National Healthcare Strategy and the Management of Risk in a National Health Service Trust

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Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of Doctor of Management

January 2005

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ABSTRACT

A central concern of this research has been to understand more about how and why organisations change. My initial research question posed was: What is 'strategy', how does it emerge in health care organisations and how can I influence its development? This is explored within the context of my field of practice as a Director of Nursing in a National Health Service (NHS) Trust. I have approached this enquiry through using a methodology known as *emergent exploration of experience* (Stacey et al., 2003). This methodology is informed by insights from Complexity Science and the theories of complex responsive processes of relating. What emerged through the enquiry were a number of key areas of concern related to national healthcare strategy and the management of risk within my NHS trust. The findings from this research radically challenge the way we are practising together in my organisation in moving from the position of locating accountability for mistakes with either the individual or the system. Instead it is suggested that, as part of our ongoing process of interaction, we co-create what others are describing as a 'system' through our participation with each other. Accepting the notion of co-creation requires us to examine very carefully the influence of our own participation in the dangerous situations that arise in our everyday work, and to acknowledge our own accountability for what emerges. I am proposing that this makes a new contribution to knowledge in this field for two reasons. First, because it explores for what I believe to be the first time the validity of the theory of complex responsive processes in the discourse of risk management in health care. I am proposing that this theory has a legitimate contribution to make in this field of practice, that is worthy of further enquiry and research. Second, in making this shift to a perspective that understands accountability for error as something that we co-create in groups, my thesis poses a radical challenge to many of the activities that are traditionally undertaken when mistakes occur in organisations. Specifically, I have questioned the usefulness of approaches that seek remedies through focusing on individuals outside the context of the group and those that focus on re-engineering what other authors refer to as the 'whole system'. I offer an alternative through describing examples in my

narrative of a different approach grounded in the research methodology of emergent exploration of experience. This focuses on the micro-interactions between participants in groups as a way of understanding the transformation of practice. I am arguing that such transformation may not always be an improvement, because we cannot always accurately predict the outcomes of our actions in advance. This perspective therefore also challenges the assumption made by some authors in this field, who believe it is possible to 'human-proof' systems and thus guarantee 'zero defects'. In seeking an answer to my research question I have therefore moved from understanding strategy as a vision for the future that can be planned and implemented by a few powerful individuals whom others follow to a different understanding. I now see strategy as an emergent phenomenon arising from micro-interactions between people in the present – hence we co-construct our future as the actions we take in the present. From this perspective I have argued we all have the potential to influence what is emerging through our actions, for which we are constantly held to account, through both our inner dialogue with ourselves and our conversations with each other.

Important note:

For the purposes of preserving anonymity, the names of all individuals, departments and organisations have been replaced with fictitious names throughout this thesis.

INTRODUCTION

This thesis *National Healthcare Strategy and the Management of Risk in a National Health Service Trust* has emerged as part of a three-year research enquiry during my time as a student on the Doctoral Programme of the University of Hertfordshire. The methodology utilised in this research is the e*mergent exploration of experience* (Stacey, 2003). The first four chapters present the four projects required as part of the programme of study. The final synopsis of the preceding four chapters is a re-examination of the major themes exploring how my understanding has shifted throughout the projects and to enable me to identify my current position with respect to the major themes of my enquiry. The synopsis also explains the research methodology in more detail and examines how my understanding of this has developed and changed through my experience of undertaking the projects.

In Project One I introduce my area of practice. I examine, through reflective narrative, some of my formative experiences in nursing and through these reflect on the theories that have informed and influenced the nursing profession. I notice how many of these theories which were prevalent in my nursing practice were also important when I moved into a managerial position. I start to question the validity of some of these ideas. It became clear that a major theme of interest in my enquiry was strategic planning. Specifically I pose the question: What is 'strategy', how does it emerge in healthcare organisations and how can I influence its development?

My second project returns to this central theme through exploring my experience of developing a Patient and Public Involvement Strategy. This poses some questions for me with respect to how other authors approach strategic planning. I identify a number of influential writers and present their perspective as part of my enquiry. I come to recognise how these writers are influenced by systems thinking. Throughout my enquiry, this is a body of literature I return to, both because it has been influential in my field of practice and because I am moving to

a different understanding grounded in complex responsive processes, which is helping me understand from a different tradition (Stacey et al., 2000) how and why change happens in organisations. In concluding this chapter, I identify further areas in which I wish to deepen my enquiry, specifically strategy as a mechanism for holding people to account and strategy as emergence.

Project Three, *An emergent approach to understanding strategy and structure through differing perspectives of accountability and performance,* addresses these latter themes in more depth. I write about the very difficult and painful process of restructuring that is occurring in my own organisation. In exploring this restructuring I also draw on theories exploring organisational structures and processes and revisit the theory of complex responsive processes of relating. Through this I come to recognise how this theoretical perspective has a radically different notion of process. I come to recognise the importance of my own participation and how this influences what is happening in my organisation. Specifically this raises issues for me with respect to my own professional accountability – which becomes another important theme within the context of my enquiry.

My fourth project, *Developing a perspective on strategy through working with Clinical Risk Management and exploring the concept of accountability in both approaches,* develops and deepens this enquiry through focusing on strategy with respect to clinical risk and the context of accountability and its significance. I write about my experience with respect to a Serious Clinical Incident in my organisation which could have led to the death of a patient. I become interested in the process we are using to investigate such incidents and seek to understand why it is that, in spite of our following the traditional approach to incident investigations advocated by the most influential writers informing the NHS in this field, things do not seem to be fitting together in the neat way these authors are prescribing. This project proved pivotal for me with respect to developing my thinking and radically challenging my understanding of both strategic planning and clinical risk.

My synopsis revisits and develops my position with respect to how I now make sense of strategy and risk management, developing my thinking with respect to challenging the use of 'simple rules' in the NHS, pointing to the importance of dialectic movement of the process of learning and the critical nature of making mistakes as part of this process. I briefly mention the importance of power and enabling constraints as part of this phenomenon, and also move to challenge strategic approaches that focus on 'whole systems'. This then leads to me stating my final thoughts and position with respect to how this perspective on learning and complexity makes a contribution to knowledge in the field of clinical risk management through a radically different understanding of causality and accountability.

PROJECT 1: IDENTIFYING INFLUENCES AND EXPERIENCES THAT HAVE INFORMED MY PROFESSIONAL PRACTICE AND THE EMERGENCE OF STRATEGY AS A CENTRAL THEME OF MY ENQUIRY

The purpose of this reflective narrative is to identify the influences and experiences in my life that have informed my professional practice and how I work. It also takes account of some of my recent experiences on the Doctorate in Management Programme, and identifies themes and questions that are beginning to shape my enquiry. In order to do this I shall first describe the context of my current post.

At the time of writing I am Director of Nursing at Sometown University Hospitals NHS Trust, an 800-bed organisation that spans three hospital sites. Our budget is around £200 million and we employ 4,000 staff. We provide acute hospital services for a local population, and specialised services to a wider catchment population. I have worked in the hospital since 1993. I started as the Assistant Director of Nursing and was appointed as Director in 1994. My eight years as Director on the Board has proved an enormous learning curve and, on the whole, this is a job that I enjoy very much. I feel passionately about my work, and am fiercely committed to the values and beliefs of the National Health Service (NHS). My underpinning values and beliefs are grounded firmly in my nursing background, based on the fundamental principles of caring for and about people; in Florence Nightingale's words, 'ensuring hospitals do the sick no harm'.

My main interactions at work are with four key groups:

1) The Trust Board, i.e. Executive and Non-Executive Directors.

2) The Directorate of Professional Practice – approximately 30 whole time equivalent staff – which I co-lead with the Medical Director.

3) The Senior Nursing Team, who report to me, and the 1,800 nurses and midwives we have responsibility for leading.

4) Other partners and stakeholders: Primary Care Trusts, Local Authority, Social Services, national bodies, patients and the public.

Sometown University Hospitals became an NHS Trust in 1992.

Having set the context, my next task is to make sense of why I practice in the way I do, and commit this to paper. Initially I set out to write a chronological description of my career. Although interesting from a personal perspective, I found the exercise extremely difficult and the results were far too long. I found it impossible to divorce the insight of recent years from the experiences of some of the earlier stages in my professional development. This made it difficult to accurately remember what I knew, how I felt, and how I practised 23 years ago. With my narrative inevitably informed by experience and knowledge that I could not have possessed at the time, and by retrospective analysis of theories read years later, I unwittingly found myself 'rewriting history'.

A vivid memory which provides an example of what I am trying to illustrate took place on my first ward placement as a first-year student nurse. An experienced Staff Nurse was teaching me how to take a patient's blood pressure. Before we began, she paused and asked me, 'Are you nervous?'. I recall I replied I was terrified. She advised me to 'hold on' to that feeling and remember it throughout my career. She said that soon, taking blood pressures will be something I would not give a second thought to. However, at some point in the future I might become frustrated with a first-year student nurse who was not competent in this skill. She told me that remembering this feeling would help me be more empathetic to their needs. The fact that she diverted my attention to this at this crucial time meant it did stay with me; I still recall details such as the ward, her face, my unfamiliarity with the sphygnomanometer, the stethoscope, and my fear of 'getting it wrong' or hurting the patient when I inflated the cuff. I am also

aware that there are numerous other skills, competencies, theories and knowledge which are now so fully ingrained in my practice that it is difficult to tease out where they came from and why I adopted some and rejected others. In an attempt to avoid the problems inherent in my first narrative, this second attempt will examine my experience in light of two key themes which I believe have been fundamental in developing the way in which I work. These are:

- The process of 'becoming' a nurse and undertaking nursing practice.

- The process of 'becoming' a health service manager/leader.

I shall start by reflecting on my nursing knowledge and experience.

Since I was a child, I have always wanted to become a nurse. The best Christmas present I ever received was my nurse's uniform and first aid kit. I worked hard at school to meet the entry requirements for nursing, and did voluntary work in a local learning disabilities unit. I left school at 18 and started a three-year programme to become a State Registered Nurse at a University teaching hospital in the UK.

Looking back on my training, it is easy to see why I had some difficulty integrating theory and practice – a process I still find problematic. The 'theory' was taught in several week-long 'blocks' throughout the training in the School of Nursing. It is a peculiarity of nurse education that the move across from practice to theory is absolute. The majority of Nurse Teachers cease their practice with patients. This is very different in the medical profession, where the majority involved in teaching remain active in practice and continue to carry a caseload of patients. Even at this early stage of my career, other students and I quickly grasped the fact that our tutors were not up-to-date with current practice, as they no longer worked on the wards.

The teaching methods also made learning difficult: I recall the first two weeks in the 'induction block' consisting solely of the tutor standing at the front of the classroom dictating, direct from a text book, a complete chapter on the structure and function of the heart. Hence the classrooms became for me something that had to be suffered, rather than a lively learning environment. We seldom interacted with the tutor or each other to discuss what we were trying to learn.

Our practical experience was taught through block placements in different clinical specialities, mainly in acute care, as this was a generalist training. However, we were required to do specialist placements in community, mental health, paediatrics, midwifery and another specialisation of our choice. The tensions between theory and practice were further evident in our placements. Rivalry between the School of Nursing and the service side played itself out through the students. Staff Nurses teaching us berated the tutors 'in their ivory tower' and advised that, in the 'real world', things were done differently. Tutors were critical of sloppy practitioners who cut corners and practised using rituals and myth rather than theory and research.

At that time there were still Clinical Nurse Tutors in post, who worked with students on the wards, although they were phased out during my training. We enjoyed working with these individuals, as they did attempt to bridge for us the gap between theory and practice and show how the two could be used together. I recall working with one who was teaching me the rudiments of how to do a bed bath. We also talked with the patient about their disease and treatment. Both myself and the patient commented how much we had learnt and I recall feeling energised by the rapport that had developed between us, as we were all asking questions of each other in order to help make sense of the patient's condition.

I remember the Staff Nurse taking me to one side at the end of the shift to tell me I needn't get any fancy ideas about thinking I could spend up to an hour bed-bathing and talking to patients – I had to remember that this was 'the real world' and we all needed to pull together to get the 'real' work done. I remember

discussing with fellow students how curious it was that there were so many different 'real worlds' and 'real work', that seemed to change depending on who I was with. The notion of what 'real nursing work' involves has intrigued me for many years. There are a few influences that are probably worth noting here with respect to my view on this 'reality', as they have undoubtedly influenced both the profession and, through that, my own practice.

Nursing has its roots in both the church and the army. Florence Nightingale was enormously influential in shaping the nursing profession as we know it today, (Nightingale, 1859). For part of her professional life she was involved in overseeing the care of the soldiers wounded at Scutari. Her *Notes on Nursing* are clearly influenced by this experience, and this is evident through her attempts to introduce a more disciplined approach. Prior to the establishment of her nurse training school, nurses were lower-order figures who were 'handy-women' of the community. They were often paid for their services with gin, and to make their calls they had to walk the streets at night – something a respectable woman would never do. Conversely, the medics were from the upper middle class and well educated – emphasising educational and class differences between the doctors who gave orders and the nurses who took them.

Nightingale's writings often contradict each other. Although she is quoted as saying that the virtue of obedience was 'suitable praise for a horse', her nursing schools encouraged traditional obedience towards the doctor. The influences she derived from religion (such as the terms 'sister' and 'vocation') and from the military hierarchy (duty and the idea of a uniform) also brought with them the expectation of unquestioning obedience (McKenna, 1997).

As a consequence of its religious and military origins, through most of its history nursing has been notably hierarchical. This is slowly changing. When I trained, status and rank were very clearly defined – and indeed this is still true of some hospitals in the UK today. This manifests itself through different uniforms, separate sitting rooms and dining facilities, and formal ways of addressing each

other by rank (for example, Sister Evans, Staff Nurse Smith). This finds some parallel within other professional hierarchies, among which the medical profession is one of the best developed. In being socialised into the nursing profession, we were quickly made aware of these cultural norms, and it was rapidly pointed out to us if we transgressed these.

Being part of this profession was at times tremendously supportive and invigorating. Many of my best friends are nurses, and as friends and colleagues we have many examples of how we have supported each other, learned together and worked through rich and diverse experiences together. Conversely, there are times when the regime proves brutal and dehumanising. I have seen staff and patients humiliated and subjected to both verbal and physical abuse. There have been a concerning number of examples in health care where the sick and vulnerable have been harmed by the very services set up to care for them. Some involve individuals who have abused their position – such as Harold Shipman, the GP who murdered in excess of 200 of his elderly female patients, and Beverley Allitt, the children's nurse who murdered children on a paediatric ward. Others demonstrate a failure of institutional systems to pick up subcompetent practice, such as The Bristol Royal Infirmary Kennedy Report 2001; or institutional abuse, as described in the recent Commission for Health Improvement (CHI) Report into abuse of elderly patients at a Care of the Elderly Unit in Cumbria (CHI, 2001). There is some evidence that this issue is prominent in other institutionalised services such as prisons, religious orders and the army (Goffman, 1961).

A seminal piece of work on the emotional labour of nursing was produced by Menzies (1970). Menzies noted that nursing can be an extremely anxiety provoking activity. As nurses, we deal with many aspects of life that are viewed by society as disgusting or distressing. For example, in Western society, being present when someone dies is increasingly rare, and death is something that is not talked about easily. Nurses deal with the socially difficult or unacceptable – death, pain, excrement – and doing so takes its toll. Menzies talks about 'rituals' that nurses construct as defence against this anxiety. This helps make sense of

some of what I was taught in my training, namely this notion that we should maintain a 'professional distance' from our patients. This, we were told, would enable patients and colleagues to respect us. It was important we did not show emotion. I remember after the particularly painful and upsetting death of a patient to whom I and some other students had become attached, becoming tearful and distressed and hugging some of the relatives. They later sent us flowers and said how this had helped them with their grief because they felt that those looking after their father 'really cared'; but we were all marked down on our Ward Assessment, with comments about our unprofessional behaviour and a note that we would have to 'toughen up' if we wanted to be good nurses.

There is an unresolved tension in the profession as to whether nursing is an 'art' or a 'science'. Throughout my career, this has been something that has caused much debate across the profession. Nursing is a strange eclectic mix of theories and practice. Much is borrowed from other professions and disciplines. A significant component overlaps with the medical profession, particularly with respect to understanding the diagnosis and treatment of disease. This is supplemented with bodies of knowledge from psychology and sociology in an attempt to recognise that there is more to the patient than the disease. Medicine is shifting in this direction too, but I still have recollections of surgeons referring to 'the kidney in bed 4'.

Some authors make the distinction between medicine being about curing, and nursing being about caring (Nightingale in McKenna, 1997). Personally I have found this overly simplistic – my experience is that the act or the 'art' of nursing in itself can be curative. I have also observed that such distinctions seem to cause particular problems for the medical profession. Some patients were unable or unwilling to be 'cured'. I have noted occasions where some doctors viewed this as a personal failure, a failure on the part of the patient, or a combination of both. Similarly, I saw many doctors who cared for patients in a very compassionate way, as I and many other nurses did. I also saw members of both professions who on occasion did not.

The 'art' of nursing is something I perceive as the more intuitive and responsive way in which nurses 'get along' with patients and their daily work. For me, it's about empathy, compassion and a sense of caring. These are difficult things to describe or to teach. One event in my life illustrates the truth of this observation. It has undoubtedly had a significant impact on my own perceptions about what nursing was about, as well as on my own practice.

In 1982, when I was a third-year student nurse, my father, a fit, healthy 52-year-old bank manager, was admitted to a teaching hospital. On visiting him at 11:00 one morning, I was shocked and horrified by what I saw. I'd seen him just a month before, when he had given me away at my wedding – where he was proud, dignified and his usual funny and gregarious self, full of life. I barely recognised the jaundiced, emaciated person lying in the hospital bed. His untouched breakfast sat where it had been left, out of his reach, by the door. Unwashed, and humiliated at being in a wet bed, he was nearly in tears – never in my life had I seen him so distressed. He had been unable to ring for help because the nurses had placed his buzzer out of reach: they had told him he was using it too much. On approaching one of the four staff chatting at the nurses' station to ask for extra pillows to enable us to sit him up to help his breathing, we were told, 'You must be joking, they're like gold-dust round here'. Later that day, after repeatedly asking to see a consultant, my mother and I were taken into a tiny broom cupboard by a young junior doctor. Clearly out of his depth with our questions, he eventually said he was sorry, but my father had cancer and there wasn't much they could do; whereupon he went out and left us in the cupboard. I could describe at length the appalling care he received on that ward; my subsequent letter of complaint stretched to six pages. After four weeks, my mother and I took him home to take care of him properly. A week later, he died. This experience clearly had a profound effect on my life, my attitude to my work, and my approach to nursing. I was determined that I would do all in my power to ensure that patients and relatives in my care would never be allowed to suffer indignity and appalling treatment. The sense of outrage I felt has remained with me ever since.

I found myself reflecting on values in nursing, how they emerge and how knowledge is developed through teaching.[1] In the 1980s, a book written by Patricia Benner (Benner, 1984) helped inform much of my early thinking on how to develop student nurses who by this time I was mentoring through their training. Benner used a phenomenological approach, which identified how novices in nursing need rigid rules, procedures and guidelines to enable them to feel secure within clinical situations. The phenomenological approach (i.e. the study of the meaning of phenomena to a particular individual) taken by Benner was, in itself, quite different from the approach taken in much health-based research. Medical science has tended to follow the Newtonian tradition and seek cause-and-effect relationships through creating replicable studies where the researcher is an outside observer. This has promoted the double-blind controlled trials favoured particularly with respect to drugs trials. However, such methods of enquiry are not so easily applied to nursing, as 'care' is a more abstract concept – identifying specific aspects which could be subjected to scientific enquiry is problematic.[2]

It is probably worth setting the context of my practice at that time. I was appointed at a young age (23) as a senior sister to run a 24-bed acute medical ward with five coronary care beds in a small local hospital. I had moved here from a major teaching hospital, and taken over from a ward sister who had been in post for 28 years. I had been alarmed at the outdated practice being carried out by the nurses on the ward. It also became apparent that hierarchical structures at this hospital were more rigid than anything I had previously encountered. I recall now how, in my first ward meeting with the team, I was met with silence when I asked for people's views on a particular topic I had been talking about. After a few moments one of them put up her hand to ask for permission to talk!

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[1] I have explored this in earlier drafts of this project, but have omitted in the final submission in order to comply with the word limit.
[2] I have explored the nursing theories that inform my practice in earlier drafts of this project, but have omitted in the final submission in order to comply with the word limit.

I quickly came to the view that there were two issues that I needed to address in my role of ward sister with this team. The first was the way in which we communicated with each other and worked together. This needed to be done in conjunction with bringing clinical practice up-to–date; in some way I perceived that the two were mutually interdependent. In my quest for the latter, I made a fortuitous telephone call to the Health Promotion Department and got talking to a sparky young woman who seemed to have all sorts of exciting ideas we could work together on. Interestingly, very few of them seemed to involve my original cause for phoning her, which was to get some leaflets on healthy eating for cardiac patients. She was undertaking a Masters degree in one of the 'ologies', I forget which, and was talking about team-building and assertiveness training for nurses – all of which was very new to our work at the time. These conversations occurred at a time when I recognised how unprepared my nurse training had left me with respect to managing a team of 25 staff. It had struck me just how much my training had focused on the management of the patient rather than on managing other team members. This, combined with the staff expectation (presumably based on my predecessor) that ward sisters were some kind of draconian authoritarian leader – not a style I was keen to aspire to – was causing me difficulties.

My first experience as a 'manager' left me feeling confused. It is only with the power of hindsight now that I can begin to see just why so much of the work we did together proved to be effective. We took time out with the team doing role-play, looking at our relationships with each other, and examining the way we communicated with patients. Enthused by this, I integrated these sessions into our daily work. Instead of sticking with the tradition of lecturing off the ward if I were teaching about (for example) the care of stroke patients, I would put one of the nurses in the bed and asked them to role-play having a hemiplegia. It did seem to shift people's attitudes about caring for these patients. Little details, such as making certain that urine bottles were close to hand, and an alarm bell left within the patient's reach, seemed to significantly improve – something I felt

passionately about, recalling how my father was treated in the last weeks of his life.

Although much of this work is now mainstream in practice, at the time it was viewed as radical and groundbreaking. We presented the work at a number of conferences and had an article published explaining our approach (Evans & Hind, 1987). I recognise now that, in many ways, my need to challenge the established way of 'getting things done' in nursing related to my frustration about our inability to deliver the high standards of patient care that I had come into nursing to achieve. Although I recognise that the notion of 'shared values and beliefs' is fraught with difficulty, nevertheless I do believe that the majority of nurses come into the profession to 'do good' and care for patients. When we achieve this, the sense of euphoria, camaraderie and satisfaction feels very special. When we don't, it often appears that there is a conspiracy of events to frustrate our efforts.

In part, I also recognise now that there were some inherited beliefs that underpinned my practice. We accepted these as absolute truths, and did not challenge the philosophical basis for them. Later, reading crystallised for me why I had perhaps found this difficult. Parse (1987) noted that nursing science has developed within two almost contradictory paradigms. The *totality paradigm* views a person as an organism whose nature is a composite of biological, physical, social and spiritual dimensions. In this paradigm, the environment is the internal and external stimuli surrounding the person, who manipulates and interacts with it in order to maintain health. 'Health' is described as a dynamic state which depends on these four components maintaining a stable balance. The goals of nursing focus on health promotion, the care and cure of the sick, and the prevention of illness. This *totality paradigm* is predominant in nursing. It has its roots in the mechanistic Newtonian and Cartesian views of science and concurs with the philosophy inherent within the medical model. This paradigm has given rise to the theories, research, education and practice in nursing. These tend to centre on helping sick people to adapt and to undertake self-care, interact and retain health. Within this conceptualisation, the authority and main decision-

maker is the nurse. The nurse in practice is guided by a linear nursing process approach where we assess patients' problems, develop a plan of care and undertake interventions and evaluate our results. This paradigm provides research which is quantitative in nature, where causal and associative relationships are testable.

Many of the nurse theorists that fall into this camp (Nightingale; Johnson; Levine; Neuman; Roy; Oram; in McKenna 1997: 101) therefore give the impression that a person is the 'sum of their parts'. The nursing care plans we were writing at the time reflected this; we routinely assessed patients against a series of criteria, which we believed enabled us to assess 'the whole'. Somewhat ironically, we were describing what we were doing as moving away from 'task-centred' nursing, where nursing activities were broken down into a series of tasks (with the most menial delegated to the most junior staff) which were then carried out systematically for all patients. I recall participating in 'back rounds' to attend to everyone's pressure areas, 'catheter rounds', 'toilet rounds', 'drug rounds', and 'drinks rounds'. This way of organising our work encouraged us to remain focused on the task rather than the patient. Menzies noted in her research that this sort of organisation was a defence against anxiety, since it was less emotionally intensive than focusing on the individual (Menzies, 1970). Ironically, the adoption of nursing models, mentioned above, was our attempt to move away from task allocation. Much of what I was reading at the time talked about this as a move towards 'holistic nursing care', which was a big shift in nursing. Although hindsight is a powerful thing, I recognise now the limitations of some of our thinking. But I take heart that we did challenge much of the dominant thinking at the time. Looking back at my early writings and publications, there is a strong emphasis on 'doing things with' patients and colleagues – rather than 'doing things to' them, which had been dominant in my training. Our approach often caused consternation among my colleagues. Some nurses higher up the hierarchy viewed me as a maverick with anarchistic tendencies and believed I was not authoritarian enough with either the staff or the patients. Similarly I recall extremely uncomfortable conversations with medical staff, for whom the principle

of patient choice was an anathema. However, I also made strong allies among some other people.

On reflection thus far, I am struck by just how much my professional training had been built on the following three themes, namely: the strong notion of cause and effect; the chronological nature of my view of the work; and the focus on 'actions' and 'tasks'. All of these have created intellectual difficulties for me in both my nursing and managerial career. Many of the things that I have done in practice have been an attempt to challenge and change some of these fundamental assumptions, which, in my own experience, were often not consistently borne out in practice. For example, some patients seemed to get better *in spite* of, rather than *because of,* professional intervention. Conversely, some patients seem to get worse when textbook care and treatment had been provided to them. In practice, the four-step process of assessing, planning, implementing and evaluating patient care was not so clear-cut. I often seemed to be doing all four activities together, so the distinctions didn't feel real to me in the way I practised. Also, the notion that we were doing this 'to' patients seemed to miss out the important role the patient had to play, both in their recovery, and in how their relationship with me influenced my thinking and behaviour. This model conceptualises communication as 'sending' the ideas to be communicated to another person who 'receives' them. For me this did not emphasise enough the interactive process of my experience. Rather than communication being analogous to a ball being thrown backwards and forwards between two people, I conceptualised it more as some sort of messy force-field between them that was both sending and receiving at the same time. This explains why the notion of complex response process, where the individual and group are both forming and being formed by each other at the same time, resonated so strongly with me when I became interested in complexity science (Stacey Griffin and Shaw, 2000).

These observations are relevant not only to my relationship with individual patients, but also to making the difficult transition when taking up leadership positions within the profession. Many of the texts I was reading at the time about

management were congruent with the observations I had made about nursing practice. They were making strong links between 'cause' and 'effect', intimating that if you did 'X', 'Y' should happen. I quickly grasped the notion of 'rational planning', as it was familiar to me as the nursing process in another guise. I attended project management courses on 'Projects in Controlled Environments' (PRINCE). These courses taught me complex project management skills, as well as how to build up detailed Gantt charts and to identify 'dependent' and 'independent' variables that would affect the outcome of the project. Although developing such plans served as a useful focus for dialogue with other project team members, I sensed that, in many ways, it was this dialogue rather than the plans themselves that seemed to assist in 'getting things done'. The reality was that the goalposts shifted continuously, and often we ended up with a completely different outcome than anticipated. Nonetheless, it was usually more appropriate to the circumstances than something we had predicted we needed months or years before. I became adept at writing project closure reports that conspired with the illusion that it was the *plan* that had led to the outcome. However, interestingly, I had a reputation as being someone who 'got things done' and was focused on 'action and results' – consistent comments on my professional ability through appraisals and references. For me, looking back over my personal development plans, I was noting as long as 15 years ago the importance of being flexible, sensitive to building relationships and seeking opportunities when they arose. I had a sense that this was at least as important as some of the more structured approaches to work that I was being encouraged to use through my nursing and management theory. Hence the tension of pulling together theory and practice was a theme that transcended my move from nurse practitioner to nurse manager.

There are a number of opportunities I took that changed the path of my career. The first was embarking on a postgraduate degree in Nursing Studies at a Metropolitan University, a part-time course. This, combined with the practical experience gained in my sister's post, alongside some of the development work I had been involved in, stood me in good stead for a senior nursing and special projects post. I found that people had different perceptions from myself of what

'good management' involved. Some authors distinguish between 'masculine' and 'feminine' styles. My gender and professional background have led to me practising more in the latter mode. Yet I have found that some people see this as 'soft' and in some organisations there is a perception what is needed is a more aggressive, masculine style. This seems to be characteristics of the government's past and current attempts to manage the NHS – the language used reflects this. It is often expressed in aggressive vocabulary that could also be used to describe physical combat: 'slashing' waiting lists, 'hitting' targets, 'getting a grip' on organisations, 'coming down hard' on poor performers. I noticed this new language and felt uncomfortable with it. At times it was like meeting together as foreigners, when each of you knows only the basic words. Top management talked about the 'bottom line', which turned out to refer to our financial status, rather than any baseline of patient care. Reports spoke of 'Finished Consultant Episodes [FCEs]', which I later found out were patients. I heard talk of 'patient throughput' and felt concern that we were talking about caring for people as though we were making widgets. At the time, government policy was to introduce 'market forces' to the NHS with trusts having to 'compete' for business with each other. I was advised by a senior member of staff I'd need to 'learn a different language' now, as 'nurses' shroud-waving' had no place in management meetings. Making sense of this strange language was something I found difficult. As Weick observes:

> ...sense-making, after all, is about the world. And what is being asserted about that world is found in the labels and categories implied by frames. These words include and exclude. These words matter. (Weick, 1995: 132)

I learned the new language, and found myself translating patient need into reports and business plans so that others could make sense of them. And, to my surprise, I found people did listen, understand, and make resources available. I had discovered a way to explore other people's 'real worlds' and 'real work'. The connection was made through the use of this specialised language.

In reflecting upon my transition from a clinical to a management role, the experiences recounted above are important in terms of shaping my management practice as a Director of Nursing. In trying to track the movement of my thought during this time, I re-read the preface from my first book (Parsley & Corrigan, 1994). Re-reading this work now, I can appreciate how I was beginning to make sense of how change was happening in my organisation by utilising many of the management theories I had learnt about in my Masters programme. Many of these are drawn from systems thinking, which describes a unitary whole which can be understood by dissecting the component parts. Cybernetics uses the concept of an outside observer who manipulates and makes changes to the system. It is clear from my writing at that time that such theories did not explain in totality the phenomena I was experiencing in my working life. I am interested by my observation that some approaches were more useful if used prospectively, while some help form a retrospective analysis. I think what I was struggling with at the time was that many of these approaches present frameworks in the Cartesian tradition – i.e. they deal with spatial relationships and not temporal relationships. These are linear and constant. They did not seem to address what was happening here and now. Similarly, many of these subscribe to the notion of the individual taking priority over the group (i.e. a cognitivist or humanistic psychology view). This belief system is then developed into frameworks that describe how to 'control' groups and organisations, something I seemed keen to do but perplexed by when it didn't work. When things hadn't worked, rather than challenging the theory I concluded that it must be because we hadn't implemented the theories properly. I can see how if one theory couldn't explain something, I'd look around for another that would. I am fascinated that I made mention of the word 'paradox' in my concluding chapter of the book. I think what I was trying to articulate here was my frustration with the theoretical approaches that reduced complex paradoxical phenomena to simplistic 'either/or' constructs.

In seeking further answers to the issues above, I had started reading more widely around the complexity sciences. These had been generating some interest in the health service, and I attended a number of conferences and seminars where keynote speakers were attempting to draw upon chaos theory, complexity science and complex systems to make sense of what was happening in health services (Plesk 2001). In my pursuit for further knowledge, I found out about the

Doctorate in Management at Hertfordshire University. Much of what I read about the programme seemed to resonate with some of the lines of my enquiries. Six months in, I have a sense that the notion of 'complex responses of relating' offers a radically different look at how organisations function which appeals to me. I intend to describe this approach in more depth in my next project, but, to summarise extremely briefly, the authors move away from understanding the organisation of a system as being subject to one kind of causality (whether formative or transformative), or the 'manager/leader' as making human choices according to another rationalist teleology. They argue:

> ...organising is human experience as the living present, that is, continual interaction between humans who are all forming intentions, choosing and acting in relation to each other as they go about their daily work together. This is not the kind of interaction between 'entities' forming a system about which some humans make choices, on which they act as if the system, or the organisation, were a tool they use to do what they need to do. Instead, there is a process of interaction, or relating, which is itself a process of intending, choosing, and acting. No one steps outside it to arrange it, operate on it, or use it, for there is simply no objectified 'it'. There is only the responsive process of relating itself. Instead of understanding 'the organisation' as a tool for humans' design and use, we seek to understand organising, that is, experience as the living present. Instead of understanding human action as Rationalist Teleology split off from a tool structured by Formative or even Transformative Teleology, we want to explore how the detail of human choice and action itself operates as the process of organising understood in terms of Transformative Teleology. (Stacey et al., 2000: 187)

However, this shift in thought also causes me some difficulties. I accept the principles of complex responses and processes; they seem to make sense to me. But if I reject much of what I have learnt through rational planning, what will I do instead? What will my practice look like? Starbuck writes:

> Strategic plans are a lot like maps. They animate and orientate people. Once people begin to act (enactment), they generate tangible outcomes (cures) in some context (social), and this helps them discover, (retrospect) what is occurring (ongoing), what needs to be explained (plausibility), and what should be done next (identity enhancement). Managers keep forgetting that it is what they do, not what they plan, that explains their success. They keep giving credit to the wrong thing – namely, the plan –

> and, having made this error, they then spend more time planning and less time acting. They are astonished when more planning improves nothing. (Starbuck 1993, in Weick, 1995: 54–5)

This resonates with some of my own observations in practice. I often describe how strategic plans and some of the underpinning theories are being used as tools to promote dialogue and create understanding. I have a sense that this was somehow important. So if I am not 'controlling' things, what words can I use to make sense of what I think I am doing? One word that feels useful for me in thinking about this is 'influence'. This is defined as *'to affect somebody or something, esp by indirect or intangible means'* (New Penguin English Dictionary 2001). The word 'influence' comes from the Latin, *influere,* to flow into; in Middle English *in-fle* meant 'flowing in' or a tributary/stream. Influent is also defined as an 'organism that directly affects other flora or fauna in an ecological community'. Influence was also an ethereal fluid supposed to flow from the stars to affect the actions of human beings. This notion of 'flowing in' and 'affecting' perhaps offers an alternative to the notion of 'control'? Pulling all the above strands together, I feel an early question that is beginning to form for me is: *What is 'strategy', how does it emerge in health care organisations and how can I influence its development?*

PROJECT 2: STRATEGY AND INVOLVEMENT IN COMPLAINTS

Moving to a different perspective on strategy

I am on stage with an audience of sixty people. The participants are a mixture of NHS colleagues, patients, relatives and partner health organisations from our local health economy. With me is Harry, a Management Consultant from the 'Working Live' Theatre Company. We are about to start a day using 'forum theatre' on a theme of 'Patient & Public Involvement'.

