Unleashing the power of reflection, action and collaboration in health care improvement

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Above is an artistic illustration of my inquiry by a cartoonist I met at the 2015 Patient First conference (chapter 6.4), who became curious about my doctorate research. I am struck by how my dialogue with the cartoonist on my research stretched me in my understanding of representing knowledge. He created these illustrations on an exhibitor stand, and they captivated the interest of all attendees, enabling greater insights, which led to presentational knowledge. This illustration conveys the diverse ways of knowing in action research.

ABSTRACT

Treating people in a safe environment, including protecting them from avoidable harm, and improving the quality of both care and leadership are the top priorities for the NHS since the tragedies and high profile cases of recent years (Berwick, 2013; Francis, 2013; Keogh, 2013).

My research describes the value of an action-based approach to research and learning in North West London (NWL) NHS organisations, in response to the challenges and recommendations of the Berwick review (2013). This proposed that the NHS should become a system in which leaders create and support capability for continual learning and improvement.

The research is in the form of a first-person inquiry (into my life as the researcher – Reason & Torbet, 2001) and a second-person inquiry (with others, into issues of mutual concern – Reason & Bradbury, 2008) including learning and sharing with others beyond NWL.

This thesis illustrates my experience – as a practitioner inquirer with lived personal experience of being a patient receiving critical care and in active collaboration with other co-inquirers (NWL practitioners and patient representatives) – of working in the complex system that is the NHS: a collective, human, living organism that is non-linear, unpredictable, dynamic and networked over multiple organizational boundaries.

My doctoral research has made a contribution to academic literature and professional practice by evidencing what it takes to operate through relational leadership in the NHS. I offer my view from the inside, capturing the emotional rollercoaster of anxiety, excitement, struggle, messiness and warmth involved and describing the dynamics we experienced. It includes exploration of the less obvious thread that connects race, voice and power to leadership practices, which was a critical part of my personal leadership experience.

My doctoral research demonstrates that nurturing effective use of the voice and power of practitioners and patients not only improves patient safety at an individual level, but also promotes the safety of the wider healthcare system. It does this through enhancing a self-reflective approach in leadership practices and thereby fostering sustainable cultural change.

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I would like to express my sincere gratitude to my supervisors Richard Hale and James Traeger for their invaluable guidance and feedback on extensive draft materials. James aided me in finding my way through the tunnels of my inquiry, and Richard's proactive support aided me immensely to develop my thinking on the stated doctorate criteria, as I mined the gems among the rubble of my doctoral research.

Thank you to my examiners Megan Reitz, Susan Fairlie and Lynn Nichol for their feedback and their reference to me as a role model in my field, with commendations for using non-conventional research approaches to address the need for sustainable change in the NHS. My appreciation goes to Lindsey Masson for her valuable support during my post viva phase.

I am grateful to my conscientious and supportive ADOC4 peers - Pleuntje van Meer, Sibylle Erdmann, Katherine Semler Hayes, Mike Stanford ADOC 4 cohort and faculty staff and Liz Hunter, all of whom have sustained their curiosity about my inquiry, encouraged at critical moments and been great companions throughout my ADOC journey. The Foundations of Safety programme would not have been possible without the support of Adrian Bull – huge thanks to him. Thanks to all my co-inquirers across North West London NHS organisations for their incredible patience as we learned together during the transformative inquiry process.

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I am indebted to my husband for his support and understanding in freeing me to pursue and fulfil my academic and professional aspirations.

Special thanks to my children - the reason I do what I do.
Dedicated to Dad – an absolute legend.

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1. INTRODUCTION

This doctoral thesis is addressed to practitioners, academics and students who have an interest in organisational change through practical forms of knowledge. In it, I share how my lived experience with others of inquiring into our daily lives led to new ways of knowing which go beyond theoretical knowledge. I hope that sharing this practical and experiential form of research will support and ignite others in their knowledge acquisition and professional development.

I sought to illustrate this inquiry into, at times, tacit knowing (such as through emotions and intuitions) in accessible language, but language that is appropriate for academic purposes. I acknowledge that I am a Black African British person, raised in Lagos, Nigeria, and presenting an intersection of five (Black, African, British, Lagosian, Nigerian) group memberships. Belonging to each group contributes to my overall view of ontology and epistemology and the way I generally view the world. They combine into a mix of childhood upbringing, historical and cultural mythology, spirituality, morality, identity, acceptability, affiliation, rights ownership and survival, as I integrate and negotiate self in those multiple groups. Further exploration of my personal inquiry is in chapter 4.

In this first chapter, I start by outlining the purpose and rationale of this research (1.1), and then describe my 'itch' and research curiosity (section 1.2) and my inquiry territory (section 1.3), I illustrate my narratives (section 1.4), and provide a short overview of the chapters in this thesis (section 1.5).

1.1 The research rationale

I undertook this research in National Health Service (NHS) organisations across Northwest London, where I worked as an Executive Director.

My research interest was born from my personal experience of being a patient. Becoming a patient brought to life a negative experience of feeling vulnerable because of the health complications I had from undergoing a clinical operation in the organisation in which I was used to being a leader. That experience inspired me to undertake this research.

At the same time, there were high public expectations of an improved health care delivery service, following the independent investigation reports (Berwick, 2013; Francis, 2013; Keogh, 2013) into failings in NHS Trusts. This outpouring of recommendations required NHS Trusts to comply with new legislative duties, such as a duty of candour. They had to come to terms with new commissioning bodies and an overhauled care quality inspection process, and cope with high workforce vacancy rates of one in 12 posts (NHS Digital, 2019) together with increased public demand for services.

As a leading practitioner in the NHS, I was keen to ensure that those investigation reports were not the end of the inquiries, and to inquire with other practitioners into opportunities to start a process of meaningful and sustainable cultural change.

To begin investigating into what it takes to produce sustainable cultural change, I began by inquiring into my personal life experience and my professional role. This led to engaging in a deep conversation with myself – asking, exploring, situating and reflecting on my actions and linking them to interactions with others. This process led to my research questions, which were as follows:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
- What approaches and methods can be used to create sustainable cultural change in the NHS?

The exploration of these questions is the aim of my doctoral research.

The purpose of my research is to collaborate as a practitioner with other practitioners to understand how leadership of a safety culture can be embedded, and how this might enable better management of organisations, a culture of openness, and greater engagement between staff and patients and carers, resulting in safer and higher-quality care.

My doctoral inquiry highlights what the NHS organisations in Northwest London have done to explore questions about enabling sustainable cultural change, in response to the recommendations from the 2013 inquiries (Berwick, 2013; Francis, 2013; Keogh,

2013). It is about furthering my practical understanding of my private and professional selves, as well as patterns of relating in the NHS. It explores the messiness of this complex relational space, and how power, voice, trust, inquiry and advocacy are catalysts infusing change.

I hope to show how non-conventional approaches to research, of self-reflective practice, participatory action research and co-operative inquiry with other practitioners and patient representatives, can improve health care delivery. My research premise is that, in order to transform health care more sustainably, it needs to move further away from isolated objective singular ways of knowing towards constructionist ways of knowing and collective system-wide leadership of patient-safety practices, as further illustrated in chapter 3.

In my inquiry into what it takes to produce sustainable cultural change, I found myself working with the behaviours and social systems of both patients and practitioners. Behaviours and social systems can be thought of as a bit 'fuzzy'. It may help the reader to consider the remaining chapters of this thesis in context to have an indication of what actually changed on the ground as a result of our work. As described in chapter 6, it was acknowledged that behaviours had started changing, and this was claimed to be at least one of the causes of an improvement in the specific organisations. The local specific key outcomes that co-inquirers claimed to have been attributable to their participation in the work at that time were as follows:

- One Trust saved 30% on agency staff spend as a result of a daily safety brief template developed on staff capacity and patient acuity.
- A participant was empowered to practise collaborative leadership and engage her team and patients in positive culture change. This led to the team (22 people) winning the annual award for organisations that employ over 3,500 staff on 'Changing culture to improve safety'.
- One group achieved a change in culture through the adoption of collaborative care principles on an acute medical ward.
- An IT system designed during the programme to assist with the thematic review of incidents was adopted by two additional sites: The Initiative for Patient Safety (TIPS) has engaged all staff in safety management and leadership in one hospital and there are plans to take it to two other hospitals.

This thesis shows the impact of relational practice, including the value of having different kinds of conversations on how to continuously promote purposeful care in the

NHS. While holding on to that aspiration, I offer this research primarily to act as a memoir to other practitioners who desire to make the NHS a learning organisation.

1.2 My itch and curiosity

This section highlights the various strands of my practice that niggled me, the areas where I was craving to scratch beneath the surface, leading to my curiosity to undertake doctoral research.

Before I began my research, I had led a two-year culture and leadership change intervention to support clinical teams in improving the quality of care delivery. At the outset of my doctorate in 2013, I felt the need to improve professional practice and my experience of engaging successfully with a group of colleagues (medics), a large majority of whom tended to be resistant to service transformation and culture change, introduced me to their ways of working.

In my Ashridge Doctorate in Organisational Change (ADOC) acceptance paper of early 2013, written prior to admission to outline the reasons for applying for a doctorate with initial ideas on areas of inquiry, I wrote about my interest in developing technical professionals (i.e. clinicians) to take on management functions, and the impact that might have on improving organisational performance.

My notion was that acquiring knowledge and understanding of the DNA common to clinicians and how to engage better and more effectively with them to win their hearts and minds would limit the adversarial relationship between clinicians and managers. As a management consultant, I was irritated by the stereotypical and negative perceptions of both groups (clinicians and managers). We tend to behave like adversaries and competitors, as if we do not have a common agenda to deliver high-quality care. The clinical group accuses management of not caring about patients and having the main objective of cost reduction, whilst management accuses the clinical group of not discussing how to improve the efficiency of high-quality care delivery.

I became frustrated by the confusion, systemic contradictions, perverse incentives and opposing priorities of the diverse stakeholders in health care delivery and felt that my research interest could solve these problems. The research went apparently well for the first few months, but I gradually realised that I was losing the focus on developing clinicians into leadership and management.

My views developed as I took forward my reflective practice at the start of the second year. I wondered how I had assumed that the research would change my own practice. Where am I in it? After all, I am not a clinician. I became more aware of my roles in working with clinicians and management peers and how the actions of management colleagues had an adverse effect on me, on others and on the system as a whole.

In early 2014, following the birth of my daughter, which had involved a traumatic patient experience with my own safety at risk, I became more focussed on my own practice, attending to the details of my work. As I returned to my doctoral research after a few weeks of maternity leave and reflected on the childbirth experience, I shifted my inquiry focus to the impact that my role had on the challenges of delivering safe care. My evolved research interest became heartfelt.

Having had personal experience as a patient in the NHS, as well as a leader responsible for service transformation and change management, and as a sponsor of a developmental learning initiative for leaders within the NHS, my research curiosity shifted from clinicians 'out there' to change 'within me' in my personal life and my professional practice. This led to reflecting on how my self and my relationship with others contributed to the tensions in leadership and safety practices.

My yearn to scratch the 'itch' to deeper levels, exploring how my research could contribute to support improvement of working relationships amongst a multidisciplinary workforce, reinvigorated my passion for the NHS as a whole.

1.3 The research context

This section illustrates my personal and professional research context. It provides an insight into the organisational context in which I worked and the role I played.

Personal inquiry

I felt compelled to attend to my own personal being, reflecting on what I am made of as a person, how it shows up in my practice and, indeed, what was changing in my approach towards myself. In my inquiry, I am on the receiving end of my change practice and have lived experience of the efficacy of my practice. In the research into my personal life, I attended to my own personal being, reflecting on how I showed up and engaged with my family, friends and ADOC 4 cohort and faculty.

My personal subjective account offers an insight into my own tussle over race, voice and power, over taking my own background seriously, while operating in the NHS. It takes into account the vulnerability and significance of being a female black leader of Nigerian descent. My personal inquiry made me aware of the effects of working in a system that discriminates, harasses and disproportionately excludes staff from Black, Asian and Ethnic Minority (BAME) backgrounds (West, Admasachew & Topakas, 2012; Jaques, 2013; Kline, 2013, 2014; HSJ, 2014; Limb, 2014; Priest et al., 2015). With 43% of the NHS workforce and 7% of very senior managers from a BAME background (Kings Fund, 2018), I hope that my account may be insightful to others. It is my intent that my sharing may provoke different, more inclusive conversations in the NHS as a whole (as evidenced in chapter 6), so that it becomes a genuine equal opportunities employer. I also found some evidence (West et al., 2012; Kline, 2014) of a correlation between the treatment of BAME staff and the quality of care that patients receive.

Chapter 4 provides illustrations from my childhood which featured in my self-reflection, leading to reflections that became pivotal to my research curiosity and inquiry.

Professional inquiry

This research was conducted in the context of my professional life in the UK NHS (an employer with over 1.7 million staff (Business Insider, 2015).

I conducted my research whilst I worked with Imperial College Health Partners (ICHP), a partnership organisation that became operational in June 2013. The organisation was set up as the Academic Health Science Network (AHSN) for Northwest London (NWL), which brings together the academic and health science communities. It comprises three leading universities and all nine NHS Trusts and eight Clinical Commissioning Groups across NWL and has a health budget of £3.4 billion. NWL consists of eight boroughs, housing more than 400 GP practices, with a total population of almost 2 million people, a quarter of the population of London.

ICHP is the driving force for collaborative working across NWL, focussed on the discovery and diffusion of best practice, including supporting wealth creation in the sector and beyond. My role in ICHP as the Director of Programmes, Change and Performance Management was to ensure that there is a systematic and disciplined approach to the management and implementation of the Partnership's programme of work.

The Berwick review (2013) states that “the single most important change for the NHS ... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end”, placing the quality of patient care, especially patient safety, above all other aims. The review advocates that the system should engage, empower and hear patients and carers at all times, and that the NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale within the NHS.

Berwick (2013) recommended that NHS England should support a network of safety improvement collaboratives to identify and spread safety improvements across the NHS. The patient safety collaborative (PSC) programme was established in April 2014 and officially launched in October 2014, in response to the findings and recommendations of the Berwick review.

Figure 1: Organisational context

There are 15 PSCs led by the 15 AHSNs across the geographical regions in England. The goal of the network of 15 PSCs is to tackle the leading causes of avoidable harm

to patients. All ASHNs received funding from NHS England to implement initiatives based on identified local needs.

The PSCs work locally to empower local patients and healthcare staff to work together to identify, develop and implement safety priorities and develop solutions from the grassroots. The insights gathered from implementation of the local initiatives are then shared nationally with the other collaboratives.

The PSCs are the largest patient safety initiative in the history of the NHS (NHS England, 2014; NHS Improvement, 2014) and work towards achieving the NHS goal of improving safety practices and reducing avoidable harm. In my role as Director of Programmes, I led the NWL AHSN PSC improvement agenda, which includes various initiatives to turn patient safety theory into practice and facilitate the implementation of evidence-based best practice. One of the initiatives within the programme is Foundations of safety (FoS), and this is the focus of my doctoral research.
As I became mindful of the need to own and leverage power as Director of Programmes, I crafted the innovative initiative of FoS (my co-operative inquiry group) in 2014, with a budget of £250,000 (from NHS England PSC funding), supported by CEOs across all NWL NHS organisations.

FoS was initiated to fulfil the Berwick review vision of a system devoted to continual learning and the improvement of patient care, in which leaders create and support the capability for learning and change at scale within the NHS.

I welcomed the importance the Berwick report placed on continual learning and improvement: a strong culture of safety based on listening and learning is a key factor in minimising the risk of harm. Leadership that is visibly committed to change in enabling staff to share safety information openly is a key foundation of such a culture. FoS aimed at supporting a system-wide approach to sustainable cultural change to safety and leadership practices through collaboration.

I took advantage of the national focus on improving patient safety practices, which made funding available to implement initiatives to achieve patient safety improvement goals locally, and the interest from leaders to try something different. My research came at an opportune time where there was a drive and willingness for practitioners to engage collaboratively across organisational boundaries to improve patient safety practices. I used the timing and interest to help me to engage with 39 practitioners, patients and carers as co-inquirers to research into our leadership practices. Each

practitioner had a change initiative in an area in their organisations for which they had senior level responsibility which was to be implemented during my doctoral degree period. The aim was to find practical solutions to issues that we face in our everyday lives. We were keen to engage in something deeper than pure window dressing, something that would make a significant contribution to practice and to our personal and professional development.

Following a competitive procurement process for an external organisational development and/or culture change consultancy to support the FoS initiative, Ashridge Consulting emerged as the successful supplier to partner with ICHP to co-design and facilitate the delivery of this initiative. Further information about FoS is provided in chapter 5.1.

Research territory

Figure 2 illustrates the two areas of my research territory, the relationships between them and how both components overlap with common inquiry interests. The summation of my personal inquiry and professional inquiry makes up “my inquiry”. Throughout this thesis, the term ‘my inquiry’ denotes experiences and insights from the inquiry process across all facets of both these components.

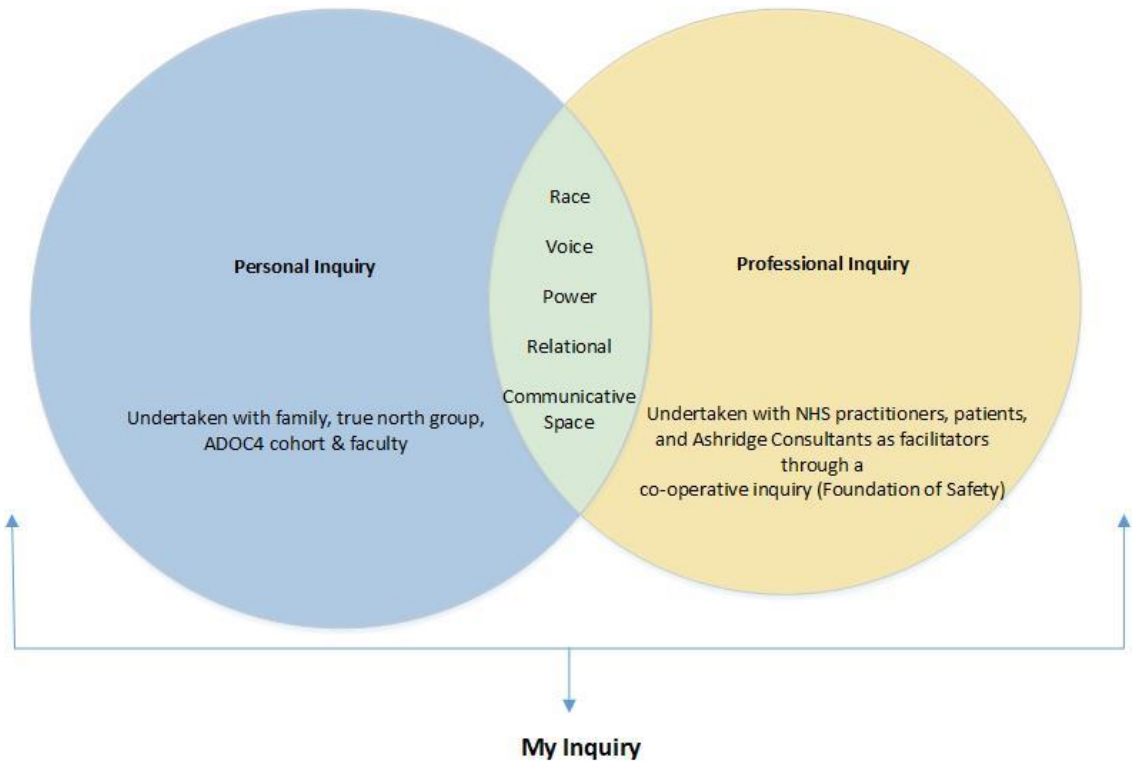

Figure 2: Research territory

My doctoral journey has led me into various paths across the two components, with twists and turns along the way. Sometimes these have been through bright and wide highways and sometimes through dim and narrow tunnels. There has been exploration of the opportunities to link the components. There have been specific touchpoints, with milestones achieved through the papers I have written, and cooling-off periods (post-progression stage) in which to pay attention again to the world around me, to unwind, to gain fresh perspective and to refuel.

Role as practitioner inquirer

As a practitioner inquirer, I am actively practising professionally in my NHS role and simultaneously acting as an inquisitive researcher. This practitioner inquirer role led me to reflect on what I was doing in practice. I was looking to the experiences of my colleagues and myself, connecting with our feelings, understanding the situations that unfolded and linking what we were doing to the theories being studied.

Schön (1983) examines the importance of context and reflection-in-action, and the balance between the reflective practitioner and professional knowledge. He stated that:

> *The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings, which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation* (Schön, 1983, p. 68).

Schön criticised approaches to practice that were grounded in a technical rationality, where professional knowledge is seen as the application of a scientific approach. My experience of such approaches has been that they left no space for creativity, artistry, reflection in action, uncertainty or messiness. This is especially so in complex systems/situations such as the NHS, where it is challenging to deduce what the root of the problem is.

The insights and discoveries presented in this thesis arise from my own practitioner research. I have referenced theory relevant to the stories that have unfolded.

Shifting sands: in between an insider and an outsider

Insider action research occurs when the researchers are existing members of the organisations being researched. They have operated effectively in the systems and

have built up experience of being an actor in the processes being studied. In the research, they engage in experiential learning cycles of experiencing, reflecting, conceptualising and experimenting in real life situations (Evered & Louis, 1981; Kolb, 1984; Raelin, 2000; Brannick & Coghlan, 2007; Holian & Coghlan, 2013). Over the past 15 years, insider action research has become established as a way of understanding and changing organisations (Raelin, 2000; Brannick & Coghlan, 2007; Coghlan & Holian, 2007).

Outsider action research takes place when a researcher enters organisational settings on a temporary basis, for the purpose of working as a practitioner to facilitate change – for example, to improve health care delivery – and, where appropriate, to collaborate to conduct action research. Their "consequential settings are elsewhere" (Bartunek & Louis, 1996).

In undertaking my inquiry, I shifted from being an insider, researching from within an organisation, to being an outsider looking into an organisation from the outside. I term myself as 'in-between', as my experience has been between the boundaries of outsider and insider. I work for a partnership organisation that comprises individual member organisations, with all staff seconded from one of the member organisations. That puts me in a distinct position.

As my research takes place across organisational boundaries, my role as both researcher and practitioner is vital. Having the unusual opportunity to hold both positions, I became familiar with the settings of member organisations, as I was considered to be part of one of them (since my contractual employer is one of the member organisations). Yet I could choose to detach myself and be an outsider looking in, since I was seconded to a different organisation (a partnership organisation comprising all member organisations).

As an insider researcher, I was able to build on the knowledge I had of the settings. I am comfortable with the everyday jargon, know what talks take place in the corridors, what keeps colleagues awake at night and of course who to turn to for information and gossip. As my co-inquirers were insiders in a range of organisations, obtaining information was easy – they knew whom and where to go to.

The challenge we experienced was interrogating, analysing and reflecting on the data, as we needed to probe deeply and act as if we did not understand the situation to expose us to alternative ways of thinking and re-framing. Engaging with facilitators,

ADOC peers and faculty on my research provided insider–outsider perspectives for reflection (stepping back from the process) and theorising.

With the support of the skilled facilitators used for our co-operative inquiry, my co-inquirers and I were supported in being subjectively reasonable, making judgments and making decisions as to what to do to solve dilemmas.

1.4 My narratives

My background and worldview affect the way I construct the world. That includes the form of this research, such as in its use of language, the way it poses questions, the lens used for filtering information, and the meaning-making, which may shape the findings.

I have employed diverse writing styles to convey my research discoveries, insights and reflections. Historically, my research expression has been honed to draw meaning from analysing empirical evidence and critiquing the literature and theories of scholars relevant to my field of study. Writing differently from the way I did in the traditional positivist research experience of my BSc, MSc and MBA thesis has allowed me to grasp and analyse differently, and has enabled a more diverse audience to access my findings. It seems important to share previous research experiences, while wondering whether I am in search of more evidence to underpin my current voice. It leaves me pondering as, after all, none of my previous theses has made a substantive contribution to the understanding of life and society.

To offer some perspective, until three decades ago in Nigeria, where I originate from, women were not supposed to have a voice – spoken or written – and, previous to this inquiry, I did not think of myself as being bold enough for this type of research. As Sparkes (2002, p. 173) noted, scholarly writers are “expected to emulate Victorian children: that is, to be seen (in the credits) but not heard (in the text)”. They stay on the sidelines and keep their own voices away from the article produced. Sparkes struck a chord with me, as I felt that my choice was not to stay on the sidelines or keep my voice out of my research and thesis.

As in my experience of the traditional positivist research approach, the expectation was for me as a researcher to keep my voice separate from the data and context studied. As I developed my voice in my personal inquiry (illustrated in chapter 4), it aided my research to have some form of richness in the descriptions of significant events,

people, artefacts, and observed cultural norms. My narratives provide readers with the inner workings of my social NHS context and become a part of the story.

Krizek (1998, p. 93) sums up the delicate balance and benefit of narratives of the self: “In short, we often render our research reports devoid of human emotion and self reflection. As ethnographers, we experience life, but we write science”. My use of autoethnography and first person inquiry methods (further illustrated in the next chapter) has led to discovery of new aspects of my practice and my relationship to it. This thesis encompasses my research narratives, empathy and connection as a woman of Nigerian descent with a scholarly writing background. It extends beyond self and includes moments (shown in conversations captured throughout this thesis) which generate insights into the lived experiences of myself and others.

Clandin and Connelly (2000) attest that humans are storytelling organisms who individually and collectively lead storied lives; our identities are constructed through the woven stories of our lives. I recognise this identity construct, deep within my life experiences of daily interactions as stories, with the present moment having a storied past and the possibility of a storied future and where stories provide a way of learning themselves.

The stories in my narratives have brought light to some hidden aspects of my being, cleared the fog in some of my confusion, made the implicit explicit and revealed to me the meanings of my experiences as an inquirer and in relating with co-inquirers.

During my self reflective journey, it has been my experience that an authentic scholarly style has emerged, allowing different forms to be equally important through creative writing, such as reflective journaling and storytelling and even an attempt at poetry.

The multiplicity of my narratives has been important in making my research accessible, first of all to myself, and I hope relevant to my very diverse group of co-inquirers as well. In search of my narratives, I have used writing as a process of inquiry, initially informed by the ‘free fall’ principles (Turner-Vesselago, 1995) and then refining and expanding the original text in further cycles. My variegated writing style is my way of dealing with the reality that my action research worldview and my preferred creative writing style cannot be separated from, let alone seen as in opposition to, my professional context of the NHS and its ways of interacting. Both writing styles have their place, as I continually communicate with diverse individuals in my personal,

academic and professional life. My style has given me the comfort and freedom to say things in my own distinct original voice.

My thesis illustrates how I engaged, developed and paid specific attention to my inner arcs – or in other words my inquiry into my interior reality – as they emerged, seeking to perceive self and make meaning. At the same time, I pursued outer arcs of attention. I reached outside myself to question and raise issues with others, as Marshall (2001) suggests.

Given that this thesis is about my experience of action research, I have written much of it in the first person. I do this to communicate the sense of passion that was evident in the experience. However, using the co-operative inquiry method, other co-inquirers participated in this research and their experiences features as well. Where this is the case, I moved from 'I/me' to 'we/us'.

My narratives illustrate a journey from who I was to who I am, a life path transformed by my Ashridge Doctorate in Organisational Change (ADOC) in a way which Bochner (2000) refers to as a "tale of two selves".

Ethical Considerations

With agreement, my employer appears under its exact name. The names of participants in my inquiry and other individuals are pseudonyms and generic job roles are used where relevant, except in cases where individuals have specifically agreed to be named and quoted verbatim.

I have adhered to strict research ethics as required by ADOC research requirements, even where I gained approval for the research from the appropriate healthcare organisation's ethics committee (Appendix 1). My guiding principle in writing this thesis is not to hurt anyone, hence I have been careful about what I write, including acknowledging that my personal accounts are characterised by risk and vulnerability.

Bell and Bryman (2007) explored the potential for harm done by the management researcher in organisations, as distinct from work on medical research ethics which focusses on the potential harm done by researchers to patients. As a management researcher undertaking co-operative inquiry with others, my primary purpose is always to protect the dignity of participants and the people we study.

I informed participants about my inquiry. We talked about the research plans and sought their consent and agreement to including them in an anonymised way in published writing and to any audio or video recording that I carried out (Appendices 2 and 3).

Simply signing a consent form at the onset of the inquiry was not enough for someone to feel fully included as a participant. That required relationality, flexibility, openness, trust – and time for those to be fully embedded in the process.

My co-inquirers have had to trust me to care for them and write my inquiry in a way that looks after them. In each story I have used to illustrate my thesis, I continually think of caring for my co-inquirers, whilst opening a space for genuine inquiry in which we can all speak about our experiences without exposure to blame and shame. There is an art to crafting action research, which Traeger (2016) refers to as an “ethics of generosity”. Traeger argues that this craft of ethical generosity is fundamental to quality action research, as it enables freedom of speech and openness to difference amongst co-inquirers.

As a practitioner researcher, my engagement with co-inquirers has been conducted purely on trust. My ethical stance on my research is that people really matter and I really matter as a researcher. Hence I cannot hide: I am showing up both as a researcher and as a practitioner.

In conducting this research, I was constantly thinking about the consequences of publishing material – for others and myself. Hence I often went back to my various sources of data (illustrated in chapter 4) to remove indications of identity and to obscure details, endeavouring to write in a way that should not harm anyone. I would ask myself, what would he or she say if he or she read this?

However, I still want others to know what happened and what I felt in a particular situation; I need to select thoughtfully what feelings I want them to know about. I cannot pick situations beforehand, since the very process of thinking through this situations, “figuring out what to do, how to live, and what [my] struggles mean”, and composing text about it is the research process of autoethnography (Bochner and Ellis 2006, p. 111). Unless I investigate the meaning of an experience, I cannot make any decision about whether and how to write about it. Therefore, autoethnography is in itself an “ethical practice” (Ellis, 2009, p. 317).

In my thesis, I have endeavoured to stay true to using stories to foster learning to improve professional practice, whilst maintaining the utmost respect for the privacy and anonymity of my co-inquirers and participants.

1.5 Thesis overview

This section describes how the thesis is constructed, highlighting the core themes in each chapter.

From a linear structure perspective, the thesis outline is as follows. In chapter 2, Discovering My Methodology, I explain my research strategy and the methods from which my reflective practice emerged. I share my philosophical research positions, including what constitutes my nature of reality (ontology) and my way of knowing (epistemology). I inquire into and seek to understand the characteristics of my action research and the other chosen methods I used, their conditions of practice and their learning impact. The chapter includes an overview of data sources generated from the research to aid in the transparency of inputs and outputs from the research process and includes how we used and analysed data, it concludes by highlighting the criteria for quality and validity of this research.

In chapter 3, The Practice Context and the Literature, I share my theoretical landscape. I inquire into characteristics of my research themes in inquiries into NHS failings, quality and safety, sustainable cultural change, leadership practices and relational ways of working and compare these with existing bodies of theory. I offer some learning theories and extend this with ideas from my constructionist inquiry paradigm.

In chapter 4, In Pursuit of Understanding Self, I share my first-person inquiry into personal stories behind this research, including my inquiry into my roots. I offer orientation points in my life as a wife, mother, NHS leader, action researcher and humanitarian, and summarise my self-reflective practice on my first-person inquiry.

In chapter 5, In Pursuit of Understanding Others, I illustrate my professional inquiry in which I reach towards second-person inquiry, working in a participatory way with others on issues of mutual concern. I share experiences of the strengths and challenges of co-operative inquiry. I conclude the chapter with material on third-person inquiry, engaging with a wider audience beyond NWL to share the learning from our research. I sought to combine the learning from both the personal and professional strands of my inquiry to understand my practice in greater depth, offering insights into a more confident and effective practice.

In chapter 6, Discovery of Renewed Practice, I offer a reflective and reflexive stance on my research and its findings in connecting my ontological and epistemological positions to see how the findings situate the research as that of a practice-based inquirer. I summarise the change in practice, contributions and impact my research has had in my personal and practical professional daily life. I offer my reflection on the criteria I set to appraise the validity of my research and conclude the thesis with recommendations for further research.

Although the period of my doctoral research has ended, inquiry into my personal and professional practice remains a continual process. It is in this light that I offer the thesis as a contribution to improving safety and relational leadership practices in the NHS.

2 DISCOVERING MY METHODOLOGY

This chapter outlines the strategy, plan of action and methods chosen to explore the research questions. I explore the why, what, from where, when and how data was collected and analysed. The chapter illustrates the activities undertaken to ensure a thorough and systematic research process.

An intellectually stretching experience in my doctoral journey was grappling with understanding the ontological and epistemological positions I bring to both my practice and research. It has taken some time and effort to reconcile myself to the reality that I will continually be exploring my understanding of the nature of reality and what can be known about it.

Guba and Lincoln's (1994) construct of research paradigms helped me locate myself on the map of ontological, epistemological and methodological approaches to research. They define a paradigm as:

> *A set of basic beliefs that deals with ultimates or first principles. It represents a worldview that defines, for its holder, the nature of the 'world', the individual's place in it and the range of possible relationships to that world and its parts as, for example, cosmologies and theologies do.*

Guba and Lincoln go on to suggest that an inquiry paradigm helps define what falls within and outside the limits of legitimate inquiry. Whilst I have my reservations about this assertion, as I perceive it as an expression of power and control as opposed to an invitation to explore, it has helped me to identify where I am on the paradigm map. It has aided to me to query the following:

- The ontological question: What is the form and nature of reality and therefore what is there that can be known?
- The epistemological question: What is the relationship between the knower or would-be knower and what can be known?
- The methodological question: How can the inquirer or would-be inquirers go about finding out whatever he or she believes can be known?
- The methods question: What procedures, tools and techniques would be useful for gathering evidence for the inquiry?

With my research questions' focus on how people develop and nourish relationships that improve their professional practice and organisational worlds, I was attracted to what Guba and Lincoln call the constructivism inquiry paradigm. In this paradigm, realities are formed through " 'intangible mental constructions' that are socially and experientially based" (Guba & Lincoln, 1994, p. 110). The preferred methods will be those where the researcher and the researched interact together to elicit and refine the constructs. This approach fits very well for me as a practitioner–inquirer, where participation with other practitioners to seek and develop understanding of our practice was a key driver for my research.

Whilst understanding of these inquiry paradigms was helpful in enabling me to position myself as a researcher in my context, there is another stance I hold to strongly which is worth mentioning. As a practising Christian, I attach strongly to my spiritual faith and believe in the theology that underpins it. I hold to the view that there is a God who is creator and sustainer of the universe. As the originator, he reveals what we need to know about the world and does this through the doctrine of the Trinity of God the Father, God the Son (Jesus Christ), and God the Holy Spirit. I believe that the Bible as the word of God contains the truth about us and equips me in my relationship with God. It is the book I dwell on for teaching and insights on the values I strive to live by. My belief in God sets the frame and acts as an influencing spiritual 'voice' for what I understand about reality. My spiritual faith is a key part of my knowledge of being in the world.

Based on my faith, I believe in the notion of the existence of the self/soul engaging and conversing with God, one which is not dependent on contingent aspects of our social selves. I experience my self daily; my soul exists, irrespective of my experience with others. My soul communicates with a heavenly spiritual being. Such a relationship is an essential experience for me and guides the way that I interact with others. Whilst I experience an ever-shifting bundle of thoughts, feelings and memories, my 'experiencing self' does the living.

A key learning whilst crafting my own research paradigm was that, though it seemed a demanding process at the outset, it is not a once-and-for-all-time fixed decision. It was a continuous dialogue with myself, my practice with co-inquirers, my supervisor and my supervision group during the research process.

This chapter aids the understanding of my underlying ontological position (section 2.1), the epistemological assumptions behind my research (section 2.2) and how they relate to my methodological considerations that gave rise to the methods used (section 2.3). I then move to how I used and interpreted data (section 2.4), and questions of quality and validity, inquiring into what it takes to ensure quality when undertaking this type of research (section 2.5) and summarise how all these assumptions connect to the findings of my research (section 2.6).

2.1 My ontological position

Prior to clarifying my ontological position, it is important to define ontology. Ontology is defined as "the study of being" (Crotty, 1998, p. 10). It is the branch of philosophy that constitutes the nature of reality and is concerned with "what kind of world we are investigating, with the nature of existence, with the structure of reality as such" (Crotty, 1998, p. 10). Guba and Lincoln (1989) state that ontological assumptions are those that respond to the question 'what is there that can be known?' or 'what is the nature of reality?'

My thinking about ontology began with a discussion with myself exploring the basic set of beliefs that I have and how these influence the way I undertake research. Whilst I had a basic set of beliefs or my 'truth' from a theological perspective, I did not know what to call my other beliefs until I dug deep into exploring research paradigms.

From my academic background in a positivist paradigm in which I studied the scientific and social world, immutable laws and mechanisms have driven my view of reality. My knowledge of the 'way things are' is in the form of cause–effect laws and generalisations. It is the viewpoint that objects have an existence independent of the knower or researcher, based on an objective reality. Hence, I have previously practised in my professional field from an absolute positivist standpoint.

As a researcher for my two masters degrees, I verified hypotheses established as facts or laws, with the generation of quantitative data from an ontological view known as that of a realist. Realism is the ontological position that an apprehendable reality is assumed to exist, driven by immutable natural laws, and reality can only be understood from empirical observation using appropriate scientific methods (Guba & Lincoln, 1994; Moon & Blackman, 2014). My view on the nature of existence aligned with the realist ontology that one single reality exists that can be studied, understood, and experienced as a 'truth': a real world that exists independent of human experience (Moses & Knutsen, 2012).

As an action research practitioner–inquirer in my doctoral studies, I began to realise that things are not as straightforward in their certainty of existence; my engagement with co-inquirers exposed me to understanding that actions and behaviours are not as predictable as that would suggest. As I developed in my use of action research in first- and second-person inquiry, I began to place more emphasis on what is happening around me, with a focus on meaning and reflecting on the totality of the situation. I used different methods (outlined in section 2.3) to establish different views of phenomena. I became conscious of my reality through my senses of real world phenomena, and I began to understand that my own ontological view was growing towards relativist ontology.

Relativism is the view that reality is subjective, and differs from person to person (Guba & Lincoln, 1994, p. 110). Relativist ontology holds that reality is constructed within the human mind, such that no one true reality exists. Instead, reality is relative, according to each individual who experiences it at a given time and place (Moon & Blackman, 2014). As such, reality is individually constructed; there are as many realities as individuals.

In being reflective, the connecting of my ontological roots was to see how this situates the research, as my ontological position shifted during my doctoral years from a realist to a relativist ontology Knowledge and meaningful reality are constructed in and out of interaction between humans and their world and are developed and transmitted in a social context (Crotty, 1998, p. 42). Therefore, the social world can only be understood from the standpoint of the individuals who are participating in it (Cohen et al., 2007, p. 19).

During the research process, my thinking gradually transformed. I started from the right or wrong reality notion and slowly came to understand that there is no such thing as a universal truth. All knowledge is constructed and can, therefore, be deconstructed. We can know only a tiny piece of our environment, and we know it just from a particular point of view (Berlin, 2013). This ontological position has helped me to understand that the meanings of social phenomena remain in a constant state of revision by social actors. I have come to understand that the nature of reality is not definitive, as such: no one ‘true’ reality exists.

I am drawn to Mead’s (1934, p. 76) claim that meaning arises and lies within the field of the relation between the gesture of a given human organism and the subsequent behaviour of this organism, as indicated to another human organism by that gesture. In

plain words, Mead argues that meaning occurs via social relationship between people, something that in my view indeed occurred during our inquiry (illustrated in chapter 4).

Whilst I agree that interaction between people allows negotiation of meaning, as we experienced in sharing our stories in FoS, there is also an interaction between 'I' and 'I' which I also see as paramount in relating to the social group as a 'generalised other'.

As we are culturally complex beings, we are encouraged by Gergen (1991) to minimise attaching specific descriptions to ourselves (either those perceived by ourself or as we are labelled by others). We should be creative in our construction of a new language of self-identity, to facilitate collaborative interaction with others and enable us to build stronger relationships. As an action research practitioner–inquirer in the NHS, I came to realise that, as separate individuals, we are always in relation with others from a particular history, culture, language, and so on.

My narratives in this thesis is not merely a record of what happened (if this was even possible to provide). Following Bruner (1990):

> *It does not matter whether the account conforms to what others might say who were witnesses, nor are we in pursuit of such ontologically obscure issues as whether the account is 'self-deceptive' or 'true'. Our interest, rather, is only in what one person thought he did, what he thought he was doing it for, what kinds of plights he thought he was in, and so on* (1990, p. 119).

However, core to my research approach is a desire to handle my encounters with others with reverence and respect. This reflects my belief that the nature of reality is relational and connected to other parts and the whole.

Whilst the realist ontology I started from might still apply to social interactions with others, it became only one (limited) dimension; hence, I needed to look beyond this scientific dimension to find help to tackle questions regarding social interactions. Heron and Reason's (1997, p. 3). view that to experience a world is to participate in it, simultaneously moulding and encountering it resonates with me. My relativist ontology on the world now shapes my practice and I feel offers a standard of judgement against which my claims to knowing are to be assessed.

