was a well designed machine with a certain function to perform, which she approached in an identical style regardless of the environment or situation. I said that I admired the fact that she wanted to check out her understanding of the other, but felt defensive in response to her confrontational style of debate. She said that she had found this way of challenging was a useful way of behaving. As we explored our perceptions of each other and the atmosphere became more relaxed, Gloria told me that she was changing her employment status with QB to become an associate. She would still lead the QB side of the partnership, but wanted the flexibility to be able to do other things, and reduce her working hours. I remembered her comment about working with her not the QB organisation, at the first meeting. I wondered if the relationship between QB and Gloria was difficult, but did not feel that it was appropriate to ask.

Gloria returned to the notion of resubmitting single tenders. I hid my frustration that she tried to revisit this possibility and reiterated that the client wanted a joint submission. I noticed that she could not move on from the desire to resubmit the tenders and that there seemed to be circular conversation as we revisited this issue. We ended the conversation by both saying that the meeting had been useful and we both said we felt that we understood each other better. I remained concerned that it was a Friday and the draft programme had to be in the following Monday. The draft had been circulated five days earlier but Gloria had not had time to review it. She agreed to work on the programme over the weekend leaving little time to deal with her comments. I was also a concerned about her commitment to the partnership.

I had a telephone call from Gloria the next day. We had only two more days to submit the joint programme, and the main sticking point between the two groups was about consistent leadership of the programme. From my group therapy experiences, I understood the philosophy of having a consistent lead to help the group feel safe, provide

consistency for the participants and help them thread their experiences together. We were happy for Gloria to provide the consistency, but she felt unable to take this responsibility alone and wanted one person from Giselle at each module to co-facilitate the programme with her. This was not feasible due to cost.

The telephone conversations were long as we tried to negotiate a compromise and Gloria continued to voice her frustration about trying to meet the WDC criteria to work in partnership. We shared her frustration but had moved from this position two months earlier, but Gloria continued to discuss exactly the same issues as she tried to make sense of the situation. As I write this I notice the energy levels rising in my body as I recall feeling suffocated and trapped in the same conversation- ensnared in a spiral of rhetorical anguish that felt stuck in irreconcilable differences.

Gloria called back again to say that if Giselle wished to submit an independent different programme the next day, then QB would do the same. I remember taking a deep breath and saying in a firm and confident manner:

> The WDC have asked us to submit a joint programme, Gloria, we have met and developed the work as requested. I would be very disappointed if QB submitted a separate programme, but you have a choice to proceed in this way if you want to. Giselle will submit the joint programme as we had agreed, if QB decided to disown it they needed to write to the WDC and say so.

I was trying to manage the hysteria I was feeling inside, and I remember the conversation vividly, because I was telling myself not to stay calm and not lose my temper. I felt like a piece of elastic about to snap.

I am surprised by the confidence that Gloria asserted. Was this about being part of a large organisation who felt that they could buck the system and ignore the rules, or a symptom of Gloria's desire to gain personal credibility and win the contract back for QB? As I reflect on why Gloria pursed this desire to resubmit the tender I think that she was concerned that QB had lost confidence in her as she had been told by the client that her tender was not creative enough and had not secured the work. She was moving to an associate position with the organisation and needed to maintain her credibility to gain further assignments.

Since my meeting alone with Gloria my respect for her had increased. I tried to understand her anxieties, but was unable to lessen her fretfulness as the patterning of our conversations felt stuck. We ended the conversation by Gloria wanting to reflect on whether to submit an independent tender and discuss the possibility with Jim her colleague. They decided against submitting a separate proposal, and eventually the programme was agreed with the client. Unfortunately the client lost confidence in Gloria and asked QB to find another project lead.

The game models

I have found it difficult to grasp the power dynamics between the two groups. I will describe the games models referred to earlier that have helped me make sense of the relationships, and will exemplify my reflections from my narrative.

When describing the models Elias ([1970] 1978) illustrates the way that human beings are interdependent, suggesting that the dependencies although reciprocal, are often unequal. Rather than using the term "power ratios" Elias uses the term "relative strength" and states that:

> All the models are based on two or more people measuring their strength against each other. This is the basic situation encounter wherever people enter into or find themselves in relations with one another. The awareness of it, however, is often suppressed when people enter into or find themselves in relations with each other. (Elias, 1978, p. 115)

Elias suggests that people suppress their awareness of this contest when reflecting on human relations, but after a while, finds a balance of power that (depending on the circumstances) may or may not be stable. As will be seen from the games models, he emphasises how the self organising patterns of behaviour emerge in the interdependence between individuals and groups. People constrain and enable each other through relating, as all human relating is power relating according to Elias.

Game 1a is a two-person game where the participants play within rules. Here participant A is a much stronger player than participant B. Elias points out that in the context of power, there is no absolute power but a power ratio, the difference between A and B's strength in the game. Elias notes that the game participants have control over each other but the difference in strength affects the moves that participant A can make to shape

player B's moves and vice versa. Not only does opponent A have a greater control over B, it also gives A, a greater control over the game.

In the model where the strength between the two players is more equal (Game 1b), each player has more control over each other and the course of the game, and less power to force a particular tactic on the other. The individual plans of the two participants are less likely to change the configuration of the game. As the power base becomes more equal, the more the participant's plans become interwoven resulting in a configuration that neither of them has planned.

Elias describes a game in model 2b where player A plays against a multi-polar group of opponents who are individually weaker but plays against all of them together. The group of players, although weaker, reduce A's superiority. There is less certainty about the control, planning and outcomes than in game 1a. If the players B, C and D do not have tensions between themselves, the power factor is to their advantage. If there are internal tensions then it is to the advantage to player A.

I notice the contrast between the game described in 2b and the "interview" I described earlier in the narrative. Player A plays against a group of opponents who are individually weaker but plays against all of them together. At this point, it felt as though QB were playing as one opponent, player A. We were working within the same rules set by the client. As I consider how QB maintained their power differential through the patterning of the conversations, I recognise that I felt intimidated by their status and kudos as an organisation. At the time, I thought that Giselle appeared to have few tensions within the group and had superior clinical expertise which should have been to our benefit. We did not have the confidence to recognise these at the time. I will use the models described by Elias later in the narrative as the power relationships moved within the partnership between QB and Gisele.

Continuing with the games model, in Game 2d two groups play within the rules which provided both sides with the same chance of winning, where each side had the same strength, is described in game 2d. Here neither group has decisive influence, nor can they control the game in isolation. There is an intertwining of moves by the group and by the individuals which develops into a type of order. This order is definable and specific as no action by either side can be seen in isolation, as it is an interweaving process that forms

an interweaving of actions made by both sides. Elias suggests that now an observer needs to distance him or herself from the two groups.

I will now use the analogy of the games model to try to make sense of the meeting with the WDC, the first meeting between the two organisations, the development of the joint programme, and my meeting with Gloria.

It appears that the WDC induced a game, and then became background participants, overseeing the implementation of their rules. They saw the two organisations as equal partners, where neither group had a decisive influence. Giselle and QB were to form a partnership. The rules were that both groups collaborate and share their expertise and produce a programme that reflected Giselle's creativity within the patronage of a respected organisation like QB.

Considering the games model and the first meeting between the two organisations I notice that at the tea break, Giselle agreed that the partnership would not work and did not wish to take the partnership further. I notice Elias's emphasis on how the self organising patterns of behaviour emerge in the interdependence between individuals and groups where no one can control the games evolution. QB and Giselle put constraints on each other but could not predict the responses to these restraints. Giselle wanted to constrain "the game" by rejecting the partnership proposal but had not predicted QB's positive response to working with us, which changed the outcomes that we had planned. We did not even consult as a group on the QB decision to work in partnership with Giselle, even though we had made a group decision to withdraw. Although I was aware of power relationships in the past, I was less aware of the notion of individuals both changing and being changed by their interactions within the relationship.

Bridie, Janet and I met QB to develop a joint programme and Gloria was the only QB member present. When considering the games model in relation to the joint programme meeting I am now aware that neither group could control the work in isolation to the other. However in Elias's game models terms Giselle appeared to have slipped back into the first game where the strong individual plays the whole group together. Although I thought that we were a united group from an ideological perspective, Gloria seemed to exert more power or strength in the control, planning and outcomes of the programme. I am more aware of my part in this relationship. I recognise that, although I had notions of

working in a less structured manner reflecting my learning from the DMan programme, I did not have the confidence to believe that working in a different way would be successful. I had only used story telling and theatre once before and was concerned about promoting a way of working partnership with a prestigious organisation. On reflection, I was frightened of failing.

When I went to meet Gloria alone, I felt that the strength between the two players, (in relation to Elias's games model) was more equal. I am, however, notice that I did not negotiate with my colleagues but took the initiative to meet with Gloria alone. As I reflect on this meeting, I wonder if there were tensions within the Giselle group of which I had been unaware of until now. Elias suggests in the games models that a weaker group playing against one strong player can increase their strength if there is little tension within the group. I had thought of tension as conflict; I now wonder if the tension was about confidence and uncertainty. We were so concerned with making the partnership with QB work that we did not focus enough on fostering the collective strengths of the Giselle associate relationship. I think we perhaps had different perceptions of the concepts of creativity that I was trying to encourage.

I have found these models useful as they offer another way of thinking about the QB and Giselle relationship, as an analogy to a game. I had been aware of the power dynamic within relationships but had not really recognised the interdependencies between the two groups and how I contributed to the relationship.

Conclusions

Within my narrative I have described the difficulty of producing novelty in an overly structured environment. The difficulties that have emerged as I have rewritten my narrative appear complex and multi-factorial

This was the first tender that Giselle had submitted and although the programme was successful we did not gain the confidence of the client as an organisation. The WDC panel members negotiated a compromise which resulted in a request for two organisations with different strengths to work together. We were working with a large organisation who felt they had the resource and expertise to fulfil the contract and, throughout the negotiations, wanted to re-tender for the contract. We were treated as

outsiders and I found the Winston Parva study significant as I have reflected on the experience of attempting to work in partnership with another organisation.

Although the use of Elias's games model may appear simplistic, the analogy helped me make meaning of the power relationships between the two organisations. The notion of power ratios is not about one person having power over the other as the ratios are co-created within the relationship. I now notice how the patterning of conversations within which the power ratios changed in a way that I was quite unaware of at the time. When working with organisations in the future I will be increasingly aware of the power dynamics within organisations and in my relationships as a management consultant.

In relation to my practice, I am more aware of the power differentials and the notion that there is no absolute but a power differential. The configuration would have been different if I had been more confident about the relevance of our clinical assets. This would have given us increased confidence and affected the power ratio between two organisations. If I work with the Giselle group again, I think that agreeing what assets the group brings to the relationship is important in relation to the confidence and strength of the group.

I think that it is difficult for new organisations to gain tenders without the backing of a large bureaucracies to reassure the client that the company is viable. The proposal for a small organisation to work in partnership is a solution to this problem. However the difference in ideology and the power differential must be considered. If these issues are too diverse the relationship is unlikely to work.

As I explored the notion of rationality and cybernetics I became aware of how difficult it is to challenge this way of working. I realised that my desire to explore the concepts associated with complex responsive process thinking did not readily translated into working with an "associate" group of colleagues used to a rationalist approach to organisational development. Although many of our values and norms were similar, the significance of this difference became apparent when attempting to design the joint programme. My colleagues accepted the rationalistic approach fostered by QB and did not share the frustration I experienced about wanting to work in a different way. The generalisability of this experience relates to the difficulty of joining organisational development agencies that are used to working in a highly structured rationalistic environment, and attempting to work in a more complex responsive manner.

The second generalisable issue relates to the concept of the WDC's expectation that two competing groups could become partners with no regard to the different cultures, power relationships, and size of the organisations, the staff backgrounds and ideologies. Similarly, organisations merge because it appears to be economically viable at the time. There is often little recognition of the potential problems associated with power relationships, the impact of different ways of working and differing ideologies, which contributes to the degree of success of the merger.

The new contribution from my work which is emerging, is an in depth discussion of the instances of working with the balance of power and creativity in a rationalistic monolith like the NHS. As an external consultant, I can bring different ways of working with small groups to affect change from a more complex responsive perspective.

Finally I am aware of the iterative methodology which has enabled me to unpick this complex and difficult experience. I notice the amount of narrative and associative theory that has been cut out to enable me to develop the main themes which emerged during the many project iterations. The role of power and gossip, a more detailed discussion of the narrative patterning of conversation, the challenging of my humanistic approach to relationships, and management and bureaucracy theory, were all removed during the many iterations of my project. The learning and exploration has not been lost and the resources may well be utilised in my future projects as I continue to purse the balance of power, control and creativity in organisations.

Reflections on Project 2

In this project I give a brief definition of novelty and I provide a more detailed discussion and further development of this theme in my synopsis (pages 75). On reflection, I recognised that I need to undertake a more critical analysis of how novelty and change arises in organisations and this is addressed in the synopsis.

I describe how novelty is thought about from a complex responsive processes perspective. This way of thinking influenced my approach to the negotiation of the development programme, and at times I tended to reify the concept. I was inclined to engage with the concept as if it had an independent existence, rather than as a construct through which meaning is negotiated. I sought an approach to programme delivery that was more reflective than structured and attempted to use complex responsive processes theory as a resource or model. However, this was not appropriate as it is not an innovative methodology or a problem-solving technique. It is a way of making sense of what is happening, which is different to thinking about organisations as systems. I also found complex responsive processes thinking difficult to articulate as I attempted to plan an 'innovative programme'. To win the tender we had to demonstrate to the WDC that we had an innovative approach. In real terms I believe that the success of the programme emerged within the relationship between the facilitators and participants, which cannot be written into a tender document in rational measurable terms. In the synopsis, I critically appraise how the dynamics of social processes adds to an understanding of novelty and innovation

It was from this project that I began my exploration of the notion of inclusion and exclusion, and further developed my thinking about the co-creation of power relationships. I undertook an analysis of the power relationships in relation to Stacey and Elias's work and I develop a broader review of the power literature in my synopsis. I now see that the inclusive/exclusive patterning of behaviour between the two organisations led to varying degrees of feelings of rejection, which stifled any open dialogue between the two groups. The power balance between the two groups was a constant feature of the relationship, and the relationship between innovation and power became more apparent as I reflected on this project. I also recognise that I was struggling more than my associate group with the theoretical notion of how to construct a creative programme, leading to tensions within the power dynamics of the group. I also consider that, in my

preoccupation with the development of the programme, I overlooked the dynamics of the relationship with my peers at a micro level.

Although I examine the theory of power in this project, I recognise that this is predominantly founded in a complex responsive processes perspective. In the synopsis, I analyse the distinctions between the different perceptions of power, including power as elitist and an observable phenomenon (Bachrach and Baratz, 1962; Dahl, 1957; Lukes, 2005), consensual (Parsons, 1967), and relational power (Foucault, 1979; Elias, 1978) within the social sciences structure and agency debate have also been considered.

I draw attention to the different ideological positions of the two groups on page 153, and describe QB's desire to make sense of what is happening to staff working in their organisations. I now acknowledge that I had been disparaging about their approach without appreciating some of the similarities to the type of programme that I aspired to create. Although this is predominantly viewed from a systems perspective, there is a similarity to the reflective analysis that I was advocating.

I refer to the generalisability of my work in the conclusions of this project. I deepen my analysis of generalisability in the Method section of my thesis. I highlight concerns about the difficulty of exploring the concepts of complex responsive process thinking in an organisation that is more accustomed to a rationalist approach to organisational development (page 170).

In the next project, I develop the themes of power and inclusion/exclusion further as I reflect on the way groups of staff collude to maintain their power relationships, and look at the role of conflict as a prerequisite for the development of innovation. I explore how the absence of conflict among a group of nursing staff inhibited the development of innovation, and also illustrate how too much conflict can become equally restraining.