I shuffle nervously on my high stool. Harry smiles and says a few words of introduction. I feel reassured that we have worked together before. I trust him to help me through the session. The audience quietens down and starts to pay attention. Harry picks up a copy of my job description. He remarks that this says I am responsible for co-leading, with the medical director, the development, implementation and evaluation of our Trust's clinical governance strategy. I glance down at the job description and find myself saying; 'Yes, that *is* what it *says*'. The audience laughs. Harry is asking me what the term 'clinical governance' means. I explain it was a term first used in the NHS Plan as part of the White Paper for NHS reform (Department of Health, 2000). It is a framework, or system, designed to ensure patients in hospital get the best possible treatment, performed by competent staff, so they are cared for safely and not caused any unnecessary harm.

I set some context to this by talking about how public confidence has been shaken by a number of public inquiries that have exposed the fact that such safety systems can be seriously inadequate. Some in the audience nod at the mention of the Bristol Inquiry. This concluded that thirty-six babies died in Bristol Royal Infirmary who ought to have survived. I also mention Harold Shipman, a GP who murdered in excess of two hundred elderly women in his care before he was caught. Many in the audience shake their heads in discomfort or disbelief at the recollection.

Henry's next question is about the term 'strategy'. I explain that one of my intentions was to use today's experience to make a contribution towards the development of a patient and public involvement strategy. Harry asks me why we need one. I reply that it's one of the requirements identified in a report on our Trust undertaken by the CHI. I explain to the audience that this is the regulatory body responsible for monitoring clinical governance in all healthcare organisations. I feel the audience is engaged with some of my intentions about the importance of coming together in a different way. My response to a question from him about 'intention' clearly resonated with a number of people. Some came to talk to me over lunch about how my answer had clarified things for them. I said something like:

> I am trying to find a different way to change things. My experience of traditional approaches to strategic planning on days like this, seems to fall into two categories. We spend time reflecting on what has already happened in the past, often writing it up as some kind of progress report. Then we spend a lot of time 'visioning'. We identify values we wish to have and come up with some kind of idealised notion of the future, then we set objectives that are supposed to help us achieve this. This often involves statements like being open, honest, treating others with respect, etc. Our former trust logo was 'Putting Patients' Interests First'. Yet we know from some of the complaints we get that some patients don't feel as though they have been put first. I feel what these approaches do is fail to focus our attention on what it is we are all actually doing, moment to moment in our working lives.

The day was a very different experience for me than the typical 'awayday' I have just described. Staff are often cynical about documents that come out of such events, criticizing them for being idealistic – or being written by people they say are 'not in touch with the real world'.

The day started and the actors played patients' real experiences within our organisation. In one very powerful scene, they portrayed the same story from two perspectives. One was the patient's story, about a visit to the A&E department which showed how he had difficulty in getting the care he needed. We could see how the bureaucracy in the process led to numerous waits and how he was not listened to by staff. We all experienced his growing frustration with the system. I

found myself feeling angry about it. The second play was the same story but from the perspective of the nurse. We could see the pressure she was under, her own frustration with the bureaucracy, how the patient's frustration was perceived as aggression and made her feel frightened and vulnerable. I felt sorry for her.

What followed involved a number of us in the audience making suggestions to the actors on how the relationships could be improved. Small changes in attitude and behaviour profoundly shifted each scene. What was interesting was that it was often small interactions that seemed to have the biggest effect, for example a smirk, holding a hand, or a particular phrase. This struck me as an illustration of a radically different notion of a linear cause/effect as advocated through other strategic quality initiatives I have been involved with before, such as Total Quality Management (TQM; Crosby, 1984). Such approaches advocate top-down, management-led, prescriptive approaches to change management, and presuppose that greater effort leads to more dramatic change. Yet I could not explain what I was observing on the stage through such a causal framework.

I also noticed a shift in audience perception. For the first time I saw both parties appreciating each other's perspective and working together to explore these. I recognised something about a dramatic process that enables people to stay present enough to identify with the actors, and yet distant enough to prevent them from taking it personally and becoming defensive. The latter is something I commonly experience when working with complainants and the teams they have criticized within my own organisation. Each party often presents their case as 'reality' yet I am constantly finding different versions of the same 'reality' – as illustrated on stage in the plays. This makes it difficult to respond in a way that will satisfy everyone's expectations. I frequently observe that a well-intended gesture is often interpreted as an ill-meaning one.

As I participate in the day and attempt to make sense of what is happening, I find myself constantly drawing analogies with some of the theories I have been struggling to understand on my doctoral programme. What I am observing on the

stage, and increasingly in my everyday working life, is that many of the traditional theories I have attempted to use to help me in my practice are failing to explain the nature of much of my everyday experience. I look again at the micro-interactions occurring on the stage. The actress is portraying Jenny, a tearful and anxious patient who is attempting to withdraw consent for an operation she has not fully understood. A member of the audience is trying out a different approach in an attempt to console her. Weeping, and clutching his arm she exclaims: 'They are going to make a hole in my throat – and I am so terrified.' Colin (a Board member) replies, 'I am not surprised!'

The audience collapses into laughter, as this remark is perceived as somehow insensitive and inappropriate. Yet what strikes me is that the intention behind the comment was just the opposite – he was genuinely trying to convey reassurance and connect with Jenny's suffering. This was a very powerful illustration for me of the enactment of the theories of Mead (1934) and Elias (1989). These authors took a different stance on which relationship has primacy in human groups – the individual or social – and the causal framework through which human action might be analysed. They wrote during the decades in which behaviorism dominated psychology and individual-centered psychoanalysis was starting to have a major impact. So the thinking from this theoretical perspective is that the individual has primacy over the group – the opposite of the stance of social constructionists, who believe that it is the group which forms the behaviour of individuals.

Mead argued that all social animals communicate via a conversation of gestures, with each gesture calling forth a response from another, and that together gesture and response constitute a social act, i.e. an act that has meaning to those gesturing and responding. The meaning cannot then be determined in advance, it can only be known after the act, when the response becomes evident. Mead suggests that self-consciousness arises when as a subject, one becomes an object to oneself – that is, experiencing ourselves from the standpoint of others. As part of this process, we take the attitude of the whole community towards ourselves and it is

through this process that individual and community display controlled collaborative behaviour. This sophisticated social process is unique to human beings because it is possible only through language. Mind and self emerge in social relationships and are, in turn, internalisations of these social relationships. Hence individuals are simultaneously forming and being formed by the group. Mind and self are a product of interaction between people rather than being located within the individual, which is a radically different perspective from that of the behaviourists and social constructionists. The individual and the group are therefore the singular and plural of the same process.

These concepts are relevant with respect to what I see being played out between Colin and Jenny cannot be explained if I think of meaning as something that is going on in a mind, as thought before action. What I am seeing on the stage is that meaning is something that arises and continually re-arises in a conversation of gestures – what Mead calls a responsive process. I see the movement here as paradoxical in that it is both continuity and transformation at the same time, the known and the unknown at the same time, the individual and the social at the same time, all arising in the micro-detail of interaction. This is a radical challenge to the idea that as an individual we always think first and then act, or that with a group of my executive colleagues we 'plan' first and then 'implement'. As I see from the interaction between Colin and Jenny, Colin's planned intervention did not go as he predicted. The accuracy with which we can predict a response to our gestures therefore seems important. Yet it seems that it is the constant surprise and how we respond to those surprises that also affects our ability to communicate successfully. In the event, Colin recovers, tries another approach and this seems to placate Jenny. The ability to improvise when faced with the unknown seems to me to be increasingly important as I reflect on this experience. As I am reflecting on the significance of improvisation I consider a series of recent interactions I have had with someone in the audience, Gabrielle.

Strategy in action – an example

Gabrielle had been a very vocal critic of the Trust after making a very serious complaint about the way she perceived her father to have been treated in our A&E department. The headline was 'War veteran left to die in squalor on floor in casualty'. It was a very high-profile report that featured on national TV and newspapers. I had met her once with the Chief Executive (CEO) and Ward Sister, when we presented the findings of the investigation. She had been a very angry lady and, in many ways, was quite intimidating to all of us.

Coincidentally, a couple of months before this workshop, I'd noticed her at an event organised by the Modernisation Team on Forum Theatre. She is also chair of the Over 60s Action Group and had been invited in this capacity. I hadn't recognised her at first. When I remembered who she was, my first inclination had been to avoid her (it was a big group and easy to do), and I had a sense she felt the same way. I did challenge myself on this response – it seemed pathetic for someone leading on 'public involvement' to take such a stance. However, such a dilemma is illustrative for me of the 'messy business' of getting along day to day and dealing with the feelings and emotions that Stacey et al. call 'getting things done anyway', that is not mentioned in strategic plans (Stacey et al., 2000:3). It is a difficult part of my work. I find writing strategies is easier than engaging with people, especially when the strategies don't seem to produce the intended outcome and people express disappointment or anger as a consequence.

I re-introduced myself and asked her how she was. It was a frosty start and difficult for both of us, and yet I did have a sense that, as a consequence, something changed. She commented it was good to talk in 'less difficult circumstances'. I agreed. We talked about our interest in forum theatre and I explained that my own interest was about using it as a way of improving patients' experience. She was really interested in this, and I found myself inviting her to the day with the theatre group. I wasn't sure if she would attend and was pleased when I saw she had. I made a point of going to welcome her and thank her. What was fascinating was the response from other very senior staff. As soon as they

had spotted her, they came to me immediately. One said, 'Jesus – what on earth is she doing here – she'll have to go!' (rather like my response at my previous meeting). Again, this reinforced for me the tension between the rhetoric in strategic documents ('putting patients' interests first') and how we actually behave in practice. Much of this involves acting into the unknown. I think this is why I am so interested in exploring more about improvisation as used in forum theatre, as a way of addressing relationship issues in organisations. This is very different from many training programmes in the NHS that promote ideas of 'off-the-shelf' approaches for 'managing difficult people'.

The next day Gabrielle sent me an e-mail thanking me for inviting her, concluding, 'We need more of this kind of thing'. This shift in our relationship gave me the confidence to invite her to a personal meeting with myself and other staff to discuss the actions we had taken as a consequence of her complaint – something we seldom do in our Trust. I felt we had learned a huge amount as a consequence, and I wrote to her to say so. She wrote back that she felt 'extremely satisfied… and also that my father (who was a great community activist) would also have been satisfied with the final outcome'. I felt extremely moved when I read this – not least because of my own perception of the terrible treatment my own father received in the NHS. There was something that happened in the interaction with Gabrielle that made this possible in a way that our traditional complaints 'system' seems to mitigate against. I wonder if we have the wrong strategy? Or whether any 'strategy', in the traditional sense of the word, can really explain this experience?

I know, on reflection, that it could equally have been a very destructive interaction; and yet what interested me about all of this is that it is exactly such experiences that help to create and shape a public involvement strategy. Something changed for all of us because of what we experienced. For me, this was more significant than being able to tick a box that we had a written strategy. By working together for a day, in a way that focused very much on the patient's experience, rather than just on an idealised set of objectives, I begin to appreciate

that this is another way of understanding emergent strategies as complex responsive processes of relating. I begin to see that this is very different from seeing the organisation as a 'system', something I find myself discussing when reflecting on this event.

I find something about these experiences challenging with respect to my central theme of 'strategy' in this project. It is changing my thinking about strategy being something that you plan first and implement later. I am struggling to make sense of this or articulate clearly what I mean. However, I am beginning to follow a line of thought that paradoxically attempts to hold together at the same time the notion of planning and implementation. What I observed on the 'Working Live' day seemed to be illustrating that the future course of events are very much rooted in the ordinary everyday interactions between people and the themes that emerge in conversation between them. New ideas emerge, with the potential for creation or destruction. It seems to be impossible to determine in advance whether these ideas will be 'good' or 'bad'; this judgement has to emerge during the fluid process of trying out new ideas. This is a radically different notion of strategy from the one I have held previously, and held by many authors who have influenced my thinking to date.

Some questions about strategy as I experience it in relation to the approach taken by CHI

I am watching the video of my interview with Harry at the Patient & Public Involvement event with the 'Working Live' Theatre Company with my doctoral learning group. I have been struggling to compose a coherent narrative about the event which holds together the paradox of theory and practice. The Professor asks me how I am coming to understand the term 'strategy'. It's a question that both excites yet confuses and irritates me. I have been reading around the subject for a year now and any attempt at a definition around the term or the process seems further away than ever. As well as my own perspective which is developing, I am having to respond to other expectations about what 'strategy' should be. I draw into the conversation other authors' views on the subject. The Collins Dictionary

defines strategy as 'a particular long-term plan for success, especially in politics, business, etc.' This would seem to emphasise an activity that is aiming at some point in the future, the notion of planning as a management tool, and also carries fundamental assumptions about predictability and time. This definition summarises the traditional rational approach to strategic planning I find advocated on a number of management development programmes and in associated reading I have undertaken in connection with my work. These approaches fall into two main groups: strategic choice and contingency theory. I summarise these below.

Strategic choice theory

Strategic choice theory makes a distinction between the formulation of a strategy and its implementation. Authors in this field typically advocate setting goals, planning the actions required to achieve them and making forecasts of the consequences of these actions. Ansoff (1990) presents a strategic success hypothesis stating that the firm's performance will be optimal when:

- The aggressiveness of the sequence of actions undertaken by the firm matches the level of turbulence in its environment
- The responsiveness of the firm's capacity matches the aggressiveness of its actions
- The elements of the firms capability are supportive of one another

He distinguishes five levels of capability and maintains that these can be identified in advance of acting by strategic diagnosis. This implies that predictability is possible.

This group of theorists fall under the wider umbrella of scientific management, describing techniques such as management by objectives, or other prescriptive tools. This is underpinned by Taylor (1911), whose implication is that there is a 'right way' to manage certain situations. Not all authors agree with this approach.

Contingency theory

Contingency theory substitutes the 'one best way' approach for the 'it all depends' approach. This is grounded in research which identifies that success is not

correlated with a simple set of factors (Berns & Stalker, 1961; Woodward, 1965; Lawrence & Lorsch, 1967). They propose that the effectiveness of a particular organisational structure, culture or sequence of actions is contingent upon a variety of factors. Of these the most significant are:

- The environment (particularly the market)
- The size of the organisation
- The technology it employs
- The history of the organisation
- The expectation of employees and customers.

These theorists postulate that success is secured and a good organisational fit is made by matching its strategies and structures to its situation. Examples are often given citing mechanistic bureaucracies as appropriate for stable environments, or flexible organic structures for turbulent environments, for example Child (1984: 1).

I comment to the group that I can see why I have found such models seductive. They put me, the manager, in charge. They instil in me a confidence that I have some kind of control within my organisation. They enable me to talk with colleagues in a meaningful way about the kinds of activities we need to spend our time on. Such models feel comfortable and familiar and I have used them extensively throughout my career. Yet increasingly I find a growing sense of frustration that they do not fully help me explain my work experience.

I describe my recent experience with the CHI in which I found myself reflecting that such models were not always delivering outcomes in the way these authors describe. One of CHI's assessment criteria is that there should be a clinical governance strategy and supporting strategies for their seven core components. There is a clear requirement that this should take the form of a written document. There is an expectation that this document should include aims and objectives, some sort of mission or vision statement, timescales and an implementation plan.

CHI then use this as part of the review process to see to what extent the plan is being realised in practice.

The CHI report commended my Trust on our wide range of activities involving patients and public. It noted that our patient's advocacy service had been held up as a 'beacon' in the NHS Plan. They also noted with concern that we did not have an overarching strategic document for patient and public involvement, and marked us down accordingly in their score. They commended us on our Information & Technology Strategy that had been developed in partnership with the local health economy, but noted that more progress needed to be made on putting this into practice.

On thinking about the CHI report, and talking about it with colleagues in the room, I find myself wondering about the emphasis placed on strategic documents, what I see happening in practice and the apparent cause-and-effect relationship that is assumed between the two. If there is a cause-and-effect relationship, how did we achieve so much on patient and public involvement in my Trust without any strategy whatsoever? And how is it that, though we have an Information & Technology Strategy, it has yet to make a difference? This returns me to the 'think then act' or 'plan then implement' dilemma I described earlier. In practice, things did not seem to be occurring in this order.

In raising these questions I can see that what I am beginning to do is challenge some of the assumptions that CHI are making about strategy in organisations. I reflect on the literature in an attempt to understand where some of the assumptions CHI seem to be making might have come from. It would seem that the approach being taken by CHI is grounded in strategic choice theory. This makes a distinction between the formulation of the strategy and its implementation. It is assumed that organisations change successfully if powerful individuals identify the right intention of the overall future shape of the whole organisation and specify in enough detail how this is achieved. The cognitive basis of this theory is clear. Autonomous individuals are assumed to be able to

model their organisations from the position of the objective observer. They therefore see the organisation as a cybernetic system. Such a systems ability to predict the future is crucial to control an organisation that is understood in this way (Stacey, 2000: 52).

I can see that if CHI believe this is how organisations function, it makes sense for them to look for strategic plans, to set targets, and assume a cause-and-effect relationship between the two. With this perspective, it would make sense to hold the powerful few who are believed to be able to develop and implement such plans to account when they fail to materialise. It also means that if 'my' strategic plan fails to deliver it must be because my plan, or the way I implemented it, was 'wrong'. This is very powerful in terms of allocating blame to a few senior executives. In the case of the NHS, staff turnover at this level is high. It is easy to see why. But what if it is the underpinning theory that is at fault, rather than these individuals?

This insight leads to a brief discussion with my colleagues about the recognition of how powerful strategic choice theory is in the NHS. I also see that if I am to follow this line of enquiry I need to explore more deeply other perspectives from writers who contend the validity of this approach.

What other authors are saying on strategy

Concept of configuration as a development of the ideas of contingency and congruence

This approach is concerned with 'getting it all together' (Mintzberg, 1989). Such authors claim to radically challenge strategic choice theorists. Configuration is usually described as a pattern of structure, culture, strategy control system features or other organisational features appropriate to a specific environment. These are then used to classify organisations.

For example Miller (1986) identifies:

- Small firms in niche markets with simple structures in fragmented industries
- Large machine bureaucracies in stable concentrated industries with high entry barriers pursuing cost leadership strategies
- Organic 'adhocracies' where the strategy is differentiation through innovation in embryonic or growth industries
- Large companies pursuing diversification strategies in mature industries with divisionalised conglomerate structures.

Proponents of this approach use these assumptions to make prescriptions about how to design systems to deliver the strategy. This typically includes the establishment of a functional hierarchical bureaucracy. Having identified a reporting structure of an organisation to fit a particular strategy, other authors move to identify the cultures, attitudes and beliefs that people within the organisation need to share in order to realise that strategy. For example, Handy (1981) identifies four cultural categories:

- The power culture
- The role culture
- The task culture
- The person culture.

Other authors categorise the strategic style of organisations. Mintzberg & Waters (1985) identify eight styles of strategic management which they relate to the kind of environment that managers face. Mintzberg (1991) also distinguishes between five types of organization: simple structures, machine bureaucracies, professional bureaucracies, divisionalised structures and 'adhocracy'. Other authors describe different ways of categorising strategic management style (Miles & Snow, 1978; Goold & Campbell, 1987).

Some authors do pay attention to managing uncertain situations. Weick (2001) is significant since he treats strategy as improvisation. Hamel & Prahalad (1989) have conducted research into Western and Eastern concepts of competitive strategy. They describe two contrasting models: the Western one that centres on

the problem of maintaining strategic fit, and the Eastern one focusing on the problem of leveraging resources. The emphasis of each is different. The Western focuses on trimming ambitions to match available resources, the search for advantages that are inherently sustainable, the search for niches, the reduction of financial risk, consistency between corporate and business levels through conforming to financial objectives. The second emphasises leveraging resources to reach the many unobtainable goals, accelerating organisational learning to outpace competitors, a quest for new rules that can devalue the incumbent's advantages, reducing competitive risk by ensuring a well-balanced portfolio of advantages, with business corporate consistency coming from allegiance to a particular strategic intent.

In reflecting on these different approaches and the distinctions between them, it strikes me that all are struggling with the notion of teleological causality or, 'Why do things become the way they are?' in organisations. I can see that answering this question becomes crucial. I mention it here since it seems to me that strategic choice theory assumes the future is predictable and there is a 'right way' of doing things that will guarantee success. In this case strategy is determined in advance and merely requires careful execution to guarantee results. Contingency theorists take account of a wider range of factors which they say determine the type of strategy that should be employed. The management role is therefore to analyse the type of organisation and then design a strategy and organisational structure that is appropriate. Again, this also suggests there is a 'right way' of proceeding. This is done in response to the perception of organisational need and demonstrates more flexibility than the strategic choice model.

Those mentioned in the third group of theorists pay attention to the human relationship issues and make reference to organisational cultures. Again, there is often an assumption that, if one can determine the 'right' organisational culture, success will follow. There is a belief that such cultures can be engineered into organisations by powerful individuals. Hamel & Prahalad (op. cit.) draw attention to the difficulties of maintaining a competitive advantage based on only the tried-

and-tested business mechanisms. They place emphasis on taking greater risks and setting stretch targets, again, assuming such approaches will deliver the 'right' outcome.

I can see that the NHS, like industry, is struggling with the notion of how to constantly improve organisations. I see elements of this kind of strategic approach coming through in NHS policy – particularly with respect to setting stretch targets on issues like waiting lists. The call for 'modernising' the health service seems to be struggling to answer similar questions to those raised in industry – i.e., Where do new ideas and creativity come from? How can we build these into our strategies? As I recap on these alternative perspectives to strategic management, I reflect on my comment in my narrative on Gabrielle about our strategy for handling complaints and the fact that 'the system' seems to impede the kind of interactions I described.

Benefits of systems thinking

When I link strategic theories, systems, Gabrielle's complaint and the approach of CHI, I see that what unites the theories described is that all these authors describe organisations as a 'system' of one kind or another. I appreciate that, as with scientific management, systems thinking has enhanced and developed understanding in management. Scientific management assisted in efficiency gains, and systems thinking has contributed through emphasising the importance of interaction and the consequent design of regulatory procedures which have helped secure reliability and continuity and an improvement in self-regulation in organisations. Second, through thinking in terms of interconnections and raising awareness of causal links that are distant in space and time, managers are alerted to the unintended and unexpected consequences of their actions. Finally, the awareness that managers themselves are also part of the systems they are identifying and designing can lead to greater attention to matters of participation and ethics (Stacey, 2000:81).

Yet in spite of this appreciation of some of the uses of systems theory, I feel a sense of growing frustration in my writing at this point as I struggle with these complex theories and wonder why I felt it was important to explore them here. I am increasingly concerned that the dominant discourse in the Health Service as I am experiencing it seems to be constructing a kind of reality in which participants talk about what is happening in practice as if it really is a system. If I take this perspective it is easier to see why I might spend a lot of my working time writing strategic documents, setting targets for others who have to implement them and measuring to ensure progress has been made. I assume others will follow the plan. It could also invite those above me to assume that, if the plan goes wrong, it is the fault of the planners. I am beginning to sense that this approach is very powerful in terms of holding individuals responsible or, more specifically, a framework for allocating blame when mistakes occur. For me at this point in time, there is one area of my work which seems to be so fraught with relationship difficulties and the notion of 'blame' that I feel compelled to write about it as a way of trying to reconcile a notion of 'strategy' with what is happening in my daily life.

Complaining about Complaints

I am rapidly concluding the meeting I am chairing, as I have a train to catch for another one in London. My mobile phone rings. It's Mike, one of my team. 'Can you talk?' he asks. Sensing from the tone of his voice that something is wrong, I immediately say yes and leave the meeting to find a private place to talk. 'It's Complaints', he says. 'Gretel says Kevin has gone ballistic.' My heart sinks, and I swear silently to myself. Here we go again, I think. I listen to Mike and feel a rush of sympathy for him. It's the usual story: some letters have gone to the boss for signing and they have been rejected. It's not just one or two, he says wearily. He sent the whole pile back. I know that Mike and the team have worked really hard on these. In order to improve on the rejection rate over recent months we have been introducing increasingly complex quality assurance (QA) processes. We have agreed that the final draft of every letter also comes to me for checking, which has led to a massive increase of my own workload.

I ask, 'Why have they been sent back?' Mike has only had a quick look at them. Some are typos, he says, and others he needs to look at more closely. I ask what it says on the others and he hesitates. Some have just been overwritten in heavy pen and underlined – 'It doesn't say what is the matter with them', he says. He continues: 'This one says, "If this has been QA'd, then I'm a Dutchman"'. I pause to seek clarification as the line is bad. Mike repeats this and we are both silent for a moment. 'Listen Karen,' he says, 'I really think I ought to resign from the acting post – I feel this is getting really personal and I am beginning to think that no matter what we do it will never be good enough.' He apologises for the typos and is angry with himself for missing them. One was an incorrect date which I had also missed. Some of the letters had not come for a final QA to me as the team were anxious that if they did, they would breach the twenty-day deadline for response – a national target.

Mike makes two main points to support his belief his resignation is needed. There has been an exchange of e-mails between the boss, the team and himself with respect to a very angry patient who had become very aggressive in the complaints team office. The team had been terrified by this individual who had demanded reimbursement for some property that had been lost. The boss had refused to sanction payment (rightly in my view, as there was no proof the items had been lost). The team were extremely agitated by this gentleman and had the perception that senior management either did not understand how dangerous he was, or did not care. The e-mails exacerbated the situation and I see the relationship between all parties deteriorating still further. I think Mike senses this. In some way I think he feels that the rejected pile is as a consequence of the boss feeling angry with him about his e-mail. I know the boss is – he has e-mailed me about it and his tone indicates he has taken offence and views Mike's approach as insubordinate. I can see why. I find myself seeing both viewpoints and being able to empathise – things never seem to me to be as black and white as everyone else sees them once I start asking questions. I also see the team's view. They seldom meet the boss –

dealing instead through his PA. They say she has told them he won't meet them to discuss complaints – he wants to see me and the Medical Director next month.

Mike also has a concern that the team will never be able to write letters to mimic the style of Kevin's PA, Gretel. A number of the letters coming back have clearly been edited by her and he feels this demonstrates the boss's lack of confidence in the team. He is quite serious about resigning, saying he will just have to live with the dent to his professional pride and go back to his previous post. I am alarmed by this recent turn of events. I had felt he was growing well into the post and exhibited a degree of enthusiasm that I had not expected for the complaints part of his work. I had seconded him in because of his expertise in Clinical Risk Management (CRM) and had been surprised by his innovative ideas on how to improve the complaints process. But what had really surprised me was how he was engaging with the complainants in some of the joint meetings we did together. I had pigeonholed him as being better on analysis and synthesis of audit and risk-related issues and strong on teaching. Yet he was doing well in coaching skills and quite sophisticated counselling-type situations, which I had not anticipated. I found myself feeling responsible for his collapse in self-confidence, as I had encouraged him to take on the role. I was also extremely anxious about the consequences if he was adamant about going back to his former job. The complaints are consuming a disproportionate amount of all the senior team's time and energy. If he pulled out now, this would compromise the whole service still further. The team's morale is rock bottom for a number of complex reasons. I felt that Mike's support was keeping them going and I thought if he left most of the small team would soon seek jobs elsewhere. In our ensuing conversation I attempted to rebuild some of his confidence and convince him that resigning was not necessary.

The team meeting

Mike, Ellie and I met the next day to chat through difficulties and plan what to do about them. They show me their action plan and talk me through the numerous process steps they are working through with the team to improve things. I am

struck by their dedication and professionalism. They have some really good ideas. They have also clearly been working hard with a demoralised team. Building confidence and capacity appears to be a problem. We all express exasperation that the new systems we are bringing in are taking a long time to get going. The quality of the complaint investigations in the directorates is still poor, in spite of new guidance scoping the questions more carefully. Time scales are not being met and it is impossible to meet the national standard (responding to complaints within twenty days), as the investigations are not completed in time. Even within the complaints team itself, agreed initiatives such as fast-tracking 'easy' complaints, and prioritising those coming close to the twenty-day limit, do not seem to be being followed. Inevitably the conversation turns to the skills of those within a comparatively new team.

What I don't share with them at that point is a series of e-mails and conversations with the boss, who has become increasingly exasperated with the poor quality of letters he is being asked to sign off. We all share his concern – they are all poor. He has told the Medical Director and me that unless we 'sort it out' within six months, he will take it out of our directorate and put it somewhere else. This has clearly added to my own anxiety about recent events. The boss refers to complaints as our 'Achilles heel'. I have a sense of déjà vu and reflect inwardly on the history of this function. The function has bounced backwards and forwards between the CEO's office and my Directorate several times. Each time the move has been an attempt to resolve what has been perceived as poor performance. What on earth keeps going wrong?

I keep thinking back to a comment from one of the professors on the Doctorate in Management programme. He drew our attention to the importance of seeing organisational issues as fluid phenomena that need to be managed rather than thinking about them as problems that can be solved. He said:

> Those who get immobilised and defensive and angry in organisations are those who see the world as a place filled with problems that can be

> solved...problems do not behave in that way... they tend to repeat themselves... problems are simply moments in interpretation of process.

This resonated profoundly with me, as I see we have developed a pattern of dialogue over the years where we think about complaints as a function that can be 'fixed'. I am again beginning to see that many of the difficulties that have been exposed through my narrative are grounded in a way of thinking that is based on systems methodology.

Complaints and systems thinking

Our problem solving is clearly based on systems thinking in a number of ways. Targets are set (for example, the twenty-day response time). We monitor and report against these. This acts as a trigger to attempt to bring targets back within normal levels if they fluctuate from the norm. We have taken quite a mechanistic view in attempting to understand the 'root cause' of what went wrong with the system (i.e. a cybernetic system).

In reading around systems thinking in more depth, I discover that systems theorists are not all linked to the cybernetic model. I mention them here since I feel it is important to appreciate the distinctions and note that there are other approaches to understanding organisation in the NHS. These are very different from the current discourse I have described that underpins much current policy in the NHS, which leads to us adopting our strategic approach to complaints management as a cybernetic system.

Learning organisations/dynamic systems

Other authors describe different ways of understanding organisational change. The notion of 'a learning organisation' has been written about extensively over the last decade. The main difference between proponents of learning organisational theory and strategic choice theory lies in their definition of interaction. The former see interaction in systemic terms, but the systems theory is systems dynamics rather than cybernetics. However, both share a cognitivist view of human nature, and the way systems dynamics is interpreted as feedback

structures retains an essentially cybernetic perspective on control (Weick 1979, Senge 1990).

I see that both strategic choice and organisational learning theory use systems theory in a way that retains a link with cybernetics by seeing systems dynamics in feedback terms. The theory of human nature is heavily based in cognitivism, but in the latter group a constructivist's slant is introduced in that mental models are used to explain how features are selected for attention – thus involving construction rather than purely representing experience. Humanistic psychology is relied upon more strongly than in strategic choice theory. So in this model, our approach to complaints would place greater emphasis on changing people's attitude and behaviour or changing their 'mental model'. Current policy documents are replete with the notion that organisations can and should 'learn lessons' from complaints and incidents. These ascribe human characteristics to an organisation that is described as if it were an organic entity. Others challenge this notion as nonsensical, citing evidence that such analogies are simply not valid (Stacey, 2003).

Open systems

Von Bertalanffy (1968) has postulated the notion that all organisms, as well as human organisations and societies, are open systems. They are systems in that they consist of a number of sub-components that are interrelated and interdependent on each other. They are open in that they are connected to their environments, or suprasystems, of which they are a part. Each subsystem has a boundary separating it from other subsystems, and systems have boundaries between other systems. Open system theory in itself allows for a completely different view of human nature than the cognitivists and humanists. Greater emphasis is placed upon conscious processes, the effects of anxiety and the ever-present possibility of defensive and aggressive behaviour. The notion that humans behave rationally and altruistically is challenged and the capacity for learning is viewed as fragile. Attention is focused on power and dysfunctional behaviour in a way that the cognitivist and humanistic assumptions of other

theories seldom acknowledge. Open systems theory also pays more attention to the micro level than cybernetics and systems dynamics through paying attention to the subsystems of which the whole is composed. Insights from such models would involve me working with the team to understand what is happening in the power relationships that leads to the kind of behaviours I have described. It places less emphasis on 'redesigning' the whole complaints process (something the government is currently attempting to do) and more on the micro-interaction.

On reflecting on these theories, I sense that problems seem to arise when we start talking about the human beings within these processes as if they were a system. This is profoundly different from human beings using systems in their work. It is evident from my experience that human beings do not automatically follow instructions, as the often cited example of a cybernetic system, a central heating system does. Yet what we have done in response to many of these 'problems' is attempt to set greater and more prescriptive rules.

People as parts of a system?

During my conversation with the boss, he had said that if he moved the complaints function, it would not be with the same people and specifically mentioned the complaints manager. Sharon had been appointed into the post several months previously. She had worked in a more junior position within complaints at the time of the merger, and was previously a very experienced Sister in A&E. Two team members from the Sometown University Hospitals NHS Trust had left when we merged and the other post holder at the Anytown end had also gone. Sharon acted up into the new post for three months with a PA who was already undergoing a capability procedure due to poor performance. The whole complaints function had been decimated. She was the only applicant for the post which had been widely advertised. Complaints is not a popular speciality and team members burn out quickly as a consequence of dealing with the anger and frustration of patients and staff alike. She had been appointed because her interpersonal skills are excellent and the panel had been impressed by her creative ideas around how to take the service forward. It was recognised that she would

have development needs, as her letter-writing skills needed improving and she had not run a complaints team before. My perception from my own interactions with her, was that she had the capability to develop into the post. Unfortunately, because of the sheer volume of workload and vacancies, she had not been able to take any time out for her own development, particularly around letter-writing skills. She herself was becoming frustrated because she was so busy trying to 'fix' things that were going wrong that she rarely had a chance to put her new good ideas into practice.

Partly playing devil's advocate, and based on my dealings with Kevin, (where I experience he often makes threats but seldom carries them through,) I ask him in my one-to-one meeting if he wants me to sack Sharon. This was because in an earlier e-mail he wrote that if he moved complaints out of my directorate, performance issues would need to be addressed with individuals and 'staff will be re-deployed or contracts terminated'. I make the point that if that is the solution we do not need to move the whole function. I can sack or redeploy them. He immediately replies that is not what he wants and seems shocked at the suggestion. I wonder what else he could have meant by his e-mail. Still, I am pleased I have forced the issue since from my previous experience of how he works I know he is unlikely to raise it again for a while.

I am thinking of this as I am discussing the problems with Mike and Ellie. They are of the view that we have not given Sharon a proper chance. Mike shows me the figures he has been collecting. For the first time in a year, the complaints team was fully recruited. Although new members needed development and induction, in the month where they had a full team, the response rate went up to seventy percent. This has fallen off again since because of sickness and leave. I agree with them it is inappropriate to blame one individual for a process that is dependent on so many different variables. Since we have not been able to give her the development agreed as part of her induction, or a fully inducted workforce with the capacity needed to run an expanding service, we agree it is much too early to form a view on her performance in the role. In writing this, I see how

powerful systems thinking is in my work. We talk about individuals' 'performance' as though it were a faulty gearbox. If we replace an individual with a new one, everything will work well again.