My ontological view of a social world of human beings who have their own thoughts, interpretations and meanings has an implication for my ways of knowing

(epistemology) and research methods, as illustrated in subsequent sections of this chapter.

2.2 Epistemology of my research

Epistemology is concerned with the nature and forms of knowledge (Cohen et al., 2007, p. 7). Epistemology is “a way of understanding and explaining how we know what we know” (Crotty, 2003, p. 3).

I have come to appreciate, as Schön (1983) says, that all organisations live by their own epistemology, their own way of knowing, and that any way of knowing uses its own legitimation criteria and standards of judgement. The dominant epistemology in the health care sector is based on an objectivist standpoint, knowledge of facts and information and is validated by testing, through controlled experimentation and the statistical analysis of manipulated variables (Von Bertalanffy, 1968).

In conducting my research, I have dwelled deeply on what my epistemology is about and how it relates to the epistemologies of my relational practice with co-inquirers and my methods. As with other action researchers (Belenky et al., 1986; Torbert, 1991; Heron, 1996; Reason, 2006), my inquiry is based on ways of knowing that go beyond the objectivist and subjectivist epistemology. My ways of knowing include knowing of self through self-reflection, knowing about my relationship with myself and between myself and others through participation, knowing through instinct, and knowing through embodiment and its link to the wider field of learning.

Based on my ontological position and my use of participatory action research with other co-inquirers, the epistemological stance that emerged in this research is constructionism. Constructionism is defined by Crotty (2003, p. 42) as “the view that all knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context.” Thus, meaning is not discovered, but constructed.

Constructionist epistemology rejects the idea that objective ‘truth’ is waiting to be discovered. Instead, ‘truth’, or meaning, comes into existence in and out of our engagement with the realities in our world; no real world pre-exists that is independent of human activity or symbolic language (Moon & Blackman, 2014).

In my research, my co-inquirers and I constructed knowledge through our engagement and interpretation of the world. During our research process, different individuals constructed meaning of the same object or phenomenon in different ways (highlighted in our research stories in chapter 4). Crotty (1998) and Creswell (2009) highlight that, for those with a constructionist epistemology stance, meaning arises through an interaction with a human community, as their world is based on their cultural, historical, and social perspectives.

Similar to my shift in ontological position in this research, my epistemological position also shifted after the start from being an objectivist epistemology, in which the researcher is separate from the objects being studied. In contrast to my objectivist position, for my doctoral research I became interested in people and the way that they interrelate – what they think and how they form ideas about the world and on how their worlds are constructed. With this interest, I had to look closely at what we are doing by using our own selves and our own knowledge of the world as people. I therefore immersed myself in the research context (illustrated further in my use of authoethnography in section 2.3), paying attention to the nuances in behaviour, to gain an understanding of myself and other practitioners.

I then became aware that each individual defines and frames problems in their own way, and these differences need to be understood and made sense of within the context of our social practices to improve our individual practices and the system as a whole. As such, it was vital to understand the meanings that construct and are constructed by the interplay of human behaviour.

Bradbury-Huang (2010) described action research as a transformative orientation to knowledge creation, in that action researchers seek to take knowledge production beyond the gate-keeping of professional knowledge makers. A characteristic that differentiates action research, and in particular co-operative inquiry, from other research approaches is what Heron (1996) and Reason (1999) argue is extended epistemology. These four kinds of knowing (Heron, 1996; Heron & Reason, 2001, 2008) of extended epistemology are the ‘experiential’ knowing that is seen as the foundation for the other forms of knowing: ‘practical’ knowing (how in the world of practice); ‘presentational’ knowing (represented in significance patterns, stories, pictures), and ‘propositional’ knowing (theories for exploration). I have found this categorisation helpful in my research, as it has helped me define the outcomes I am seeking of improvement in practice. My experiences and the relevance of these forms of knowing are elaborated on in chapter 4 on my practice of co-operative inquiry.

To support the validating of the production of knowledge in my doctoral research and in subjecting my research to critical scrutiny, I have adopted and refined the framework developed by Checkland and Holwell (1998). As practitioners, we (my co-inquirers and I) are interested in real-world problems that are areas of concern in our daily lives (labelled as A in Figure 3), based on our existing knowledge of the problems; we then engage to generate ideas to change the problems (labelled as F), and then take part in the real world of our daily lives to apply and test out the change ideas (F) through agreed methodologies (labelled as M). Hence, change ideas (F) are used through methodologies (M) to investigate areas of concern (A).

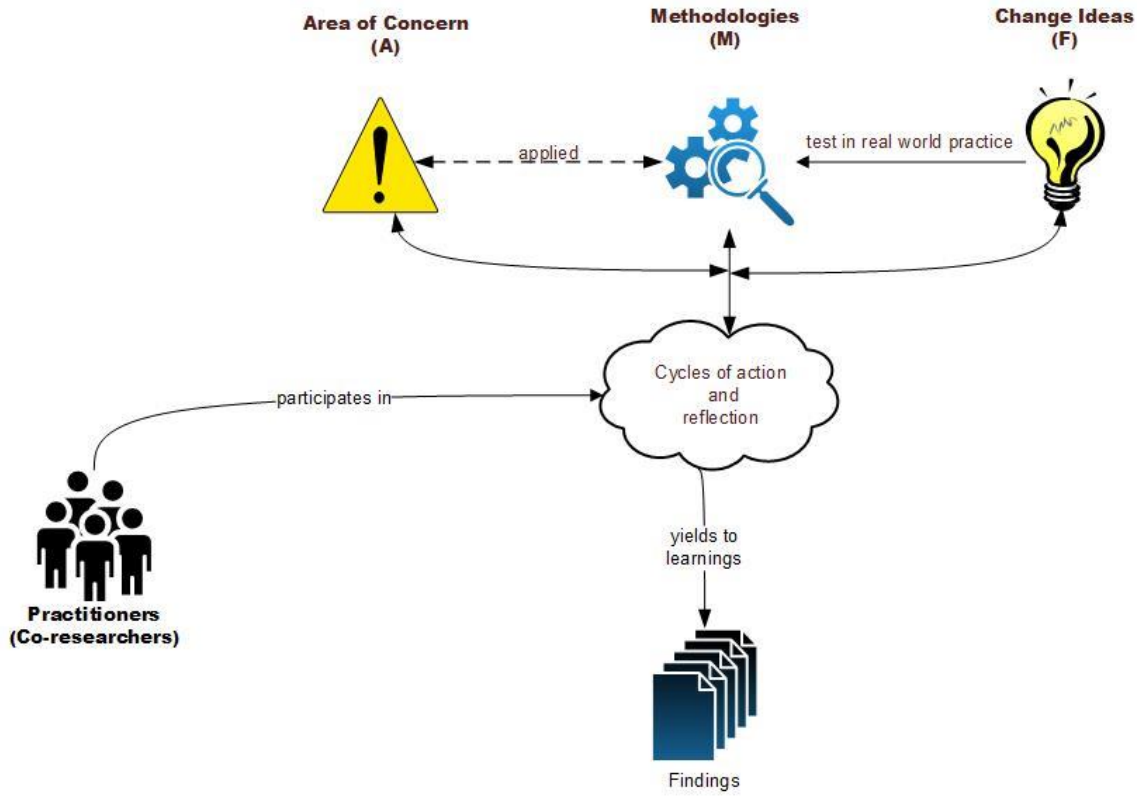

Figure 3: My justification of knowledge

Source: My own diagram, adapting a framework by Checkland and Holwell (1998)

During our action and reflection cycles, we (my co-inquirers and I) take notes and record the unfolding experience of F and M. Our use of M has taught us about A and the appropriateness of F and M. As our real-world situations continually evolved, we agreed on a point at which our actions had been sufficient to allow us to stop applying F and M to A, to enable us to tease out and reflect on our findings and thus gain new knowledge.

Using this framework (via F and M) with co-researchers in my inquiry has enabled me to make findings on the improvements needed in leadership and patient safety practices in the NHS in my local context. From my experience of acquiring knowledge, as shown through my diagram above, it offers an alternative way to create sustainable cultural change.

2.3 My method

Methods are the "procedures, tools and techniques" of research (Schwandt, 2001). This section provides an illustration of the varied qualitative methods used, based on my epistemological and ontological positions in considering my research questions.

Action Research

Reason and Bradbury (2001) describe "action research as a participatory democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes". 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, to the flourishing of individuals and their communities.

To aid me in responding to my research questions as a practitioner-inquirer with a passion to engage with other practitioners and service users to improve the delivery of services, I chose to adopt action research as a method for my doctoral research. Adopting this method as a participatory process aids other practitioners, service users and myself as co-inquirers to inquire into concerns we faced in our daily life of 'real world' practice, whilst questioning and reflecting on 'how' and 'why' we do things. "Action without reflection and understanding is blind, just as theory without action is meaningless" (Reason & Bradbury, 2001, p. 2).

Action research scholars (Heron, 1996; Greenwood & Levin, 1998; Anderson & Herr, 2005; Mills, 2000; Reason & Bradbury, 2001; Gall & Borg, 2003) agree on the action research practices categorisation of first-, second- and third-person inquiries.

First-person inquiry

First-person inquiry is the ability of the researcher to inquire into their own life, monitor the impact of their behaviour and act with conscious choice and awareness (Reason & Torbert, 2001). The first-person inquiry component of this research was undertaken as

a personal inquiry into my own life. For my personal inquiry, I made use of self-reflective practice, including the use of the left-hand column tool, journaling, autoethnography, storytelling, acknowledging the existence of race introjections, showing up of voice, understanding power relations for social change, creation of communicative space, and engaging in constructive thought-provoking conversations and learnings with family, friends and ADOC cohort and faculty. My first-person inquiry is further illustrated in chapter 4.

Second-person inquiry

Second-person inquiry, according to Reason and Bradbury, addresses our ability to inquire with others into issues of mutual concern; it starts with interpersonal dialogue and includes the development of communities of inquiry and learning organisations (Reason & Bradbury, 2008).

With my early career as a business analyst and service transformation manager, I have always thrived on working with colleagues and external stakeholders interested in implementing changes to business processes and systems as a way to improve efficiencies, job satisfaction and service delivery. The rich examples of co-operative inquiry in Reason's (2002) *The Practice of Co-operative Inquiry* inspired me to follow this research approach, which was very new to me and is seen as countercultural in my professional context of the NHS.

Co-operative Inquiry is a form of action research that emerged from John Heron's quest for experiential inquiry. This approach to research was introduced in the 1970s (Heron, 1971) and Heron developed it over the following decades (Heron, 1996; Heron & Reason, 1997) in collaboration with Peter Reason, as it became apparent to Reason during his postgraduate study that it was impossible to undertake inquiry into human relationships as an outsider.

Heron (1996) describes Co-operative Inquiry (CI) as a model that involves two or more people researching a topic through their own experience of it, using a series of cycles in which they move between the experience and reflecting on it together. Each person is co-subject in the experience phases and co-researcher in the reflection phases. It is a vision of people in reciprocal relation, using the full range of their sensibilities to inquire together into any aspect of the human condition with which the body–mind can engage.

I developed an interest in using a method that promotes engagement with internal and external colleagues in which we are able to draw on our own subjective experiences from outside and inside the group as data for discussion and analysis.

In my experience with traditional (deductive, hypothesis testing) research methods, the researcher is left to do the thinking, generate ideas, design and draw conclusions from the research; the subject often has no knowledge of what the researcher is thinking or progress on what is being researched. The involvement of the subject is mainly during the action phase, in which they are 'studied'. With CI, the subject and the researcher are co-researchers and co-subjects. We develop, process, manage, draw conclusions and disseminate learnings from the research, whilst also experiencing the actions that are being researched.

With traditional research methods, I was limited to a form of learning that focussed on what I know, and which excluded how I come to know it. It was based on individual work with limited interaction with real-work experiences as it unfolded. With CI, learning is done through interaction with peers and co-inquirers, making it a collaborative teamwork process.

As a practitioner–inquirer, I was keen to adopt CI as my method, so that I could engage proactively with practitioners and patients to form a community of inquiry with people who were keen to effect change in leadership and patient safety practices. This method of research is well suited to the NHS where, despite our diverse complex human experiences, there is an appetite to develop new ways of working with people.

As a practitioner–inquirer, I am drawn to this method of inquiry as it enables me to undertake research "with people rather than on people" (Heron & Reason, 2006) and provides a channel to engage proactively with other practitioners who have similar concerns and interests. When participants are co-researchers, there is an opportunity for new knowing to occur and for meaning to be constructed. I envisaged that the strength of our collaboration could lead to a profound change in leadership and patient safety practice.

I used co-operative inquiry as an action research approach in the form of second-person inquiry to engage with others in the wider system. My second-person inquiry is my professional inquiry with the co-inquirers in NWL NHS organisations and the facilitators (Ashridge Consulting). In conducting this research, I navigated through the

complex healthcare system with careful political and relational constructs, to clear the way for practitioners to inquire with me on system priorities.

In my research, I sought to use the ideas and methods of CI. Within a few months of applying the method, however, I realised that it was not particularly straightforward; this experience is illustrated in section 5.4. The ideas felt too conceptual for my inquiry, and I had to tweak specific elements of the method to make it useful for my FoS co-operative inquiry group. Further illustration of my second-person inquiry is in chapter 5.

Third-person inquiry

Third-person inquiry, according to Reason and Bradbury, aims to extend these communities of inquiry to create a wider impact, involving people beyond the direct second-person inquiry. This form of action research has featured when I have presented our work to others and engaged with others to explore areas relevant to our inquiry (Reason & Bradbury, 2008). My practice of third-person inquiry is presented further in chapter 6.3, which highlights how we have shared inputs and outputs of this research including learning across a wider audience in the UK beyond NWL.

Action learning

> There is no learning without action and no (sober and deliberate) action without learning
>
> R. W. Revans 1907–2003

"Action learning is a process that involves a small group working on real problems, taking action, and learning as individuals, as a team, and as an organisation. It helps organisations develop creative, flexible and successful strategies to pressing problems" (World Institute for Action Learning, n.d). Pedler (1997) defined action learning as an approach to the development of people in organisations that takes the task as the vehicle for learning. The method has three main components: people, problems, and a set of six or so colleagues. Action learning implies both self-development and organisation development. Action on a problem changes both the problem and the person acting upon it. It proceeds particularly by questioning taken-for-granted knowledge (pp. 12–13).

Edmonstone (2003) categorised action learning as a method for individual and organisational development where individuals work in teams to tackle real problems or issues, getting things done, reflecting and learning as they progress. Pedler, Burgoyne,

and Brook (2005) identified action learning as a method and a culture of learning. Marquardt et al. state that action learning is a process in which a diverse team uses a problem-solving methodology that emphasises asking questions to create a solution for a real problem that is both urgent and important, with an agreement from senior leaders in the organisation that the solutions would be implemented if good and feasible (2009, p. 7). In view of the above definitions, it can be suggested that scholars agree on the basic tenets of action learning as a method to work on real problems, for the purposes of participant learning and solving organisational issues.

With the desire of my co-inquirers and I to tackle real-world problems in our daily practice, we decided to address and inquire further into these problems in smaller teams within our larger co-operative inquiry group. These smaller teams, referred to as shared interest groups (SiGs) were the platform we used to practise the action learning method. There are further illustrations from SiGs in chapter 5.

Action based approach to research and learning

My research is positioned within action research, co-operative inquiry and action learning methods. My use of these has led me to refer to my method as action-based approach to research and learning. This term acknowledges the commonalities on principles across these methods of action-oriented, problem-driven, solving real-life issues, multidisciplinary learning. They start from the stance of ignorance, where people with similar interests come together to help each other to take action on their problems and learn from such work to produce personal and organisational improvements.

The use of action-based approaches to research and learning has evolved from the pioneering work of Reginald Revans in the UK in the 1940s (Revans, 1982) to a method that is adopted globally to aid with complex problem-solving and leadership development that produces actionable practitioner knowledge in diverse settings (Kramer, 2008; Raelin, 2009; Marquardt, 2011; Pedler, 2011).

Action-based approaches to research and learning emerged in the health care sector in the 1960s through the work undertaken by Revans. The aim of the action research designed and led by Revans was to improve communications, morale and performance in ten participating London hospitals (Wieland & Leigh, 1971; Clark, 1972; Wieland, 1981). The Hospital Internal Communication (HIC) programme was a 4-year (1965–68) initiative supported by the King Edward VII Hospital Fund for London. It was conducted

across the participating hospitals via project meetings, which tackled 38 projects in the three years from December 1965. The approach was to collect data, write a report and then take action on the report. Action was taken in “over half” of them, whilst “the rest did not go beyond report stage” (Wieland & Leigh, 1971).

A defining aspect of the HIC programme was Revans’s rejection of theory-led organisational change, including the development of an actionable form of management learning. Revans stated that learning and living are so interdependent that we should design living to facilitate learning (Revans, 1977).

> *Revans argues that an organisational change programme should be guided by the “maximum of practice and the minimum of theory”, and that theory should consist of the study of action research projects in parallel fields. This observation reflects his theory of learning in organisations* (Clark, 1972).

However, Clark (1972) disagrees with Revans’s stance, arguing for the value of no less than four types of theory in action research – “ethical, utopian, empirical and goal-based empirical” (1972, pp. 73–77).

From my research experience, attaining sustainable change in NWL NHS organisations was not characterised by these various types of theory, and the value of theory was minimal. Rather, it was from a ‘bottom-up’ or ‘inside-out theory of organisational learning. Based on my experience, the traditional theory of research and learning was of little value to the hospital administrator, porters, healthcare assistants and other practitioners. These practitioners were aware of the specific challenges they faced on a daily basis in delivery high-quality care. Whilst it is one thing to be clear about the issues, it was another to be clear about one’s own responsibility for causing or helping to cause them. My research experience of my first-person inquiry into self gave me clarity on my role in the issues faced, and my second-person inquiry with co-inquirers highlighted that practitioners should be empowered and encouraged to develop their own learning to produce sustainable change.

The HIC programme, being the first large-scale test of action-learning-based research in health care is rich in learning on how to do an action-based approach to learning and organisational development, and on how to manage learning in group meetings to support improvement in healthcare delivery. It highlights that the action-based approach to research and learning should intentionally develop and cultivate the

learning process from the outset, and that teams who have experienced the learning process could then apply it to groups in their own hospitals (Wieland, 1981).

With the changes in health-delivery systems in the past 50 years, the fundamental essence of the action-based approach to solving real-world problems whilst gaining deep learning in the process remains unchanged. Fifty years on, the action-based approach to research and learning is alive and kicking. Its application is increasingly gaining popularity within the healthcare sector (East & Robinson, 1994; McVicar, Munn-Giddings & Abu-Helil, 2012; Montgomery, Doulougeri & Panagopoulou, 2015), and the concept is as relevant today as it was when the initial work was done by Revans in the 1960s. Particularly relevant is the concept of building teams around problem-solving, often across professional roles and functions, including the use of diverse teams that emphasise asking questions to create solutions for real problems (Revans, 1982).

With the complexity in the nature of healthcare delivery, it is not surprising that limited progress has been made with regard to gathering consistent and reliable evidence on the most effective organisational culture change approach to improve patient safety, leadership and delivery (Parmelli et al., 2011). Hospitals, in particular, embody a unique organisational culture, which is made complex by competing and unequal voices.

Montgomery et al. (2011, 2015) assert that relatively little systematic research exists on how this unique environment contributes to job burnout and/or quality of care. Yet, the Institute of Medicine (1999, 2001) advocates that there is a link between patient safety, staff well-being and organisational culture.

Hospitals generally have processes in place to reflect on patient safety issues (e.g. morbidity and mortality panels, safety committees, incident reporting and root-cause analysis review teams) with dedicated resources (e.g. people, educational materials, training) to address patient issues, but these efforts are often focussed on “putting out fires” to address urgent needs or on “checking off the boxes” (Francis, 2013) with the aim of meeting regulatory requirements. This approach seems to view action and learning as separate tasks; hence, it lacks a system that combines both action and learning effectively. To effectively produce learning and sustainable change, a systems approach that values humility, curiosity, compassion and diversity may have more impact, as shown by my research findings.

This thesis describes the application of the action-based approach to research and learning within a complex system that is non-linear, unpredictable, dynamic and networked over multiple and diverse scales, which produces unexpected results. It illustrates my experience of addressing the challenges of relational ways of working and sustainable change in patient safety and leadership practices.

Authoethnography

Reed-Danahay (1997, p. 145) defines autoethnography as “research (graphy) that connects the personal (auto) to the cultural (ethnos), placing the self within a social context.” Autoethnographers study their own culture as they “conduct ethnographic research on their ‘people’ ” doing “backyard ethnography” (Wolcott, 1999, pp. 170–71). The study could either be the group the ethnographer belongs to or their own personal experience. The autoethnographer’s interactions and subsequent thoughts, feelings and emotions are central in order to understand their own experiences (Ellis, 1999), and an autoethnographer would incorporate their own personal narratives in the research.

Sparkes (2000) suggests that autoethnographies are highly personalised accounts that greatly depend on the author/researcher to facilitate an understanding of the culture studied. Ethnography, on the other hand, is often described as the study of cultures (or parts of them) by participation and observation. In this case, the ethnographer takes part in the activities of the group studied but is not a part of the culture. It is a method of exploring what others are doing.

Based on my personal life experience as a patient with a child-birth safety incident, my use of autoethnography as a method was to investigate the patterns of relating in my personal and professional life in the NHS and how to develop more effective relational ways of working between multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety.

As a practitioner–inquirer, I am a part-time doctoral degree researcher and full-time healthcare leader. In my role as a researcher, I also juggled responsibilities of being a leader in the NHS, a co-operative inquiry coordinator and a programme director with accountability of demonstrating the outcomes and impact of the FoS programme. As Jenks (2002, p.173), I agree with Ellis and Bochner (2000, p. 738) that autoethnography is a place where social scientists can examine “the contradictions

they experience". Real life is cluttered and evolves; those that write about their own self's experience change over time.

In comparison to the positivist research method, autoethnography helps the practitioner to understand situations, their complexity, and their own reactions and emotions better (Adams, 2012) and to learn from experiences for better future actions (Brookfield, 1995; Ellis, 1999). To enable me into these experiences in my research, I had to become fully reflective of my personal child-birth experience and my role as a leader in my environment. It was in taking different perspectives on the event, in trying to step into the shoes of the other, that I began to understand the complexity of the situation and how others might understand my actions.

As a practitioner, being constantly forced to reflect on my own professional conduct is an invaluable source of learning. I had the opportunity to apply and test newly acquired knowledge in real time, and it produced different insights, as learning took place in me as a practitioner–inquirer.

Unlike other research methods that focus primarily on an observer's point of view, authoethnography aids the study of a lived experience, which can add great detail and richness to qualitative research. Van Manen (1988, p. 4) suggests in regard to lived-experience research: "the fundamental model of this approach is textual reflection on the lived experiences and practical actions of everyday life with the intent to increase one's thoughtfulness, and practical resourcefulness or tact".

However, there are debates regarding the narcissistic nature of autoethnographical studies. The key criticisms (Parks, 1998; Delamont, 2007) of authoethnography are to do with 'the self' and its lack of objectivity. On 'the self', autoethnography has been criticised as self-indulgent (Holt, 2003) and romantic in construction (Atkinson, 1997) and lacking in scholarship (Parks, 1998). A central debate is around the possible relationship(s) between theories of self and identity, and methods for representing the self.

Coffey (2002, p. 320) asserts that autoethnographies allow "the self and the field [to] become one" as the subject and object merge to reveal crises and epiphanies. This assertion captures both the value and potential risk behind this method. The risk is that it becomes a challenge to maintain the ethnographic distance, as both an insider inquirer on self. As hard as I might try, I could never be an outsider to myself. I acknowledge that there is a danger of being too inward looking; however, the insider's knowledge, the depth one reaches in using this method and personal experience make the research rich and provide a different view compared to researchers using other methods. The use of self as the source of data can be restrictive, yet, based on my

own personal experience, it was a powerful way to unpack the many layers involved in the study of culture in a complex organisation such as the NHS.

Gilmore and Kenny (2015) suggest that researchers of organisations have tended to neglect their own emotions, even when they research other participants' emotions. Denshire (2014, p. 845) claims that, as an antidote to this: “Autoethnography demonstrates the potential to speak back (and perhaps differently) about professional life under prevailing conditions of audit culture so as to make and remake ethical relations in contexts of professional practice.”

My belief is that a research that discounts the role of the researcher in the process is not providing a holistic view regarding the culture being studied. It is difficult to reflect and answer the question, “What is happening here?” if ‘the self’ is removed from the experience. The experience is part of me and I am part of the experience and I cannot remove my involvement in the process.

What makes a good story scholarly? This question is central in determining whether a personal narrative is credible, dependable and trustworthy. Ellis (1995) argues that a story could be considered scholarly if it makes the reader believe the experience is authentic, believable and possible.

My use of autoethnography provides an opportunity for the reader of my thesis to become a co-participant in the recorded experience (Ellis & Bochner, 2000). With regards to the challenge of authoethnography lacking objectivity, Ellis et al. (2011) describe autoethnography as “one of the approaches that acknowledges and accommodates subjectivity, emotionality and the researcher’s influence on research, rather than hiding from these matters or assuming they don’t exist”. Whilst it is difficult to avoid subjectivity in any form of research, acknowledging it exists in some form is appropriate.

My approach to a literature review and the use of co-operative inquiry with others have provided superior understanding and knowledge of our organisational issues and solutions than research methods using surveys. Engagement with other practitioners as co-inquirers has provided learnings that are more measured and reflective, and therefore more constructed and thoughtful.

In being subjective, I have paid attention to self-observation and reflection. I have benefitted from self-conscious reflexivity, whilst taking a mental note to recall in detail salient events to illustrate *who I was whilst the experience unfolded? How did I respond emotionally? What did I learn that I was oblivious to before?* It has become a process of continual internal dialogue and critical self-evaluation of my position, whilst

acknowledging the impact it has on the people I engage with, either for research purposes or in everyday-life situations.

In using autoethnography, I was willing to question my own practices as a researcher and practitioner in a deep and often uncomfortable way. I developed becoming comfortable in dealing with my emotions. Autoethnography is indeed a challenge for those that are not capable of dealing with their feelings. Ellis and Bochner (2000, pp. 738, 754) state: “Most social scientists ... are not sufficiently introspective about their feelings or motives. ... Not everybody is comfortable or capable of dealing with emotionality. Those who aren’t probably shouldn’t be doing this kind of research.” This thesis illustrates what I thought, heard, saw and felt in my inquiry journey.

Literature exploration

The purpose of this section is to be explicit on the key literature that informed my inquiry, in order to ground my professional experience as well as to generate new perspectives on my research aims and to identify themes that enhance the quality of data analysis in subsequent chapters. To recap, my research questions are:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
- What approaches and methods can be used to create sustainable cultural change in the NHS?

This thesis reflects on my role as a practitioner–inquirer in the context of my research undertaken at NWL NHS organisations between 2013 and 2017. My research questions have defined the scope of my literature review, as opposed to literature defining the scope of my research. This approach is appropriate, as it reflects the practice-based focus of my inquiry.

The research design consisted of a systematic review of the literature in research paradigms, and in healthcare and business contexts of organisational development and change management.

As I was curious to explore sustainable cultural change through the lens of leadership and patient safety practices, I focussed my search strategy on theory and research into participatory inquiry methods, public inquiries into NHS failings, human dimensions to

quality and safety, sustainable culture change in health care, leadership practices and relational ways of working in the NHS.

I made use of a variety of search engines available through OpenAthens, resources available from Middlesex University library catalogue, and Summon as a search tool for all print books, ebooks, journal articles, newspapers and databases. The databases used for searches included Business Source Complete, Proquest, Science Direct, Scopus and Ethos. This wide selection reflects the reality of accessing a variety of published sources to scan the environment for anything that seemed relevant to my research scope.

I searched these sources, using the keywords 'participative action research', 'action learning', 'co-operative inquiry', 'autoethnography', 'practitioner inquiry', 'qualitative data analysis and validity', 'transactional analysis', 'mechanical cybernetics systems', 'communicative spaces', 'social construction', 'shared leadership', relational leadership', 'patient involvement', 'patient safety', 'safety culture' and 'learning culture'. I conducted separate searches, using the key words 'culture change' and 'health care', and for 'race, voice, power, trust' and 'health care'. I chose not to examine broader literature on organisational behaviour in depth, as I was particularly interested in the micro-context of leadership and team behaviour change. My search strategy, like the inquiry cycles, was organic, unfolding and informed by my personality, preferences and interests.

Shulman (1999) views literature reviews as having the ability to stimulate generativity by enabling the researcher to build on the scholarship of those who have gone before. This metaphor reflects my experience of researching into my professional practice. I am building on what has 'gone before', whilst working to generate what is to 'become' in my work. A visual representation of a knowledge map (figure 5) in chapter 3 helps to highlight the diverse theory and literature landscape that makes up my research territory.

My engagement with literature in this thesis is specifically focused on:

- exploring, often in a reflective style, concepts in the literature that appear to have relevance to my research questions
- blending concepts in the literature to offer potential themes that will enhance data analysis
- generating concepts, by building on the work of other scholars and practitioners, that contribute to the achievement of my research aims

- acknowledging bias and pre-understanding that will shape aspects of my research
- stating clearly the practice and theory stances I adopt, whilst being cognisant of an action-research worldview.

On reflecting on literature, I chose to step back from scholarly engagement with the literature and take a more reflective and reflexive stance in order to explore emergent themes, complexities and possible contradictions. I have gained perspective by not taking anything for granted and asking questions constantly – What is going on here? What am I learning from this? Why do some of the co-inquirers want a pre-defined outcome from the outset and early phases of the inquiry? Why this curiosity? Who is co-inquiring? Where is the final destination? and How do we know we have made an impact and improved practice? I have come to appreciate reflection as both a state of mind and as an ongoing component of my practice, and reflexivity has challenged me to rethink the moral dimensions of my practice.

This learning approach links to my desire for my engagement with the literature to be a generative process, building on past scholarship (Shulman, 1999). In my experience, reflection, reflexivity and generativity (the emergence of new thinking) are intimately interwoven. In this sense, my process of engaging with the literature shifted from an academic pursuit to a way in which professional practice experience could be tested and contextualised. This has helped me to understand and improve my practice and has contributed new knowledge to the wider theoretical and practice debates outlined in chapter 3.

Learning journal

I have kept a learning journal throughout my doctoral study as a resource to help me remember, clarify and reflect on happenings, ideas and the ongoing quest for a clearer sense of self and my practice.

I chose to use a learning journal throughout my research to do the following:

- make me adopt the discipline of writing as a means by which to order my thoughts and motivate me to continue inquiring
- be a means to reflect and hold a dialogue with my own ideas – I was able to return and pick up the conversation from where I left off

- act as a form of exploratory content that included questions for further inquiry/reflection
- act as a bridge between my experience and my sense-making
- act as a piece of data

As I cycled through acting, observing, reflecting, sense-making and experimenting in my action research, my relationship with my learning journal deepened. My learning journal shows the records of events as they were captured whilst fresh, followed by comments and reflections on the occurrence. My relationship with my learning journal reflects Kierkegaard's view that: "Life can only be understood backwards; but it must be lived forwards' Kierkegaard (2013). The excerpts incorporated in this thesis show my journal as a place where I go to express myself when happy, hurt or unsure of what is next. It has been a greatly nourishing ground for my feelings and thoughts.

Barclay (1996, p. 29) cites Kolb (1984) and Schön (1990) when she argues that "reflection is a key element in the learning process. It converts informal and perhaps accidental opportunities into efficient learning." The use of my learning journal and of walking as a method became useful as a way of reflection. The space created during my 10,000-steps-a-day walking challenge provides me with an opportunity to think through critical issues, connect to my inner self, calm my mind and reflect on my life experiences, and serves as a form of meditation.

My journal was my means of recording and reflecting on experiential learning, as I recognised that learning is a personal, individual process. Bolton defines reflection as "learning and developing through examining what we think happened on any occasion and how we think others perceived the event and us, opening our practice to scrutiny by others, and studying data and texts from the wider sphere" (2010, p. 13).

This method, unstructured in format, was kept confidential and used informally to track my personal development. It has helped to re-create experiences, feelings and ideas that are valuable to me, whilst living life as an inquiry

Communicative space – opening up dialogues to listen and learn

The opening up of communicative space appears to be an important aspect for practitioner–inquirers facing deep-seated dilemmas (Eady, Drew & Smith, 2015). Such spaces allow professionals to engage in meaningful modes of collaboration, and democratic and non-judgmental dialogue in order to devise workarounds (Gaya Wicks

& Reason, 2009). The concept of the communicative space was developed from the critical social theorist Jürgen Habermas (1981, 1987, 1996). Communicative space is described as the "social space generated through communicative action" (Habermas, 1996). Communicative action is a social process, aimed at reaching understanding in a way that transforms the lives of those involved (Habermas, 1981). Communicative spaces should be viewed as physical and emotional (de Souza, 2007; Newton & Goodman, 2009).

For me, communicative action is always embedded in situations where people relate to each other through interpretation of their experiences, in a process that is open and not imposed by those with power. Such communicative action is premised on effort by people in sharing perspectives that consider others' interpretations to try to come to an understanding of shared meanings. My co-operative inquiry originated because leaders across NWL NHS organisations said they had no space in which they could discuss their common experiences and concerns in a safe, focussed manner without fear of blame and shame.

Opening communicative spaces was the first step taken at the outset of my inquiry. Communicative space offers a container in which leaders, practitioners and patients from the dominant community and from the margins can interact with each other in meaningful ways in a democratic process in which all relevant voices are heard and arguments are accepted and acknowledged. We embraced communicative space as a way to create an equitable forum for people to have their voices heard.

Physically, we established a space and time to enable people to come together to engage in conversations. The location of our space in Ashridge was generally accessible and in a safe suburban environment. It was conducive as a neutral ground for all participants and allowed easy car access. In addition, it was a space which I as lead researcher (a doctoral student at Ashridge) and the facilitators were familiar with and comfortable in. The rooms we held our co-operative inquiry sessions in had no table in the middle of the room. The presence of a table could have detracted from the openness of the communication.

In healthcare organisations, diverse skills are required to deliver services and the input of multidisciplinary practitioners is vital for system-wide change. Hynes and colleagues' (2012) co-operative inquiry on chronic obstructive pulmonary disease with respiratory and palliative care nurses concluded that participation is compromised in health-related action research projects that are uni-disciplinary or those that do not engage competing

voices that are inherent in everyday practice, as each one of them is implicated in the change process. From my inquiry experience of engaging competing voices through communicative spaces, there is a balance to be struck in whose voices should be deemed relevant and how such relevance is determined.

The healthcare environment could be described as a sea of voices (Hynes, Coghlan & McCarron, 2012) of differing perspectives. In my inquiry, the voices of different specialist disciplines (medicine, nursing, physiotherapy, pharmacy etc), managers and patients continually interacted with each other throughout the inquiry cycles, which brought out different personal and professional world views.

> *It always felt that changes were imposed on us through a theoretical manner with no reference to impact on real operational practice. Through our discussions here, we've been able to deeply understand the root cause of some of our tricky issues and it seems to boil down to lack of respect of each other's viewpoint, especially amongst our areas of disciplines. Now, I fully appreciate our varied perspectives. As I move away from my silo-ed view of the system, this has helped me to stop finger pointing on others.*
>
> – Specialist Nurse at a CI group session

The communicative space we created to engage with competing perspectives was a necessary first step to integrating them. This opened up a shared interest to communicate meaningfully with each other. Our practice curiosities were aroused, and we tasked ourselves with revealing individual beliefs and practices about patient safety.

In establishing communicative spaces in our SIGs, it was hard to decide who should be included in the wider dialogue on leadership practices across the organisations until we knew which aspect of the system we wanted to inquire into. At the same time, it was equally hard to decide which aspect to inquire into, until we knew who would be involved in the inquiry. Herein lies the paradox. We therefore had to decide things together iteratively, through dialogue conducted in the form of communicative action. This was done through inter-subjective understanding of the language to use, mutual acceptance of each other's point of view and unforced consensus about what to do.

Engaging in communicative spaces is a sometimes messy and time-consuming process. However, we used it as a channel to uncover layers of interpretations and understanding that were meaningful for the co-inquirers involved. Chapter 5 illustrates

some stories of the trickiness of establishing communicative spaces through our co-operative inquiry approach.

As we progressed through our inquiry cycles, co-inquirers became confident to challenge others. We became comfortable about voicing the challenges faced and we did not always agree with each other, nor did we feel pressurised to agree with each other, on the ideal course of action to change practice or the solution to system issues. This led to “argumentation” as Habermas (1998) called it. Whilst argumentation can be awkward, it brought out an exploration of co-inquirers’ different approaches to leadership and patient safety practices. We acknowledged others’ views and used them to reflect on our own practice.

According to Habermas (1998), it is ideal for discussions to reach a “truth”. However, all co-inquirers did not have to accept the same conclusion. From my experience, reaching consensus though dialogue in reasoned argument is helpful, as I believe consensus is not a measure of truth. My belief in truth is a contrast to the traditional culture in healthcare practices, which tends to view the world from a scientific standpoint.

> *I have formed new living relationships, which is quite different from those that exist in our transactional interactions in the system. These relationships have provided openings for other forms of learning.*
>
> – Deputy Director of Nursing, one of my co-inquirers
> Cycle 4 SIG Meeting, February 2016

As I experienced the blossoming of new relationships, I also observed interdependence amongst group members as we complemented each other.

Facilitation

The use of skilled facilitators in opening and sustaining our communicative space was incredibly important. Co-operative inquiry is political and demanding. It requires its practitioners, especially those who initiate and facilitate the inquiry groups, to possess a range of skills beyond those required of orthodox social science inquiry: an understanding of group behaviour, proficiency in group facilitation and emotional competence (Reason & Heron, 1995).

The early work of Revans (1966, 1977, 1982) on action learning did not pay specific attention to the role of facilitator and doubted people who took on such role. As he had no one single definition of what action-based research and learning might be, he

believed that there was no one right way to facilitate. Pedler and Abbott (2008) are of the view that every facilitator of action learning is condemned to be continually asking the question: am I doing it right?

From the beginning of FoS, a 'must have' requirement to support the programme was to commission experienced external facilitators, whilst I remained the internal facilitator as the mobiliser and learning catalyst for the FoS programme. I was glad that Ashridge Consultants as facilitators supported both the wider collaborative forum and my SIG. It took the weight off my shoulders, as I possess limited expertise or prior exposure to group process and facilitation, and it also freed me to participate fully in the group, despite being the initiator and main researcher. Ashridge Consultants also supported the getting-on-board process by individual phone conversations with each new participant, which generated a sense of curiosity about the philosophy of the FoS programme and its ambition to effect change.

The greatest benefit of being a participant rather than a facilitator was that I was on the receiving end of a change project that I had initiated, scoped and helped to shape by engaging with key stakeholders. I had first-hand experience of how change theory is lived out and how it translates into and manifests in my daily work and that of others – how change really happens (or not!). I am the subject of my own research – the prescriber and also the consumer! As a participant, I designed each of my inquiry cycles around the inquiry-based process of the FoS programme and explored ideas and insights about change that were emerging from the learning of my SIG and the whole FoS collaborative forum. I was learning by doing – by participating in the group's inquiry – about what it means and what it takes to facilitate co-operative inquiry.

Wadsworth (2001) states that the task of facilitation of an inquiry may be understood as shared, with the nature, extent and quality of the sharing in turn determining the nature of the outcome. The FoS facilitators responded to the needs of participants, acknowledging how people were showing up, holding the balance in conversation, stepping into the background and taking the stage where appropriate, encouraging action and reflection and aiding us to generate insights, whilst staying true to the core principles of our inquiry. The facilitators are co-inquirers, too, but they paved the way for the leadership of the group to be fluid amongst the participants.
Our facilitators enabled us to reflect on our individual selves, establish ways of seeing and doing. They helped us to consider underlying values and beliefs, hold together opposing views and re-evaluate issues from different perspectives, whilst we continually engaged with discourse.

SIG Facilitator: My career experiences, from being a ward nurse to retiring as a Director of Nursing who worked directly in a hospital delivering patient care, provided me with both insider and outsider knowledge of daily practice, enabling me to empathise to a degree with practitioners on the dilemmas they face, yet challenge assumptions about existing practices by getting them to engage with contradiction.

From my experience, facilitation helped to progress us through stages of individual reflections, enabling personal findings that were shared with the group. Our facilitators played a crucial role in provoking deeper critical reflection on values, beliefs and purposes of professional work.

2.4 Data analysis and interpretation

Data analysis and interpretation shapes the structure of my written work, so, in this section, I account for the data choices I made in my thesis. The data analysis illustrated in this section relates to facets of my professional inquiry, in which I aim to state not only what our choices were, but also why I made them and the implications of how they might be understood as valid inquiry practice. The approach I used in data analysis of my personal inquiry was slightly different, as it was an emergent and personal process –an extended epistemology in an embryonic state, as outlined in chapter 4.

Ellis and Bochner (2000) assert that the analysis of data in a personal narrative involves a process in which the researcher emotionally recalls the events of the past. The researcher looks back on specific, memorable episodes and experiences, paying particular attention to the emotions and physical surroundings during the recollection. Emotional recall is expressed through writing that includes thoughts, events, dialogue, and physical details of the particular event.