CHAPTER 4
Project 3

Power, conflict and novelty in a healthcare organisation

Introduction

In this project I have described the conflict that emerged during the first day of consultancy work in a Children's Hospital which is part of a wider hospital trust. I was asked to work with a group of Senior Sisters who were criticised for their ineffective management in an environment which strives to create order through setting and measuring targets. They appeared to avoid conflict and challenge resulting in patterns of working which had become institutionalised. They worked hard to preserve a harmonious working milieu within an aggressive and antagonistic environment.

The aggressive and assertive style of the medical staff resulted in an atmosphere of paralysis and fear at times, as less powerful groups were intimidated. The Senior Sister group was taken to task by their manager about their lack-lustre performance but little action was taken about the behaviour of the medical staff.

I consider different types of conflict as an every day part of organisational life vis-à-vis conflict as a negative anxiety producing force, which must be "managed". I also explore the notion of power relationships between various staff groups. I discuss my role as a consultant in providing a forum for the Senior Sisters to relate and reflect upon their anxieties about the day-to-day conflicts of working life through an action learning set.

I explore my research question – how can I help clients make meaning of the conflict and power relationships, which exist as part of human interaction, so that novelty can emerge? I then consider complex responsive process ways of thinking and reflect on the concepts in relation to my practice as a management consultant. As I have reflected on my narrative I realise that there needs to be enabling qualities and constraints within relationships for novelty to arise and change to occur. I found that the forum of action learning was a vehicle to bring attention to organisational defensive routines and enable participants to examine their behaviours and make changes.

The first meeting

I received a letter from Hannah, the Business Manager of a large children's hospital. She requested that I undertake a piece of work to "realise the full business case for the new Children's Hospital". I was not sure what this meant but knew something about the hospital from a previous piece of work. The following extract from the letter outlines the work that was required to:

- assess the current situation and give a clear direction in relation to recruitment and retention;
- give a clear reconciliation between budget establishment and manpower;
- assess the profile and skill mix currently available and benchmark against other paediatric hospitals of similar status;
- recommend a workforce profile to suit the needs of the current requirements;
- develop a transitional plan from current data to move the Children's Hospital, with phased workforce planning against the revenue implications of the children's services in 2007;
- develop a robust workforce planning model and a commissioning model for students;
- develop an educational framework to support staff in the transition
- develop a business plan to apply for the phased application of revenue in line with the new model of care;
- develop a paediatric commissioning plan for the next five years;
- work with partner organisations to maximise the scarce resource of paediatric nursing across the catchments area.

(Extracts from the Directorate Managers letter, November 2004)

I felt quite bewildered by the project brief. I did not understand some of the jargon, even though I had worked in the National Health Service (NHS) for my entire career. There appeared to be a number of years work outlined and I was not interested in working 200 miles from home for this length of time. I was however curious to explore the brief further as I felt I had the skills to undertake some of the work and was interested in extending my expertise. I had met Hannah the General Manager during my previous work and liked and admired her.

Hannah telephoned to discuss the work further. She was very concerned about the Senior Sisters' lack of managerial control over their pay budgets and the poor coordination of nurse recruitment and retention. The four Senior Sisters managed the nurses who worked in the inpatient medicine and surgery, outpatient and theatre areas. I agreed to visit hospital to discuss the brief further with the lead nurse, Liz and herself.

The meeting had to take place at Hannah's home as she had to care for her sick child who was too unwell to attend school. She opened the meeting by describing the service. The hospital provided general paediatric care, surgery, orthopaedics and accident and emergency facilities (which were located in another hospital). She was concerned that the majority of the Senior Sisters did not seem to be able to fulfil their roles. Hannah felt they supported each other too well, resulting in a lack of challenge. For example when there was a staffing shortage, they all became involved in solving the problem rather than letting the accountable Senior Sister resolve it. The Senior Sisters were then unavailable for meetings where their operational management work needed to be progressed. Hannah described the Senior Sisters as expert clinical nurses who took refuge in clinical work, because it was familiar and rewarding. She felt that they avoided the business side of their roles, which they found more difficult and demanding.

Liz described the senior nurses as a powerful group of staff with a reputation for being rather formidable on the one hand, but avoided dealing with confrontation on the other. There was one Senior Sister who was working well. Beth was a new appointment and had a different management style, which the other Senior Sisters found difficult. Apparently, Beth had a more commanding style of management and was willing to challenge the norms and question decision-making rationales – a style of interaction that her peers were unused to. They speculated that the Senior Sisters were threatened by her. Hannah and Liz felt that Beth managed her budgets well, was energetic, enthusiastic, and had made positive changes to her departments.

Hannah described the relationship between the different professional groups. There was conflict and antagonism between medical and managerial staff, and at times the relationship between medical staff and nursing personnel was strained. She felt that the conflicts between the groups inhibited change and increased what was already a very stressful environment. Hannah sought to calm the situation and support the "injured parties". She was interested in my thoughts on how "to manage" the conflict between the

two groups. I felt anxious about this request. I did not have experience in conflict management, but said that I would feed back my thoughts on how I saw the groups working together.

My research learning set colleagues challenged me on this “lack of experience of conflict management” statement and I recognised that I have been working with conflict in organisations for most of my career, and wonder why I negated this experience. My concern related to my lack of confidence, as I had not studied conflict management frameworks. This comment led me to enquire further into the theoretical literature about conflict, which I will consider later.

I asked Hannah to describe her top priorities from the list of issues within the brief she had sent me. The amount of work Hannah had described felt unfocussed and I suggested that I began to work with the Senior Sisters. Further work could then progress once their inadequate performance was addressed.

Hannah agreed that I would work with the Senior Sisters to help them understand their staffing budgets and agree their staffing frameworks to recruit the right numbers of trained and untrained staff. I was intrigued that I was being asked to undertake this type of work which should have been the remit of Liz the lead nurse who was managed by Hannah. I suggested that the Senior Sisters would benefit from working together in an action learning set. They appeared to be struggling with their operational duties and needed the opportunity to reflect on why they were behaving in this manner. I wanted the Senior Sisters to reorganization their operational management systems so that they could then focus on the creative planning that was required for the 2007 hospital move.

Liz, the lead nurse gave me a lift to the railway station. She said that “Working at the **** hospital is like working in a glue-like pudding, we go round the same issues but get no where – which ever way you mix it the results are the same”. When I asked her to describe this further she said that they seemed to get stuck in a sticky mess, which was very difficult to get out of. I noticed the lack of energy in her voice, especially as she reflected on her performance. Liz appeared to doubt her ability to manage the Senior Sisters, although she had been told by Hannah that she was doing a good job. I wondered if Hannah was avoiding taking Liz to task.

I immediately contacted the Senior Sisters to explain my role and said that I wanted to work with them individually and as a group. They were very responsive and agreed to meet me after the next directorate meeting.

The directorate business meeting

I agreed to attend a directorate meeting two weeks later. Although Hannah and Liz had briefed me, I was not prepared for the degree of conflict I observed during my first visit. I was looking forward to the meeting and felt excited about commencing the work. I took an early train, and arrived at the hospital four hours later. As I attempted to negotiate the security code of the room where the meeting was being held, Talib the Head of Surgery noticed my struggle from the meeting room window and let me in. I had worked with Talib the previous year, and he greeted me in a welcoming manner. I was invited to join the meeting and Hannah apologised for keeping me waiting as they continued their meeting agenda. The group sat in a circle around a low coffee table, laden with beverages and croissant. I listened to the discussions and noticed that Liz the lead nurse and the Directorate Financial Manager sat silently, leaning back in their seats as though they were on the edge of the meeting. The Head of Anaesthetics said little, as the main conversation seemed to be between Hannah, Frank the quietly spoken Clinical Director, Ted, the junior manager and Talib, the Head of Surgery.

As I drank coffee and looked around the room I wondered what Hannah had said to the group about my work. I was concerned that she may have been vague and I was silently practicing a short succinct resume of what we had agreed. The team continued to discuss the unacceptable number of cancelled operations.

As I contemplated what I was going to say I noticed that the discussion had become increasingly heated. The conversation had moved on to the shortage of parking places and Ted, the junior manager responsible for car parking, felt that spaces should not be saved for medical staff visiting the hospital to undertake specialist out patient clinics. Frank, the Clinical Director (a doctor) and Talib both felt that car parking space was a contentious issue and could lead to visiting clinicians refusing to travel to the hospital. The hospital was built before the advent of cars and this is a problem in many old hospitals. I was surprised that the discussion was escalating into a heated argument. Talib leaned forward, pointed his finger at Ted and said “this issue is not for negotiation – you

need to reserve the car parking places and that is an end to it". Ted responded aggressively and said "just stop wagging your finger in my face and stop threatening me – just back off."

I felt uncomfortable about witnessing such an outburst within a group of people I did not know. I wondered if this type of exchange usually took place at this meeting and as a consequence people sat quietly and did not enter into the debate. I noticed that everyone appeared to shuffle in their seats and Hannah immediately intervened asking everyone to calm down. She suggested they explore a local agreement with a car parking company near to the hospital. Talib looked almost stunned that the problem could be solved so easily and relaxed. Ted however appeared very angry and tense as he clutched his papers and glared at everyone. The telephone then rang and Hannah took the call as the car park discussion continued. I noticed that the call sounded very one sided and she became increasingly flushed as the call progressed.

On returning to the meeting she briefly described her conversation with an angry surgeon who threatened to involve his lawyers in the negotiations of his new employment contract. The CEO was involved and was annoyed that the problem had been elevated to such a senior level. I later discovered that this problem should have been managed by Talib as Head of Surgery or Frank the Clinical Director. Both had ignored the problem according to Hannah, expecting "management" to sort it out.

The atmosphere seemed to change as I described the work that I was going to undertake with the Senior Sisters and I was relieved by their positive response. Talib expressed frustration about the shortage of nurses, which resulted in the closure of beds, and hoped that the work would help solve this problem. He then had to leave the meeting, and I noticed that the tension in the room reduced further as people changed positions in their seats, sat back and appeared more relaxed as more humour was introduced into the conversations. I noticed the Head of Anaesthetics comment of "well I feel intimidated by the surgeons at times, so no wonder the nurses find it tough". Talib's behaviour in the meeting appeared to mirror the manner in which the surgeons generally conducted themselves, and on this note the meeting finished.

I had planned to have lunch with the lead nurse, Liz, and then meet the Senior Sister group. However, Liz took a telephone call from a very angry and tearful ward sister who

had been challenged by the Senior Sister called Beth about the number of beds that were empty on her ward. She felt that Beth had called “a liar” and Liz hastily left the meeting to sort out the problem.

I had a long conversation with Ted the junior manager. He felt very unhappy about being continually in conflict with one group or another. He felt that the Senior Sisters were not managing their budgets or the recruitment of staff efficiently. This impacted on achieving some of the performance measures that he had responsibility for and he felt angry that they did not appear to make this a priority. He gave the example of allowing too much flexibility in the implementation of staff retention policies. Many part time staff with families “dictated” that they could only work weekends, resulting in too many staff employed at the same time. As weekend workers are paid more this contributed to the pay overspend. He felt that the whole nursing service appeared to be out of control. His role was at the same level as Liz the lead nurse. He appeared to respect Liz but was frustrated that she never brought the Senior Sisters to task when they did not implement the actions agreed at their regular management meetings.

Ted declared that some of the medical staff were bullies and he did not intend to become a victim, even though he knew his colleagues disliked him. I asked how he coped with such an unenviable role. He said that he had a job to do. Performance management was unpopular with both nursing and medical staff and although Hannah was very supportive, he was looking for another job. He felt that the degree of conflict he encountered from the different professional groups was intolerable and spent most of his time at work feeling anxious, angry and resentful at the lack of personal respect that he received.

Reflections on the meeting

In trying to make sense of what happened at this meeting I recognised that there appeared to be a tense ongoing relationship between doctors and the managers. Many stories about the conflicts were related during the time I worked in the Trust. The doctors appeared to think that the managers’ role was to “sort it” but found taking their colleague to task for poor performance too difficult. When considering the behaviour of the medical staff I am drawn to Meads (1934) notion of social object. A social object is not an entity or a thing. Mead uses this notion in relation to a “tendency to act”. This pattern or tendency to act is common to groups of people and occurs in the present moment as a “rather repetitive habitual pattern of action” (Stacey 2005 p. 35). The doctors’ tendency to act in the

directorate meetings related to telling the managers what to do and blame the Senior Sisters for not recruiting enough nurses to open enough beds to meet the waiting times targets.

I noticed the pattern of power relationships within the room. Stacey (2003 p. 353) suggests “those who exaggerate power difference by behaving in an autocratic manner, or even in too directing a way, are likely to evoke either compliance in group members or … rebellion”. The majority of the group at the meeting appeared to take a compliant role whilst Ted became rebellious and confrontational. I will return to the notion of power and enabling constraints, later in this project.

I was also intrigued by the meeting and the level of conflict I had witnessed within a short space of time. What was my role going to be within such a dysfunctional group of staff? The whole team seemed to be “held together” by Hannah the General Manager. She appeared kind and respectful to her colleagues and was able to solve problems in a calm and energetic manner. I had an excellent relationship with Hannah and had many long conversations as the project progressed. She used me as a sounding board about how she managed the service and her contribution to the dysfunction. She was concerned about the level of anxiety and conflict generated by the medical staff’s behaviour. She admitted that she was uncomfortable with confronting aggressive behaviours and regularly acted as peacemaker. I wondered how her approach contributed to the “sticky pudding” analogy that Liz had used at my first meeting.

One conversation made a particular impact on me and I wrote down the exact words at the time. Hannah was at a meeting with the Senior Sisters and Ted, the junior manager. The overall management of the directorate was being discussed. Hannah said “we all want the best care for the children, but we need to describe the systems – who does what and, more importantly, the output – then we can decide what people we need for the system, review what they do, and measure our success”. Rather than bringing the Senior Sisters to task about their lack-lustre performance, Hannah opted for a rationalist systems thinking approach to solving the problems. This way of thinking is common in the National Health Service and I will now consider the systems approach to management and explore the central government policy which supports this way of thinking.

A systematic approach to management

The system is called rational because

> the means are expressly designed to achieve certain specific goals (i.e. the organisation is like a well designed machine with a certain function to perform and every part of that machine contributes to the attainment of maximum performance of that function). (Pugh and Hickson, 1989, p. 7)

The initial development of systems thinking was conceived in the 1950s, where the whole organisation is thought of as a system, and the parts of the organisations are subsystems or silos within it. The interaction between the parts is significant, as the subsystems interact to form a system. A number of systems then form a suprasystem. So the parts were seen to affect each other rather than being considered in isolation, and thus the whole system was thought to be greater than the sum of the parts. So the children's directorate was part of the hospital system and the Senior Sisters were part of the directorate system. The Senior Sisters managed the ward sisters who managed the nurses who cared for patients. From systems thinking the notion of cybernetics developed (Ashby, 1956; Wiener, 1948). In cybernetics systems, goals are set with performance targets that are fixed for sometime in the future. The outcomes are then measured against the targets, and action is taken to self regulate the system by taking steps to reduce any outcome variance from the set target. As Stacey and Griffin (2006) suggests there is an implicit assumption that "even organisation as large as the National Health Service, are actually cybernetic systems and can be operated as such" (Stacey and Griffin 2006 p. 30). In the NHS, goals are set by government, who then measure the hospitals' performance against their pre-set goals. It is the function of the regulator (or hospital organisations) to monitor and control the environment to reduce instability and ensure that action is taken to reduce any variance in performance from the set targets.