We update the latest action plan and agree some deadlines. Many of the actions involve strengthening the process and systems for managing complaints. The team has started process mapping and looking at some time lines in order to improve performance. Mike will monitor these. We also express our exasperation with the QA process. A problem seems to be that all of us have a different perception of what a 'good' complaints letter should look like. We also have different ideas about what needs to be covered by the investigation. This is mirrored all the way up the line by everybody who QAs and changes responses. Those writing the letters and reports are becoming increasingly discouraged and demotivated as there is a lack of consistency about what they are being asked to produce. They want training on the 'right' way to write a letter or report. This proves impossible to give, because we all have such divergent views. Indeed, they are pointing to inconsistencies from those of us who QA the letters ourselves. When the boss, myself or other senior team members send letters back, and it comes back for a second time to QA, we have often changed things we had not altered originally – which means it has to go back to a third cycle. We conclude (somewhat illogically I now think as I write this) that we all need to tighten up on the QA process.

The QA process of the letters is a spectacular example of how this way of thinking cannot yield the results it intends. Adding more checking steps into the process seemed to cause more stress within the system and people felt increasingly under pressure. We discovered that there was no 'right' way of writing a letter. I do not mean the issues of grammar, spelling, etc and a generally coherent response. I am talking more about the complexities of one person's perception about the kind of letter a complainant would want to receive.

The complexity is further compounded since it is not only the complainant who will have a view on the letter but the staff that are being complained about. There is a precarious balance in many responses between addressing the patients' concerns and ensuring staff complained about are also justly treated. It is often impossible to judge, in the absence of any other witnesses, whether or not (for example) a doctor was rude to a patient. A doctor may threaten to take legal advice if we apologised on his behalf, if he views this as unnecessary. Yet without some kind of apology, the patient will see it as a cover-up, feel affronted and suspect we haven't believed them.

The seductive idea that we can 'fix' complaints by introducing a 'perfect' system is one that I am coming to the conclusion is not helping us explain what is happening. I do believe there is much we can to do improve our internal processes. Spending so much time QAing and patching up bad work prevents attention being paid to the relational aspects of working with patients and staff on a case-by-case basis and beginning to put things right. Yet as I read more around systems thinking I note that one strand of this discipline seems to attempt to address the weaknesses I have described when applying systemic ideas from natural science to human critical systems in organisations.

Critical systems thinking

Early systems theorists (cybernetics, systems dynamics and general systems theory) have been criticised for implying that organisations are like organic physical entities, with clear boundaries, structures and functions, because this limits the domain of effective application. Concerns were also expressed at hard systems theorists describing individuals as deterministic thinking machines and ignoring the aspects of emotion, conflict, politics, culture and ethics. Hence the critics of hard systems thinking were taking a much more social perspective. West Churchman (1968, 1970) focused on boundaries and ethics: Ackoff (1981, 1994) focused on interactive planning and Checkland (1981, 1983) developed soft systems thinking. He argued that very few real-world situations allowed one to think of systems with clearly defined goals and objectives. I describe critical

systems here since I see that the main approaches to strategic management are based on systems thinking. Therefore it is important that I understand how this thinking has been evolving and what the implications are for my practice.

There has been a movement away from a realist to an idealist view of systems. These authors do not postulate that a system actually exists, but that systems can be understood as mental constructs. To qualify as systems, mental constructs would need to constitute meaningful wholes produced by interacting ideas, beliefs, habits, values, etc. They describe the construction of systems models to facilitate the process of creating solutions to problems and changes to organisations and societies. As it can be seen, two forms of causality are applied to such models – firstly the model that follows the rules of interaction. Secondly the constructor of the model somehow stands outside to construct the rules. No paradox is noted, thus soft systems thinkers think in terms of causal dualisms, as do hard systems theorists. In hard systems thinking, process means interaction between real parts to produce a system. In human terms, process is straightforward interaction between people in which they together produce a real system of which they are a part. In soft systems thinking:

> ...process means interaction between ideas, values, power positions and so on, to produce whole conceptual and value systems, or paradigms. Social and mental interaction between people is thought of as producing conceptual wholes of some kind. (Stacey, 2000: 193)

In writing this I can also see some influence of second order soft and critical thinking systems upon the CHI approach. I see an ideological position in relation to improvement, patient freedom and liberation, and participation of patients and staff. They seem keen to develop the social and participative aspects of decision making and problem solving in organisations. I see this illustrated when they make reference to the importance of our Board having a 'vision' for the organisation. This for me creates an interesting paradox between mixing hard and soft systems theory. Thus on one hand they stress the need for a powerful few to set a vision and direction, while on the other hand espousing values of public participation.

To conclude here, I see some parallels between the assumptions made about reasons for 'failure' of the complaints department and our zero star rating in national league tables. In effect we are describing both as a cybernetic system. We are talking about our complaints department and Trust as if it really is a system. Targets and objectives are derived from the NHS or local strategic plans. Hierarchical structures establish detailed sets of procedures for measuring and comparing outcomes, with systems being designed to monitor movement towards the detailed objective. Softer elements such as belief systems, power and management style are also prescribed in much the same way. Under such a belief system the logical conclusion if it appears not to be working is to change the management team, to sack those 'in charge' or 'design in' a new set of cultural values through a new 'vision'. There is a growing discourse in the NHS that is challenging the validity of such approaches. This is led by a group of writers who claim that the science of complex adaptive systems (CAS) offers radically new insights into strategic management that overcome the limitations of other authors cited earlier.

Changing thinking in the NHS? – A complexity perspective

Two years ago I attended an Institute of Quality and Healthcare conference in Bologna. I had signed up for a one-day mini-course with Paul Plesk, as a number of colleagues had strongly recommended this after hearing him speak before. I was interested in attending as I had heard he had a lot to say about chaos theory and complexity science. I had also heard that he was advising the Department of Health on a modernisation programme, and since this was likely to inform future policy this raised my curiosity further. His presentation style was flamboyant and entertaining and I recall a number of us being excited about some of the ideas he was proposing. It did seem to offer us some kind of alternative way of making sense of some of our experiences in organisations. Plesk appealed to CAS as a mechanism for offering new and different insights into how change happens in organisations. Plesk is becoming recognised as an authority on the subject in NHS circles. I was curious that so few people in the audience challenged the

ways in which he validated his insights into managing change and strategic development in organisations through appealing to CAS. However, since this is a field very few of us were familiar with, it was perhaps not surprising.

I have discovered that complexity science cannot be treated as though it were a monolithic consensus, although this is what many writers do. Aside from the fact that nearly all authors call for thinking about management as a self-organising system that produces emergent outcomes as a replacement for mechanistic thinking, the range and spectrum of both the science itself and its interpretations by various writers is vast. Such writers appear to draw on three strands of complexity science:

- Chaos theory (Gleick, 1988; Stewart, 1989).
- Dissipative structure theory (Prigogine 1997; Prigogine & Stengers 1984).
- The theory of CAS (Reynolds, 1987; Ray, 1991; Gell-Mann, 1994; Holland, 1995).

Having read more widely around the subject I was interested to see how these compared with some of Plesk's interpretations. Since this seemed to be important with respect to my central theme of strategy and making sense of my narrative around complaints, I undertook a critique of an article he had written in an influential book *Beyond the Quality Chasm* (Plesk, 2001). What I found fascinating was that ideas that on first hearing had appealed to me and felt relevant to my practice, I now challenged strongly with respect to his interpretation of complexity science.

I recognise that part of this reaction is due to my thinking being influenced by other authors, notably Stacey, Griffin & Shaw (2000). In this book I was fascinated by their exposition of the theme of 'teleology'. It was not a word I was familiar with. It stems from the Greek word 'telos', which means the goal or end for the sake of which an act is understood. The proponents of a complex responsive processes approach describe teleological perspectives as falling into two categories (Stacey et al., 2000:14). First, some kind of movement into the

future is assumed – with a key distinction as to whether their movement is considered to be toward:

- A known state; or
- An unknown state.

Second, they seek to establish the reason for the movement into the future through asking, 'For the sake of what is a phenomenon moving?'. They distinguish whether it is assumed that the phenomenon is moving towards the future in order to realise:

- Some optimal arrangements
- A chosen goal
- A mature form of itself
- Continuity and transformation of identity.

Stacey identifies five causal frameworks to answer the above questions in different ways. These include:

- Secular natural law teleology
- Rationalist teleology
- Formative teleology
- Transformative teleology
- Adaptionist teleology.

The first three of these frameworks assume movement towards a known future state, but each has a different reason for that movement. The final two assume a movement towards an unknowable future. I connect this back to my observations on the strategic theorists earlier – and the struggle with the question of why organisations become what they are. I see that the different answers they have to this question affect the assumptions they make on the shape strategic planning could take. I can see I need to answer this question for myself if I am to validate my own approach to strategy. If the future is unknowable, how can I plan for it?

I undertook a critique of the article by Plesk in order to explore which teleological perspective he is taking in what he describes as 'a theoretical framework for

approaching the design of complex systems and its practical implications' (Plesk, 2001: 309). I concluded it would be unfair to criticise him for not paying attention to teleological cause, since this was clearly not an issue he sought to address in his paper. Yet this causes difficulty for me since I feel he contradicts some of his own arguments as a consequence. He cites CAS as indicating that the future is unknowable; he is critical of systems designers who design complex human systems as if the parts and behaviour are predictable, and notes that fundamentally they are not. Later in the article he cites Holland (1995) and the Darwinian notion of survival of the fittest (i.e. adaptive teleology). He uses this as validation for his belief that you can enhance the spread of 'good ideas' and impede the spread of 'not-so-good ideas'. Yet this implies that one can know in advance whether an idea is good or bad – a notion I would challenge. Later in the paper he advocates the adoption of 'simple rules'. This is formative teleology – since it implies a blueprint or plan that is already enfolded. He states, 'self-organising innovation occurring in the healthcare system suggests there is an implicit set of simple rules already in place.' This strikes me as inconsistent with his argument of an unpredictable future. He then shifts to a rationalist teleology by suggesting that certain individuals can change the rules and asks, 'Who should take on the role of continuing to evolve the plan as the CAS plays itself out?' (Plesk, 2001: 317).

What he does not do is explain how these hidden 'simple rules' came to be there, or how they can be discovered, or why he thinks certain individuals can change them. My understanding from the thinking on complex responsive processes of relating, and using a strand of complexity science known as dissipative structure theory, is that the 'rules' emerge as a result of human, local interaction. Because they emerge, they therefore cannot be predicted.

Understanding the importance of teleology

As I reread the list of five causal frameworks and reflect on Plesk's article, I instantly make a connection with my first work experience with the 'Working Live' Theatre Company as part of the Doctorate in Management programme. I

have been struggling enormously to understand why an understanding of teleology is in any way relevant to my practice. If I am honest, I was struggling even to remember the definitions of the different terms, which sounded very academic. I had been quite ashamed about my struggle and was worried I was going to show myself up on the programme. I had convinced myself that everybody else understood it. This was playing on my mind as we were watching a series of short plays produced by 'Working Live'. The format was similar to the work we did in Anytown, with the audience making suggestions to the actors on how to change the scenes. I found myself becoming increasingly frustrated with the management consultants in the audience. It seemed to me that they had a prescribed way of dealing with situations which was very alien to my own way of working. I watched as one went onto the stage to execute the proposals suggested. I must confess I found it amusing to watch her surprise and frustration as other people failed to act as she predicted. She seemed genuinely perplexed by this. Others in the audience then started contributing. Suddenly I had a moment of illumination. It struck me how we were all talking as if there was a 'right' way of dealing with the situation. Somehow by re-rehearsing it we would get improvement. I understood this to be formative teleology – where it is believed we are moving towards a known state, the future already enfolded and therefore in someway predictable.

Yet this form of thinking is not describing what I was seeing on the stage nor does it describe what I see in my everyday life. What I was seeing in front of me, and indeed I now feel I am experiencing in my practice, is transformative teleology. This means a movement towards a future that is under perpetual construction by the movement of itself. There is no final state, only a perpetual iteration of identity and difference, continuity and transformation, the known and the unknown, at the same time. The future is unknowable yet recognisable: known/unknown. What I had initially viewed as a complex academic theory suddenly became important to me because it drew my attention to something I had not seen before. This was that systems theory and complex responsive processes have a completely different concept of 'process' and teleological cause. In

complex responsive processes, the entities are themes that organise patterns of relating. The individual and the group are simply different aspects of one phenomenon – relating. The cause of change is transformational teleology.

So I ask myself if Plesk's plurality of perspectives with respect to teleological cause and application to my experience really matters? I feel strongly that it matters very much in answering my question with respect to how strategy links in helping me understand why things become the way they are in my Trust. In thinking about human organisations I see that Plesk has taken human choice (rationalist teleology) and substituted this for chance mutations (from adaptionist teleology) whilst the 'simple rules' are chosen by him (which is a formative teleological perspective). What this gives then is a causal framework which is effectively the same as the current dominant management discourse, about which Plesk (like myself) is critical, because it is built on the same causal assumptions imported from physics and engineering. Hence, although Plesk uses different jargon and calls for a 'new understanding of design', he still talks about generating 'a good enough plan'. His belief that the answer is 'to create the conditions for self-organisation through simple rules under which massive and diverse experimentation can happen' (Plesk, 2001: 316) is still very much grounded in the notion of systems thinking, and some kind of external intervention by a person or people unknown, which can, allegedly, transform that system. I find myself strongly disagreeing with his conclusions, as I believe this fundamentally misses the point of how a CAS functions. I find that in seeking alternative explanations for this teleological phenomenon, Stacey et al. (2000: 35), Elias (1978), and Mead (1934) postulate a paradox reflected in a different time structure of action. The present then becomes not simply a point in time but also has its own temporal structure.

They explain this in the following way:

> What is happening here is truly paradoxical for the future is changing the past just as the past is changing the future. In terms of the meaning the future changes the past and the past changes the future, and meaning lies

> not at a single point in the present but in the circular process of the present in which there is the potential for transformation as well as repetition. (Stacey et al., 2000: 35)

I ask myself if reflecting on 'time' is relevant here? I feel strongly that it is very relevant, both with respect to critiquing Plesk's article, and to my practice. This is because the notion of time described above is much more consistent with the principles from the complexity sciences, than those of other writers advocating the use of 'simple rules'. For me, the fundamental insight from this is that the past and future are both important, but the root of change comes from the action that is taking place in the living present. In terms of accounting for my practice and professional ethics, this raises profound implications for what I am doing in the here and now, or what I referred to in my last project as 'the real work' or what Stacey refers to as 'just getting things done anyway' (ibid.: 3).

I can see why I am struggling with these concepts. If, unlike Plesk, I can hold the paradox of predictability and unpredictability, this means I have to explore what control means in situations. Taking the lessons from complexity science, I see how this way of thinking is unlikely to mean that a few powerful individuals alone can be 'in control' of their organisations. This is a radical challenge to much of the leadership thinking and the common management discourse. It also raises serious questions about the appropriateness of corporate governance arrangements which place, by and large, sole responsibility for organisational performance with the CEO and to a lesser extent other Board members. It also raises ethical issues for all members of such organisations with respect to their own accountability for what happens in organisational life.

I find myself concluding that Plesk has fundamentally misunderstood many of the key learning points from complexity science. His interpretations overlook what many other writers are saying about the subject, and also appear to misinterpret what many of his source writers are saying (Prigogine, 1997). As a consequence, I feel his descriptions of the interpretation of this in terms of organisational life are also flawed.

Complexity at work

Stacey, Griffin and Shaw (2000) postulate an alternative view, which they are calling complex processes of relating. This is based on a different teleological cause, identified as transformative teleology. The central proposition of transformative teleology is that human actions and interactions are *processes*, not *systems*, and the coherent patterning of those processes is inevitably shaped by the intrinsic capacity of interaction and relationship to form coherence. Hence it is not caused by anything outside of it or 'levels' above or below it. There is no other 'it', other than the actual experience of participants in the living present.

I find this useful when thinking about complaints and incidents in health care and it seems a more helpful explanation for my experience than Plesk, for reasons identified above. In the past, there was an emphasis on blame and finding who was at fault (Kennedy, 2001). Kennedy recommended that individuals should not be blamed for 'systems failures', and there is a strong emphasis now on focusing on strengthening systems that 'fail'. I was pleased to see some attention to this, as ethically I felt uncomfortable with the former approach. My concern now is that there is a danger that we abstract staff as individuals from the process by our tendency to reify the 'system' as if it were a 'thing' with human characteristics. Griffin writes about this powerfully in his book and illustrates how employees use such a defence mechanism to abrogate themselves of any personal accountability for actions taken (by commission or omission) in their working life. They blame 'the management' or 'the system' (Griffin, 2002).

To conclude, I can see that my perspective and understanding on strategy has shifted. Themes have emerged that I wish to explore more deeply in Project Three are:

- Strategy as a mechanism for holding people to account
- The role of systems in emergent strategy.

PROJECT 3: AN EMERGENT APPROACH TO UNDERSTANDING STRATEGY AND STRUCTURE THROUGH DIFFERING PERSPECTIVES OF ACCOUNTABILITY AND PERFORMANCE

Emergence of organisational structure

The atmosphere in the boss's office feels tense and uncomfortable. I look round at my Executive colleagues. We are about to start a meeting to talk about changing management structures in our Trust. We are waiting for Miranda, the new Director of Clinical Operations, who is late. I am feeling intensely irritated by her lateness as this is an important meeting. Mary, the newly appointed Director of Performance Management, comments quietly to me about her exasperation with wasting yet another half-hour as she has so much work on her desk. Other Directors are using the time to catch up on the myriad of things that seem to be happening across the organisation at the moment. I reflect briefly on the events of the last few weeks that have got us to this point, in order to mentally prepare myself for the forthcoming discussion.

I cast my mind back in time to a fortnight previously when we had our first of a newly formed, weekly, one-hour Executive Directors' meetings started at Miranda's request. I am not particularly happy about how these meetings have started. At the first one, Miranda tabled a paper outlining a series of proposals which quite radically changed the management structure. She wanted to increase the number of clinical directorates from seven to ten and remove the role of Directorate Nurse Managers (DNMs). I'd felt incandescent at the latter proposal – not least because she had not discussed it with myself or the Medical Director prior to the meeting. I had not been entirely surprised by the suggestion – I had had a steady stream of worried nurse managers coming to see me in the preceding week as apparently she had been sharing these ideas in the directorate meetings. I had felt this was inappropriate and unprofessional, both as she had not discussed the proposal with me, and because of the impact on the DNMs – who had already had to reapply for their jobs eight months ago when we merged with another NHS Trust. I was also cross at the boss for letting her table the paper. He had read it

and could have anticipated our response. I knew he was unhappy about the proposals too and I felt that he had set her up in the expectation we would reject it. Hence, it would be us rather than him that had to confront her.

I see the DNM role as extremely successful. It was introduced five years ago and I had worked hard to convince colleagues of the benefits of strong, senior, local nursing leadership. The subsequent work produced by this group of managers through the Strategy for Nursing & Midwifery was commended by the CHI. It proved an excellent vehicle for succession planning. Nursing in Sometown University Hospitals NHS Trust now has a reputation of being strong, powerful and effective – something Miranda alludes to and I suspect feels extremely uncomfortable with. From a corporate perspective, to disestablish these posts would be unprecedented – no other Trust I can think of has no tier of nurse management between the Director of Nursing and Ward Sisters.

What is the cause of our 'performance' – the 'structure'? the 'system'? or 'individuals'?

Miranda's argument for the proposals is grounded in her early observations of our Trust and comparisons with the management structure in her previous Trust with which she feels more familiar. She is also understandably concerned that she has too many direct reports to supervise and manage – thirty-two in total. She feels uncomfortable with our directorate 'triumvirate' structure which has a doctor, nurse and a General Manager (GM) working as equal partners to maintain the stewardship of the Directorate. This had been quite a radical proposal by our CEO, and one I wholeheartedly supported in order to develop a diverse senior team who work together to balance financial and clinical agendas, with no one designated individual in overall charge. Miranda feels this arrangement leads to a lack of clear accountability between the individuals, and she wants to rectify the situation. She makes the point in her tabled paper that:

> Within directorates, between directors there is a belief that the current triumvirate arrangements work not because of the structure, rather because of the personal relationships within the incumbents within it.

We debate this briefly in the first Monday meeting. For me, if the personal relationships are working well, this seems to be a fundamental reason for *maintaining* them not dismantling them. I cannot see the logic in the proposals for this reason. Crispin, the Medical Director, also agrees strongly with my view. Miranda's view is that for a structure to be robust there needs to be greater clarity in the job descriptions and reporting lines. This is in part her rationale for changing the structure and responsibilities. She says the job descriptions should rely on clear accountabilities and not on relationships. This is because she believes it may cause problems if individuals leave.

I look again at the sentence quoted above from Miranda's paper. It reminds me of the old adage, 'which came first – the chicken or the egg?'. I find myself questioning the assumptions about cause and effect inherent in her statement. I wonder whether the organisational structure is the causal factor for more effective teamwork, as Miranda is proposing? Or do the working relationships in some way contrive to reshape the organisational structure? It seems to me these are important questions to answer if we are to argue for a proposal that we once again change our structure.

I notice that a particular way of talking about structures seems to predominate amongst the executive team. There is the belief that if we can get the structure 'right' then this will improve organisational performance in some way. We often describe the organisation as a 'system', with the emphasis on getting the component parts working smoothly together. As I see it, this is a dominant discourse in the NHS at the moment. The management journals are replete with references (see Plamping, 1998 and Solberg, 2000) to 'whole systems working' – which alludes to a pan-organisational approach to health care in which acute, community and social care providers work together 'in partnership' (Attwood & Pritchard, 2003). This way of viewing a 'whole' organisation reifies our organisational structure. This has the powerful effect of leading us into a way of thinking about structures as if they were 'things' with attributes of their own. For

example, Miranda says, 'This structure is not delivering the performance we need', and a number of colleagues agree with her. I am coming to see that this way of thinking alienates the people who are working within a structure. This leads to endless conversations about structures, hierarchical charts, roles and accountabilities and how many clinical directorates we need so that 'the organisation' will improve its performance. It seems to me this argument ignores the fact that it is only *people* in our organisation that take action. I am arguing that the organisation is not something that has a 'mind' that can take action to improve our performance.

I am reminded of Dornbusch & Scott (1975) who challenge this way of thinking:

> An organisational design is not a monolithic entity. Any reference to 'the' organisational design is misleading because it makes the 'assumption of homogeneity' (Dornbusch & Scott, 1975: 11)

This resonates with me since I have also noticed that we are talking about different parts of the organisation as 'performing' differently. Some are perceived to be doing very well and others less so. By homogenising our analysis in this way we avoid drawing attention to these distinctions. This is important, since our solutions (in the form of a new structure) assume similar homogeneity. For example, I later establish that it is only two of the directorates that wish to make changes to their nursing structures. One is because the GM herself wants to retain part of the DNM portfolio; and another because the specialist nature of the directorate would like to use the Care Centre Managers. I feel this observation is significant. I note how proposals about structure seem to be arising as a result of individual preferences, prejudices, beliefs and other local influences, which are locally negotiated as part of an ongoing shift of power in groups rather than (as some of my colleagues believe) because we 'design' and implement structure. What is being proposed is the same structure (without DNMs) for the total of ten directorates. I am not persuaded by the arguments that we need ten directorates instead of seven. I think that Miranda has made assumptions about the career aspirations/preferences of the current DNMs and GMs after brief conversations

with them. She presents her arguments and states how the current post holders would be 'slotted into' the new roles. This new structure (she says) would clarify lines of responsibility, reduce the ambiguity of the triumvirate structure, and enable individuals to be called to account and be 'performance managed'.

I am cynical about this. This is the third restructuring I have been part of in five years. My experience has been that each time, similar things are said. Many of the managers involved in these structures are still the same. Yet none of these re-organisations ever seems to lead to much difference about how we speak about our performance, nor do they seem to be able to demonstrate a clear link with improved performance. The directorate teams are said 'not to have a grip on performance'. I have been participating in conversations like this over many years within the organisation. The explanations tend to fall into two categories: we either blame the structure (i.e. the system) or conversely at other times the people in the structure (often ourselves) are blamed for not delivering. So it seems that we have a concern about our performance and what we are trying to establish is who or what is responsible for this. I have come to realise that addressing this concern is a primary aim of this project.

Relationships and their influence on structure

My thoughts return to the Monday meeting with the Executive. Although I feel angry and upset when Miranda tables her restructuring paper, I am also conscious of the importance of maintaining relationships within the new team. I recognise within a split second that I have a choice of actively opposing all of the proposals – something I would feel confident doing if necessary. However, I can also see an early fracture in the executive team being counterproductive only nine months into an organisational merger. A number of us had argued strongly for a Clinical Operations Director. I feel it is important we make it work, as we believed our old Trust was disadvantaged by not having one.

I remember thinking at this point about how crucial my response and reaction to this situation is. I am mindful this is both with respect to the relationship I need to

form with Miranda, the impact this will have on the rest of the team and the outcome of any forthcoming decision on people's jobs and roles. I am acutely aware of my conflicting responsibilities in this present moment, wanting a robust structure for Nursing whilst recognising the importance of my contributing constructively to the newly forming executive team. In searching for how to make sense of this experience, I reflect on some of my reading for the D.Man. programme on how other authors describe this phenomenon. I wrote in my second project about teleology, i.e. the final cause or sake for which our action is understood. I find myself wondering for what purpose we are restructuring? A question I struggled with in Project Two was on how I was coming to understand the theme of strategy if I accept a key insight from complexity science – that the future is paradoxically both predictable and unpredictable at the same time. I struggle again with this question in this moment that for me some things feel familiar and others alarmingly unfamiliar. I turn to Margaret Wheatley to inform my understanding of what is happening.

Wheatley on 'presence'

Wheatley writes about the importance of being present in the moment and learning to live with the unexpected. She notes that being present in the moment doesn't mean that we act without intention or flow directionless through life without any plans. She stresses the importance of attending carefully to the process by which we create our plans and intentions (i.e. structures). She writes:

> We need to see these plans, standards, organisation charts not as objects that we complete, but as processes that enable a group to keep clarifying its intent and strengthening its connections to new people and new information ... healthy processes create better relationships among us, more clarity about who we are, and more information about what's going on around us. With these new connections, we grow healthier. We weave together an organisation as resilient and flexible as a spider's web. (Wheatley, 1999: 145)

I find myself agreeing with her first statement: the notion of a sense of process seems to make more sense to me than some other mechanistic theories of structure which I describe later. However, I find myself challenging Wheatley's

interpretation of how complexity theory, structure and process within organisations. It seems to me from this quote that she is assuming that, through shifting our interpretation of structures and charts to a view of this as a process, something healthy is guaranteed to emerge. This in turn guarantees a resilient and flexible organisation. These observations do not resonate with my experience at work. In complexity science, one of the key insights from quantum theory is that matter is paradoxically stable and unstable *at the same time*. I feel Wheatley idealises one side of what I see as a paradox around creation and stability. She pays scant attention to the negative aspect of destruction and instability. What I have come to see through my reflections on my relationship with Miranda, is that *both* stability and instability are present *at the same time*. I would refute very strongly any suggestion of healthy processes leading to some kind of harmony and stability. That is certainly not how I describe my feelings where I perceived that much of the work I had done in recent years could potentially be destroyed by Miranda's proposed structure. I experience instead that structural changes like these inevitably lead to power shifts – with people often protecting their own self-interest.

Introducing causality

I sense everyone is waiting for me to lose my temper with Miranda and get defensive about the proposals and the way she has handled it. I know it will be evident I am angry and upset, but I take care to lower my voice and speak slowly and clearly – I am keen to appear professional. This is not easy. I *am* angry, but I feel strong in the sense of being able to make my case in more appropriate ways – and not in this meeting. I say I am very concerned about the proposals but as Miranda has not discussed these with Crispin or myself it would be inappropriate to comment further at this point. I suggest we need to have more detailed discussions outside the meeting.

My recollections of the previous two weeks and the first meeting just described are interrupted as I glance again at the clock – Miranda is now thirty-five minutes late. Most of the team is expressing exasperation and I wonder whether the

meeting will go ahead at all. I flick through my notes of last night's meeting. There have been some interesting developments since Miranda's initial proposal two weeks ago. I had suggested that some of us go out for an informal dinner and try and develop some proposals that would work for all of us. This had been moderately successful and we followed it up with another meeting of all the executive team at Ian's, the Director of Facilities', house. Part of the dialogue at Ian's meeting had served to inform Miranda's understanding about the Trust. I had been surprised at just how little she had found out about the organisation or us as a group of people. My own view was that she should have spent longer doing this – it was apparent she had not even asked the boss about his rationale for the structure he had introduced only eight months previously (after being CEO for ten years and consulting widely across the organisation prior to its implementation).

I am interested to see how Miranda constantly attempts to make sense of what she was experiencing by trying to draw analogies with her old organisation. It makes me appreciate just how useful my own organisational knowledge is in respect to getting things done. I have worked here for over ten years and have a very strong network of relationships both within and outside the Trust. I can see that how I get things done is occurring not through the formal structures that everyone seems to be focusing on, but on understanding the informal structures and the power relationships within the organisation (see Stacey et al., 2000: 3). Miranda does not have these yet. This reinforces for me my feelings that the performance of our organisation is somehow connected to the quality of the relationships of those of us working in it, and the history inherent in these. I try to make sense of this observation. In order to do so I turn to my past experience and theories that have influenced my practice in order to seek a greater understanding of this restructuring.

Linear models of cause and effect

Ironically, I can recall a time when I also placed great emphasis on structures. In a textbook I co-authored, I drew heavily on theorists advocating a rational planning approach (Parsley & Corrigan, 1999). Our text is replete with diagrams

of organisational structures and with language that talks about setting a clear vision or mission and cascading this through the organisation. This way of working was endemic in my field of practice at the time around implementing TQM (Crosby, 1984). As a management consultant working for Crosby Associates, I learned that one of the key marketing phrases was that the Crosby approach to TQM would help you get it right first time. I was a strong advocate of Donabedian's approach to quality improvement, based on structure, process and outcome (Donabedian, 1976). I remember how I explained it when I was teaching clinical staff. I told a story about Donabedian being a good cook. I would teach the groups that his outcome was a bit like the picture at the top of a page in a cake recipe. This gave you a clear idea of exactly what it was you were trying to achieve. In order to consistently achieve this, you needed the right raw materials in the correct amounts. Structure was therefore analogous to the section in the cake recipe which identifies eggs, butter, etc and the utensils and equipment you need to make the cake. I went on to explain that Donabedian's process was analogous of the section in the recipe that stipulates how these should all be mixed together. I worked with colleagues to apply this approach to a range of clinical procedures.

I found a similar way of thinking advocated when I attended management courses. Although these no longer focused on clinical tasks, I can see how these ideas were still very powerful in the way in which I and colleagues made sense of what was happening in our organisation. For example, in our meeting, we are all talking about some point in the future in which we will get it right. In order to do this, our attention is focused very much on Miranda's organisational charts. There is then the process component. I recall a question I was asked by a participant in one of my Donabedian/Chef workshops. She wanted to know why, when she had lots of cook books and a state-of-the-art kitchen, nothing she baked ever came out looking like the cake in the picture? A number of us in the group agreed with her and told stories about our culinary disasters. By the second edition of my textbook I was asking myself similar questions about strategic planning. Why was it that in spite of clear goals, management structure and some attempts at

process redesign through TQM, nothing ever came out like we had drawn in the picture? And I wonder, now, why, when we restructured only eight months ago, are we once again thinking we have to restructure to improve performance?

Other perspectives on structure

In seeking answers to these questions, I turn to other theorists. It became apparent as I read what other authors have to say about structures, that there are fundamental differences in the way different organisational theorists view, understand and interpret structure. Some approach organisations from a mechanistic understanding and describe it as fixed and static, i.e. Frederick Taylor (1911) and Henri Fayol (1916). Taylor believed that optimum performance of organisations could occur through controlling the physical activities required to achieve its purpose.

In writing about my personal experience of the restructuring in my Trust, I came to see how powerful many of the assumptions made in systems thinking have become in organisational life in terms of how we understand structures in organisations. A number of authors from this discipline believe that structural change brings about a change in human behaviour (e.g. Senge, 1990).

Senge is important since he was an important part of shifting from early hard systems theorists who took a mechanistic view of human organisations (Optner, 1965). He developed the work of the soft systems theorists who made a radical move to focus instead on the inter-relationships *between* the parts of a system. Senge developed this further by his concept of the learning organisation. He also developed a perspective on structure. For this reason I will explore his work in more depth below.

It is easy to see how, from some of the above standpoints, structural reconfigurations in organisations become important. The intention behind changing structures appears to be to realise the organisation's strategy and somehow improve its performance. This will occur because humans are believed

to behave more effectively as a result of changes in the organisational structures. Other authors have challenged understanding human organisations from a mechanistic or systemic viewpoint (Wheatley, 1999; Plesk, 2001) through exploring complexity theory. In Project Two I began to explore a perspective on organisations that appeals to the complexity sciences in a slightly different way from these latter two authors (Stacey et al., 2000). These authors draw on Prigogine's (1997) theory of dissipative structures as an analogy for understanding human experience, but the each interpret this differently. The section below draws from the above authors to explore their perspective and note how they differ, to help me make further sense of my experience of restructuring.

Senge's perspective

Senge believes that organisation can improve performance by tapping into the commitment and capacity of its staff to learn. He locates learning ability within individuals – but also sees this occurring when teams work together (Senge, 1990). There are some similarities between the emphasis Senge, Wheatley and Stacey put on the importance of interrelationships and an ongoing flow of processes over time that involve human relating. However, here the similarity ends. Senge notes that systems thinking is based on 'feedback' which shows how actions can reinforce or counteract (balance) each other. Senge concludes that this insight simplifies life by helping us to see the deeper patterns lying behind events and the detail. What Senge is doing here is placing emphasis on some kind of 'hidden' structure that 'causes' events in organisational life. I see my colleagues seem to do this in my narrative. I note that this is an example of the kind of thinking that is informing how some of my colleagues account for what they see happening. For example, Miranda says: 'The structure is not delivering the performance', and others agree. From such a standpoint it is easy to see how the logical conclusion to this problem would be to change the structure. Senge locates the ability to spot which structures to change and action the change within individuals. For example: 'To change the behaviour of the system, you must identify and change the limiting factor' (ibid.: 101). Hence he moves towards a standpoint similar to Wheatley (described below) in terms of emphasising how

certain 'actions' by individuals lead to a healthier organisation. Yet I have described already how this was not how I experienced what was happening in my organisation.

Senge concludes that systems thinking shows us that there is no 'outside', that we are the cause of our problems and part of a single system (ibid.: 67). What I see here is an example of a dualism (ibid.: 25–54) with respect to the root cause of change. On the one hand, Senge's case study of organisational life leads him to conclude that when placed in the same system different people produce similar results. Elsewhere, he calls on key managers to determine leverage points that they can identify by observing higher level structures and archetypes, which they can be trained to spot and change. The manager then has to step back into 'the system' and presumably is subject to the same rules s/he has set.

Senge's interpretation would be that it is the structures that are causing our 'poor performance'. His prescription would be that we need to change our thinking (he refers to these as 'mental models') in order to be able to spot the archetypes and leverage points. My problem with this explanation, is changing the way my colleagues think (i.e. their 'mental model') is not possible; I can only try to influence it. I have come to see that such notions discount individual freedom and ability to make choices.