Until I began to write the thesis, my experience lay in piles of apparently unconnected stories, notes and journal scribbles. As I have attempted to name reality in written form, I have written myself towards understanding (Richardson, 2000). This thesis offers an account of my professional life in narrative form, with selected anecdotes sequenced in a way that aids the shaping of my emerging understanding of my research. This gives me the opportunity to think about stories and also to think with stories, bringing coherence to the research.

Throughout my doctoral inquiry process, I collected data from multiple sources for a variety of different purposes. It was imperative that the method of data collection used was able to create psychological safety for participants. The sources of data collection were:

- a learning journal, in which I recorded my own responses and experiences of the research process
- audio recordings of 108 hours (outlined in Appendix 9) comprising:
    - conversations from the FoS co-operative inquiry action and reflection sessions
    - discussions with black colleague co-inquirers
    - informal discussions about my research with a diverse group of stakeholders throughout its course
    - discovery and action dialogues with ADOC 4 cohorts and faculty
    - ADOC progression, mock viva and final viva sessions.
- ethnographic observation in formal and informal settings with practitioners
- multi-column analysis (Senge, 2006).

Figure 4 provides an overview of the data sources of my research illustrated as a graphical map to serve as a point of reference to aid with traceability and verification of research data. The illustration below highlights the complete set of data that exists for my research from a variety of research methods.

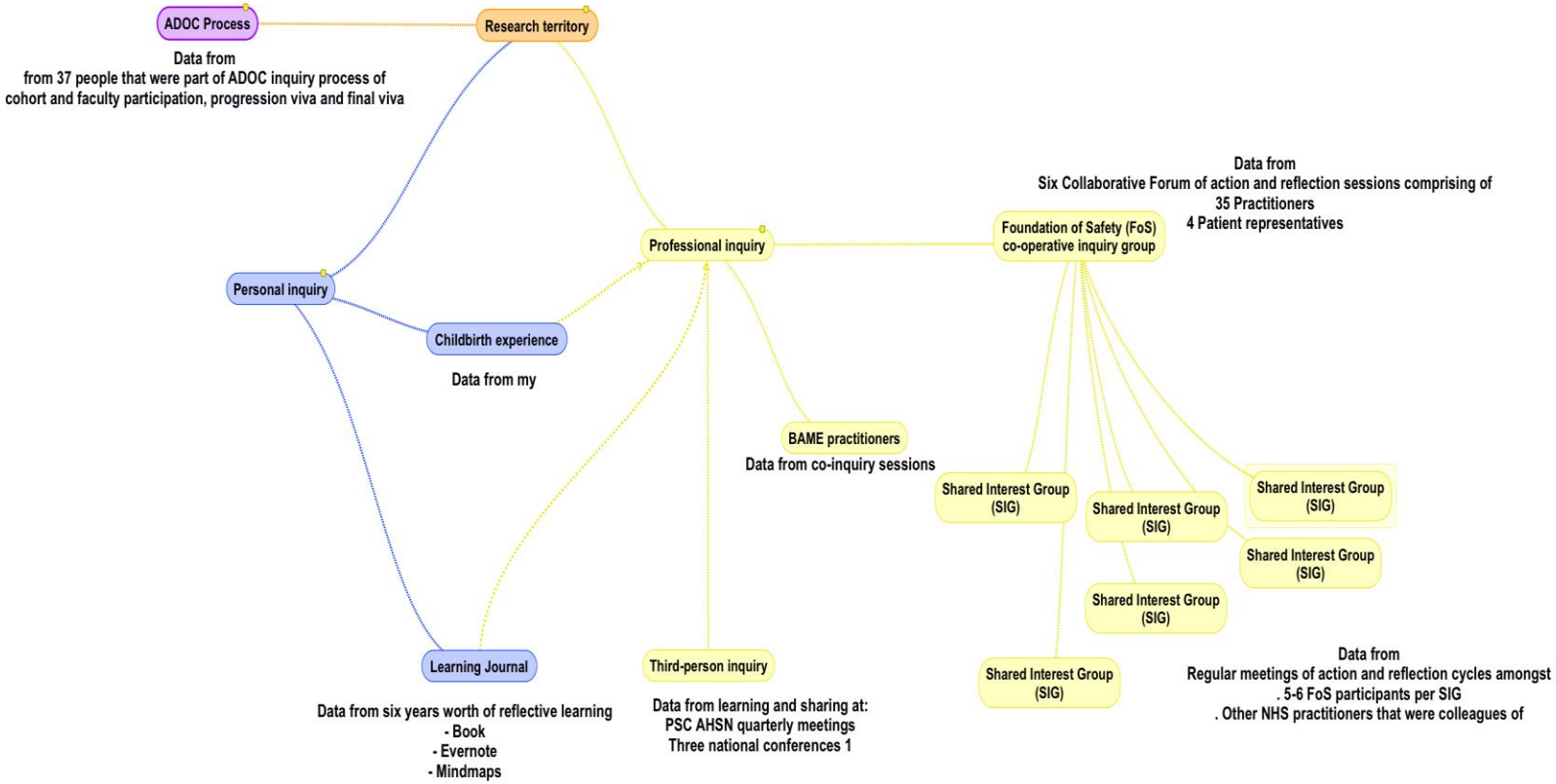

Figure 4: Map of data sources

The raw data relating to this research is not included in this thesis. However, it exists in the files I have archived in a cloud DropBox folder for this research. Appendix 9 provides a synopsis summary of the data sources used in generating the output of my research.

My co-researchers and I analysed the various forms of data collected immediately, as opposed to waiting to complete cycles of inquiry, to aid with prompt reflection on data gathered and responsive action to influence practice from data insights.

The data collection methods were not all selected at the beginning of the research but were also selected in response to emerging findings, the literature review, and my reflections and discussions with co-inquirers. All of the data gathered from the sources above were audiotaped and transcribed in full or captured as they occurred in written form in field notes, to which I refer to frequently.

To aid rigour, I triangulated data through sense-checking data from different sources, and I shared the data collected with co-researchers to check accuracy and verify whether specific actions had achieved the desired goals. For example, after observing multidisciplinary staff treating patients in an endocrinology ward, four co-researchers and I invited them to read our field notes and interpretations. Where appropriate, they commented on our interpretations and added their own. I responded non-judgmentally to amendments and found the process a great learning experience. It helped to challenge our world views, and made us reflect and learn to improve practice. This process also helped to create an open climate of trust between us (researchers) and other colleagues, as they felt involved and in control.

During my research, I needed to make sense of the research data collected, choices about how data would be handled and the approach taken to engage with the material that resulted from my inquiry activities. In making sense of the data gathered throughout my inquiry activities, I treated the data as representations of social processes. I queried the data with:

- What has gone well or not in the process?
- What seems to have enabled that to happen?
- What appears to be dissipating and emerging?
- What resonates with my understanding of cultural change?

Qualitative analysis is “a process of reviewing, synthesising and interpreting data to describe and explain the phenomena or social worlds being studied” (Fossey et al., 2002). This definition gives a flavour of the process I engaged in when working with the material from my inquiry activities.

An attribute of my co-operative inquiry was that the group comprised a wide cohort identified as the FoS group and five subset groups identified as SIGs. Participants freely chose their area of leadership and patient safety inquiry interest at inception and formed a SIG on the theme. They could choose to cease the inquiry once they recognised that most of the questions that occupied their minds at the beginning had been answered, enabling them to shape the meaning of the world around them.

For the purposes of framing my data analysis and interpretation and my writing of this thesis, it is important to acknowledge my inquiry position in relation to authorship. In our FoS co-operating inquiry group, all inquirers agreed that each one of us could write whatever we liked and put our individual account and experience of the co-operative inquiry to the world. In doing so, we had to take responsibility for presenting these accounts as our own or as speaking from a place that other group members also spoke from. Heron (1996) suggests that in co-operative inquiry there “is clearly a limitation on any claim that the findings of the inquiry are based on authentic collaboration”. Whilst I acknowledge Heron’s caution on what counts as authentic collaboration, in contrast I present data interpretation in my thesis not from a position of limitation, but from one of fulfilment of the aim that, as a co-operative inquiry group, we had built trust in each other to interpret our data, whilst hearing our own voices speak our own knowing into the world.

I would like to encourage caution in myself and others on considering some types of data interpretation as less collaborative or less valid than others. I have been encouraged from my practice of co-operative inquiry to believe that we know things in different ways and that we experience other people's knowing and our own in these ways. We gave each other permission to author our own accounts, to find our own stories and tell them in a voice that each of us identifies as being our own voice. In my opinion, that is evidence of authentic collaboration. It is not about speaking for other group members. It is about speaking for and from myself, in order to honour the work done in the FoS group.

Given that choices needed to be made about how data would be handled, I decided that an analysis of themes would be most relevant. As I am not aspiring to develop a detailed model for how relational practice should be undertaken in all NHS organisations, I adopted the use of thematic analysis, as it offers a way of interpreting the data that makes it useful for understanding what emerged in this particular inquiry context. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). It organises a data set in rich detail and

interprets various aspects of the research topic. Braun and Clarke define a theme as an idea that “captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (2006, p. 10). Defining what is important and whether it amounts to a theme within the data rests with the judgement of me as the researcher.

One reason I chose thematic analysis is that it is an approach that can be used across a range of methods and is not confined to a specific theoretical position. This is especially relevant, given the paradoxes and tensions that exist in the research paradigms within which I choose to work. The process used in the thematic analysis is as follows:

1. I read and then re-read the transcribed materials or field notes. In the case of the co-operative inquiry sessions, listening to the recordings helped me to reconnect with the emotions that were part of the group conversations. I found it useful to return to my journal maps, as it helped me to reflect on the scenario afresh, at times when I fell stuck. Doing this helped me to see how I treated certain discourses over others. This kept the fluid, non-mechanical social processes I engaged with daily in a range of perspectives as opposed to a fixed lens. Insights and reflections from my data analysis were discussed regularly with my ADOC supervisor.
2. I engaged with co-inquirers individually and as a collective to get feedback on my data analysis. I have endeavoured to represent a multiplicity of views and interpretations, including my own.
3. I developed a set of codes, using my inquiry topic and aims as the source material upon which all the individual codes are based. This logical approach starts with the data and then explores the themes that emerge. The inquiry questions included in this activity are:
    - How can I develop a deeper understanding of the patterns of relating, both in my personal life and in my professional life in the NHS?
    - How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
    - What approaches and methods can be used to create sustainable cultural change in the NHS?

Table 1 below lists the individual codes that indicate the link with my inquiry questions and offers my interpretation of each code.

Code	Interpretation
Understanding patterns of relating	
1. Awareness of self	Descriptions of experiences of my self-discovery, self-awareness and self-reflection of both my personal life and professional life.
2. Interacting with others	Descriptions of experiences where engagement amongst practitioners and / or patients was perceived to have impacted on their relationship with each other
3. Exploring relational ways of working	Insights that explore and open up what this notion means, both in terms of practice and as an abstract construct
Developing skills in leadership and patient safety practices	
1. Exploring effective leadership and patient safety practices	Insights that explore and open up what this notion means, both in terms of practice and as an abstract construct
2. Developing aptitude	Description of behavioral patterns, skills or aptitudes that have appeared to developed through the inquiry process
3. Development of confidence in relational leadership and patient safety practices	Narratives in which inquirers and I either explicitly or implicitly indicate our confidence in exhibiting improved practice
4. Perceived improvement in effectiveness of professional practice	Judgements of inquirers in relation to how they and others experience the change in their practice over time
5. Perceived improvement in organisational performance	Output from inquirers in relation to how improvements have been made in service delivery and patient care
The value of inquiry paradigm approach	
1. The development of inquiry skills	Comments or examples which show how co-inquirers and I have developed skills

	associated with inquiry, such as crafting inquiry questions, reflection, being present to others and supporting each other in the inquiry processes
2. The experience of action based approach to research and learning	Narratives which relate the experience of the co-inquirers and myself of participating in the inquiry, which indicate how our approach to reflection, action and collaboration developed over time
3. The benefits of an action-based approach to research and learning as a vehicle for personal and/or professional development	References by co-inquirers and myself to the impact of the inquiry on development of either professional or personal practice
4. Impact on self of leading the inquiry process	Reflections by me on the impact of leading the inquiry process
5. Impact on co-inquirers of participating in the inquiry process	References by inquirers to how they perceive their participation in the inquiry made a difference to their work

Table 1: Thematic analysis

4. Using the above coding scheme, I explored the data and coded each relevant piece of information.
5. I collated all the material belonging to each code into separate documents and then reviewed how the codes and the material allocated to them formed specific themes in their own right.
6. I looked for patterns, interpreted them as themes that appeared to relate to my research aims and wrote my output as an integral aspect of each section in my thesis.
7. At appropriate intervals, and when satisfied that I had all the possible themes, I spent time considering the data that I had in front of me for sense-making and to gain intelligence.

My co-inquirers were active contributors and co-creators of the research process, as opposed to being subjects studied. During my engagement with the co-researchers, I

interacted freely with them (within the constraints of what is ethically and socially acceptable) and was alert to multiple ways of seeing. Whilst there was input from co-inquirers, it was up to my judgement to determine the importance of the material that fed into my thesis inquiry, based on my inquiry aims and objectives.

When I am writing, I am aware of the need for clarity for the reader and for me as an inquirer. I long, however, to remain true to the words of myself and fellow inquirers. I have incorporated direct quotes transcribed from the raw data. Whilst the quote may seem not wholly clear to the reader, it respects the speaker and helps to show some of the complexity present in the topic and inquiry process. A paraphrasing of quotes would add another level of unwarranted interpretation. This approach was agreed by all co-inquirers, as indicated earlier in this section.

The use of the thematic analysis approach as shown above and in Appendix 9 brought a critical reflective rigour to my thinking, beyond simply locating myself in the situation. It brought to light the wide range of discourses that were in the situation thereby supporting my reflexivity.

2.5 The quality and validity of my research

I am a practitioner–inquirer and storyteller, yet also a writer of a doctoral thesis. The calling of storytellers is to weave together the threads of life experience to create an imaginative space where both teller and listener can perceive new insights in the data (Adams, 2011).

Tsang (2000, p, 47) states:

> *I have claimed these stories to be my own, yet a story of myself, of my identity, necessarily involves and depends upon a story of the other too. So these stories belong to them as well (albeit not in the same way or invoked with the same power) – the other being the characters in the stories with whom I interact and compare myself and allude to. These are also the readers' stories, for through reading, readers construct their own meanings and identity with or resist certain elements of a story. How they do so not only reflects back on them and their own values and notions of themselves, but also implicates them as collaborators in the creation of the meaning of the text.*

As with Tsang, the letting go of my stories provides a chance to help others, to be of relevance beyond myself, with a purpose to help others change and produce ongoing conversation with people that respond to my story.

The stories I have told about my life and experience are those that serve me well in fostering relationships with the people I am surrounded by, such that it gives life a new meaning and purpose. The stories in chapter 5 are examples of co-inquirers acknowledging through our cycles of reflection and action the validity of the claims made in my research.

Having been intensively schooled in positivist objective research methods, I need to resolve for myself the issue of the quality and validity of action research. There has been continuing interest in the quality and validity of action research practices (Heron, 1996; Checkland & Holwell, 1998; McTaggart, 1998; Turnock & Gibson, 2001; Champion & Stowell, 2003; Chandler & Torbert, 2003; Bradbury & Reason, 2006; Reason, 2006; Feldman, 2007). Kvale (1995) proposes that the validity in post-modern inquiry is located in the quality of craftsmanship evident in the work, introducing aesthetics and communication skills as criteria and raising questions about the integrity of the researcher. Lincoln, Lynham and Guba (2011) show how positivist and post-positivist research needs predictability or control mechanisms and how this means exclusion of external influences from the research subject.

I propose that the notion of validity, as proposed by positivist research, is too limiting as the criteria for assessing my action research, because it requires the assessment to include "the trustworthiness of inferences drawn from the data" (internal validity) and "how well these inferences generalise to a larger population or are transferable to other contexts" (external validity) (Anderson & Herr 2005, p. 50). This assumes a notion of truth that corresponds to the world they describe. My relativist ontological position with a constructionist epistemology of multiple truths or multiple realties of the world resonates with Lather's (1993) view that validity is multiple, partial and endlessly deferred.

The question for my inquiry validity is not about whether it is true or false, but whether it can explain my current practice and propose change ideas to address future occurrences of the phenomena that I am inquiring into. The concept of 'validity' used in my research relates to the reasons I have for believing the truth of my claims – how I justify the claims I make. These claims are portrayed as tentative facts, stories, interpretations, propositions, generalisations or judgements that have all come from the

accounts of my experiences. The narration of stories and descriptions of events in my thesis are intended to justify the claims I make, irrespective of the forms in which they have been portrayed. What is constructed as 'valid' for my co-researchers and me (all practitioners keen to change their practice, with an interest in the immediate application of the learning), however, might not wholly correspond with what is considered as 'valid' in academia (a doctorate-awarding group with an interest in learning and the ability to influence other parties) or with those from positivist and realist research paradigms.

My first-person inquiry relies on my subjective experience. My experience and encounters are unique to me and confront me with all kinds of possibilities to inquire into. I emphasised reflexivity, by showing my historical upbringing / settings, related to the biases I bring to work and my personal investment in my doctorate research. Through that, I seek to understand how I bring into my inquiry my own unique history, perspective and strata of privilege. Having delved into issues of race, voice and power, I became freer to incorporate my own voice and power into my professional practice.

In analysing my data, I have held up to scrutiny my own participation and probed my own desire. My reflexivity and research approach have moved me towards unlearning my own privilege. In my learning journal, I record some of my experiences and my reflections, using it as a means for developing new knowing, based on my experience during my inquiry journey.

In my search for validity, I discovered that who I am, what I observe, what I write and how others react to what I say affect how I speak about, for and with others. The use of journaling and audio-recording has aided in contributing to the credibility of my inquiry. Undertaking this research and embracing this paradigm have developed a new mindset in me, which has led me slowly and surely to become looser, enabling me to be more detached from my old self, alert to closing down lines of thought too early and staying open-minded. My willingness to look at myself and be self-critical in a constructive manner has influenced the quality of my research claims.

In my second-person inquiry, the rigour of cycling through phases of action and reflection with those on the receiving end of my change efforts is instrumental to the validity of our inquiry. It relies primarily on verbal reports of the experience of the co-inquirers. Reason and Heron (1995) assert that the validity of this encounter with experience in turn rests on the high-quality, critical, self-aware, discriminating and informed judgements of the co-researchers. Of course, this means that the method is

open to all the ways in which human beings fool themselves and each other in their perceptions of the world, through cultural bias, character defence, political partisanship, spiritual impoverishment, and so on.

I am engaging with my co-inquirers to make sense of the experiences, to share thoughts and review the results of our actions subsequently undertaken to validate our sense-making.

> "Ronke, I am quite unclear on the criteria that are being used to evaluate your form of doctorate. It doesn't feel to me that there would be objective methods and procedures to appraise the concepts you've used in your research protocols", a colleague (academic scientist at Imperial College) remarked.
>
> "I agree that the criteria are not as objective as you've experienced in the science world, and I feel these are subtle things that differentiate it as meaningful research that contributes to our understanding of social life through our lived experience. The concepts used for my research are tied to my values and to an extent our subjectivities", I responded.
>
> Excerpt from recording of Patient Safety Collaborative Forum – May 2016

Bochner (2000) points out that conversations focussing on criteria deteriorate into unproductive conflicts circling around differences in values. There is an unspoken desire to go for a pre-existing or static set of standards, to hinder subjectivity and enable rationality. Academics perceive action research as an acceptable form of knowledge that may lead to change in local practice settings, but not "when it is presented as public knowledge with epistemic claims beyond the practice setting" (Anderson & Herr, 2005).

Some scholars (Maxwell, 1992; Lather, 1993; Scheurich, 1996) have questioned the appropriateness of conventional constructs of validity. The view posed by others that research is deemed good if it: provides rich evidence and offers credible and justifiable accounts (internal validity/credibility); can be made use of by someone in another situation (external validity/transferability); and the research process and findings can be replicated (reliability/dependability) resonates with me (Richie & Lewis, 2003, Cohen et al., 2007).

Validity criteria are tentative and meant to democratise action research, cautioning against a narrow insider or outsider view of the problematic situation under study.

Most scholars of action research (Brooks & Watkins, 1994; Greenwood & Levin, 1998; Jacobson, 1998; Anderson & Herr, 2005; Mills, 2000; Reason & Bradbury, 2001; Gall & Borg, 2003) agree on the following goals:

a. the generation of new knowledge
b. the achievement of action-oriented outcomes
c. the education of both researcher and participants
d. results that are relevant to the local setting
e. a sound and appropriate research methodology.

I frequently interrogate myself on the concept of the validity of my knowing. I ask myself questions such as: How do I know what I know? How is it useful? Does it bring meaning to my life? Am I doing good work and how will it help to improve the life of others? Is my conceptual learning making a significant contribution to my practice? How? In relation to co-operative inquiry, am I doing this right and should the participants be less or more involved?

Based on the above goals and to address these burning questions, I developed for myself the following criteria to appraise the quality of my research:

- Human flourishing: my inquiry should contribute to the flourishing of self and other individuals and the flourishing of the healthcare system in which I practise and the community of which I am a part.
- Practice based: a worthwhile practical purpose. My inquiry is part of my personal and professional practice. I have a disciplined method for reflecting on my daily work and for generating ideas and actions undertaken in everyday lives and in real time in our complex healthcare system. It is through the daily interactions between people in the course of social life that our versions of knowledge are made (Burr, 2003). This will provide the necessary rigour to ensure the validity and legitimacy of the findings.
- Continuous learning: my inquiry embodies expansiveness and interpretive insight. It creates learning that translates into change in personal and professional lives. My inquiry provides an opportunity to participate with others to conceptualise and validate the learning process, including exposure to many ways of knowing.

- Theoretical grounding: my inquiry is strongly grounded, to progress bodies of ideas and theories that exemplify relevance and rhetorical force. This includes a deepening in the clarity of thinking and critical sense-making with co-inquirers.

As a reader of my thesis, I invite you to judge the validity of the findings on the basis of knowledge generation and how useful the knowledge has been in helping me to act intelligently and more skilfully as a practitioner. In the concluding chapter 6, I reflect on these criteria.

Flyvbjerg (2006) argues that "Good narratives ... may be difficult or impossible to summarise into neat scientific formulae, general propositions, and theories" (p. 237). With my experience as a practitioner action researcher, I shift away from cause and effect questioning of the positivist research and theoretical analysis that expect infinitely repeatable solutions to social human world issues to consider: "Did I investigate the phenomenon encountered in daily-life practices within my inquiry aims?" However, inquiring further raises questions on validity in inquiry practice. As the main researcher, I am deeply embedded in the inquiry and there might be contamination of truth, as I might take for granted some aspects of my practice. I find myself questioning What counts? , Who decides what counts?, How does it count? and For whom does it count? These questions are embedded throughout my thesis. They are for me bigger than questions about validity of my inquiry practice and are about knowledge and how it is constructed, questions about race, voice and power – these are agencies that I carry as central in my life.

Using the autoethnography mode of inquiry, I am telling my own stories and those of co-inquirers as they represent our beliefs, practices and feelings. Waterworks (i.e my unvoiced wet palms and/or teary eyes – elaborated on in chapter 4) has not been an easy process to reveal without a hint of embarrassment or stigmatising.

The stories highlight my vulnerability, as I dig underneath my actions, showcasing self on a page, revealing infused cultural scripts that resist change and the emotional credibility of co-inquirers. Yet, I remain encouraged despite the risk. These are my experiences and I have chosen to share them.

As Richardson reminds us, writing itself is a "method of inquiry" (2000, p. 923). The process I went through in writing the stories during my research has developed me. Cycling through my inquiry journey has led to moments of stillness; I mean stillness that has made me pause, dwell, feel, acknowledge, cultivate. The stories have had different meanings for me whenever I go back to them, as I have evolved and am at a

different place from where I was. They project a different meaning, depending on how I read them. That brings to light that settling into one version or one final interpretation is risky.

All of a sudden, it feels uncomfortable to be this open on paper to the world about my personal stories. I am letting my secrets out … this is hard. I muster up the courage!

> How much of myself do I want to commit to print?
> How much information is sufficient about myself without being perceived as self-indulgence?

These are questions that I ask myself, but I chose to go forward with two notions in mind: my stories would either leave me more constrained than I was pre-ADOC or would leave me liberated, with freedom to reach for the skies. I question myself on the impact it could have on my personal relationships and professional brand, including the consequences of deciding to publish.

From an academic standpoint, I constantly challenge my goal as a researcher. As I progressed on my research journey, it became apparent that my goal is to generate actionable knowledge about advocacy and change intervention that will be useful for both the practitioner and the academic communities. Through a collaborative second-person approach, we validated the effects my research has on practitioners, encouraging them to learn to do something better, to become empowered to help patients, ourselves and other practitioners, and to voice and create space for all to articulate their world, despite the presence of power structures.

Whilst conscious that, to be awarded my doctorate degree, my thesis will undergo academic evaluation, I have intentionally stepped back at various phases of my inquiry and endeavoured to be transparent and to articulate clearly the choices I am making in my inquiry practice to co-researchers, readers and the wider audience. An example of such choices has been the use of ‘I’, ’we’ and ‘our’ in narrating stories and experiences from our co-operative inquiry group. Later in my inquiry cycles, it dawned on me that – except in instances where co-inquirers have shared or voiced their thoughts and experiences as we constructed the meaning-making – only I could attest to my learnings and validate my experience of the inquiry. The choices made have been open to scrutiny of both co-researchers and of myself.

For critical analysis of my research data, I have made use of various validity practices such as multiple voicing, member checks, and peer debriefing to bring out meaning-making and interpretations. Peer debriefing and member checks have enabled me to juxtapose the voices of participating researchers. Participant voices and reactions are present in the stories, and provide a rich collection of perspectives.

Throughout the inquiry I have been conscious of stepping back, zooming out and in, observing the different insights that come from the ways I frame the inquiry in the moment. It has happened much more easily when I am reflecting on action than when I am in action. There are various instances described in subsequent chapters in this thesis that illustrate how emotional, embodied and different ways of knowing have influenced my actions.

Despite my existing theoretical knowledge on quality improvement and culture change in leadership practices, undertaking action whilst doing action research has led to the solidifying of my understanding through practice with practitioners. My action research with practitioners has been based on real-world problems in the swampy lowland and abstract change ideas on the high ground. Through our work in the swamps, I have endeavoured to adhere to strict validity practices in both my professional and personal inquiry.

The validity of my research is in seeing the product of my learning translated into different actions and outcomes on the ground.

2.6 Summary

Describing my ontological and epistemological positions is vital to assessing and understanding the methodological choice I made and it is helpful with regards to framing my contribution to practice in chapter 6. Understanding of the philosophical assumptions that underpin my chosen research paradigm and how my assumptions manifest themselves within the methods will enable readers to better comprehend, question and apply the research that they read.

My use of action research was a way of conducting research to enhance real-time practice. It offered an opportunity to analyse a situation, identify possible solutions and determine the best course of action, based on the nature of the situation. The felt need amongst co-inquirers and me to participate collaboratively and that a change in our practices is necessary led to a positive collective adoption of the method.

The use of autoenthography can be critiqued as self-indulgent, introspective, and individualised. However, my collection of multiple sources of data (outlined in chapter 2.4), the establishment of a chain of evidence and the use of a literature review have helped to establish my report as a scholarly rather than an emotional or unreasoned account. The autoethnographic approach I employed in the study of my personal and professional practice was the ideal method to answer my research questions. I urge readers of my authoethnogrpahical accounts to become co-participants in the research stories, and engage with the stories morally, emotionally, aesthetically and intellectually.

The raw data of this research is the lived experience in my daily practice – those moments that captivated my attention and made me pause to connect with my circumstances. As I inquired into the reality of my daily practice, I began perceiving, thinking and doing in real time, which aided the knowing-in-action (Schön, 1983) and led to spotting the gaps between my values and the values in use.

What knowledge is and the ways of discovering it are subjective. My chosen research paradigm sought to understand my professional practice in my particular culture. My methods helped me organise my research, figure out what was going on, and then put away events and feelings in order to deal with what happened next.

3 THE PRACTICE CONTEXT AND THE LITERATURE

In this chapter, I inquire into the theoretical context of my research and explore my ideas in the context of existing bodies of theory. The purpose of this chapter is to be explicit on the key literature that informed my inquiry, in order to ground my professional experience, generate new perspectives on my research aims and identify themes that enhance the quality of data analysis in subsequent chapters.

To recap, my research questions are:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
- What approaches and methods can be used to create sustainable cultural change in the NHS?

This chapter engages with the literature from my perspective as a practitioner–inquirer undertaking research in NWL NHS organisations between 2013 and 2017. My research aims have defined the scope of my literature review, as opposed to the literature defining the scope of my research. This approach is appropriate as it reflects the practice-based focus of my inquiry.

Engaging with the literature and texts is integral to all chapters in this thesis, hence this chapter is not a comprehensive account of all the literature. Relevant content will be referenced in subsequent chapters.

In this chapter, I briefly take a look at the landscape of my theoretical resources. Next, I undertake a review of the government-funded inquiries into fallings in NHS trusts (section 3.1). I explore the human dimension of patient safety practices in relation to people, leadership and culture (section 3.2). I then turn to perspectives from practices that aid sustainable cultural change (section 3.3) and challenge leadership practices (3.4) in relationship with others (section 3.5). And lastly, I return to connect the ideas from this chapter to my research questions (section 3.6).

The visual mind-map below (figure 5) aids to visualise the diverse bodies of knowledge ('sky') I engaged with in exploring how to tackle the challenges I face as a practitioner–inquirer with colleagues in everyday practice ('ground'), whilst not ignoring the various factors that aid sustainable cultural change ('underground'). In putting this together, I was inspired by Hale (2014), who developed the concept of 'knowledge mapping' to aid in the practical process of supporting the investigation of existing knowledge related to the real-world business challenges that action learners face. The knowledge map seeks to show my sources of knowledge in the 'sky' (external research, publications, experts or other organisations), on the 'ground' (organisational contacts or data), and 'underground' (politics, influences, culture, values).

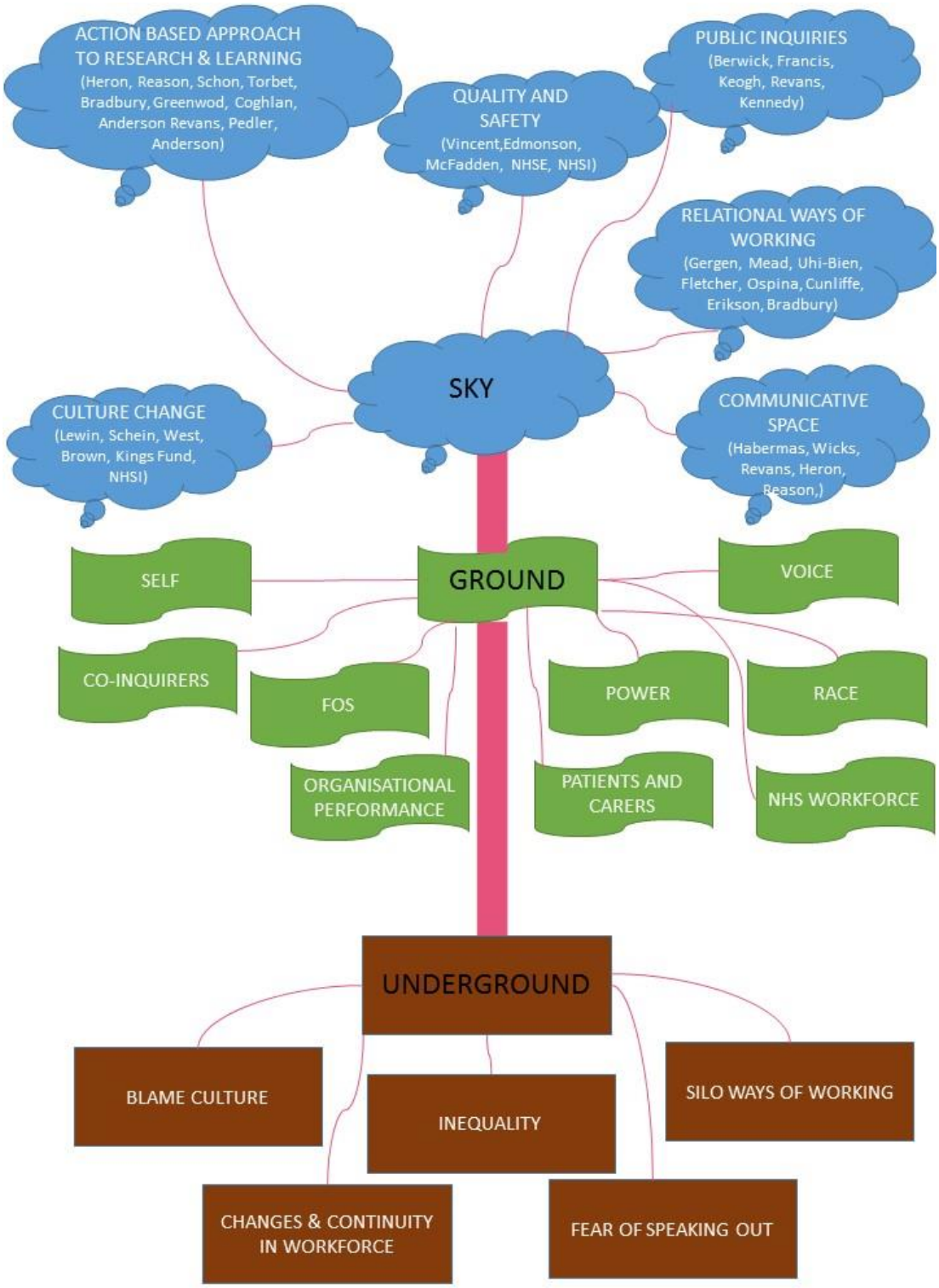

Figure 5: My research knowledge map

My knowledge map feels formative, representative and inclusive of my research exploration. I hope that as a reader you can imagine the liveliness, interdependence and interconnections that informed my theories as represented by the visual symbols in the map.

3.1 The road to 2013 inquiries

In this section, I explore the use and impact of the inquiries in the NHS in attending to my research questions. This section engages with the literature and provides an overview of the history of the inquiries, describes their purposes and reviews whether their findings and recommendations are used. The subsequent chapters provide the insights and lessons learned for practitioners and other stakeholders in the NHS from my experience in NWL NHS organisations of implementing the recommendations from the 2013 inquiries.

Walshe and Higgins (2002) define an inquiry as a retrospective examination of events or circumstances specially established to find out what happened, understand why, and learn from the experiences of those involved. The Public Administration Select Committee (2005) considered that "the primary purpose of an inquiry is to prevent recurrence" and that "the main aim is to learn lessons, not apportion blame".

Inquiries help to establish the facts of the incidents, gain lessons from these events to prevent their reoccurrence, provide an opportunity for reconciliation for those involved, rebuild public confidence, hold people and organisations to account and contribute to changes in the wider government agenda.
Inquiries and reviews of service failures take different forms, although most major NHS inquires are set up as independent external investigations with full interrogative powers and are commissioned by the Department of Health and/or NHS England. Statutory inquiries are established under the Tribunals of Inquiry (Evidence) Act 1921 or by the secretary of state under the NHS Act 1977.

Taking Stock

The failings in health care delivery have led to many inquiries, which have produced many reports. The investigation into Ely hospital in Cardiff in 1969 is widely seen as the first public inquiry into the NHS. Since Ely, there has been no shortage of inquires and it is difficult to ascertain a definitive list (Walshe & Higgins, 2002). Black and Mays (2013) state that, in addition to the many local inquiries, 15 national inquiries into individual hospitals were undertaken between 1969 and 1989. Powell (2018) states that approximately 126 took place between 1945 and 2005. A Department of Health and King's Fund library database search of healthcare inquiries in the UK identified 138 between 1974 and 2013. Table 2 illustrates a selection of major inquiries from my database search across the decades in the NHS from 1969 to 2018.

Date	Issues Investigated	Inquiry Context	Findings and Recommendations	Changes Made
1969	Allegations of gross mistreatment, abuse and neglect of psychiatric long stay patients with learning difficulties at Ely Hospital in Cardiff in 1967	Committee of inquiry set up chaired by Geoffrey Howe QC. Inquiry took about 16 months.	Allegations were confirmed with key issues identified as - Poor clinical standards and leadership - Poor staff training - Isolated culture - Limited resources.	• Hospital Advisory Service visited and evaluated long-stay hospitals • More funding allocated to long-stay hospitals • Ely and other subsequent inquiries into long-stay hospitals in the 1970s helped to drive the closure of those institutions, leading to redesigning of the care pathway for people with learning difficulties and chronic mental illness.
1978	Allegations by angry nurses that the regional health authority ignored issues of poor care, conflict, and breakdown of working relationships at Normansfield Hospital for learning disabilities in the mid-1970s	Committee of inquiry set up by the secretary of state and held for over a year.	History of fearful working relationship between nurses, administrators and consultant (Dr Lawlor) confirmed. His style emerged as abusive, oppressive and intolerant.	• Dr Lawlor and several senior nurses and administrators were sacked and never allowed to work in the NHS again • Redesigning of care pathway for people with learning difficulties and chronic mental illness.
1986	Major outbreak of salmonella food poisoning, affecting 355 patients and 106 members of staff and	Public inquiry set up, chaired by J Hugill QC. Inquiry took 14 months.	The cause of the outbreak was contaminated chicken brought into the kitchen, and the spread of infection was from unrefrigerated cold roast beef.	• Inquiry into the development of the public health function including the control of communicable diseases and the specialty of community medicine

	causing the deaths of 19 patients at Stanley Royd Hospital, Wakefield in 1984		Findings included: - Errors in the control of infection - Unhygienic and unsatisfactory practices in the kitchen - Poor staff training and supervision. - District and regional health authority criticised for failing fully to inform themselves of the situation once the outbreak had occurred.	in England • New guidance regarding hygiene practices and standards in hospitals • Strengthened inspection for infectious disease outbreaks.
2001	The management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995. Between 30 and 35 children undergoing heart surgery died between 1991 and 1995 who would probably have survived if treated elsewhere	Public inquiry set up chaired by Professor Ian Kennedy. Inquiry took place over 2 years 9 months.	The inquiry found serious clinical and organisational failings, with the existence of a club culture amongst leadership (too much power in too few hands). Other findings included: - Flawed system of care with poor teamwork between professionals - Punitive management style - Unsafe environment to speak out or be open - Paternalistic attitude towards patients	• Led to the creation of the Commission for Health Improvement • Contributed to the development of clinical governance in the NHS
2001	The clinical practices of	Public inquiry set up, chaired by	Inquiry found major flaws in the	• Drove fundamental reforms to

	Dr Harold Shipman, a general practitioner in Greater Manchester, who was convicted of murdering 15 patients, with inquiry establishing he had killed had killed 250 patients	Dame Janet Smith.	processes of death registration, prescription of drugs and monitoring of doctors.	health professions regulation.
2013	The examination of the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009	Public inquiry set up, chaired Sir Robert Francis QC.	The inquiry found that hundreds of hospital patients died needlessly as a result of substandard care and staff failings at two hospitals in Mid Staffordshire. Other findings included: - Trust board was weak - Leaders did not listen sufficiently to patients and staff - Tolerance of poor standards - Lack of compassion - Disengagement of senior clinical staff from managerial and leadership responsibilities - Management/leadership failure to remedy the deficiencies in staff and governance - Focus was on business priorities such as achieving	• Led to national changes to nurse staffing levels, new legal duty of candour, and reforms to protect whistle-blowers • Led to reforms to hospital inspection and a redesigned CQC inspection framework • Raised awareness on priority of patients in healthcare delivery and provision.

			performance targets and financial balance and seeking foundation trust status, at the cost of delivering acceptable standards of care with a focus on patients - Regulators missing what was important for patients.	
2013	Review into the quality of care and treatment provided by 14 Hospital Trusts in England, July 2013	Review into the 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh in his role as Medical Director of NHS England.	The review focused on 14 hospitals with high mortality rates and highlighted concerns that required urgent action to be taken to improve quality and safety of some of the services they provided. The report set out the following ambitions for the NHS in England to achieve over the coming 2 years: - Reduction in avoidable deaths in hospitals - No hospital, however big, small or remote, will be an island unto itself - Professional, academic and managerial isolation will be a thing of the past.	• Trust boards focus to confidently and competently use data and other intelligence on mortality in the forensic pursuit of quality improvement • Trust board reviews of nurse staffing levels and skill mix to reflect the caseload and the severity of illness of the patients cared for .
2013	A review to advise the NHS on how to prevent patients being harmed whilst receiving health	Led by Professor Don Berwick, commissioned by the Department of Health.	The report sets out a transparent framework for continuous quality improvement within the NHS. The report condenses the 290 Francis	• Available national funding and commissioning of two major initiatives: - Patient Safety Collaborative

	care		recommendations into 10 recommendations, which provide a structured framework for implementation. The review stated that: - The most important single change for the NHS is for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.	- Sign up to Safety Campaign to create an open, transparent, caring and compassionate culture with a continual drive for zero harm, with continual quality improvement being the key • Provided a strong platform for the Trust board to discuss Quality Improvement Framework and strategy.
2015	An investigation into the concerns, management, delivery and outcomes of care of the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013)	Independent Inquiry set up by Secretary of State and chaired by Bill Kirkup CBE.	The inquiry found the existence of a tribal and insular culture. Other findings included: - Dysfunctional and poor working relationships between midwives, obstetricians and paediatricians - Poor clinical decision-making - Clinical competence was substandard, with deficient skills and knowledge - Geographical and professional isolation of the unit - Response to adverse	• Always Events toolkit implemented in Maternity Services • High Fidelity Neonatal Simulation • Antenatal Drop In Pregnancy Care & Grow Package. However, the Trust is still rated as “Requires Improvement” in CQC 2019 inspection - The Trust came out of special measures in 2017.

			incidents was grossly deficient - Inadequate internal investigations/governance procedures that were overly protective of staff.	
2018	Review of widespread failings surrounding community health services based in Liverpool from November 2010 to December 2014	NHS Improvement invited Dr Bill Kirk to undertake an independent review of Liverpool Community Health NHS Trust.	The inquiry found the existence of an intolerant and bullying leadership culture. Other findings include: - Inexperienced leadership intent on attaining Foundation Trust status - Bullying, harassment and intimidation - Fear of repercussions and demoralisation of staff - Denial of root causes of problems and inattention to governance and quality improvement.	• Recommended changes yet to fully implemented are: • NHS Improvement should take note of the level of experience of appointees and level of risk in approving Trust board appointments • The Department of Health should review the working of the Care Quality Commission fit and proper person's test, to be enhanced and much more effective for NHS executive and non-Executive Directors to include the ability to bar from any further NHS appointment any director whose behaviour has been beyond the pale.