So the staff working at the children's Hospital are not being seen as "human beings with autonomous choice of their own but as rule-following entities making up the whole organisations" (Stacey et al 2000 p.62). This appeared not to be the case at the children's hospital, as the medical staff and Senior Sisters did not "follow the rules" and were not committed to the system of performance management. The next section outlines the use of performance measures or targets within the context of National Health Service policy.

The NHS Plan and performance

In 2000, the government published the NHS Plan (Department of Health 2000), which outlined their plans to invest in and reform the NHS. National standards were set and monitored by the Commission for Health Improvement (now the Healthcare Commission). The NHS was to be redesigned around the needs of patients rather than run centrally. However the monitoring of centrally set standards was with central government who had the power to intervene when organisations failed.

The Healthcare Commission monitors the key targets and balanced scorecard indicators. According to the Healthcare Commission (2005) performance ratings for an acute and specialist trust include twelve key targets. Some targets are as broad as "Hospital Cleanliness" and "Financial Management". Others are more specific e.g. "Total time in A/E; four hours or less". As can be seen the indicators are broad with the measurements ranging from a more simple yes or no answer to whether waiting times were achieved, to more complex measurements such as assessing "hospital cleanliness".

Davies (2004) reports that health service staff detest the star ratings simplistic distortions and suggests that local people's experience is often wildly at odds with their local trusts star ratings assessment. Bosanquet et al (2005) suggests that "the concentration on targets for elective care has made it difficult to give priority to other areas of services" (p.26)

The doctors' trade union, the British Medical Association (BMA) (2003) take the view that performance indicators do not measure interpersonal care, which is an important attribute of the efficiency of care and an important aspect of care for patients. Measures need to be combined with a culture that trusts health care professionals to find innovative solutions to local problems. These types of measures, they suggest, are less likely to produce dysfunctional behaviour.

As I have shown there appears to be unrest about performance targets at a local and national level. At a local level the poor performance of the Children's Hospital affected the results of the whole hospital trust leading to further conflict. The argument about car parking probably reflected a deeper rebellion by the medical staff against the use of performance management systems, and an exercise of power against managers at a local level.

On reflection I think that the Senior Sisters were also rebelling against the pressure to focus on centrally driven targets. Hannah wanted the Senior Sisters to organise their work around the targets by opening beds to meet the waiting list measures. The Senior Sisters wanted to ensure that the capacity was available to care for all children regardless of whether their diagnosis had a performance target attached.

In the earlier narrative I described the aggressive exchanges that I witnessed in the directorate meeting and the lack of challenge within the Senior Sister group. I will now consider the notion of conflict from the literature.

Conflict

Bolman and Deal (1997) suggest that as human beings interact within organisations, different goals, values, styles and situations create tension.

Lewis et al (1997) suggests that

> the component of conflict, which may be a healthy incentive for action and competition when present in some forms and degrees, but can be damaging when it becomes the culture's dominant feature. (Lewis et al, 1997, p. 275)

Lewis et al (1997) differentiate between aggressive, combative conflict and conflict which provides a more healthy non-destructive exchange. It appeared that the surgeons had a long history of being aggressive and adversarial. The Head of Anaesthetists comment at the directorate meeting suggested that it was not just managers and nurses who feared the surgeons. Although the Senior Sisters group seemed to lack the prerequisites for a healthy non-destructive exchange as postulated by Lewis et al (1997), at the other extreme there was an ethos of damaging conflict perpetrated by other staff groups.

Edelman (1993) suggests that minor or heated disagreements at work are inevitable. He suggests that

> such conflicts can be productive if they generate creative solutions, and are, in fact, compatible with high levels of work satisfaction. However when differences and disagreements, whether real or imagined, provoke ill feeling, they can result in long-term stress and unhappiness. (ibid., p. 1)

He suggests that the positive effects of conflict at work are less well-documented. These include strengthening relationships as people recognise their differences and work toward resolving them; increase in trust if the differences are resolved; increased self-esteem, again an outcome from resolved conflicts; enhancing creativity and productivity. Edelman (1993) also suggests that if the conflict is "effectively managed, (it) is a necessary condition for creativity and that discussion between people with differing interests or opinions can lead to productivity" (ibid., p.4). Although there is acknowledgment of productive conflict, the remaining book deals with negotiating through difficult conflicts with frameworks to attempt resolutions.

Crawley (1992 p.10) defines conflict as "a manifestation of differences working against one another. Some conflicts can be very explosive, as these differences clash and cause untold damage". He goes on to state that

> conflicts need not always turn out this way". Constructive conflict management will enable you to transform the interaction between the ingredients so that when the sparks occurs, there will be heat generated, but it will not last, destroy the ingredients or damage the surroundings. Constructive conflicts are not easy to achieve. (ibid., pp. 10-11)

He asserts that constructive conflict management "will enable you to be active creative and effective…but this is not an easy path" (Crawley 1992 p.12). Crawley writes as though the conflict manager has the power to "transform the interaction", as though constructive conflict management has a life of its own, enabling the manager to be creative and effective.

After participating in the directorate meeting described earlier and seeing the anxiety experienced by many of the staff, it is unsurprising that manages try to control conflict. Johnson (1990) suggests that sometimes there are conflict reduction approaches to "minimise or contain disunity" (ibid., p.192). Shelton and Darling (2004) however were critical of managers who avoided or tried to control conflict. They did not acknowledge the stress, fear, anger and sometimes humiliating emotions that may be generated by conflict. Without this acknowledgement I found it difficult to engage with the argument that "conflict challenges the status quo providing a breeding ground for innovation" (Shelton and Darling 2004 p. 23). It appears that Edelman (1993) Crawley (1992) and Shelton and Darling (2004) describe people as though they were objects without feelings

or memories. What strikes me is the importance of acknowledging the significant emotional impact that conflict may have even though conflict may also be a catalyst for change.

Schermerhorn et al (1991) differentiates between substantive conflict and emotional conflict, acknowledging the anxiety that emotional conflict generates. He argues that: Conflict occurs whenever disagreements exist in a social situation over issues of substance and/or emotional antagonism. *Substantive conflicts* are natural in organisations and centre on disagreements over ends and means. Different views of such things as group and organisational goals, the allocation of resources, distribution of rewards, policies and procedures and the assignment of roles are the everyday life of a manager. *Emotional conflicts* involve feelings of anger, mistrust, dislike, fear, resentment and personal clashes. Since organisations are hierarchies of unequal power, it is often difficult for a manager to separate substantive and emotional conflict and to deal with each on its own merits (Schermerhorn et al, 1991, p. 409).

Although Schermerhorn et al (1991) acknowledge the stress and anxiety that may accompany conflicts, they separate out emotional conflict from substantive conflicts, which they calls “disagreements over ends and means”. It is as though the ends and means exist as a separate entity to emotion. Surely disagreements relating to factors such as the ends and means are generated and intertwined within the body of the disagreement, rather than a separate component.

Glasl (1999) develops the emotional aspect of conflict further and suggests that:

> Conflicts affect our whole personality. The more a conflict escalates i.e. the more we become entangled in it, the more it threatens to corrupt all our thoughts, feelings and will and to dominate our actions. In disagreements about our opponent we can be overcome by profound doubts about the issues in the conflict, about the purpose of the disagreement and about ourselves. [sic] (ibid., p. 29)

Ted was often preoccupied with the degree of conflict that he encountered and the conflict affected his actions. Glasl (1999) sees conflict as a negative trait and goes on to suggest that conflict is an existentialist issue – wondering if we are attempting to preserve intrinsic norms and values or sacrificing them to “assert ourselves physically or

psychologically"? (Glasl, 1999, p.29). Glasl appears to focus more on the individual rather than Mead's (1934) notion of the conflict between groups which I will consider later.

If hospitals are to participate in high quality patient care Skjorshammer (2001) suggests that organisations need mechanisms to handle the disputes and conflict, which will emerge between the different groups of "actors". He suggests that there is an expectation that these disputes result in positive outcomes and suggests that there are few empirical studies in health care, which deal with these challenges.

Shelton and Darling (2004) argue that:

> traditional organisational structures promote conflict. Functional silos and a plethora of different skill sets, and technical specialities lead to communication challenges that often result in conflict. These factors along with many others make conflict an organisational reality. (ibid., p. 23)

I noticed how the professional groups at the children's hospital stayed in their silos. The medical staff blamed the nurses for not recruiting enough staff and the managers for the loathsome waiting targets. The managers blamed the medical staff for not arranging flexible operating lists, and the nurses for the staff shortages leading to bed closures. This resulted in a lack of shared meaning about how the problems could be solved.

Kolb and Bartunek (1992) describe conflict in relation to three bi polar opposites, public–private, formal-informal, rational and non-rational. They argue that most conflict management theorists focus on public conflicts. Private disputes, they suggest, occur as covert or hidden conflicts, often fused with other activities. There are informal norms within private conflicts, which may include bitching, sanctioning hidden agendas, and ignoring requests, rather like the car parking dispute described earlier. They also describe the emphasis on rationality within formal or public disputes. The many conflict management frameworks focus on the way that disputes should be handled and "rationality captures the preconceived, logical, and systematic side of conflict."(Kolb and Bartunek 1992 p.20).

Many of the models (Glasl, 1999; Mastenbroek, 1994; Isenhart and Spangel, 2000 and Edelman, 1993) appear to take a rationalist linear problem solving approach to dispute

management, briefly noting the emotional elements contained within the disputes. The models focus on providing a linear cognitive step-by-step approach to managing conflict.

In contrast, the non-rationalist approach to conflict emphasises the unconscious or spontaneous aspects of disputes, driven by impulse and the feelings of participants and not simply by their cognition. Emotional reactions such as venting feelings, expressing displeasure, and feeling hurt become a means of conflict management. Irrational displays that hinder logical thinking are unhelpful (Morrill 1991), rather like Talib's outburst at the Directorate meeting. Non-rationalist approaches to conflict according to Kolb and Bartunek (1992 p. 20) are "sometime denigrated as the ones exhibited by those who do not know better or have not learned the appropriate social responses". It seems that most conflict situations contain both a cognitive and emotional duality, but traditional conflict theories have only attended to part of the trajectory.

According to Damasio (2000) neuroscientific research on brain damaged patients with loss of function in certain parts of their brain "lost a certain class of emotion from their brain and, in a momentous parallel development, lost their ability to make rational decisions" (Damasio 2000 p. 41). He asserts that:

> selective reduction of emotion is at least as prejudicial for rationality as excessive emotion. It certainly does not seem true that reason stands to gain from operating without the leverage of emotion. On the contrary emotion probably assists reasoning especially when it comes to personal and social matters involving risk and conflict. (ibid., p. 41)

Damasio is arguing that that emotion supports the ability to make rational decisions especially in conflictual situations, rather than separating out a cognitive from an emotional response. I felt dissatisfied with the way that many of the authors acknowledge the presence of emotion in conflict situations but focused on problem solving rationalist frameworks alone. Although these approaches may be helpful there seemed to be a lack of exploration of the emotional impact arising within these circumstances.

I decided to move towards the more social psychology and philosophically orientated literature to explore a different way of thinking about conflict. Mead (1934) suggests that conflict is part of human behaviour. He argues that the main impulses or behaviours,

which lead individuals to organise themselves into societies or communities from a social perspective, fall into two main classes:

> Those which lead to social co-operation, and those that lead to social antagonism amongst individuals; those that give rise to friendly attitudes and relations and those that give rise to hostile attitudes and relations, among the human individuals implicated in the social situations. (Mead, 1934, p.304)

Although there seems to be an extreme polarity in Meads description I felt that I had met both ends of the schism when I attended the management meeting.

Mead also suggests that we continuously develop and recreate our world through conflict. He states that "the individual is treated as if he were quite separable from his environment; and still more is the environment conceived to be quite independent of the individual". (sic) (Mead, 1908, p.318). He goes on to say:

> if we were willing to recognise that the environment which surrounds the moral self is but the statement of the conditions under which his conflicting impulses may get there expression, we would perceive that the organisation must come from a new point of view which comes to consciousness through conflict. (ibid., p. 319)

Mead is suggesting that conflict is central to our day-to-day existence. I was asked to work with the Senior Sisters on how they ought to be acting focussing on what parts of the role they should be undertaking, rather than discussing how they were behaving and what they were doing.

Mastenbroek (1987) suggests that there needs to be a balance between diversity that involves regard for others and behaviours fuelled by anger, mistrust, dislike, anxiety and resentment, where conflict becomes difficult to handle at best and avoided if possible. If the ratio tips to one extreme behaviour becomes aggressive. If the balance is tipped the other way, the "behaviour becomes too indulgent" (Mastenbroek, 1994, p. 22). This seems to be a rather simplistic way of viewing conflict. It is not clear how the balance will be achieved or what type of interventions are required to "control" behaviours within a linear continuum of aggression at one end and indulgence at the other.

If conflict is part of human behaviour as many of the writers suggest, a different way of looking at this is to consider the paradoxical nature of what is described above. In this sense conflict can be creative and destructive at the same time. Stacey et al (2000) suggests that "creativity and destruction, order and disorder, are inextricably linked in the same creative process" (Stacey et al 2000, p.8). Stacey also suggests that the dynamics of interaction is determined by the nature of the relationships. As the diversity within the conversation increases, the energy within the relationship rises. The properties of the relationship then shifts from stability and predictability towards randomness and disintegration:

> At some critical range in information/energy flow, connectivity and diversity, the dynamics of bounded instability appears, that is the simultaneous presence of stability and instability, order and disorder. It is in this dynamic, at the edge of disintegration, that novel forms of relationship may emerge, (Stacey, 2003, p. 352)

Stacey is suggesting that too little access to information or diversity within the relationship results in repetitive patterns of behaviour. Too much difference however results in the disintegration of the relationship. There is a randomness and self organisation to this way of thinking about relationships which is different to Mastenbroek's idea of "balancing the tensions" which suggests that behaviour can be controlled by particular interventions to reduce the degree of conflict.

Hannah saw conflict as being destructive, and tried to control and stifle it; she seemed to hold an idealised notion of working in a harmonious team where conflict was eliminated and creativity would materialise. Yet I had been told that the Senior Sisters appeared to have a harmonious relationship, but were criticised for being uncreative. The conflict within the directorate team was never discussed or confronted, and Liz the lead nurse was not reproached for her lack of leadership. There was no acknowledgment or attempt to work with the conflict, which may have allowed creativity to emerge. Of course there is no way of predicting that positive outcomes will emerge from working with conflict, making the roles of general managers like Hannah difficult and anxiety-provoking.

I had been briefed that the Senior Sister group avoided challenge and conflict but I felt anxious that they may be reluctant to work with someone from outside the Trust

environment. I was aware that they might not agree with the perception that they were stuck in unproductive ways of working.

Meeting the Senior Sisters

According to Hannah the Senior Sisters appeared to be locked into patterns of conduct that they had set up amongst themselves, which had become institutionalised ways of behaving, (Argryis 1986). As I reflected on my role as an external consultant I wanted to provide a forum in which they could reflect on their behaviours. I could help them to set up systems to improve the organisation of their work but unless they agreed to participate in the changes, they would continue to work in a "pudding" like environment.

We gathered in a dilapidated old house across the road from the main hospital. I introduced my previous experience as a children's nurse and said that I had been asked to help them review their skill mix (the amount of trained staff to untrained staff) the budgets and recruitment and retention issues. I asked them how they felt about my being asked to undertake the work. To my relief they said that they felt that they knew they were in a muddle. However they felt resentful that Ted the junior manager was critical about the way that they managed their services. One of them said:

> He is only interested in budgets and targets. I have a responsibility to maintain a safe service and he does not care about this. He is aggressive and at times I refuse to speak to him because I get so upset. He is not our manager and all he does is criticise me and I am fed up with it. Life is difficult enough without him shouting all the time.