What I see in Senge's approach shows strong similarities to the kind of thinking that is emerging in my own organisation with respect to the restructuring. People attribute two reasons for poor performance. One lies within some underlying structural system. The leverage point or opportunity for change is therefore to alter the structure. Conversely, at other times we locate poor performance within a few key individuals. In these conversations the solution that constantly emerges is usually to talk about the need to 'performance manage' those people, and to discuss what support and development they need. As leaders, we seem to think we are able to stand outside the system, interpret what is going on and make changes to the underlying structure. Like Senge, we are accounting for our

practice in a way that understands organisational life as *both* participating in the self-organising whole (systems thinking, shared visions and teams) *and* the autonomous individual (personal mastery, mental models and visions). My difficulty with this is that in my experience neither of these seem to consistently deliver the improvements in performance that are expected. I see a pattern emerging where our response to this is to seek even tighter, clearer structures, or more detailed approaches to individual management practices (job descriptions, appraisal, personal performance management). On reflection, such a solution seems to have the potential to exacerbate the stifling of the creativity we seem to need to improve our performance. I turn to other authors to see how they address this.

Wheatley's perspective

Wheatley is one of a number of authors who turns to complexity science for new insights into human organisations. She draws on Prigogine's (1997) work on dissipative systems and uses this to draw analogies for human organisations, concluding:

> We are beginning to see organisations that are learning how to use the power of self-organisation to be more agile and effective. There are increasing reports of organisations that have given up any reliance on permanent structures. They have eliminated rigidity – both physical and psychological – in order to support more fluid processes whereby temporary teams are created to deal with specific and ever changing need. They have simplified roles into minimal categories: they have knocked down walls and created workplaces where people, ideas and information circulate freely. (Wheatley, 1992: 82)

In interpreting Prigogine's work in this way I feel she has missed the fundamental importance of the concept of paradox in complexity theory, by implying that simplifying roles in some way leads to better circulation of ideas and information. I resist such 'recipes' for success as my experience of restructuring has not led to this outcome. I note how in this statement she also reifies the organisation as if it were a 'thing' and then describes how 'it' can 'use' the power of self-organisation for its own end. This for me is very different from my interpretation that *self-*

organising systems are just that. No single agent can change or 'use' this phenomenon. Change emerges spontaneously from the interaction of agents within it. This insight underpins the theory of complex responsive processes which I explore below.

In engaging with the ideas of these other authors I see how important the theories we believe in are in informing our management practice, since we use these to account for why we are practising in a certain way. Doctors have seen a drive in recent years for 'evidence-based medicine', i.e. requiring them to account for their practice through drawing on the latest research evidence. Yet I sense a reluctance of many managers to engage in a similar activity. My experience is that theory is seen as something 'academic', something that is 'not real work' and gets in the way of operational management. With this in mind I turn to explore a common concern in my narrative – 'performance'.

What is 'performance' and how do we account for it?

A theme emerges once again in our conversation is that we are 'not performing'. This is a dominant concern, particularly amongst the newer Directors. Some of us draw attention to the fact that we have evolved from a no-star Trust to a two-star Trust. We note we did this whilst managing a Trust merger when we had only half an Executive Team in place. Some present point to our financial position as cause for concern – others of us point out that it is better than most other Trusts and that we are breaking even each year. I also point out that we have had no performance management structure within the organisation since we merged. In the absence of any evidence of performance review meetings, it is difficult to see if we can draw objective conclusions one way or the other about our performance. Again, it strikes me that we are talking about performance as if it were a 'thing' that can be manipulated and controlled from outside. This perhaps explains another key concern that emerges in conversation. People keep talking about a 'lack of clear accountability'. The triumvirate structure seems to raise anxiety because it is felt the job descriptions between three posts have some areas of overlap which 'fudge' the perception of who is really accountable for what.

Miranda feels that, by removing the DNM role (which by now we have agreed will be replaced by a slightly more senior role, possibly two or three who will report directly to me) and re-clarifying the GM and Clinical Director (CD) job descriptions, this will be addressed.

Miranda tables a document from her old Trust, which had been developed in two awaydays with the CDs and GMs. It distinguishes between CD focusing on 'strategic leadership/goals/excellence', and the GM focusing on 'operational/executive leadership/goals/excellence'. The focus of the CD is strategy; and GM, implementation/operations. This is further distinguished by clarifying the role of the CD as leading (the 'what') and the GM as managing (the 'how'). A number of executives like this clarity and feel it is helpful. I reflect that it was probably the conversations that the team in her last Trust had held that were useful rather than this final piece of paper. The notion that this can then be uprooted and imposed on teams that have not had that conversation is illustrative of a wider approach being taken in the NHS: it assumes that 'good practice' from one area can automatically be transposed into another. Again, I think this is grounded in a mechanistic way of understanding organisations in terms of merely taking one part and planting it into a new organisational whole (Taylor, 1911). Miranda's document from her old Trust stressed the importance of making clear distinctions between the roles of GM and CD and reinforcing these through clear job descriptions. The job descriptions would then be the tool by which both were held to account for performance of the Clinical Directorates.

The proposals from our evening meeting are synthesised into a short discussion paper by Scott, our Director of Human Resources, which we agree we will present at our next meeting with Kevin, our CEO.

Reflections on the importance of roles and individual accountability

It seems to me that significant emphasis is placed on individual autonomy and accountability. The paper produced by Scott for our meeting makes reference to this in terms of 'key principles' we describe for 'ensuring delivery', for example:

'clear, simple, unambiguous and strong lines for accountability and responsibility for each individual within the structure'; and 'the need for a single point of responsibility in each directorate'. We emphasise the importance of the strong, singly accountable responsible person in order to be 'in control'. Strong correlation seems to be drawn between the importance of achieving this and our ability to improve our performance. In order to achieve such clarity, great emphasis is placed on the importance of job descriptions.

There is a belief that by redefining the job descriptions and then 'slotting' people into these, this will address and clarify the confusion that we understand people feel surrounds their role. On reflection, this seems to be a very mechanistic interpretation of organisational change. I find it interesting to reflect on our motivation for doing this. In some parts of our discussion we speak of the importance of this in order to 'empower' the GM and CD. Yet in others there is much talk about the importance of doing this, so that we can then 'performance manage' them against the objectives in their job descriptions and 'call them to account' for 'performance'. I note the dichotomy here. On the one hand we think we can define roles that people are slotted into, with criteria in job descriptions that define what to do. They account to us, the controllers and designers of the structure and job descriptions. On the other, we talk of empowered autonomous managers to whom we 'devolve responsibility'.

I am increasingly coming to understand that connections between the concepts of 'accountability' in the public sector and 'performance management' are very important. This is because this way of thinking either locates the 'cause' for good or bad performance in the individual (rather than the group), or abstracts it completely in a higher 'system'. It therefore seems logical from this perspective to fire individuals when 'performance' dips or to blame the system. I am increasingly coming to challenge these ways of thinking – which I will now explore in more detail.

Exploring accountability

In making sense of my narrative in the last section I notice that the words 'account' and 'accountability' occur a number of times. This feels significant for me in order to further understand my practice. It occurs to me that my interpretation of the word may be different from others. As a nurse, professional accountability is something that is emphasised throughout one's career. Pennels (1997) defines accountability as being the 'requirement that each nurse is answerable and responsible for the outcome of his or her professional action' (Pennels, 1997: 162–164).

Nurses are bound by the regulatory body's *Code of Professional Conduct* (UKCC, 1992). As a nurse, I was taught that there are others to whom I am accountable. These include:

- The public (through criminal law)
- My employer (through contractual law, including being answerable for breaches in the contract of employment or job description)
- The patient (through a duty of care and the common law of negligence and through civil law)
- The profession (through the code of professional conduct and other relevant documents

(Dimond, 1995: 3)

Therefore, if a civil or criminal action is brought against me as a nurse I will be accountable simultaneously to my employer, to the Nursing & Midwifery Council (NMC), and to the patient. There are occasions when these obligations can directly conflict. For example, my employer may ask me to do something in breach of my professional code, such as make staff cuts to meet financial targets, which could seriously compromise patient safety. Yet as a Board member I am also responsible for complying with financial governance. I see through this observation that one of the key challenges to my practice that emerges through my narrative is how I have to constantly deal with competing priorities and account for my decisions. Yet those to whom I account have a different set of criteria against which I will be judged. This includes my executive peer group, who, as

described in the narrative, are also all constantly accounting for, and renegotiating, actions taken and actions we need to take. Many of these actions may be in direct conflict with what other individuals view as important.

It occurs to me when writing this that perhaps my professional background has led to a particular perspective on how I understand the notion of accountability. I undertake a brief examination of the relevant literature to see whether any research could provide further insight. I find a study which illuminates a very different set of perspectives on 'accountability' between GM, doctors (both those in clinical management and those not) and nurses (some in clinical management and some not). This study identified:

- GMs hold strongly systematised conceptions of clinical work, financial realism and transparent accountability.
- Medical managers tend to hold individualist conceptions of clinical work, and to support financial realism and transparent accountability.
- Medical clinicians hold strongly individualist conceptions of clinical work, and are equivocal about financial realism and transparent accountability.
- Nurse managers tend to hold systematised conceptions of clinical work and to be somewhat equivocal about clinical purism and opaque accountability.
- Nurse clinicians hold systematised conceptions of clinical work and strongly support clinical purism and opaque accountability.

(Degeling, 2003: 649–652)

Some of the terms above have a specific meaning within the healthcare field. 'Individualist conceptions' refers to the fact that doctors hold themselves accountable to the individual patient they are consulting with. It is interesting to note the doctors were the only group to fall into this category. 'Systematised conceptions' refers to a way of organising clinical work in systematic ways. I wrote in Project One about how nurses are trying to move away from 'task allocation', where they viewed their work as a series of clinical tasks (e.g. observation rounds, drug rounds), towards a system of holistic nursing that focused on the whole patient. One study identified that they did this as a defence

against the anxiety of their work (Menzies, 1970). The Degeling study noted that nurses were extremely good at developing systematised approaches such as integrated care pathways and clinical guidelines. These are effectively 'recipes' for caring for groups of patients with similar conditions.

I am well versed in the arguments for such care pathways. As a patient, I want to be treated as an individual by someone who wants exactly what is right for *me*. Doctors argue strongly that their clinical judgement and autonomy is not to be compromised by 'cook-book medicine'. The counter-argument is that this individual approach has led to wide variations in clinical practice and a 'postcode lottery', where people with the same condition will be treated very differently in different parts of the country. Thus nation-wide mortality rates differ as a consequence. The terms 'transparent' and 'opaque' were also used in the article. The former means accountable to all stakeholders, and the latter means accountable only to their peer colleagues and to patients.

I believe these findings are very important when making sense of my narrative. First, there is a different interpretation of how different professional groups define 'accountability'. These are underpinned by a very different set of professional values and beliefs. This helps to explain that, regardless of what we write in job descriptions, doctors in particular do not see themselves as part of the management structure. This explains why the Medical Director and I were perhaps less convinced of the need for Miranda's proposed restructuring. The notion of managers calling doctors to account is for them anachronistic, since they do not consider themselves as accountable to anyone but their patients and peers. Nor do they consider themselves accountable for anything other than their professional practice. I see this manifest itself when we struggle to meet government targets, such as ensuring that patients do not wait on trolleys in an A&E department for more that four hours. Managers are typically frustrated by what they perceive as limited co-operation from clinicians in achieving these targets. Similarly, clinicians are equally frustrated when the perverse

consequences of such targets leads to patients' operations being cancelled at very short notice.

I note in my narrative that organisational structures are described as fundamentally important in terms of 'delivering the performance we need.' I see now how inextricably the notion of structure is bound to the inherent accountability that comes with it. Organisational charts and job descriptions are powerful tools in showing who is accountable to whom and for what. The other thing I notice is that we seem to think we can define the outcome of our action (i.e. 'design' the structure) and then implement it. Yet I am describing something much less rational and somehow 'messier'. I wonder how I make sense of this. In order to seek an answer, I turn to the work of Weick (2001).

Karl Weick

Weick (2001) identifies that sense-making for an organisation is a retrospective, not prospective, activity. He outlines how people can only understand what they are doing by interpreting what they have done. They impose meaning retrospectively on what they have done. Meaning, purpose, vision and mission all emerge from what people have been doing and are doing – they are not organisation-wide intentions. This approach therefore radically challenges strategic choice theory. It helps me understand how Miranda's analogies with her old Trust structure, and me with mine, are crucial to our sense-making. Weick observes (ibid.) that organisations create and invent their own environment, both in the sense that 'the environment' is their perception of what is happening, and in the sense that their actions impact on 'the environment' which then impacts back on the organisation. This description resonates strongly with me in terms of the 'messiness' in the way our organisational structure is emerging and evolving as we go along. I could not explain this through strategic choice theory. The notion that one individual at the top of the organisation 'designed' the structure and then 'implemented' it was not borne out by my experience. Where I differ from Weick is that I do not believe in a reified notion of an 'organisation' as a 'whole' that

acts and impacts back on itself. I shall explore an alternative explanation, the notion of 'local interaction', as an alternative to this below.

I discovered through my narrative that I came to form a strong view on whether or not what the authors I refer to were saying could be validated by my own experience. This was particularly important in terms of 'accountability'. As a corporate Director, organisational strategy is a core component of my work. The 'success' or 'failure' judgements about 'performance' of the strategy for which I have lead responsibility is a fundamental part of how I and others perceive my professional competence and credibility. Therefore, how I account for why I am practising in a particular way becomes a crucial issue for me. With this in mind, I return to the boss's office where we are still waiting for Miranda to arrive.

Deciding the structure

I am abstractedly leafing through Scott's discussion paper when Miranda arrives. It had been agreed amongst us that Scott would present the paper as he was seen to be more 'neutral'. This was based on a perception that Miranda and I were too emotionally involved in some way. It was also felt to be important to show some kind of unity on the proposals. Scott starts by drawing attention to the summary in the paper and the concerns about the current structure and its ability to support the delivery against the four pillars of performance (activity, money, people and governance). We had felt as a group that it was important for any changes proposed to be seen within the context of improving strategic delivery. A selection from those listed in the report include:

- Accountability and responsibility had become diffused due to the triumvirate responsible for delivery in each Directorate – as a consequence it was difficult to hold individuals accountable and staff were not empowered to deliver.
- Structure can be disempowering, with a regular inclination for issues to be upwardly delegated, often ending up on the CEO's desk.
- The triumvirate arrangement as set up will not enable the issues raised to be resolved (particularly with respect to clarity about accountability) since it relies too much on good interpersonal relationships to succeed.

(Sometown University Hospitals NHS Trust – Internal Paper, 2003)

Various people were chipping in with comments as Scott presented. The boss wasn't saying much. I have learned that this usually means he is not in agreement with something. It was a complex meeting, and I shall contain my narrative around the short interactions which feel to me to be significant.

Ian, Director of Facilities (who has also worked in the Trust for many years), comments that the current structure is not working. He says that within the current structure lines of accountability are unclear. I have been sensing that the boss was finding it increasingly difficult to keep quiet, and something in Ian's comment triggered an emotive response. He was clearly extremely agitated. The boss said he categorically disagreed with many of the conclusions that had been drawn in the paper. He wanted to know why those of us who had signed off the structure in April were suddenly so unhappy with it. Why had we not said anything at the time about these problems that were now being presented? I had a sense he had taken many of the comments personally and as a criticism of the structure he had introduced. I could understand why he would feel like this, particularly as Miranda seemed oblivious to the impact her rather scathing critique could have on those of us who had been around for some time. She had made virtually no acknowledgement of any leadership or achievements of the last ten years. This had irritated me intensely and I was imagining that it must be even more acute for the boss, as the CEO. Yet he had also made it clear to all of us that he expected us to work with Miranda to ensure she had a structure to deliver her objectives. It struck me again that we have a multitude of things for which we are all accountable – many of which conflict. So the conflict between us is hardly surprising – although we seem surprised by it. I also recognise Weick's insight that we won't actually know the impact of our actions until after we carry them out.

The discussion continues with the second part of the paper, which focuses on the key principles of ensuring delivery. These included:

- Clear, simple, unambiguous and strong lines for accountability and responsibility for each individual within the structure.

- The need to streamline the number of staff reporting to the Director of Clinical Operations and the size of the span of control.
- The need for a single point of responsibility in each Directorate.
- The need to ensure that the role currently undertaken by the DNMs is still delivered through the new structure.

Kevin becomes extremely agitated as the list is worked through. I notice he is clutching the document in his hand which is clenched into his fist. As he is making his points he is punching this forward as he is speaking to emphasise the points he is making. He is saying he absolutely and completely refutes the idea that the lines of accountability are not clear in the current structure. The work done on the job descriptions is spelt out word by word, and says exactly who is responsible for what. He says no one has any excuse for not knowing what they are responsible for. Miranda interjects and says this is what the GMs and CDs have told her. He becomes even more exasperated, referring to the interviews of these individuals, in which he says it was made clear what the reporting arrangements were. He concludes: 'It couldn't have been spelt out more bloody clearly – what else do they need, for God's sake: a *Janet and John* book?'.

Everyone is silent for a few moments. Miranda seems tense and nervous and the pitch of her voice indicates to me that she is finding this very difficult. She says she had a meeting with one of the CDs this morning who told her he did not realise he was supposed to be reporting to her and that as far as he was concerned he would still be reporting to the boss. I notice that the boss suddenly stops contributing to the discussion.

Others pick up the conversation and other themes emerge. The first is around how it will affect the current post holders and their respective jobs. We get intensely involved in conversation about these individuals, and where people see them fitting into the new structure. Miranda seems sure that it would be a relatively straightforward process. I feel extremely uncomfortable about this because it undermines all of our Human Resource policies about equal opportunities. I also know she has been talking to them and already promising some of them the jobs they want. I suspect her structure proposals are based on

her early discussions with the key individuals, at which she ascertained some of their own career aspirations. I have a suspicion that, in part, the structure she has drawn up took account of these early discussions and has been designed to appease those who it will affect. I think this is in order that they will be broadly supportive of the proposals. As she sees it, each person will slot easily into one of the posts; she presents a list of what these will be. She and the boss refer to this as a minor 'tweaking' of the current structure – a phrase he uses in presenting these proposals to the Operational Executive and the Trust Board. I have a sense of unease about this, and reflect on why this could be. I recollect the numerous other reorganisations I have been involved in. My experience warns me that when such proposals become public, it seldom becomes a case of 'simply' slotting people into posts. Inevitably, small unforeseen issues seem to become amplified. The second major theme is ongoing, and is around the issue of monitoring and performance. We constantly question each other about how we will measure the impact of the new structure, when this should be done, and how we might quantify this.

The boss suddenly interjects. He is saying that he doesn't agree with a lot of points in the paper, that there is no point wasting time in the meeting by going over old ground. If this is what we want to do, we will take it to the Operational Executive and we can proceed as planned. He makes reference to some reservations he has about it, but declines a request to expand on these further. He says something to Miranda about letting her do what she wants and getting on with it. He elaborates with a metaphor about throwing her in with a rope around her waist and remarks he can pull her in later if it gets a bit choppy. He then runs through a list of action points and draws the meeting to a close.

Reflections on 'performance'

I want to pause at this point to make an important observation about how the word 'performance' seems to be used within the narrative. In my experience, this is used synonymously with our position as a Trust within the NHS league tables. The intention of the government was that this initiative would enable comparisons

to be made between Trusts in order to provide greater transparency for the public, who in the longer term would be able to make informed decisions about where to go for treatment (Department of Health, 1998). In addition, the CHI was established to inspect healthcare organisations to check that there were robust quality frameworks in place to ensure the delivery of safe effective patient care. The government has argued that this approach raises the standards of care and enables Trust Boards to be held to account for performance (Department of Health, 1998). To reinforce this point, the Secretary of State introduced a system whereby zero star-rated Trusts would be 'franchised', with the Management Board being replaced by a completely new team. I see this as reinforcing the point I made earlier about accountability for 'performance' being under the control of a limited number of senior people at the top of the organisation. Yet this is an assumption I would challenge from the basis of my own experience. As a ward sister, I watched the frequent restructuring at the top of the organisation with some ambivalence. We often used to comment that these never made any difference to what happened at the 'coal face'.

I am not the only one to question the usefulness of star ratings. An analysis by Health Economists showed that there was no relationship between star ratings and death rates at acute hospitals. The same study found a highly significant link between mortality rates and the trust performance in CHI reviews. Generally, Trusts with high CHI scores had low death rates, whereas Trusts with lower scores had higher death rates (Smith, 2003). Other authors are also critical of such approaches (Drummond, 1993; Fletcher, 1995; Lewis, 1990). This has also been borne out in other public-sector studies, most recently that the Schools Inspectorate, Ofsted, has had no significant impact on performance and in some cases may have made it worse (Smithers, 2003). Without exception, nearly all of these star-rating indicators are based on quantitative rather than qualitative assessment. They also seem to be based on some kind of outcome indicator founded on a snapshot in time. My concern is that I see these are increasingly viewed as *the* barometer of performance. Other authors also caution against this quantitative bias, with one noting:

> The first step is to measure whatever can be easily measured. This is okay as far at it goes. The second step is to disregard that which can't be measured or give it an arbitrary quantitative value. This is artificial and misleading. The third step is to presume that what can't be measured easily really isn't very important. This is blindness. The fourth step is to say that what can't be easily measured really doesn't exist. This is suicide. (Daniel Yankelovich, as quoted by Smith, 1972: 286)

This quote resonates with me. In my narrative I see I am constantly frustrated by what I perceive to be a lack of attention being paid by my colleagues to the importance of clinical governance and some of the 'softer' elements of management 'performance'. It strikes me as I reflect on these points that this kind of measurement (i.e. the setting and measuring of 'targets' and subsequent presentation in league tables) has a number of very powerful features. First, this kind of approach focuses on criteria that are easily translated into numerical data. Hence, they are mainly around issues such as access to service (how long people wait) and efficiency (how many treatments are given and at what cost). This then creates a bias away from qualitative aspects of treatment by drawing attention away from the experience of patients in emotional and human terms at a time they are extremely vulnerable. In Project One I wrote about the importance of the therapeutic relationship established between nurse and patient, and how research has shown that the caring aspect of nursing is in itself therapeutic and can lead to improved patient outcomes (Benner, 1984). My first concern is therefore that this kind of measurement is limited. I note how our use of language reinforces this; for example, we speak of 'hard evidence' (read 'good' objective, masculine) and 'soft measures' (read 'weak' subjective, feminine). Interestingly, I find that another research study concludes:

> Patients looking for the best chance of a cure would benefit just as much from league tables on the performance of HR directors, showing which HR practices they have implemented and whether they are members of the Hospital Board. In a study of sixty-one hospitals in England we found strong associations between HR practices and patient mortality ... the extent and sophistication of appraisal systems in hospitals was closely related to lower mortality rates, there were also links with the quality and

> sophistication of training and the number of staff trained to work in teams. (West & Johnson, 2002: 36)

I have left this quote and point in, as it felt significant in an early draft to show how 'soft' elements of performance may be equally, if not more, important. Yet I can also see that in doing this I am falling into the same methodological trap of attempting to find a 'cause' for performance through seeking some kind of correlation between two phenomena. Since I am arguing against the validity of this approach, I now see the weakness in doing this – but find it interesting to see how I attempted to construct a response to the initial argument. I see how this is grounded in an empirical methodology – something I return to challenge later.

A second powerful feature of this kind of measurement is that it splits off the 'performance' from the source of action so that these phenomena become distant in time and space. The reification of the word 'performance', along with the reification of the word 'organisation', through describing it as a 'whole system', creates a way of thinking that ascribes human features and characteristics to something that is not in reality human. Like our patients, Trusts are then labelled as 'healthy' or 'critical'. These judgements are made by observers outside of the system. (I note the influence of cybernetics, system dynamics and cognitivism here (Bateson, 1972; Senge, 1990). This way of thinking pays little attention to the possibility that what is being described in this narrative as 'performance' might be the consequence of the interrelated activities *between* people rather than as a direct consequence of it. This creates an alienation of the humans within the 'system' from the consequences of their action. This is a crucial discovery for me, as I see this has profound implications for my emerging theme, 'accountability'. This is because (as evidenced in my narrative) it enables accountability either to be located in some outside 'system' over which we have no control, or at other times within individuals inside this system (usually the Executive) who are held accountable for everyone else's performance.

My third observation on the power of this type of measurement is that what constitutes 'good' or 'bad' performance can create perverse incentives. Solutions

to the time patients wait on trolleys in A&E perversely affect other patient groups, whose operations are then cancelled. We have to deliver on financial, activity, workforce and quality targets, which often conflict with each other. Public and ministerial judgement on performance criteria is constantly shifting. I find myself constantly having to account for my practice to others within the context of these complex and often conflicting criteria. This is the problem when 'outcome' is split from 'process' and predefined before action, and when outcome measures are set by those who will not be participating in the action to meet them. This is an important discovery for me, and something I shall return to at the end of this project.

In making the latter observations, I am also reminded of the contrast of the boss's powerful intervention at the end of the meeting, in which he refuted the idea of the lines of accountability not being clear in the current structure. He referred to the current job descriptions which 'clarify exactly who is responsible for what' and expressed great frustration that the post holders do not appear to understand this. This seems to indicate that even if I write a clear job description and recruit someone to that post, delivery of the objectives cannot be guaranteed. A great deal of effort was put into doing this only eight months ago in the last restructuring. Yet in spite of this, post-holders tell Miranda they are not clear about their roles and how these link with others in the triumvirate. The CDs say that Kevin is their boss, not Miranda (their job descriptions say the opposite). Yet ironically, our conclusion is that it must be the way the job description is written that isn't clear. The solution reached is that we need tighter job descriptions so we can 'performance manage' the people working within them. No one seems to wonder why this didn't happen last time we tried it, or why highly intelligent consultants do not seem to comprehend their job descriptions. Perhaps even more perversely, I now see there is limited discussion as to the logic of how moving four DNMs into GM roles, and reshuffling some of the GMs, is expected to improve performance. Ultimately, it is the same set of individuals involved.

I am reminded, when noting this, of one of my key conclusions from my second project. This was that those interpreting insights from complexity science in a systemic way and advocating the application of 'simple rules' have a fundamental flaw in their argument (Plesk, 2001; see Stacey, 2003). This is that creativity cannot emerge from such systems, since they are only programmed to follow the same simple rules. So on the one hand, we want somehow to improve our performance and encourage new and creative ways of addressing this. Yet on the other, we think we can do this by specifying in job descriptions what people should be doing and predefining the outputs of their work (i.e. setting the simple rules). Hence I see we are falling into a trap outlined by MacLean (2003) in which we explicitly or implicitly subscribe to a view of human action as predominantly rational or normative (or both) and then attempt to link this view to a novel theory of strategic change. MacLean quotes Joas (1996), who makes a strong case for taking a new perspective on action. He is critical of the rational and normative approaches to action and describes a theory of action based on American pragmatism and German philosophical anthropology. He questions the validity of approaches which assume a teleological view of intentionality (such as those described above which set goals and targets before action), instrumental control of the body (such as the belief that we have control over our and others' actions through setting objectives) and autonomy of the individual (i.e. believing 'I can change my mental model' as described earlier, an idea drawn from cognitivism.).

Joas (1996) proposes a framework where:

- Intention is seen as a continually emerging facet of ongoing dialogue between means, ends and context
- The body is seen as the 'source' of pre-reflexive impulses to action and not necessarily as an instrument of the intellect
- Identity is seen as an evolving process in social interactions.

Creative action theory has a different view on intentionality. Joas denies a teleological concept of intention (e.g. what we thought we were doing in the restructuring: we 'design' a structure that we then agree how to implement).

Instead, he describes intentionality as an emergent part of action in which biographical and social context are of paramount importance and behaviour is not necessarily purposive. This for me seems a much better explanation to help me make sense of the 'messiness' in our restructuring. What I now see through my narrative is that, paradoxically, we are forming our organisational structures at the same time as they are forming us. This is a radically different notion from some of the interpretations I outlined earlier, where there was a belief that top management plan the structure and then proceed to implement it. A recent experience brought home to me extremely strongly how insights from this different teleological perspective, also described by other authors within what they are calling complex responsive processes (Stacey et al., 2000), has changed how I account for events that were occurring as part of our restructuring.

Structures as an emergent phenomenon

I was attending a conference which brought together practitioners with an interest in complex responsive processes and improvisational theatre. We were watching a play about a team of staff in a supermarket. The team was experiencing some relationship difficulties. As is customary in forum theatre, the play had stopped at a particular juncture and the audience was invited to make sense of what was happening. One member of the audience described a series of actions which he felt would solve the situation. He said the manager just had to tell the employee he couldn't discuss this issue with her now, so that she would have to wait until his boss came in the morning. He was invited onto the stage to try out his prescribed course of action. It was fascinating to watch what happened. He quickly got sucked into the improvisation and ended up by promising the employee a more senior job. Many of the audience were laughing because we immediately recognised the situation as having resonance with our own experience. This is an illustration of how, for me, the 'sender/receiver' (a rational/normative concept of action criticised by Joas [op. cit.]) model of human interaction does not explain what is happening. If it were valid, things should have gone ahead as he planned. Yet what I saw was a series of gestures and responses in which a new meaning was created and new things emerged as part of

the interaction. No one individual was 'in control'. But, paradoxically, neither was there complete absence of control. Both were enabling and constraining each other's actions at the same time. This is a perspective I have come to understand through drawing on the theories of Mead (1934).

An important connection I want to make with the insight from the conference is how I used this learning to reinterpret and understand my narrative. The right structure is not, I now believe, already 'there', in some way just waiting to be discovered. Nor was there some kind of 'blueprint' created by us that we planned first, and then implemented later. The structure emerged through our conversations and the spontaneous self-organising themes that arose as a consequence of these. Past structures emerged in a similar way, and paradoxically these change again as we make a new sense of them in the present. Our identities are shaped by how we perceive ourselves within the context of this structure. At the same time, we are constantly shaping and changing these structures. Our past experience therefore is important, since we constantly refer back to this to try to make sense of what is going on now.

As a consequence of our different experiences, the Executive Board constantly have to account for and justify our different perspectives and rationale for the restructuring. Like the man on the stage, I have seen Miranda publicly offering people jobs and drawing up tables with other colleagues, with names against posts and salaries beside these. I note in my narrative my discomfort about this approach, which I feel lacks fairness and integrity. I also note a possible cause of my discomfort; namely that in my experience, once news of restructuring becomes public, it seldom becomes a case of 'slotting' people in. This reflects my own experience of other 'messy' reorganisations where people became angry and upset and felt badly treated. In the event people did not end up 'slotting in'. Three people ended up applying for one job and there was a great deal of conflict, anxiety, anger and grief as a consequence.

Without the recent shifts in my understanding from complex responsive processes, in the past, I probably would have located the blame for all of this with Miranda. Of course, there are still some components which I feel angry with her about. But I now account for what has happened in a different way. I now think Miranda's ideas about the structure were not solely formed from ideas in her own head (where I see I was influenced by cognitivist theory). I now think she believed she was acting in good faith based on a number of brief conversations she had had with key individuals in GM and DNM posts. She took a particular meaning from those, which she used to inform her proposals for her structure. When she reflected this back to a wider audience, she got a wide range of responses. These varied from those who were possibly happy with seeing job roles enhanced or a promotion offered, to others who felt the proposals would disadvantage them in some way. I was in the latter group, since effectively it decimated my nursing structure and I believed would seriously compromise my ability to deliver against my own corporate responsibilities. Thus over the next few months there were constant renegotiations around the structure, which I can see were also driven by the importance of power relations between individuals. This was not solely between Miranda and myself, although, interestingly, many polarised the conflict in this way and it was suggested that there was a 'rift' between us. Similarly, for Miranda, what she ended up with was not what she initially proposed. The components of what should comprise the ten new directorates were constantly shifting. For example, I attended a meeting with Miranda where an angry consultant described proposals to take Ophthalmology out of Surgery as 'absolutely ridiculous'. She immediately rescinded. A significant number of her initial plans were also changed as others expressed their views. I shall now outline some of the features of reflexivity, a feature of this research methodology that has helped me gain these insights.

Reflexivity

A fundamental feature of complex responsive processes and their associated research methodology – the *emergent exploration of experience* (Stacey, Griffin & Shaw, 2003) is the importance it places on being reflexive. Shaw stresses the

importance of this as a tool to help us as a participant observer in organisational change. She describes how these insights help us frame views of ourselves in the very act of doing the framing, so that they become reflexive tools to help us as participants (Shaw, 2002: 171). Conversation therefore clearly plays a crucial part in this process. She describes how this influences her practice:

> ...I have slowly developed a practical feel for the process of shaping and patterning communication as I participate. I have a keen sense of the move toward and away from agreement, of shifts of power difference, the development and collapse of tensions, variations in engagement, the different qualities of silence, the rhetorical ploys, the repetition of familiar terms of phrase of image. I try to play a part in this by participating in the conversation in a way that helps to hold open the interflow of sensemaking, rather than as would occur in my absence, to hold open the experience of not knowing. ...I try to shift people's perspective to see that organisational change is process rather than being an end product of it. (Shaw, 2002: 33)

This quote resonates with my experience. For me, the key shift I note is how I account for what I understand is happening in the groups I work with and the wider organisation. I am constantly asking questions of myself and others to get us to try to examine more closely what is happening. I also recognise they are doing so too. For example, I initiated a conversation with Miranda about the perceptions of a rift between us. Starting such conversations is difficult, and managing joint emotions through those is not easy. Yet I strongly believe the meaning and understanding that emerges warrant the effort. I therefore agree with Shaw's observation that such interactions *are* the organisational change (ibid.). This is an important discovery for me through this research, because it is a radically different notion of the linear 'process' than that described by other writers such as Donabedian (1976).

One of these 'rhetorical ploys' I believe I am observing in my own organisation is the avoidance of handling conflict and discussion of power relations. Hence it is easier for people to talk of a rift between Miranda and myself and discuss potential feminine rivalry (a theme that developed significantly, although not expanded here) than engage with either of us on the issues of whether DNM posts

should stay or go. I think this was because that meant they would have to take sides or engage in conflict. In the event, it was left to Miranda and me to resolve things between us. Yet this insight somehow enables me to carry on working with my colleagues and understand what is happening in a different way. I now accept that this is all part of our ongoing interaction – a snapshot in time. I am therefore less focused on blaming individuals, and more interested in how the outcomes arose from interactions between us. Exploring this offers the potential for change.

What I also realise is that the reluctance of other Executives to engage in this debate was also profoundly influential in the structure that finally emerged. This is a phenomenon that is also taken up by Winograd & Flores (1986). They take Heidegger's idea (1958) that people find themselves 'thrown' into ongoing situations and have to 'make do' if they want to make sense of what is happening. They describe situations of 'throwness' in terms of six different properties, which I think reinforce how I am arguing the structure (and accountability for how this arises) is emerging. These include:

- You cannot avoid acting. Your actions affect the situation and yourself, often against your will.
- You do not have a stable representation of the situation: patterns may be evident after the fact, but at the time the flow unfolds there is nothing but arbitrary fragments capable of being organised into a host of different patterns or possibly no pattern whatsoever.
- Language is action: Whenever people say something, they create rather than describe a situation, which means it is impossible to stay detached from whatever emerges unless you stay nothing, which is such a strange way to react that the situation is deflected anyway.

(Winograd & Flores, 1986: 34)

Reflecting on these points, I now see how the boss's comments at the end of the meeting, and unwillingness to explain his objections to the structure, were just as powerful as Miranda's proposals in forming the structure that finally emerged. This has helped me understand the paradox that even by 'not acting' I will influence the outcome and am therefore accountable.

I can see through this narrative methodology that I no longer view what I am doing with a notion of a manager as purely objective observer. I also see myself as a participant, actively engaging in an emergent enquiry into what I think I am doing and what steps I need to take next. As part of this I enquire into the nature of my own complex responsiveness of relating. For example, I am constantly reflecting on my relationship with Miranda and other key members of the team. This provides a profound shift in my practice that is causing me to focus on what I am doing, and how I make sense of what others are doing. This means I have come to value (or not) some kinds of activities more than others.