Table 2: Selection of Major NHS Inquiries

Since Ely, we have seen Stanley Royd, Bristol, Shipman, Mid-Staffordshire and Morecambe, for example – and in the coming years, whenever something goes badly wrong in the NHS, there will be loud calls for yet another inquiry.

As I conducted a literature review into the investigations into quality of care in the NHS, the questions that kept coming to mind were:

> Do these inquiries lead to sustainable cultural change? and
> How much impact do these inquiries have?

The following sections in this chapter illustrate how I explored the above questions further.

Do these inquiries lead to sustainable cultural change?

The review of the inquiries illustrated above highlights that, in 50 years of inquiries in the NHS, there have been similar findings of which many are cultural and require change in values and behaviours. The consistency in the failures and findings suggest that lessons are not always learned and that recommendations are either not properly implemented or misapplied.

The common themes from these inquires are:

- Weak and incompetent leadership – a lack of ownership and responsiveness to tackle known problems, including a failure to make the patient the priority in everything done (Ely, Bristol, Mid Staffordshire, Berwick, Morecambe and Liverpool)
- Dysfunctional working relationships amongst multidisciplinary teams, resulting in poor clinical decisions (Ely, Normansfield, Bristol, Mid Staffordshire, Berwick and Morecambe Bay)
- Poor communication – both within the Trust and between it and others, and a reluctance to listen to patients, families and staff (Normansfield, Wakefield, Stanley Royd, Bristol, Shipman, Mid Staffordshire, Morecambe Bay and Liverpool)
- Disempowerment, marginalisation and victimisation of staff and patients – individuals who might have raised concerns were discouraged from doing so and those who did act as whistleblowers were victimised and marginalised (Ely, Normansfield, Bristol, Mid Staffordshire, Berwick and Liverpool)

- System and process failure – systems and processes are either not present at all or not working properly (Normansfield, Stanley Royd, Mid Staffordshire, Keogh, Morecambe Bay and Liverpool)
- Professional, organisational or geographical isolation – looking inwards not outwards, with limited learning and sharing of information and practices (Ely, Bristol, Mid Staffordshire, Morecambe and Liverpool).

All the above themes were similar in the various investigations, although there were different daily practices and circumstances. Ian Kennedy (2001) remarked of his findings at Bristol "that you could pretty much have substituted Ely for Bristol throughout" and the same or remarkably similar findings recur time and again.

The Francis Inquiry undertook a lot of work to understand the role of culture in the healthcare delivery context, just as the Kennedy Inquiry did into failings at Bristol Royal Infirmary a decade earlier. Some critics (Davies & Mannion, 2013; Timmins, 2013) feel that the inquiry recommendations were very aspirational and over optimistic about the feasibility of implementing purposeful sustainable culture change, and I agree with that. According to Sir Liam Donaldson (2000), inquiry recommendations are not always sufficiently helpful or focussed. Black and May (2013) state that any recommendations should be few in number, focussing on priorities, rather than trying to be comprehensive, and implementable at a reasonable cost. Timmins (2013) stated that Sir Robert Francis himself observed after publication that he was advised that a good public inquiry makes five or ten recommendations. Berwick's report endeavoured to streamline Francis recommendations into ten actionable ones.

How much impact do these inquiries have?

Whilst there are similar themes from the findings of these inquiries and the notion that the NHS is still failing to learn from the things that go wrong, there have been commendable changes made in affected organisations and the wider system towards improving care delivery.

These inquiries can lead to positive change and have brought about some key turning points in health policy, system reconfigurations and healthcare regulation. Examples of areas of remarkable impact are:

- A review of all long stay hospitals for people with severe learning disability, which led to the closure of most units, leading to an improved care pathway in the community (Structural change – Ely)

- The creation of the National Institute for Clinical Excellence to provide guidance on clinical practice and standards, including publication and use of much more clinical data to aid clinical decision-making (Structural change – Bristol).
- Radical changes to the CQC inspection regime, which include greater clinical and managerial expertise, more extensive use of monitoring data and the appointment of a chief inspector of hospitals. The new inspection regime began in October 2013 and was completed for all acute hospital Trusts by March 2016 (CQC, 2016). Trusts are now inspected across five domains: safety, effectiveness, caring, responsive and well led. The CQC now combines and publishes ratings with four performance levels: Outstanding, Good, Requires Improvement and Inadequate. (Structural / Cultural change – Mid Staffordshire)
- The adoption and embedding of a "duty of candour", where every healthcare professional must be open and honest with patients when something goes wrong with their treatment or has the potential to cause harm or distress. The requirements of the duty of candour are contained in Regulation 20 (under the Health and Social Care Act 2008). Regulation 20 sets out the requirement and procedure to be followed by health care providers where any "unintended or unexpected" incident had occurred which did, or could have, resulted in death, or severe harm, moderate harm or prolonged psychological harm to the service user, in the "reasonable opinion of a healthcare professional" (CQC, 2017). The duty of candour became law for providers on 1 April 2015. (Cultural change – Recommended by Bristol and reinforced 12 years later by Mid Staffordshire)
- Fit and Proper Test - From 1 April 2015, all providers of care registered with the CQC were subject to a new regulation, which put a requirement on the chair of an NHS body to ensure that all directors are fit to hold their positions. The CQC's guidance (CQC, 2015) explains that this goes beyond the standard requirements of "good character, health, qualifications, skills and experience", but also means preventing individuals from holding office who "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity" (Cultural change – Mid Staffordshire)
- Patient Safety Collaborative initiatives to improve quality and safety of care (Cultural change – Mid Staffordshire, Keogh and Berwick)
- Board focus on monitoring of clinical quality of care – The boards of English NHS Trusts have been found to devote a greater proportion of time to quality

> monitoring than their equivalents in the United States and Scotland (Chambers et al., 2018). Jha and Epstein (2013) found out that 72% of English board chairs compared with 31% of US chairs chose clinical effectiveness as a top priority, and quality of care performance was on the agenda at every board meeting in 98% of English hospitals, but in just 68% of US hospitals. (Cultural change – Mid Staffordshire, Keogh and Berwick).

In addition to these changes, Chambers et al, (2018) reported in their study of changes in board leadership and governance in acute hospitals in England in response to the Mid Staffordshire inquiry that the Francis report had had an important impact on board priorities and on perceptions of culture change. Some Trusts have developed or revised a raft of policies, including on the handling of complaints and serious incidents, and board members are exercising leadership that is more visible to staff and patients.

Whilst acknowledging some key outcomes from the inquiries, I question whether public inquiries are worth the costs? Full-scale public inquiries are costly: Bristol cost £14 m, Shipman £23 m and the Mid Staffordshire inquiry £13.7 m (Timmins, 2013). Other commentators have equally questioned the cost and time value of inquiries, including Janet Smith who conducted the inquiry into Shipman. She remarked that the costs were worth it “beyond doubt” because “it provided the families with reliable answers to their questions, in a reasonably short time”, including revealing Shipman’s methodology and provided the basis for the later parts of the inquiry into what might be done to prevent a repetition. However, as her recommendations were not all implemented, she is unsure about whether the subsequent parts of the inquiry were worthwhile. On balance “yes”, she has said, but “a close run thing” (Timmins, 2013). The question of value on a public inquiry after the event is rarely mentioned, on the assumption that inquires are undertaken for purposes that are difficult to measure, such as calm public concerns and media calls, therefore it is difficult in some cases to determine their value.

However, based on their huge costs, it is paramount that investigations are run to the best standards, with lessons from the procedures of previous inquiries learned. IfG (2017) highlights that, of the 68 inquiries that have taken place since 1990, only six have received a full follow-up by a select committee to ensure that government has acted.

There is no central repository of lessons learned from inquiries or way to keep track of implementation of recommendations. There is no formal mechanism or monitoring process in place, and the National Audit Office (2018) pointed out that ministers have

failed to implement promises made to two Parliamentary committees to establish such repositories. Hence the government itself can be slow to learn the lessons from inquiries.

My inquiry premise focusses on implementing the recommendation from Berwick (2013) which states that the most important single change for the NHS would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end. It should place the quality of patient care, especially patient safety, above all other aims. My practitioner-inquirer focus is on enabling sustainable cultural change through leadership, specifically in my work context and job role, and how to translate the recommendations from these learned reports into new ways of working, aiding us as leaders to address the challenges we experience in delivery high-quality safe care at all times.

The subsequent sections explore the literature in the areas of quality and safety, sustainable cultural change, leadership practices and relational working in health care to aid in understanding my research questions and connect the contribution of my research to addressing common themes from previous government-funded inquiries.

3.2 Quality and safety

Safety is a critical factor in improving quality care, and healthcare professionals are expected to treat patients in a safe environment and protect them from avoidable harm.

Safety is often seen to be abstract, obscure and taken for granted and only becomes visible when it is breached and lives are compromised. Whilst engaging with co-inquirers and in our interactions with patients and staff at the coal face during our cycle of inquiry, it became apparent that patient safety had different connotations to different people: some termed it as ‘poor quality’, ‘incidents’, ‘risk’, ‘clinical governance’, etc.

With no single definition of ‘patient safety’, I adapt Vincent’s (2010, p. 4) definition of patient safety for the purpose of my research. At its simplest, patient safety can be defined as: “The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare”. The NHS technical term for something that should not have happened, did not have to happen, and nobody intended to happen is adverse event. Patient safety issues can be perceived as the avoidable errors in healthcare that can cause harm to patients. Harm in this context means injury, suffering, disability or death. To err is human; not all harm is avoidable. Some errors cause harm, though many do not, but errors can be prevented.

In the UK, at least 30–50% of major complications occurring in patients undergoing general surgical procedures are thought to be avoidable. Between 8 and 12% of admissions to hospital are associated with one or more adverse events (injury caused by medical management) (Vincent, 2010). When it comes to adverse events in the UK's healthcare, recent evidence concludes that the majority of errors originate from system and process failures, as opposed to human failures (Chassin & Becher, 2002; McFadden, Henegan & Gowen, 2009).

Following the recommendations of government inquiries and policy documents, there have been commendable improvements across the NHS in clinical practices (surgical checklists, infection control initiatives, pressure ulcers skin bundles amongst many others) to improve safety and quality of care.

The NHS was declared by an international panel of experts from the Commonwealth Fund (Guardian, 2014) as the best healthcare system in the world, with health outcomes improving rapidly through new and more effective treatments and its care rated superior to countries that spend far more on health.

NHS Resolution (formerly known as the NHS Litigation Authority) is the organisation that handles negligence claims on behalf of NHS organisations and independent sector providers of NHS care in England. In 2014-15, the organisation received 11,497 clinical negligence claims that cost the NHS over £1.47 billion (NHS LA, 2014-15 Annual report). The NHS in England has experienced an increase in the costs associated with clinical negligence claims in recent years. This means increased costs to NHS Trusts and less money available to care for patients. NHS Resolution is supporting organisations to learn from and reduce the incidents that lead to claims and thereby improve patient safety.

In my role as a practitioner in the NHS, I have witnessed patients being injured or dying from avoidable harm. I watched a family stand helpless as their dear mother was dying from an adverse event. The family could only watch, horrified, as their mother's vital organs, one after another, ceased to function and her senses, one after another, were shutting down.

It is horrifying.

Appendix 6 illustrates a true-life account of a patient safety incident that occurred during my research in a NWL NHS organisation. This and other safety incidents exist throughout the NHS and in other healthcare systems across the world.

The event highlights that it is the failure to listen to staff and patients, instigating fear amongst staff, the presence of huge constraints in the system, the presence of a system that identifies faults and places blame, the lack of open and honest dialogue and obliviousness to clear warning signs that create the nightmare world that leads to patient safety problems. My research into quality and safety explores what it takes to introduce, support and embed a patient safety culture of openness, self-reflection and compassionate practice, so that together we can to improve patient safety practices.

In Sennett's (2008) book *The Craftsman*, he pointed out how the value of craftsmanship in health care is imbued with conflicting values and how the conflict is raw and unresolved. The conflict in values is between getting something right and getting it done. The use of numerical measures of the right way to provide care was meant to serve the interests of patients compassionately. Yet from the findings of inquiries (Francis, 2013; Keogh, 2013) strict adherence to quantitative targets has diminished the quality of care provided. It produced an ethic that doing just what is practicable on the ground is good enough, which is prone to excusing mediocrity.

McKee et al. (2010) assert that a common barrier to patient safety is poor communication between staff and limited awareness of risks. Leadership, teamwork and learning are key factors to improving safety and care (IOM, 2000). There is a growing body of literature (Ruchlin, Dubbo & Callahan, 2004; Chuang, Ginsburg & Berta 2007; McAlearney, 2008; Khatri, Brown & Hicks, 2009; McFadden et al., 2009; Künzle, Kolbe & Grote, 2010; McKee et al., 2010; Kim & Newby-Bennett, 2012; Dixon-Woods et al., 2013; West, 2013) on the interaction between aspects of leadership, organisational culture and behaviour in relation to quality and safety.

The subsequent sections of this chapter examine the role of cultural change, leadership and relational ways of working in improving safety practices to building a safer health system in NWL.

3.3 Sustainable cultural change

In the extensive inquiries (Howe, 1969; DoH, 1978; Kennedy, 2001; Francis, 2013; Keogh 2013; Panel and Jones, 2018) into failures in the NHS over several decades, the culture of the NHS is strongly stated to be a key contributing factor leading to those failings and is typically prescribed as the remedy for change. The need to change the

culture of the NHS in order to deliver a service “fit for the twenty-first century” (DoH, 2001; Berwick, 2013; NHS England, 2015) has been a recurring theme in high profile reports and policy documents.

In addition, various commentators (McMillian, 2006; Denton and Spencer, 2010; Whiting et al, 2011; Willard et al., 2012; West et al., 2014) have stated that, to respond to the challenges of meeting increases in population demands and service delivery and of financial constraints, the organisational culture in healthcare will need to change in parallel with systems, processes and structures. The Kings Fund (Ham, 2014) has argued that regulatory systems, increasing competition and setting targets are inadequate levers for bringing about the fundamental changes required to respond to the challenges. Instead, it argues that culture change within organisations is fundamental for health services to deliver continually improving, high-quality and compassionate care.

The factors that have been identified as impeding culture change across healthcare organisations include inadequate or inappropriate leadership, professional allegiances, subcultural diversity, lack of ownership and constraints imposed by external stakeholders (Scott et al., 2003; Carroll & Quijada, 2004; Antwi & Kale, 2014).

That begs questions of what the culture in health services is and, if the culture is the main culprit, how do we change it? There are some clues in the policy documents on how this change is to be brought about, emphasising “new ways of working” and “shifting the balance of power” to frontline staff (DoH, 2000, 2001; NHS England, 2015). However, the imposition of centrally determined targets and top-down directives raises questions about what this shift in power means in practice.

Organisational cultures have been stated as perhaps the most difficult of organisational concepts to define (Hatch, 2018), and the wide range of overlapping definitions has been referred to as “an embarrassment of definitional riches” (Brown, 1998).

Culture can be referred to as the underlying reasons and mechanisms for why certain behaviours occur in an organisation, based on fundamental assumptions, beliefs, and values (Ostroff, Kinicki & Tamkins, 2003). Culture is the implicit assumptions that members hold, and determines how they perceive, think about and react to things. According to Schein (1992), the way things are done in an organisation is dependent on the collective artefacts, values, and assumptions of the organisation. For the

purpose of this research, I adopt the everyday definition of culture as simply “the way we do things around here”.

My view of organisational culture is of a social phenomenon, with expressive forms of human consciousness that members are capable of espousing, articulating and verbalising. I perceive organisational culture as a metaphor that runs deep and may not be explicit or even always consciously determined. Since it could sometimes be difficult to discern, it makes it even more difficult to change, because it is hidden and may rely on the existence of unspoken rules without the conscious knowledge of the membership.

Over the last two decades, the literature on organisational culture has exploded, with a variety of types and theories including a surfeit of perspectives presenting a very diverse and conflicting picture. This consequently makes the notion of organisational culture a complex one. This complexity poses a challenge to researchers and leaders alike – it is difficult to be sure of the cause and nature of culture change in organisations, or to understand the critical enabling factors of successful sustainable culture change.

One of the cornerstone theories underpinning organisational culture change initiatives is Lewin’s (1951) model of change management. The model proposes three stages to the change process: unfreezing (overcoming inertia and destabilising old and existing behaviours and mindsets), changing (efforts in developing of new behaviours and patterns of thinking) and freezing (new behaviours and mindsets are crystallised and sustained in everyday practice).

Some theories soften the significance of the human dimension as a source of culture change (Ogbonna, 1993; Handy, 1995; Johnson & Scholes 1999) and other theories view leaders’ purposeful action as a key driving force (Bate, 1994; Davies, Nutley & Mannion, 2000).
Those theoretical concepts that do not include reference to how culture change integrates the human dimension do not synchronise well with the perception of organisational culture within the NHS.

Most models of organisational culture change can be mapped onto the fundamentals of the Lewin (1951) change model. Lewin’s model continues to be a widely applied generic template for organisational change (Weick & Quinn, 1999). However, some have been against Lewin’s model of change (Martin, 1985; Burnes, 2004), because of

its broad or unspecific approach, which limits the extent to which it is prescriptive in describing the processes affecting change.

From my experience of leading business change and transformation initiatives across the private and public sectors, I consider that Lewin's broad approach can indeed be applied to a range of culture change initiatives across different settings, and allows us to document, analyse and review lessons learned on the processes across the three stages.

Early studies in Canadian, UK and US hospitals found, for example, that hospitals with inwardly oriented cultures that emphasised managing through informal interpersonal relationships performed significantly above average on measures of employee loyalty and commitment compared to those with outward-looking cultures (Gerowitz et al., 1996). Equally, hospitals with outward-looking cultures and procedural management performed better on measures of external stakeholder satisfaction. Large-scale longitudinal research on NHS Hospital Trusts replicated some of these findings (Jacobs et al., 2013).

A qualitative case study (Mannion et al., 2005) of six NHS hospitals found clear differences in the cultural profile of 'high'- and 'low'-performing hospitals in terms of: leadership style and management orientation; accountability and information systems; human resource policies; and relations with other organisations in the local health economy. These highlight the influence of the wider organisational context in purposeful cultural change aimed at performance improvement. Clearly, the relations between culture and quality, safety, or organisational performance improvement are unlikely to be straightforward.

My research draws on Lewin's model of change processes in reviewing and understanding actual change interventions in the specific NHS organisations across NWL, to aid our understanding of the outcomes of those change initiatives. In addition to this model, the use of action research is the focal point to aid understanding of how the psychological human experience of sustainable culture change actually unfolds.

A case of many subcultures

Across the globe, healthcare organisations are known to be dynamic mosaics, fractured by speciality, occupational groupings, professional hierarchies and service lines. The NHS is a distinctly British organisation that has recognisable overall identity

with certain apparent core values (Scott et al., 2003). My experience of working in the NHS for almost two decades is that, within that overall NHS culture, there are a number of distinct subcultures with differentiated clear occupational lines, ethnic cultural groups, differing religious beliefs, dominant genders in professions, and varied types of occupational ethos in each specialism, which are not mutually exclusive.

A hospital, for example, is not a single culture, but rather a fragmented collection of occupational cultures, such as of medicine, nursing and management (and subcultures within those, such as of surgery, anaesthesiology, midwifery, pharmacy and finance). Within these professional groups, there are international cultures, such as Nigerian doctors, Filipinos nurses, Romanian cleaning crews and Irish maintenance workers, within the local culture of being in London, Wales, or Scotland.

Edmondson (2004) found that even similar work groups in the same nursing unit or operating room can have different cultures, based around leadership style. A strong organisation leader may try to meld those bits and pieces into a single identity and culture, or a crisis may bring everyone together with common purpose and force some cultural blending in answer to the crisis, but the individuals and groups are likely to retain diverse cultural elements, within a more or less uniform organisational culture. These cultural divergences have important implications for collaborative work in the delivery of everyday practice and in improving the quality of care.

In conducting my research, I paid great attention to the multi-layered and multi-faceted complexity of culture, whilst recognising the varied subcultures that make up our NHS organisations. I endeavoured to make sense of this subcultural diversity, as that is an essential part of exploring how things are done in seeking sustainable cultural change.

Reflective practice and sustainable culture change

The NHS goal is to have organisational cultures that put patients first, promote trust, respect and equality and are sufficiently open and transparent that staff feel able to challenge each other robustly, regardless of status, without fear and are encouraged to voice concerns and come forward when difficulties arise (Francis, 2013; Keogh 2013; Berwick, 2013; NHS England, 2015).

As I reflected on that cultural ambition, a lived experience as a leader where I participated in a serious incident meeting (outlined in Appendix 6) during my research

flashed back to mind. From the meeting, it was evident that a junior doctor had taken the flak for an error by a senior doctor (Consultant Grade). The junior doctor had follow-on discussions with me and highlighted that, as employees' mistakes and errors could be included in their personal files, they feel compelled to hide information that might have a negative impact on their performance and evaluations.

My experience of the meeting brought to light a culture in our NHS which could be perceived to reprimand staff for mistakes, rather than genuinely engaging with them to discover and understand the underlying problems that led to the issues. From that interaction with the junior doctor and other colleagues, I understood that they feel afraid of being caught making mistakes; hence, they are mostly hesitant to speak up and voice concerns about potential risks, even if that could prevent errors from happening. Existing research (Chuang et al., 2007; Khatri et al., 2009) reports that punitive cultures are prevalent in hospitals and that employees feel safer being silent in the system, instead of revealing problems or asking questions, due to the fear of punishment.

It is therefore valid to argue that, unless organisations address blame and punitive culture as a starting point, a learning culture cannot thrive. Existence of punitive cultures breathes fear on employees, who are compelled to hide their mistakes for fear of punishment, and poses a threat to collecting information and nurturing a learning culture (Tucker & Edmondson, 2003; Chuang et al., 2007; Khatri et al., 2009; Kim & Newby-Bennett, 2012).

From the incident described in Appendix 6 and the other practitioners' stories in this thesis, it is evident that, for the NHS to commit to an ethos of a learning culture and live out the values of compassion and care, we need to work continually on improving our personal reflective practice and place culture and behaviours on an equal footing with financial measures and targets.

The work we (clinical and non-clinical practitioners) do daily in the NHS can have a profound emotional impact at a personal level, and there is a lot of emotional effort in healthcare that goes into managing feelings – one's own and those of patients and carers. Opportunities for colleagues and/or I to debrief about our emotional experience of the work we do are rare.

A culture that values the practice of reflection would prioritise clinical supervision and explicitly support staff at all levels. Francis (2013) stressed the importance of staff having time to explore issues and share good practice. He recommended that NHS

organisations should be encouraged and supported to develop a reflexive ethos in which the nature of “how we do things round here” can be thought about in depth, openly and honestly.

Sustaining momentum and passion for change is a long-term investment, and ensuring that culture change is sustained over time can be a challenge. Sustainability is influenced by social convention (Antwi & Kale, 2014). The factors that have an impact on sustaining culture change in the long term are quite different from the factors that are necessary to prompt initial favourable conditions. Factors that have been identified to increase sustainability include reflexive practice, enthusiasm, multiple levels of leadership, the generation and use of evidence, and performance monitoring (Davies, Tremblay & Edwards, 2010).

Participants (my co-inquirers and I) in the FoS co-operative inquiry group agreed from our experience during the research that sustainability of NHS culture change must be viewed as a continuum and not as a final steady state. We concluded that it is a moving goal, based on the need to respond to changing expectations and priorities of external stakeholders and policy makers.

In order to achieve sustainability, changes must become part of the organisational culture. There needs to be a ethos of “raising the bar”, constantly improving and innovating, “never accepting that we are good enough, relentless rigor, sustaining credibility, never losing sight of values, seeing through the patient’s eyes and remaining open to all possibilities” (Kimball, 2005).

3.4 Leadership

Hartley, Martin and Benington (2008) attest that leadership has a substantial role to play in creating organisational climates that support patient safety and a commitment to quality improvement.

Edmonstone and Western (2002), Hartley et al. (2008), McFadden et al. (2009) and West (2013) have all advocated that it is about time that leadership across healthcare organisations and networks was taken seriously. The King’s Fund (2017) suggests that leadership is the biggest influential factor in creating a positive organisational culture. West et al. (2014) state that the single most supple and powerful influence on the culture of modern organisations is leadership, which includes leadership from the

strategic top through to the front line, informal as well as formal leadership, and the qualities of the individuals who occupy leadership positions.

The importance of leadership is promulgated in a recent intervention study focused on leadership actions to promote positive changes in organisational culture (Curry et al., 2018; Bradley et al., 2018). It found that changes in culture over a two-year period varied substantially between hospitals. In the hospitals that experienced substantial and positive cultural shifts, changes were most prominent in specific domains, such as perceptions of the learning environment, sustained and visible senior management support, psychological safety, and ability to speak up when things were felt to be going wrong, including when there were increases in risk-standardised mortality rates (in this case for treatment of acute myocardial infarction).

I view leadership as "a social influence process through which emergent coordination (involving social order) and change (i.e. new values, attitudes, approaches, behaviours, etc.) are constructed and produced" (Bolden, 2004). My ontological position on leadership is social constructionism, where as practitioners we construct meaning and lead, together with a philosophy of leadership that is resonant with that of Bolden and Kirk (2006), who view leadership as "being a universal responsibility". Leadership is not permanent, but becomes evident in those moments when people are connected in an enterprise they value. It is the mobilisation of human effort in a collective enterprise. They assert that it is "an endeavour, which takes place within realities that encompass all contradictions, power differentials, inequalities, conflicts, disappointments and hopes" (Bolden & Kirk, 2006).

However, from my experience of the NHS and my study of literature it seemed that only a few hospital boards had truly made patient safety their top priority, as evidenced by inquiries and reports (Berwick, 2013; Francis, 2013; Keogh, 2013).

My research responds to the call to improve leadership practices and illustrates how co-inquirers and I have taken the development of our leadership practices seriously across our individual organisational boundaries and networks. My research focus is on enabling change through leadership, specifically in my work context and job role, and how to translate the recommendations from the government inquiries (Ely, Normansfield, Bristol, Mid Staffordshire, Berwick and Morecambe Bay) into new ways of working, aiding us as leaders to address the challenges we experience in delivery high-quality safe care at all times. It pays attention to leadership for sustainable change, using patient safety as the ground for enabling cultural change. I respond to

Stogdill's (1950) early definition of leadership as being "considered as the process (act) of influencing the activities of an organised group in its efforts towards goal setting and goal achievement".

To be clear and explicit, in this thesis I am using the term 'leadership' to refer to a process within a group (not individual leaders) with purpose. It is not based on a person, but rather on the process of influencing others; hence, it is relational within a group.

Beyond the individual leader

In my experience, there are a lot of books, articles and manuals defining leadership by ideal traits or prescriptive behaviours and competencies required in leaders. This corresponds with research by Hartley et al. (2008) that much of leadership writings is a list of qualities or skills and attributes that are aspirational and prescriptive, with some providing a set of guidance principles of the 'do this, don't do that' kind for effective leadership. This individualistic (heroic) focus of much leadership writing means that there are relatively few frameworks for taking a more holistic or system-wide view of leadership (Hartley et al., 2008).

The Healthcare Leadership Model was developed by the NHS Leadership Academy (2013) to provide and justify a clear sense of purpose and contribution to motivate teams and individuals to work effectively with a focus on improving system performance. The Healthcare Leadership Model is to help those who work in health and care to become better leaders. It is a set of key characteristics, attitudes and behaviours expected of leaders to deliver the future NHS. It is made up of nine 'leadership dimensions': leading with care, sharing the vision, influencing for results, engaging the team, evaluating information, inspiring shared purpose, connecting our service, developing capability, and holding to account. Each of the dimensions has leadership behaviours shown on a four-part scale which ranges from 'essential' through 'proficient' and 'strong' to 'exemplary'. The intention is for leaders and those who want to develop as leaders to use the model to review their individual leadership abilities and use it as a focus for personal development.

The dominant approach to leadership development in healthcare in the UK has, for over 10 years, been based upon this notion of leadership competences (Edmonstone, 2011, 2013). This intention of "putting leadership into people" such that they can transform themselves and their organisations (Raelin, 2004) does not seem best suited

to the current needs of our NHS organisations and may ultimately not be fit for purpose.

I challenge this model for healthcare leadership, as it is based on the assumption that leadership is context-free with a focus on the development of individual leaders rather than on leadership. The model's emphasis on competence claims that certain key characteristics, attitudes and behaviours can be identified, measured and developed, and that leaders in the NHS should aspire to them. It asserts that individuals could have sufficient intellectual flexibility in their leadership styles to match the needs of a number of different situations to make things happen, drive and deliver service results. The model diminishes leadership to a reductionist set of fragmented skills. Such an approach struggles to take account of situational or complex organisational factors (McKimm and Swanwick, 2011).

A concentration on developing a framework of personal mental and physical characteristics, once called "the right stuff" (Wolfe, 1979) downplays the importance of building and rebuilding (or 'making and mending') strong local dialogue and relationships with others (Edmonstone, 2013).

The emphasis on leader development, the assumption that leadership exists only within individuals and a concentration on individual leaders through the enhancement of their personal attributes, qualities, behaviours, knowledge and skills have been referred to as the "fundamental attribution error" (Ross, 1977) – the tendency to overvalue personality-based explanations of behaviour, while undervaluing situational explanations (Edmonstone, 2013).

The model promotes the notion that it is leaders who inspire and motivate others to achieve successful outcomes. An articulation of personal qualities and behaviours could be useful to highlight some of the things a person does, is or aspires to; but, from my experience, the model is prescriptive, over-simplified and limited in its practical applicability within the current climate of complexity, fragmentation, interdependence that is present in our multi-disciplinary NHS organisations.

Based on climate and rather than leaders, my view is that we need leadership of social democracy that can emerge and be expressed through the various subjective accounts and interpretations of other stakeholders. The significance of leadership needs to move beyond leaders as discrete individuals in abstraction who are independent of social relations to leadership as a socially constructed phenomenon.

Leaders that are visionary, communicative and honest may exist but I feel they can only be successful in the NHS as a consequence of collective action, with negotiation and debate and gaining results from the bottom-up actions of others.

Leadership development should therefore be about:

> *expanding the collective capacity of organisational members to engage in leadership roles and processes. Leadership roles refer to those that come with and without formal authority. Leadership processes are those that generally enable groups of people to work together in meaningful ways (Day, 2001).*

"Capability cannot be 'taught' in any formal sense or passively assimilated, but can be reached through individual and group transformation processes in which competences are continuously re-adapted and re-tuned to changing circumstances" (Edmonstone, 2013).

My research explores how we improve leadership practices in the system to create sustainable cultural change. It examines how individuals and groups learn by experience, read a situation, recognise patterns and respond creatively to what is seen and experienced. It is about turning instinct into insight, by thinking about what we are doing as we work and talking about it with others – theorising about practice during practice.

My research explores an alternative approach to leadership development that moves beyond the leader as an individual. Table 3 highlights my research exploration into a leadership form that is collective, relational and communicative, and has social awareness.

	Leadership Approaches	
Comparison dimension	Individual leader	Collective leadership
Capital type	Human Capital	Social Capital
Leadership Model	Individual • Personal power • Self knowledge • Trustworthiness	Relational • Power with others • Shared knowledge • Trust • Mutual respect • Negotiation and

		debate
Competence base	Intrapersonal	Interpersonal
Skills	Self-awareness • Emotional awareness • Self-confidence • Accurate self image	Social awareness • Empathy • Service orientation • Political awareness
	Self-regulation • Self-control • Trustworthiness • Personal responsibility	Social skills • Building bonds • Team orientation • Joint responsibility and ownership • Change catalyst • Conflict management

Table 3: Leadership Approaches

Source: My own modified content, adapted from Edmonstone (2013)

I view leadership as a social capital. Social capital is defined as the "goodwill available to individuals and groups. Its source lies in the structure and content of social relations. Its effects flow from the information, influence and solidarity it makes available" (Adler & Kwon, 2002).

Leadership exists in the active connections among people, where trust, mutual understanding, shared values and behaviours act as links, making co-operative action possible (Prusak & Cohen, 2001). As such, relationships are both within and between organisations. Edmonstone (2013) states that an individual-based approach to developing leaders does little or nothing to develop such relationship-based social capital.

I agree that leadership development is necessary for enhancement of personal qualities, knowledge and skills, leading to the creation of human capital. However, I am also of the belief that the creation of social capital is a sustainable and the most effective approach to leadership development in healthcare delivery.

Goodwin (2000) recommended that it was increasingly inappropriate to focus on an individual's ability to lead. Rather, the need is to focus on developing a "local leadership mindset", which should be mandatory rather than ad hoc or optional, and should be developed on action-learning principles.

As the NHS moves towards integrated care, a significant shift away from individual leaders and organisations as separate entities towards working collectively in systems of care is required for leadership. Whilst the qualities and capabilities of formal 'leaders' are important, improvement to the delivery of safe quality care which is sustainable is more likely to happen through creating and fostering a culture of collective leadership. The research into leadership for sustainable change is challenging the concept of leadership being a set of attributes of a singular leader and the presumption that, if we fix them – the leaders – as a component, the whole will be good.

Collective leadership: towards a sustainable change practice

As the findings from the literature (Ruchlin et al., 2004; Chuang et al., 2007; McAlearney, 2008; Khatri et al., 2009; McFadden et al., 2009; Künzle et al., 2010; Kim & Newby-Bennett, 2012; Dixon-Woods et al., 2013) differ in scope and methodology as well as in their selected leadership models, it is difficult to distinguish the actionable salient features to put into practice a learning culture and effective sustainable leadership in the NHS. The challenges that face the NHS are too great and too many, however, for leadership to be left to chance or to piecemeal approaches.

From my regular interactions with ten CEOs across NWL, most have delegated responsibilities for quality of care and patient safety to colleagues in Executive Board positions, such as medical directors or directors of nursing, and they, in turn, have delegated them to their managers. There is a perceived need for a senior leader to champion the quality and safety cause, and this sentiment is much endorsed by the learned reports referred to earlier.

This leads me to challenge the notion, however, that a quality patient safety mindset is best served by being owned and driven by an individual leader.

> *In academic medicine, we tend to think of leadership as being about a person in charge who wields power and stands apart. The word 'leader' may bring to mind vivid images: the gifted surgeon who pioneers a new procedure; the brilliant researcher who advances our understanding of a disease … By and large, our view of leadership tends to centre around visible individuals and their talents, contributions and achievements. This view of leadership is not wrong, but it is no longer adequate.*
>
> (Souba, 2004)

This quotation sheds some light on the academic clinician view of leadership. It helps me to understand my experience of specific clinicians better in the way they behave and use my meaning-making as I strive to enable change in the NHS through my work.

Research undertaken by Millward and Bryan (2005) on clinical leadership is now recognising the importance of relationship management, advocating for more attention to be paid to inter-relational aspects of leadership. Shared leadership emphasises the significance of communication and deliberation to empower staff for organisational development.

The definition and distinction of 'distributed leadership' and its close allies – 'shared' or 'collective' leadership – are still open to debate and create a certain level of ambiguity. In my attempt to unpick the distinction between the three models, I came to the conclusion that they are a continuum of sorts, can co-exist in an organisation and can be used in the same team at different times according to changing circumstances.

I see and experience shared leadership as an emergent team property of mutual influence that emphasises social interaction, and does not automatically include sharing of responsibility, authority and power at hierarchical levels. Distributed leadership is some form of fuller group engagement in leadership, through distribution of tasks and responsibilities, without necessarily distributing authority and power. Collective leadership refers to the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within organisations, depending on situational requirements (West et al., 2014).

The concept of collective leadership was informed by insights from two major programmes of study (West et al., 2014). The first is a study of cultures of quality and safety in the NHS (Dixon-Woods et al., 2013), involving 299 interviews with key stakeholders, over 650 hours of ethnographic observations, 715 survey responses from patient and carer organisations, team performance data from 651 clinical teams and archival analysis of 793 sets of minutes from 71 boards over 18 months. The second (Dawson et al., 2011) involved analysis of NHS national staff survey data from 350 organisations surveyed each year from 2004 to 2011, sampling the national workforce of 1.4 million employees. Responses were received each year from a sample of 150,000–200,000 staff, with response rates varying from 55 to 60%. The data from these surveys were linked to national patient satisfaction surveys, mortality data, and data on quality of care, financial performance, staff absenteeism and staff turnover.

West et al. (2014) concluded from these studies that nurturing high-performance cultures requires developing and implementing a collective leadership strategy, in which organisations have the leaders needed, who are displaying and modelling the desired leaderships behaviours and working collectively around reinforcing the values, behaviours and practices that are core to the desired culture. In addition, they proposed that the key elements for sustaining cultures that ensure high-quality compassionate care for patients are inspiring visions, operationalised at every level, supportive and enabling people management, high levels of staff engagement, learning and quality improvement embedded in the practice of all staff and effective team working.

The Ham et al. (2011) report on the future of leadership and management in the NHS argued that we need to shelve the concept of heroic leaders who turn around organisational performance as being out-dated and move towards seeing leadership as shared and distributed throughout the NHS. For my research, I adopt and test the concept of collective leadership (West, 2013) in which everyone takes responsibility for the organisation, depending on his or her expertise, capability and motivation. This concept is proclaimed (West et al., 2014; Eckert et al., 2014; NHS Improvement, 2017) as the key to unlocking cultural change throughout the NHS. An attractive perspective on leadership is to consider it as a process that exists within relationships between people that gives rise to organisational effectiveness, rather than as individual leadership qualities (Bolden & Kirk, 2006).

Leadership development as a shared and collective process in the NHS is yet to be fully researched, though much of the available evidence highlights its importance and advocates for a balance between individual skill development and collective leadership for organisational capacity-building (Edmondstone, 2011; West et al., 2014b, 2015).

I explore the use of collective leadership, where the flow of power is distributed and situationally dependent on who has the expertise at each moment, which is vital for knowledge and continual learning to occur. My research encompasses the process of working together (in a relationship) across teams, departments, organisations, networks and service users, in a way which shares knowledge, responsibility, authority and power.

My research into leadership is not located in the upper echelons of the organisation or about specific individuals, as this would distort and/or impair my focus on leadership being a collective process. I view it as leadership for all, by all and for all.

The changing nature of healthcare organisations, with their increased ambiguity and the interconnectedness of the different healthcare professionalisms, different organisations and across boundaries in different sectors of care (health, social, community), calls for a form of leadership that is collective to address quality and patient safety issues. This form of leadership goes beyond an individual; rather, it requires leadership that is co-operative, relational and integrative and addresses the interdependencies of the system, especially for the increasing needs of patients, service users and communities at the systems level.

3.5 Relational ways of working

In this section, I examine the relational leadership literature, to explore how the patterns of relating in personal and professional life between multidisciplinary colleagues and patients in order to improve leadership practice and patient safety in healthcare have been conceptualised to date.

My research has led me to understand that we exist in a mutual relationship with others and our surroundings, and that we both shape, and are shaped by, our social experience in everyday interactions and conversations (Berger & Luckmann, 1966; Gergen, 1999).

Hosking (1988) argued that, rather than studying leadership within the perceived physicality of organisation structures, we needed to pay attention to the social constructions of organising – how leaders construct organisational 'realities' and identities in social-psychological processes occurring in relation to other people.

My social constructionist position on relational ways of working in the NHS is a practical stance that healthcare professionals need to communicate and work with each other to have an impact on the quality of care delivered to patients. My ontological perspective is that leadership exists in the relationship with others, rather than leadership being the property of the leader alone, detached from the situational context in which it occurs. It suggests that organisational members actively create their organisational world through their relationships with one another, and that what we say is important (Fairhurst, 2009).