I asked how they thought they were managing their roles as Senior Sisters. They said that no one understood how difficult it was. They had to work clinical shifts because of the staff shortages, had difficulty recruiting staff due to national shortages, and had to manage budgetary constraints. They felt anxious about being pulled in different directions which made their working environment very stressful.

Beth, the most recently appointed Senior Sisters, said that her service had different problems. She did not have staff shortage difficulties, had challenged the way that her services were configured, and had made changes. This had been tough but she was pleased with the way that the changes were progressing. She worked across two hospital

sites and at times, felt estranged from her Senior Sister colleagues. I noticed the sideways glances between some of the other team members, as she said this and I asked her to say more about her discomfort. Beth began to speak but was unable to complete her sentence as colleagues interrupted her. They said they were concerned that she felt estranged, as this was not their intention. I felt energised by her response and noticed how the group immediately attempted to support her.

Reflecting on this conversation now I am challenging my interpretation of the Senior Sisters intervention as being "supportive". Although I believe that there was a genuine concern, Beth's experience of feeling estranged challenged the notion of the harmonious Senior Sister group. As she voiced her concern the group immediately attempted to return to their sense of harmony. I had a sense that Beth would not collude with the desire to maintain accordance. She had been the Senior Sister who had challenged the ward sister earlier, when Liz had rushed off at the end of the directorate meeting. As I consider this conversation between Beth and the Senior Sisters I now sense that something new and exciting happened. Beth broke the pattern of collusion that suggested that harmony was the only acceptable behaviour between the Senior Sisters.

Beth became an important catalyst. The other Senior Sisters tried to maintain a congruent relationship with the ward sisters. At a later action learning set the Senior Sisters acknowledged that they initially thought that Beth was aggressive but on reflection acknowledged that she was fulfilling a part of the role, which they usually avoided. They wished to steer clear of conflict within the group and with their ward sister subordinates and tried to stifle any threat to their perception of harmonious working.

I asked the Senior Sisters how they thought that the work should progress. One Senior Sister said:

> We work really hard – we work shifts to fill in the gaps and are then expected to go to management meetings – how can we be at two places at the same time? We do our best to keep the service going, the children are the most important thing and none knows how much we put ourselves out.

I agreed that they had a tough job but reflected back that they had said that they were in a muddle. They looked blank when I asked how they could get out of the chaos. Nolan (in Stacey 2005) suggests:

> Practice … becomes struck through increasingly less reflection in the moment of action, less spontaneity, more ritualistic or more rule-governed behaviour. (Stacey, 2005, p. 82)

The group responded to day-to-day crisis but there was no opportunity for reflection. They had their operational procedures (the way we do things here) – most of which were unwritten and were rarely questioned.

As I write about this meeting I am aware of the power dynamics within this group. They were very angry about Ted's behaviour. They were clear that working in a culture driven by targets undermined what they considered to be important. They were also a commanding group in the way that they maintained the harmonious relationship. They stifled the discussion with Beth during the meeting as she began to draw attention to her discomfort, and regularly failed to implement the actions agreed with Hannah and Ted at management meetings. In trying to make sense of how the Senior Sisters related to their medical and managerial colleagues, I will now consider the issue of power dynamics in relationships.

Power

Isenhart and Spangle (2000) suggest:

> If conflict only involved a decision between two choices, most of us would compromise or negotiate. But often conflict involves a struggle for power, the way decisions are made, the way we talk to each other, or unresolved problems from past interactions. Several of these factors may be occurring at the same time, so we are not sure what the real problem is. (Isenhart and Spangle, 2002, p. 2)

Mastenbroek (1987) suggests that "a person exercises power when he influences the behaviour of another person". He also suggests that the more dependent parties are on each other, the more power they can exercise over each other, in the sense that they will have to take each other into account (Mastenbroek, 1987, p. 49). Elias ([1970] 1978) describes power differently, suggesting that the figuration or patterning of competitive and co-operative relationships reflect the interdependencies between individuals and groups. Power ratios are created within the relationship rather than one person having power over the other as the ratios are co-created within the relationship. As I reflected

earlier, one of the themes or patternings of communication between the doctors managers and nurses relates to power. Although the Directorate meeting felt as though the medical staff were exercising their will over the managers, the ratios were co-created by the two groups as the aggressive behaviours were ignored thus maintaining the power ratios.

There appeared to be an interdependent relationship between the medical staff and the Senior Sisters. The doctors' blamed the nurses for not organising their work, which resulted in the medical staff not meeting the performance management measures, which they did not agree with any way. At some level the two groups appeared to collude and rebel against the culture of performance management.

According to Coser (1967) "conflict involves a struggle over values and claims to scarce status, power and resources in which the aim of opponents is to neutralise, injure, or eliminate rivals" (Cosner 1967 p.8). These comments resonated with the exchange I had witnessed between Talib and Ted. There was a struggle for power about who could decide whether visiting consultants should have a parking space. The way that they addressed each other was a result of unresolved past interventions as suggested by Isenhart and Spangle's (2000) comment about the struggle for power reflecting the style of interactions associated with decision making and communication.

Hallier and Forbes (2004) describe the relationship between managers and doctors and the power and social relationships between the two groups. They suggest that doctors are concerned about their power and status in relation to becoming managers. Their role as managers has a social impact on their membership of the medical profession as doctors mistrust managers. The merger of doctor and management roles was perceived by the managers to potentially dissolve the tensions between the two groups. The doctors however seemed reluctant to take up the managerial role as the doctors envisaged no such merger with hospital management, (Fitzgerald 1994).

Elias ([1970] 1978) described a series of models as a kind of mental experiment to demonstrate the relational characteristics of power. He emphasises how the self organising patterns of behaviour emerge in the interdependence between individuals and groups. People constrain and enable each other through relating, as all human relating is power relating, according to Elias.

The power relationships within the Directorate were complex. If, as Elias suggests, power relationships are co-created within the interaction, the Senior Sisters and medical staff constrained and enabled each other. The patterning of aggressive behaviours had been allowed to develop over a long period of time and had not been confronted.

Similarly the Senior Sisters appeared reluctant to confront their junior staff over issues such as the management of beds to avoid upsetting their colleagues. Whether power was exercised or avoided, conflict appeared to be an issue within the team. Neither as I have described earlier, would this confrontation have been supported by Hannah. At times both the nurses and doctors were reluctant to use the power imbued in their roles.

As I reflect on the notion of power I am aware of how the medical staff exaggerated power differences by behaving in an autocratic manner, evoking compliance, as in the case of the Senior Sisters or rebellion as in the case of Ted. Liz the lead nurse did not confront the behaviour of the Senior Sisters leaving a power vacuum. I did not wish to fill the power vacuum left by Liz's lack of leadership. I needed to be continually aware that my suggestions may have a particular influence because of my experience as a senior children's nurse and my position as a management consultant.

Reflections on my role

Returning to the meeting with the Senior Sisters they said that recruitment and budgets were their main areas of difficulty. We went around in circles, as they appeared to defend a position of helplessness, working within an environment of hostility, lack of funding and staff shortages. I felt split between a longing for the Senior Sisters to come up with a way forward and my desire to be directive. I had read (Shaw 2002) deliberations on the term facilitation "to help complicated, difficult, conflictual situations of human engagement flow more easily and productively" (Shaw 2002 p. 2.). Shaw comments that "the conversations that recreate these habitual patterns also have the potential for evolving novel forms of practice." (ibid.). I was disappointed that this was not my experience in this situation and did not feel that the conversation was evolving at all. I had a fixed amount of time and felt that the conversation was stuck.

I now realise that this concern about "doing it properly" was a result of seeing Shaw's work as a methodology. Therefore as a student on the DMan course I ought to be

experimenting with new “methodologies”. As I have discussed my thinking with supervisors and learning set colleagues I am starting to feel more confident about the way that I work. I feel less concerned with methodologies and more concerned with ways of thinking. I have begun to recognise that working in a less structured way may or may not enable new ideas to emerge and that there is no way to predict how the conversations will evolve. I will discuss my use of action learning and complex responsive ways of thinking in the next section.

I asked the Senior Sisters if co-facilitating a working group on skill mix, budgets and recruitment and retention might be a way forward. I wanted them to lead the projects but agreed to work with them, provide administrative and background support. They smiled and nodded in agreement as they thought about my proposal and I felt that the tension in the room reduced. I had the skills to help them to set up systems and processes to manage their work. My concerns lay with how they could sustain and continue to develop more sophisticated ways of working when I left. I voiced my concerns and volunteers agreed to lead the groups with me.

As I reflected on what happened at this point in the meeting I was concerned that I was imposing the direction that the work was going to take, rather than facilitating the group in such a way that they found the answers themselves. I am noticing that I had already formulated what I wanted to do before the meeting. I wonder if I was trying to “ask the right” questions so that the group came to the same conclusions.

I also notice that I was belittling my knowledge and skills as an experienced nurse who had found methodical ways of organising my work. I was aware of the power that I may be seen to hold as a management consultant, which I was uncomfortable with. As I reflect on this I recognise my tendency to deny the experience and knowledge that I brought to the meeting. My role was to share that experience as well as facilitate the group so that they had an opportunity to reflect on what needed to be done. They did not appear to know what to do and it was appropriate to share my expertise in this situation. Although this may seem obvious there has been a shift in my thinking about my role as a consultant. This shift relates to confronting my reluctance to “give the answers” rather than facilitating others to come up with the solutions. Proposals made in the spirit to move the conversation on are only suggestions on how the work may proceed, which may or may not be taken up.

Action learning

I felt that I had established a rapport with the group, and discussed the action learning set proposal. I said that this would provide a forum to reflect on how they worked as a team, their unhelpful patterns of behaviour and ways of challenging each other in a constructive manner.

I went into more detail with the Senior Sisters about how the action learning set would work. I described action learning as a process of learning and reflection, which occurs with the support of a group or "set" of colleagues working with real problems with the intention of getting things done (McGill and Beaty, 2001).

I suggested that the learning set would be made up of the four Senior Sisters, and the Professional Development Nurse. We agreed that one of the Clinical Nurse Specialists would join as she worked closely with the group, and the group would meet monthly. Time would be allotted for each person to describe their issue or story. The group would not interrupt the story until it had finished, and then ask open-ended, probing questions such as "what do you really think is going on" what do you think would happen if", "how would you know if" "how does that make you feel". The questions are aimed at prompting the individual to reflect more deeply and try and make sense of their world in a way that they are unlikely to encounter in their every day relationships. They would be encouraged to look at the process of what was happening during the learning set. This means noticing how they felt about the questions that were asked, what did they observe about body language, what physical responses did they notice in themselves during the interactions, why were particular questions asked?

At the end of their allotted time each member would agree the actions that they would take about their problem. I also described my role within the learning set as demonstrating different ways of asking questions. I would also ask the "difficult questions" to encourage them to own some of the unsaid emotions that may be present within the group and encourage the group to explore the process of what was happening between them.

I asked what they thought of the idea. The energy in the room changed as they laughed and joked about knowing each other and their inadequacies well. The majority of them

had worked together for years. This was valuable but resulted in difficulties in challenging each other as they did not want to upset their friends and colleagues. The thought of being allowed to take time out to think about how they worked in a safe environment, was appealing. One of the group said “I think it is a great idea and feel positive that the hospital is willing to invest this time in helping us develop”.

> Action learning is a process of learning and reflection that happens with the support of a group or “set” of colleagues working with real problems with the intention of getting things done. The process helps people to take an active stance towards life and helps overcome the tendency to be passive toward the pressure of life and work. (McGill and Beaty, 2001,
> p. 1)

There appeared to be a degree of passivity in the patterning of the group interaction. I hoped that action learning might be a way for the Senior Sisters to confront their tendency to blame others, rather than take responsibility for their own behaviours.

I facilitated five action learning sets in total. The sixth and final set was cancelled by the Trust’s Director of Operations due to a lack of resources. Over time the Senior Sisters said that they noticed that they were becoming more aware of how their behaviour and the behaviour of others, impacted on each other. During the learning set meetings they dealt with difficult issues in relation to styles of management behaviour by describing specific problems. They reflected on what had happened, why they thought it had occurred and how they contribute to the situations they described. They appeared to become less anxious about the situation when they had named their anxieties and reflected on ways of dealing with the circumstances.

Issues relating to power, conflict, support and challenge continually arose. This provided the opportunity to explore the notion of power and conflict in relation to their behaviours. At times this was uncomfortable, difficult and emotional. They felt that the learning set was useful as they were challenged to find creative solutions to their problems. They agreed the actions they decided to take, what resulted and how they felt they had changed. Sometimes they felt that they experienced a real shift, other times they were disappointed that the changes they made did not appear to help the situation. The action

learning gave them one day per month to reflect and try to make meaning of their work environment in a way that they had never experienced before.

Further reflections

I noticed on the train home that in my earlier projects I had made observations about the NHS as an overly structured environment, which stifled innovation and creativity. It felt incongruous that I was now in an environment where staff worked in a milieu, which lacked structure and organisation, and constantly reacted to crisis because there was little planning. Stacey et al (2000) suggests that systems' thinking is useful when "trying to design interactions of a repetitive kind to achieve kinds of performance that are known in advance" (Stacey et al 2000 p.186). He also suggests that a system cannot embrace all the nuances of day-to-day living and people work with and around the systems depending on the circumstances. I recognised that systems and processes were necessary to bring order to their work environment, rather thinking of the Senior Sisters as part of "a system".

I saw more clearly the difference between the need for a framework to manage tasks, and the reified manner in which staff sometimes valued their systems and processes. For example, I was concerned that Hannah and Ted believed that if the Senior Sisters devised better systems and processes the problems would be solved. This did not address the issue of whether they had the ability to organise their work or the discipline to work within the systems and processes they devised.

The key questions arising from my reflections on the directorate meeting and the Senior Sisters meetings relate to conflict, power, and anxiety. If conflict is part of human behaviour as Mead suggests, then at times work relationships are likely to be both creative and destructive. Conflict is often hidden and not discussed, so how do staff grasp the notion that work will contain conflict that is both enabling and constraining and that destructive behaviours need to be deal with?

Similarly, if all human relating is power relating as Elias suggests, people constrain and enable each other through competitive and co-operative relationships, which reflect the interdependencies between individuals and groups. Nurses and managers often see doctors as a highly educated, significantly well paid group of staff who exercise innate power that is intrinsic to their roles. The doctors level of authority and decision making

capacity is greater than other clinicians and managers. Although it is reasonable to argue, as Elias does, that power is co-created, enabling and constraining, how do non-medical staff challenge their perceptions of the inherent power of doctors in an environment that seems to value the roles of doctors more than other groups?

If staff were able to discuss hidden conflicts and recognise the constraining and enabling patterns of relationships, they may be better able to contain the anxiety that working life often generates. “When the patterning of relationships can contain the anxiety ‘in a good enough’ manner then there is the possibility of change” (Stacey, 2003, p. 353).

My research question

As I considered the two key work based questions that have arisen from my narrative my research question has evolved. My question is: how can I help clients make meaning of the conflict and power relationships, which exist as part of human interaction, so that novelty and change can occur? Part of “making meaning” is being able to discuss the patterning of relationships and behaviours and how to find a “good enough” way of containing their anxieties. In the following section I will consider this question further as I reflect on the conceptual framework of complex responsive processes and how these notions relate to the way that I work.

Complex responsive approaches to relating

Stacey suggests that “complex responsive processes constitute a theory of human psychology, which takes as fundamental the processes through which people relate to each other” Stacey (2003 p. 359). Rather than thinking of organisations as systems, complex responsive process posits that the experience of interaction produces further interaction. It is the ongoing processes of people relating in which they shape the patterning of the conversation and are concurrently shaped by this patterning of conversation that brings about change in organisations.