My interest is on focusing on what we are doing in our daily interaction and trying to make sense of this. Yet drawing attention to these behaviours is difficult, ridden with conflict, and paradoxically can either be creative or destructive. What I find powerful about how Stacey et al. (2000) use insights from complexity science is that it does go some way towards helping me to understand in a different way why these conflicts and difficulties may be occurring. This in turn is shaping how I respond in these situations. So, for example, a priority for me was to try and maintain a relationship with Miranda, to explore our differences and attempt to renegotiate a way of moving forward. Interestingly, six months on from the meeting I described, Miranda was agreeable for me to present new joint proposals from us both at a meeting with the boss that she was unable to attend. Yet the notion of retaining the paradox of creation/destruction being present at the same time cautions me against presenting this as some kind of 'happy ending'. I find it interesting to see how small shifts over time have led to a more trusting relationship. I now see this as part of an ongoing process.

Reflections on this project

What I have come to understand through this inquiry is that what Stacey et al. (2000) are talking about is a completely different notion of 'process' from that with which I am familiar concerning my own experience in using tools based on 'structure, process and outcome' (Donabedian, 1976; Stacey et al., 2000). This is underpinned by a very different notion of understanding 'causes' of organisational

change (which, as I have already demonstrated, are very different from traditional approaches). Hence assumptions about a linear relationship between structure, process and outcome is fundamentally challenged. Managing human organisations is not the same as baking cakes. The outcome cannot always be determined in advance – although sometimes it may be. But of course we cannot know until it happens (Weick, 2001). I now see how structures are concepts that human beings within organisations visualise, rather than physical structures like cooking utensils. These ingredients cannot be mixed together as part of a mechanistic process as described in my narrative when individuals were expected to 'slot in' to their new post. This then radically challenges, for me, the whole notion of 'performance', how we account for it and to what we ascribe its 'cause'. The constant debate on whether to blame the cook (the individual) or the recipe (the system) therefore shifts.

What my insights into complex responsive processes have helped me to realise is that surprise is part of the internal dynamic of the process itself. It is from this process that the actions/outputs arise which are then judged (as 'performance'). Thus I shift from a linear notion of structure/process/outcome to one where both structures and outcomes are paradoxically emerging at the same time as part of the ongoing complex responsive processes of relating. So I don't see that we 'design' a structure first, and predetermine an outcome – my narrative bears out that this is not what I experience in practice. What I see happening instead is emergence of outcome and structure occurring and shifting through the ongoing process – the complex responsive process of relating. This observation highlights a profoundly different distinction between systemic theories, and challenges the assumption that the criterion for selecting a quality action is its outcome (an important consideration for measuring 'performance'). In systemic terms, quality actions are those that produce desired outcomes. Yet if I accept the insights from complexity science, I see that in an unpredictable world, the outcomes of an action cannot be known in advance. What then becomes crucial is how I act and then deal with the consequences. This is where accountability becomes paramount, which was an unexpected discovery for me as part of my enquiry.

'Accountability' and 'performance' have therefore emerged as new central themes for my ongoing enquiry. Stacey (2003) succinctly summarises my response to living with this phenomenon – and answers the challenge I often face from colleagues that these ideas are some kind of recipe for anarchy, or a laissez-faire approach. He notes:

> One is not absolved of responsibility simply because one does not know the outcome. Even if I do not know how my action will turn out, I am still responsible and will have to deal with the outcome as best I can. (Stacey, 2003: 420)

Thus what becomes important is how one improvises as the outcomes arise. .

Summary

To summarise, I started with my theme of 'strategy'. As part of my exploration of my experience through the narrative, I sense I have shifted my understanding of what 'strategy' means to me. I explained in Projects One and Two how I first embraced the mechanistic/rational approach. When this failed to answer all my questions, I found further insights in systemic approaches. As part of this project, two strong themes emerged that seemed important as the newly formed Executive Board struggled to identify an organisational structure to 'deliver the objectives' and 'deliver the performance'. These were 'structure' and 'accountability'. Structures are important in any organisation, since (using analogies from complexity science) it is impossible for organisations to become more complex *without* structure. What this project has illuminated for me is that structures are not something selected individuals design, then implement. Neither are they 'hidden' and waiting to be uncovered. I have come to see, through my writing about my experiences in Sometown University Hospitals NHS Trust, that they emerged (and are continuing to emerge) as a result of everyday micro-interactions between people, where there is constant negotiation/renegotiation – and power plays an important part.

Accountability emerged as important, in terms of both structure and strategy. I am beginning to link strategy and accountability in a different way. I now think

they concern the way I constantly account to others and myself for our actions, in a working life full of situations where priorities conflict and people's perspectives differ. It is what I am doing as I constantly negotiate what to do next. Through uniting all these themes, another emerged – that of 'performance'. 'Performance' is our way of trying to ascertain whether our strategies and structures are making any difference. It is a way of demonstrating to ourselves and others that our efforts are worthwhile, that we have some value, that in some way we are making things better. Yet 'performance', in itself, is for me a slippery theme. I have argued strongly against how this is currently being functionalised within the NHS at the moment. The intention of measures such as star ratings is no doubt an attempt to improve the NHS. Yet what I see in my narrative is how such interventions, paradoxically, will lead to all kinds of local interactions which can result either in improvements, or in a perception that things are getting worse. We set up structures to monitor both 'strategies' and 'outcomes' that seek, with the benefit of hindsight, to make sense of this 'good' or 'poor' performance through locating the *cause* either with individuals, who are then called to account for what has happened, or with a system. This creates a situation where, in order to succeed (since it is based on comparisons), some must also fail. Therefore tied to accountability are strong notions of fear, blame and shame.

PROJECT 4: DEVELOPING A PERSPECTIVE ON STRATEGY THROUGH WORKING WITH CLINICAL RISK MANAGEMENT AND EXPLORING THE CONCEPT OF ACCOUNTABILITY IN BOTH APPROACHES

The experience of clinical risk assessment in the health sector

I am at Shoreham Airport with a group of colleagues who have been nominated as the 'Clinical Risk Pillar Leads' for their Clinical Directorates. The purpose of the day is to introduce them to the concepts of CRM and explore how they might want to develop these ideas within their directorates. We are about halfway through the morning and the presentations thus far have generated some lively debate and interest. Stephen, the Associate Medical Director for Clinical Risk, has caught people's attention by some staggering statistics regarding the level of harm caused patients as a consequence of errors in health care. Stephen's slides summarise some of the key findings from the 1999 National Academy of Science's Institute of Medicine report, *To Err is Human* (1999). This found that medical errors in hospitals in the United States killed somewhere between 44,000 and 98,000 people a year – which he notes is the equivalent of three 747 jumbo jets filled with patients crashing every two days. He states that medical errors kill more people than AIDS, breast cancer or highway accidents. The report also revealed that medication errors reach more than 1 of every 100 hospital patients, and seven percent of inpatients contract a hospital-acquired infection. Although I have seen these figures a number of times I still find myself feeling shocked by them. I also enjoy watching colleagues' responses to this – there is often a tendency to think of CRM as somewhat boring but these figures inevitably assist in challenging some of these assumptions.

Stephen switches on a television documentary I have not seen for some time. This tells the story, through dramatic reconstruction, of a young boy, Ritchie, who was admitted to Great Ormond Street Hospital and who died in agony after Vincristine was mistakenly injected into his spine. The initial thrust of the documentary appears to be one of seeking the individual who was responsible for the mistake. At the time, allegations of manslaughter were made against the

doctor concerned and this raised significant consternation in the medical and national press. Halfway through the documentary, we are introduced to the professor who has been asked to lead an enquiry into the death. He takes over as the main protagonist of the story. Dramatic camera angles accompanied by suspense generating music show the professor sweeping majestically down the corridor armed with piles of notes that will enable him to reach his 'verdict'. He describes how initially he was totally convinced that it was gross negligence on the part of the individual doctor. However, after the arrival of two new piles of evidence, he had begun to piece together a catalogue of errors which had lead him to conclude that it was *'the system'*, rather than the individual doctor, which was at fault.

The programme reconstructs these events in a compelling and emotive way that leaves me feeling extremely distressed. Ritchie's mother describes the terrible suffering he went through before he died and describes some of the events leading up to this. These events are tracked backwards to reconstruct a linear pattern consisting of a chain in which one action led inevitably into another. We learn that Vincristine is normally never stored in the area where the procedure is carried out because of the known risk of mistakenly administering it. But on this occasion, the staff were unfamiliar with the procedure and not aware of the rule about storing the drugs. The documentary takes us back to the beginning and describes how Ritchie was mistakenly fed a digestive biscuit and as a consequence (since food should be withheld for several hours prior to an anaesthetic) his treatment was delayed. At this point, the camera zooms in on a hand holding a biscuit and a voice-over cuts in to inform us: 'What emerged was a much more complex picture of small mistakes all the way down the line leading slowly but directly to Ritchie's tragic death. When Ritchie arrived at Great Ormond Street in the early hours of July 25th 1997, doctors discovered that he had recently eaten a biscuit. This one digestive biscuit turned out to be the bizarre catalyst that defied the hospital's safety procedures and lead to Ritchie's tragic death'.

I am surprised to find myself extremely irritated at the way the film unfolds. Last time I watched it, I recall thinking it was a useful way of moving away from a more traditional approach, initially advocated in risk management where the blame for mistakes is located with the individual practitioner, to one which takes account of problems in a wider 'system'. This is now being increasingly promulgated as a useful framework in CRM. I try to identify for myself what it is I the film that now irritates me so intensely. I conclude it is because:

- The inference that a biscuit can in some way be responsible for the death of a child seems ludicrous to me.

- The latter point seems to me to be a misrepresentation of some of the useful elements of systems theory.

- The documentary postulates a position where the 'cause' of the death of Ritchie lies *either* with the individual *or* with 'the system'. This is a position which I find myself disagreeing with – for reasons I shall explore further in this project.

Understanding clinical mistakes as described in the traditional discourse on CRM in the NHS

On reflecting on the narrative in my prologue, I can see how clearly some of my learning and exploration around strategy and accountability in my previous projects has shifted my understanding and interpretation of the issues that arise in my everyday working life. Looking afresh at the video, rather than accepting its conclusions as before, I find myself questioning the way the arguments are presented. I am noticing how this particular way of thinking is reinforced through the frameworks that practitioners like myself are being taught to use. One such framework, which has recently been issued to NHS Trusts for guidance with respect to suspension of medical staff who are involved in clinical incidents by the National Patient Safety Agency (NPSA), is shown in Figure 1.

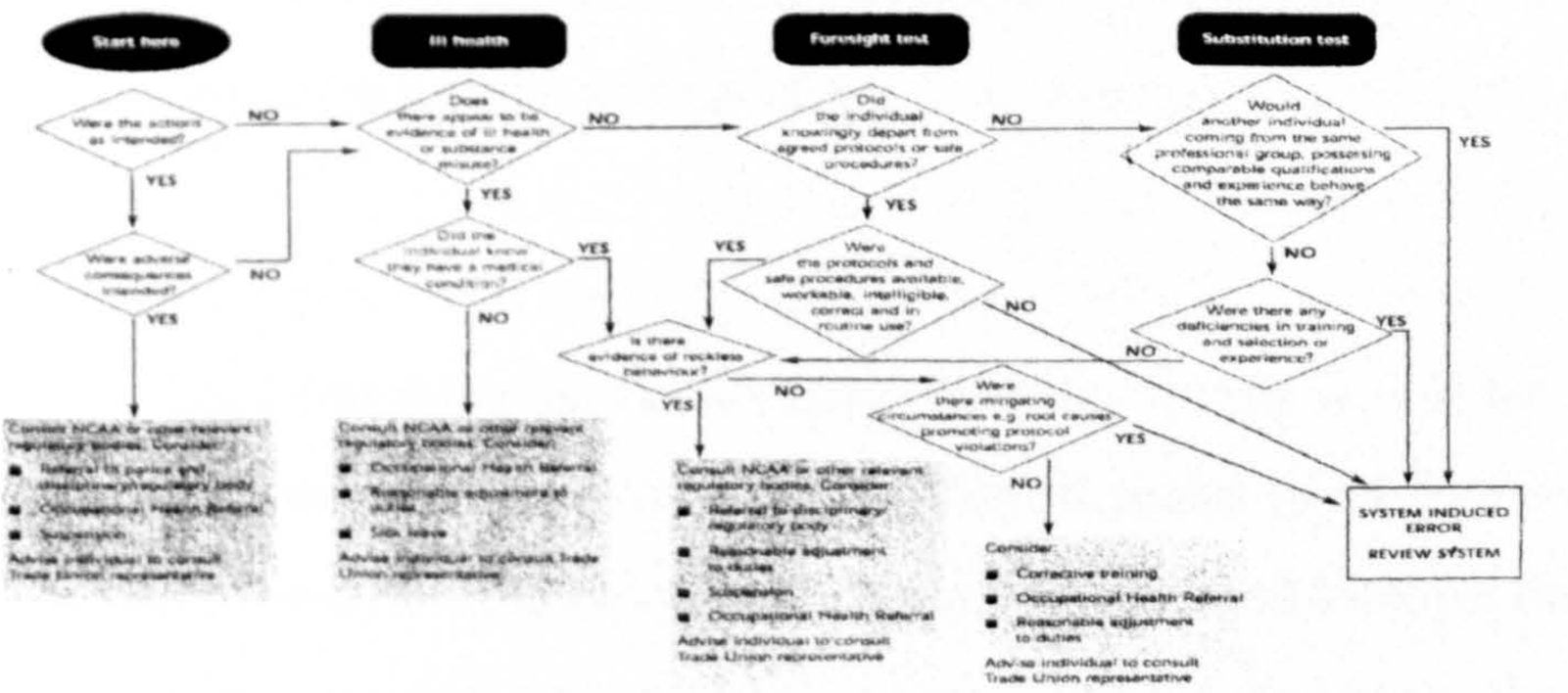


Figure 1: Incident Decision Tree – Based on James Reason's culpability model

Decision-making tool to reduce unnecessary suspensions and support a safety culture (NPSA, 2004)

When I use this flow chart, I notice how I am led to conclude that culpability for the errors lies *either* with the individual *or* with the system. It is therefore perhaps not surprising that when guided by such frameworks, those of us following them draw the conclusions outlined above. I now recognise this way of thinking as a dualism that is a feature of systems theory – which I have explored in earlier projects with regard to its limitations in strategic planning. This characteristic has to do with the nature of human beings where on the one hand, humans are thought of as rational, autonomous individuals who objectively observe systems and ascribe purposive behaviour to them. Causality here is rationalist and a rational human being is free to choose – such as in an assumption made in the first decision point in the diagram above (i.e. through asking the question as to whether the actions by the individuals were intended?). On the other hand, humans are also thought of as part or members of the system being observed and so subject to formative causality. (i.e. in the diagram above, it is also assumed that clinicians will follow protocols and procedures as laid down by the organisation). Such assumptions imply humans cannot be free to choose but are subject to the purpose and formative process of the system, a phenomenon I describe further below where some authors make reference to the impact cultural factors have on human

behaviour. Systems thinkers themselves have identified problems with this analysis and the evolution of soft and critical systems thinking towards the end of the 20th century has attempted to address these (Checkland, 1983; Midgely & Jackson, 2000).

In considering this, I feel this raises interesting questions for me with respect to my research enquiry and my theme of accountability. It seems to me that it is important to understand how and why it is that we have come to look for the cause of clinical errors in a way that locates it either with the individual or in 'the system,' and the implications for this in how I work. This is relevant because a systematic approach to CRM is being mandated in all trusts as part of an inspection process (Health Care Commission, 2004). As part of this, we are required to have a strategy and system in place for investigating, reporting and learning lessons from Serious Clinical Incidents (SCIs). What starting this project has made me realise is how, when talking about systems, many authors do not make the distinction between the systems and frameworks that groups of individuals design and use in organisations (such as CRM systems) and speaking about the organisation as if it were itself a system. I am beginning to think that that the former is a necessary and desirable part of my work, but that the latter is less helpful. In order to explore this more carefully the next section develops the key features I now recognise in aspects of risk management that appear to treat the organisation as if it really were a system.

Traditional approaches to undertaking investigations into SCIs

What the Panorama documentary demonstrates very powerfully for me is a familiar sequence of actions and a set of assumptions that are made when undertaking investigations into SCIs (Kennedy, 2001; Hutton Inquiry 2004). I reference these latter enquiries here, since the kind of approach is also typified in the way in which we investigate clinical incidents within my own organisation. What I now notice about such approaches is that they have the following characteristics:

- The purpose of such investigations/enquiries is to uncover some kind of 'objective truth' that it is believed to be enfolded in the set of circumstances that led to the incident.
- Emphasis is placed on the importance of 'objectivity' in order to uncover this 'truth'. Hence those investigating are selected on the basis of some kind of impartiality, in the belief that it is important to maintain some kind of objective distance from the issues of concern. This is in order to avoid biasing the findings through utilising people with some kind of emotional connection to the incident or personal prejudices that preclude them from maintaining this essential impartiality. Personal credibility, expertise and integrity also form a part of the selection criteria for investigators.
- Such investigations are grounded in the paradigm of a scientific research method. (Hence an independent objective observer constructs a hypothesis through scoping the investigation or agreeing terms of reference to identify the questions that need answering which she/he then seeks evidence for in a rational and logical manner in order to generate conclusions.)
- In order to do this, different tools and techniques are used to extrapolate, collate, analyse and synthesise data in a way that enables robust conclusions to be drawn about the 'cause'. Such techniques include:
  - Root cause analysis
  - Barrier analysis
  - Informal interviews
  - Written statements
  - Time lines/chronology of events

  (Dineen, 2002: 3–50)

- At the conclusion of the enquiry, the panel identifies its findings with respect to 'what really happened' based on the chronology of evidence, and identifies where accountability for this lies.
- It makes a series of recommendations for improvement which typically stress the importance of 'learning lessons' from this incident and the importance of disseminating these more widely so this can reduce the likelihood of reoccurrence. It is commonly said that this is to ensure that 'this can never happen again'.

Investigating a SCI

The SCI in the Clayton Unit involved the admission of an unconscious patient known to be on continuous ambulatory peritoneal dialysis (CAPD). The patient's husband (a doctor) accompanied her to hospital having diagnosed that his wife was hypoglycaemic (i.e. suffering from low blood sugar). The patient's blood sugar levels were checked by the nurse on the ward on our portable machine and, her blood sugar readings were within normal limits. However, she remained unwell and her husband insisted that she was given a bolus of dextrose after which she subsequently improved. The husband contacted the CEO's office to complain when he was later made aware that a Medical Devices Alert (MDA) had been issued to the NHS by the Medicines and Healthcare Products Regulatory Agency (MHRA) some three months previously. This alert highlighted the risk of a potentially fatal overestimation of blood glucose results when Brand A test strips are used where patients are on treatments containing maltose (i.e. patients such as his wife who was on CAPD). In conversations with the nursing staff on the renal ward, he confirmed that the unit was using the 'Brand A' monitor and that the nurses were aware that there was a potential problem with this. The husband was understandably concerned that the nursing staff were openly prepared to practice using equipment that they knew was potentially dangerous and requested that the event should be investigated as a SCI. The investigation identified a whole range of complex issues which I shall now explore further.

Reflections on the causes of the Clayton Unit SCI

It is late one afternoon and I am on the phone to Mike. Mike is an Assistant Director of Clinical Governance, with responsibility for CRM. We have worked together in different capacities over the last ten years. We share an interest in complexity science and our meetings are peppered with lively conversations and debates about our interpretations of this and its potential application for practice. I think we both share an enthusiasm for enquiring more deeply into our practice with respect to risk management and a desire to improve risk management in Sometown University Hospitals NHS Trust. I have just been reading an early

draft of the report he has produced on the Clayton Unit investigation. We have been chatting and Mike expressing his frustration with writing this report. I can hear the exasperation in his voice as he is explaining how difficult he is finding it to come to any conclusion about 'what really happened'. He was describing how he'd *think* he'd grasped some conclusions and then how he would interview someone else as part of the investigation who would completely turn all these ideas upside down again. He explained it was like turning over lots of different stones and then finding a whole new can of worms that needed 'sorting out'.

As I am listening to him I find a lot of what he is saying resonates strongly with me with respect to my experience of being involved in similar investigations. I am recalling my own annoyance with the impossibility of getting the facts fitting together neatly to form a clear picture so I can write a report. Mike describes very vividly how everyone seems to have a 'different take' on what happened – even amongst several staff involved in the same incident. As I am listening to him, I find myself recalling a sense of déjà-vu with respect to an experience I describe in an earlier project for my D. Man. when a number of us watching a production by the 'Working Live' theatre company were commenting on what was happening on stage. When hearing other people's perceptions of the production I found myself wondering whether I had been watching the same play as they were. I describe this to Mike; it's a topic that grabs our imagination. We start reflecting on the work we were doing together when we were managing the Complaints department, and recall that this was a theme that also emerged as an issue for us then. (Project Two discusses this in more depth and describes how complainants and the staff involved often have different perceptions of the same incident).

This spark of creativity develops into a strand of work by Mike, who tries integrating the issue of differing perceptions and perspectives into a seminar using an analogy of a critical incident in a football match for training people investigating SCIs. This has the added advantage of combining Mike's passion for football and I even find my normal ambivalence for the subject caught by his enthusiasm as he develops this. In the film clips he has selected from 'Match of

the Day' the commentators, players and fans are all expressing very different perceptions, both about what they think they are seeing and who they believe is responsible for the incident on the pitch. Through working in this way, we start noticing how people's past experience and biases and prejudices affect their perceptions of what has happened (particularly from Manchester United or Arsenal fans in the audience). Mike shows clips of footballers recalling 'a long history' of rivalry between the clubs and 'history repeating itself'. This always seems to generate lively conversation with our seminar participants, who also have 'different takes' on what they think they have seen. He shows clips against a time line and we find ourselves making one judgement when we look at a snapshot of the incident itself, but that our perspective seems to change when we look later at clips taken before and after the incident.

We have run this seminar several times now. Last time, Mike mentioned he'd changed his mind yet again about what happened based on seeing the clips again and discussing interpretations of this with participants. These reflections question the validity of the linear way in which we have been making connections in this line of work, and our assumption that objective facts lie in the past in a way that views the past as unchanging. It seems to me that we are struggling with the first assumption listed above with respect to our taking for granted characteristic of investigations – namely that there is an objective truth that is 'there' and waiting to be discovered.

I recognise that the use of the video has its limitations as an analogy, since in our lived experience (or the use of theatre) we are unable to provide such action replays which, at least on film, remain the same. Yet for me, this strengthens my sense of the relevance of this observation. Even in spite of having action replays, in viewing them and discussing them together, our understanding of what happens nonetheless constantly shifts. This reminds of the case in the US where a jury found the assailant of Rodney King not guilty in spite of video evidence showing police physically assaulting him. I am interested in how I can make sense of this,

since the rational causality which underpins many of our root cause analysis tools are inadequate in helping me understand how this could happen.

I re-examine the literature on human interaction and consider that the process of testing and hypothesis and formulating of conclusions happens in human organisations very differently from the approach being postulated in the natural sciences and systems theory. In exploring this further, I discover studies into how juries make decisions (Garfinkel, 1967). Garfinkel identified that jurors did not seem to first decide the harm and its extent, then allocate blame and finally chose the remedy. Instead, they first decided a remedy and then decided the 'facts', from among alternative claims that justified the remedy. Jurors essentially created a sequence that was meaningfully consistent and then treated it as if it was a thing that actually occurred: 'If the interpretation makes good sense, then that is what happened' (Garfinkel, 1967: 106).

Hence facts were made sensible *retrospectively* to support the juror's choice of verdict. Garfinkel summarised decision-making in common sense situations of choice in this way:

> In place of the view that decisions are made as the occasions require, an alternative formulation needs to be entertained. It consists of the possibility that the person defines retrospectively the decisions that have been made. *The outcome comes before the decision.* (ibid.: 106)

What I find intriguing about the above is the implication for our whole approach to investigating clinical incidents. This is a radical challenge to explanations of decision-making that believe that we think first, and then act.

Exploring retrospective and prospective approaches to risk management

In re-reading the above section I reflect on the learning I have gained through our seminar. I draw parallels with how, on discovering new information and discussing this with people through our SCI interviews, we then constantly make new sense of what happened during the incident. As we do this we re-interpret other information we had gleaned previously. I see that the theoretical approaches

outlined above seldom make reference to these kinds of activities. In particular I am struggling with the proposition that leads us to believe we are establishing the 'facts' from the past which in some way are fixed. I now understand that the meaning we place on events leading up to the incident will inevitably change *after* the incident as we make a new kind of sense of it. In doing this I am drawing on a different notion of causality from those evidenced in much of the risk management literature – namely rational (cause/effect) and formative (systems theories). I have gained these insights through exploring the theoretical perspective of complex responsive processes of relating (Stacey,. 2000). Stacey describes this phenomenon that I am experiencing in the following way. They maintain:

> ... that micro-temporal structure is the gesture and the response the gesture calls forth, taken together. The here-and-now, then, has a circular temporal structure because the gesture takes its meaning from the response (micro future) which only has meaning in relation to the gesture (the micro past), and the response in turn acts back to potentially change the gesture (micro past). The experience of meaning is occurring in a micro-present and it accounts for the fact that we can experience presentness. What is happening here is truly paradoxical for the future is changing the past just as the past is changing the future. In terms of meaning the future changes the past and the past changes the future, and meaning lies not at a single point in the present but in the circular process of the present in which there is the potential for transformation as well as repetition. (Stacey et al., 2000: 35)

This radically different notion of time, which they attribute to the philosopher Hegel, is grounded in a very different notion of causality. This is an alternative to the idea of 'simple rules' based on an understanding of a movement towards the future based on formative teleology where movement into the future is believed to be toward a final state that can be known in advance (Plesk, 2001). In this way of thinking, it makes sense to develop detailed action plans as part of SCI investigations in order to guarantee that similar mistakes do not occur again in future. What I find interesting is how, in spite of these action plans, they can and they do reoccur. Ritchie's death from this kind of mistake was the twelfth example of such an error in the UK in recent years in spite of action plans aimed at changing the future.

Another teleological perspective evidenced in the literature is natural law teleology, in which movement into the future is based on a repetition of the past. In this alternative way of accounting for how change happens in organisations, it therefore becomes very important to discover what has happened in the past in order to make interventions that learn from the past as a way of changing the future. Again, I would use the example from the television documentary to question why it is, in spite of the extensive investigation into what happened, that this still reoccurred subsequently elsewhere in the NHS.

Proactive risk management (grounded in formative teleology)

As I reflect on these differences, I come to realise that they have the potential to orientate our approach to SCIs in very different ways. One focuses on attempts to design the future in a way that reduces risk, which we refer to in risk management as a proactive approach. The literature on CRM identifies a number of characteristics which typify the traditional discourse on strategic planning. Specifically, I see parallels with the approach referred to as 'gap analysis'. To summarise, these include an attempt (known as 'clinical risk profiling') to predict key areas of concern in order that preventative action can be taken in order to reduce the risk of things going wrong. Hence we identify a 'gap' between where we are now and where we need to be, and through action planning we identify how to 'close' that gap. For example, one approach currently being promulgated involves identifying potential risk issues, utilisation of a formula that multiplies the 'probability' of something happening by the 'severity' of the consequences, in order to calculate an overall risk rating. The list of risks is then ranked in order and colour-coded using a traffic light system in which the red-rated issues require urgent and immediate attention (Ireland, 2002). Whilst these can be useful, I see that they have their limitations if they are utilised in a way that abstracts their meaning from people's everyday practice; i.e. they become an end in themselves, rather than a means to achieving an end.

Reactive risk management (grounded in natural law teleology)

Conversely, if we base our thinking on natural law teleology, this focuses on learning from the past (commonly referred to in the risk management literature as a 'reactive' strategy), which is what we are doing when we investigate SCIs to discover what went wrong. In order to explore this latter approach in more depth I return to my conversation with Mike, before developing some of my own ideas about what an alternative approach to CRM which focuses on the present, rather than past- or future-orientated approaches.

Undertaking SCI investigations in order to learn from the past

As we continue with our telephone conversation, Mike and I joke about the fact that when we had undertaken our training on tools and techniques for investigating incidents it seemed as though the process of collating the incident report should be very straightforward (see Dineen, 2002). It was presented to us as a matter of collecting all the different pieces of the jigsaw and putting them together in a way that gave a very clear picture. From this 'evidence' it should have been easy for the lead investigator to unveil some kind of *denouement* and present the real truth about what had really happened. I now notice that such approaches are grounded in a mixture of rational causality based on cause/effect (hence 'root cause analysis') and formative causality where the 'parts' of the system somehow fit together into a 'whole'. Dineen's investigation training was informed by the work of two influential writers on CRM within the NHS. I shall now turn to these in order to provide a brief summary of their approach to managing SCI investigations.

A summary of approaches to SCIs advocated in the risk management literature in the NHS

Most of the literature reviewed identifies similar stages in an investigation process to those described by Reason (1997) and Vincent (2003). These writers have informed other NHS authors in this field. The literature has built and developed these approaches rather than challenging them or offering alternatives. These include: a review of the case records; scoping or framing issues to be investigated;

undertaking interviews and receiving statements; and undertaking an analysis in preparation of the final report. Recommendations are included on preparation of the report. These are that once the interviews and analysis are completed, the writers of the report makes a composite of all of them detailing the whole incident from start to finish. He notes that if the protocol is followed systematically and the interview and analysis conducted thoroughly, the report and implications of the incident should emerge from the analysis in 'a relatively straightforward fashion' (Vincent, 2001: 449). Once this composite is complete, it is stated that there should be a clear view of the problem, the circumstances which led up to it, and the flaws in the care processes should be readily apparent. He recommends that the report should consider the implications of the incident for the department and organisation and that this section should summarise the general contributory factors and the implications for action. Lessons learnt should be drawn out and action plans developed to deal with the problems formulated.

Use of Vincent's framework in practice

In spite of our understanding of this model, Mike's experience was that pieces of evidence he was collecting did not seem to be fitting together in this neat way. He said something like:

> Initially it seemed a straightforward case of human error. The MDA alert should have gone to the Clayton Unit and the person responsible for sending it did not do this – so they never received it. In spite of this, it seems many people were aware of it. Now I am sitting here having interviewed a dozen people who all tell stories that contradict each other and send me off in a completely new direction – which unearths a whole new can of worms. This uncovers a whole new set of issues I feel need investigating. It seems to involve everybody in the Trust! I have even discovered something connected with this that came over my desk some months ago – and yours – so we are all implicated! I can't believe how complex it is – and how difficult it is to piece together and make any sense of it.

We have a detailed discussion around our difficulties in trying to piece together in a coherent way all the different fragments of information collected during the interviews and to determine the 'root cause' of the factors that had led to the error.

What our experience of this investigation seemed to be indicating is that it is virtually impossible to identify a linear chain of events from which we could demonstrate a cause and effect to link back to some underlying 'root cause' as suggested. This notion of causality – where cause and effect are linked – is very powerful within the NHS risk management literature. This is well understood by clinicians whose practice is grounded in the scientific paradigm which has the features listed above.

In risk management, systems thinking has helped develop alternative frameworks which make a useful contribution to overcoming the limitations of rational approaches critiqued in earlier projects. Specifically, they seek to overcome the problem of locating the 'cause' or 'blame' for the mistake with the individual practitioner. A common framework is the 'Swiss cheese' model of accident causation. It is based on the analogy of errors being like the holes in a Swiss cheese. Normally, the holes in the cheese do not go all the way through. By analogy, mistakes in hospitals often get 'blocked' (as in the cheese), by a barrier (a check in the system). I notice how this way of thinking assumes there is a 'right way' of doing things which, if we can in some way unlock or discover it, we can control through putting in place the necessary barriers. However, on rare occasions, the hole goes all the way through the cheese: our 'barriers' fail, the holes 'line up' and a catastrophic incident occurs. Authors of such approaches then typically make the move towards trying to identify where the 'holes' may line up in order that preventative action can be taken. A common feature of such systems is to encourage staff to identify 'red flags' in processes in order that feedback can be used to return the system to a safe (or stable) state – a way of thinking I can now see is informed by cybernetic systems. Some approaches seek to build these 'red flags' into 'the system' itself in an attempt to 'human-proof' it. Yet there are other features of this approach which remind me of the useful work done by Senge (1990) in this field in addressing some of the shortcomings of hard systems thinking. What I see in some of the CRM approaches (which are struggling with similar issues) is to attempt to identify what Senge would call 'leverage points', in order that the manager can spot and in some way intervene to

control them. What this kind of thinking does not address is where 'the system' comes from in the first place: I see a tendency for it to describe the professionals within its as passive victims, rather than active participants in its creation. This has a fundamental impact on the concept of accountability – where 'the system' is to blame in a way that abrogates individuals within it of any accountability for their actions.

My discussion with Mike leads me to go back to review the literature in order to reflect more deeply on the methodology we had adopted to investigate incidents, to identify more specifically how the application of this model was proving problematic. What was interesting was that in so doing, I stumbled across a more recent article by Charles Vincent in which it would appear he has subsequently adopted similar reservations to mine, and signals a move into a systems-based approach. He notes:

> The purpose of such analysis is often framed as the need to find the root cause of an adverse incident, tracing it back over a series of events to some fundamental problem. However, this perspective is misleading … First, it implies that the incident has a single root cause, or at least a small number of causes, but this is an over-simplification. Usually, a chain of events and a wide variety of contributory factors lead up to the even …. For these reasons, we prefer the approach called 'systems analysis' over 'root-cause analysis'. (Vincent, 2003: 1051)

Hence he seems to be moving more strongly to a systematic approach, which is similar to the position taken by Senge as identified above.

Introducing a perspective informed by complex responsive processes

My study of complex responsive processes has led me to consider a different perspective to the proactive and reactive approaches in the way described above. Complex responsive processes focus on the root of all change arising from our interactions with each other in 'the living present' (Stacey, 2000). This offers a fundamentally different theoretical perspective from those I have just described that inform the retrospective and prospective approaches in the dominant discourse on CRM. This notion of focusing on the present (as opposed to past and

future) and how this orientation could offer a radically different perspective on risk management has become a key interest in this enquiry. I shall therefore explore this in more detail.

Complexity and complex responsive processes

I have identified in previous projects a growing interest in complexity science in the NHS with respect to what this can teach us about how organisations function. Stacey (2000) has identified that many writers homogenise terms such as 'chaos theory', whereas in reality there are many different interpretations being developed. The same is true of how people within the NHS are using these ideas. I have already critiqued Plesk's (2001) approach referring to CAS, in which he emphasises 'simple rules'. Reference is made in risk management literature to this branch of science as well. For example, Firth-Cozens (1995) uses an analogy from chaos theory to argue that healthcare behaviours can be divided into those that are habitual and routine; those that are largely routine and able to adapt to fit changing circumstances (which I see as past-orientated); and those that cannot easily be foreseen, and so require a different type of learning activity around anticipation. She notes that, although many of the routine procedures arise from previous training and are informed by guidelines and protocols, in other areas working practices exist which should be tackled through the establishment of habit. She suggests that a team is an appropriate organisational unit to determine what these are and how these should be tackled through the use of evidence or guidelines where these exist. She also advocates periodic use of 'horizon-gazing' in order to anticipate potential changes and new risks and share these within the wider organisation (which I see as future orientated). She also notes the importance of diversity in teams (Firth-Cozens, 1998; Ilgen, 1999), noting that this broader knowledge base increases the team's ability to address its tasks well, so long as all team members feel able to participate in decision-making.