Uhl-Bien and Ospina (2012) remark that bringing relationality to the leadership field means viewing the invisible threads that connect actors engaged in leadership processes and relationships as part of the reality to be studied. The term 'relational leadership' is relatively new and sits under the umbrella of 'collective leadership' with other forms of leadership such as 'shared', 'distributed' and 'post-heroic' amongst others (Drath, 2001; Uhl-Bien, 2003, 2006; Fletcher, 2004; Ospina & Sorenson, 2006).

Uhl-Bien (2006, p. 655) defines relational leadership as a social influence process through which emergent coordination (i.e. evolving social order) and change (e.g. new values, attitudes, approaches, behaviours and ideologies) are constructed and produced. This perspective views leadership as occurring in relational dynamics throughout the organisation.

Cunliffe and Eriksen (2011, p. 1434) assert that relational leadership is not a theory or model of leadership; it draws on an intersubjective view of the world to offer a way of thinking about who leaders are in relation to others (human beings, partners) and how they might work with others within the complexity of experience. Relational leadership means recognising the entwined nature of our relationships with others. It is a way of being-in-the-world that embraces an intersubjective and relationally responsive way of thinking and acting. Bradbury and Lichtenstein (2000, p. 552) state that "knowing occurs between two subjects or phenomena simultaneously, therefore we must attend to the multiple meanings and perspectives that continuously emerge".

My inquiry presented in the stories brings yet more evidence of leadership being a social process. In my research, I have explored the relational perspective of leadership, which assumes all social realities (knowledge of self and of other) are interdependent or co-dependent constructions, existing and known only in relation to each other, focusses on communication as the medium in which all social constructions of leadership are continuously created/changed and emphasises the importance of 'relating' and relatedness in leadership (Uhl-Bien, 2006).

Reitz (2015) noted that nowhere had she found scholars asking the question "what is it like to be within relations where leadership is being constructed?" I endeavour to capture the emotional rollercoaster of anxiety, excitement, struggle and warmth we experience in this leadership space. My interest is in leadership as it is constructed in relations rather than on the leader as an entity. We have minimal understanding of the relational (social) processes by which leadership emerges and operates. This is

because the vast majority of our existing studies of leadership have neglected to focus on process (Uhl-Bien, 2006).

There have been several calls by scholars (Bradbury & Lichtenstein, 2000; Ospina & Sorenson, 2006; Uhl-Bien, 2006) for leadership studies to be conducted through participatory methods of research. Since there is the recognition that leadership *is* relational, and cannot be captured by examination of individual attributes alone, even when entity approaches are adopted, it cannot be fully understood by traditional research approaches.

My research responds to the call and takes up the challenge to study collective leadership through a CI method in a complex system. Using a participatory method for research makes it highly interpersonal, requiring direct communication between everyone involved, which often creates social change in the process of research engagement (Bradbury & Lichtenstein, 2000). CI as a method in itself is relational, emergent and grounded in the context of its participants (Heron & Reason, 2001).

Ospina and Sorenson (2006) invite us from a constructionist standpoint to pay attention to traits, behaviours, styles, processes, relationships and activities to gain an understanding of leadership and how things happen when a group with a purpose tries to achieve it. I welcome the invitation, as this research explores the points raised, in addition to understanding how people working together make leadership happen and the role individuals and groups play in bringing leadership into being.

As a result of the limited methods employed in researching relational leadership until now, my research enables me to taste my own medicine as a leader. It will bring to light the messiness and dynamics present in the emergent nature of leadership, including an ability to view the invisible threads that connect actors engaged in the leadership process as part of the reality being studied. My research aims to offer an understanding of the construction of collective leadership, in which relations are fundamental to exploring differences and possibilities for action.

The stories from my research in subsequent chapters highlight how other co-inquiriers and I have demonstrated relational leadership in our professional lives, and how I have demonstrated it in my personal life and in leading this research.

3.6 Summary and reflections

I have explored theories that inform my practice context which come from literature exploration of the action-based approach to research and learning in chapter 2 and the review of literature on NHS inquiries, quality and safety, sustainable cultural change, leadership and relational ways of working in this chapter.

The insights generated from the literature review offer the thinking needed to connect research questions to the daily experience and operations of organisations.

The potential themes emerging from this exploration of the literature for the analysis of the research data collected during this research period are that there is no single 'best' culture that always leads to success across the full range of safety, quality improvement, financial and all organisational performance domains. It is it is clear that changing culture is complex and takes time, determination, and resources from all parts of the organisation.

The stories in chapter 5 are from my experience of action research, and highlight the shortcomings of individualistic and hierarchically driven leadership cultures in delivering healthcare. They evidence that reflective, more inclusive, communicative, emergent and relational leadership has the potential to make a difference to quality and safety of care.

From our FoS co-operative inquiry experience, I was able to test collective leadership ideas in practice. It enabled me to study how we (co-inquirers) decide, act and present ourselves to each other, develop foremost as individuals through first-person inquiry and develop as a team/organisation/network to meet the pressures and changing demands in the system. It became clear that, within a hospital environment, the ethos of collective leadership limits the strong hierarchical culture that tends to pose obstacles for junior doctors or nurses to communicate with senior doctors or managers.

In summary, the engagement with the literature in this chapter is intended to make clear the practice and theoretical stance I adopted in my research. It also helped to generate concepts that contributed to my research interest, so that I could build on the work of other scholars and practitioners.

4 IN PURSUIT OF UNDERSTANDING SELF

In this chapter, I describe how I found my feet with my story of self-discovery. I show and reflect on my own practice (first-person inquiry), by attending to my own personal being. I reflect on what I am made of as a person, how it shows up in my practice and what has changed in my approach towards myself. This chapter shows my self-reflective practice, to situate my thinking in the subsequent chapters, which are about my professional practice in health care.

My writing style in this chapter is slightly different from in the preceding chapters. Thinking why this is so, I relate it to my authentic reflective writing style and my search to find a style which makes my narrative accessible to individuals in the personal and the professional territory in which I exist.

In this chapter, I offer the stories of my personal life as a gift. My intention in this section is give an account of my personal being, to show my intimate fears and experience as I open up to new possibilities, in the search to embrace and know myself fully.

The content of this chapter is as follows: illustrations of self-discovery from my childhood through accounts (section 4.1) that I consider as pivotal to my own curiosity and inquiry; an autoethnographical account of undertaking research in my professional context (section 4.2) and other aspects of my identity such as race (section 4.3), voice (section 4.4) and power (section 4.5) which were pivotal to my self-reflective practice; and a summary of the findings from my first-person inquiry (section 4.6).

4.1. Self Discovery

My wet palms are coming through as I write this. The water is the stream of semi-conscious emotions that come out in certain situations – what I call ‘the waterworks’. It is the unvoiced me that springs out from my body in wet palms and occasional teary eyes. It seems that my body has a tap that produces water in certain situations, like an innovative heating control system that automatically turns on the heating when the house temperature is below a certain level.

When I was nine, my parents were quite concerned about my wet palms and made efforts to seek medical intervention.

‘She just can’t hold a pencil for too long as that produces water’, says my worried Mum to Dr Smith.

‘The pages on the school book get wet!’ Mum elaborated.

‘We have done numerous tests and she seems fine; we’ve prescribed her Valium medication, and minimal improvements were noted. Unfortunately, there is not much more we can do. She will grow out of it’, says Dr Smith.

Mum’s face fell and my heart sank.

Oh no! I will be going back to school as the child known for having a wet exercise book. How I really wish this wet palms thing could be fixed. Such a shame I would not be able to take part in sewing lessons, as the fabric goes wet as well.

When asked by clinicians during my investigative visits to find out what causes the wet palms, my fixed response is, ‘I only notice it when I hold a pencil for too long when doing schoolwork.’

More than 30 years on, the wet palms still show up occasionally, and I have grown to just live with it … although I have never really reflected on why it happens.

“Ooooops … my keyboard is wet!” I notice as I type.

My wet palms have once again shown up. Could this be due to anxiety? Could it be due to the fact that I am conscious I will be sharing this writing, and others will read about my wet palms? Or could it just be that this is something quite personal for which I have never explored the triggers!

My teary eyes! This is definitely an awkward one. I never really dwelt on it or brought it to anyone’s attention, as I seemed to be aware of the situations that turned on this tap. On reflection, I wonder what it was really about.

As I write, I remember instances when such emotions have been created, especially in discussions with others. I remember a scene when I was 13 years old and my Aunty had gone to my mum’s closet and taken an outfit and jewellery to wear to a party, whilst my mum was on holiday away from the house.

‘Aunty, did you ask Mum before you took her clothes?’ says my innocent voice.

> ‘Shut up! Respect your elders and don’t challenge grown-ups, even if you don’t like what they are doing or agree with their view’, responded Aunty Titi abruptly.
>
> Sob … sob, tears trickling down my cheeks as I ran out of the room.

Another scene was at my magical tenth birthday party, filled with a funfair, food and party goodies, with a special appearance from Disney characters. It was tidy-up time and I heard:

> ‘I didn’t expect to find so few beers left here. Not a lot of my friends drank them, after all’, murmured Dad as he emptied the drinks cooler.
> ‘They drank loads more than you can imagine’, said Uncle Bola.
> ‘No, they didn’t. There are some beers hidden under the table that Uncle Bola and his friends sat at’, I said softly.
> ‘Who told you they were hidden?! They must have been left there mistakenly!!’ said Uncle Bola in a loud voice.
> ‘Oh … I thought it had been covered away there. Sorry.’ I walked away from their sight, as tears fell from my eyes.

As I reflect on both situations, one thing is constant. I was sure that both individuals were untruthful in their responses, and that evoked a teary emotion in me. Could I have been bold enough to respond to adults in a defiant manner? Hell, no! I dared not! Who does that? It was forbidden for children in my family and in my social upbringing to challenge an adult. That is considered disrespectful and offensive, and the child would surely get a smack from the grown-up. After all, a respectful child is the pride of any parent in the community.

Barnes (1997) points out that transactional analysis draws on some of Bateson's (1979) ideas, including on epistemology (the way of understanding) and cybernetics (the study of communication). Berne identified three ego states, namely Parent, Adult, Child, as states that are present when two or more people encounter each other in a transaction. The states do not necessary correspond to the common English language definitions, but are phenomenological realities experienced through observable behaviours. Reflecting on Berne’s ideas on transactional analysis in social structure of cultures (1963), I found myself wondering on the ego state behind every interaction that exists between individuals.

As a child growing up with strong parental controls in an authoritarian culture, there was the presence of an unspoken repressive ethos, which disempowered children by requiring compliance to all things mandated by parental/adult authority. My experiences as a child described above, with the display of my waterworks, show the emotions and feelings I felt because of the external stimulus of the parent ego state. As I reflect on the experiences of my upbringing, I see that the potent introjections of the social norms in my environment have influenced my ability to develop my agency and voice.

In my forties, I still have experiences such as I had in my upbringing, including some instances during my doctoral journey. As I ponder about self, my experience at an ADOC supervision group session in January 2015 comes to mind, from the writings below in my learning journal.

> *Eyes wide open in bed … gazing at the clock. It's just 2.54 am. Gosh! I have only slept for approximately three hours. It dawns on me I have had a busy past three days, post ADOC, and I really need a Saturday lie-in till at least 8 am.*
> *I roll back on my side, keen to return to sleep, but tears roll down my eyes, sob…sob…sob.*
> *I wipe my face and a sense of hurt with sad feelings and heavy heart clouds my consciousness. I hope this writing serves as a healing process and allows me to inquire further into the feelings erupting from my heart.*
>
> Personal Journal, January 2015

The journaling continued with the story of the scene that had flashed back to mind and seems to have woken me up at 3 am with a heavy heart, disturbing me from a well-deserved good night's sleep.

On sharing the journal writing with my ADOC supervisor, he suggested the use of the two-column model developed by Chris Argyris and Donald Schön in 1974 and extended recently in Senge's work on mental models in *The Fifth Discipline* as a potentially suitable tool to find a theoretical stance and method for inquiring into the phenomenon that had caught my attention.

In Peter Senge's *The Fifth Discipline* (2006), he explains how the 'mental models' discipline enables us to clarify our deeply ingrained assumptions, the generalisations of our internal images of the world and the stories we carry in our minds of ourselves, other people, organisations, society and every aspect of the world. The two-column or left-hand column tool aids people in exploring how we might choose to be more open

and honest in a safe way. It enables proper understanding of the assumptions and opinions that are actually being communicated beneath the words used.

Table 4 below illustrates the scene using the left-hand column tool. It captures the audio-recorded spoken dialogue that actually occurred in the right-hand column and my own internal dialogue (what I was thinking and feeling but not saying) in the left-hand column.

What I was really thinking/feeling	What was actually said
In shock to hear the abrupt, confrontational and accusatory tone. His remarks have come as a sword directed to pierce my heart: it felt hostile in a group discussion on improving group support and working relationships. Inaccessible???? I presume he is referring to group dedication and commitment, as – despite the work, school and family demands we all have – I have participated in all group calls and met deadlines, yet he has recently missed our group call and didn't provide me with feedback on my additional transfer paper. So I wonder who is inaccessible here. Being accessible needs to be bilateral; I feel action is more important than words. With the thought that my wet eyes were unnoticed, I responded not by addressing his attack on me but rather by focussing my comment on the discussion at hand. My gut voice was on the verge of shouting out but I silenced it as the words could be perceived as insensitive and antagonistic Oh JT…. STOP IT! PLEASEEEEE don't go there!	J: Ronke, I find you inaccessible and feel more connected and closer to M and K than I am to you. Ronke: Tears trickled from my eyes. Ronke: I feel there is an improvement in our group engagement and communication when it was last discussed at our group meeting, following the transfer paper process three months ago. A few comments ensued on the general discussion on group engagement from the other three (M, K and JT) present, but discussion shortly came to a halt when our attention was drawn back to the remarks made by J. JT (Facilitator): I feel a tension here in what has just transpired. Ronke, do you have any comments to make? Have you got any response for J? Ronke: Nothing to say (as more tears trickle down from my eyes). K: I don't think it's a tension between J and Ronke. JT: I feel you might have a response. Ronke: I feel the opposite (with a teary voice).

	JT: Can you clarify? What do you mean by that?
I wondered as I spoke why I had to justify why we weren't both best buddies.	Ronke: I feel it's your choice, J, to be closer to the other two members of the group than you are with me. I feel I have engaged in all group calls, met deadlines on feedback on writings and other group-related tasks whilst you didn't provide feedback to me on my additional transfer paper. Also I believe you have similar interests, background and epistemologies to the other two, whilst it seems mine are different. You possibly have a lot to chat about outside ADOC work and might have experienced common themes in your upbringings, since all three of you were brought up in America/Canada. I feel I am closer to others in the group and others outside the supervision group within the ADOC than I am to you. And does that bother me? No. Within my family unit, I am closer to some of my cousins and sisters than I am to my youngest sister. My youngest sister and I have a different ethos and different attitudes to life, yet we engage when required to discuss family issues. I had a great night yesterday with the wider ADOC community, when I felt very included in the music performances despite not knowing some of the songs. At a previous outing with all three of you, you went down memory lane and shared similar experiences, video and music interests – I was particularly mute throughout the discussion because I had nothing to contribute, as I did not have such experience, which of course isn't bad and I really enjoyed being in the conversation as it exposed me to your individual interests which is very helpful for our bonding. So I really don't understand why it's an issue that you find them both more accessible than me.
Not surprised my response did not resonate with him nor did he get it, always acting like he knows it al!	JT: Ok, Ronke, I seem to understand your stance. J, do you understand where she is coming from and her views? J: No, I don't get it! I also originate from a diverse background. I also did not know all the songs from last night, as some songs were from a different generation. J: I accept my comment could have been abrupt and apologise for the manner in which it was directed at you, but my request is to be connected to you and form a closer bond with you.

Hooorayyy….. just what I needed.	Ronke: I am also happy to make myself more accessible and form a closer bond. K: I suggest we have a five-minute break.

Table 4: The Left Hand Column Tool

Phew!!! sob…sob…sob, a brisk walk down the corridor and into the ladies restroom I dashed. I was met by K, who hugged me tight and consoled me. I came back into the room feeling strong, with a positive attitude to continuing with the group meeting.

Further discussions took place thereafter, and we all walked out for lunch with J and I holding comforting hands. It was a productive meeting on return from lunch, free from emotions, and we explored further into our inquiries.

Lo and behold, at the end of the day my feeling was that the dynamics that had occurred in the morning session were all over in my mind, with no untoward feelings towards anyone, but with a grateful heart to JT for creating the space for my voice to be heard.

As I lay down at the awkward midnight hour, I re-evaluated and self-reflected on the incident. My first instinct was “this has to stop!’ – why did I become all teary – I was voicing through my waterworks. I was so confident that, if it had been someone else in the group who had confronted me with such remarks, my waterworks would not have surfaced.

Is there something about J that evoked such a response in me? Oh absolutely ... Yes!

I am not particularly bothered by the fact that there was no basis for the accusation of ‘inaccessibility’ (which at the time I interpreted as not being committed to engaging with the group, in which of course he is an outlier, although after feedback received from sharing the left-hand column above with all present in the group, including reflecting and recycling further on it, ‘inaccessibility’ could have meant not being an open book to him with regards to social interaction).

But, rather, I was curious about whether transference had occurred – whom did J represent for me? What did this experience show me in relation to power and voice?

As a researcher, what have I learned of self through the experience? How do I develop self to manage such situations involving others with similar personas to J's in my own contented manner – one that would not lead to further sleepless nights?

These questions went through my head for days and months at this phase of my doctoral research, and I began to be possessed by enthusiasm to inquire further into self in relation to voice and power and links with transference from my childhood.

In my research into transactional analysis, I examined how feelings and childhood experiences could have suppressed my 'Adult' state in transactions with specific individuals, leading to the emotional charge I had felt. My reflections led me to suspect that there was a deeper root in need of exploration. As I reflected on the scenes described above, I became aware that, despite my personal achievements and professional advancement, I had been engaging in my relationships with others without conscious awareness of my voice and power.

How could I have gone to work without my voice? How could I have functioned proficiently without acknowledging that I had power? How could I expect to be counted upon or sincerely know the 'other' without building trust? It all felt normal: it just did not occur to me that I had the choice to change it.

My quest to change it involves exploring my research question of:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?

In attending to the question above, I start with the concept of Voice.

This leads me to recalling the early months of 2015, when I got curious about the different voices in conversations. I wanted to explore the voices we speak in, the unspoken voices we hold back, the unheard voices, the voices of the marginalised – the right to speak, the right to be heard and the power dynamics in voicing. In April 2015, five ADOC peers and I collaborated to design, organise and facilitate a participant-led session with the ADOC 4 community to co-inquire on the theme of 'Voice'.

I became alert to three interlinked voice channels that wrestle for my attention and began to explore the presence of these voices. This is an excerpt from my journal, illustrating my reflection process.

My most cherished Head voice, my closest ally, I grew up learning about developing your intellectual self.
I have always made you rule over my Heart and Gut voices.
You seem to be dominant in me.

Oh, my beloved Heart voice,
You bring forth the ever caring, sensitive, joyful, playful, bubbly and, in comfortable settings, the life of the party self of me.
You exhibit the cheerful heart of continual feast.
You bring forth the response that turns away wrath, the soothing tongue that could be a tree of life.
They say you portray a heart of gold and an indispensable precious jewel to those around you.
Yet, you sometimes show yourself as Waterworks, when nervousness sets in with the onset of being powerless.
Oh … how I am embarrassed by Waterworks when flowing openly. Does the world need to see the vulnerability in you? Yet, you don't want the pity party, which lends itself to an untrusted show of compassion from the dominant force.
Oh … Waterworks, let me accept the validity of your existence as you tend to silence and not pave the way for the Gut voice to speak forth its undefiled insight.

Gut voice – my inner pilot light, I sense you as the nuts/butterflies in my tummy.
Oh, Gut voice, I occasionally kick myself for not activating you. Your dark side could stir up confrontation and anger, which comes with drama that I truly can't stomach. Hence I tend to mute you when upset, to my distaste.
I beckon thee to occasionally stand in place of Waterworks … please go gently and be observant! I feel the need to tame you, as you could be poisonous, with a fear that you might crush their spirit.

Personal Journal, February 2015

As I reflected on these different voices in me, it became obvious that I am most at ease with my Head voice. Based on the concept of Johari Window (Luft, 1982) of a self-disclosure model, this is how, I am "known by self, and known by others".

I became keen to explore further my ability to speak up in conversations when I have a feeling of powerlessness, and to examine the random display of my Heart voice, including my waterworks, in specific situations and with certain individuals. I wanted to find the ability to finish a conversation with peace in my mind, knowing that I have spoken in all my voices, and without the baggage of the unsaid, which often leads to a sleepless night and me dwelling on the matter.

During the April 2015 ADOC voice workshop, I was presented with a question, amidst the entire ADOC 4 community (faculty and students): *"*As a black woman who has successfully risen into a senior management role, how do you project your voice in the

midst of the power and gender dynamics present in executive teams within organisations?"

My response, which included my views on race, sex, seduction, gender and power, seemed to have caught the attention and interest of all fellow students. Whilst I was comfortable being engaged in the exploration of the question and welcomed being probed further on my responses, a female peer interjected, requesting the conversation to come to an end. She felt I was being picked on, and that it was becoming a bit of banter and awkward for her and others present to watch and listen to. To her surprise, the group responded that they were intrigued by the conversation, and I informed her that I was very comfortable voicing my experience and responding to the questions.

My response to such a situation would have been different had I not already reflected on my different voice channels through my journal writing. I would have spoken purely from my Head voice, which reasons and scrutinises situations and delivers logical responses. Instead, I chose to engage my Gut voice to respond sincerely about my experience of being a black woman in such settings.

My instinct was just to "Say it as it is" and, if it portrays a defamatory image of my race or gender, tough! I said it as I knew it – no sugar coating, no barriers up. After all, it is better that they know it, since I am the only black person in the ADOC 4 community.

In most cases, I am the only black person in the room. In the past seven years, whilst working at senior level in four different organisations, I have usually been the only black person and in some cases the only woman in the executive team or on the board. Has this ever bothered me? Hell ... no! I was very comfortable being questioned by my 23 (mostly white) ADOC colleagues. I was confident it was a genuine inquiry into knowing the other and my sense of self. The genuine nature of the inquiry gave me the confidence to answer with my Gut voice.

This attests to Berg's (2002) beliefs that the reactions we get relate to other people's impressions of or experience with the groups to which we belong (or are thought to belong). I label these reactions as stereotyping. It is a complex process, which occurs consciously or unconsciously in interpersonal relationships and relationships between individuals and organisations.

It reminds me of Chimamnda Adiche's Ted talk (2009) titled "The danger of the single story", in which she advocated for the rejection of the single story, as there is never a single story about any place or person. She highlights that the single story:

> *creates stereotypes, and the issue with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story. The consequence of the single story is this: it robs people of dignity. It makes our recognition of our equal humanity difficult. It emphasises how we are different rather than how we are similar.*

I could equally be guilty of "the single story" if I chose to rely only on media coverage for the definitive story of a group's identity.

Reflecting on what invites my different voices to speak well, my mind turns to a different ADOC experience in July 2015. A participant-led workshop on the theme of radical epistemology included sessions exploring ecological grief. One of the sessions involved the process of 'smudging' each individual at the entrance of a labyrinth with unknown particles (those particles/ashes could have been absolutely anything) with incantations from an ADOC peer playing the role of a 'priest'. I felt uncomfortable about the 'smudging' and incantations and, in order to respect the process flow and not make a scene, I reshuffled to be at the end of the line so that I was the last entrant into the labyrinth and could choose quietly to decline the smudging process.

On completion of the labyrinth session, the group was led by the 'priest' as we all circled round for another session. The priest proclaimed a series of chants, with supplication calls to a spiritual being. Then the priest took a jar of water and walked around to sanctify each of us. She chose to start with me … Outwardly I think I did not show much, but inwardly the conversation must have been something like:

> *What's all this ritualistic sh**t! How dare you perform such rituals on people without gaining their consent! Who does that? I wouldn't have expected this group to perform such an act without informing participants of the detailed activity and gaining consent from people, thereby making participation optional.*
>
> *What utter nonsense!!! Why choose to start with me, despite knowing I had declined the smudging process?! Shouldn't that have sent a message that it is vital I have an option either to decline or to see the process conducted on someone else, so that I can decide whether to participate!*

I silently fumed as the water sprinkling/sanctification process was conducted on others till the session was completed.

> "Ronke, what did you think about this last session? I found it strange and it didn't sit too well with me. It felt so ritualistic …", one of my ADOC colleagues said to me, as we walked back together.
>
> "Really … I thought I was the only one upset with it. Sincerely, I am furious about it … how could they conduct such a ritualistic process with no reference to other people's spiritual beliefs? I am even more aggrieved that the 'priest' chose to start the process with me, especially since I declined the smudging process", I responded.

We agreed it would be appropriate to share our views when given the opportunity to provide feedback on our experience.

I pondered over the experience later in the night and scribbled a few lines in my journal:

> *It has been an awkward day. I got insights from specific sessions, but felt very uncomfortable with the 'smudging/sprinkling' session. I felt my space and belief encroached upon, and I felt I neither had choice nor voice and had allowed it to be done unto me. I felt that I was an object that an activity had been imposed upon.*
>
> *My old self would just keep quiet about it and let sleeping dogs lie, as I would rather not ruffle the feathers of the workshop organisers, being friends of mine, but I need now to start taking a stance and being outspoken about my discomfort, irrespective of whether it brings discomfort to the other.*
>
> Journal Excerpt, July 2015

At the beginning of the next day's session, the organising group enquired about our views and experience of the previous day's sessions. Feedback was received from a few people. I was quite conscious that I could open Pandora's box if I gave my honest view of my experience, but I was happy to risk it.

I spoke about my experience of the 'ceremony-as-inquiry' session and did not mince words. I spoke of imposing a Holy Communion service on everyone without respecting,

let alone inquiring into, their beliefs or gaining consent before luring us into a ritualistic process. Phew!!! Point made! Finito! I felt a sense of relief on having voiced my experience to the full.

These examples illustrate how I was beginning to take my experience seriously and be curious about it. However, when I write this today, I also notice my own judgment of other people's views, and the need to grow more open in understanding where they came from, as well as allowing my own discomfort to become visible. It seems a part of the learning journey I am undergoing. I sought to be interested in what I experienced, to notice my own patterns of thinking, voicing them inwardly and relating them to my primary responses. I also wanted to allow secondary ideas, such as curiosity for others' views, to inform my outward voice.

I was surprised by the comments I received below from members of the ADOC community in April and July 2015, following my voicing as described above.

> *Well done! Ronke, that was superb, didn't realise you've got so much in you.*
> *Ronke, absolutely amazing! I love your style, your persona, and you really exhibited yourself well.*
> *Go girl! You've got some great energy within you. Where has this been all the while? I seem to be seeing a different you – keep it up, girl!*
> *Ronke, that was great! I really enjoyed seeing you in great form, well composed with great authority – at one point, I felt like standing up from my chair to hug you with a big high five.*
> *Thank you, Ronke. That was awesome. You did really, really well.*
> *Ronke, I am seeing a different side of you that I have never seen. You are a person amongst the group to be listened to. I like your views and insights.*

These comments and episodes made me reflect further on myself and how I seemed to show up now, in contrast to when I started ADOC two years before. I began to wonder what constrained me before from being the full multi-voiced me. Looking at myself then, I noticed that I used to have a façade of being really clever, trying to win others' approval. I may have sounded overconfident or perhaps even superficial. I wanted to be seen as the 'professional Ronke, a management consultant in full control, skilled in her role and highly confident'. That was my Head voice talking, over my Heart and Gut voices.

Voice became a key component of my research, as my voice became prominent in my action research into professional practice. There are further illustrations of the concept of voice in the subsequent sections in this chapter.

4.2. An autoethnographical account of myself in professional practice

As I seek to find form in the writing of my action research doctorate, I am inspired by Marshall's (2001) notion of writing itself as a method of inquiry. In this section, I continue with a writing pattern, style and flow that strive to evoke multiple ways of knowing (propositional, practical, experiential and presentational).

My experience of childbirth in December 2013 involved health complications which led to a condition known as paralytic ileus (the occurrence of intestinal blockage in the absence of an actual physical obstruction) caused by adhesions and surgical complications from undergoing two Caesarian sections. The day after giving birth, I was admitted to the intensive care unit and stayed there for three days. Those three days were a terrifying experience for my entire family and myself, even though I was fortunate to be treated by senior clinicians who were my professional friends, as I gave birth in the organisation in which I worked. During my seven-day period in hospital (much more than the expected two to three days following birth) and the three weeks of healthcare service received at home, patient safety alarm bells were noticeably ringing, as I observed the care that I and other patients received.

In inquiring into my personal experience as part of my professional practice, I start with a reflection on my experience of childbirth, in which I was unexpectedly on the receiving end of my change practice. The date chosen for the birth of my daughter was 31 December 2013, and it seemed that all was going to plan. The best-performing obstetrics clinical team was booked (I took advantage of knowing the clinicians as colleagues), my bags were packed and all I needed to do was show up.

Memories of my elective caesarean section flood in: the surgery did go to plan with the joyous arrival of my daughter, but no one had planned for the side effects that could result from the surgery. We had not foreseen a traumatic post-natal experience, with three days' bed stay in the intensive care unit (ICU).

'ko..ko..kah..ko..ko..kah' are the sounds of my high heels echoing to me as I lay on the ICU bed.

They reminded me of me, the manager of change – Director of Quality Improvement – in an acute NHS Trust, strutting down the hospital corridors to talk to general managers, service managers and divisional clinical directors about how they needed to manage the operational performance of their respective units better. I see myself questioning them on effective use of bed-capacity after planned surgery and the delayed discharge of patients who were labelled as 'bed blockers'. A few days later, ironically, I am lying on the bed being an outlier. In the system I had co-created, I had become one of the unachieved targets for bed usage and discharge from hospital.

"That's not my problem. I can't be bothered about achieving operational efficiency or targets", I muttered, as my focus as a patient was on receiving safe quality care irrespective of the associated cost to the system.

Blimey … as I dwell on my practice and role within organisations, especially in my current role where I am expected to lead a host of transformation programmes in improving patient care, it strikes me how nauseating my 'own medicine' tastes when I find myself at the receiving end of the systemic practice I had contributed to.

I have used the metaphor of 'prescription' and 'medicine' to shed light into my research. Metaphor in language can stimulate physical connections and specific pathways in our brain and our bodies as a whole. I have come to appreciate the embodied quality of metaphor through the work of Lakoff and Johnson (1999), and learned to interpret metaphors as potentially rich depictions that surface in my work. Lakoff and Johnson argue that we cannot think about our experience and judgements without using metaphor. They advocate that all our thinking is metaphorical and that metaphors help us to think about the world and ourselves.

My metaphor of having tasted my own 'medicine' is of being a prescriber and consumer of my own professional practice. I relate this metaphor to a visit I made to my local GP with a persistent cough, three days ahead of my much-awaited ADOC intensive weekend with my peer supervision group in Barcelona in May 2016,.

> "Could you please give me a medication that would stop this cough tomorrow? It has been going on for over two weeks. It started with a blocked nose and occasional headaches. I have used various off-the-counter cough syrups, nasal decongestants and paracetamols but it seems to be getting worse", I explained, as I sat staring at Dr Jeg – my family physician.

> “You really look tired and not your bubbly self; this cough must have knocked you out”, Dr Jeg responded, as she stood up and examined my throat with a torch and tongue depressor.
>
> “From the symptoms you’ve described and what I can see here, you have a chronic chest infection”, she diagnosed.
>
> “I really need to feel better within the next two days, as I am travelling away to Barcelona for a four-day study session. I need to be in top form to get back into the swing of my doctorate programme”, I appealed to her.
>
> “A high dose of antibiotics would be appropriate for you. It should relieve you of your illness and put you in a good state to enjoy Barcelona.” She smiled comfortingly as she wrote out a prescription for a week’s course of 450 mg of amoxicillin three times daily.
>
> “Yikes … didn’t realise I would need to take such an intense drug protocol. If there are no side effects, I would be fine to take it as I want to improve my current state”, I stated as I collected the prescription.

Two days following the visit to Dr Jeg, with strict adherence to the prescription, I was on the positive road to recovery.

I reflected on this ordinary situation – a visit to a GP, an everyday reality to hundreds of thousands of people – from the perspective of my doctoral research. As a patient in need of good health, my interaction with Dr Jeg was based on the conviction that she had the power to fix me. I engaged with her with the notion that whatever she prescribes would relief me of my condition, though I also had power, either to use the prescription or to chuck it in the bin.

The change practice and mind-set in my professional setting is that there is a physician who is an expert with an exact knowledge of the condition and in an authoritative position to ‘fix it’. Based on their role and expertise, it is the expectation that such an individual knows what needs to be done and how it needs to be done … to a patient.

In my professional role as a leader with responsibility for delivering change programmes that led to quality improvement and the adoption of innovation, I have a mandate and expectation from the system to be the organisation’s physician. I prescribe the appropriate intervention (the right pill with the right dose) to a multidisciplinary workforce to change conditions for the better. I know that, in order to

enable change, I needed to meet my colleagues where they were – in their ways of thinking and in their daily realities. The doctor–patient mind-set dominates the healthcare profession, and not to engage with it would mean not engaging with 'what is' – the prevailing paradigm. It would have been received as if I were speaking an alien language. Reckoning with this mind-set was paramount for effecting change in my healthcare context.

Through experiencing and observing the NHS, I knew that prescriptions needed to be taken diligently by the workforce ('patient'). There are major conditions, however, for prescription to be successful, which are that the patient must understand why they are being prescribed a specific 'pill' and be fully engaged with their change lead ('doctor') in co-creating a 'treatment plan' for their condition.

The well-known quotation from Gandhi:

> *Be the change that you wish to see in the world*.
> Mahatma Gandhi

resonated with my research method, as the change I wanted to effect in my professional setting needed to begin with me. I was compelled to take the journey with co-inquirers to explore whether the treatment being prescribed would indeed improve the condition being treated.

Deliberately being part of the group I was researching with meant "simultaneously being an onlooker in the stalls and a member of the cast" (Shaw, 1996, p. 10). My work takes place within the prescriber and consumer paradigm, and in my research I am the 'doctor' and the 'patient' at the same time, hence I had skin in the game.

My research inquiry leads me to ask and reflect on these questions: "How do I live out relational practice in relation to those to whom I am also prescribing it?", "How do I need to behave, in order to be the change I want to see in others?", and "How do I take my own medicine and, whilst experiencing the effects myself, incorporate my experience into my work in real time?" Being the change agent through my job and, at the same time, being on the receiving end of my practice as a participant in the change effort that I was responsible for gave me a mini social laboratory, full of rich learning material in which to explore how I could bring change into my professional practice. As I began to consider the prescription and medicine metaphor in my work, I came to know differently and quickly through my unconscious self, without knowing how it was

that I knew. That attests to Lakoff and Johnson's notion (1999) that our thinking takes place in our cognitive unconscious.

In my doctorate research, I was curious to understand the effects of consuming the medicine outlined in the prescription paper below:

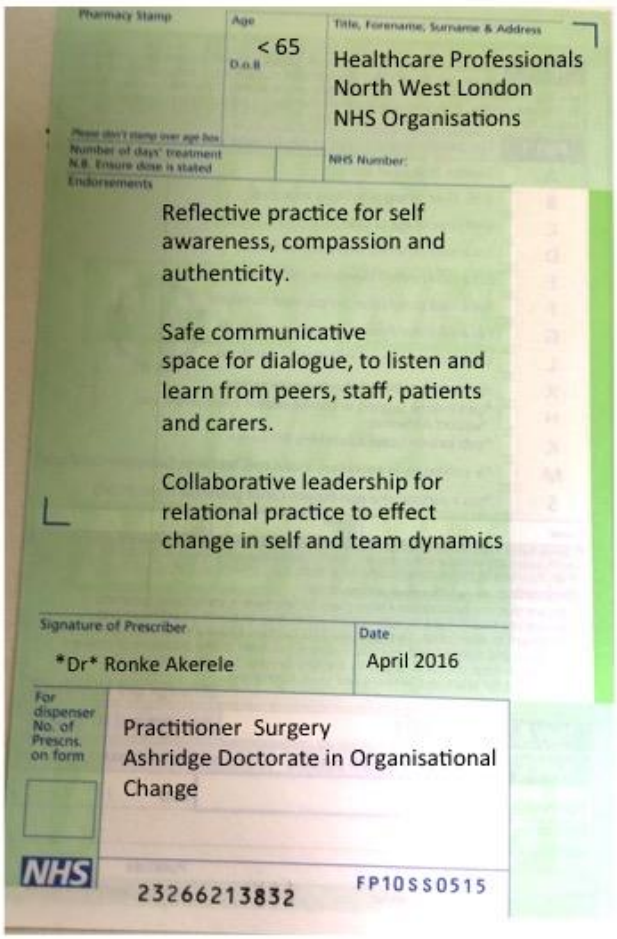

Figure 6: My organisational change prescription

Using the prescription paper as a metaphor aided in opening up and calling attention to the system. Unlike Dr Jeg, who prescribed high-dose antibiotics for me without herself taking the medicine or experiencing its positive or negative impact on her wellbeing and recovery, the peculiarity of my research method is that I have deliberately included myself in the research (authoethnographer) and chosen to consume the medicine I was expected to prescribe to colleagues. As the prescriber, I took the risk of exposing myself to the experience, including the side effects, of what I prescribed. I was on the receiving end of my change interventions; I was a subject of my change efforts.

The next ‘scene’ illustrates my experience of tasting the medicine (including its side-effects) of being a co-inquirer in my professional practice, as I cycled between first- and second-person inquiry. During a research cycle with my FoS co-operative inquiry group, I ventured to participate in discussions in a ‘fishbowl’. As the discussions steered towards an area of interest, I stood up from the outer circle of listeners to take a seat with five men and one woman (who also just sat) in the inner circle to voice my view on the topic. I sat on one of the two empty seats, which was next to the facilitator in the inner circle.

As the discussions progressed, he invited everyone in the inner circle to add their views to comments and respond as appropriate. I signalled a few times to add a comment and sat patiently, waiting to be invited to share my thoughts. Unfortunately, I did not get the opportunity to voice them. The discussion then evolved onto other topics; as I did not have any views to contribute to those topics, I stood up to take a seat back in the outer circle. The activity ended in a lively manner, and I found the comments that followed on the topics that had been discussed insightful.

> “Ronke, how did you find the morning session?” Viola enquired, as she took a walk with me after lunch.
>
> “It was an inspiring session. It’s encouraging to hear what people are learning in their smaller groups and how some are making an impact in their organisation”, I responded.
>
> “Hmmm … we had an interesting discussion at my lunch table about the fishbowl activity in relation to you”, she stated.
>
> “Really….”, I interjected, surprised.
>
> “Yes, we felt it wasn’t well facilitated and managed. We felt it was mostly dominated by elitist individuals, egoistic male breeds, purely medically inclined minds with no iota of respect for any other individual”, Viola stated disgustedly.
>
> “Vicky is particularly irritated by it, and she mentioned that she would share her views on her irritation about that session later in the day if we are expected to provide feedback on the day”, she remarked.

"Oh My God! I exclaimed, with my eyes wide open. I didn't realise you had all spotted that I didn't participate in the discussion. Sincerely, I didn't see it the way you've summarised it – as the people in the inner circle being egoistic male breeds – though I sensed a bit of elitism in one or two of them, as they spoke. I sensed that the facilitator could at least have acknowledged my presence in the inner circle, to create the space for me to talk", I said, unassumingly.

"Ronke, not only could the facilitator have done a better job, but even the egoistical medical men could have made an effort, by keeping mute for a minute to enable you speak", Viola remarked.

"I agree they could have been mute for a minute: at some point, I felt like speaking over them to inject into the conversation, but felt it wasn't courteous so I just stayed mute instead. Awww … Viola, thanks a bunch for sharing your thoughts and lunch table conversation, I feel so bemused that others feel so strongly about it", I concluded, as we hugged.

I sighed deeply, as I replayed the scenario in my head.

I flashed back to work out who had sat at Viola's table during lunch, and would have had these conversations: it was Viola, Vicky, Sam, Alice, Bridget, Lisa and possibly Jane. I subconsciously analysed them as individuals and as a group. It seemed to me that they had some things in common – they were all white, all females, two were leaders with a medical background, four were leaders with a nursing background, one was a middle manager with a nursing background and one a managerial member of staff with no clinical background. From the feedback, what I sensed from their discussion of the activity were impressions of snobbery, power, trust and silence.

As I stood up from the chair in the inner circle during the activity and sat on my chair in the outer circle, I also felt a sense of power, the silencing of voice and the lack of inclusivity. I was not deflated or disheartened about it and just it took as one of those flaws in the method or the skills of the facilitator. In fact, I did not feel that any participant had noticed or would interpret it except me, and possibly other observant facilitators.

I did feel overlooked, but I found it amazing how others got upset and irritated about it and I wonder if I would have felt equally dismayed had I been purely a participant in the outer circle. My instincts say 'Yes', I might have been irritated about it and might also

have categorised the fishbowl group in the way that Vicky *et al*. had done, had I not had a stake in the success of the programme.