Stacy and Griffin (2005) suggests that the thematic patterning of interaction is understood to be

> complex in that it refers to a particular dynamic or movement in time which is paradoxically stable and unstable, predictable and unpredictable, certain and uncertain, known and unknown, all at the same time.
>
> (Stacey and Griffin, 2005, p. 7)

This is a very different view to how many in the NHS view organisations. The introduction of performance management tries to ensure that the NHS is stable, predictable, certain and known. Setting measurements is a way of trying to predict outcomes by measuring the performance of hospitals against these targets.

Stacey and Griffin (2005) go on to argue that the thematic patterning of conversational processes are also self organising and emergent, suggesting that people interact with one another based on their own local organising principles, not following any pre-conceived blueprint. “Cults are maintained when leaders present to people’s imagination a future free from obstacles that could prevent an organisation from being what they all think it should be”, Stacey (2003 p. 397). Hannah tried to convince the Senior Sisters that the cult value of “the best care for children” involved sorting out their systems, suggesting that if they organised their work better, the performance targets would improve, as would the care of children. However the senior Sisters did not think that performance targets improved care. They self organised their work to provided a good standard of care for all the children, not just those whose care had a target attached. They rebelled against the blueprint that Hannah wanted to impose because they did not advocate the performance management values, which she promoted.

Finally Stacey and Griffin (2005) suggest that the thematic patterning of interaction is understood to be evolving, and this inevitably involves choice and conflict. Hannah believed that implementing her particular types of systems would improve the performance targets and conflict would be reduced. In fact it seems that the functionalising or implementing the notion of the “best care for children” brought conflict, uncertainty and anxiety. This is because the Senior Sisters did not agree with her stance on what constitutes “best care” and chose to focus on their clinical rather than managerial work.

I recognise that a complex responsive process way of thinking about organisational development was beginning to influence the way that I worked. I was continuing to challenge my thinking about organisations as spatial metaphors of systems. I was coming to the view that a better way of understanding change is to notice the ongoing local interactions and patterning of conversations in which people contribute to the patterning and are also shaped by it. I am interested in how local interaction could shape what an

organisation becomes, rather than being shaped by performance management targets or the strategic direction and business plan written by the executive directors.

I used action learning sets to think about the patternings of relationships. The manner in which the Senior Sisters related within the learning set reflected their day-to-day relationships. The learning sets offered the opportunity to reflect on these patternings, and the power and conflictual relationships that constrained and enabled there abilities to get things done. It was also an environment in which they could discuss ways of containing their anxieties.

Feelings of anxiety and the unpredictability of confronting conflictual issue are likely to prevent people from speaking out. I have referred to this earlier in my narrative and I recognise my own discomfort with conflict, and wonder how this affects my work as a management consultant. I can think of occasions when I have managed situations that are conflictual, equally there are times when I have felt too anxious and avoided the situation. I recognise there has been little creativity in my work in arenas where aggression and conflict have been overt.

As I consider my work as a management consultant I have become more aware of the conflict and power relationships that exist as part of human interaction. Although I have focused on the action learning aspect of my work within the children's hospital there were a number of meetings about recruitment and skill mix where I challenged what they were doing and my assumptions were challenged in return. The discussions were sometimes robust and heated. However the opportunity for all levels of staff to have an open forum to discuss these issues had not been available before. Some positive outcomes emerged, like a process for staff recruitment.

Conclusions

In my narrative I have described my first day at the hospital where I attended two meetings. I was surprised by the conflict that materialise during the first meeting. I have considered the power relationships between the professional groups and have shown that power and conflict exists as part of every human interaction.

I have reflected on how difficult it is to live and work with the tensions created within the paradox of creativity and destruction, order and disorder (which exists at the same time). This is particularly difficult in an environment, which strives to create order through setting and measuring targets.

I recognise that I have not discussed the issue of identity when dealing with power figurations. This is an issue that I dealt extensively within Project 2 and one that I will consider further in Project 4.

I have also contemplated the power relationships that arise between the client and management consultant roles. I was concerned that sharing my experiences could be a way of exerting my role as an experienced nurse and consultant. I now recognise that my role is about being present in the way that I work. By this I mean being aware of the processes of interaction and being cognisant to the power relationships that are likely to be present. This means noticing how I use my learning and knowledge to try to move the conversation on rather than exerting my position as a consultant. My experience may or may not be taken up by the staff with whom I work. This is not a personal rejection of my experience, but during the process of interactions, choices are made about the value of my experiences in the moment, as we explore and exchange ideas.

As I have reflected on my narrative I realise that there needs to be conflicting constraints on relationships as well as enabling qualities for novelty to arise and change to occur. Without conflict and challenge relationships become stagnant and unproductive. Dissonance and diversity however is different to disrespectful and aggressive conflict. In fact I see my role as one of bringing attention to aggressive styles of behaviour, so that conflict is not ignored but openly discussed.

My question was: how can I help clients make meaning of the conflict and power relationships, which exist as part of human interaction, so that novelty and change can occur? I have found that acknowledging that conflict and power are part of human interaction is important. I see my role as helping staff to use the conversational process to notice what they are actually doing within their day-to-day working lives, and make changes which will foster growth and novelty. Although this can be upsetting and painful at times ignoring the existence is stifling and suppresses novelty. I found that the action learning sets were a vehicle to reflect on the past and as Shaw (2002) suggests gain a new sense of where to go next.

Reflections on Project 3

In Project 3, I wrote about the commitment the Senior Sisters felt towards the children they cared for. As I reflected on this further, it prompted me to return to the theme of inclusion and exclusion, which I explored in Project 2.

I describe how the Senior Sisters were antagonistic towards an ideology that gave preference to children whose conditions had targets attached, for example children waiting for particular operations. Although the managers saw the Senior Sisters as an ineffective group, I now wonder whether the Senior Sisters might have considered themselves as a group of higher value than their managerial colleagues. Although I did not write about inclusion and exclusion in this project, it now seems apparent that they became an inclusive group who excluded and rejected general managers as the 'newcomers'. They preferred to blame their difficulties on 'the newcomers', thus enabling them to maintain their identity and power difference. As I reflect on the power dynamics between Hannah and the Senior Sisters, it is clear how reluctant the Senior Sisters were to account for themselves. On some level, they were constraining the managers by repeatedly agreeing to do things and then reneging on their promises by taking no action. In the next project, I deepened my inquiry further into the benefits and difficulties that staff experience with the implementation of performance management.

In this project, I describe systems thinking in relation to the NHS (pages 181) and describe the difficulties experienced by the staff in working within this paradigm. I oscillated between viewing systems as good or bad, (page 200) and at times found myself idealising a complex responsive process ways of thinking about organisations again. On reflection I consider that it was at this point in the DMan programme that I began to understand that the complex responsive process way of thinking was no more than that: a way of thinking.

I notice that my research question focused on my practice. In my sense making of the narrative, I included the theory, which was implicit within my professional practice but I did not make this explicit in my project. I examine this integration in the original contribution section of the synopsis.

In the synopsis I examine systems thinking further and examine why systems thinking dominates UK healthcare and how it is identified with, and drawn on, in practice. In this context I also elucidate the potential contribution and limitations of complex responsive processes theory with regard to organisational theory (pages 49-57).

In this project, I raise concerns about the emergence of novelty within a systems paradigm, and now recognise that this is not explored in depth. In the synopsis I examine a number of different models in which innovation is studied, measured and monitored. These authors include Bessant and Tidd, 2007; Van de Ven et al, 2004; Schumpeter, 1934; Van de Ven et al, 2008; Poole and Van de Ven, 2004; Seo et al, 2004.

I also critically evaluate complex responsive processes theory and the emergence of novelty and innovation using literature from Mead, 1938; Fonseca, 2002; Shaw, 2002 and Stacey, 2007. I have then examined how a complex responsive approach may enhance an understanding of how the dynamics of the social process promote novelty and innovation.

I had been working independently for two years when I wrote this project (which was later abridged for publication; see Appendix 1), and I began to develop my inquiry into my own role as a healthcare advisor. My *raison d'être* was further challenged as I struggled for many months to focus on my research question for Project 4. I had chosen to write about redundancy, knowing that recalling my redundancy experience would be difficult. As I continued to use a reflexive method to broaden my inquiry about redundancy and rejection, I finally decided that I needed to build on what I could offer staff from my personal experiences of being made redundant.

CHAPTER 5
Project 4

Dealing with redundancy in the National Health Service: Messages for managers and policy-makers

Introduction

In Project 4 I consider the themes of domination and rejection in the context of involuntary workplace separation. I base the enquiry on my narrative, where I recount a recent project, which led to the development of a framework aimed at supporting staff that were at risk of involuntary workplace separation.

I use the term involuntary workplace separation (rather than redundancy) in relation to the experiences of a group of DoNs, as there were a number of reasons that they had to leave their posts. These include issues such as the breakdown of the relationship with their line managers, and the appointed of new CEOs and chairs who decide to appoint different executive teams. These reasons differ from job losses due to organisational mergers which lead to redundancies. When referring to job loss from a more generic perspective, I have used the term redundancy.

My inquiry considers, “In making sense of my own experience of redundancy how can I help others in similar situations “move on”. As a consultant, how do I support those at risk of redundancy who work in organisations where managers, primarily influenced by a systems way of thinking, make others redundant”?

As I explore my experience of compulsory job loss, I examine the literature on the management of workplace separation and the individual impact of, and response to, job loss. I analyse my narrative from a systems thinking stance, and from a complex responsive process perspective. I also consider these theories in relation to my own role in making someone redundant. I warn managers that poor HR practice could result in staff feeling like the victims of bullying and provide examples of good practice. Finally I contest that the NHS has invested highly in training staff that are now being made redundant. There are implications for managers and policy-makers in the NHS who lose this often loyal and committed resource because there is no way of redeploying staff at risk of losing their jobs.

The narrative

I was asked to participate in a meeting with other DoNs who had faced involuntary workplace separation. My friend and colleague Lisa was the driving force behind the gathering. She had read a disturbing article in the Health Service Journal about staff turnover in the NHS.

According to the article, Foster, the then Department of Health (DH) Human Resources Director, stated that the Audit Commission estimated that at least £1.5 billion was spent each year replacing senior NHS staff (Harding, 2004). Mr Foster considered this an underestimate especially in professions such as nursing because of the "additional costs of losing the productivity of experienced nurses, the learning curve of new nurses, and the time existing staff spent helping new nurses" (Harding, 2004).

Lisa had been a Director in a number of high profile NHS organisations and had recently been made redundant. She read the article and contacted Mr Foster at the Department of Health (DH) and the main nursing union and professional organisation, which I will call the Nursing College. She suggested that the issue of retention within the NHS needed appraisal. She also contacted staff from the Department of Health (DH) Human Resource Department, Spectrum, an NHS employer organisation and the Nurse Directors Association (a not for profit professional organisation of nurse directors) who also agreed to work with Lisa.

There are 476 acute hospital and primary care trusts in England. Each Trust has a DoN on the executive management board. According to the Chief Nursing Officer's department, there are no figures collated to indicate the staff turnover of this group of staff. Since the meeting of the DoNs took place approximately 151 DoNs will have lost their jobs due to the current NHS reorganisation of primary care trusts. The meeting that I will describe is a snapshot in time and is not presented as a representative group of displaced Nurse Directors. The majority had been represented by the Nursing College, others attended through word of mouth networks via the meeting participants.

Fourteen DoNs met at the Nursing College to discuss our experiences of job loss and issues relating to the retention of experienced NHS staff. They had all been the subject of involuntary workplace separation. The previous year I had been made redundant from an

NHS Director post where I was the professional lead for nursing and allied health professionals.

None of the participants at the meeting had chosen to leave their jobs prematurely and had a variety of reasons for leaving their jobs. The majority maintained that they lost their jobs because the relationship with their CEOs or chair became untenable. A small number were made redundant post organisational merger and some had lost their roles for more extraordinary reasons, such as the impact of the CEO's affair with a junior colleague. It was agreed that "Chatham Rules" applied to the discussions. I have gained agreement from the Nursing College to write about the meeting content for my Project 4, but I am unable to relate individual stories, which could identify individuals, as I am unable to seek permission from each individual participant.

The email from Lisa, which accompanied the invitation, stated that the purpose of the meeting was to "share corporate intelligence, wisdom, experience and histories that get lost when staff leave". She hoped that the information might be used to influence the development of national human resource (HR) policies. I resonated with the purpose of the meeting and I wanted to participate in a forum where I could potentially influence the development of policy. I was not clear how this could happen at this point.

The meeting was opened by the General Secretary of the Nursing College. This gave a sense of legitimacy to the raison d'être of the discussions and I had a sense of optimism that the work would be taken seriously. The facilitator asked a series of questions, initially asking us to reflect on the impact of involuntary workplace separation, as opposed to other life changing events. We were asked to represent our responses on a scale of 1-10 (10 being worst). The majority scored between 7and 10. I scored 9 and although the exercise may appear trite, I found it useful to hear the range of answers. The personal impact of losing my job had been immense. I said "this exercise helped me to contextualise the experience in relation to other serious events in my life; it reinforced how significant my career was to me, and how momentous a life event being made redundant had been". Many agreed with my view that learning about the impact of redundancy on others helped to validate their feelings of loss and rejection.
Then the group was asked to consider what factors had contributed to the workplace separation, and what signals members of the group might have missed in the lead-in to losing their jobs. This included being ostracised from the "top table", and finding it

difficult to get items on the management agenda. A number of people had not survived the appointment of a new chairperson or CEO who wanted to appoint a new team.

I found the sharing of the participants' experiences absorbing and disturbing. Many were not clear why their CEOs had decided that their relationships had become untenable. Several of the contributors now run thriving companies; others have successfully gained employment in the NHS. Most however continued to feel upset about the way they had been treated.

I told my story but I was limited in the amount of information I was able to share due to the compromise agreement I signed with my employers, which outlines the ongoing terms and conditions associated with my termination of contract. These include not publishing any information to any third party without the prior written consent of my employer, which clearly affects what I am able to disclose in this narrative. Under these circumstances I will reflect on my experiences of redundancy and examine my perceptions of the experiences related by the DoNs.

There was an air of incredulity that senior staff could be treated so badly and often have no sanctuary or support. One person said "I have just got on with it since then but I do not want to go back into the NHS – I have lost confidence in it". There was also a sense of camaraderie as many of the fourteen participants knew each other.

It was proposed that the information generated from the discussions would be used to help others at risk of losing their posts. When this work was discussed with a group of existing DoNs a few months later one person commented, "Sometimes staff in senior positions do need to go". This was a poignant comment and a remark that is difficult to refute. Although staff find themselves in untenable positions for many reasons, they had a wealth of knowledge and experience that was being lost to the NHS. I was later commissioned to develop a "Personal Review Framework" (Appendix 2) based on the information obtained from the DoN meeting. The Framework aimed to help individuals at risk of redundancy to reflect on their positions within the organisations and consider a series of actions that they could take to support themselves through a difficult experience. The desire to influence NHS policy was fulfilled a year later when the Personal Review Framework was launched by a junior health minister as part of a number of initiatives to support NHS staff at risk of redundancy.

In this section I have described a meeting in which a number of similar narratives were woven together, and where there was recognition of the struggle that each had endured during their workplace separation experiences. My narrative is limited at times because I do not have the Directors' of Nursing permission to use their compelling personal experiences as they would be attributable to specific individuals. I acknowledge that this reduces the impact of my narrative. The other limitation relates to the Compromise Agreement, which has a bearing on the way that I can describe my experience. Nevertheless, I feel that these limitations are more than compensated for as I utilise the narrative as a vehicle to explore my own experiences of redundancy. I also drew on the information generated from the meeting to develop the Personal Review Framework to help others at risk of losing their jobs.