My observation would be that although claiming to draw from branches of chaos theory, interpretations such as those above still have a number of features of systems thinking and as a consequence, the limitations which I have already

identified. I now see that this kind of interpretation leads to the split I have described above between reactive and proactive approaches which are either past – or future – orientated rather than re-orientated in the present. I notice in the above quote how Firth-Cozens assumes we can divide healthcare behaviours into the 'habitual and routine' and, depending on which we are dealing with, describe different kinds of learning activity. This way of thinking therefore also has implications for the actions we choose to take when considering how 'organisations' learn – which is a central concern for those of us working in risk management (Senge, 1990). The difficulty I have with such interpretations is that I am now arguing that we cannot know what the outcome of our action will be until we reach consensus with others about its meaning (Mead, 1934). Therefore in the movement of our action, we cannot know until it is complete whether the outcome will be 'habitual, expected, or a surprising unexpected', we can only judge this in retrospect. For me the use of the word 'habit' is problematic since it implies it is a 'thing' which is there, rather than (as I have come to understand it) as something that emerges in our interaction with each other which has the potential for replication or change. I am no longer thinking of habit as something we can decide beforehand through a blueprint which we then enforce or socially re-engineer. This is because my experience of the Clayton Unit investigation is that the guidelines that are in place are often not routinely followed. In the past, my response would have been that we therefore needed to reinforce the content of such guidelines. Many of our action plans post – SCIs include a requirement that all unit staff attend training on them, or confirm they have read and understood them. Yet it strikes me now that such strategies do not seem to eradicate a common root cause in many of our SCIs – namely staff failure to follow procedures. Addressing the question as to why we are unable to follow guidelines (or simple rules) in human organisations seems to have emerged as a central theme of my enquiry – and one I shall return to address in my synopsis.

I also have difficulty with respect to tools such as 'horizon-gazing' when the justification for their use is grounded in complexity theory. This is because I have learned that one of the features of complexity theory is the nature of

unpredictability in complex systems. Therefore if we take seriously some of these ideas, the notion of trying to predict the unpredictable would seem to be inconsistent with the insights from complexity science; we cannot, therefore, appeal to it as a source of validation for such approaches.

For me, one of the fundamental insights about causality in CAS which I find fascinating is one found in natural systems, which many branches of this science explore using computer models in order to gain greater understanding. In recent years research such as that with convection (Nicolis & Prigogine, 1989) identify a unique feature in such organisations (in which the component parts are referred to as 'agents'.) This is that genuinely new emergent patterns and phenomenon can arise from *within* the organisation itself, and that this occurs as a consequence of the resonance and interaction of the agents within it. Hence no one single component can effect change on its own, yet all play a part. In this sense, organisational change is genuinely as self-organising and emergent as an organic process.

My argument would be that these two insights, if used as an analogy for understanding some of the phenomenon I have described in my narrative, offer a radically different understanding to what is going on than that offered by systems thinking. The first of these is that patterns of activity that we experience in organisations emerge not from some blueprint or plan, or because someone at the top of the organisation has set the mission and values, but are a self-organising and emergent phenomenon. These daily micro- interactions, which are expressed through our everyday conversations and the patterns that emerge through our conversation, are (to use the language of complexity) both predictable and unpredictable and stable and unstable *at the same time.* Hence what I experience has an element of familiarity about it and this is grounded in my past experience. It is very rare in my daily life that things occur which are so unfamiliar I can make no sense of them at all. Yet, at the same time, small and unexpected differences can occur and become amplified which surprise me.

I see this expressed in my narrative when people such as Mike remark: 'This was an accident waiting to happen' – which reflects the recognition that what has occurred in some ways was anticipated; and conversely expressions of complete surprise such as 'I never expected this to happen to me', indicating an encounter with the unexpected. I also note that the explanation of causality here is very different from that expressed in systems thinking as evidenced in the risk management literature. Unlike a linear process of cause and effect which is tracked back to an underlying root cause, or a formative framework informed by systems thinking ('Swiss cheese'), causality in complex systems emerges from *within* the organisation itself. All actions and inactions by the agents contribute to the next iteration or pattern of the organisation and each gives rise either to a new iteration or replication of previous activities. This is very different from systems thinking and its notion of cybernetic feedback which works to maintain a system in a state of equilibrium, thereby dampening down any unexpected amplifications in order to keep a system within pre-existing parameters. In the latter, genuine novelty cannot arise, whereas in complex response processes of relating – which draws on analogies from the studies of CAS – it can and does. This radically different notion of causality for me offers a better explanation of the phenomenon Mike and I are discussing with respect to his frustration regarding his inability to identify clear root causes in the Clayton Unit incident. What he seems to be describing to me feels more analogous to a complex system which gives rise to a range of patterns that are both predictable and unpredictable at the same time.

This way of understanding has had a fundamental impact on my practice for the following reasons. First, it presents a radical challenge to one of the underpinning assumptions in risk management – namely that we can fix or solve the root cause of mistakes to prevent the same thing from ever happening again. In recognising patterns of human interaction as offering the potential through replication or transformation – both at the same time – there will always be the potential for mistakes to be repeated or for things to radically improve. In this way of thinking, the root of all change lies in the action that we take the living present. Therefore what has become a major issue for me is focusing on my contribution to what is

happening 'here and now', because I am accountable for the outcomes. I now understand these outcomes as paradoxically controllable and uncontrollable at the same time, in that I can influence them by my acts and omissions but my control of them is also constrained by the actions of others.

This raises very serious questions with respect to the notion of accountability because I have to accept responsibility for the outcomes that arise from my action or inaction with respect to the things I pay attention to in my everyday working life. What therefore becomes important is how I improvise within the situations that present themselves to me which have both an air of familiarity about them and sometimes an element of surprise. Second, what takes on an increasing significance in this way of thinking is recognising patterns and themes in conversations which have the potential for replicational transformation at the same time. Themes such as how we can effectively distribute Medical Device Alert notices how the actions people take on receipt of these are recognised as things we need to continually revisit. Stacey elaborates on the importance of patterns through analogies with complex systems and notes:

> When it operates in the paradoxical dynamic of stability and instability, the behaviour of the system unfolds in so complex a manner, so dependent upon the detail of what happens, that the links between cause and effect are lost. One can no longer count on a certain input leading to a certain given output. The laws themselves operate to escalate small chance disturbances along the way, breaking the link between an input and a subsequent output. The long- term future of a system operating in the dynamic of stability and instability at the same time is not simply difficult to see: it is, for all practical purposes, unknowable ...

He goes on later in the paragraph to say:

> ... If this is applied to organisations, one would raise questions about decision-making techniques that involve step-by-step reasoning from assumptions about the future. One would have to rely instead on using qualitative patterns to <u>reason by analogy and intuition.</u> Those who succeeded would be those who saw patterns where others search for specific links between causes and events. (Stacey, 2003: 229)

To summarise, the intrinsic patterning properties of interactions and self-organisational emergence in complex systems include a number of features, namely:

- The paradoxical dynamic as simultaneously predictable and unpredictable interaction.
- The importance of connectivity and diversity in the dynamic at the edge of chaos, and how this is essential to the emergence of novelty.
- The emergence of continuity and transformation at the same time.
- The importance of relationships between the 'agents'.

These insights give me a powerful sense of offering an alternative way of understanding and dealing with some of the issues Mike and I have been grappling with. As yet they feel uninformed and lacking in clarity in terms of how or why they can help. In order to explore this further, I feel curious to learn more of the approaches I am experiencing difficulty with, in order to articulate more clearly what these are to help me formulate an alternative understanding.

Implications for practice when locating causality for incidents in the individual, the system, or both

Vincent (2003) highlights the difficulty of locating responsibility for mistakes solely with the individual. He deals with this problem by concluding that, by way of a solution, 'systems analysis' should be an absolute priority in any risk management and safety strategy. This reference to 'systems' immediately grabbed my attention, since this was a topic I read extensively around in previous projects in order to gain greater insight and understanding into strategic planning in organisations. I learned that many authors ground strategic planning in systems theory. I had already begun noticing how elements of systems thinking have permeated into the risk management field. I notice this again here now with respect to a linear notion of cause and effect. I am wondering if some of the difficulties we seem to be experiencing with trying to find a human cause, a root cause, or systemic cause are as a result of the theories that underpin our practice. In reflecting on this, I recall how Mike said his initial conclusion was to locate the

cause of the incident with the individual risk manager. Vincent (op. cit.) also draws attention to the fact that often, the most readily apparent place for allocating responsibilities when untoward incidents occur is with the individual member of staff. He notes that this focus is perhaps not unsurprising, since the cause of the mistake is most usually seen at this level; it is comparatively simple to acquire quite detailed knowledge about the professional and the situation concerned. It is also noted that this creates the smallest possible sense of responsibility for the rest of the organisation.

In reading these interpretations I recognise another feature of systems thinking – in that these writers understand phenomena as a 'whole' formed by the interaction of parts. Whole systems are separated from others by boundaries and they interact with each other to form a suprawhole. This introduces the notion that there are different 'levels' at which phenomena either exist or need to be thought about. Such notions of wholes, boundaries and levels are central distinguishing features of systems thinking. Diagrams such as those in Figures 1 and 2 illustrate this way of thinking, since they describe problems as arising at different 'levels'.

Interestingly, as I am speaking with Mike, he describes how, after interviewing the staff, he changes his mind about sole responsibility being with the risk manager and instead is starting to think that this is a 'systems error'. He starts explaining to me how our internal system for cascading MDA alerts is a systems problem. His investigation has shown that over the last year this is a topic that has been discussed at three formal trust committees and numerous informal meetings between staff across our trust. It seemed clear at the time that the MDA system was set up with the Risk Manager having responsibility for cascading alerts through an agreed route, which would then be actioned locally by relevant staff. Although the alert stated it needed to go to the Clayton Unit, because he was new in post and in the absence of any comprehensive trust directory of services, it seems this was overlooked. Mike is identifying that in spite of this oversight, numerous people were nonetheless aware of it through other means. The question that we keep returning to throughout our investigation is why it

appeared none of these had taken any decisive action about the alert or the problematic machines? However, as the investigation continued, it became clear there *were* things that some people had done. In theatres, the manager had decided to purchase a different machine (which we later discovered was in breach of our trust policy). Ironically, there was a meeting planned in the Clayton Unit on the day of the incident where this issue was on the agenda to be discussed. Nevertheless, for me a fundamental question remains regarding the issue of responsibility and accountability within this incident: how we deal with and speak about accountability implications if we think a 'system' can itself make mistakes or take decisions.

Interestingly, our final conclusion was that 'both staff and systems failed to mitigate the error', which I now recognise is the kind of dualism I have described above. I would now explain it differently. Rather than seeing staff and systems at different levels I would account for this in a different way. Drawing on the work of Mead (1934), I see that as part of one act, it is we, the staff who are forming the system (through our acts and omissions) at the same time as 'the system' (i.e. the groups of agents and environment with whom we are interacting), is simultaneously influencing our actions. This is a fundamental change in the theoretical basis which is now informing my practice and consequently shifting my understanding regarding the concept of accountability. This notion of 'forming and being formed' at the same time offers me a different concept of accountability with respect to the cause of mistakes. In order to explore this in greater depth, I re-read a section of the report which has been concerning me regarding corporate responsibility. I notice in our report how we also make assumptions about the kinds of 'levels' described above in the CRM literature. We quote from a nurse who stated that: 'As I understood it, it would be the Trust decision on what blood sugar monitoring equipment we used.'

It is also noted in the report that if this is the case, 'it appears unclear about where corporate responsibility lies' – an interesting question, which it seems to me that the systemic way of thinking is unable to explain adequately. Within this context

I am troubled by the lack of clarity with respect to what we mean when we talk about 'corporate responsibility'. This is because it is not something or someone I can point to in our structural chart or have a conversation with about my concerns. I have come to notice through this investigation how common it is for us to talk about Sometown University Hospitals NHS Trust as an 'it' to which is attributed the capacity to act with intention. Hence the quote from nurse above who believes 'the Trust' will make the decision about the equipment is an opinion which is frequently echoed in our work.

This brings me back to my point made earlier about the important distinction I see between talking about systems that humans develop in the course of their everyday work and talking about the organisation as if it really were a system, as the nurse (and those of us who wrote and endorsed the report without questioning this) are doing. I am reminded of Griffin's (2002) work on this phenomenon. He describes how in today's society we speak about large organisations, consisting of thousands of employees, acting with culpable intention and being ethically responsible. He notes:

> When we talk in this way, we are talking 'as if' an inanimate, nebulous entity called a corporation, or a 'system', can have intention but in doing this we tend to forget the 'as if'. (Griffin, 2002: 2)

This resonates significantly for me with respect to the quote from the nurse – which typifies the approach to CRM in the NHS, as identified in the television documentary where initially culpability was placed with the doctor and later with 'the system' within which the biscuit was identified as the catalyst. This way of thinking is well developed in the literature on CRM. For example, as well as identifying the human causes (either individually or in teams), the literature makes the distinction between 'active' failures (consisting of mistakes made by practitioners in the provision of care), and 'latent' failures (which represent flaws in the administrative and productive systems) (Eagle, 1992).

Hence what I see in the literature is that in the move to address the problems with locating the blame solely with the individual, frameworks have been developed which take account of wider organisational issues which are grounded in systems theory. However, what I notice about such approaches (e.g. Figure 1) is that they are formulated in a way that ignores the paradox of us 'forming' the system whilst simultaneously being 'formed' by it. Figure 1 forces me to conclude it is either the system or the individual that is to blame. This is a key issue for me in terms of my enquiry into the concept of accountability and how it is understood within such frameworks. This thinking has been refined over time and culminated in the most recent model for organisational accident causation which Mike and I and the risk management team have been utilising in our practice for the last few years. This is summarised in Figure 2.

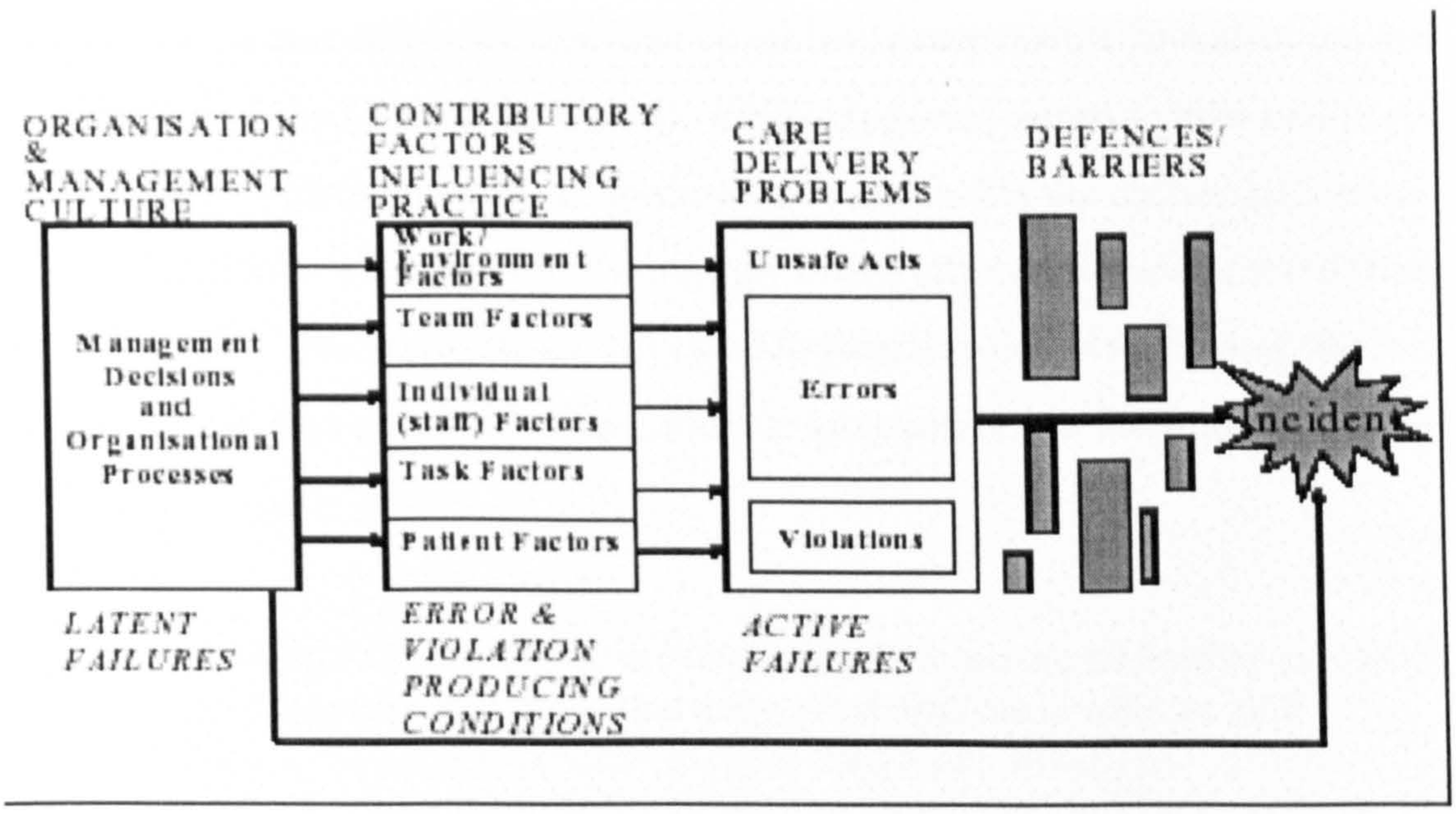


Figure 2: Stages of development of organisational accident (Vincent 2001: 15)

As I look anew at Figure 2, I think about Griffin's observation regarding how we talk about the organisation as an 'it' which acts with intention. I see how Figure 2 reinforces this way of thinking. Hence the management decisions and organisational processes are seen at a separate 'level' from those of the individual practitioner. The defence barriers at a different level 'fail' and the holes in the 'Swiss cheese' line up and 'cause' an incident. This way of thinking has clearly powerfully influenced the conclusions in our Clayton report. Recognition of this

reinforces for me the importance of the impact that our theoretical assumptions have on our practice. Hence I am arguing that one cannot split theory from practice in a way that many authors would have us believe is possible. Both are present as we act.

This conceptualisation regarding different 'levels' is reinforced in our everyday conversation at work, where I often hear people talking about the importance of the need to take patient safety more seriously 'at Board level' or 'at Trust level'. Yet in re-reading the SCI report, I can see the limitations and indeed the dangers of this way of thinking. This seems to me to abrogate individuals from any personal responsibility for their participation in the set of circumstances that contributed to the manifestation of a clinical incident. What happens when we think in this way is that we locate ethical responsibility in 'the system', simply taking it for granted that a 'system' can be ethically responsible, and also in a few individuals (i.e. the CEO of the Board). Griffin (op. cit.) points to how in doing this, we adopt a particular view of leadership in which it is the individual leaders who are blamed or punished when things go wrong or praised and rewarded when things go right. The rest of us are allocated to passive roles as victims of 'the system' and of manipulative leaders, and our salvation lies in the actions of heroic leaders. He concludes:

> In thinking in this way, we are obscuring how we are altogether involved in the dangerous situations that arise. Perhaps this is why we find ourselves repeatedly exposed to these dangerous situations. It then becomes a matter of great importance to understand just how we have come to think in this both...and way in which we ascribe an 'as if' intention to the system. (Griffin, 2002: 4)

Hence, in this way of understanding organisations as an autonomous whole, we typically describe how this 'whole' organisation has a purpose of its own (defined in many texts as 'vision' or 'mission') and a morality of its own (described as 'values' and 'culture'). In this way of thinking it is the role of the senior managers to define an idealised future, purpose and ethics for the organisation. Ethical responsibility falls on those who form part of the organisation and

therefore consists in conforming to these idealised values (for example, 'the Trust' should be responsible for patient safety). Griffin's analogies draw my attention to similar observations in the risk management literature. On the one hand, there is concern about locating blame with individuals for clinical mistakes and on the other, as evidenced by the quote above, there is a growing emphasis on the importance of looking at systemic (often referred to as 'latent') causes for mistakes.

It seems to me that what Mike and I are struggling with are the limitations of such frameworks to adequately explain the phenomenona we are experiencing in our practice when trying to investigate clinical incidents. Specifically, we seem to have moved from one unsatisfactory way of working (in which clinicians were blamed and shamed and punished for making mistakes) to another which seems to locate the cause for the mistake at some higher 'level' by defining it as a systems error that the 'Trust' has responsibility and accountability for. This also seems to be to be unsatisfactory, both in terms of its theoretical basis – for reasons outlined above – but also in practical terms with respect to co-creating a situation where it is possible for professionals to believe they are a passive victim of some higher system that takes responsibility for their practice.

Further developments in systems theory have recognised these limitations and problems and attempted to deal with them. For example, some do focus on social relationships as a notion of communities of practice (Wenger, 1998). However, Stacey (2003), whilst noting that these developments have introduced very important social, ethical, ideological and political aspects of the decision-making processes encountered in organisational life, also notes they do not depart from the key aspects of systems thinking. Hence they continue to be based on the spatial metaphor of an 'inside' or 'outside', which introduces a dualist way of thinking in which one causality applies to the inside, and another an outside. The 'inside' moves according to formative causality and the outside, ultimately in the form of autonomous individuals, who draw the boundaries, is still subject to rationalist causality as seen in the television documentary. Stacey notes how this

way of thinking, therefore is that of the 'both...and' mode that is inevitable when reasoning is constructing a dualism. This eliminates paradox (for example, the paradox of the observing participant) and any paradox to do with freedom of choice. As with other theories of systems thinking, the source of novelty and the processes of transformation cannot be explained in systems terms.

To summarise, thus far, I have argued for the important distinction between designing and using systems in our work (which I believe is useful) and the problems inherent when thinking of the organisation as if it really is a system. I have begun to explore the distinctions between risk management approaches that either look to the past (through learning lessons from mistakes) or are future-oriented (through risk assessment and horizon scanning.) I have also introduced the theory of complex responsive processes of relating which gives a different explanation of causality in organisations. This focuses on the root of all change arising from our interactions with each other in 'the living present'. What I have found is that in recognising these distinctions, these insights have started to influence me with respect to my actions when investigating SCIs. I will explore this in more detail below.

Objectivity and the scientific method

I return to my conversation with Mike about his draft report on the renal incident. We turn to a slightly different topic which had been of concern to me. A number of sections in his report contain quite a lot of detail and some attempt to draw conclusions. Yet the section Mike had written about the MDA notice and why this had not been distributed seems to make virtually no mention of the responsibilities of the named individual who was supposed to trigger the process. I noticed that it seemed to go into quite a lot of detail about a whole range of (seemingly justifiable) mitigating circumstances as to why this had not happened. While talking through my observations about this with Mike, there was an uncharacteristic silence at the end of the line for a short while. His reply was something like:

> ...Yes – I know. To be absolutely honest when I interviewed him he seemed like a nice bloke. I felt really sorry for him because he was obviously upset about what had happened and worried the consequences. I've also heard that his boss has got a reputation for being a bit of harsh about things like this and I was concerned that if I did not focus on the wider issues there could be a danger that he might lose his job.

Some time later, Mike and I discuss this conversation in our one-to-one. We reflect on how, in spite of what the theory on our incident training had taught us, it is virtually impossible to remain truly objective. We note how we all bring our own biases, prejudices and previous experience to each new situation. Thus, even though we may know very little about the specific situation if we are brought in as an 'outsider', we quickly form relationships with and opinions about the individuals we are investigating. Inevitably this affects the conclusions that we draw. We talk about the sense of accountability and responsibility we both felt when leading such investigations and drawing such conclusions. If we 'get it wrong', we could either unfairly jeopardise someone's professional reputation or, conversely, fail to take action that could prevent another incident causing harm to other patients.

I see how such approaches are grounded in the scientific method, in which an independent observer uncovers some kind of universal truth. What Mike and I seem to be discovering is that the 'truth' (or people's perceptions of it) is different and shifts constantly and that there are limitations and flaws in an investigation framework promulgated on the importance of an 'independent' investigator.

Challenging the notion of an 'independent observer'

These insights provoke further discussions between Mike and myself and the rest of the CRM team. This leads to us changing a number of features in our investigation process including:

- Convening a small diverse team to scope and oversee investigations.
- Peer reviewing of progress of each ongoing investigation at our weekly meetings.

- Ongoing discussions on the balance between 'insider' investigators from within the area and 'outsider' support from our team.

These changes have been influenced by our growing recognition (from insights from the theories described above) of:

- The importance of diversity in changing patters of behaviour.
- The importance of reflection with others as a means of generating new knowledge and sense-making processes.

To summarise, Mike and I were becoming increasingly sceptical of the validity of the notion of the objective investigator. I became curious about how this had been developed, and revisited the literature to explore this further.

In the natural sciences, a radical challenge to the concept of the independent, unbiased and objective observer came with some surprising results from experiments in quantum physics. These found that when scientists tried to observe light waves and particles this fundamentally changed their properties, which changed yet again when experiments were conducted in the absence of an independent observer, (Wheatley, 1999: 27–47). Hence the important discovery that the presence of the observer has an impact on the phenomenon observed. The complex responsive process perspective appeals by analogy to these findings to validate a methodological research position in which people are both participants and observers at the same time. Hence, as Stacey (2003) notes,:

> Neither researcher nor manager can step outside the conversational processes that are the organisations simply because their work requires them to talk to others. What they say affects what they hear and what they hear affects what they say. From this perspective, then, a manager cannot stand outside organisational processes and control them, direct them or even perturb them in an intentional direction. All such intentions are gestures made to others in an organisation and what happens unfolds from the ongoing responses. One might call this a methodology of emergent enquiry. (Stacey, 2003: 413)

Complex responsive processes therefore move away from the notion of manager as objective observer. Instead, we are understood to be participants in complex responsive processes, engaged in emergent enquiry into what we are doing and

what steps we should take next. We may also be enquiring into the nature of our own complex responsive processes of relating. This is what it means to be reflective. This theory provides an explanation of what managers are doing, rather than of what they should be doing (ibid.: 414). This is why, in my narrative, I increasingly focus on the detail of my everyday practice and how I make sense of it. I now find myself doing this with my work colleagues with increasing frequency, whereas in the past we spent more time speaking of what we should be doing, rather than what we *are* doing.

As Stacey observes, it would be methodologically inconsistent of such a theory to attempt to yield general prescriptions on how that self-organisation should proceed and what should emerge from it. Such an interpretation would be the direct opposite of what it is explaining. Instead, the theory of complex responsive processes invites recognition of the uniqueness and non-repeatability of experience:

> Organisations characterised by the dynamics of bounded instability will therefore all be unique in some important way. The experience of one cannot be repeated, at important levels of detail, by another. Giving examples of success in one organisation to managers in another is likely to be spurious. (Stacey, 2003: 415)

This causes Stacey to postulate that this is probably why the track record of identifying attributes of successful organisations is so poor. He suggests that, instead of looking for understanding in other people's experience, one might look for it in one's own experience (ibid.: 415). In this way of thinking, intention and design are understood as emergent and problematic processes. These insights are significant for me with respect to my work on CRM. Mike and I are constantly 'tweaking' our investigation process through negotiation with the team as a consequence of our discussions on what we are doing and what seems to work and what needs to change. It also helps explain why our attempts at following frameworks to disseminate best practice are only partially successful.

I now understand that organisations change when the themes that organise conversation and power relations change. Learning is change in these themes. Knowledge is language and meaning emerges as themes interact to form conversations (ibid.: 417). From a complex responsive processes perspective, surprise becomes part of the internal dynamic of the processes themselves. This approach offers a different interpretation of the notion of accountability from those offered earlier which locate accountability for error either with individual clinicians, the system or both. As Stacey notes:

> Another profoundly different distinction between systemic theories is to challenge the assumption that the criterion for selecting a quality action is its outcomes. Quality actions are those that produce desired outcomes. However, in an unpredictable world, the outcomes of an action cannot be known in advance. It is necessary to act and then deal with the consequences... One is not absolved of responsibility simply because one does not know the outcome. Even if I do not know how my action will turn out, I am still responsible and will have to deal with the outcome as best I can. (Stacey, 2003: 420)

I also now recognise that this perspective does not mean there is no control; simply that it is understood in a different way. Stacey frequently points out that all acts of relating impose constraints on all of those relating together. Control takes the form of relating itself, that is, it is a mutual constraint. Self-organisation involves a process of mutual constraining and hence a paradox or enabling and containing. These insights have sometimes proved difficult for me to make sense of. I have come to recognise that rather than being an independent investigator whose responsibility it is to discover 'the truth' about what happened, I now see myself as an active participant in the ongoing enquiry into how we can make our hospitals safer for our patients. The focus on my work is therefore different. I find myself having a greater sense of responsibility for trying to focus on what I can do 'here and now' to improve things. I place a greater emphasis on conversations with staff to encourage interpretation of what happened, sharing drafts of reports in order to explore together what went wrong and encouraging them to think about what we are learning and what is changing. We have started a new section in our reports which attempts to capture these changes as they are

emerging. Although uncomfortable, there is also a richness to this way of working which I enjoy. I used to become frustrated with our old reports – the findings of which were often contradicted by staff, who also often failed to complete the agreed action plans. I had wondered what needed to change to engender a sense of ownership or accountability for change. I came to understand this differently through another conversation about the Clayton Unit incident.

Accountability and learning lessons

Mike and I are discussing his progress with the interviews as part of the renal investigation. He is relating the story of one of the nurses he has interviewed. At the beginning he had a sense that in some way she felt what had happened was peripheral to any of her own actions and it didn't really have much to do with her in practice. He said that what was interesting was that as they had began exploring the issues more deeply he had sensed a sudden change in the conversation. He said something like: 'It was as though she suddenly recognised that in some way she was implicated in all of this.'

He had gone on to say that she had made a comment like 'Goodness – this seems to come back to me!' This resonated with both of us – as noted earlier, we had already acknowledged that this particular investigation seemed to have its links back to ourselves – and this had evoked a sense of anxiety for both of us. Was it our fault? Would someone blame us for this? This 'felt' experience of accountability is expanded in the risk management literature:

> ...I felt a sense of shame like a burning ulcer. This was not guilt: guilt is what you feel when you have done something wrong. What I felt was shame: I was what was wrong. And yet I also knew that a surgeon can take such feelings too far. It is one thing to be aware of one's limitations. It is another to be plagued by self- doubt. One surgeon with a national reputation told me about an abdominal operation in which he lost control of bleeding while he was removing what turned out to be a benign tumour and the patient died. 'It was a clean kill', he said. Afterward, he could barely bring himself to operate. When he did operate, he became tentative and indecisive. The case affected his performance for months. (Gawand, 2002: 61)

And the implications of the absence of this feeling:

> Even worse than losing self-confidence, though, is reacting defensively. There are surgeons who will see faults everywhere except in themselves. They have no questions and no fears about their ability. As a result they learn nothing from their mistakes and know nothing of their limitations. As one surgeon told me, it is a rare but alarming thing to meet a surgeon without fear. 'If you are not a little afraid when you operate,' he said, 'you are bound to do the patient a grave disservice. (ibid.: 61)

For me, what is important about these stories is the shift in awareness and attention which enables us to see ourselves as active participants who somehow contribute to what is going on. I believe this insight is fundamental to the notion of accountability. I think Mead's theories help me understand what happens here (Mead, 1934). Once this insight is gained, I think we account to ourselves in our own internal monologues in a different way, about who we are and what we think we are doing. This 'conversation' with ourselves occurs at the same time as we are accounting to others for our ongoing contribution to the process. I think this is a very different notion from the perception of being some kind of objective observer or alternatively a passive victim within a 'system' which is somehow believed to cause all these incidents to happen.

I ask myself if learning occurred as a consequence for this nurse as part of her interview with Mike, and if so, how do I explain how this occurred? I would argue undoubtedly yes, as evidenced by the following sequence of events that happened a few weeks after Mike relayed this conversation to me. Another Medical Device Alert (MDA) was issued from the MDA concerning a particular piece of equipment used by diabetic patients. The first thing I noticed was how my own response to this alert differed from those that had arrived before the Clayton Unit incident. Although I am copied in on these 'for information only', I now find myself scanning the distribution list to check that everyone I think should have been copied in on it has in fact been. I forward it on to a few additional people and recall thinking they will probably get it through one of the other distribution routes – but it is better to be safe. I then noticed another interesting shift. In a very short space of time I had received a plethora of e-mails

from a number of nurses who had been involved in the Clayton Unit incident. They were asking questions about this latest alert – double-checking we had done everything we should have done. Some had suggestions for things they thought we ought to be following up on. This was a marked difference from an observation in the SCI investigation, where everybody thought everybody else must have been taking some action. What I noticed here was a shift where people had recognised personal responsibility in ensuring that things had happened.

Similarly, Mike had also sent some e-mails with advice on how to act. He also dropped me a note commenting that it seems that 'lessons had been learned', as a consequence of the Clayton Unit incident. So what had been learned – and how? To me, the process was much more complex than 'the sender – receiver' model (described in earlier projects) would advocate. This would account for the change through our 'sending' the messages which were 'received' and enabled the recipient to change their 'mental model'. I do not think this theory adequately explains the learning process in the preceding narrative. One could perhaps have argued this if they had introduced our new system for distributing MDAs and changed the process – which was one of the recommendations arising from the SCI report. However, this had not yet been completed, and the nurses who contacted me were not aware of any changes. Therefore, they were not simply following some newly imposed rules. I account for the changed responses of Mike, myself and the nurses through the theory of complex responses processes. I am arguing that what we experienced was the transformation of familiar patterns of working because of the shift in our attention that arose from our direct personal experience in the SCI in the Clayton Unit. For me this raises the importance of the theory which forms the basis of experience and emotion in relation to any given theory learning. This was also, I believe, more profound because the intense emotions that arose as a consequence of potential serious harm for a patient. I think the feelings that arise at such times with respect to the emotions of anxiety, shame and fear are a fundamental part of that learning process (Aram, 2002).

In re-reading the above section I am reminded of my observation in Project Three with respect to the importance of the functionalisation of values. I notice how these values were not things that were 'there' but emerged in our daily interaction with each other. These are therefore things we need to reiterate, and as such have the potential for continuity or for change. This springs to mind because I felt guilty in reading the above paragraph as it occurred to me that in the months that have elapsed since I wrote them, if I am honest I am probably not paying as much attention to the MDA alerts as I was then. On returning from a week's leave I had over 300 hundred emails and I had forwarded the MDA alerts for my PA to print out so I could read them later. Yet interestingly, feeling guilty and raising my anxiety through re-reflecting on this I know I will go back to this on Monday and double-check them all. This highlights an important issue with respect to sustaining changes in practice. The emotional engagement is a strong motivator and we need to find ways of keeping alive the themes and replicating and amplifying these – it is not something that can be done via a one-off campaign and we cannot assume that changes in the short term are always sustainable.