I also chose deliberately to enrol as a participant on the FoS programme that I had commissioned for leaders to allow space for the reflection and learning that fosters a culture of trust and transparency. As the programme sponsor, brave enough to enrol myself as a participant and thus be at the receiving end of my own practice and change intervention, I was experiencing along with others what it takes to challenge my mindset and the barriers to change.

It seemed an irony that I had prescribed the pill of safe communication – a space for dialogue in which peers listen to and learn from each other – with the fishbowl scenario. I got feedback from colleagues on their taste of the pill and, through the value of being a participant, I also tasted the pill as my own research subject. Despite my role and the status I had on the FoS programme, I was curious to understand what it truly takes to stimulate and effect change in the system. This scenario gave great input to my reflection on the quality of my practice.

The prescriber–user and prescription metaphor illustrated in Figure 6 made me curious to inquire into race, voice and power, as it became apparent that they were key to the quality of my practice. Based on my observations and reflections about my own practice, and in dialogue with other practitioners, the themes of race, voice and power began to emerge as vital in improvements to leadership and patient safety practices.

4.3. Self inquiry on race

I write on race from the ontological position of my particular reality, which is very specific to the place (Nigeria), time and class I was brought up in. I also write from the perspective of race in relation to healthcare improvement, as opposed to the wider context of racism in healthcare or organisational settings.

My epistemological view on race is based purely on who I am and on my past experiences. I realise that those have coloured my perspectives, and that my perspectives will be different from what other people ‘know’ as true for them. I realise that it is not the prevailing view on race, and my co-operative inquiry with the three BAME co-inquirers (described further below) attests to that, as does the evidence from research.

My curiosity into race in my professional setting emerged from my acknowledgment that the environment in which I am practising is on the boundary of two (British and Nigerian) distinct cultures, in which my race is not the dominant one. My race inquiry helps me to explore my research questions of:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?

I started the inquiry into my race and relational working midway into my research, despite frequent encouragement from my research supervisor to inquire into it. Here is an example of what I mean by 'encouragment' from one of my supervision sessions. On reading about my experience of being invited to take centre stage at national events to present our learnings from our FoS CI initiative and my involvement in being a judge and co-presenter at the prestigious Health Service Journal (HSJ) award ceremony, he remarked:

> *I notice how you are becoming well known and successful as an advocate of this type of research approach. Bravo! I am pleased for you! But, I wonder if there is a seduction in that. How do we ensure when that happens systemically that we stay focussed on the main goal? This is a systemic effect – does the NHS or systems like it do strange things such as turning people into figureheads for issues whilst missing the main point?*

Figure 7: FoS at Patient Safety Congress

Figure 8: FoS at Patient Safety Congress Judge and co-presenter at HSJ Awards

My initial response was to be surprised. I thought I was conscious of not being carried away by perceived fame or losing myself in these grandiose acts. I was determined to keep my eye on the ball, and was conversant with the seduction that comes from being thought of as a figurehead. However, on reflection, it dawned on me that I cherished every moment of becoming 'well known', and the perception of being used as a figurehead did not register within me for a second. What is that about ... was I perhaps being seduced by some external gratification? Is there perhaps a hidden aspect to being on stage?

Oh my … have I become defensive here? I murmured, as I reflected on his comments. But why should it be that, when a non-dominant race speaks on stage (a very rare occurrence in healthcare) at highly acclaimed events, presenting the achievements proudly attained through our innovative CI approach to leadership practice, there is the connotation of being used in a tokenistic tick box exercise? Could there be an element of truth in that, despite my having been invited to centre stage at three events to share learnings? Then so be it! After all, it takes two to tango – it takes two for someone to be used: in these cases, the event organiser and myself.

Reflecting on what I wrote, I take a pause ... I take a breath... As a woman, as a black woman, I recognise that I literally add colour to a stage full of predominantly white influencers. Assuming that the event organisers may also have invited me to include minority groups (leading to me being the only black person on stage) or to deflect accusations of discrimination, why then can I not be unapologetically grateful for it and take this as an opportunity to gain credibility, brand and accolades for myself, whilst I enjoyed the privileged experience.

It just does not stack up for me. Come on … were my fellow (white) speakers who also graced the centre stage being used as well? (Eyes rolling.) Of course, one can argue that their race is invisible. I sincerely believed that, in these three instances, if it had been any of my white colleagues who had led the FoS initiative and achieved similar outcomes, they, too, would have been invited to share their learnings with the audience.

Following the comments from my supervision session, I took on the challenge to inquire into my race and the effect it has on my professional practice. As I began this cycle of inquiry, I received these comments from my out-going CEO at my last appraisal meeting with him:

Ronke, this might sound odd, but I need to mention that I am very impressed by the way you carry your race and colour. You do it beautifully well. You are one of the unique women of colour that people should emulate.

– Paul (a white male CEO)

I blushed as I heard Paul's comments. It felt strange to hear him speak about my race. It tends to be an unspoken topic when interacting with colleagues within public sector organisations. Having worked with him for three years, I was interested that he had observed my disposition towards all things concerning race relations and diversity.

As I pondered his comments and the encouragement from my research supervisor, it aroused my interest in inquiring further into my race, which is grouped as BAME. My inquiry into race inequality is relevant for patient safety, as there is clear evidence (West et al., 2012; Kline, 2014) that the workplace treatment of BAME staff is a good predictor of the quality of patient care and patient experience.

Extensive research (Kline, 2013, 2014; Limb, 2014; Priest et al., 2015; Stevenson & Rao, 2014) has established that discrimination, harassment and exclusion are pervasive experiences for staff from BAME backgrounds in the NHS. Whilst I acknowledge that, so far in my career path, I have not experienced discrimination or harassment directly, it is apparent that these are prominent in the system.

The NHS recruitment processes have been shown to favour white applicants disproportionately (Jaques, 2013; Kline, 2013; Priest et al., 2015). BAME NHS staff experience discrimination in recruitment, and evidence (Becares, 2009; Jaques, 2013; Kline 2014) shows that they are three times less likely to secure a senior role than white staff. Sadly, this situation has not changed significantly in over 20 years (Esmail & Everington, 1993). In his final interview (HSJ, 2014) before retirement as NHS England chief executive, David Nicholson said that he "regrets not making more progress in increasing the number of black and minority ethnic senior NHS leaders". He asserted that "senior NHS management was too monocultural", and he described the barriers to improvement as a "systemic problem". When listening to statements like this, I wonder how I can bring some change, if someone like David Nicholson cannot. In some ways, it feels essential to contribute to this change, being one of the few black and minority ethnic senior leaders in the NHS. My inquiry into this with other BAME practitioners provided insights into our lived experiences, which contributes to the wider discussion on race in the NHS.

So what are the facts? Across the UK, 43% of the NHS workforce and 7% of very senior managers are from a BAME background (Kings Fund, 2018). London as a NHS region is a city where 41% of NHS staff, and 45% of the population are from BAME backgrounds (Kline, 2014). There is evidence (Esmail et al., 2005; Kalra et al., 2009; Kings Fund, 2018) of substantial under-representation of BAME staff in senior leadership positions in the NHS, including on Trust boards. These figures made me reflect on my position of "marginal privilege" and how it serves and relates to me as a practitioner in my practice of change. How does it emerge for me? Having received comments on my race from white co-inquirers (ADOC cohort, CEO, ADOC Supervisor), how do other BAME people see me?

My curiosity about these questions led me into undertaking a co-operative inquiry cycle with three other black women in middle management roles within the healthcare system on their experiences of race. This is an illustrative audio-recorded account of a dialogue during our inquiry:

Co-inquirer 1: I have stopped aspiring to get to that floor up there. There is no one of my colour there. The generation after us might be lucky to secure a seat.

Co-inquirer 2: I doubt they even want us there, name it … I have done it, some of them don't even have half the qualifications I have. It's very demoralising. It is the subliminal messages, lack of role models and lack of support networks that make it twice as hard for us BAME people to achieve, so we invariably don't. Those who manage to reach their potential do so at a later age than their white peers.

Co-inquirer 1: It's very sad that in this modern age, despite all the policies on equality, nothing has changed in the colour that occupies those seats.

Ronke: I sincerely wish I could share your frustrations or resonate with your comments, though I can see that they are valid as indeed I can count the number of BAME people across London in executive positions on my fingers.

Co-inquirer 3: Ronke, you are very fortunate to be one of the very few. Your tenacity has brought you this far. You will not share our frustrations because you didn't have these race scars on you

from your childhood. If you had grown up in this country, I doubt you would be where you are today.

Ronke: Really … that's surprising. I would have thought those of you that grew up here had more opportunities than those of us who migrated as an adult. After all, I have an accent; I don't have the privilege of benefiting from an alumni network of primary, secondary or university school friends to get links, etc.

Co-inquirer 3: All those didn't matter, when we were growing up in these schools – we hardly mixed. Our parents were low in the social class settings. They raised us up with money from the menial jobs they did. They came home with tales of how they were mistreated at work by their white bosses. They stayed in jobs as a means of livelihood. We didn't have any family members or people in our network that had middle class jobs, no mentors to help us aspire to become something. We grew up with horrid stories of oppression amongst blacks.

Co-inquirer 1: Back in school in those days, the only knowledge of blacks the teachers had was of blacks as slaves. History has taught us that the whites are superior to the blacks. Those stories were hurtful and broke the dignity of us black people. And of course, when we looked around us then and probably up until the past decade, there were indeed no blacks in senior management positions, nor did we have any support networks to guide us in flourishing.

Co-inquirer 2: In fact, getting our first jobs in an organisational setting in our early thirties called for celebrations. Regardless of being entry-level roles then, it made our community proud of us and slowly we exposed others to similar vacancies.

Ronke: Hmmmm [a deep breath] it's insightful to hear from you all. I can only imagine how such an upbringing could have formed your perceptions on career aspirations, and possibly those of many other black Africans/Caribbeans who have been raised up here in the 1960s to 1980s. It's a big contrast to my upbringing, where my parents held high positions and were leaders in our society, despite the cultural differences amongst the diverse 20+ ethnic groups in Nigeria that lived in cosmopolitan Lagos.

Though my parents lived here in the UK in the mid 1960s to early 1970s, they came here as students for undergraduate and postgraduate degrees, with my Dad obtaining a PhD. Once they completed their studies, they worked here for about three years in their chosen profession in corporate organisations and returned to progress their careers and raised us all at home.

Co-inquirer 1: It's interesting to hear of your parents' background and coincidentally I have met two other people who are breaking glass ceilings like you and guess what you have in common? Your parents returned to their countries with their children in the 1970s, and these two other people also came back in their mid-twenties, focussed to achieve their career aspirations irrespective of race or gender. Sometimes, I feel our parents held us back – they should have just returned to their countries.

That dialogue brings to the forefront my upbringing, which I summarise now. I was born into a wealthy, political and influential family, and in my childhood I had "a silver spoon in my mouth". At the early age of three, when I could confidently articulate a sentence and engage in the surroundings I lived within, my father was the Minister of Science & Technology, a senior member of the executive ruling council and an influential person in the country I originate from (Nigeria). He later also became a senator and a diplomatic ambassador. My parents were educated internationally to the highest standards.

Throughout my preparatory and junior high school days, I remember the luxury I lived and grew up in. My siblings and I went to the so-called posh expensive schools in the country, being taught by international/expatriate teachers from well-advanced developed countries, with infrastructure in the schools that was not seen in other schools locally. During my childhood and early adulthood, I often spent summer holidays in the UK and USA and, of course, as the currency exchange rates were very strong and stable in those years, such holiday trips came with money to spend in shopping trips to the west end whilst staying at 5 star high-class hotels and serviced apartments. As was the norm, we had live-in domestic help, home security guards, chauffeur-driven cars, and were surrounded by people who were at our beck and call.

Then, 19 years ago, on completion of my BSc degree, I relocated to the UK to commence my master's degree. I had the choice of returning to Nigeria on completion

of my MSc degree to start a role in a corporate organisation, based on my family's connections, or to stay in the UK and find a job with no links to anyone to offer me a role. The decision to live in the UK came with stern warnings and an unwritten contract from my parents, which stated: "You are not allowed to do menial jobs. If you settle for any job below a graduate-level role, you will be on the next flight back home. If you are focussed and work hard – the sky is your limit." Such stern words from my parents shaped who I am today. I took them on as truth and I started to live up to those words. They made it clear to me that, irrespective of my background or race, whilst living in a foreign country I had to aspire to the best and shatter glass ceilings. My parents embedded in me that success was achievable, and the only stumbling block was myself.

This perspective sheds light on why race is constructed differently for me when compared to my BAME co-inquirers and other people of similar race in this country. I come from a family of high social status, and this seems to create a different perception of race – which might not have anything to do with being black or white but be a perception of where I belong in the society, whichever society I reside in. It seems that the model I fit into and belong in in any society is one of significant social status. Though I reside in the UK, I have very close connections to Nigeria. I have remained resolute that the level I achieve in my professional career should fit with the social class I belong to in Nigeria, in which almost all my contemporaries are leaders in their ventures in corporate or entrepreneurial life.

From a wider BAME perspective, there are concerns about inequality in relation to race in the society we live in. People of my race get into a car and worry about being pulled over by the police; they worry about being treated unjustly in society; and I have heard stories of many black people with an upbringing in this country who grew up in fear.

The culture of the NHS is sustained by a set of core values, including respect and inclusion. The question could be, does the NHS bring those values to life? With the diversity of the NHS workforce, a commitment to treat everyone with respect is of particular significance. The investigative inquiries (Berwick, 2013; Francis, 2013; Keogh, 2013) all highlighted shortcomings of a culture that fails to value and respect staff. With widespread acceptance that a transformational rather than transactional leadership style is needed to improve quality and safety, it is paramount that we address the systemic discrimination towards BAME staff within the NHS. The inquiries sanctioned the view that we should create a culture in which staff are valued. Such

recommendations would apply, among others, to the most undervalued and least rewarded group of the NHS workforce – BAME staff.

In acknowledgement of the limited progress in achieving the goals of the NHS Race Equality Action Plan (DH, 2004), the NHS has now agreed a mandatory workforce race equality standard. The standard requires NHS organisations to collect baseline information from April 2015 on nine indicators of workforce equality for ethnic minority staff. Organisations that fail to make progress on these indicators will be in breach of the NHS standard contract, which might affect whether regulators judge them to be 'well led'. It is early days to review the impact of these standards. Whilst I welcome the well-meaning intention of these standards to provide more opportunities for BAME staff, I also have an uncomfortable feeling of twitchiness that such indicators can become tokenistic.

Kline (2014) concludes that a key hindrance to the lack of representation of black and ethnic minorities in senior leadership positions is stereotyping and the preconceptions of others. On the other hand, the evidence of best practice to promote ethnic diversity from other sectors (Priest et al., 2015) has shown that mandatory policies backed by committed leadership across all levels of an organisation work.

At a national conference at which I was invited to speak about FoS in November 2015, I received lots of positive feedback and compliments, as various people walked up to me after the session.

> "Hello, excuse me", he beckoned to me, as he walked hurriedly towards me to catch my attention.
> I stopped in my tracks. We exchanged pleasantries and introduced ourselves.
> "Sorry to stop you. Have you got a minute? I would like to ask you a personal question", he enquired.
> "Yes, go for it", I muttered, as my mind wandered elsewhere
> "Your accent, did you school here? I mean your name is of African origin and I just wondered if you've always schooled in the UK, but from your accent I wasn't sure", he enquired.
> "Oh…Not really, I did my early years education up until completion of my bachelor's degree in Nigeria. I then returned here in my mid-twenties to further my education with my Masters degrees" I responded, puzzled, as I became at ease with him.
> "That makes it even better and make me really proud", he exclaimed. "A big well done to you. I am surprised you didn't go to the posh independent schools

> growing up, or graduate from Oxbridge. I am really impressed by your achievements in your bio in the conference booklet. You spoke really well, and the audience really liked your presentation. There have been loads of tweets on you. I have been coming to this event for eight years and it's the first time I have seen a black person on stage. You've made all of us proud. As a black clinician and Lead Surgeon, I know that there isn't a lot of our colour in top management positions and it's really good to see you there. That's inspirational to other people of colour", he commented happily.
>
> "Auuuuhhhh…thank you. I appreciate your compliments and it's sure made my day. I am really glad you and others found it inspiring", I responded, grinning as we parted ways.

As a leader in the NHS, I frequently receive motivating comments from BAME colleagues. For them, knowing and encountering a leader of African origin is inspirational. This particular feedback stands out for me, as I remember my experience at the event. I shared the feedback at my progression panel session in January 2016 and, to my utmost surprise, I had teary eyes as I finished describing the experience. My waterworks had shown up again – one of my ways of voicing that I explored earlier in this chapter. I reflected on that, curious once again to understand what my body was telling me – what creates such emotions from discussions with others? I had been greatly at ease in the progression panel session, as it was a lively, curious and, at the same time, safe environment where I thoroughly enjoyed the thought-provoking and insightful discussions with everyone involved in my practice viva. Through various inquiry cycles in my reflective practice, and my first-person inquiry in particular, I have come to learn more about it, to appreciate and welcome its appearance as indicating that I have been touched by something.

There is evidence (West et al., 2012; Kline, 2014) that there exists a correlation between the treatment of BAME staff and the care that patients receive. BAME staff also witness discriminatory treatment of BAME patients (Stevenson & Rao, 2014). The workplace treatment of BAME staff is a good predictor of the quality of patient care and patient experience. For the NHS genuinely to achieve its ambition of improving the quality of patient care and patient experience, in a setting where 43% of NHS staff are BAME (Kings Fund, 2018), there needs to be a deeper understanding of the complexities of race. From my lived experience and inquiry, such complexities include a shift of mindset to one of valuing other people, irrespective of their racial history, and acknowledging the role of power and voice in relational dynamics, without simply expecting individuals from BAME backgrounds to 'fit in'.

4.4. Self inquiry on voice

My inquiry into voice explores the various scenes described in earlier sections from my upbringing, my ADOC engagement with peers and faculty, and our practice together as co-inquirers.

My curiosity is about voice behaviour that speaks up and speaks out constructively in challenging the status quo surrounding self, processes, systems and practices to effect change. It is in the context of my personal and professional practices, and is to aid in exploring my research questions of:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?

The term 'voice' that I am intrigued by originated from Hirschman's (1970, p.30) model of exit, voice and loyalty, in which voice is referred to as "any attempt at all to change, rather than to escape from, an objectionable state of affairs".

Voice research has since expanded, with many organisational voice scholars and researchers (LePine & Van Dyne, 1998; Edmondson, 1999; Morrison & Phelps, 1999; Morrison & Milliken, 2003; Liu et al., 2010) agreeing that voice is good for work and has beneficial effects for employees, such as a sense of control and the feeling that one is valued. Conversely, silence creates dissatisfaction, stress and cynicism (Morrison & Milliken, 2000; Perlow & Repenning, 2009). Morrison and Milliken state that, despite the advantages of diverse perspectives, employees still "feel that speaking up about issues and problems is futile or, worse yet, dangerous" (2000, p. 721).

In understanding myself as a practitioner–inquirer, I discovered the different voices in me, a construct that enabled me to conquer my fear of speaking out (voice towards peers) and speaking up (voice towards managers). Liu et al. (2010) argue that "employees make the distinction between speaking out and speaking up, and that they are most likely to voice their thoughts toward a target whom they strongly identify with".

In our healthcare organisations, the notion of speaking up if you see something of concern is anything but simple. From my experience, stories from co-inquirers in this

thesis and the various research data sources highlighted in chapter 2.4, it has been affirmed that we as practitioners see things all the time in the course of practising our profession and in engaging with patients where there are opportunities for improvement. Yet, rather than engage our voice to speak out and speak up, most choose to remain silent.

In my interaction with a junior doctor following the serious incident described in Appendix 6 and referred to briefly in chapter 3.3, I learned that his choice of silence was influenced by his perception of what his clinician peers would think, a fear of damage to relationships and a fear of isolation. The choice to stay silent is also learned, tolerated and reinforced in the hierarchical hospital culture. Most staff members are subordinate to other managers; most managers also have bosses. It has been stated that such intensely hierarchical cultures impede the constructive use of voice for service improvement (Edmondson, 1999; Morrison & Milliken, 2003; Liu et al., 2010; Morrison, 2011). Most middle managers serve as linchpins between the workforce and leaders, and could use voice to influence change on the issues that the workforce raises.

McClean, Burris and Detert (2013, p. 529) state that “managers who influence the decision-making process of senior-level managers have the ability to advocate for issues that employees raise”. They attest that, if there is a lack of managerial responsiveness and an inability to respond effectively to voice and act on employees’ ideas of improvement, voice leads to negative outcomes, and employees resign. In April 2016, in addressing the freedom to speak up and challenge in the NHS, the regulators and commissioners produced a policy document, entitled *Freedom to speak up: raising concerns (whistleblowing) policy for the NHS*, There is yet to be a study or evaluation of whether this policy has thus far made an impact in creating the step change needed in the system.

My inquiry into voice and its effect on my self guided me to be willing to speak up and speak out. This then went beyond my first-person inquiry, as it opened up to and provided opportunity for others in my second-person inquiry using the co-operative inquiry method to inquire into their individual and collective voices being heard as they speak out and speak up. Further examples of research on voice with other practitioners and co-inquirers in my professional practice are described in chapter 5.2.

4.5. Self inquiry on power

In my research, I started to identify patterns of power and encountered this dilemma in myself. This inquiry thread made me somewhat uneasy, requiring me to look inward

into my interior power dynamics, including their links to my personal upbringing, to historical patterns and to insights on my upbringing. My use of self-reflective and co-operative inquiry approaches led me to ask how power relations and prevailing interpretations of power shape the rules of my personal and professional practice.

My exploration into the research questions of:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?

led me to further questions, such as How do I grapple with the operation of power in my personal life? What are the processes through which power operates that inform whose voice is excluded and whose is heard? What are the links between power and social change? What is the power relationship between groups?

I explored these questions through my self-reflective practice and in dialogues with co-inquirers. My inquiry focus was on informal power, which is distributed throughout a setting and operates in all relationships, and which shapes the development process. Power is contentious because power as a concept can be understood in many different ways. My personal history, cultural context and ideological position add to the diversity in the understandings of power.

This then leads to inquiring exactly *what is power?* Weber (1947) defines power as the ability to control the behaviour of others, even in the absence of their consent. Weber linked power with concepts of authority and rule. An actor should be in a position to carry out his will, despite resistance to it. My experience of this form of power, in a setting in which the military willingly activated power, was that it led to domination, command and control and authoritarianism, with no respect for the interests, voice and freedom of human life. This form of power submerged the views of other actors.

The writings of Michel Foucault (1980, 1990, 1991) marked a radical change to previous schools of thought on the concept of power. For Foucault:

> "Power is everywhere: not because it embraces everything, but because it comes from everywhere. … Power is not an institution, nor a structure, nor a

> possession. It is the name we give to a complex strategic situation in a particular society (Foucault, 1990, p. 93).

He rejected the notion of identifying those who possess or lose power. His approach was to decentralise the position of power.

As opposed to the theories of Weber and others, Foucault's view is that power is not something that can be owned. It cannot be possessed, but rather is something that can be diffused, and enacted without a subject, manifesting itself in the form of a chain without individual actors. It should be conceived as an element of broad 'strategies' that have to be exerted and which cannot simply be acquired. "Power is employed and exercised through a netlike organization . . . Individuals are the vehicles of power, not its points of application" (Foucault, 1980. p. 98). Consequently, Foucault moves the concept of power away from oppression of the powerless by the powerful or a reduction to master–slave relations. This view is the opposite of Weber's, who regards power as a form of oppression that forces individuals to obey.

> *We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production* (Foucault, 1991, p. 194).

Gaventa (2003) agrees that power is not necessarily a negative or repressive thing that forces us to do things against our wishes, but can also be experienced as a positive and productive force in society.

I grew up with the meaning of power as: "Power tends to corrupt, and absolute power corrupts absolutely"- Lord Acton, 1887. My view of power was shaped by my own experience of engaging with power relations in a political and cultural context. I grew up in an era of repressive military governments who, through their power, forcefully overthrew democratically elected governments via military coups that suppressed the voice of citizens. It was a society in which the dominant culture included a stereotypical role for women as 'housewives', in settings in which wives were subservient and expected to be seen and not heard, living in extended family units. As a child, I saw the overpowering of citizens and the disempowerment of a gender. A kind of normalised fear of power unconsciously occupied our lives. We accepted such power positions for the sake of the stability that they provided, as the short-term benefits were better than

rocking the boat through radical change. With democratic government back in power and with the advent of the modern age, radical change in the expression of power emerged in the past decade.

This inquiry focussed mainly on the intersection of power with processes of engagement. It understood power as constructed through patterns of social relations, enabling a change in the way people relate to each other, including changing the meanings we give to our relationships.

Power is described in different ways. VeneKlasen and Miller (2002, p. 55) describe **four 'expressions of power'** as follows: **'power over'** (the ability of the powerful to dominate the powerless); '**power to'** (the potential to exercise agency to shape one's life to act or voice); **'power with'** (the synergy that emerges through collaboration, mutual support or collective action with others); and **'power within'** (an ability to gain a sense of self-identity, self-worth and recognition of individual differences). With power being a vital attribute for relational ways of working, expressing power positively as something to use in effecting change is vital. My inquiry explored whether individuals could be empowered to gain 'power within' and 'power with', which could be expressed as a new 'power to'?

At the outset of the FoS initiative and my co-operative inquiry within it, I was concerned about how to run CI, given the idealisation of equality, within a hierarchical system which contained people who may not feel equal. As Gaventa (2006) affirmed, power must also be understood in how spaces for engagement are created and the levels of power in which they occur. I began to notice the presence of the power that comes with facilitation – the facilitators' use of power was crafted skilfully in the service of creating a communicative space for collaboration amongst us all, and for the group to flourish. By the end of the second inquiry cycle, equality seemed to have been the norm, and the power that potentially comes from the 'facilitator–participant' split felt non-existent. I was especially surprised by the Non-Executive Directors engagement in the process. Despite their being board members at the top echelons of the organisation's structure, they did not exhibit a persona of being powerful, which brought ease to the other participants, so that they could feel safe to speak out.

Power over

From my background and professional practice, something about power led to defeat when voices had been raised and when voices had been silenced. My understanding of power was expressed as 'power over' and was shaped by the social order,

supported by the threat of intimidation. In my experience, such use of power in our political landscape in Nigeria was practised as command and control. It was used to dominate and to prevent others from gaining power. The hospital setting within the healthcare sector is predominantly hierarchical, which creates huge power disparity. Use of power amongst colleagues in a densely hierarchical structure has led to a win–lose relationship; decision-making is made in isolation of people on the ward floor who are at the forefront of delivering care, and that has contributed to patient safety issues. Both experiences produce negative connotations of power for people, such as abuse, oppression, discrimination and corruption.

At the FoS's fourth co-operative inquiry session, the following remarks were made during participants' check-out slot, a point at which individuals shared whatever had intrigued them as we closed the session.

> *It's intriguing that I have learned so much more from the conversations taking place here than I have learned from the voluminous board reports I have being reading for the past three years since I became a board member. I feel so uncomfortable with the disconnection at the board table, where other NEDs and I engage with executive directors, reviewing highlights from incident reporting and colour-rated improvement action plans. The power other NEDs and I have over the organisation is huge and, until the last quarter's session, I hadn't realised how such power distanced us from the undiluted truth – the hierarchy in the organisation doesn't foster safe discussions.*
>
> *The dialogues I am having with you individually or as a group are changing my mode of practice. I went on my first ward round last week, where I spent a full day on the wards working as a volunteer, and it truly confirmed most of the stories I have heard here. What I really enjoyed about it was that the staff didn't know me. They welcomed me as a volunteer, which helped them to relax around me whilst conducting their daily routines. It's been four days since that visit and I have been reflecting daily on my experiences and what I will be doing to ensure my other board members are exposed to the undiluted truth to aid them also to change their practices.*
>
> Co-inquirer (Non-Executive Director)

Her voice became shaky as she finished her comments; her reflection was heartfelt and seemed to have connected with some of us in the room. Her comments resonated with me as, until I tasted my own medicine during my childbirth experience, coupled

with developing my self-reflective practice on my inquiry journey, I did not realise that indeed I needed to change my approach to the way my role expresses 'power over' others. As the NED had done, I experienced the conviction that engaging with the workforce in a relational manner led to safe discussions that enabled us to challenge perceptions and learn from each other's roles, and minimising the tension or conflict that are offshoots of power.

Power to

Acknowledging my 'power to' achieve the best outcome with the prescribed medications in relationship with myself and others requires me to accept that I am powerful and then learn to exercise my power with firmness and grace.

> "You are in a powerful position. By virtue of holding the job role you have, you have power. You can hire and fire people. You engage and regularly present at board meetings to over 14 CEOs of NHS organisations across NWL. You can address 14 AHSN CEOs across the country, and they would listen to you. You are indeed in a powerful position to do good things," remarked my Coach.

By virtue of holding the role I have, I am in a powerful position! Yikes … eyes rolling as I type. Stating that publicly and appreciating and acknowledging it internally can come across as pride, snobbery and being a dictator. I have these feelings, yet none of these attributes resonates with me. I felt that I had failed to acknowledge the fact that I am indeed powerful.

I owned and leveraged my own 'power to' design the innovative crafting of the FoS initiative and won the hearts and minds of 18 CEOs of NWL NHS organisations to release their leaders to participate in the programme. My 'power to' shape such an initiative as a real-life co-operative inquiry has benefited the system, whilst simultaneously benefiting my doctoral inquiry. My belief in initiating the CI group was based on the premise that each individual has the 'power to' make a difference. Based on the sign-off and support from CEOs across NWL healthcare organisations, it opened up the opportunity for joint action and 'power with'.

For some of us, 'power to' is expressed easily through self-confidence and a belief that each one of us possesses the power to make a difference by shaping our life and world. As we have experienced on FoS, when 'power to' is based on mutual support, it opens up the opportunity for joint action, or 'power with'.

Power with

In our co-operative inquiry, ‘power with’ was dependent on individuals releasing their power through a self-conscious process. Participants on the FoS found common ground to inquire together via their SIG, building collective strength to improve specific areas on patient safety. Based on mutual support, collaboration and power with diverse individual talents and knowledge, transformation was brokered and achieved.

> *The greatest benefit of the FoS and the inquiry process to me has been the networks, connections, new friendships and relationships I have formed whilst pulling together to bring about change to our ways of working and improvement to the organisation. These connections have been forged [to last] beyond the life of the FoS programme.*
>
> – Clinical Governance and Safety Manager

Through our practice of collaborative leadership and relational practice, multidisciplinary teams across the interfaces between acute and community care and beyond created conditions to improve staff and patient safety.

> *The new approach to ‘handover meetings’ has been transformational. The meeting now includes all acute medical, surgical, anaesthetic and bed management teams. It has aided appropriate decision-making in the best interest of the patient that is being cared for by members of the team and has put the healthcare professional at ease in treating the patient safely, as it removed the fear of ‘not knowing the care pathway journey of the patient’.*
>
> – Consultant Diabetologist

> *I have greater confidence to talk with diverse multidisciplinary colleagues in a different team and/or organisation, which has helped with being able to influence what comes next.*
>
> – Junior Doctor

The expression of ‘power with’ has helped to build bridges across different interests to transform and minimise conflict in relationships.

Power within

In an environment in which most of the media coverage of your professional practice is of failings of the system and where public inquiries are undertaken when things go wrong, ‘power within’ is fading away. The workforce is coping, and in some cases struggling, under the increasing demands on their time. ‘Power within’ is the capacity to

imagine and have hope; the idea of there being space to be imaginative and act for change is becoming far-fetched for most healthcare professionals.

At one of our FoS sessions, we invited a guest speaker who is a highly accomplished and formidable CEO for one of the largest NHS Trusts in the country, with over 9,000 staff. It was an interactive dialogue with participants, who shared their challenges in our group discussions with the CEO. Concerns raised included:

> *As a Divisional Clinical Director, I work closely with my clinical colleagues. Despite our knowledge of what we can do to improve service delivery and patient care, our views are not considered or asked for and we only see the forced change to processes after they have been implemented. These hardly make a difference in the long term, as such changes are always imposed on the team.*
>
> – Acute Medicine Clinical Director

> *We've seen some methods and best practice interventions working in other organisations to improve quality and patient safety, but it's always so daunting to implement it in our Trusts, as we tend to wait for board approval.*
>
> – Associate Medical Director

> *It's just so hard to have time to think out of the box or engage with ward staff during our daily busy schedules on implementing improvement initiatives that we are aware will make a difference both to staff safety and to patient care.*
>
> – Quality and Safety Manager

The CEO's response to these points was:

> *Why are you seeking permission to effect change? Why do you need the board or an executive team to empower you to act? You are all senior managers in your respective organisations, yet you are awaiting permission, despite your power to do as you so wish. You should have the power within you to act, as an individual, a team or a directorate to effect change so long as you are not doing anything that breaks the codes of conduct of clinical care.*

Her response and challenge to us made us ponder deeply on the notion of awaiting permission to improve care quality. It brought to light how we as individuals, despite

being in senior roles, have unknowingly relinquished 'power within' to shape the effectiveness of work and improvement of our practice, yet placed the responsibility on others. It occurred to most of us that small changes that produce a big impact on improving patient care could take place in reality without obtaining any permission.

The initiative we have undertaken in our SIGs evidenced that our small changes produced ripple effects on other colleagues across teams, as they became empowered to act for change without permission. "The SIG gave us confidence to proceed. We didn't wait for permission", remarked a Deputy Director of Nursing. The understanding of what is possible or even doable is formed by historical context or organisational history in enacting change. Hence we have found that it is difficult to create new ways of working or form relations, even when spaces for dialogue and change are opened up. Enacting 'power within' affirms our search for self-worth and fulfilment.

Power to empower

Through my doctoral inquiry, co-inquirers and I reconceptualised our own power positions and our capacity to develop 'power within' and 'power with'. As senior leaders in our respective organisations, we have challenged ourselves in expressing and sharing power more appropriately.

> *I have stopped thinking of power relations as them and us.*
>
> – Consultant Anaesthetist

> *Some of us just want to resist power. It has been a learning process for me not to internalise conflict and to have a counter-aggressive reaction to power.*
>
> – Consultant Psychiatrist

In addition to thinking about these comments from co-inquirers, I have consciously made efforts to be reflective, especially in confrontational power relations which bring with them emotional stress. My journaling and self-reflective practice have helped in nurturing me during such confrontational times. These strategies have enabled me to maintain openness to learning during periods of conflict and stress. The challenge for me remains the development of trust of a genuine collaborative working ethos to alter power relations in confrontational situations. I have experienced that the way to confront negative dispositions in power relations is to address issues of power in daily professional practice.

Feedback from co-inquirers on how they have been able to develop the power to empower included the following:

> *At our performance management meetings with providers, I now sit down, listen and learn. I have changed my approach to engaging in these meetings, which has been tremendously valuable to all parties.*
>
> – Quality and Safety Commissioning Manager

> *I do a lot of asking these days. I ask patient-facing staff what they know, their priorities, their ideas, advice and views. It's been refreshing as they come up with ideas that are new to those of us in the executive team.*
>
> – Director of Nursing

> *One major thing I have learnt from developing my self-reflective practice is to shut up! It's surprising how hard it is to practise the empowering power of silence. It has really helped in my relational practice with others. I had assumed that no one else had noticed my practice of silence in understanding others, until I received three different positive feedbacks from people on their observation of my change in practice with my approach to listen more.*
>
> – Medical Director

I have come to realise that, irrespective of role or organisational position, people hold authority and have 'power to' influence beyond their immediate team and to have an impact on the delivery of services. In our CI, we experienced the redistribution of leadership power within and across teams, departments and organisational boundaries to whoever has the expertise. The individual with the 'leader' title enabled team members to exercise power within their capabilities and in the service of situational demands.

> *During the dreaded weekend night shifts, I am a bed utilisation duty manager; on a calm Tuesday afternoon, I am a Divisional Nurse Lead, depending on what is needed in order to deliver quality patient care. Sometimes, I am the big cheese and in charge, sometimes I am clearly not.*
>
> – A co-inquirer, Cycle 4 SIG Meeting, August 2016

Such experiences of repeated shifts of power have become a norm for many who are working with a collaborative leadership approach. They are, however, at odds with the

prevailing culture in our NHS organisational settings, which is predominantly one of a hierarchical structure within groups.

My practice of power has become an unstable element that is embodied and socialised. As such, my power relations are regularly renewed and reaffirmed.

4.6. Research Findings

As I thought about my formative experiences, various triggers for the use of my inner and outer arcs of attention (Marshall, 2001) have emerged. These have made me emotional, alert, practical, intuitive, creative and multi-sensing and have enabled my inquiry to be open to greater opportunities of learning by being inquisitive and staying responsive to moving between the inner and outer arcs of attention. It was insightful to note the formation of the psychological scripts in childhood that get activated by a certain stimulus in adulthood that catapults a perfectly competent and capable adult into a place in which they become the child that they once were. My inquiry into self has enabled me to interrupt and do away with potent introjections from my upbringing and cultural background, enabling me to own my independent adult voice. Based on my first-hand experience, I know that it can be hard and a huge challenge for an individual to have the courage to speak out, especially if their views are counter to dominant thought.

From my experience of self-reflective practice during my doctoral inquiry, I came to understand that my personal and social histories cannot be ignored, and neither should my voice and power, as they shape my life. Not until I was able to come to terms with them within myself could I develop a meaningful social relationship with others. My development of self, in addition to meaningful relational practice with co-inquirers, led to the impact achieved (outlined in Chapter 6.2) on FoS.

From my experience, voice is a broad and complex construct which, if withheld and stifled in an organisational setting, means that both the individual and organisation may suffer significant consequences. All my experiences described in this chapter of inquiry sessions with my ADOC cohort, my engagement with professional colleagues on FoS and beyond, and my experience at national events have intertwined and paved the way for me to find voice, give voice and shape, and come to ‘voice’.

I am at times still astounded by the fact that I do speak up more now than ever before. It shows to me the strength I have developed to engage more freely in the

‘unspeakable’ at various instances, and how I have mustered the courage to speak up openly on what I could have perceived as ‘something that upsets’ two or three years ago. I know I am now speaking out in a purposeful manner, regardless of the dominant thinking paradigm. My learnings from my first-person inquiry have enabled me to stand tall, hold on to my deepest ethos, push through my fears and speak forthrightly, which was once upon a time frightening to me.

This cycle of inquiry gave me a broad sense of how courage, power and voice link with the phenomena of transference and transactions in engaging with individuals. I became more disciplined in reflective thinking, developing myself to hear what others truly say, with more tolerance of diverse interpretations of events, rather than just ‘seeing’ my interpretation using action research methods. Being an autoethnographer change practitioner, I was “coming to see that the problem is more ‘us’ than ‘them’ ”, so I became consciously self-reflective as I chose to start with myself. It was easy to point fingers without looking at myself. Gradually, my attention swayed from them, to me, to the world I was sharing with them. I became the captain of my ship and also the waves upon which the ship sails.

The change I was advocating had first to start within. Being vigilant in understanding the ‘stuff’ going on in me within the settings I exist in was vital to supporting others. As I participated in my FoS CI sessions and other work-related meetings, I was continually reflecting on how to conduct myself, how to articulate – engaging in first- person action research in the moment. I moved between different frames whilst judging my potential purposes. I observed how my inquiry in the moment often took the form of overtly reviewing different ways of making sense of meetings and then jointly considering appropriate behaviour.

Listening with great interest to understand differing views brought rich insights for me, such as the way in which I identify with different views inside myself. I found that I could manage the varied threads, including the uncertainties, to co-exist, allowing different views alongside each other rather than seeking one joint perspective. I was previously uncomfortable about this, as I had preferred a more settled, one-sided form of truth. Developing such an attribute has helped me to improve my professional practice of change management, as I became more flexible in allowing people to have different constructions of processes, experiences or events, I observed a growing freedom in myself at the same time.

In my inquiry into self, I have come to acknowledge my race as part of my identity. In particular, I find it is a trait that has consequences for my public role and the role other people are constructing for me. In trying to balance the 'we' (other BAME colleagues) and 'I' narration conundrum, it is hard for me not to conclude that indeed race inequality exists in the system in which I co-exist with other practitioners.

I have come to appreciate that stories matter: stories from the past on racial subordination have been used to dispossess and to malign; such stories have broken the dignity of people. Our changes in practice to become self-reflective practitioners are stories that can be used to repair the broken dignity, empower and humanise.

The following chapter describes my second-person inquiry, in which I worked in a participatory way with others on issues of mutual concern. I conclude the chapter by connecting aspects of the themes from my first-person inquiry to those of my second-person inquiry.

5 IN PURSUIT OF UNDERSTANDING OTHERS

This chapter is about my professional practice. It gives the reader an insight into my professional context, in which I was encouraged to research and engage with co-inquirers (second-person inquiry), including sharing and learning with others beyond co-inquirers (third-person inquiry) in my quest to exploring my research questions of:

- How can I develop a deeper understanding of the patterns of relating in both my personal life and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
- What approaches and methods can be used to create sustainable cultural change in the NHS?

I have written in a style that shows, rather than tells, how knowledge emerged from action and collaboration, influencing the methods I used to work in a participatory way.