Ways of thinking about the NHS as an organisation

To begin to answer my research question I will describe the traditions of systems thinking based on the principles of the scientific method. According to Jackson (2000),

> it was assumed that systems of all types could be identified by empirical observation of reality and could be analysed by a simple enhancement (for example replacing laboratory experiments by the use of models) of the methods that had brought success in the natural sciences. Systems could then be manipulated the better to achieve whatever purposes they were designed to serve. (Jackson, 2000, p. 3)

From systems thinking the notion of cybernetics developed (Ashby (1956) Wiener (1948), where the organisation is seen as a whole system, which can be divided into inter-connecting sub-systems. The characteristics include:

- Being driven by goals or objectives – seen as an existing reality;
- Goals and objectives that are a "given" and not questioned by practitioners;
- Objectives that are scrutinised by an observing individual, applying rules or control systems and drawing conclusions as to what is to be accomplished;
- Outcomes that are compared to pre-existing goals, and any discrepancies are seen as negative feedback, to influence the next actions to be taken with the aim of reducing the discrepancy gap;
- Prompt comparisons between the objective and actual performance and continuously taking rapid corrective action (if necessary);
- The need to achieve stability and maintain the equilibrium;

- The system is seen as a whole, with a boundary between the system and the environment.

This way of thinking has been embraced by many public sector managers, and the following quote in the context of HR management is typical of the way that it has been applied:

> A way to link micro activities of managing individuals and groups to the macro issues of corporate objectives with three steps: setting clear objectives for individual employees derived from organisation's strategy; formal monitoring and review of progress towards meeting objectives; utilisation of outcomes of the review process to reinforce desired behaviour through differential rewards and/or identifying training and development needs. (Storey and Sisson, 1993, p. 219)

Here the focus is on designing, self-regulating, planning, performance appraisal and quality control systems. From their designs, managers often act as if they are able to control the whole system through their actions.

I argue that systems' thinking encourages managers to approach the improvement of productivity in a highly rational and instrumental way. I described earlier my redundancy experience due to my boss leaving. From a systems thinking perspective, my new employer observed the system from the outside and made a decision to change the structure to improve the outcomes. By reducing the "waste" associated with posts like mine, he estimated that productivity would improve as money was allocated to posts that had a direct impact on the achievement of the performance targets. My line manager was able to detach the difficult decision of making me redundant in personal terms, by thinking about the benefits to be yielded by losing a post from the organisational structure. In my worst moments, I rationalised what had happening from this perspective. I was a victim of the "system", and had little redress about the decision that had been made.

There are many criticisms of this way of thinking including the difficulty of defining clear objectives, treating people mechanistically as parts of the system, ignoring issues that are not open to quantification, and discouraging conflict and challenge by using

complex mathematical formulisation, which discourages contribution and novelty (Jackson, 2000).

In hard systems thinking the observer of the system is seen to be outside the system. This notion was later questioned and it was acknowledged that the observers of the system were also part of the system. Rather than thinking that organisations were actually made up of systems, the focus of attention moved to a more Kantian idealist position in which organisations are thought of as mental constructs ascribing an "as if" quality. (Stacey, 2003). So organisations were thought of "as if" they were a kind of system.

This movement in thinking became known as an interpretive systems approach and is frequently referred to as "soft systems thinking" (Jackson, 2000, p. 211), based on the work of Checkland (1978). The principles of soft systems thinking include:

- A focus on people rather than the organisation of the system, process and skills;
- A concentration on perceptions, values beliefs and interests where managers are aware of their own foundations of understanding;
- The acceptance that multiple perceptions of reality exist;
- The promotion of understanding the others points of view and intentions;
- Seeing people as having free will rather than being a mechanistic component within the system and must be involved in the designing and changing of the systems;
- Including the observer within the boundary of the systems, being aware of their impact, their mental processes and their perceptions of reality rather than focusing on organisational systems and processes.

Jackson (2000) argues that "soft systems thinking is one of the most vibrant in the systems movement and provides managers with methodologies, methods, models and techniques which are extremely useful for resolving problems" (Jackson, 2000, p. 212).

Thinking about my experience from this perspective, I propose that my new employer's value system was based on the belief that the core value of the organisation was financial balance. The organisation was thought of as a whole and my line manager's role within the organisation was to ensure that the fiscal targets were achieved. He perceived that moving the organisational development function to a subsidiary organisation was the most effective way to achieve this. From a soft systems perspective however, he did not seek the views of the management team, and made the decision in isolation from his

colleagues. I am postulating that when making difficult decisions like making staff redundant, some managers revert to a hard systems way of thinking. They use structures like the organisational management arrangements to protect themselves from the emotional impact of making tough decisions.

A radically different way of looking at organisations is from a complex responsive processes way of relating. Rather than thinking about organisations as though they were systems, a complex responsive way of thinking explores organisations as "temporal processes" (Stacey, 2003, p. 291). "The term processes does not mean the interface of different parts of a system, rather it is referring to the interaction between people producing further interactions within their relationships" (Stacey, 2003, p. 291). Stacey and Griffin (2006) argue that organisations are processes of human relating. It is through the every day processes of relating that people in (not outside) the organisation, cope with the complexity and uncertainty of organisational life. As this occurs, people "perpetually construct their future together as the present" (Stacey and Griffin, 2006, p. 4). This is a different way of thinking to perceiving people as contributing to the construction of, or as victims of, the "system".

Other elements of complex responsive process organisational dynamics:

- Since relating immediately constrains, it immediately establishes power relations between people. Complex responsive processes take the form of propositional and narrative themes that organise the experience of relating and thus power relations. These themes organise the conversational life of an organisation.
- These themes take many forms. Of great importance are the official ideological themes that determine what is legitimate to talk about in an organisation. Of even greater importance are the unofficial ideological themes that make current power relationships feel natural, and the unofficial themes that organise the subversion of current power relationships.
- Themes organise patterns of conversation and power relationships…
- Conversational patterns may take stable forms of repetition in which people are stuck … [or] free-flowing forms, analogous to the dynamics of the edge of chaos.

- Change occurs in novel ways through the presence of sufficient diversity in organising themes. This is expressed in free flowing conversation in which shadow themes test the legitimate
- The evolution of free flowing conversations and the emergence of creative new directions are radically unpredictable
- Free-flowing conversation becomes possible when the pattern of relating has the quality of good enough holding of anxiety
- There is no guarantee of success.

(Stacey, 2003, p. 383)

When considering my experiences of redundancy from a complex responsive process way of thinking, when my line manage left, the patterning of the local conversations changed from one of promoting organisational development, to one where the attainment of financial balance and performance targets became central. The choices made to achieve the targets in my case put my job at risk.

Reflecting on the experience from my line manager perspective, I speculate that the pressure from the Department of Health provoked feelings of anxiety, which left him feeling uneasy. He decided to re-organise the department as a defence against his feelings of disquiet. From a complex responsive way of thinking about anxiety he was unable to provide a "good enough holding" position. "Good enough holding" is characterised by trust and closely related to the quality of power relations (Stacey, 2003, p. 379). There was no free-flowing conversation between the management team and myself about different ways of managing the demands. The plan to reduce management costs in this manner was presented to an astonishment management team who had not been consulted about moving my team to a subsidiary organisation.

Looking at my experience of being made redundant from this perspective does not lessen the impact that the experience had, but does give me a different viewpoint. I can see how the patterning of conversations with colleagues (excluding the management team) might have contributed to my line manager's decisions. There was no similar post in comparable organisations as the position was the creation of my old boss. From the time of the appointment of the new CEO the conversation had changed from one of thinking about how to engage staff, to one of cost saving. I made a choice to apply for the role

because I trusted my old CEO but I knew that the appointment of an Organisational Development Director was unusual.

On reflection I recognise that when I was feeling hurt and upset, “blaming the system” was more satisfying than taking responsibility for the consequences of taking a ground-breaking job. Organisations function in unpredictable and turbulent environments and I had to live with the disappointment that the role had not worked out. I am not blaming myself for taking a chance but acknowledge that as conversations in organisations change, the consequences are unpredictable, as are the consequences of change in systems thinking. The difference for me is that from a systems thinking perspective I felt more like a victim, bullied by an uncompromising inventor who was redesigning the redundant components of the “machinery”. The notion that redundancies occur because the conversational themes have changed and refocused might have felt impartial and alienating at the time, making it more difficult to blame an individual or entity, and thus less satisfying. However, as I reflect on this experience of three years ago, I am more aware of my contribution to the situation and feel less of a victim.

I have found that thinking about my experience from a complex responsive process perspective challenging. This way of thinking is not easy to understand and for a manager does not provide a collection of tools to problem solve. Zhu (2006) in his unpublished paper challenges Stacey about “appearing keener on pursuing theoretical arguments than on caring for managers immediate concerns”. He is not suggesting that Stacey ignores the practical concerns, but suggests that there is an imbalance between theoretical sophisticated arguments and making a practical difference. I argue that leading a practice-based doctorate about complexity suggests that Stacey has a considerable commitment to practice. However, in my practice I have found it difficult, at times, to articulate some of the complexity concepts. This is partly due to the way in which my understanding has progressed and partly due to translating the language used to describe the concepts, such as “calling forth responses” and “patterning themes of conversations” into modern parlance. I concur that this is not a necessary prerequisite to my practice, but I find the concepts useful in stimulating conversations about different ways of looking at organisation. In this project I have found the concepts particularly helpful in making sense of my experience of redundancy. I have challenged my propensity, and I assert the tendency of my DoN colleagues, to blame redundancy on the dominance of an inanimate entity called the system.

In this section I have examined different ways of looking at organisations in relation to my experience of redundancy. I will later consider how these different perspectives might help others to move on from their redundancy experiences. In the next section I will analyse the impact of redundancy from the literature, to some of the experiences expressed at the meeting described above.

The impact of redundancy

According to the NHS Employer website "There has never been a better time to consider careers in the NHS. Services are being modernised and expanded and there is a need for more staff to provide excellent care. New employment policies are making the NHS a better place to work and to build successful careers" (NHS Employers, 2006). I feel somewhat cynical about this information in view of the number of reported job cuts and am surprised that it is still on the website.

However, as Doherty (1997) asserts, "organisations have rarely been able to guarantee that the number and type of people they employ will remain constant, therefore redundancy has always existed as one legitimate means of manipulating the internal labour market to enable adjustments to the size and composition of the workforce", (Doherty 1997 p. 343). There is a legitimate argument for the improvement of healthcare services and these changes might lead to redundancy. However the degree of current job losses in the NHS is a recent phenomenon.

Easteal (2002) interviewed people who had been made compulsorily redundant in the private sector in a small but in-depth study. Her study supported the literature, which said that only a minority of people think that there is a sense of social stigma or sense of failure associated with redundancy. I have not been able to find any literature about the stigma of redundancy in health care, possibly because up until recently, it has been an unusual event. However all the participants indicated "that they had felt in some way bad, useless or unwanted", (Easteal 2002, p. 44). Easteal identified three experiential themes in her work on the effects of redundancy: shock and sadness, worry and anger, rejection and loss.

The DoNs and I experienced all the themes outlined in Easteal's work. We all expressed surprise at our lack of anticipation of the impending job loss and our feelings of

helplessness. The participants were particularly interested in how they could help others recognise when they were at risk of losing their jobs and help themselves by taking decisive action. I shared the anger that many of the participants felt and recognise that part of wanting to undertake further research in this field was a way of working through my experiences.

Donnelly and Scholarios ((1998) examined the phenomena of worker displacement resulting from redundancies within four defence related industries over a three year period. All the participants of the study admitted to some feelings of fear, humiliation and depression. “These feelings were attributed directly to the ‘shell shock’ of redundancy”, (Donnelly and Scholarios 1998 p. 336). There was a strong feeling that the redundancies had been “handled insensitively with little regard to shown for the personal impact on the individuals or the loyalty shown by the workforce”. (Ibid., p. 337).

This raises the question as to whether it is possible to make people redundant in a sensitive way. The process of making people redundant could be seen as a self-organising phenomena where impersonality has emerged as the most effective way of dealing with a difficult issue. This may protect the managers from facing difficult issues but, from the literature and my experiences, I cannot concur with this argument.

The majority of the participants at the meeting felt that their situation had not been handled well. There was a belief that the purpose of Human Resource (HR) departments was to support the employer. A few of the participants found the Nursing College supportive but the majority either did not find them helpful, or did not ask for help. I had found asking for help from the trade union difficult. My only contact with trade union staff had been over the negotiating table, and perceived their behaviours as brash and manipulative. I finally found that I was too upset to negotiate my final Compromise Agreement alone. My trade union representative was supportive, confidential and trust worthy, and I wished that I had gained her help earlier in the negotiations.

Although the context of Appelbaum et al (1999) studies is focused on large scale redundancies rather than individual job loss, they argue that not only were the HR departments inessential, they were often harmful. “This is mainly because expectations were violated, commitments were not kept, human dignity was bruised, secrecy and politics dominated, and long-term scarring occurred”. (Appelbaum et al 1999, p. 487).

Doherty (1997) cites the need for good practice polices on the management of redundancy, which focus on the humane management of employees. HR she suggests "is positioned as the key player in ensuring that good practice is implemented" (Doherty, 1997, p. 344).

Although the DoNs were experiencing workplace separation in isolation from their colleagues, it is reasonable to expect these principles to be in place at an individual level. Doherty (1997) asserts that there is a difference between major organisational change resulting in redundancy and change at a more individual level. "In addition to the more macro level models of change management, owing to the potential for unfair treatment of employees, employment law provides recommendations on the justifiable use of redundancy and further guidelines on the management of redundancy situation", (Doherty (1997) p. 344). Although it is not possible to know the reasons why each of the DoNs lost their posts, some of the narrative experiences do not suggest that they were treated fairly. They also maintained that HR colleagues were unsupportive but did not pursue any legal challenges.

I now question why none of DoNs defy the decision to remove them from their posts at an Employment Tribunal? My employment solicitor advised that I did not have a case for unfair dismissal as my employer had a right to re-organise my department. Other participants in the meeting had less clear cut reasons for losing their jobs but had not challenged their employer. Stacey 2005) argues that

> together, the voluntary compulsion of value and the obligatory restriction of norms constitute ideology. Ideology is the basis on which people choose desires and actions, and it unconsciously sustains power relations by making a particular figuration of power feel natural … complex responsive processes of human relating form and are formed by values, norms and ideologies as integral aspects of self/identity formation in its simultaneous individual and collective form. (Stacey, 2005, p. 10)

I purport that one of the ideological values of the NHS is that DoNs do not challenge the CEO's right to dismiss staff in whom they have lost confidence. The social stigma associated with challenging this norm is a method of maintaining the power relationships between CEOs and their subordinates. Staff collude with these ideologies and in doing so sustain the ideology. Challenging the ideologies would be unacceptable to the wider NHS

and would harm future employment prospects in the NHS. It is also in the interests of the Directors to tolerate this ideology to secure their final financial settlement.

Another reason to collude with the decision is the element of shame. Elias argues that "shame and embarrassment are personal emotions, deeply affecting the individual's state of mind; at the same time they are socially induced emotions par excellence" Elias (1998 p. 19). Shame is a powerfully controlling element. The DoNs are likely to be concerned about what others might think. Staff that have been rejected by the society of the NHS are unlikely to want to bring attention to their plight by inviting criticism from their peers. Finally, the DoNs might have felt intimidated by the belief that they are challenging the NHS monolith rather than confronting a decision made by their line manager.