This is reinforced as I reflect on a number of patterns that seem to repeat themselves every few years with respect to patient safety. We seem to get a cluster of patients falling out of bed followed by a flurry of activity and audits that show significant improvement. Yet some time later the cycle is repeated. I recall my CEO getting very cross with me because he 'thought we had fixed that'. I have noticed similar patterns with respect to certain medication errors, elements of documentation, and compliance with Health and Safety regulations. Through this enquiry I have identified that organisational change initiatives aimed at spreading good practice and disseminating lessons learned (as in, for example, repeated deaths from spinal injections of Vincristine as described earlier), whilst having some impact, seem unable to deliver 100% compliance. I have described how some of these approaches are 'prospective' or future-orientated, and others 'retrospective' or orientated towards the past. The difficulties I have experienced with both these and how we identify changes that need to be made is that we cannot possibly know whether these in themselves will lead to further unintended

consequences. We have the potential both to improve or, it is important to remember, aggravate the potential for such incidents to happen in the future. We have to act on the best evidence and our experience at the time. For example, Mike and I identified that the system for disseminating MDAs was designed with the best knowledge and intention at the time. When we 'learnt lessons' about our system and refined and modified it, we did so on the assumption that this would improve it. In fact, of course, we cannot know whether or not changes we made will be an improvement or not until we see what happens as a consequence. After 'improving' our MDA distribution systems, later we had more concerns raised by a cardiologist who had failed to receive a MDA alert under the new 'improved' system.

Reflections on this project

I am starting to recognise that the theories that underpin CRM have a number of distinctions from complex responsive processes and the application of the former theories seems to be less helpful to me in explaining why it is we are not eradicating medical errors through developing mistake-proof systems and creating a 'blame-free' or 'blame-fair' culture (Ottewill, 2003). I would summarise the observations I have been developing through this project as follows.

First, the split that is made between past – and future – orientated approaches seems to avoid dealing with the paradox of how our perceptions of the past change as we make judgements about the future in the process of making sense of our experience. Stacey notes how this occurs not at a single point in the present, but in the circulation process of the present in which there is potential for transformation as well as repetition. These insights have caused me to pay greater attention to the following in my work:

- Exploring with others, through conversations, their perspectives on what has happened in the past; identifying with groups how and where these perspectives differ; and noticing how this can either lead to a recognition of these difficulties in a way that leads to transformation (as in the sister who exclaimed 'this comes back to me') or repetition of a 'stuck' pattern

as people's perspectives remain unchanged (as in the staff nurse who thought the Trust should make decisions on which machine to use).

- Shifting my understanding of the process of how we 'investigate' SCIs to a perspective informed by the research methodology of emergent exploration of experience (see synopsis) which, as evidenced through my narrative, has led to changing practice, including:
  - Moving away from an approach where an objective observer seeks to uncover an absolute truth, to a team-based approach where diversity is provided from a member of the CRM team and local knowledge from an internal investigator.
  - Seeking to discover different perspectives on 'what happened' and bringing together practitioners to make sense of, and learn from, their experience.
  - Exploring ideas around storytelling in organisations as a way of sharing lessons that describes the emotional content of such experiences rather than our formal reports which seem to ignore this dimension.
  - Expecting and seeking differing perspectives rather than trying to force a consensus upon what happened where no such consensus is apparent.
  - Placing much greater emphasis on 'the present' when incidents are first reported, in order to explore with staff the learning and actions that are happening now rather than a focus/belief that learning/action happens at a distant point *after* the incident, rather than being *part* of the process.
  - Avoiding locating blame/cause for accidents and mistakes in a higher 'system' or solely with an individual, and working with others to explore their own individual responsibility and accountability in forming and shaping the 'system' whilst also recognising the external influences that impact on such situations.
  - Recognising the importance of the quality of relationships within teams and the correlation between poor team working and clinical

errors, and paying more attention to these factors when exploring what went wrong as part of our 'investigation'.

- Using our CRM meetings to explore and critique what we think we are doing, recognising the small changes that emerge each time we do this, and capturing this learning in a written form.

Yet I also recognise that these are my observations and perspectives based on my own personal experience. As such I appreciate others may see what I am doing in a different way, and so these are ideas for further exploration – not a list of 'top tips' for CRM. To suggest they are replicable or transferable is inconsistent with the theory of complex responsive processes.

Finally, this project has given me a different perspective on my central theme of accountability, which I also plan to revisit in my synopsis. I notice through my narrative how important the theoretical perspectives that inform my practice are in influencing how I account for what is happening when things go wrong in organisations. This changes depending on whether they are past – or future – orientated, linked to the scientific method, or grounded in systems thinking. As I have come to challenge these theories, this has begun to influence the actions I take in my everyday practice.

When reflecting on my work from this theoretical perspective, I am reminded of some of the difficulties that have emerged for me when trying to explain some of the phenomena from my practice using systems thinking. Some of the ideas that interest me with respect to my work project and risk management are as follows. In such an analogy, there is no higher 'system' which somehow makes individual agents act in a certain way. Nor can the root of the change be located in any one individual, since it is the action or inaction of individual agents which resonate together to create the outcome. In such systems, there is an element of predictability but there is also an element of unpredictability, and both are paradoxically present at the same time. I am arguing that if we take such analogies seriously, this offers a radical challenge to some of the underpinning

theories we have been using in risk management in the NHS, and specifically with respect to approaches based on an assumption of linear causality.

SYNOPSIS

Introduction

The purpose of this synopsis is to provide the opportunity to reflect on the work in my previous four projects. In order to achieve this I shall:

- Identify the main themes of my enquiry, exploring how my understanding of these has been developing, and describe my current thinking around these now.
- Describe the methodology used as part of this research and explain how my understanding of it has emerged as part of this enquiry.

How and why organisations change

A central concern of my enquiry has been to understand more about how and why organisations change. At the end of my first project I identified a question I wished to pursue following reflections on the influences on my professional practice. This was: *What is 'strategy', how does it emerge in health care organisations and how can I influence its development?*. I have attempted to explore this question within the context of my field of practice as a Director of Nursing within a University teaching hospital, which is part of the NHS in England. I have approached this through using a methodology known as *emergent exploration of experience* (Stacey, 2003). This methodology is informed by insights from complexity science and by the theories of complex responsive processes of relating, which I have described and developed in my preceding four projects.

There are two key areas of literature from this traditional discourse with which I have engaged as part of this enquiry in an attempt to explore this question more deeply. The first is strategy; specifically what it is, how other authors deal with this and how I have come to understand it through making sense of strategic planning and implementation within the context of my own field of practice. Specifically, I have focused on authors who are moving away from the traditional discourse on strategic planning since the challenge these authors make to such

approaches resonate with my own frustrations in attempting to apply these in my work. This has enabled me to develop my thinking in projects two and three with respect to identifying how other authors define strategy, and through this to establish my own position on how I understand the concept. The second area of literature I have engaged with as part of my enquiry is CRM. This emerged as a particular area of interest and is connected with my central theme of strategy in that in enabled me to narrow down my field of enquiry to a specific area of practice. I have described in my projects how a central concern of writers dealing with both strategy and risk is how and why change happens in organisations. I have engaged with these theories as part of my everyday practice and reflected on their usefulness through appealing to my own experience through my narrative in this research. A crucial discovery for me that emerged in my work is that the majority of writers in the field of both strategy and risk management write from a perspective which is heavily informed by systems thinking (i.e. the notion of 'wholes', 'feedback systems' and different conceptual 'levels'). I have argued that this is also apparent even with respect to those writers claiming to draw from the theories informing CAS. They postulate a theory of human behaviour grounded in cognitivism, i.e. a sender/receiver model of communication and a belief that we are free to choose and change our 'mental models'.

Identifying the limitations of systems thinkers (and of course, writers claiming to draw from CAS who I have argued are still working within a systemic paradigms) was a crucial insight which is central to my research. This enabled me to develop what I am arguing is a radically different understanding of causality with respect to clinical incidents, which draws instead from the theory of complex responsive processes (Stacey, 2000). I am arguing that in the process of making this theoretical transition this has led, at the same time, to a significant shift in practice with regard to the way I and my colleagues approach our area of CRM. This is evidenced through the changes I describe at the end of Project Four with respect to the new ways in which we are thinking about and dealing with SCIs. In noticing how my shift in theory influences my practice, I also understand this process differently as a consequence of my research. Specifically, it moves me

away from an understanding that I can decide first what theory to use and then 'apply' it in some way. I now understand that practice is being informed by theory at the same time as theory is informing my practice; and when there is a dissonance, I have pointed to how both then shift at the same time, which is what leads to change and allows the truly novel to emerge.

These insights are crucial with respect to my central question seeking to understand what strategy is, how it emerges, and specifically the issue of 'influence'. I am arguing that through my participation as part of an ongoing process of relating with others, we are constantly accounting to ourselves and to each other for our actions. Hence the importance of accountability as a central theme in my work, in that I am now arguing that it is through this process that strategy emerges rather than something we plan first, then implement. The work of this synopsis is to develop these ideas further and crystallise my position with respect to how I am arguing that this makes a significant contribution to knowledge in strategic approaches to risk management in the NHS.

'Wholes'

I have explained in my projects how some writers are moving from a systemic perspective on human action to one that draws analogies from chaos and complexity theory. These writers observe the dynamics of the edge of chaos and the self-organising emergent properties of such systems. They do describe unpredictability, but their analysis points to the macro level of the organisation as a whole, with some acknowledgement to the importance of micro-interaction and diversity. Complex responsive processes are based on a radically different theory of interaction. Interaction between people is seen as iterated processes of communication and power relating. There is no notion of a whole or whole system, and what people are producing in their interaction are further patterns of interaction. This theory therefore represents a move from a spatial metaphor of 'inside' and 'outside', to a temporal process of continual reproduction and potential transformation. These processes are fundamentally conversational in nature, forming and being formed by power relations. Analysis is focused on the

micro level and concentrates on the dynamics of bounded instability in which self-organisation might produce novel forms of relating and conversation. It emphasises the importance of diversity and deviance as essential to the internal capacity to change spontaneously. In this evolutionary, potentially creative process, unpredictability is central, inviting further exploration of how people come to act into the unknown.

Attempting to understand these concepts has proved important with respect to informing how I make sense of what I am doing in my approach to risk management. Specifically, this theory has legitimised for me the importance of focusing on fragments of an ongoing process of relating rather than making spurious connections to a 'whole system'. Within this tradition, focusing on micro-interaction becomes an important issue. I am arguing that this has significant implications with respect to investigating clinical incidents, since it challenges many of the central assumptions that those of us in this field are using to inform our work. I have covered these in detail in my fourth project, and they include: the belief that we can improve patient safety by making interventions that will change the whole system; the assumption that a few key individuals can engineer a safety culture through re-engineering an organisation's culture so that it is 'blame-fair' or blame-free; and a belief that we can disseminate learning and best practice.

What is important in making this transition is to understand that the meaning of 'participation' is completely different in systems theory than in complex responsive processes. From a systems perspective, participation means participating in an abstract system or 'whole', and from a complexity perspective this means participating in direct interaction with other people. In noting this, it is important to stress that I can see that managers can and do form organisation wide intentions, structures, simple rules and design systems. What I am arguing that we cannot do is design the responses to these gestures, nor is the output of these interactions some reified 'whole'. Thus I challenge writers who postulate that we can 're-engineer' the 'whole system' (e.g. Hammer & Champney, 1993). These

observations are important because this stance has influenced my approach to my enquiry and my writing. For example, in Project Four I see I am less concerned with trying to describe the 'whole' picture or show how changes at one level of a system influenced another in the way I did in my early academic work. This is because I have questioned the value of the concept of 'levels'. I can also see from my narrative how this has challenged and changed what we are doing with respect to CRM. Specifically, I am struggling with an approach which attempts to show a linear causality with a chain of events which do not 'line up' like holes in the 'Swiss cheese' model. Similarly, our investigation does not fit together in the 'relatively straightforward fashion' as advocated by Vincent (2001). I find myself asking: what if there is no 'whole system?' What am I left with then, and what does this mean for my practice? Addressing these questions is therefore important with respect to the discipline of CRM. I now understand this in the following way.

What I now see in re-reading my narrative are numerous fragments from ongoing interaction in organisational life. There is no 'big picture' already there. I am only able to make sense of this through fragments of interaction that I have with a small proportion of individuals with whom I come into contact on a daily basis. That this is a radical challenge to the theories that have underpinned my practice has proved both depressing and liberating. Depressing, because I recognise it is not possible to accurately predict the future. I cannot control and dictate what happens in the areas for which I have responsibility, and there is no 'right' way to do things that I can both learn and teach. Liberating, because I recognise that, although I cannot predict and control the responses of others, I can influence and impact on what is happening through my own participation. Through this process I am accountable to myself and to others for my actions. I can see how these insights have lead to me placing less emphasis on activities such as gap analysis and planning because I have found that activities that focus on an idealised future have in my experience, seldom delivered such 'visions'. I have also argued they prevent people from focusing on what is actually happening in our daily experience – hence they alienate practitioners from what is happening in the present. Instead I now focus more on working through the micro detail in the here

and now with practitioners who have been involved in SCIs. This is because I see that the potential for learning in these moments is heightened, and it is at these times that the potential for transformation of practice is present. I am therefore less concerned with interviewing staff about what happened in order to discover the 'truth', than in exploring with them their reflection and perspective both individually and in teams. I recognise that it is here that lessons are learned, rather than through listing them in a reified and objective way at the end of a report. Similarly, I see how the methodology on this programme has also influenced my approach to writing the SCI report itself. We now share rough drafts with each other and develop these through our conversations. Before, I would have been annoyed to receive drafts as something that wasn't 'finished'. I have noticed how, in discussing draft SCI reports, further learning often emerges, both in our approach to investigating such incidents and with respect to the incident itself.

These insights are proving particularly significant in terms of also helping me address the difficulties in terms of what I was writing about when investigating SCIs. In Project Four I note how writers such as Vincent (2001) understand the organisation as a 'whole' which is formed by the interaction of the parts. Whole systems are separated from others by boundaries and interact with each other to form a supra-whole – a key feature of systems thinking from which many of these approaches are drawn. I can see how this introduces the notion of different levels at which phenomena exist or can be thought about. This leads to a way of thinking powerfully illustrated by the nurse described in Project Four who thought that it would be a Trust decision on what blood sugar monitoring equipment to use. Unlike many of the writers in risk management in health, I am moving away from a position that assumes that interaction between people creates a whole, a system of which we are a part and are so in some way subject to the purpose of the whole in the way described in the television documentary or the frameworks I have described in Project Four. My fourth project helped me recognise that I can never see the 'whole picture', because this is not a 'thing' that exists; only something we conceptualise. From this perspective, my attempt at understanding

'fragments' of experience therefore becomes a legitimate activity as part of a process of inquiry. This is therefore a radically different perspective from writers exploring CRM in the NHS. Since these insights also have relevance for the selection of my research methodology, I shall now examine them here in more depth.

Research methodology as an emergent phenomenon

My first reflections on my methodology began in Project Two as I struggled to understand the theory of complex responsive processes and endeavoured to address this through a critique of Plesk's work. I undertook this using the academic approach I was accustomed to taking. To summarise, this involved a debating or polemic approach. Hence I tested hypotheses which were either proven or disproved. I undertook to critique other authors' work in a manner that sought to disprove their arguments and validate mine. I have developed skills in writing in this way over a number of years and it is also a style and approach that is recognised and valued by my peers (who viewed me as very competent at it). It had never occurred to me that there were other alternatives or to think about its limitations. These became evident to me only through my attempts to write my second project. Those in my learning set coming from a strong academic tradition were very supportive of this approach – one commented how he admired my ability to do what he called a 'demolition job' on other authors. My supervisors were less impressed, and I was challenged as to why I was using this type of methodological enquiry. Interestingly, they were not saying I should not use it – merely asking me to account for my choice. In our ensuing conversations, I began to see that one of the weaknesses of approaching an enquiry in a tradition that seeks to prove or disprove something and conclude it is either 'right' or 'wrong' is that this ignores the notion of paradox in our working lives – a feature of the theories I am working with.

This is an important point with respect to justifying my use of a research methodology that is consistent with the theoretical perspective I am writing about. I am now thinking that for this reason, more traditional approaches that require the

researcher to take the role of 'objective observer' or seek to isolate phenomena from their everyday context would be inappropriate. Initially, I failed to see why dealing with this was important, but in this struggle I gained a number of insights which I feel strengthened and developed the way I enquire into my practice using the methodology of *emergent exploration of experience*. I was encouraged by the faculty to take a more sympathetic approach to Plesk and other authors with whom I was disagreeing. Through this, I was able to appreciate how their work had developed and was informed by previous ways of thinking, as they too engaged and debated with theories they found themselves opposing. This in turn encouraged me to read more deeply for myself about the issues they were critiquing, which required me to go back to the source material for strategic planning. This helped me form my own questions and conclusions, and in the case of Plesk's work I also came to challenge the interpretations he had made of much of the source material. That said, I also recognised it was important for me to retain an element of critical reflection at the same time as sympathetic engagement. Hence the kind of methodology I am describing is not advocating a purely appreciative approach such as outlined in appreciative enquiry (Watkins et al., 2000). What I now see is that emergent enquiry recognises the importance of the paradox of appreciation/criticism in the evolution of new knowledge, and seeks to include both of these as a mechanism of enquiry.

I recall feeling interested and excited about my critique of Plesk and discovering how his interpretation of 'simple rules' contrasted with the position taken by the theory of complex responsive processes. I was surprised when I ended up with quadruple the number of words required for my project, something I had never done in other academic assignments. So, in what became a characteristic of all of our projects and I believe is a feature of this methodology, I did not include a vast proportion of what I wrote. Yet I was also discovering that without these 'discarded' drafts, or speaking about our work in the learning group, I could not produce my final version of the project. The numerous versions, the comments, and our arguments were all part of the methodology; I came to recognise that, unlike other approaches, this was not something I could complete near the

deadline and hand in after a few attempts. These activities were an essential part of the process of enquiry; the final draft was just a point in that process. I also recall being told that my initial work on Project Two did not constitute a project, and feeling surprised by my acceptance and recognition of the fact that this kind of methodology required much more of my own reflection and narrative about my own practice. The challenge was to find out how to do this, and as part of this journey I discovered that this was different for all students. There were therefore no 'simple rules' with respect to approaching the methodology. Hence it is not simply replicable or generalisable: its validity stems from appealing to our own experience, both as writer and reader. From the underpinning theories informing this research, it would be inconsistent to use a methodology that claims to be either replicable or generalisable, since complexity theories indicate we cannot guarantee either. Therefore, I am pointing to the fact that this strengthens, rather than weakens (a perspective those in the traditional scientific tradition would take), the insights gained through this enquiry. This is because they are about my own personal practice and its transformation. Through this discourse, in my projects I co-create with others knowledge about our practice. As part of this, I have pointed to new insights as they have arisen and explained how this has transformed our practice. These insights into the process of generating my thesis are also relevant to my practice, which I will point to throughout my synopsis. For example, a recognition of the importance of trial and error, and the subsequent redundancy of developing expertise as part of a process. This is very different from a position that argues for a 'right' way of doing things, which can be determined in advance and which we can achieve by working through a series of systematic, predetermined steps.

As a consequence I am now recognising the limitations of rational approaches to strategic planning and risk management, which set out a list of 'steps' to move through that I am discovering seldom seem to deliver the intended outcome. What is frustrating me is what to replace it with. For example, colleagues are asking me to develop a complex responsive processes ten-step guide to completing SCI investigations. I have to find ways of articulating why I do not

think this is appropriate. I do this through re-engaging with my attempts to identify why I find the theories of 'simple rules' so unsatisfactory.

Why don't human beings follow 'simple rules'?

The second assumption I have alluded to from normative and rational approaches to change management is that once we have identified what it is 'right' to do, we can capture this in some way through describing it in guidelines or protocols and professionals will then follow these. I shall now explore this in more depth. I am undertaking this here as I recognise in re-reading my projects that, although I pay attention to the importance of 'simple rules', I do not adequately explain why I do not think the analogy holds for human organisations. I notice I attempt this on a number of occasions but fail to address this to my satisfaction. This reinforces another insight into the methodology – namely, each time a pattern is reiterated there is the potential for new patterns (and by analogy, meaning and learning) to emerge.

Working live with 'simple rules'

My thinking about 'simple rules' developed further when I was able to reflect anew on these in an exercise I participated in 'Working Live'. Around fifty conference participants were in a large room and given a set of rules to follow. These were: identify two other people in the room, move until you are equidistant between both of them; no speaking is allowed. This was a human simulation of the 'boids' flocking exercise that Plesk and others use as an analogy to support their argument that complex patterns emerge from a few simple rules. Plesk draws from computer models to validate this use of simple rules in human organisations. At conferences he shows the models, which look like birds flocking. He states how this models the ideas of complexity to show how small changes in behaviour can bring about a large-scale change in the behaviour of a system of interacting individuals; in other words, how large-scale effects can be built from small scale changes in behaviour. He notes how these patterns arise from simple 'rules' in the programme, such as the distance between the boids, and the velocity and direction of travel. He moves towards a similar position to

Wheatley (1992), stating that CAS emerge from simple structures or what he calls 'rules'.

The resulting pandemonium in our simulation of the boids exercise at the 'Working Live' event concluded with a final sense of order. Our subsequent reflection together crystallised for me why it is that human beings cannot follow simple rules in the way Plesk describes. This enabled me to draw analogies to help me answer my questions with respect to why it is that clinicians may not follow guidelines. First, some people misunderstood the instructions. This meant that their behaviour confused and disrupted others who were trying to follow what they thought were the 'rules'. This then created different patterns of sense-making. Some who were doing it 'wrong' found themselves unable to make sense of others' actions, concluding that it was the others who were 'wrong', and continuing as before. Others recognised their mistake and copied others who were doing it 'right'. Some who were following the rules, but confused by others acting unexpectedly, altered their movements and also began a pattern of non-compliance with the 'rules' because they thought is must be those that were 'wrong.' Some said they resented being told what to do. They started experimenting with walking backwards and forwards and varying the speeds of their movement – embellishing and changing what they had been asked to do. One person said he felt the whole exercise was a waste of time, and refused to participate at all. What we were not able to do – nor have I when replicating this exercise with other groups since – was to persuade everyone to follow the rules exactly as the person setting up the exercise intended, in the way the boids flock in the simulations demonstrated by Plesk.

A number of points strike me as important from these insights, which I am arguing make it impossible to assume that humans can behave like the boids. This is why I argue against Plesk's deterministic interpretations of CAS. First, we have a choice regarding whether or not to participate in the following rules. Second, our understanding about what we are being asked to do (which will be informed by our previous knowledge, experience and perspective) will be

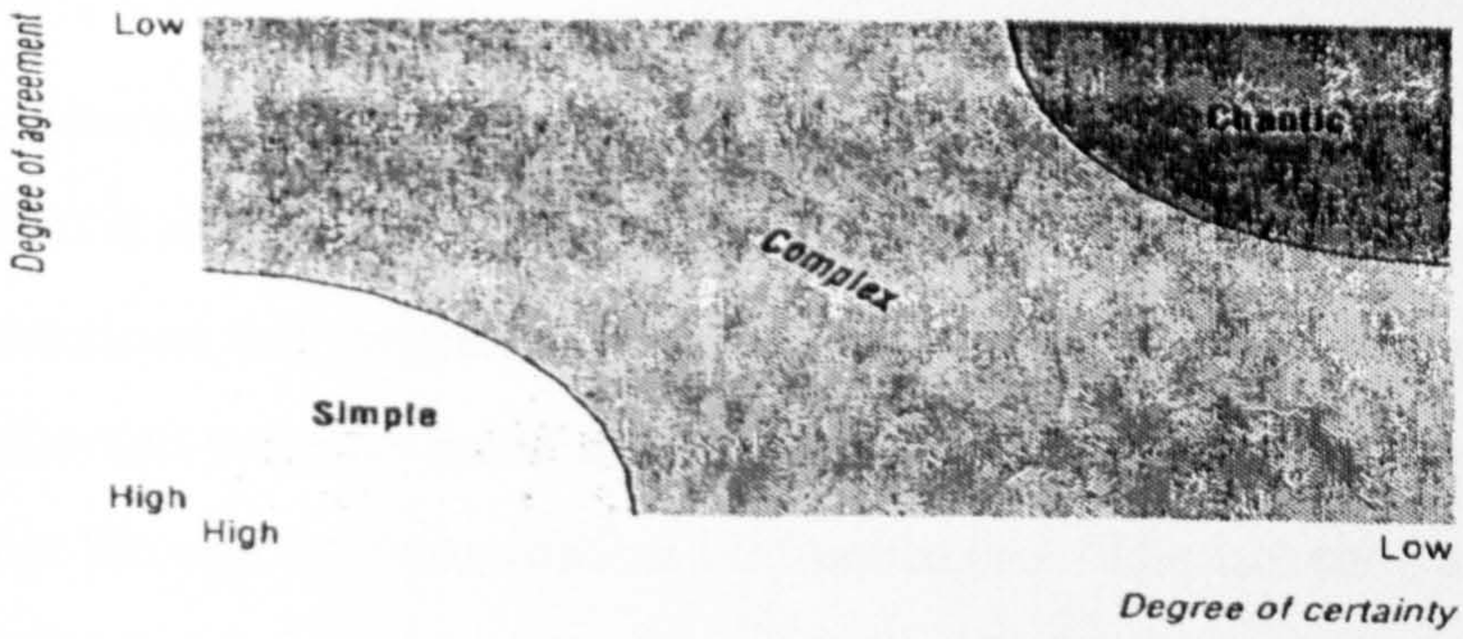
different from other people's. Third, I now recognise how I am influencing, and am influenced by, the power relations and my relationships with others within the group. Do I upset the facilitator and risk being excluded? Or do I feel superior to them and not bound by what I am asked to do? How do I feel about being accepted or rejected by others who are participating? How do I account to myself for the value of this activity? These are all questions I notice clinicians struggling with when considering changing their practice when asked to comply with new guidelines. As such, then, understanding the rules alone will not guarantee compliance. This helps me understand how strategies that rely on 'sender/receiver' theories do not always work. I am arguing this is because the guidelines (using Mead's theory) are a gesture and we cannot know in advance how others will respond to this.

In questioning why clinicians do not follow clinical guidelines in Project Four, I can see that there is the potential for repetition or transformation of patterns of human interaction in which genuine novelty of clinical practice can and does emerge. I am arguing that this is analogous not to the boids simulation, but to the Tierra simulation which has diverse, rather than homogenous, agents (Ray, 1991; Reynolds, 1987). I have learned this is therefore grounded in transformative teleology, whereas Plesk draws on a formative teleology in which the 'rules' are already enfolded in the system so that we just need to discover what they are. Since it is not possible to consistently predict the response to the gestures of others, I have also questioned the notion of replicability – both with respect to more traditional research methodologies and with respect to the notion of 'spreading best practice'. Stacey argues that this is possibly why the track record of successful organisations is so poor, leading him to postulate that instead of looking for understanding in other people's experience one might look for it in one's own (Stacey, 2003: 415).

To conclude this section, I want to draw attention to the importance of what I am suggesting to the field of CRM. Much of the literature is founded on the

assumption that replicability of best practice is both possible and desirable. What I am challenging here is both of these assumptions.

This is where I am now seeing how Weick's work makes a valuable contribution – both his insight that human beings can only make sense of what has happened retrospectively, and his emphasis on improvisation as a way of dealing with the frequent unexpected situations that arise in the numerous serious incidents he explores in his work (Weick, 2001). This moves away from the idea that the solution to addressing such problems is solely through the production of detailed guidelines and protocols and training people to follow them. I am careful not to suggest that this cannot be a useful activity. I have cited Benner's work showing that, for novice nurses, such guidance is crucial; and I remember my reliance on such manuals early in my career (Benner, 1984). The point I am making is that Benner and other authors have also identified that expert practitioners in many ways deviate from such guidance, and it is their ability to improvise in radically unexpected situations in appropriate ways that distinguishes them as expert practitioners. It is also not possible or reasonable to have guidance for every situation that arises. The way a number of authors in this field tackle this difficulty of the paradox of predictable/unpredictable (appealing to CAS as a source of analogy) is to suggest that we use guidelines for the predictable and something else for the unpredictable. Many writers draw on Stacey's original diagram (which he has now said he no longer believes is helpful) and use models such as those below in order to determine whether guidelines should be used.



The certainty-agreement diagram (based on Stacey[23])

Figure 3: The certainty–agreement diagram (Stacey, 2004)

(Plesk, 2001: 625)

My difficulty with such approaches is that they make the assumption that we know before we move into a situation what the output will be. I have argued that this is inconsistent with a central insight from CAS, namely that at the 'edge of chaos' the outcome cannot be known in advance, and this may generate genuine novelty (Prigogine, 1997). I am arguing that these observations are significant in the field of CRM. This is because from this perspective it would be impossible to predict the future through 'horizon-scanning' activities (Firth-Cozens, 1995). These observations are crucial in this field of practice because they present a radical challenge to a proportion of the activities many of us working in CRM spend our time on, for example, clinical risk profiling. I am not arguing that this is not a worthwhile activity: sometimes I have found it has led to some significant improvements in practice. At other times, however, it hasn't; and my point is that until I see the response of others to my gesture of working with them together to undertake this activity, we cannot know for certain what the outcome will be – because no two groups are the same. In recognising this, I see that my colleagues and I now have different expectations of this kind of activity, and anticipate that a proportion of this kind of work will not proceed as we have expected. It is in our trial and error that we gain our experience – something I shall explore in more depth below.

Other reasons why professionals may not follow 'rules'

Sender/receiver model of communication

What is clear from my narrative is that sometimes new ideas are taken up and sometimes not. Understanding why such change strategies succeed or fail is an important issue for me with respect to my central question regarding strategy and how through my participation I influence this. The current discourse in the NHS explains this in a way that is grounded in the sender/receiver model of

communication that I have explained in earlier projects. They locate the source of adoption or rejection with individuals (Fraser, 2002: 30).

I am moving towards a different way of understanding why and how changes in practice (which may be positive or negative) occur, which locates the source of change in the interaction *between* people and is grounded in Mead's theory of gesture/response (1934). In this way of thinking, I do not 'send' messages which are then 'received' by others and understood in the same way as I understand them myself. Instead, the gesture and response occur simultaneously, as part of one act, and the meaning of my gesture emerges as the response from others. These insights were powerfully informed by the work I describe in my research through the use of theatre. In the SCIs in my narrative, there are numerous examples of misunderstandings and differing interpretations of events. Within these micro-interactions, the understanding or misunderstanding that occurs between people seems to have fundamental importance in the context of my research into strategic approaches to risk management. There is significance in these moments and the feelings they evoke – either arising from the shame, discomfort or anger from feeling 'wrong' or from the exhilaration of seeing something new for the first time, which I have discovered is inherently linked with learning. I am starting to see this as part of one unified process: that learning is occurring when familiar patterns of practice and behaviour change – and this occurs *at the same time.* Hence learning is something that is an inherent part of this patterning of complex responsive processes, not something we 'do' afterwards or part of a cybernetic loop in which theory informs practice and vice versa.

Dialectic movement as a process of learning

In writing this, I recognise how this kind of analysis is also informed by another component of the methodology which draws on Mead's interpretation of Hegel's notion of the dialectic movement of thought (Mead, 1934; Hegel, 1807). In what is described as 'negation of the negation' (Griffin, 2002), new knowledge and ideas emerge as we come across ideas or ways of thinking with which we

disagree. Engaging in dialogue, either with others or (drawing on Mead's notion of the 'I – me' dialectic) in my silent conversations with myself, I find ways of articulating my arguments in a way that enables my thinking to develop (Mead, 1934). I am noticing that an important component of what I experience as 'learning' is that I have to first recognise what was 'wrong' in order that I can identify how to do it 'right'. My experience is that in such moments I also sense an emotional response – I am 'feeling' the difference, and this feeling somehow shifts my awareness as I find myself responding to events and people in different ways.

As novel situations arise from interactions with others, I can see from my narrative that as we make sense of this together new knowledge and understanding emerges. It is only through my recognition of what is 'wrong' or different that I am able to identify what is 'right' or what to do differently. This recognition occurs in my interactions with others and my silent conversation with myself. As Gawand notes:

> In surgery, as in anything else, skill and confidence are learned through experience – haltingly and humiliatingly. Like the tennis player and the oboist and the guy who fixes hard drives, we need practice to get good at what we do. There is one difference in medicine, though: it is people we practice on. (Gawand, 2002: 20)

This is, I think, a fundamental issue with respect to risk management and health care. I become competent through this process of my experience. Benner identified in her research that, although novice nurses needed rigid rules procedures and guidelines to enable them to feel secure within clinical situations, conversely expert nurses often found such rules an unnecessary encumbrance and were said to practice more intuitively (Benner, 1984). Research by Dreyfus & Dreyfus (1979: 33) notes that as long as the pilot, language learner, chess player or driver is following rules, their performance is halting, rigid and mediocre; but with mastery of the activity comes transformation of the skill. What I am pointing to is that it is not possible to gain expertise without making mistakes in order to

learn; yet the difficulty comes because when as clinicians we make mistakes, we can potentially harm patients. Gawand sums this up when he observes:

> As patients, we want both expertise and progress. What nobody wants to face is that these are contradictory desires. In the words of one British report, 'there should be no learning curve as far as patient safety is concerned'. That is entirely wishful thinking. (Gawand, 2002: 28)

This is a crucial finding of this enquiry because it is a challenge to a dominant perception in the CRM field that we can some how 'mistake-proof' activities that are undertaken by humans; and I cited in my fourth project that this is done in an attempt to ensure that what went wrong before 'must never be allowed to happen again'.

The importance of experience

What I am coming to realise through my enquiry is that our knowledge arises through our ongoing patterns of relating together and how we make sense of these, which I refer to as 'experience' – an ongoing process of interaction. Since our experience is different in some way to other people's, the perspective and sense we make of a given situation will therefore also be different. So another reason why humans do not follow 'simple rules' in a unified and mechanistic way is because of the potential to interpret them slightly differently. Another is that it is only through our experience that we learn when it may be appropriate to follow such a rule. I have pointed to the differing responses of those of us involved in the SCI in the Clayton Unit in how we dealt with receiving an MDA alert before and after our experience in which a patient could have died. I notice how those of us who lived through this experience acted differently as a consequence. I believe this is because we paid more attention to MDAs because of our emotional involvement in the SCI and in recognising our own accountability for taking action. This created a heightened awareness of the fallibility of our MDA system in a way that could not have been present prior to this experience, nor would this awareness be present in others who were not involved. What therefore becomes an important question for me is how we can raise people's awareness of dangers of which they have no direct experience. This is a central concern of risk

management with respect to learning lessons and spreading good practice, and in Project Four I describe some of the ways in which my colleagues and I are trying to do this through the use of stories, video clips of the football match and forum theatre. This seems to bring our topic to life in a way that reading an abstracted list of recommendations devoid of their context does not.

It is also important with respect to my question regarding how I influence the emergence of strategy through my participation in interaction with others. I am proposing that my ability to influence the emergence of strategy is linked to prior experience, first because in encountering a situation similar to the one I have encountered before, I recognise it and can base my assessment of how to act on what happened the last time (i.e. my response to MDAs following the SCI). Second, this experience has the potential to place me in a more powerful position over others who do not know what to do.

The importance of enabling constraints

It is important that I stress here I am not suggesting we have no power or control over mistakes happening in organisations just because we cannot predict the outcome of our actions. In fact, just the opposite. Stacey also points to this when he notes:

> One is not absolved of responsibility simply because one does not know the outcome. Even if I do not know how my action will turn out, I am still responsible and will have to deal with the outcome as best I can. (Stacey, 2003: 420–1)

I have also argued that through our actions and inactions, we can and do influence what is happening in the moment. This creates the potential for new and novel patterns of activity to occur whilst also recognising the potential for repetition of old patterns, both of which are a feature of transformative teleology.