I consider this chapter to be pivotal to my thesis: it illustrates my quest as a practitioner-inquirer to effect change, whilst being on the receiving end of my own practice as a participant in the change effort. I highlight the conceptual threads that run through leadership as a way of being in the world, which include working out with others dialogically what is meaningful and recognising that working through differences is a moral responsibility and involves self-reflective practice.

I begin this chapter by describing the quest to use an innovative inquiry method (section 5.1). I show how I used CI as a method to engage others in this wider process (section 5.2). I then describe my views on the strengths (section 5.3) and challenges (section 5.4) of the method and the experience of engaging with others beyond the shores of NHS NWL (section 5.5). I conclude with reflections on my experience of using the CI method, highlighting what it takes to create sustainable cultural change in relationship with others (section 5.6).

5.1. My co-operative inquiry

As described in chapter 1.3, I undertook research into my professional life as a practitioner–inquirer in participation with 39 co-inquirers (NHS practitioners, patients and carers) using CI in an inquiry into foundations of safety.

In February 2014, there was an interest from CEOs across the NWL NHS organisations to enrol leaders across the system onto a patient safety leadership development programme, to aid in addressing the recommendation from the Berwick (2013) report that NHS organisations should become continuous learning organisations. The offer on the table was to take part in a didactic approach to learning through a traditional style of leadership development programme, with textbook-based modules. The intention was to develop a series of modules structured around the diverse academic publications, knowledge and expertise of a world-renowned professor in patient safety, who could dedicate time to 'teach' leaders the methods to improve patient safety.

In my role as Director lead across NWL on the Patient Safety Collaborative, I put the initial proposal for a 'classic' taught leadership development programme to the test as an experiment. My colleagues and I organised a workshop with potential participants to discuss this proposed outline design as the possible format for the patient safety programme. However, I was struck by how strongly it was rejected. "And this comes from people who are very much used to operating in a highly structured, prescriptive and hierarchical environment", I thought to myself. The sense I made of this was both straightforward and powerful – this initial idea of a didactic leadership programme for what is effectively a change initiative had failed to acknowledge and respect the profound knowledge and significant expertise that already exists amongst NWL healthcare leaders.

The feedback reflected potential participants' need for an initiative that would ignite their leadership competence whilst capitalising on their combined expertise and experience in the world of patient safety. It was apparent that they did not want to improve patient safety and the quality of their leadership by studying theories of patient safety which they were already comfortable with, but would rather improve patient safety through exploring their daily practices of leading in a safety-critical system.

Based on their feedback, I was steadfast in my determination to create something that would create change that was multi-dimensional, multi-level across the organisation, innovative and revolutionary and would lead to sustainable change.

As we were co-designing the proposed new programme in summer 2014, I was beginning to notice in myself a change to my practice, as illustrated from my first-person inquiry process in chapter 4. I wanted other colleagues to be exposed to new ways of knowing which would result in a new state of being (thinking and acting). I became determined to sculpt and craft a programme that would create a reflective space and foster real personal and professional learning with a human dimension. Owning my own power and recognising that I had authority and allocated funds to develop and scope the initiative, I took charge, got a vote of confidence from our managing director and won the buy-in of the CEOs of 18 NWL NHS organisations to release their staff to participate in the programme. The invitation for CEOs to nominate participant is shown in Appendix 4.

This created a basis for my CI FoS programme, in which 35 senior leaders across NWL and four patient representatives engaged in learning together about how to effect change in the mindset, culture and daily practice related to patient safety. FoS was initiated to fulfil the Berwick vision of a system devoted to continual learning and improvement of patient care, in which leaders create and support the capability for learning and change, at scale, within the NHS.

The FoS CI group included individuals in the following roles:

- Non-Executive Director (board member) with great interest in and passion for safety and quality improvement;
- Executive Director (i.e. Medical Director or Director of Nursing) with corporate responsibility for safety and quality improvement;
- Senior Leader responsible for safety, clinical governance, risk management and quality assurance; and
- Senior Leader responsible for organisational development or service improvement.

I conducted an open recruitment campaign for four local citizens, who acted as patient champions.

This is a dialogue from the interview process for the patient champions:

Interviewer: What attracted you apply for this initiative?

Patient Champion: I have both positive and negative experiences of using the system and, on the times I had negative experiences, it felt that things went wrong because there was lack of communication between the various staff involved in my care, and neither my family member nor I was communicated with during my treatment journey. The approach you plan to use in this leadership development programme is different to others I am aware of. I like the fact that it is collaborative in its approach and that it will allow space for open discussions, where all of us can practise some form of mindfulness in our approach to engaging with each other and understanding each other's needs.

From discussions with the patients during the recruitment process, they all had a common goal of rolling up their sleeves to support healthcare professionals in improving patient safety practices, as, from their experiences of when things went wrong, the problem was behavioural.

I was adamant that, if we got the right mix of patients, it could bring a wealth of experience from service users into the group. I was keen to explore relationships between healthcare professionals and patients, and the impact on learning, improving safety and quality of care. After all, the recommendations from all the relevant published reports (Francis, 2013; Keogh 2013; Berwick, 2013) call for us to put patients first and to empower and develop the leadership potential of patients and carers. FoS provided a good platform to explore in practice the dynamic of bringing healthcare leaders and patients/carers together. The impact of the patients' involvement in the CI is illustrated in chapter 6.1.

Below is an excerpt from my journal about my concerns, during the process of involving a subset of patients in the FoS participant group.

> *I sincerely have a strange feeling of apprehension about including patient champions on FoS. Would it be a genuinely safe space for staff to voice their concerns, will we be able to build trust amongst ourselves, would some things*

> *be swept under the carpet, would there be finger pointing and blame of staff by the patients? How I wish these questions were nothing to worry about and it will be fine – but I sense it won't be. The daughter of one of the patient champions died from the perceived failings in one of our hospitals in NWL. How would she engage as a participant amongst staff from that hospital? How would our individual practices change in the midst of the patient voices?*
>
> Personal Journal, November 2014

My CI group consisting of active participation from patients, carers and representatives as co-inquirers, is distinctive, on the evidence of McVicar, Munn-Giddings and Abu-Helil's (2012) bibliometric review of published UK healthcare action research studies. That review identified that only 13% of published action research studies directly engaged with patients and carers, and that their engagement in these studies was generally "consultative", as opposed to being active or making a direct contribution to stages of the research process. Although it is advocated that action research in healthcare should rightly place emphasis on the inclusivity of inquiry groups, patient participation is often limited to a passive role (Munn-Giddings et al., 2008).

Patient and carer input to healthcare service improvement can sometimes be tokenistic, with service users being invited to meetings "in which the 'pause button' is subtly deployed whenever a service user speaks" (Cowden & Singh, 2007). My approach of fully engaging patients and carers as co-inquirers was to allow all stakeholders to engage in new ways of relating.

Following the recruitment of patients and nominations for senior leader members received from the CEOs, I contacted all the participants and had an individual coming-on-board meeting with most of them, before the launch of the FoS programme. I wanted to meet each nominated participant to familiarise them with the objective of FoS, to gather their views on their individual needs and expectations from being a participant and to negotiate the time commitment needed to take part fully. I was also quite curious to understand whether there was enough appetite from the participants to really learn from and support others. I wondered whether the participants were risk-takers: they were signing up to a programme that had no prescribed content structure and which could be seen as fuzzy. A facilitator engaged with other co-inquirers who joined after the start of the FoS so that the new people could be brought on board appropriately. Until we met for the first time as a group, most of the participants did not know much about the others, and I had known only five of the participants prior to the inception of FoS.

I chose to use a mixed-model approach to CI, suited to the diverse needs of my co-inquirers. My research group comprised different kinds of practitioners from different organisations who had an interest in exploring similarities and differences in modalities of practice in relation to leadership and patient safety and included a medical director, deputy chief nurse, consultant diabetologist, patient, healthcare commissioner, former physiotherapist turned organisational development consultant as facilitator and myself as a management executive.

The whole FoS group had six 1.5-day meetings over an 18-month period, and my SIG, a subgroup of the whole FoS cohort, met at least fortnightly over the same period. There were a total of six SIGs, which came together during the FoS meetings for the reflection phase, to share their insights, discoveries and learning, make meaning out of it, revise their thinking and plan their next course of action. The action phase took place in the participants' respective organisations. The data that the participants gathered during their working hours and in their personal lives, based on interaction and insights from the outside world, were fed back by the inquiry group members. The table in Appendix 5 illustrates the process we undertook in our FoS CI.

My CI was an open group with an open boundary, with participants working with their colleagues and other external parties interested in leadership and patient safety. In between inquiry cycles, interested colleagues who had heard about FoS through their experience of change in a co-inquirers practice showed an interest in participating. As we had not achieved our 45-participant target at the start, we were happy to enrol new participants, on the understanding that they would remain committed until the end of the programme.

Figure 9: SIG and FoS co-operative group

Mead's (2002) CI on leadership practices was a closed group of co-inquirers with an informal structure, in which systemic leadership issues were not addressed or communicated about more openly with others during the life of the group. In contrast, my CI group adopted a rigorous structure from the outset, in which we spoke openly about the challenges of our individual leadership practices. This exposed strong personal agendas and helped us to build a level of safety in which inquiry would flourish. My aspiration for the CI group has been for it to provide a safe place in which inquiry would flourish and shared learning would translate into new ways of approaching our day jobs.

FoS – First Session

The writing style in this section is personally reflective, as it illustrates my reflections and detailed account of the first CI session.

I start with an excerpt from my journal:

> *Hoooray!!! My inquiry with fellow participants into my professional practice has officially started.*
> *It sure started with a bang! I am glad it's taken off well, though I was a bit apprehensive on how participants would receive this form of learning – effecting change by inquiring into what it is.*

I am hopeful this could be a transformative programme for all participants and the beginning of a change to patient safety culture and patient care. I will give my accounts of the FoS programme events for they are part of my action I am researching into. I will reflect on what I have discovered and learnt through my participation – my actions – and how this learning affected my ways of understanding and leading change.

Personal Journal, March 2015

The inaugural FoS event was well attended, with about 40 participants. On both days, we discussed our hopes, apprehensions, life stories and constraints, all in relation to effecting change in the healthcare system. Below are comments taken from the audio-recordings of both days:

I am frustrated by the constraints in the system we operate in.

– Deputy Director of Nursing

There is lack of ownership of the patient care pathway.

– Consultant Paediatrician

We are experiencing a lack of accountability for hand-over on patients that move across care settings.

– General Practitioner

We are irritated by the fragmentation in the care of patients, with the different groups not engaging with each other on their patients' treatment.

– Patient Champion

Despite all the concerns, we made a commitment that we would take ownership of building relationships to bring about change, whilst exploring ways to be collectively collaborative on patient safety improvement initiatives. Most of the participants were strangers to each other, and I was conscious that they might not want to let their guards down, but surprisingly they seem to have spoken freely on their concerns.

The group was invited to determine the agenda of the FoS project: "We would like you all to ponder on the various challenges and obstacles you face in providing safe care. What big safety improvement question do you want this group to collaborate together on and change?" was the framing question posed to the group. Participants' responses to the question were then grouped into common themes. Six themes arose from the activity; these became the areas for further exploration for groups; and participants were encouraged to join the theme group that was of interest to them. The six themes are:

1. Board culture - What can we do to help Boards to ask patient safety questions and help them achieve patient safety culture?
2. Collaborative care - How can we collaborate across the interfaces between acute, community, and beyond for better patient safety?
3. Measurement - How do we develop patient safety measures?
4. Patient involvement - How can patients, relatives and the public be part of co-creating safer care?
5. Repository and dissemination - What are the key factors in successful dissemination and adoption?
6. Staff safety - What makes frontline staff feel safe at work?

The participants in each theme formed a SIG, with each having a facilitator. SIGs would meet regularly to reflect on what their members were learning from acting on the chosen theme and to design their way forward. Each group found different ways to make progress with their respective themes. On reflection, this approach to solving and learning from our daily real-world problems suited the concept of action learning. Action learning places emphasis on starting with real-world problems, multidisciplinary teams, and action-based and social learning.

We stressed that the work in the SIGs was not meant to be a series of additional projects to be carried out by the FoS participants on top of their already extremely busy jobs and tight schedules. Instead, the aim was to support the participants in exercising their leadership in a way that would help them to translate their passion for patient safety into sustainable practice. Each SIG worked on behalf of the whole FoS group.

My Shared Interest Group

I joined the SIG that suited and aligned with my inquiry interest (Collaborative care). At the end of our inaugural session, all six of us who had enlisted to join this SIG had found that we shared a similar curiosity to explore this area further. The initial inquiry questions that my SIG started with were:

- How can we claim the necessary power to stimulate culture change in the quality and safety of patient care?
- How can we enable other people's sense of empowerment, so that they can act with responsibility through collaborative leadership to improve quality and safety?

This is how we conceptualised the task and purpose of my SIG:

> *Patient safety isn't in our view just a property of the technology and the environment in the healthcare delivery setting. It's a whole set of decisions, thinking, perspectives, actions and activities that occur across the patient's whole life. It begins at their first touch point with the service and lasts until they are well enough that they don't have contact with the health service.*
> *There's a huge spectrum of stuff that all contributes to whether or not we feel patients are being handled safely.*
>
> *So we were very conscious that in my SIG we're working at a micro-level of interactions at the clinical interface and I think there is very rich learning that fits our overall purposes as a SIG which is to explore how we enable staff, patients and their families to feel empowered to take more responsibility for the care they need.*
>
> *We all talk about transformation of healthcare. The transformation will occur at the clinical interface, that's where it's happening.*
>
> *My SIG in the wider FoS has the opportunity to really work out what transformation is going to look like, what it is about, what the facets of it are and how we all play a part in it. There is a role for leaders, but unless we understand what it is we are trying to achieve, we don't really know where we are leading people.*
>
> - Excerpts from SIG meeting, December 2015

5.2. Method in practice

At the outset of our inquiry, during our second SIG meeting, the following comment was made, taken from the audio-recording: "We welcome your expert input to solve our problems". I remember that other participants nodded. At the outset of my action research with practitioners, I was perceived as an 'expert' from the outside, able to solve the issues faced in delivering safer high-quality care. I felt it was a defence angle to project their anxieties onto me; I had to accept those anxieties and work collaboratively with them through it.

As I engaged further with co-inquirers, we developed trust in the interactions amongst ourselves, and the shift of power led to dissolution of insider/outsider boundaries, so

that I was then identified as a team member. I regarded a shift in positions as a positive, as my sense of being an outsider to practitioners dissipated, and this brought about a sense of greater understanding.

> *Ronke, your outside perspective on changing the care pathway was very insightful at our ward meeting yesterday – it re-energised the team. We are so engrossed in our ways of working throughout our busy routines that we don't get time to look up or look out to learn from others that have improved this care pathway. The team felt that you brought a fresh perspective and objectivity to our mode of operation, with examples of other places we were unaware of that you had supported to improve the care pathway. It's just not easy to analyse clearly what we embedded and are part of*.
>
> – Clinical Director, Acute Medicine

As an outsider action researcher, I had the privilege of distancing and detaching myself from the settings, to view and assess things critically. My detachment from the insider role enabled me to be more reflective, attentive and reasonable in challenging and confronting the insider practitioners' approach to change.

As an in-between researcher, I have been able to manage the ethical challenge of role conflict in the dual roles of practitioner and researcher that is frequently described in the insider action research literature (Ferguson, 2001; Alvesson, 2003; Coghlan, 2007; Holian & Coghlan, 2013; Coghlan & Brannick, 2014). In circumstances where I took the role of an insider action researcher, I was conscious of what Coghlan (2007) raised as issues pertaining to pre-understanding, role duality and organisational politics faced by insider action researchers. I have consciously managed any ambiguity that arises from holding dual roles, whilst managing the boundaries of the hierarchical roles dominant within the NHS. I was able to manage my identity as a researcher, whilst stepping in as insider and out as outsider across my organisation and member organisations. I believe this brought a particular character to the quality and integrity of my research.

Exploring further the research questions and insights from learning in SIG meetings, what follows is the recollected story of a consultant in geriatric medicine (a co-inquirer), nurse and porter during a ward round. In normal ward rounds, a porter is not part of the multidisciplinary staff who participate in the process; the porter was invited to join the ward round to test some of the ideas that had been generated from the inquiry cycles. The story is about diffused power and fluid expertise, and illustrates how I obtained insights in my action research.

Consultant: From my review of this patient's notes, we would need to undertake a chest x-ray to ascertain the cause of his vasovagal attacks. Could you please wake the patient up and get him ready for an x-ray whilst I complete the referral form to the radiology team?

Nurse: I will start getting him ready and in 10 minutes by 8.30am he would be ready to be moved away, hopefully results should be available by 10.30am.

Consultant: Oh, it takes that long!! That's two hours away. The results are available on our system electronically within minutes of the x-ray so I am quite surprised it takes that long. Anyway, if we have to wait till then, it's okay – I will review results during my midday ward round.

"Is it okay for you to take him to the radiology unit now so we can get the result in time for my next ward round?" he said, looking at the porter.

Porter: Yes, the results are available within minutes on the system. But I would suggest we hold off till 10am before I move the patient away for x-ray. You would still get the results by 10.30. The radiology unit is very busy at this time of the morning with long queues: we would end up queuing for over an hour before being x-rayed. The wait is uncomfortable for the patient and, by the time we come back, his breakfast will have been served and left to go cold on the tray. If we go later, I would also be able to support the moving of other patients to other wards as appropriate during that time, rather than being unproductive queuing for over one-and-a-half hours.

Consultant: Of course, please take the patient at the most appropriate time that is less disruptive to all of us. Thank you for highlighting the delays at the Radiology department at this time of the day. It helps to put things into perspective, and I will bear that in mind for other patients as well.

The above conversation took place during my day of 'field' research – being with colleagues on the ward. The consultant is a participant in my CI group. This little vignette illustrated his approach to multidisciplinary team working and collaborative care, based on the insights he gained from our CI and his self-reflective practice.

Following my experience of watching the events described above, I asked the consultant if there had been a change in his engagement with colleagues from his experience of action research as a co-inquirer. His response was:

> *My attitude in engaging with colleagues' especially junior staff and colleagues at lower levels of the hierarchy has changed and improved tremendously. My*

participation in our co-inquiry has helped me reflect on myself, especially on the support, appreciation and respect I give to colleagues. I have become more willing to consult with multidisciplinary staff and others for their viewpoints on caring for patients. My ability to listen more has improved, and with that my knowledge of the system. This, too, has enabled me to provide better care for patients.

This story is not only an example of collective leadership (defined in chapter 3.4) but also of relational ways of working (defined in chapter 3.5) through which the porter felt safe and empowered to voice and challenge the status quo, rather than simply to obey an order from a superior to move the patient to another department at a specific time which would not lead to a good experience for all concerned. If he had done what was always done by taking the patient for an x-ray at 8.30 am, it could have resulted in the same negative patient experience, outcome and, potentially, complaint. Instead, the porter noticed and named the problem and challenged the previously unquestioned solution.

This experience gave me an insight into what is possible in the NHS and how change can be achieved. It is about how we achieve change within the pattern of relating that has been constructed. The solutions resulting from this pattern of relating often perpetuate what is perceived as the problem. However, my findings show that change in organisational culture can happen as a result of collaborative engagement and trust of each other.

As we started our cycle 4 SIG meeting, a co-inquirer chose to share his reflection of his experience thus far. These are his audio-recorded comments:

From the learnings thus far, I have created a completely psychologically safe environment, with my colleagues working together as a team. We have eradicated the practice of looking daggers at each other, which had created an explosive environment. We can now own up to our mistakes and say sorry to patients where appropriate.

– Consultant Clinician, one of my co-inquirers
Cycle 4 SIG Meeting, February 2016

This is a dialogue with Andrea (FoS co-inquirer) on her recent experience, illustrating how she is shaping her voice, owning her own power and enabling a change in culture, based on the sense-making and meanings we were constructing on FoS. It is taken from an audio-recording.

Andrea: Can I share with you an example of what happened to me this week? It has helped me to understand what we are doing better. I've learned a lot from participating in these SIG meetings /phone calls.
I have an elderly cousin named Steve who lives alone, and I'm the only living relative. He was admitted to his local hospital and had a very unsafe discharge about a week ago. He fell out of bed last week; a neighbour went in and found him in the morning.
We called 999 and got him back into hospital. So I thought, I must get myself out there and have a chat with the ward staff, because I was just not confident about the decisions that were being made about discharging him.
I went to the hospital; I had arranged for the social worker and occupational therapist (OT) to join me to have a conversation about what help and support he might need when he gets home, because he is very resistant to having help, like a lot of elderly people.
The OT and the social worker arrived and they stood towering over him with a pen and paper in their hands. They just launched in and said, "Right, we think we are probably going to be discharging you later this week, so let's have a think about what you might need at home." I thought about some of the discussions we've been having in our CI sessions and I thought, "It's about time I got in here and sorted this out".
I found myself saying, "Should we grab a couple of chairs? Would you like to sit down and gather around Steve's bed? Perhaps you might want to introduce yourselves to him, as he might want to know your names".
I then went on to say "Shall we ask Steve to tell us a little bit about his life: where he lives, what his home is like and what he would like to achieve and what he wants his life to be like when he gets home?"
The social worker was really interesting: she looked daggers at me. "I prefer standing," she said. I responded with, "well I would really prefer you to sit down. It would be more respectful for Steve." I said, "we are equals in this room and we will have a proper conversation."

Ronke: Waoooo…You really did that!!! That's brave and really great (Burst of excitement in my voice … giggling).

Andrea: There were two chairs stacked in the corner, so I said "There are a couple of chairs over there". Then the OT went out to get the chairs for both of them and they sat at each side of his bed and I was on one side. Honestly, immediately the atmosphere changed, and the social worker looked at me in less of a daggers-drawn way.
We had a really good conversation and we agreed a care plan. I asked them if they could write it down on the board in his room for Steve to fully understand and remember it, though I had talked it through with him. But they said "No". I couldn't believe it.
As soon as they walked out of the room, I asked Steve what they had said about his care plan, but he couldn't remember. So, I wrote it down on the board.
These are just simple things … this is how we transform healthcare. We get a better way of conversing, relating and just understanding the insights and perspectives on a person's life.
As I was leaving the ward, I could see the social worker sitting in her office. So I popped my head round the door and I said: "Thank you, that was a really helpful conversation. I am sorry that I was a bit assertive at the beginning, but I wanted to have a good quality conversation so that this time we have a safe discharge." She looked at me and said: "No,

thank you. He is lucky to have you there for him, and I have learned a lot today."

Ronke: OMG!!!! Well done, Andrea. This is really what we are talking about, I am so moved with your brave actions and in you shaping your voice, including putting into practice the conversations we are having in our SIG sessions through this experience. I am particularly moved by the social worker and how your engagement has brought about new learnings for her and possibly the OT. Honestly, this is exactly what it means to change practice.

Andrea: When I am talking about transforming healthcare, that's what I mean. We are not going to get safer patient care if we don't sort some of this stuff out. That's what collaborative care is all about and that's the great opportunity of this SIG and FoS in general.
It's the improvement in communication and interaction that has the biggest impact, because most unsafe care is of that nature. It's not purely the medical errors, it's not mostly taking out the wrong kidney: effective communication, relational leadership and collaborative care would lead to a reduction in all the medical-related errors. This is going on numerous times every day in the NHS.
I think that's the opportunity of FoS; we've got a golden opportunity here to work out how, at every level in the health system, we can work together to avoid the story I've just told you. The social worker is a nice woman, who was just stuck in a pattern of working. What I did was interrupt her pattern of relating to Steve. She didn't like it to begin with; people don't like disruption. But, to give her her due, she worked with me on this and we agreed a care plan.

- Transcribed from Cycle 3 action phase meeting, December 2015

My reflection on the dialogue above is that it seemed that some of my co-inquirers also took ownership of the learning from the research and became a consumer of their own prescription when they were at the receiving end of care as a carer of a family member who was a patient as such using every opportunity in their interaction with the system to transform practice and service.

In our exploration of relational leadership and ways of working, we explored the art of healthcare – the human side of caring for a patient and staff that aids in the cultivation of a relationship with self, the team and with the patient. This is an audio-recorded shared experience from a co-inquirer (clinical governance lead) during our CI cycles on her experience of how her profession has evolved in recent decades.

> *In our practice today, nursing as a science is more apparent. I can attest that, when I first became a nurse, others and I saw it as the art more than the science. But with all the demands in the system now, it seems that the art has bled out as we've become accustomed to fire-fighting on operational effectiveness rather than engaging with patients and colleagues.*

I think to myself: "We were called to do relational and collaborative work with patients and multidisciplinary colleagues. It's about time I take control of my individual practice, reflect on my actions, take hold of myself, acknowledge and support the weaknesses and strengths in others, and keep the art in me continuously burning."

Following four further cycles of inquiry, the same co-inquirer reflected on her experience:

I almost screamed down the theatres yesterday, though it ended up being my best day of the week. I saw how the ripple effect of my change in practice arising from being a participant in co-operative inquiry is flowing to peers. I heard a nurse at the theatre pre-assessment clinic consulting with a patient on operative procedures and post-recovery care. She spoke about all the science of the ailment and treatment protocol, but hardly looked at the patient's face during the conversation. She completely missed connecting with the patient on a human level and didn't notice the discomfort and fear built up within the patient.

I observed the next appointment and it was done in a similar way. She conducted the sessions in a hush-hush manner, which made my blood boil.

I waited for the patient to leave the clinic and offered to see the next patient, requesting that she observed the session. I ended up seeing four patients afterwards in the clinic, and the first thing she said was: "It seems I have been consulting with my patients in a transactional manner with no interest to relate to them, and it's quite surprising how you consulted with them in the allocated time to see each patient. You got to know each of them, inquired about their feelings towards the operations and addressed any concerns raised, whilst building trust and relationship with them. You seemed to have spoken only briefly about their clinical condition and informed them to review all the information leaflets on their specific health condition following your session with them. You also offered to see them in the reception area if they needed further clarification on the leaflet content or if they have any other questions. It's amazing that no one had more queries to ask you following their readings. You've inspired me to change my approach on engaging with patients in the clinic."

From my co-inquirer's experience and us reflecting on it together, it was apparent that my co-inquirer's colleague treated the patients in a technically correct but, ultimately, depersonalised manner. It had not dawned on her that her well-intended interaction did not produce the desired outcome (patients feeling safe and comfortable with upcoming treatment) until she experienced my co-inquirer interacting with patients differently. My co-inquirer engaged with patients through new eyes and a new mindset that she had developed by co-inquiry with us, which enabled her to evolve her practice and her approach to patients. She was able to see the fact that well-intentioned actions do not necessarily produce the desired outcome, and that trying harder will not make the outcomes any better.

> *Good work of this sort tends to focus on relationships; it either deploys relational thinking about objects or attends to clues from other people.*
>
> (Sennett, 2008)

As I reflect on the above, it is amazing how the practice of a co-inquirer and her colleague's change in practice had an impact on my own work. Such improvement in practice relieves my own work pressure from developing improvement action plans every time performance measures or target waiting times are not achieved and complaints on patients' experience follow. Most importantly, it provides assurance that we are providing patient-centred care that connects with each individual patient. The outcome of this change in practice on organisational performance is highlighted in Chapter 6.1.

5.3. Strengths of my Co-operative Inquiry practice

Divergence and convergence

Divergence and convergence are connected forms of research cycling (Heron & Reason, 2006). To improve our quality of knowing, we had an overall balance of divergent and convergent cycles. Participants chose to inquire into their own specific questions within the theme (in a divergent cycle), whilst, in other situations, everyone inquired into the same question (in a convergent cycle). We as co-inquirers chose to explore our inquiry interests in variations of both divergence (exploring different aspects over successive cycles) through the SIGs and convergence (exploring an aspect in depth over several cycles).

On inception, we started with five groups of people inquiring into five different but connected areas, based on each group's special interest on patient safety. Two cycles then took place. By the second cycle, a new group emerged, focusing on a different area of special interest. Members of SIGs moved on to join the new sixth group or a different existing SIG. During the reflection sessions, each participant shared our recent experiences and how we had made sense of them; we gave comments and feedback on the experiences of others, which aided both divergence and convergence.

On our third cycle, members of one SIG felt that it was right to dissolve their group, as they did not feel right to continue with such a degree of divergence. They had concluded their exploration of their common inquiry interest. My reflection on their decision to dissolve the group created an appreciation of the fluidity of CI groups. As participants freely chose their area of interest at inception and formed a SIG on the theme, they had the choice of ceasing the inquiry, once they had recognised that most of the questions that had occupied their minds at the beginning had been answered. The insights from members of the dissolved group helped to give direction to shaping the inquiry in my SIG.

This form of divergence in shifting from the particular to the general and back again in cycles of action and reflection, inspired by the new meanings, helped sustain the creativity and commitment of the members of the dissolved SIG and encouraged them to join an existing group that had captivated their individual interests.

As I progressed on my inquiry journey, I used the reflective analysis of stories and experiences shared by co-researchers as sense-making for this thesis. Each of them has its own individual importance. These stories and experiences in my writings have been assembled to allow me to explore the relationship between varieties of perspectives and events.

Extended epistemology

Co-operative inquiry, as Heron and Reason describe it, recognises at least four ways of knowing, termed as 'extended epistemology' (Heron, 1996). Epistemology – the theory of how we know – is extended in the case of CI, as it goes beyond the principal theoretical, propositional knowledge generated within academia (Reason, 1999). In my experience of CI, knowing how we know is a duality of mind and body, which has a role in making sense of our experience of our world. I have come to realise that knowing is not out there; there is 'me', 'the other' and the reality of how we engage in our world.

Knowing is part of my process of engagement in the world, and my mind partakes in the formation of such knowing in an integrated way.

In my ADOC inquiry proposal document in July 2013, I wrote:

> *I would rather my inquiry use the participatory paradigm concept where people (myself and other co-researchers) collaborate to define the questions we wish to explore and the methodology for that exploration (propositional knowing); together or separately we apply this methodology in the world of our practice (practical knowing); which leads to new forms of encounter with our world (experiential knowing); and we find ways to represent this experience in significant patterns (presentational knowing - as experienced at Patient First Conference, see cover page).*

From the start of my doctorate, I was interested in a participative method of inquiry, to experience an alternative way of knowing that differs from my experience of traditional research, in which knowing is based on intellect and conceptual knowing. We know what we know through the action we took. Knowing-in-action led to practical knowing. It was a long way from knowing-about-action, as we became actors that did, rather than those who just thought about doing.

My knowing-in-action has been through empathy, engagement in action and practical competence: I am 'in' it and observant of it. I have learned from my experience of human relations in my personal and professional life. I have been able to 'know how' through action and practical competence. Other people are able to identify my knowledge, based on their ability to see and/or experience the practical output, rather than from my description of knowledge through traditional research approaches. The outcomes from our cycles of action and reflection were the evidence for my inquiry.

Learning occurs when understanding, insight and explanation are connected with action (Argyris, 2003); action research draws on an extended epistemology that integrates theory and practice (Reason, 2006).

My CI through the FoS programme has built relationships through our encounters with each other and our experiences with ourselves and with other external colleagues who have interest in our inquiry at our work base (experiential knowing); we have told stories through artistic movement and drawing – see page 2 (presentational knowing); I have made sense of the data and ideas that have emerged, as illustrated in different

sections of this thesis (propositional knowing); and I believe that, whilst cycling in this doctoral journey, I have improved in my competence to accomplish worthwhile changes in my practice (practical knowing), as evidenced in the impact of our FoS initiatives as described in chapter 6.1 and Appendix 8. I seek to capture experiences in the interplay of the four strands of knowing encountered during the various phases of the inquiry.

Trust and construction of new realities

As we progressed in the CI, my co-inquirers and I became increasingly trusting of each other and open over our shared stories and encounters. By our third cycle (the timeline of the research cycles is in Appendix 5), almost 12 months into the process, we felt more comfortable in letting our guard down, putting much at risk to speak out with our own version of truth, beyond fear and collusion.

Here is a dialogue captured through audio-recording that evidences how my co-inquirers and I were open in speaking out, creating and (re)shaping our shared understanding of reality, during one of our CI reflection cycles.

Zara (Acute Provider): My gripe is with compliance on patient safety issues; we have to provide evidence, there is no trust within that relationship at all.

[Murmuring in the room as Maureen eagerly and impatiently raises her hand to respond]

Maureen (Commissioner): I have to raise this from a commissioning perspective. We have experienced … what I would describe as a top-down management approach from NHS England. They wanted to understand our processes for outstanding quality and patient safety. We spent weeks identifying every single document … giving specific examples of how we could answer the questions and assure NHS England on how issues of patient safety are managed. … We probably submitted about 50 files. …

… The top-down system we have says that if you can't provide us with the evidence and put it into that box then we don't validate it or agree with you and we will grade you poorly. …

… We want to explore things, to be innovative, collaborating and thinking together, because actually this could be the way forward. But if we can't fill that box that says this is our evidence … we are potentially at risk of not meeting the terms of our assurance as a CCG.

Jude (Facilitator): I am struck by how we create systems within systems, and how patients are squeezed when actually it's really about

> their care. So I think innovation is surely going to be how we – all of us here – redefine what that looks like.
>
> Collaboration is required; this is an opportunity for us in this room and others in the workforce to rise up to the challenge, step up and redefine it.
>
> Cycle 3 reflection session, October 2015

Despite creating a communicative space for open and safe dialogue through FoS, whilst the conversation was taking place and before Maureen responded to the comment, I had prejudged her response, assuming that it would be a defensive one (based on her role in the organisation and her eagerness to respond promptly). It is amazing how the assumptions we hold about people play through in conversations, and my subjective view of her anticipated response emphasises the need to listen and be responsive to sensitivities within conversations and the importance of understanding … who the other is and who we are.

This excerpt illustrates the value and power of CI – the co-inquirers felt sufficiently safe to voice their concerns about the demands placed on them by each other. ("Ouch!" I gasped as the conversation took place, "this feels like finger-pointing and placing blame, brewing tension".) They had overflowing workloads and felt that these demands were not an efficient use of their valuable time and limited resource. They recognised and brought to the surface the preconceived and conflicting viewpoints they held. They had anticipated defensiveness, but were inquisitive to 'know' the things that were influencing the 'other'.

My reflection on the conversation brought to light the parallels for a high-functioning safety culture. As the conversation began, I sensed an unspoken hierarchy. I heard insightful constructive comments. There was a direct challenge to commissioners and there was an eagerness to respond. I was a bit stunned that the response was not a push-back or blame: instead, the response articulated the day-to-day challenges of practice well. Gradually, there was a smoothing out – acknowledging, listening to and supporting each other's challenges. This is where, as a safety culture, we show our capacity to learn; it is in a constant readjustment of the world. These were the interactions I saw playing out in this conversation, and it is what happens in a safety culture world in an environment of asymmetric power, in which people worry about holding onto a job and meeting external parties' (funders/regulators) expectations.

For myself, I noticed my initial discomfort during the dialogue as the initiator of the CI. This was because I saw that anything could unfold, which highlights the risks that come

with doing something innovative. I experienced the spaces created through an emotional disposition of learning about myself in relation to others. It provided an opportunity to connect with other co-inquirers, as I learned to work in the full presence of others. It has been crucial to my transformative learning and took priority over the original inquiry questions.

Re-interpreting experience of each other, being open to and surprised by one's own emotional response, and being there for others whilst establishing a space in which the right accidents (such as goofing, opportunistic dialogues, etc.) of communication might happen enabled the foundations for professional learning about practice (Newton & Goodman, 2009). In the established communicative spaces, dialogues were opportunistic and we simply rode on the back of the dialogues that ensued. They were not prescriptive rehearsed dialogues. A statement could lead to different paths, and being open to what happens opportunistically defined a different type of leadership practice in the NHS. Establishing a communicative space and building participative relationships evidence the possibility of reaching intersubjective agreement in our conversations, one that was reflective and free from coercion (Habermas, 1981).

By understanding the factors present in the terrain of the 'other', a new relationship was created; new 'knowing' of system controls emerged for us all and aided us to see and do things differently. We all welcomed shared meaning-making in the scenario described and discussed what could be taken forward to support future requests and situations that might arise.

Through a CI approach in the FoS programme, the research I conducted with colleagues helped to (co-)construct new realities (knowledge of self and of other people and things as interdependent constructions known only in relation to each other). The conversations on things, incidents and experiences created our shared understanding of reality. Consequently, our conversations created and (re)shaped a shared reality. In group settings, a key finding for me was the idea of suspending the obvious (Gergen, 2009) in our language and conversation. We did something very different here: we stayed with people's experiences and listened to each other very carefully (moving from listening to respond to listening to understand). We engaged in dialogue rather than debate.

As McArdle (2002) suggests, through CI, I was able to engage with others in safe 'voicing spaces', in which experiential knowledge would be understood as providing valid positions, silence could be recognised and interrogated, 'talking back' was seen

as a process through which valuable information could be shared, and ways of being would be (in)validated through rigorous self and peer inquiry practice. The safe 'voicing spaces' we created enabled co-inquirers to share their concerns in the early phases of the inquiry. These are some comments from co-inquirers, captured through audio recording:

> *I had concerns about what I was bringing to the table to offer to the group: whether my experience was relevant, and about my capacity to make a useful contribution* – Patient Champion.

> *I felt a little bit of an outsider initially, as it seemed that some people had well-established relationships from working in hospitals ... whereas I knew no one in the group* – General Practitioner.

> *Despite being a leader at an NHS Trust, I felt a bit like a fish out of water. It seemed some people understood action research whereas it's a new approach to me* – Non-Executive Director NHS Trust Board.

From such expressions of concern, I learned that, if suitable communicative spaces are created in which feelings can be tapped into, extensive knowledge occurs. Enabling people who perhaps might not be comfortable in communicating their fears because of their status or professional role is not a skill that can mastered from a book, or 'captured' by interview or questionnaire surveys. This process of practice requires the transfer of experiential knowledge from one setting to another, and this can be achieved through action research.

As a result of my experiential knowing, I have stopped feeling voiceless and powerless. Co-inquirers have shared drawings and stories (as evidenced throughout my thesis) on their leadership practices and how we were able to shift and respond differently to bring about cultural change. We moved away from the same old stories to new realities and new beliefs.

5.4. Trickiness of my co-operative inquiry practice

Inquiry cycles, action and reflection

My CI took place over five cycles. In organising our third cycle, we planned to engage fellow participants in co-designing the next whole-group session. Here are excerpts from my journal on the thoughts and questions that went through my mind when I

noticed that the numbers of participants planning to attend the upcoming session were very low:

> *What's happening here? After all, the CEOs (their bosses) had signed off their participation in this change initiative. The last excuse I want to hear is that they are too busy with operational demands so just can't afford to take the time off work, I thought to myself.*
>
> *What do you do when participants are not turning up to a co-operative inquiry? Have the pageantry and excitement in being part of the innovative learning process with fellow leaders expired already? We were only six months into it, with two cycles completed; yet we have a plan for 12 more months of three cycles. How can we sustain this?'*
>
> *We had all seemed thrilled about our cycle 1 experiences, and we were all enthusiastic about being part of a group that could find ways to be collectively intelligent about improving patient safety. Where had all the positive energy gone?*
>
> Personal Journal, September 2015

I organised a meeting with the facilitation team to reflect on the situation, make sense of it and figure out what to do next to reignite people's interest in a commitment to fostering change in their organisations through CI. In this meeting, I was a co-inquirer as well as the FoS sponsor and an officer responsible for the outcomes and impact of the programme. The insights we discussed that I took away from this meeting about leading and change can be summarised as follows:

- the importance of being real;
- the importance of being leaderful; and
- the importance of recognising that we are in it together.

By being real about this change project (and organisation change in general) I meant that we needed to recognise that it had been an effort to participate in the programme and that the feeling of additional effort might have been exacerbated by us thinking: "This is another initiative that has nothing to do with my day job". By being leaderful, I meant that we needed to recognise that we did have a choice here.

And we would find that choice much better if we recognised the potency of ourselves as a group and found an agency with colleagues in the group. By recognising that we are all in it together, I meant that the underlying premise of the programme was that improving patient safety as a collective mindset and practice is a leadership issue. But some people who signed up for this change project may not see themselves as

leaders. Specifically, they do not see themselves as initiating anything and they feel that they are only fulfilling somebody else's expectations.

These are excerpts from my journal on thoughts on acknowledging the potency of the group to have more impact through the strength of the collective.

> *The ambition for the FoS programme was to be a forum in which people felt energised to think differently about something that everybody sees, as a prerequisite for acting differently.*
> *We had been very keen for the programme to help people to do their day job in a way that is going to make a difference to patient safety – something that everybody wants to see and is committed to.*
> *At the first event, we inquired about the aspects of patient safety that people wanted to change in their areas of responsibility. The responses generated converged into shared interest themes. We then invited people with common interests to belong to a Shared Interest Group.*
> *Our assumption was that people joined the SIGs in order to join an inquiry process with the view of thinking together differently about something that everybody sees, to learn from examining their own ways of leading the focus on patient safety and to support and challenge one another to find clarity and resolve about what they needed to do to make a difference.*
> *We underestimated how difficult it is for anyone in the NHS world to understand and adjust to this style of thinking about change. In our minds, we were convening novel interactions for people from different parts of the NWL Patient Safety Collaborative that would generate new insights and energy for doing the day job differently.*
> *It seems, however, that people got confused and defaulted to what they know how to do well in the NHS – create a new task and a project group. They retreat to that familiar way of thinking which had created where we had got to – which was that people's energy for the FoS programme had stalled.*
>
> Personal Journal, September 2015

Baldwin's (2002) experience of facilitating CI groups suggests that discussing and agreeing in advance the democratic group processes that will be used was a vital aspect to facilitating CI. My engagement with CI facilitators at the meeting evidenced the democratic skills required in facilitating a diverse group of individuals. The response from the facilitators to my concerns was not to collapse or be defensive, but to highlight that they had thought this through carefully, that they had a plan for the things that they

were working to achieve and that perhaps the creation of SIGs was intentional. The sense was that we wanted more time for reflection, in which the group could really talk about leadership and seeing things differently.