Donelly and Scholarios (1998), in their study of redundancy in the defence industries, argue that the job losses are a direct result of government decision. They continue "there is a widely held belief that government has some responsibility to assist affected defence-dependant companies and communities in responding to the impacts of defence expenditure cuts", (Donelly and Scholarios 1998, p. 340). Although I have depicted the job losses at an individual level rather than large-scale redundancies, the same argument could apply. I am not convinced that redundancy, caused by government decision making, assumes a different type of responsibility from any employer making staff redundant. Regardless of the source of decision making, I believe that staff should be treated with dignity and employers must take responsibility for the welfare of their employees. Conversely, I maintain that the NHS invests significantly in the education and training of staff. I argue later in this project that policy-makers and managers need to look at ways of retaining this resource.

Doherty (1997) notes that for some, redundancy is a devastating incident, for others it can be a liberating experience. This was not a view expressed by the DoNs. Although many of the participants had gone on to successful careers, there was a feeling that they had been rejected by their employer and found that they had little redress in the situation.

All of the emotions depicted in this section had been described by the DoNs to some degree or other. From the literature reviewed it appears that the education and training of human resource staff is a theme that might help staff feel that they have been dealt with in a fair and equitable manner. To begin to answer my enquiry about making sense of my

own experience of redundancy, it has been valuable to review literature on redundancy, and recognise that the emotional turmoil that I experienced is usual. I will now consider the phenomena of self identity and power in the context of my narrative and personal experience.

The effects of redundancy on the self, identity and power

In this section I will reflect on the work of Mead, Dalal and Elias in relation to the effects of redundancy on the self, identity and explore the notion of power, as I continue to consider the experience and effect of redundancy.

According to Mead (1934), self-consciousness is a function of our ability to see ourselves as an object – from our view of how others see us:

> He becomes a self in so far as he can take the attitude of another and act toward himself as others act … It is the social process of influencing others in a social act and then taking the attitude of the others aroused by the stimulus, and then reacting in turn to this response, which constitutes the self. (Mead, 1934, p. 171)

I was concerned about how the attitudes of others affected how they perceived me, fostering the feelings of shame I referred to earlier. Mead also argues that we have dissimilar relationships with diverse group of people and within the social process are different things to different people

> There are parts of the self, which exist only for the self in relationship to itself. We divide our-selves up in all sorts of different selves with references to our acquaintances … There are all sorts of different selves answering to all sorts of different social reactions. It is the social process itself that is responsible for the appearance of the self; it is not there as a self apart from this type of experience. (Mead, 1934, p. 142)

This is relevant to my experience and to many of the DoNs. We had worked in organisations at senior levels for many years. In being made redundant we had lost our roles in the work place and were unable to maintain established relationships where we had a role and purpose. This affected our sense of self and our sense of work identity. Dalal (2002) argues that “identity is not a possession owned by a person, but the name of a relationship between people… The name itself and the province that it delineates are

predicated on the function it is to serve". He goes on to propose that "…'who I am' and 'what I am' is the same as 'where I belong'". This then leads to the assertion that there is an isomorphism between the sense of self and identity (Dalal, 2002, p. 187).

I contend that my relationship with my colleagues at work was as a Director of Organisational Development and "the province" was as a Director within a Strategic Health Authority in the NHS. This felt like the place where I belonged. Stacey (2003) postulates that the notion of belonging to an organisation is an essential part of a person's identity. When they are ejected from an organisation "what is threatened is far greater than economic well being; it is the very identities of people that are threatened" (Stacey, 2003, p. 390).

Elias and Scotson (1994) describe life in Winston Parva, a Leicestershire suburb. There was a clear distinction between those who had lived there for several generations, (inhabiting the village), and those who were new to the area, (the estate). There were little apparent differences between village and the estate, and yet an ethos of the insider-outsider appeared to exist. The old residents (the insiders) had developed a specific social order, which developed a distinguishing way of behaving that they all had in common. They had developed an identity and had come to think of themselves as a "we" group with common attributes that had emerged because they had been together over a period of time. I would have identified myself as a resident of the "old village" but suddenly found myself ostracised and did not belong. I was no longer part of the common identity especially as I had not found myself a job elsewhere in the NHS. I felt isolated especially as I was the only person losing my job. Before I left I told my Management Board colleagues.

I have the opportunity to look for other roles – but I do not want you to feel that you cannot speak to me about what is happening – I do not want you to avoid me over the next few months whilst this is being sorted – that would feel very difficult for me.

I was afraid that I would be both excluded and rejected by my peer group. I did not know what the future held and wanted to maintain as much dignity as I possibly could, whilst still going into work. I was also concerned about the future of my team and wanted them to be seen as part of the insider group. However I felt like an outsider within a work environment where I had lost my sense of belonging. This was compounded by the many

months it took to complete my Compromise Agreement. Naturally, life for my colleagues continued as ever but I was excluded from their projects and plans as I had no role within the organisations. I felt bewildered and disturbed by how easily I had become dispensable.

Although the DoNs did not say that they felt powerless, there was a sense that they had little power in the situations they faced. They are likely to concur with the Mastenbroek (1987 p.19) argument that "a person exercises power when he influences the behaviour of another person". Elias (1978) emphasises a different view as to how the self-organising patterns of behaviour emerge in the interdependence between individuals and groups where no one can control the future, (Elias 1978). At times I felt that my line manager was controlling my future and felt helpless. I attempted to overcome these feelings and worked hard to interact with my peers as I did not want to isolate myself entirely from my colleagues in the workplace.

Elias (1978) illustrates the way that human beings are interdependent by describing his games model, suggesting that the dependencies although reciprocal, are often unequal. Rather than using the term "power ratios" he uses the term relative strength and states that:

> All the models are based on two or more people measuring their strength against each other. This is the basic situation encountered wherever people enter into or find themselves in relations with one another. The awareness of it, however, is often suppressed when people enter into or find themselves in relations with each other. (Elias, 1978, p. 115)

Elias (1978) suggests that people suppress their awareness of this contest when reflecting on human relations, but after a while, finds a balance of power that (depending on the circumstances) may or may not be stable. I recognise that the experience of redundancy is likely to highlight feelings of extreme powerlessness. However, I recognise that I had choices about how I related with my line manager and the support that I sought.

In this section I have reviewed some of the literature on the effects of redundancy and tried to make sense of my experience through the work of Mead, Dalal and Elias. One theme that continues to be evident is one of choice. Although it is a helpful exercise to rationalise the situation in this context I am still left with the difficulty of dealing with the

negative emotions that are evoked by recalling this episode, and the challenge I experienced to my identity. These will be considered later in the section on the victim.

In the next section I will discuss my role as a manager who made someone redundant and later in the project reflect on the patterns of interactions between the CEO and board members at that time.

My role in making people redundant

A friend read my project and asked if I had ever made anyone redundant. It had not occurred to me as I wrote the first few iterations of this project, that I had had to mange this kind of situation earlier in my career.

I was working as the DoN in a teaching hospital trust. During the six years that I worked in the hospital the senior nursing staffing structures changed a number of times. During the third re-structuring, fuelled by financial constraints, Paul, the CEO decided to increase the financial controls. The nurse manager posts were to become business managers, and focus on financial management. As part of the cuts one of the nurse manager posts needed to be lost. Although I did not have direct line management for these posts, the staff were professionally responsible to me.

Mary was an immaculately dressed woman in her early forties. She had worked in the hospital for many years and was well liked. She had been the Quality Manager and applied for the nurse manager post just after I was appointed as DoN. She interviewed very well and I was impressed by her energy and enthusiasm. In time I had a number of discussions with her line manager (a business manager) about her lack of effectiveness and poor sickness record. I had a number of meetings with her about the slow progression of her work. She was always friendly but would become defensive when I challenged her reasons for not achieving her agreed work.

Argyris (1986, p.74) argues that by avoiding conflict “some executives eventually wreak organizational havoc”. Stuart and Lucio (2000) compared health performance appraisal in the public and private sectors. They found that health was more orientated to “career development than to performance management” (p. 320). Truss (2001) found that half the participants in her study thought that performance management did not enable the

organisation to assess the strengths and weaknesses of the workforce. She argues that "line managers play a key role in interpreting the appraisal policy". (Truss 2001 p. 1137.) From a complex responsive process way of thinking this illustrates the difference between issuing a policy, which will then be interpreted at a local level by managers in a myriad of different ways within the local context.

Mary was seen as a very sympathetic person who spent time chatting to staff to make sure they felt supported. From a complex responsive process perspective she appeared to be good at fostering free flowing conversations but she did not appear to achieve her performance goals. I am also aware that we did not look at whether she achieved other important issues. The patterning of conversation within the organisation implied that she was a pleasant woman who "did not get things done". This, coupled with her sick time, possibly contributed to her lack of performance, which was not managed by her line manager.

As part of the restructuring, Mary was interviewed for the business manager post. The CEO asked me to participate in the appointment as the post holder had responsibility for nursing. I felt reluctant to participate because I suspected that this was a vehicle to make Mary redundant but felt that I had little choice, as the financial constraints were so great that the CEO and I feared for our jobs. Mary demonstrated at interview that she did not have the skills for the job. I was asked to tell her the outcome of the interview. I remember not being able to contact her, and she eventually called me when I was in the car driving home. It was a difficult conversations and I felt very upset. She was remote and distance and immediately ended the conversation when she learnt that she had not been appointed.

My CEO decided to restructure the management arrangements and assumed that by changing the structure, efficiency would follow. These assumptions were not fulfilled as I do not recall that we became more efficient after Mary left. I imagine that if Mary was asked to recall this experience she would perceive that the organisation was an individual perpetrator. This "relegates people to the passivity of helpless victim of the "system", potentially negating a sense of personal responsibility. (Griffin 2002). She might also perceive that I bullied her, though this was not my intention. It is doubtful that she would agree that her lack of efficacy and poor sickness record contributed to the situation as she was never confronted with these concerns. The Trust eventually paid her a redundancy

payment, which in some ways was ostensibly compensating her for performing inadequately.

In the next section I outline my research question and then continue my exploration of the themes of domination and rejection by examining the literature on perceptions of the bully and the victim.

Research question

I left the meeting with the DoNs, with a desire to participate in work that could support staff who feel rejected and defenceless in the face of a potentially dominating style of management. The encounter was the catalyst for the evolution of my thinking for my research. This has been a complex process as I have found it difficult to acknowledge and deal with the rejection I feel about my experiences of being made redundant. However, I feel that it is time to deal with this issue and this has enabled me to develop my research question. My inquiry will consider, “In making sense of my own experience of redundancy how can I help others in similar situations “move on”. As a consultant, how do I support those at risk of redundancy who work in organisations where managers, primarily influenced by a systems way of thinking, make others redundant”?

Part of making sense of this experience is to analyse the notion of domination and rejection in the context of the victim and the bully.

Perceptions of victim and bullying behaviours

As described earlier, I felt an acute “loss” of identity when told that I no longer had a job. I also felt like a victim and at one point in my exit negotiations felt bullied by my employer. I will now consider the notion of victim and bullying in organisations.

Zapf (1999) reported on a study involving 143 German and Scandinavian people who felt that they had been bullied in the workplace, comparing the results with a control group. Zapf uses the term “mobbing” in the article as an interchangeable term with bullying. Mobbing is described as an extreme type of social stressor at work, which is “long lasting, escalated conflict with frequent harassing actions systematically aimed at a target person (Zapf 1999 p.70). The definition of bullying used to recruit the participants to the study was “harassing, bullying, offending, and socially excluding someone in the course

of which the person confronted ends up in an inferior position". Rayner and Cooper (1997) contend that bullying in individual cases can be extremely hard to identify. Behaviours such as withholding information, springing meetings on staff unexpectedly, physically isolating staff from the tools required for the job and engaging in micro management were cited as subtle ways of undermining staff.

There are similarities between the Rayner and Cooper (1997) definition and the DoNs remarks about missing the signs that their position was becoming untenable. Their comments included having information withheld, offensive behaviours like being ignored, poor eye contact with their line managers, poor administrative support, comments about their mediocre performance whist often exceeding their personal objectives, and exclusion from meetings and social events.

Luzio-Lockett (1995) argues that that there is the possibility of victims of bullying being victimised twice; once by the original perpetrator and secondly by those who the victim chooses to speak to about the ordeal. I was reluctant to "go public" and confront the behaviour that I encountered because I was silenced by a sense of shame. I was concerned that I would be persecuted by my peers who would think that I was incompetent as I had been rejected by my employers.

Many of the DoNs perceived that they had been bullied by their line managers. Luzio-Lockett (1995) argues that there has been a reluctance to recognise bullying at work as a factual entity. This is partly due to the connotations linked to childhood bullying, (Luzio-Lockett (1995, Hannabuss 1998), which leads to a dismissal of the experience, as "this cannot happen to adults or in a work environment", (Luzio-Lockett, 1995, p. 13). The victim also fears being seen as a child, unable to stand up for themselves as an adult who needs to "toughen it out". This could be seen from a complex responsive process way of thinking as maintaining the collective ideologies of the organisation..

The participants in Zapf's (1999) study were asked to complete a series of questionnaires to measure the potential causes of bulling in the organisation. The most frequently reported reason given by the "victims" of bullying for being negatively treated by managers and colleagues was "they want to push me out of the company". According to Zapf (1999) this is believed to be the final goal of the bullying process. It was often not until after the event that the DoNs realised that there had been a number of signs

indicating that they were going to lose their jobs. This was why it felt important to capture this information as part of the Personal Review Framework, to help others assess their individual situations and take appropriate action.

Zaf's (1999) work on the causes of bullying at work, found that people showing unassertiveness and avoidance types of conduct, showed the worst conflict resolution behaviour. I had worked with a few of the DoNs and would not have described them as unassertive or avoidant. Many of them had functioned in jobs at national levels, had a high media profile in the health service, and were well respected. According to Hannabuss 1998 p. 309 "the assertive position for the victim is one where you identify and stand up for your personal rights and acknowledge your personal need".

I was concerned by the number of DoNs who felt "bullied by their organisation" and saw their rejection as in keeping with the role of "victim" and their "organisation" was seen as the perpetrator. As Zapf (1999) points out, "leadership problems or organisational problems cannot "harass" an employee. Such behaviour is only possible for human beings" (Zapf, 1999, p. 72). The term "the organisation" can be used as a metaphor to talk about the way in which people feel treated by their line manager. I am arguing that the perception of bullying by the "organisation" is a result of thinking about the organisation as a system, as if it were an individual entity, rather than the behaviour of a peer or line manager towards another person.

Stacey argues that "conversations are complex processes of themes triggering themes through self-organising association and turn taking that both reflect and create power differentials in the relationship" (Stacey, 2003, p. 349-350). It is not possible to know what happened in the case of each DoN and Zapf (1999) comments on how difficult it is to identify the reasons for bullying in the case of high performing people. He concludes that it is difficult to know if the high performing person does not conform to group norms, which is not tolerated by the group or whether the group cannot tolerate high achiever who demonstrates their success in an arrogant or provocative manner.

I am speculating that when the DoNs were appointed they must have demonstrated that they had the ability to fulfil the role. At a later point this was questioned by their CEOs. It is very unlikely that this was done in complete isolation from the rest of the staff in the organisation. Stacey 2003 argues that

> The thematic patterning of communicative interaction has many continuously intertwining, inseparable aspects. These aspects are formal and informal, conscious and unconscious, legitimate and shadow themes organising and being organised by the experience of interaction. Furthermore, interaction is always evolving as the past is iterated in the present in which the future is perpetually constructed. (ibid., 2003, p. 390)

The relationships that each DoN had with their line manager will be influenced by their previous experiences, preconceived ideas, and the opinions of others. Additionally the CEOs' concepts of how they want the role to evolve in the future, and their judgments about their DoNs capabilities, also affect their relationships. These factors coupled with their face to face relationship which, in terms of a complex responsive process way of relating, purports that they will form and be formed by the relationship at the same time. This way of thinking fosters the concept of individual accountability yet the individual is not functioning in isolation. They are affected by the dominant norms of relating and the collective ideologies within the groups of staff with whom they work. These constraining norms may however be perceived as the unassertive and avoidant behaviours referred to by Zaff (1999). This is a different perspective to the notion of being an isolated victim being "done to" by a perpetrator.