In re-reading this section I recognise there are a number of other important factors influencing organisational change. In identifying these, I also sense their relevance to CRM. I notice that systematic approaches to risk management such

as those I describe in Project Four fail to address significantly the concepts of power or perspective in teams. A question that repeatedly cropped up for me in reviewing many of the NHS catastrophes I refer to throughout my projects was: if it was that bad and that obvious, why did no one take action sooner? Why did no one speak out? Or why did no one listen? I could not answer this to my satisfaction using the traditional theories I reviewed, nor even from some of the newer thinkers such as Senge (1990) or Wheatley (1999). Hence for the 'mad' or 'bad' practitioners (such as Dr. Shipman as described in Project One), it has been shown that many professionals and lay people had concerns – but nothing definitive was done until he had murdered in excess of 200 patients.

Many enquiries into such SCIs talk about a 'culture of fear' and 'lack of transparency' with regard to how decisions are taken, and mention a lack of clear accountability in the organisations within which they occur. It seems to me from such observations that there is something that needs to be explained with regard to why it is that people in such situations feel unable to speak out. I have come to understand through my research that this is connected to the power dynamics in teams. I mention this briefly here, but emphasise that since the exploration of power in groups did not emerge as a central theme on my enquiry thus far it is not one I have chosen to develop further. Yet I have noticed that this is an area that is under-emphasised in risk management. Typically, explanations emerging from the traditional discourse on risk management emphasise weak organisational systems and processes that failed to pick these mistakes up. They also write of how an 'organisation's' response to a signal that there may be something wrong is disproportionate to the size of the signal (Weick, 2001). I am arguing that 'organisations' cannot recognise signals; people within them do. Furthermore, I am pointing to the fact that it is only in retrospect that we can account to each other and negotiate whether or not the signal was significant; this is not something we can predict.

Many authors also touch on what are often described as dysfunctional relationships in teams. Responsibility for this is usually located in a few key

individuals. In Bristol it was the CEO (a doctor) who lost his job and was later struck off by the GMC (Kennedy, 2001). I notice how in this discourse culture is typically described as if it were a 'thing' which is somehow forcing people to behave in certain ways; its co-creation and power in groups is seldom mentioned. Similarly, changing the culture is described as if this is something that can be re-engineered by a few powerful individuals through re-educating staff with the 'right' values (Crosby, 1979), thus locating power within individuals rather than (as I am suggesting) as something that is co-created among group participants. In stating this I do acknowledge that powerful individuals in these teams do profoundly influence strategies for practice. I see through my research how these power dynamics and 'dysfunctional' teams are not the things we write about in our strategic documents. They are also seldom discussed in formal meetings, instead forming part of the 'shadow side' of conversations (Stacey; 1996; Shaw, 1997). This insight is important in addressing my central question with respect in influencing strategy, since it challenges the traditional definition of 'strategy', as well as the idea of 'influence' being something located solely with an individual.

Power as an important component in risk management

My reading of Elias gave me a different insight into why some of these phenomena may be occurring. I was struck when I read:

> We say that a person posses great power, as if power were a thing he carried around in his pocket. Power is not an amulet possessed by one person and not another; it is a structural characteristic of human relationships – of **all** human relationships. (Elias, 1989: 113–37)

This prompted me to think about how we co-create these situations amongst ourselves as we are enabled or constrained by our power relations with each other. For example, I think of myself as an assertive, well-informed professional, yet when I have been a patient I have been astonished at how quickly I assume the supplicant sick role and tolerate what I judge as poor practice. Yet in recognising this, I also have to accept that I am co-creating a situation that could harm me, through what Elias would describe as holding the current power configuration and deferring to the professionals (Elias, 1978).

These insights have also been crucial in informing my insights about the methodology of *emergent exploration,* since the concepts of complex responsive processes that influence how I understand my practice (such as transformative teleology arising from human interaction, dialectic and paradox) are also features that underpin this methodology. This perhaps helps explain why I found it difficult to write much about the methodology in my earlier projects, since my understanding has been emerging as I have worked with it and discovered it as part of my practice, rather than seeing it as something that is abstracted from my experience. I shall now explore this below.

Further reflections on the research methodology

I am now appreciating the impossibility of writing about this research methodology in a reified and abstract form which lists a step-by-step approach on how to undertake this kind of enquiry. I understand that attempting to do this would also be inconsistent with many of the underpinning concepts of complex responsive processes. What has therefore been challenging for me is to find a way of writing about the methodology that is consistent with these ideas. I am sensing that the only way to do this is to describe my experience of writing these projects, and through this to explore how my knowledge of this methodology and the themes of my enquiry have emerged, in a way that makes sense to both myself and my reader. In undertaking this kind of enquiry I am also noticing how, as part of this process, I also influence and change what this methodology means to others.

In requiring me to write about my own practice in a narrative style, I think this methodology takes seriously its theoretical stance on how change happens in organisations. It does this through forcing me to interact with and account to both myself (through the silent conversation in my writing) and others (through having to discuss my work with my learning group) in a way that more the traditional approaches I used before did not. In these, I wrote and worked alone, showing my supervisor the draft only when it was finished. There was no requirement for

discussions with other students. I have explained earlier how the formation of identity through interaction with others is a central component of the theory of complex responsive processes and how new knowledge is created as part of that interaction. In exploring this now I am appreciating how undertaking my research in this way is consistent with some of the arguments I am putting forward about how and why individual groups (as a singular and plural of the same phenomenon) change (Elias, 1989; Mead, 1934).

What strikes me now when I look at my earlier dissertations is my irritation at my choice of title with respect to the notion of 'application' of theory and how I describe what I am doing – namely in 'choosing' and 'testing' these as an activity that is separate from the 'doing' of my everyday practice. I see now that what I did using such research methodologies was to determine which research instruments to use and then 'apply' these in the way described to a particular predetermined area of study. I now understand that such an approach is grounded in a theoretical perspective which believes that human beings think first and then act – something I have come to challenge in my third project, where I am taking the view that this is part of one unified activity (Mead, 1934; Joas, 1996). I was also heavily influenced by a rational approach to strategic planning that was heavily informing my work on strategic planning at the time (Ackoff, 1981). Following this formula, writing up my dissertations should have proved relatively straightforward. I was presenting the findings of the outcomes of these predetermined activities in the same way I recall Vincent describing how SCI reports conducted using a similar rational approach should come together in a 'relatively straightforward fashion' (Vincent, 2001: 449).

Somewhat frustratingly, I experienced similar difficulties to those explored by Mike and myself in my fourth project when writing SCI reports. Some of the interventions that I was testing, which should have made a difference, didn't seem to have done so. There were other unexpected findings arising from my interviews that didn't quite fit in with the scope of my research, which seemed much more interesting to me; but I was constrained by my original research

proposal. What I also notice is how insights such as these are equally relevant to both the methodology and my practice in helping me understand how and why change happens in organisations. As such, then, both are informing the other, reinforcing for me the inappropriateness of alternative methodologies when seeking to understand organisational change from a perspective of complex responsive processes.

Another difference I noticed in this methodology was that we were encouraged to change our research questions as we progressed through the projects: they emerged from the narrative and my exploration of themes from my practice rather than the other way round. Hence it was only in retrospect at the end of all the projects that I could determine the title for my thesis. Although this seemed strange to me at first, I now see that it is also consistent with another of the observations discovered through my enquiry – namely that sense-making can only occur in retrospect (Weick, 2001).

I am noticing other differences in this methodology from the rational approaches I have used in the past. We were not given a predetermined set of tasks that told us how to 'do' this kind of research. I don't even recall us giving it a name until some time around the third project, and the name itself has changed a number of times since. As such, I found it difficult to write much about the methodology in the projects themselves because my understanding of what 'it' was and what 'it' meant for my work was constantly shifting. I also see this inability to 'fix' this approach and define and describe it in some way is entirely consistent with the theory of complex responsive processes which underpins it. Hence it is a genuinely emergent phenomenon which I discover increasingly as I enquire both into my professional practice and the research methodology. Thus I am also discovering more about the methodology, how it compares and contrasts with other research methodologies, and how I work with others to develop and refine it and our understanding of it. In making sense of it, I find myself drawing on my previous experience in learning groups; and through doing this I notice the similarities and differences that enable me to synthesise my own perspective.

The learning group as part of this methodology

I have come to see how important my learning group has been as part of this research methodology. Insights from the group have informed my writing and the nature of my inquiry, and this has been iterated back to the large group each time we meet. I also, in turn, contribute to the discourse through sharing the ideas I have been developing through the writing and with my learning group; or, to borrow the language of Mead (whose perspective is central to this methodology), I am forming the group at the same time as I am being formed by it (Mead, 1934).

Research methodology – other approaches to action learning

I think it is important to understand the similarities and differences among my learning group as part of this research methodology as distinguished from other approaches. Action learning has become increasingly popular in the NHS over the last decade, and I have participated in a number of action learning sets throughout my career. All have proved powerful learning experiences, and one in particular – which I formed with a group of other newly-appointed Nurse Directors ten years ago – is still meeting. In reflecting on the methodological grounding for this approach, I re-read the action learning guidebook which informed much of our early work together (Neubauer, 1996). Our approach was grounded in the work of Revans (1991) and has tended to focus on personal development through sharing case studies about problems in our working life. Action learning is described as the best way to educate managers, and it is based on the premise that 'there can be no learning without action and no (sober and deliberate) action without learning' (ibid.). I think that in defining it in this way, Revans is also seeking to address the traditional split between acting and thinking as separate activities occurring in a linear way. Revans also seems to be suggesting the interrelationship of both action and learning as one act. Complex responsive processes of relating also seeks to address this through drawing on the work of Mead, who emphasises that gesture and response are part of one act (Mead, 1934). Revans seems to be grounding his approach in the tradition of cognitive psychology. He suggests that organisations (and the individual people

in them) cannot flourish unless their rate of learning is equal to or greater than the rate of change being experienced. The distinctions I notice between these two approaches are that Revans describes an organisation as a reified 'thing' which can in itself learn, whereas I have argued against this approach using the theories of complex responsive processes.

Action learning is described as a method of management in organisational development. People work together in small groups over a defined period of time to tackle important organisational issues or problems and learn from their attempts to change things. The framework for action learning is represented in Figure 4.

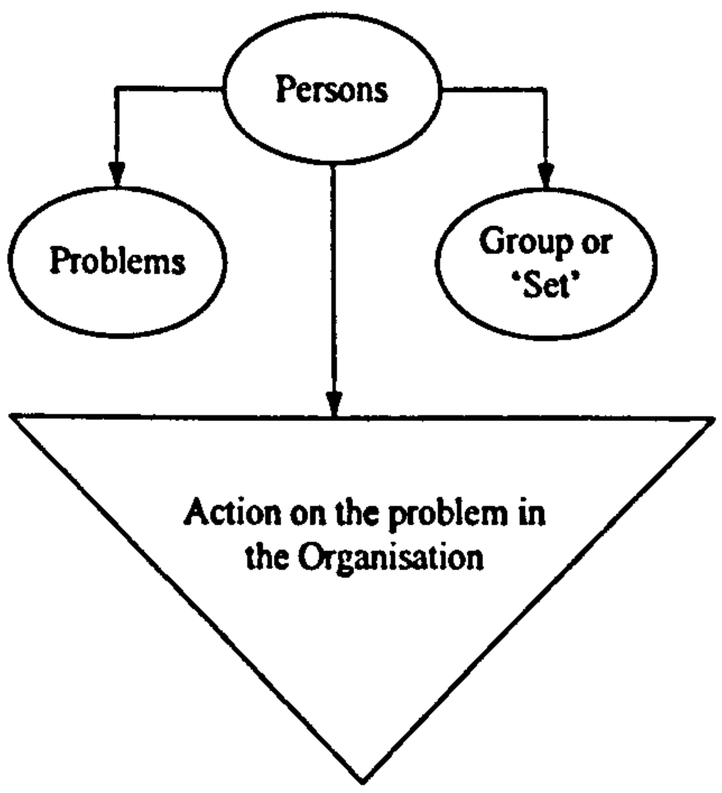


Figure 4: Action Learning framework

(Neubauer 1996:4)

In this model, it is individuals who take action to solve organisational problems.

In my learning set informed by this approach, each of the five members would have a slot of about an hour. We were given time to prepare material to present to the group that was based on a particular problem or issue at work. We were encouraged by the facilitator to prepare for this session in different ways, either using mind maps, painting pictures, selecting postcards or developing collages from magazines. We were given about 20 minutes to present our problem. One of the 'rules' was that no one interrupted while we were presenting or until we had finished talking. The facilitator and the group then used different techniques

to help us to explore the issue or the problem in order to understand this in different ways and by identifying approaches for dealing with this.

I see a number of important differences between action learning and my experience of participating in a learning group on the D.Man. programme. I would summarise these as follows. We did not bring 'problems' to the group and identify actions we were going to go away and complete. The format was also different. We did all take it in turns to focus on our specific projects, but this was not prefixed by uninterrupted 'air time'. Instead I found myself constantly interrupted or interrupting as we explored specific comments and points, which at first I found very uncomfortable and challenging. Yet at times I noticed this felt more 'normal' than the rules imposed by my other learning set, where I found it difficult talking for long periods without interruption, whilst saving questions and comments for others until they had finished their slot seemed to lose some of the spontaneity and immediacy of our exchange. At other times I resented the interruptions, and missed the more familiar structure I had become used to at the Kings Fund.

The central focus of our work in the D.Man. learning group was our projects, which were about our everyday experience. Part of these sessions inevitably covered more detailed discussions about how we were coming to understand the theory of complex responsive processes, and how this understanding was influencing our practice. This occurred through discussing what we were reading and writing and also through drawing attention to the way we understood what was happening (both within the large group and in our various learning groups) in a different way through the insights we were gaining through the programme. I notice how we spent very little time on theoretical perspectives in my King's Fund group after our initial introductory sessions.

What is important about both approaches to learning in groups is that they stress the importance of learning with others. To me, action learning seems like a positive and constructive move away from more traditional models of learning,

the limitations of which I describe in Project One with reference to the way I was taught as a student nurse. The distinctions between the two approaches are noted by Margerison (1988) and shown below in the first two columns of Table 1. What I have attempted to do is complete the third column with the distinctions as I see them between the learning group methodology (based on my experience on the D.Man.) and action learning as defined by Margerison.

Traditional learning	**Action learning**	**Learning group**
Historic case studies	Current real cases	Exploring the themes emerging from the narrative in our projects and the theories of complex responsive processes
Individual orientation	Group-based learning	Knowledge arising from interaction within the group, in which we are forming others at the same time as they are forming us as part of one unified act
Learning about others	Learning about self and others	Reflecting on our everyday experience and exploring how our own identities are shaping and being shaped by this
Study other organisations	Study own organisation	Enquiry into our own practice
Programmed knowledge (P)	Questions (Q) plus (P)	Grounded in the dialectic movement of thought
Planning	Planning and doing	Actions emerge from our interactions with each other, hence 'planning' and 'doing' are not distant in space and time: our conversations *are* the action
Arms length	Arm-in-arm with client	Supervisor works with D.Man. students
Input-based	Output/result-based	Process-based (grounded in complex responsive processes)
Past-oriented	Present- and future-oriented	Grounded in 'the living present', which takes account of past and future
Low risk	Higher risk	Potential for both high and low risk at the same time
Passive	Active	Potential for both passive and active interaction

Table 1: Contrasting theories for learning
(Expanding on Margerison, 1988)

Having explored some of the distinctions between this methodology and action learning, I shall now explore a comparison with action research.

Understanding the similarities and distinctions between action research/collaborative enquiry and emergent exploration of experience

In October 2003 I was invited to attend a joint workshop between the Centre for Action Research in Professional Practice from the University of Bath and the Complexity Management Centre from the University of Hertfordshire. Each of the faculties started the day by providing an overview of their theoretical perspective and research methodology. The Hertfordshire Professors discussed the features of complex responsive processes of relating and the research methodology, which was referred to at the time as Emergent Exploration of Experience (Stacey, Griffin and Shaw, 2003). The Professors from Bath identified the features of co-operative enquiry and action research. Their working definition of action research is:

> ... A participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory world view which we believe is emerging at this historical moment. 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, and more generally the flourishing of individual persons and their communities. (Reason & Bradbury, 2003: 3)

I shall outline some of the key insights I gained regarding these respective methodologies below. Before I do so, I want to make one brief observation regarding some of the interactions on the day which had a powerful impact on me. It became clear to me that the work of Reason and his colleagues is underpinned by a very clear ideology (Reason & Bradbury, 2003). They are explicit about the values underpinning their work, which include co-operation, collaboration, emancipation, democracy, liberation, challenging existing power structures, flourishing of the human spirit, and sustainable developments. Action research as they describe it therefore has a clear political purpose which is a prerequisite to undertaking this kind of enquiry. I notice that this is a very different perspective from what I am coming to understand regarding the 'emergent exploration' methodology. This is not based on a given ideology, and the values listed above were not emphasised. In emergent exploration, attention is paid to how ideologies

and the power relations are either sustained or become the means by which change emerges. For Reason et al., ethical considerations would therefore seem to take the form of thought before action, since it is assumed that these can be determined in advance.

I was interested in descriptions of how the co-operative enquiry group works. Students from Bath described to me the cycles of action and reflection that occur in their enquiry groups. I have outlined these below and considered these against my experience of the methodology of emergent exploration. These are:

Phases 1–4 of action research

Phase 1 is where co-researchers discuss interests and concerns, agree the focus of their enquiry and develop a set of questions to explore. They agree what actions they are going to undertake. Procedures are agreed by which they will observe and record their own and each other's experiences. This struck me as a very different kind of experience to the way in which I have been working with my learning group. Like them, we meet and discuss our areas of interest; but I sense the difference is that we spend more time focusing on what is actually happening within our organisations and how we are making sense of this. It is from these discussions that the themes from our enquiries emerge. Hence we write about our everyday experience and then inquire more deeply into how we make sense of this. This to me seems a fundamental distinction between the two types of methodologies. I did not start with a predetermined list of questions, nor do I agree to undertake any specific action in my working life and then reflect on it. Hence in my projects I am developing and deepening my narrative and enquiry and we are simultaneously reflecting on these together, through communicating with each other within and between our meetings.

In **Phase 2**, the group apply their agreed actions to their everyday life and work. They record the outcomes of their own and others' behaviour. It is noted they may simply watch to see what happens to develop a better understanding of their experience. Again, I notice this is markedly different from the methodology I am

using. I am not 'applying' any predetermined actions to my work. I notice that the approach they describe makes the assumption that thought occurs before action, which is different from the position being taken in complex responsive processes of relating. In this, drawing on the work of Mead (1934), thought and action, gesture and response are part of one unified act. Since I am accepting this position, it would not make sense for me to adopt a methodology that effectively splits them.

Phase 3 is described as the 'touchstone' of the enquiry method, where researchers are described as becoming fully immersed in their experience. They become more open to what is going on, and it is anticipated that they will begin to see their experience in new ways. They can find themselves exploring new insights, and they may become so absorbed that they lose awareness that they are part of an enquiry group. It is in this phase that the new practical skills of understanding may emerge for the researchers. The distinction I notice is that the methodology I am using does not describe phases which lead to deepening levels of understanding nor different levels of awareness or insight. However, there is a structure in that we have to produce four projects and a synopsis. What I learned was that each of us tackled this in many different ways; at times this did demonstrate deepening insight, while at others it seemed as if our enquiry seemed to be increasingly confusing and obscure rather than moving along a predetermined pathway where the clarity was heightened the further along it we got.

In **Phase 4**, co-researchers consider their original question, which they may choose to change. They may also decide to change the focus of their original enquiry, and the group may choose to change its enquiry procedures as a consequence of their experience of the first cycle. In the methodology I am using, there were no set points in the process where we reviewed and changed our questions or enquiry procedures. Both of these emerged in our interaction as we developed our respective projects.

Reflections on approaches to action research and collaborative enquiry

To summarise, collaborative enquiry suggests that knowing will be more valid, richer and deeper if the four ways of knowing Reason identifies are congruent with each other (i.e. experiential [knowing through direct face-to-face encounter with others], presentational [knowing that emerges from experiential knowing and expresses the knowledge using words and imagery], propositional [knowing about something through ideas and theories], and practical [knowing how to do something through acquiring a skill]). Reason identifies a number of procedures that can help improve the quality of 'knowing', which include developing a truly collaborative approach to ensuring all voices are heard and reflecting on the group's workings; learning how to deal with distress; and recognising the need to balance the order and chaos that it is anticipated will emerge through each cycle. The key distinctions I notice between this methodology and the one I am using are that complex responsive process theory does not distinguish between deeper levels of knowing or different types of knowledge. Emergent exploration does not prescribe how specific techniques can be used to engineer and improve this quality of knowing: my experience has been that we discover these through our engagement in this kind of enquiry, but this process will not be replicable or transferable because no two enquiry groups will be the same. Complex responsive processes describe power and conflict, and shame and anxiety, as inevitable components of human interactions. These are therefore themes in our everyday relating that need to be explored and understood together rather than ignored or 'managed' in the way other methodologies describe. Reason seems to pay limited attention to these issues, giving greater emphasis to ideas such as harmonious co-operation and collaboration.

In contrasting different research methodologies, I start to notice many similarities between these and the underpinning assumptions of different theoretical perspectives on strategic planning. Hence, I can see the limitations of a quantitative, rational research methodology in my field of practice because I have argued against the position of an objective observer who can somehow control and manipulate my working environment towards a predetermined outcome in the

same way as some strategic planning themes do. I have discovered how both strategic planning and scientific and social research have appealed to systems theory in seeking to overcome such theoretical limitations. Since this is explored in detail in my projects, I shall not re-examine it here. However, I do want to return to one of the underpinning themes which has emerged for me as significant – namely the notion of accountability. This is important, as my enquiry has led me to move to a different position which is central to this thesis.

Accountability: moving away from a position of locating this in individuals

I notice in my narrative how we are constantly having to account to ourselves and others about why we are doing what we doing (in the present) or why we did what we did (in the past). In this sense, accountability has emerged as an important theme for me because I think I now understand it differently from the way in which it is being used within performance management and clinical risk frameworks used by the NHS. In these, accountability is vested either in the individual (e.g. the nurse who gets struck off by the NMC or the CEO who loses his job for zero star ratings) or in a higher 'system' (e.g. 'systems failures' causing medical accidents). I have pointed to the frameworks we use in the NHS (Figures 1 and 2), and noted that this way of thinking has become so ingrained in CRM literature that practitioners do not seem to question it or notice it. I am arguing instead that we co-create what we call 'systems' in our interactions with each other.

This is a radically different approach to those in the current discourse, and I believe it offers a new contribution to knowledge in this discipline. It is significant in that, first, it offers a different understanding of causality from the notion of cause/effect illustrated by the 'Swiss cheese' model or the root cause analysis described in Project Four. This challenges the validity of techniques such as looking for the 'root cause' of an incident. I have noted that the seminal writer in this field has also acknowledged this problem (Vincent, 2003). His solution is to move towards a systemic notion of causality, where the cause of mistakes is believed to be in a 'system' rather than located with individuals. My difficulty

with this is that I see how this creates a perspective in which professionals see themselves as passive victims of some 'system' that is held accountable when things go wrong – as evidenced by the diagnosis of 'systems failure' in the television documentary described in Project Four, and in the example cited of the nurse who thought 'the Trust' would take a decision on blood sugar equipment.

I am arguing, through the theory of complex responsive processes, that we co-create what other authors call 'systems' in our interaction with each other. This is fundamentally important in gaining a radically different perspective on accountability, since it moves from locating this within an individual, within a system, or both, to one in which all participants, through their participation with each other, are accountable in some way for what happens in organisations.

I also notice in my narrative that the way staff involved in SCIs account for *why* things happened differs. I am arguing that this is because we all make sense of this in different ways. This is dependent on our past experience, our values and beliefs, and how we then make sense of this together in retrospect. I have argued that because of this it is not possible to identify an objective and definitive account of what 'really happened' in the past, in the way that public enquiries and SCI investigators seek to do. This is because I have argued a theory of time grounded in the theory of complex responsive processes which argues that the past is not 'fixed' in some way, but constantly changes. Therefore how we account for what happened will also shift, as evidenced by the football analogy I describe in my fourth project. I recognise I am reaching a position – informed by the theories of complex responsive processes – that accountability is therefore something that we socially construct, both in our silent conversations with ourselves and in group conversations with each other. As such, then, it is not 'fixed', but rather something that changes as part of ongoing negotiation in social interaction. This is important because, with respect to SCIs, 'accountability' is a word that is often used synonymously with 'blame' and 'fault'.

From such traditional approaches, it is believed that the rules (which include our perceptions about 'values' and 'culture') are determined by a few powerful leaders within organisations. Elias (1978, 1989) argues an alternative view, proposing that the individual and the group are the singular and plural of the same process. From this perspective, then, no one individual can set rules for others to follow: the rules emerge from social interaction. Hence, this offers a radically different social theory from those I have identified that underpin CRM in the current discourse. From this theoretical perspective, it is therefore inconsistent to locate the blame with individuals or hold them solely to account for mistakes; nor to abrogate them of responsibility for the outcome of their contribution to what emerges, in the way systems perspectives do. These insights are crucial for the field of CRM since, with the exception of the comparatively few examples of gross misconduct, it can be appreciated that removing or blaming a few individuals who are held to account for mistakes which have occurred cannot necessarily ensure that such patterns will not repeat themselves. I have argued that, if the power configuration within the remaining team is strong enough, these are likely (although not always) to continue in a similar pattern even if some group members may change or be removed altogether.

In drawing attention to the notion of differing perspectives, I recognise this as an issue that is also addressed by the postmodernists. My position is different from theirs for the following reasons. First, I am not concurring with the notion that because everyone has a different view on the world, the world cannot be changed. The stance of complex responsive processes goes a step further in arguing that, in our ongoing interaction, we struggle to understand and make meaning of these differing perspectives, and in this process we co-create a different understanding. Secondly, through introducing the theories of power informed by Elias (1989), this moves away from the notion that 'anything goes' because the enabling constraints of power figurations introduce an element of control and restraint in group interaction that prevent chaos from emerging.

Accountability: the problem of locating this in a 'system'

The alternative position taken by many writers outlined in my projects accounts for why things go wrong by locating the cause for this in some higher system - i.e. a 'systems' or 'latent' failure. I have noted that this seems to me just as unsatisfactory as locating it with individuals. I have argued that this posits a position that abrogates individuals of *individual responsibility* for their actions, and I have pointed to how it is our interactions with each other that actually create such systems in the first place. In this sense, I have argued that we have to accept some responsibility when 'systems' do not work as expected. The notion of recognising and accepting responsibility has emerged as a critical insight from this thesis. Using Mead's (1934) notion of dialectic, it is only as I reflect on my practice, recognise my own role in co-creating the situations that emerge in my working life, and accept responsibility for these, that I am able to respond differently. My narrative is full of examples of this, such as the sister who exclaimed 'this comes back to me?' and the anxiety experienced by Mike and myself regarding our part in establishing an MDA alert system that failed. It is in such moments, where I am able to see something genuinely 'new', that I see there is the potential to either acknowledge this – and in so doing transform in some small way the patterns of our practice – or reject it and continue with a familiar pattern. This is a new perspective on the question regarding how I influence emergent strategy that has developed through my enquiry. I do this through accounting to myself and to others for the outcomes of our actions.

'Blame-free' culture

Similarly, the debate about whether we have a 'blame-free' or 'blame-fair' culture for SCIs, as currently debated in the literature, also seems spurious from this perspective. I no longer believe that blame is something that is 'there' that can be allocated or removed by a change in strategy or a statement of organisational values. My experience has been that blame and shame inevitably arise as an integral part of human interaction. In the incidents that I have been involved with, the harshest critics are often the practitioners themselves, some of whom are never able to reconcile themselves to, or forgive themselves for, the harm they have

caused to others. Blame is therefore an integral part of human relating, something that is constantly being negotiated in our interactions with each other, and something that is also influenced by power dynamics within teams. This helps me to explain why it is that doctors who are popular with patients can (and in the case of Shipman, cited in my second project, actually do) quite literally get away with murder in a way that other theories grounded in systems thinking or rational planning cannot explain. Power dynamics arise from our ability to take the position of what Mead calls 'the generalised other' (1934). It is this ability which both enables and constrains how we act – hence our human concern about what others will think of us.

These insights are informing my central thesis, since they offer a radically different perspective on strategic planning and CRM by moving away from locating the root of change in organisation with either the individual or the system (or both) towards the concept of change being co-created in our micro-interactions with each other.

How do these thoughts on learning and complexity inform risk management?
My position, grounded in complex responsive processes, is that we co-create paradoxically 'dangerous/safe' situations through our interactions with each other. (I have linked these words to highlight the paradox, since what is safe for one individual could cause harm; even for one particular individual, what may be potentially help their health could also harm it – for example, many drug regimes have side effects that can prove harmful.) This observation is important since it emphasises the fact that, in CRM, 'best practice' is not always replicable or generalisable. I have also noticed that we cannot always know in advance whether our actions will create a dangerous or safe outcome. I also see in my narrative that my previous experience informs the reliability of my prediction of the outcome – but can never be certain of others response to my gesture, I am sometimes surprised by their response. Hence 'risk management' is a term that has within it an inherent paradox. We can only know in retrospect that something was a risk because a mistake has occurred. Similarly, 'patient safety' has been

described as a 'dynamic non-event', i.e. nothing appears to happen because of the actions we take in our anticipation of the potential for harm (e.g. checking we have the right patient before giving a drug).

I am arguing that clinical incidents do not arise from deeper hidden structures, from higher systems, or from different 'levels' in organisations, and that it is not possible for any one person to stand outside as an objective observer and make interventions that will change the patterns, nor move an organisation to 'the edge of chaos', nor create conditions to encourage emergence in the way described by many writers I have covered in my projects. I am arguing that this is because we are both enabled and constrained in the outputs of our actions by others. I am proposing instead that making mistakes is a fundamental part of learning and an inevitable part of the ongoing processes of human interaction, as small misunderstandings are amplified between humans who have diverse levels of expertise in what they do.

To summarise, the focus of my enquiry has been national healthcare strategy and the management of risk in an NHS Trust. I have drawn together a number of strands that have emerged from this enquiry regarding the main themes of my research. I have re-stated my position with respect to these, and pointed to how this offers a new contribution to knowledge in the field of practice of strategy in CRM. Specifically, I have challenged the usefulness of 'simple rules' as a mechanism for improving practice, because I have argued (through appealing to my own experience) that these do not always work in practice. Furthermore, I have identified what I see as fundamental flaws in simple rules as an analogy for use in human organisations. I have come to challenge the cognitivist theory of the sender/receiver model of communication, again through citing examples of my own experience where this does not seem to provide a satisfactory explanation for the phenomena I experience in my own practice. Specifically, I identify that the interventions underpinned by this approach do not seem to have prevented the re-occurrence of the deaths of patients through mistaken injection of Vincristine into the spine. I have drawn from the theory of complex responsive processes of

relating, and through this exploration offered a different explanation for why mistakes happen in organisations, again drawing on examples from my own experience of investigating a SCI within the NHS. As part of this enquiry I have also touched on the importance of experience and making mistakes as an inherent, valuable and unavoidable part of learning. I have identified that this is a different perspective to the approach taken by a number of authors also writing in this discipline, who are advocating the possibility of 'zero defence' or 'human-proofing' the 'system'. I have also come to radically challenge the usefulness of systems thinking with respect to strategic planning through the work I have undertaken in all four projects.

I have argued instead for understanding the phenomenon I am writing about as an ongoing process grounded in the theory of complex responsive processes. Inherent within this is the challenge to the notion of a 'whole system'. In taking this approach I have argued from this perspective that the examination of fragments of our own experience becomes a legitimate and worthwhile activity. I have drawn on the insights from CAS and noted how organisations characterised by the dynamics of bounded instability are all unique in some important way. This means that the experience of one cannot be repeated, to important levels of detail, by another. This therefore challenges the idea of being able to replicate best practice. I have cited Stacey's observation (2003: 415) that this is probably why the track record of identifying the attributes of successful organisations is so poor. I have developed his suggestions in my work, in that instead of looking for understanding in other peoples experience, I recognise that I might look for it in my own. In this way of thinking, intention and design are understood as emergent and problematic processes. I have described through my narrative how, as I share these insights and questions with my colleagues, new patterns of practice for our investigation of clinical incidents are emerging. Yet in acknowledging my latter comments with respect to sharing best practice, I am also aware that the kind of innovations I am describing at the end of my fourth project cannot be regarded as a recipe for improving investigations in other organisations.

This challenge to the notion of replicability, applicability, and generalisability when looking at strategic change in organisation is relevant not only in challenging the validity of the idea that we can share best practice in the ways I have described, but also relevant with respect to this research methodology. In a traditional research methodology, validity is contingent upon findings that are replicable, applicable and generalisable within the field of practice into which they are researching. Yet what I have shown through my descriptions of the theory of complex responsive processes of relating is that there is a question as to whether or not these assumptions are valid. Since I am arguing from this position, it would be inconsistent of me to present the findings of my research in a way that argues it meets these traditional criteria. What I am pointing to here is that, through the work in this research, some new insights have emerged for me and my colleagues with respect to strategy and management of risk in an NHS Trust as outlined above. I have argued that the above insights offer new and different perspectives on this field of practice which other practitioners may accept or reject as I enter into dialogue with them.

However, of all the findings from this research, the one I feel has most radically challenged the way we are practising together in my organisation – and about which we feel most excited – is moving from the position of locating accountability for mistakes either with the individual or with the system or both. Instead I am suggesting that, as part of our ongoing process of interaction, we co-create what others are describing as a 'system' through our participation with each other.

Accepting the notion of co-creation requires us to examine very carefully the influence of our own participation in the dangerous situations that arise in our everyday work and our own accountability for what emerges. I am proposing that this makes a new contribution to knowledge in this field for two reasons. First, because it explores for what I believe to be the first time the validity of the theory of complex responsive processes in the discourse of risk management in health

care. I am proposing from my enquiry that it has a legitimate contribution to make in this field of practice that warrants further enquiry and research.

Second, in making this shift to a perspective that understands accountability for error as something that we co-create in groups, my thesis poses a radical challenge to many of the activities that are traditionally undertaken when mistakes occur in organisations. Specifically, I have questioned the usefulness of approaches that seek remedies through focusing on individuals outside the context of the group, and those that focus on re-engineering what other authors refer to as the 'whole system'. I offer an alternative through describing examples in my narrative of a different approach grounded in the research methodology of emergent exploration of experience, which focuses on the micro-interactions between participants in groups as a way of understanding the transformation of practice. I am arguing that such transformation may not always be an improvement because we cannot always accurately predict the outcomes of our actions in advance. This perspective therefore also challenges the assumption made by some authors in this field, who believe it is possible to 'human-proof' systems and thus guarantee 'zero defects'. I am proposing that these insights offer the potential to come to a different understanding of how strategy emerges in organisations through ongoing processes of relating.

Glossary of acronyms and abbreviations

A&E.....Accident and Emergency Department

CAPD.....Continuous Ambulatory Peritoneal Dialysis

CAS.....Complex Adaptive System(s)

CD.....Clinical Director

CEO.....Chief Executive Officer

CHI.....Commission for Health Improvement

CRM.....Clinical Risk Management

DNM .....Directorate Nurse Manager

FCE .....Finished Consultant Episode

GM .....General Manager

GMC .....General Medical Council

MDA .....Medical Devices Alert

MHRA.....Medicines & Healthcare Products Regulatory Agency

NHS.....National Health Service

NMC .....Nursing & Midwifery Council

NPSA .....National Patient Safety Agency

QA.....Quality Assurance

SCI .....Serious Clinical Incident

TQM.....Total Quality Management

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