I had worked with some of these staff and did not perceive that they were incompetent people. I also struggle with the premise that they all had "bullying" line managers. Some gave examples of bullying behaviour e.g. comments about their performance that had not been mentioned at performance appraisal meetings, noting that information was being withheld from them, and exclusion from social events. Others gave examples of being ignored because they no longer belonged in the organisation, having to move from their desk or offices to accommodate their successor, and not being able to complete projects as information was withheld because they were not included in the future of the organisation. None of these issues were necessarily resolute acts of bullying, but may well be perceived as harassment by a person who is trying to come to come to terms with a distressing situation.

I am not advocating that systems thinking equates to bullying and harassment. However I am arguing that managers who are heavily influenced by systems thinking may behave in highly mechanistic ways. This might contribute to individuals feeling at best dominated

by their “organisation” and at worst, bullied. By its very nature redundancy is the rejection of an employee who is likely to feel angry and vulnerable. I argue that if staff are not kept informed of the redundancy process, if managers avoid them because they are embarrassed by the situation, it would not be unreasonable for staff to feel bullied by their employer.

In this section I have argues that there are different ways of making sense of the redundancy situation in relation to the notion of the victim and the bully. I am not suggesting that bullying does not take place or that in some situations CEO do not behave in an autocratic manner. Nevertheless, even if a manager behaves in this manner the subordinate has a choice in whether they respond as a victim or not. In the next section I will look at different ways of dealing with the phenomenon of redundancy

Good practice

Earlier in the project I questioned whether it is possible to make people redundant in a sensitive way. In the next section I will argue that although redundancy is likely to be a difficult experience, there are examples of good practice that lessen the distress.

Cangemi and Miller (2004) review some employment-sensitive exit strategies. These include working with employees to help reduce waste and cut-costs. One organisation offered part time work to employees who had worked over 20 years with a lump sum paid over 2 years with no effect on pension rights. Another example included a company with mounting financial loses who included their staff in the discussions to find solutions. The workforce agreed to work a four day week and take a cut in salary. Eventually the organisation went under, but the experience of the workforce was much more positive because they had been involved in the decision-making. In both of these examples the employers showed sensitivity to the feelings and attitudes of their employees. They understood the value of maintaining a “positive relationship with the workforce during a very difficult time in the history of the company and the life of the worker”. (Cangemi and Miller 2004, p. 984). This second example supports the notion of free flowing conversations by including the workforce in finding alternative ways of managing the situation.

Appelbaum et al (1999) argues that a right-sizing rather than a down sizing approach can shift the organisation to look at future possibilities. They outline 30 issues to be considered before downsizing the company. I was surprised at the way in which the sub-headings matched many of the suggestions made in the Personal Review Framework that I was commissioned to develop.

Doherty (1997) argues that the role of HR in the sphere of redundancy is staff support. She posits that the locus of this support is embodied in the concept of outplacement to help people through the major transitions such as job change and redundancy. This is achieved by providing practical and psychological support through programmes focused on CV development, reviewing job skills, and facilitating networking in the job market personal and career counselling. Evaluations of outplacement programmes, she suggests, show the benefits to the individual "in terms of practical support and maintaining self-esteem and self-confidence" (Doherty 1998 p.346).

Over the past two decades there has been a shift in the relationship between trade unions and managers. (Stuart and Lucio, (2000), Du Gay and Salaman (1992). The relationship has become less adversarial and more collaborative. Trade unions play a unique role in representing the rights of its members and providing support to individuals facing job loss. Donnelly and Scholarios (1998) argue that trade unions should be more proactive in facilitating individual adjustment to redundancy rather than just focusing on the need to safeguard jobs. Although trade unions have recently developed a wide range of legal and financial services, many staff interviewed in their survey raised issues such as "employment training" and "welfare rights", and the need to negotiate better access to independent financial advice. I discussed the role of the trade unions earlier and argue that they have a valuable role in representing staff at a vulnerable time, by negotiating with employers on behalf of their members.

Anecdotally, I discussed my project with a friend recently as we took a Saturday afternoon walk by the local canal. She expressed her grief at recently making a number of staff redundant. When it was clear that this action had to be taken she said, "I was determined to take responsibility for what needed to be done. I made sure that I was the person who saw every member of staff, I tried to re-deploy as many as possible and worked hard to keep them informed of what was going to happen". She then expressed her surprise when a number of individuals said that although it had been a terrible

experience they applauded the way that she had dealt with them. She listened to their anger and concerns, and took responsibility for providing individual help rather than resorting to blanket policies in place to “manage the situation”
In this section I have considered a number of options available to line managers and employees when faced with the prospect of job loss. I will now consider as a management consultant, how can help others to move on from redundancy.

My consultancy ranges from working with managers who are required to make staff redundant, staff at risk of redundancy, and staff who have been made redundant. In relation to my work with managers, I encourage them to participate in supportive actions such as individually negotiating with staff where possible, keeping staff informed, involving staff in navigating the options available and the importance of the role of trade unions. I acknowledge the difficulty of wanting to avoid facing staff who are struggling with facing redundancy and encourage managers to utilise the types of interventions outlined in this section.

In relation to staff coping with redundancy, I ask staff to tell me about their experience. This often leads to a conversation about feeling rejected and the notion of victim and perpetrator. This is challenging work and I have no blueprint for success. Conversations often get stuck and the notion of behaving as a victim and blaming others often provides protection for individuals not wanting to face what has happened. Many of the DoNs felt that they were unable to think logically as the impact of the situation became apparent. The Personal Review Framework (Appendix 2) encourages staff to take actions that may help them regain some feelings of power and control in a very distressing situation. The Framework is not a strategy to success and may not be a device that is useful to all.

I have experienced redundancy at first hand and have studied the phenomena for this project. This knowledge gives me the confidence, where appropriate, to discuss the nature of organisations, power relationships and organisational norms and ideologies to help staff make sense of their situations. Sometimes the conversations are stuck and at others they are creative and free-flowing. I recognise that my insights and perceptions may or may not be helpful to others and respect the notion that everyone brings their own unique perspective and coping mechanisms into the situation.

Discussion

My inquiry has considered “In making sense of my own experience of redundancy how can I help others in similar situations “move on”. As a consultant, how do I support those at risk of redundancy who work in organisations where managers, primarily influenced by a systems way of thinking, make others redundant”?

The experience of redundancy for many is a difficult and humiliating experience. I found some consolation in the realisation that my response to losing my job was shared by others. For some people redundancy might be seen as a liberating experience and provide financial support to explore new opportunities. On a good day I am able to view my experience in this way. The experience has given me insights that I am able to utilise in my practice and this project has been a useful vehicle for me to “exorcise some of my demons” and take a more pragmatic view of the episode.

I have analysed the way in which the NHS is heavily influenced by systems thinking. I have argued that some managers distance themselves from the distress of making staff redundant. They sometime focus on the structure and processes under pinning the changes and distance themselves from the management of the employees. I also maintain that individual line managers are under constraints, which influence their decision making in a local context. This has reduced my notions of the organisation and/or line manager as a perpetrator, and emphasises the concept of individuals’ choices in negotiating their exit strategies. However managers and policy-makers need to realise that poor human resource practice might lead to staff feeling that they are being bullied. I recommended earlier that there needs to be better training of HR staff about human resource good practice. I also contend that redundancy is sometimes used as a vehicle to remove poorly performing staff rather than confronting poor performance. This results in staff being paid large severance packages for working inadequately.

The NHS is constantly changing and there is always the potential that staff will be made redundant. I am concerned that policy-makers and managers are losing a considerable resource that will be difficult to replace once the current financial problems are resolved. I am mindful of the DoN comments in my narrative suggesting that some of their colleagues “need to go”. I am not arguing that the NHS should provide jobs for life or

that groups of staff who are unable to, or do not wish to fulfil their working obligations are protected.

I am arguing that the NHS has invested large sums of money in training and development and do not have a way of retaining a potentially valuable resource. Although there is a website for people looking for jobs in the NHS (NHS Employers -jobs website 2006) there is no national scheme to redeploy staff in the NHS. I propose that there needs to be a proactive attempt to redeploy staff in an organised and managed approach to retain staff within the NHS. This does not negate the issue of jobs for life regardless of performance, but redundancy needs to be the last resort. In spite of the distress and angst caused, it is a drain on public funding that could be considerably reduced. The NHS is constantly changing and needs to resource re-training programmes so that staff with a wealth of experience, have the potential for a future in the NHS.

The experience of writing this project has given me a different perspective on the phenomena of redundancy. I encourage clients to make sense of their experience by sympathetically confronting their feelings of victimisation and being "done to" by the organisation. From a complex responsive way of thinking I encourage them to consider their power relationships and the part that they played in the interactions. This can be a painful and difficult experience and might not be a conversation in which all my clients wish to participate. However I think that if clients are going to move on from the situation they need to confront the notion of being a helpless victim. I encourage staff to use the Personal Review Framework (Appendix 2) developed through the DoN meeting, again acknowledging that this is not a blueprint to success.

The examples of good practice that I have cited need to be considered by policy-makers and managers. The examples highlight the need to help the individual deal with the situation at the time and move on to other jobs. These include dealing with staff on an individual basis, by keeping them informed, providing support to find other jobs and offering psychological support. These options may not be taken up by the individual but demonstrate an acknowledgement that although the situation is difficult, options are available to help the individual. Equally I argue that trade unions are well placed to provide a negotiating role on behalf of displaced staff. I contend that trade unions need to develop and market their service to provide greater support for staff facing redundancy.

Conclusions

I have described a meeting with DoNs who had faced compulsory workplace separation, and analysed their feelings of rejection and defencelessness in the face of potentially dominating styles of management. This encounter was the catalyst for the evolution of my thinking for my research. I have included my role as a manager who made a member of staff redundant, which has brought a different perspective to my experience of redundancy as I reflected on the patterns of interaction that contributed to the decisions made.

One limitation of this enquiry is that the study was based on a particular staff group who were made redundant rather than related to mass down sizing. However, I argue that the principles are relevant to larger-scale redundancies even though it is more difficult to provide the type of individual support that I am suggesting.

My contribution to the subject of redundancy in the NHS is to warn managers and policy-makers that in a climate of high anxiety over financial performance there is a propensity to focus on the structure and processes under pinning the changes. If managers distance themselves from the management of good human resource practices, staff might feel at best demoralised and at worst the victim of a domineering and bullying organisation. I also argue that redundancy when viewed from a complex responsive way of thinking reduces the notion of victim. It provides a different way of thinking about the concepts of power and ideological norms that enables and constrains behaviours in organisations, which is ignored within the theories of systems thinking.

Reflections on Project 4

I have built on the themes of exclusion and inclusion, power and rejection as I have focused these concepts within a narrative based on the experiences of a particular professional group. Many of the conclusions are relevant to other staffing groups and have a wider generalisability. The Personal Development Framework, for example, could be used by any staff group; it is not just aimed at senior nurses.

I have described the traditions of systems thinking based on the scientific method and engaged with by public sector managers (pages 210) I have used examples from my narrative to illustrate why systems thinking is a useful way of analysing organisational life for managers. I build on this further in my synopsis and consider the benefits of systems thinking and some of the unintended consequences. I have described a complex responsive process way of thinking about organisations in this project (page 213), and develop this analysis further in the synopsis to distinguish the contribution and potential limitations of this way of thinking in organisational life.

On reflecting on this project, I notice a return to the concerns I outlined in Project 1 about frequent changes in the nursing management structure and the apparent lack of understanding about the role. Many of the DoNs I worked with in Project 4 were similarly disturbed by the lack of clarity associated with their roles. I outlined in my reflections on Project 1 that I now recognise that each successive cycle of change and reversal involves different circumstances, policymakers, politics, politicians, and constraints.

Several DoNs in Project 4 experienced a loss of work identity and sense of rejection when they were made redundant. As I analysed my projects, power, innovation and systems thinking have been the main themes that have dominated my narratives. In the synopsis I deepen my enquiry within these themes and identify a number of conflicts that I propose are particular dissonances that nurses and healthcare workers are experiencing as rejection within the day-to-day working environment. These include:

- Potential job loss due to the introduction of new ways of working as a result of innovation and change
- The difficulty of getting individuals to commit to organisational visions

- The potential for discrimination against staff who do not share the value systems within the prevailing organisational vision
- The difficulties that managers experience when trying to balance the implementation of central targets against the specific needs of local healthcare institutions
- Changes in the power dynamics between staff who work in commissioning and contracting with those providing healthcare services
- Consumer loss of confidence in clinical professionals through the acts of malevolent nurses and doctors
- The resultant reduction of clinical autonomy of doctors and nurses and the increased regulation of professionals
- An apparent loss of clinical professional power in favour of managerialist approaches to healthcare organisation.

Through examining the redundancy literature in this project, and identifying the dissonances outlined above, I begin to question the nature of the employer–employee relationship. In the synopsis, I will study the prevailing literature on the psychological contract, a familiar concept within the human resource management literature.

Final conclusions

I was attracted to the DMan programme because of the emphasis on complex responsive process thinking. This theoretical stance has provided me with useful insights into the nature of understanding human interactions in organisations and provides an alternative discourse to the systems thinking that dominates the NHS. Rather than viewing one of the central aspects of employment as the psychological contract, I have proposed that complex responsive processes theory offers a new contribution to knowledge in the field of employer/employee relations.

In the current climate of redundancy, NHS staff are questioning their relationships with their employers in an unprecedented way. Themes such as inclusion and exclusion, power, innovation and rejection continue to arise in my work. My original contribution to practice offers a different way of looking at healthcare organisations from what is advocated by many healthcare consultants. I encourage staff to consider how they engage with their colleagues in their day-to-day relationships and how they contribute to the development of their wards and department. I have learnt that I can only provide opportunities for staff to work in this way; they may or may not wish to participate.

The Personal Development Framework was developed to help staff at risk of redundancy. This is of value to other staff groups, and further work is needed to promote its use and evaluation.

Finally, this programme offers an inimitable approach to the reflexive method through the iterative process of sharing research drafts, as well as through participation in the learning sets and large group meetings. Further research is warranted into different paradigms of research networks, to investigate more fully the social nature of reflexivity.

Appendix 1

Publication

Reflective management narrative 3 in Stacey R. D. (2007) Strategic Management and Organisational Dynamics fifth edition Essex Prentice Hall pp. 586-609.

Appendix 2

Web Publication

Retention of Experienced NHS Staff: A Personal Review Framework (2006)
http://www.google.co.uk/search?hl=en&q=personal+Review+Framework&meta

Glossary of acronyms and abbreviations

AHP.....Allied Health Professional – physiotherapists, occupational therapists, podiatrists, speech therapists etc.

CEO.....Chief Executive Officer

CNO .....Chief Nursing Officer. The most senior nursing role based at the department of Health

BMA .....British Medical Association

DH.....Department of Health

NHS.....National Health Service. Publicly funded organisation responsible to the Secretary of State for Health, Her Majesties Government.

HR .....Human Resource

HRM.....Human Resource Management.

PCT .....Primary Care Trust – the publicly funded healthcare organisation that commissions healthcare and provides primary care services

QB .....Queensborough consultancy company

RCN .....Royal College of Nursing, nursing trade union and professional organisation

RO .....Regional Office – old term for a healthcare section of the Department of Health based in a region of England

SHA.....Strategic Health Authority – healthcare section of the NHS based in a region of England. They replaced Regional Offices.

STBoP .....Shifting the Balance of Power – Department of health policy document

WDC .....Workforce Development Confederations – departments that are part of Strategic Health Authorities who allocate funding for healthcare education and training

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