In Cycle 3, I used the insights from the facilitation team meeting to inquire into what difference the FoS CI group was making to my fellow participants.

I was asking myself as I scribbled in my journal:

> *I agree with the theory of change underpinning the design of the programme, but how is it for the clinical leaders who are in the thick of delivering care in the highly stressed, highly politicised NHS, which has its specific patterns of interaction? How do I pace and lead?*

As part of my research inquiry, I deliberately chose to engage with a co-inquirer who had given my colleague this feedback:

> *Eve (co-inquirer) was quite unsure of what exactly they would deliver on FoS, as she hasn't seen a concrete project plan with goals to reduce pressure ulcers, infection control or surgical errors developing from discussions in the wider group or within her SIG. Her interest is to hold onto something tangible – a project that can be implemented to reduce clinical errors – as a deliverable of FOS. Also, she felt FOS was labelled as a leadership development initiative – to date, she is yet to receive any structured module on leadership techniques. She did not feel confident of any change happening, based on her experience thus far, but would rather want her comment to be confidential and categorically stated: "Please don't mention it to Ronke".*
>
> Feedback from colleague's discussion with a participant, October 2015

She had specifically said "please don't mention it to Ronke". I was curious to find out if her views remained the same, or if she would indeed be open to share with me the same comments she had shared with my colleague.

Ronke: How are you experiencing the programme so far?

Co-inquirer: I don't really know to be honest. It seems to be OK, but I wouldn't call this a leadership development programme. I have attended a few 3–5

day programmes that are intense with techniques to use to effect change.

Ronke: It's unfortunate that you feel this is not a leadership development initiative. My guess is that it's different to what you've previously experienced. This approach to learning is not expected to offer techniques or change models for participants, and we made that clear from the outset.

Co-inquirer: I am just concerned that I have some goals to achieve on reducing avoidable harm in the system, such as medication errors, pressure ulcers and hospital acquired infections and doubt that my time here would enable me to achieve those. I occasionally feel that our precious time here together is a talking shop. I want to do something tangible that I can point to back at the ranch and on the shop floor to stop these avoidable harms. [She shrugged.]

Ronke: Sincerely, if you are purely focussed on improving the clinical related incidents, I have a feeling that you will be disappointed, as I doubt you would get a guide with six steps to reducing medication errors or five ways to quality improvement.

I suggest you reflect on whether this is the right place to make the best use of your time, given the focus you want to place on clinical related errors.

Co-inquirer: So, what do you think I will learn from here?

Ronke: FoS could help you to understand the human dynamics and factors that exist in the systems that result in those errors and how we could reduce them through the relationships we build amongst ourselves. There is a need for us to make meaning together and be willing to challenge our deeply held beliefs and assumptions.

Co-inquirer: Yes … even though it feels we've been doing loads of talking, I have learned a great deal from hearing the stories that have emerged. It's insightful to hear Frank's experience earlier about how he has started interacting with colleagues.

– Record from a breakout session that I employed as the Cycle 3 of my inquiry

This conversation stood out for me. I said to myself:

I have lost the will to persuade or prove FoS is worthwhile to any participant. Each one should decide from their experience thus far, as they are mid-way through it, and decide whether it is for them or not. If they decide to leave, they should be bold enough to tell their CEO of their stance and should not feel that they are obliged to carry on just to represent their organisation.

This was a critical moment and milestone in my inquiry. At this juncture, I would have rather that we were left with only 15 people, provided that they were willing to learn and effect change through thinking differently about something which everybody sees. This highlighted to me that CI is possibly not for everyone. Like the co-inquirer described, some participants found the open and flexible approach to inquiry and learning difficult. The uncovering of many issues in our professional practices and the 'keeping hold' of emerging issues was uncomfortable, as such people would rather forge ahead to fix those issues in the old ways they were accustomed to.

This approach to inquiry – one that is emergent and was not tightly pre-planned – contributed to the learning for the group at the beginning of the programme. An example was at the first FoS CI session, when I discovered that the document that was supposed to have informed participants about the inquiry method had not been read by most participants. It provided us with the opportunity to explore and discuss in detail the method that we would be using.

Appendix 7 contains comments from other co-inquirers at the mid-phase of the programme on their learnings (as an individual or a collective) on leadership and what they felt was emerging for the wider FoS group to achieve. At the end of that session, it was evident that most participants felt re-energised about FoS CI, and we gradually deepened trust and empathy amongst ourselves, allaying some of our concerns by building relationships and getting to know each other better.

I experienced in my CI that not all co-researchers contributed in similar ways. From the beginning of my inquiry group, I saw a difference in the quality and quantity of participants' contributions. I sensed that some of the participants felt that our FoS CI was 'my inquiry'. I did not get the feeling from some of them that they saw it as 'our inquiry'. This was a misunderstanding of the premise. This group of co-inquirers did not understand that FoS was theirs; they expected others to lay it out for them. Through my experience, I learned that there is an ownership and leadership issue in CI. Some of the co-inquirers did not see that initiating anything was down to them. In most of their NHS work, the definition of what was required was largely given in instructions from the

government. They had lost the sense of ownership that is required for leadership of transformational thinking about quality of care. In their day jobs, they were only fulfilling somebody else's expectations. For me it was important that I found my choice, my voice and my preparedness to act according to what I believe in.

Authentic collaboration

After a year of experiencing CI through cycles of action and reflection in which co-inquirers and I shared our experiences from distinct angles and developed new ways of engaging, constructing and testing ideas, I felt confident to write about our experiences in my doctorate progression paper in December 2015. During my progression to the next stage of my doctorate programme, at a point where my inquiry was assessed by a formal progression panel in January 2016, I heard:

> *"The 'I/we' confusion made me cross – 'we' need to be really precise – who is I and we and our? I lost you. What is your practice, what is our practice? The 'we' narrative got me very annoyed!" said an academic peer.*
>
> *I stared at her, shocked, whilst I tried to make sense of why my narrative of 'we' made her blood boil. Oh dear … she seems to have become all worked up and upset with the 'we' narration of experiences. Hold on … I murmured as I gathered my thoughts.*
>
> *"My narration of 'we' is based on the principle of CI where 'we' are all co-researchers. Since 'we' are not all writing our experiences, as the initiating researcher I have a vested interest in writing about our experiences in my doctoral thesis. Hence I chose to use the 'we' term in the narration of our experiences", I responded.*

This dialogue from the audio-recording led to an interesting discussion during the engagement with the progression panel on authorship of CI.

As I reflected further, I began to dwell on myself as I cycled through my CI phases in my inquiry:

- Where and who am I in these voices?
- What is my interpretation of the conversation?
- Where am I in the discourse in the conversation?

- Where do I strike the balance in narrating our experiences of CI? Are we all doing this as a fully fledged CI, or am I being driven to narrate this due to my vested interest as a practitioner undertaking doctoral research?
- How do we construct what this means to us a group?
- How can I illustrate the meanings we are making together?

It dawned on me that only I could validate constructively my experience of the inquiry, attest to my learnings on the journey and authentically voice the input and output of my development, both in action and reflection.

At the beginning of this inquiry with practitioners and patient representatives, I had concerns about authentic collaboration, including:

- a tension between myself as the initiating researcher and the others being a blocker;
- whether doing research to meet our needs would be useful to the others; and
- how much I could let go and really be sincerely collaborative.

I discussed these concerns with my coach and the facilitators, and we planned to ensure that my voice or presence was not dominant in the group. The facilitators and I encouraged equal voices and contributions. We hoped to gain full and authentic engagement of all participants, both in the action and the reflection phases, where appropriate.

As we have progressed, it became apparent that everyone had distinct contributions to make in the group. Some with specialist knowledge were perceived as subject-matter experts, some had the ability to listen, some had the ability to facilitate, confront and help the group to learn together, whilst some of us knew about the inquiry method. There were other external colleagues who were not full co-inquirers but were collaborators through dialogue and participated in the action phase.

Heron (1996) states that exclusivity of authorship is a limitation on any claim that the findings of the inquiry are based on authentic collaboration. I agree with this, because, as the initiating researcher, I had a vested interest in writing our experience in my thesis. As I reflected on this, I realised that exclusivity of authorship does indeed remain a limitation on CI. However, all co-inquirers are fully acquainted with the practice of CI and have a vested interest in the publications.

In summary, authorship of this thesis is solely mine. I take responsibility for it as purely my storied accounts of our experience.

5.5. Beyond the shores of NHS NWL

From the work undertaken in this research, we have shared out inputs and outputs on a quarterly basis with the other 14 AHSNs, the Patient Safety Collaboratives and NHS England.

This is an email on my research from NHS England's Director of Sign Up to Safety (a campaign to strengthen patient safety in the NHS and to make it the safest healthcare system in the world).

> *On 7 Jul 2017, at 15:44, wrote:*
>
> *Hi Ronke*
> *I am reading your thesis with fascination. It is highly unusual and I like it.*
> *Lots of resonance with our work at Sign Up to Safety. You are so right. People in the NHS don't do conversations!*
> *I shall enjoy continuing reading.*
> *Kind Regards*
>
> *Email received on date above*

Following a review by NHS Improvement on the impact of Patient Safety Collaboratives, the impact of the work we did in FoS was published as an exemplar of best practice improvement made in leadership for safety practices.

Figure 10: NHS Improvement Publication on FoS

We have been invited to various national events to share the learnings from our FoS CI group with a wider audience beyond NWL. However, I have had to skilfully choose the language in which to speak, using terms that feel more connected with people. Our presentations at these events and in publications have communicated the benefits of a collaborative approach that uses self-reflective practices for leadership and patient safety.

Here are examples of contributions to the field and wider conversations:

Conference presentations

1. Leadership for safety. Patient Safety Congress: Birmingham 2015.
2. Leadership, teamwork, communication. Patient First Conference: London 2015.
3. Building grass roots leadership in a London Trust. International Forum on Quality and Safety in Healthcare: Sweden 2016.
4. Foundations of Safety Leadership Programme - emerging lessons from collaborative inquiry. Patient First Conference: London 2016.

Following our presentations, one region in England and four other NHS organisations across the country are currently engaging with us to look at possibilities of adopting our approach to learning for improvement.

This doctoral research has generated powerful insights into what it takes to achieve the goal of a learning culture. It demonstrates that nurturing leadership and relational practice fosters cultural change and promotes the safety of the wider healthcare system.

5.6. Research Findings

> *For every complicated problem there is a solution that is simple, direct, understandable ... and wrong.*
>
> H. L. Mencken (1920)

My inquiry into the complex system of the NHS brought to light how the challenges faced in our daily professional practice could be resolved through non-conventional dominant change approaches. It has highlighted that, to accomplish the role of leadership, anyone who can affect the behaviours of others for a shared positive outcome at any particular time in a particular context does leadership (irrespective of their official leader authority or power). The story of the co-inquirer (consultant) and colleague (porter) described shows a healthy fluidity of leadership, in which leadership flowed to where the expertise resided.

Our stories illustrate the use of a new power that is fluid and accessible and is held by others for collective leadership practices that can work across multidisciplinary teams. My research experience challenged the traditional hierarchal power structure that is particularly present in hospitals, where there is an assumption that an official leader is superior to others in their team. In the story of the consultant and the porter – in the practice of collective leadership – shared knowledge and power was dispersed.

The improvement in practices (evident in chapter 6.2) that took place was sparked by people seeing and acting on local needs. The human motivation and the desire to collaborate with others to improve their practices in order to make a difference were very powerful. In creating sustainable cultural change, we experienced the importance of giving people time and space to think through practices, to understand the struggles and worries we face, and to offer support instead of demanding change with no time to prepare or engage.

The stories show our work on collective leadership and relational ways of working and the importance of developing cultures to support open and inquiring minds, including the value of physical spaces in which to reflect, learn and share. Our practice of collective leadership as evidenced in the stories was effective in removing the status barriers and motivated the multidisciplinary team to speak up. This approach created a climate of psychological safety in the group that made it acceptable to raise concerns or problems. Speaking up enabled positive implementation of new practices.

My research provides experiential evidence and advances the understanding of withholding voice, the approach peers and leaders may use to empower the workforce to voice their views and feelings, and to whom employees may choose to voice their thoughts. Based on my extensive literature review, I found that only a few studies, such as Morrison and Milliken (2003) and Liu, Zhu and Yang (2010) have explored this through empirical research.

Reflection on use of methods

My experience of self-reflective practice, the use of the left-hand column tool, journaling, acknowledging the existence of race introjections, acknowledging my waterworks, showing up and reclaiming my voice, engaging in constructive, thought-provoking conversations and learning with the ADOC community and FoS group, understanding power relations for social change, and owning and expressing power positively have all made me a better person, researcher, practitioner and leader in the NHS.

The use of the left-hand column brought ‘mental models’ to the surface, to explore, write and voice out about them. Although it looked like a straight-forward tool, I had to take a risk, weighing up the opportunities and risks of using it purely as a tool to develop my practice or to embody an open relationship, treating it with curiosity with the hope to learn. I was conscious that, as I chose to share it with my co-inquirers, I had to be honest about my thoughts, feelings and judgements as I tried to step into the shoes of those involved to empathise with them.

In undertaking participatory action research with other practitioners, I chose CI as a research method, so that I could research by living out our daily practice. In my role as an ‘in-between’, one of the difficulties I experienced in engaging with co-researchers who were insider researchers working wholly in member organisations related to the

political and power dynamics within organisational settings where there are limited resources, and fairly rigid hierarchical structures, overflowing with policies and regulations. I struggled with this at the initial stages from an outsider position. As the inquiry progressed, we made it clear that the ownership of the organisational issues belonged to the insider co-inquirers and practitioners from the local member organisations. This made the co-inquirers feel at ease, as they owned the power within their settings to effect change.

Being an 'in-between' researcher has led me to become more politically astute, with a growing ability to know when to shift between power structures and interact in ways that are in line with the political conditions in each organisation. I experienced the diversity of my insider/outsider role as an advantage, ensuring that the research remained relevant and representative. 'In-between' insider/outsider boundaries can be both difficult and rewarding and helped me understand the importance of my reflexivity and critical awareness in optimising the advantages and minimising the disadvantages of the positions.

On our use of communicative spaces, the co-inquirers at the early stages of the inquiry were finding their places in the group and questioning its purpose and time commitments. During the second of the five cycles of our CI, a shared comment from three co-inquirers was: "how do all the discussions we are having in these spaces make me go back to my daily job and make an actionable change?" Since the practitioners were from an action-oriented background, they felt the need and urgency for practical action. It felt awkward for participants who ordinarily did not reflect on different perceptions. We spent time exploring amongst ourselves our expectations of communicative spaces. Co-inquirers became cognisant of the reflective processes of practitioner research and their roles in examining their utterances. Stories then started to unfold in subsequent inquiry cycles, with experiences and frustrations shared and people feeling comfortable to respond without fear of censorship.

Clinical Director: Removing us from the hustle and bustle of a busy healthcare delivery environment has helped to create space and time to reflect on our individual practice, and re-examine our beliefs, whilst freely exploring misunderstandings and assumptions of our practices.

Theatre Lead: In my SIG, we crystallised around a practical task we all had as an interest. This brought us all together to know one another in a relationship rather than in a role. As a manager in the NHS, I am

used to a work culture that expects immediate action and quick results. I am struck by how this space has given us a right to reflection, and pausing before action.

Director of Quality and Governance: I have experienced this as a communicative space where we've all entered on an equal footing. It seemed all the board members, for example the non-exec directors and medical directors, left their roles at the door – I felt at ease to share my reservations, despite being a lone voice and left-winger on common issues. We respected all opinions and reached a consensus on actions to be taken.

Transcripts extracted from audio-recorded reflections at Cycle 3 session, July 2015

Initial actions raised by my co-inquirers at the onset were an understanding of the problem. We reflected on and shared stories of our experiences of the problem and unanimously agreed that the issues and problems could not be solved through writing protocols and checklists on monitoring the environment of care.

Similar to experiences in other studies (de Souza, 2007; Gaya Wicks & Reason, 2009; Newton & Goodman, 2009), access to communicative space over a sustained period of time is essential for professional learning, as it enables professionals to examine and reflect upon their work practices. In addition, as Gaya Wicks and Reason (2009) state, we experience communicative space as a platform that results in deeper understanding of the dilemmas in practitioners' roles, enabling us to engage freely with each other in a non-judgmental way. From my experience, simply creating a communicative space does not guarantee cycles of reflection and action. Rather, it provides for a channel for communication that previously did not exist to be opened up and for discussion that fosters the democratic expression of diverse views.

As I stood back from my inquiry process to reflect on how we had practised CI for professional practice, I have learned that CI is not a standard 'plug and play' method for organisational change, nor is it a tool for personal development that can be used to meet all needs. It requires diligent crafting for specific needs and contexts to realise its powerful potential to allow human flourishing and sustainable organisational transformation. As we have stated to the other NHS organisations that have shown an interest in adopting our approach to leadership development and quality improvement, there are neither assurances of achieving similar results to us nor a guarantee of

success. But with a curious initiator, openness to risk-taking, a creative mindset, a little bravery and a lot of drive and hard work, much is possible.

From my experience of CI, the participation of initiator, researcher, facilitator(s), and co-inquirers has not been equal. How does this relate to Heron's view that all co-inquirers should become fully participative? In my view, participating fully in the different CI processes of design and decision-making, and being fully present in the experience of action and reflection is aspirational – and a tall order for the busy healthcare professionals who participated in this inquiry. At the same time, this does not mean that their voices were less important. It meant that I needed to work to understand the messages, and this inquiry was enriched by the very fact that participation happened alongside daily work.

My experience of the group is of people with different commitment levels and mixed understanding of their roles and their position in relation to the roles of facilitator and initiator, who were uncomfortable with the ambiguity of what the end result would look and feel like. To enable a strong commitment to participation, it has in my view been vital to propose an approach that is attractive and stimulating. The approach became one which provided personal and professional development opportunities, whilst helping to transforming our practices through collaboration with cross-organisational boundary colleagues.

Nearly all participants of the FoS CI group described the process as worthwhile and rewarding. Here are transcripts extracted from audio-recorded reflections of co-inquirers at our final meeting in September 2016:

> *Despite the pressures on the system growing, my outlook to my work has greatly improved as I have stopped internalising my pressures and am able to engage better with others to address concerns.*
>
> – Quality and Governance Manger

> *It has been time well spent and I will do this over and over again. I have learned a lot about other colleagues' viewpoints and have stopped making it a battle between them and us.*
>
> – Consultant Physician

> *At our break-out session earlier, all five members of our SIG were commenting on how this programme has made us become self-reflective, calmer, better able*

to work under pressure and more relational in our engagement with colleagues in our day-to-day lives.

– Director of Nursing

At last, I am feeling, doing and seeing change in the NHS. It gives me hope and faith in the system, as I have experienced and witnessed the change in communication amongst healthcare professionals and also in their interaction with patients. I just wish all healthcare professionals could be exposed to this type of programme and ways of learning.

– Patient Champion

Whilst most had a positive experience, it should be pointed out that it did not work out for everyone. Three members of the group dropped out – stating lack of time to dedicate fully to it. One of them felt uncomfortable with the approach to learning, with no structure or taught modules to aid development. We respected their decision to withdraw. However I took away a sense of disappointment initially, whilst searching to bring them in. It took me some time to start noticing how the approach of co-inquiry may simply not fit into everyone's sense of learning, or how other life events might mean prioritising different agendas.

We experienced different ways of knowing from an extended epistemology lens. I came to realise that my co-inquirers were more interested in practical knowing and some form of presentational knowing. This may seem an easy statement, yet my sense is that the pace of work in NHS hardly allows any deepening of knowing in the day to day. This does not in my view diminish the impact of the inquiry itself. My co-inquirers would happily share stories of their inquiry experience and take on ideas on actions to test in their daily practice, but, when discussing, they shared how they did not have the bandwidth to write reflective reports following the reflective sessions. As the researcher, I valued such reflective forms of knowing, as they are paramount in seeing the change on the ground – but equally had an interest in propositional knowing from my doctorate academic standpoint. This illustrates my dilemma or what at times may be perceived as an inequality between my aim as a researcher, which was to generate new knowing, and the aim of other co-inquirers, which seemed at times more action and result oriented.

The drawbacks I encountered in my use of CI in the inquiry context were in relation to ownership of the inquiry process by all co-inquirers and authentic collaboration. Some

participants found the open and flexible approach to inquiry and learning difficult. Initially, it seemed that people got confused and defaulted to what they knew how to do well in the NHS – create a new task and a project group. My experience was that it was too far-fetched to expect all co-inquirers to internalise the method. I also found out that co-inquirers had different commitment levels and mixed understanding of their roles and were uncomfortable at the outset and early phases with the ambiguity of what the end result would look and feel like.

In my experience of practising CI, there is an inequality in participation: as the researcher/initiator, I am producing a report; the facilitator(s) are delivering a service; the sponsor is expecting a successful learning outcome; and other participants own the process to varying degrees. Ideally, to achieve authentic collaboration, group members should internalise the inquiry method and make it their own, though this requires willingness and time. My experience was that it was too far-fetched to expect all FoS participants, or even my immediate group of co-inquirers (my SIG), to internalise the method. It was wishful thinking to believe that they would make it their own. That is a contrast to Heron and Reason's theory.

From our practice of CI and the impact we have achieved (outlined in chapter 6.1) on the FoS programme, it is evident that creating sustainable cultural change in leadership and patient safety practices needs to be through understanding human behaviour and involves communication and empathy rather than prediction or control. The experience of practitioners is very important in transforming the healthcare system and should not be captured by reports or surveys on states of mind, but as stories expressed by practitioners on how things are to them. I have experienced that using CI is useful for a practitioner researching professional practice and organisational processes, because it locates the meaning of experience with those involved, rather than with the researcher. Ownership of the learning from the inquiry is also with those involved, who have an opportunity to learn from their investigation and transform their practice.

Reflection on first- and second-person inquiry

In this section, I reflect on the learning from both my personal (first-person) and professional (second-person) strands of inquiry.

The acknowledgement of my race projections including the self-awareness and development of my voice and power (described in chapter 4) in my first-person inquiry influenced my conduct and capability as a researcher in taking a collaborative leadership role to craft, co-ordinate, co-facilitate and actively participate in the FoS

initiative. My exploration of race raised equality issues and how the voices of BAME matter in improving the quality of patient care and leadership practices in the NHS. Understanding the viewpoint of others on race through my second-person inquiry has provided me with greater insights into the complexities and stereotyping of race and what it means to be fully connected and relational as a collective, in order to come to genuine, existential change.

My first-person inquiry into voice gave me impetus to show up fully in my interaction with others, and I believe it paved the way for other co-inquirers in FOS to have an opportunity to be self-reflective in their individual voices. The stories shared by co-inquirers in the transcripts extracted from audio-recordings highlight the shift in the use of voice by co-inquirers in their everyday professional practices.

My personal inquiry into my childbirth lived experience as a leader in the system led to my curiosity about inquiring into power. In my first-person inquiry, I became fully aware of owning my power, and the role my power plays in delivering high-quality care, including through leveraging my power. That led to initiating a CI group with leaders across NWL NHS organisations for my second-person inquiry. The learning from my second-person inquiry on power dynamics in the workforce and patients highlighted the need to move away from the heroic (individual) leader to collective leadership practices for patient safety improvement and sustainable culture change.

Revans's (1997) early work in London hospitals (HIC Programme) in the 1960s had found low morale in the workforce, associated with power imbalance and communications problems, which ignored patients and families. An independent evaluation of the HIC programme was undertaken by George Wieland: first in 1971 (Wieland & Leigh, 1971) when, in Revans's words, he "found little of interest to report" (Revans, 1985), and again ten years later (Wieland, 1981), when, according to Revans, "the complex interactions of the approach had worked for another decade in these venerable institutions … (he) … was able to report changes of profound importance" (Revans, 1985).

From the early views of the evaluators, HIC was perceived as a failure and it was not until ten years later that the evaluator gave a revised positive opinion. Wieland's later evaluation (1981) stated that these "demonstrated improvements are over and above the improvements 'naturally' occurring in all hospitals as a result of their efforts towards shortened length of stay" and that the "multiple time series" statistics are powerful enough to remove most alternative explanations for the differences. Furthermore, "in

the two cases in which the project hospitals showed significant negative effects, there seemed to be plausible reasons. These were the hospitals which rejected the project early and decided not to participate further" (Wieland, 1981). The issues on voice and power in Revans's work in the 1960s are similar to those faced by our healthcare service, as highlighted in the inquiries of recent years (Black & Mays 2013; Francis, 2013; Berwick, 2013; Keogh, 2013; Chambers et al., 2018).

My inquiry explored the limitations of punitive cultures (Chuang et al., 2007; Khatri et al., 2009; Kim & Newby-Bennett, 2012) of naming, blaming and shaming when error occurs in the NHS. Berwick (1989) referred to these as another form of the 'theory of bad apples'. I sense that my first- and second-person inquiries have guided me as a practitioner and other co-inquirers to effect cultural change within our local context during the specific time of the research in spite of the punitive culture that is stated to exist in the system.

In summary, through these experiential stories in this chapter and others, I have tried to 'show' the reader the varieties of dialogue we experienced as they happened in the moment during my CI journey, rather than 'tell' the reader about them. I introduced other voices and perspectives, developing the critical subjectivity that is vital for this narrative research process (Heron & Reason, 1997).

6 DISCOVERY OF RENEWED PRACTICE

Who was the research
I saw you with last night?
That was no research,
That was my life.
(Reason, 1998, p. 18)

In concluding this thesis, I reflect firstly on this research in generic terms, asking: "What in essence was this research about?"

For me as a practitioner–inquirer, this research was undertaken essentially to reconnect with my sense of purpose, rebalance my life, create a positive shift in my practice and make a contribution to both professional knowledge and practice in my field through practical action.

To elucidate this, I chose the statement below to explain why I think this research matters for me and potentially for others as well.

> *The fact that all of us, and our families and friends, may also be patients at some point also provides an imperative for improving patient safety in our own spheres of influence. Patient safety is not only about patients – it is about us.*
> (Walshe & Boaden, 2005, p. xi)

I could not agree more with Boaden and Walshe and only add to their statement that research about patient safety is also ultimately about us all, for we all have to find our way with health throughout life.

In concluding this thesis, I have chosen to step back from deep mental engagement with my research and take a more reflective and reflexive stance, to explore emergent aspects of my renewed practice that have arisen from the learning in my research. To do justice to my experience, I notice that I could end up writing a chapter the size of this thesis. Instead, I hope to reflect more briefly on the breadth and depth of learning my inquiry has offered me and, I hope, others alongside.

In this closing chapter, I start by capturing and outlining the impact and contributions my research has had in practical NHS daily life (section 6.1). Following that, I illustrate how I connected my inquiry questions with my process, the resources I used, my claims and outcomes, and my reflections on the criteria I had set to appraise the validity of my research, including what it is to live purposefully (section 6.2). I conclude with recommendations for further research (section 6.3).

6.1. Impact and contribution to practice

As a Director of Performance Management, I possess great confidence in stating returns on investment (ROI) and identifying expected measures with baselines and targets for key performance indicators (KPIs) for the various service improvement and business transformations I lead. FoS was the first initiative for which I was uncertain of the quantifiable KPIs and ROI from the outset; neither could I promise that it would meet the expectations of all participants.

“Ronke, as you’ve committed this significant budget on this innovative programme, how do you measure the success of the project? We suggest you develop KPIs to measure the outcome of this initiative”, said the NWL board of CEOs and NHS England concurrently in the ICHP Board Meeting, back in March 2015. It seemed a big ask, but definitely not a surprising one, as that is the performance management approach we undertake on all large-scale programmes, and I had spearheaded the development of this approach.

Why did I then feel it was a big ask? After all, there should not be an exception to the rule of law. As far as the paymasters are concerned, it is just another programme. The NWL board of CEOs were impressed at the previous meeting in January 2015 with the report I presented to the board on the progress we had achieved on our neuro-rehabilitation programme, which was reducing length of stay in hospital for patients, improving hospital bed capacity and improving patient care, enabling access to the right care at the right time in the right place. This and other similar clinical care pathway improvement projects could be measured, based on the prevalence of such clinical conditions before and after the implementation of the more effective and efficient methods of treatment.

Patient safety does not really fit into this category. It is a cross-cutting theme across the entire patient journey: it is complex. Its complexities lie in it being a multi-faceted organisational and leadership issue. It requires a change in behaviour to occur and, for

such change to occur in practice, it was vital that patient safety had some meaning within the experience of the practitioners who are expected to change.

To confess, as a perceived expert in performance management (as per my job title: Director of Programmes, Change and Performance Management), I did not have a succinct response to measuring the impact of FoS at the outset, at least not in the way that the CEOs would have wanted to see it – i.e. in terms of x participants + x spent on programme equates to x reduction in patient safety errors = x reduction in ligation claims.

Here lay the conflict in the approaches to change I had to navigate in my context: as a senior leader in the NHS, I operate in an environment that lives by the cause and effect positivist theory of change, using an analytical mindset that seeks certainty and control. Yet as a leader in this context, I could not guarantee a reduction in patient safety issues at the outset, as expected by stakeholders. However, I had a strong conviction through my ontological and epistemological position that, if patient safety had a meaning, and was co-constructed and owned by practitioners through an action-based approach to learning and research, that could result in the desired behavioural change, with ripple effects of improvement to patient care and staff wellbeing. My belief in experiential learning and my exposure to action-research methods of effecting change gave me an impetus to forge ahead and take the risk of no KPIs or targets set on the outset.

Two months following the completion of the 18-month programme, it was acknowledged that behaviours had started changing, and this was claimed to have brought about an improvement in quality of care within the local context (KPIs Appendix 8). The local specific key outcomes that co-inquirers claimed to have been attributable to their participation in the FoS CI from the audio-recordings in FoS CI session in September 2016 and presentations at the NWL CEO board meeting in November 2016 were as follows:

- One Trust saved 30% on agency staff spend as a result of a daily safety brief template developed on staff capacity and patient acuity.
- Using the learning from the CI group, a participant was empowered to practise collaborative leadership and engage her team and patients in positive culture change. This led to the team (22 people) winning the annual award for organisations that employ over 3,500 staff on ‘Changing culture to improve safety’.

- One SIG achieved a change in culture through the adoption of collaborative care principles on an acute medical ward.
- An IT system designed to assist with the thematic review of incidents has been adopted by two additional sites: The Initiative for Patient Safety (TIPS) has engaged all staff in safety management and leadership in one hospital and there are plans to take it to two other hospitals.

I should state that, whilst all the deliverables above were attributed to FoS by co-inquirers and colleagues, I acknowledge that other factors in the local systems might have influenced their achievement. Appendix 8 provides further details on the overall achievements of each SIG on the delivery of high-quality patient care, including lessons learned on the use of methods.

In addition to the specific SIG outcomes on improvement to delivery of high-quality care that were specific to their place and time, Figures 12 and 13 below provide an overview of the value behavioral cultural change and use of my research methodology had on their professional practice, as reported by co-inquirers on FoS.

As my inquiry is focused on everyday real-world practical experience, the process we undertook on the inquiry is as important as the new and improved organisational outcomes we achieved. This is based on the FoS evaluation in Figure 13 and co-inquirers feedback on the impact of their SIG in Appendix 8, which highlights that 72% (13 of 18) of the comments and feedback received related to the inquiry process.

Two years following FoS; Carolyn Regan - the CEO of a NWL Trust, who had participated in FoS shared her experience of FoS and its impact on continual learning and on improving patient safety in a publication (WLMHT, 2018).

ICHP are collaborating with WLMHT and Central and North West London NHS Foundation Trust to explore the delivery of Human Factors training for staff. Carolyn has written about collaborating with ICHP on the Foundations of Safety programme, which has resulted in multiple local improvement initiatives, and how this work has nurtured a particular interest in Human Factors.

Through participating in the Foundation of Safety Programme, the Trust has facilitated joint learning on key areas of patient safety.

Carolyn writes:

"This led us to consider our understanding of and learning from Serious Incidents (SUIs) and particularly the role 'human factors' play in understanding and improving patient safety. We worked with Dr Jane Carthey, an expert in human factors and patient safety, to carry out a thematic analysis at Broadmoor Hospital and West London Forensic Services using human factors methodology, and as a result we are producing 'cause and effect' diagrams in key areas. These include: suicide self-harm; physical health; and assaults and physical restraint and we are sharing these with other trusts."

Figure 11: CEO release on FoS impact

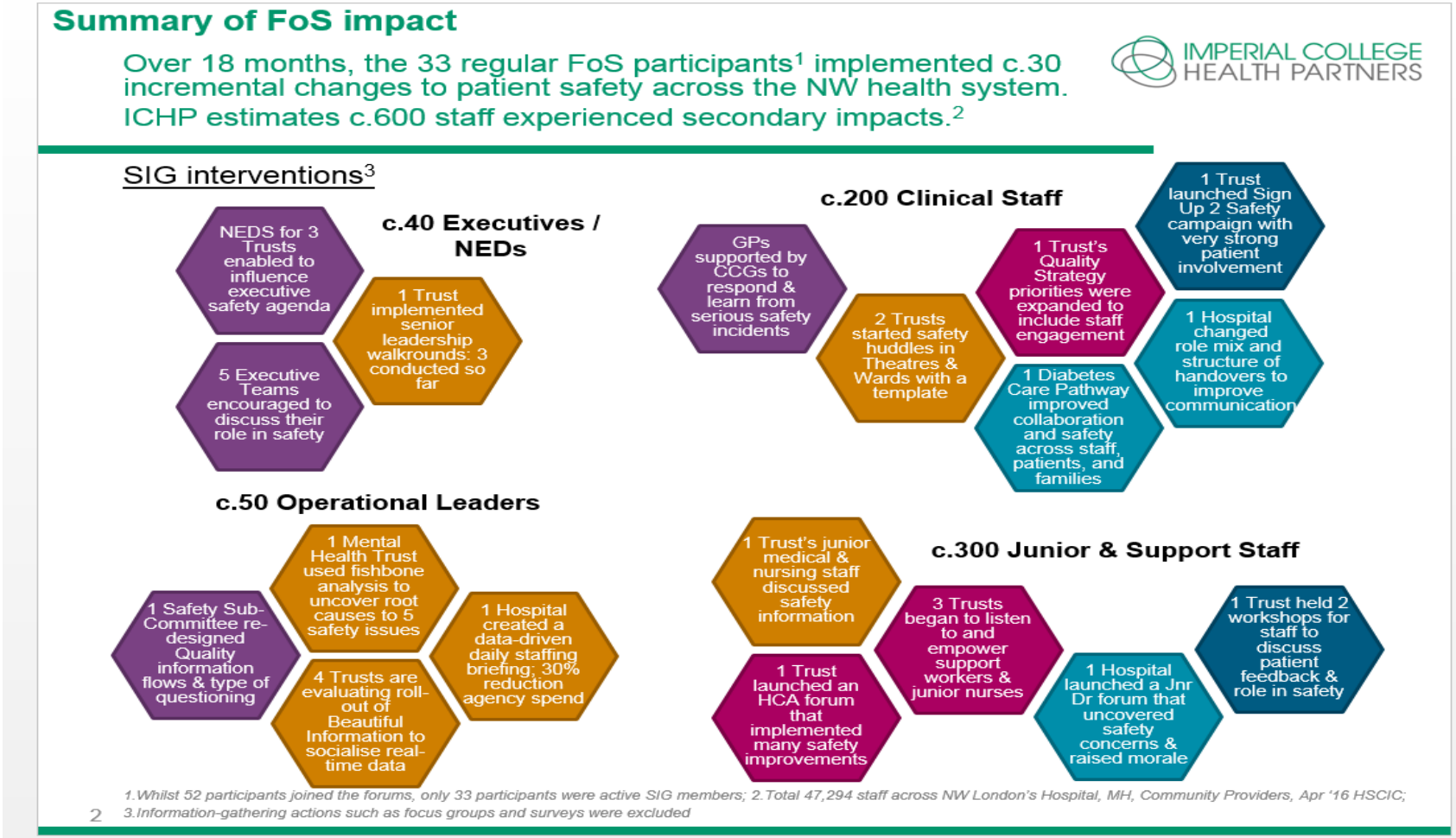

Figure 12: Summary of FoS impact

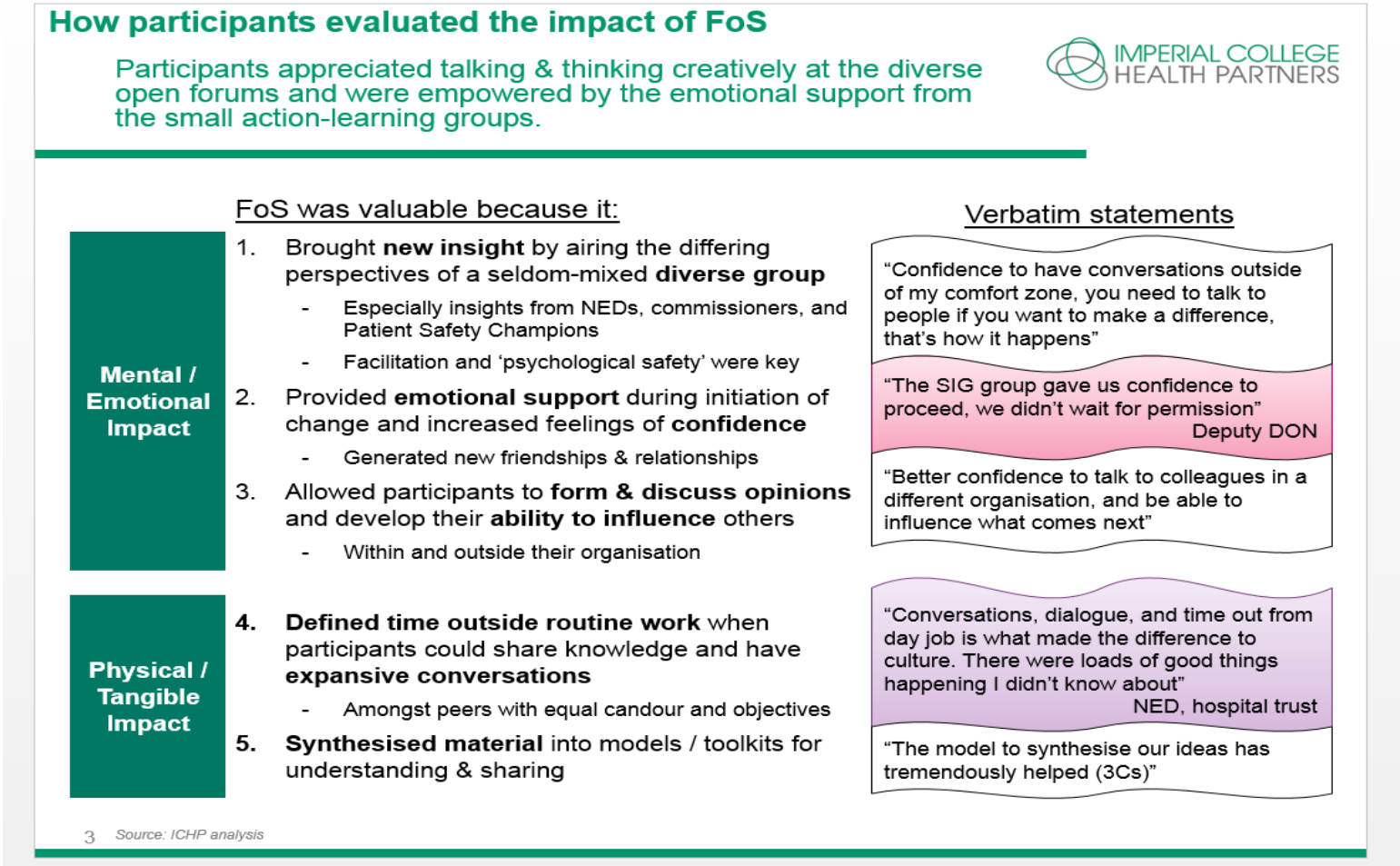

Figure 13: FoS participant evaluation

Contribution to practice

In this section, I set out my view on the contributions my research has made to the practice of organisational change in the current NWL NHS organisations context.
My specific contributions are:

1. A practice-based and action-learning approach to aid collaborative care and patient involvement, responding to the call in the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and the call for leadership potential of patients and members of the public in the review into the quality of care and treatment provided by 14 hospital trusts in England (Keogh, 2013).

My research offers an experiential and practical type of knowing through the use of an action-based approach to learning and research which goes beyond the traditional research approaches to health care practices, making a moving beyond purely externally mandated inquiries to first- and second-person inquiry. It provides a practical demonstration of why action research as an approach to learning is needed to transform the NHS, especially at a period when resources are constrained and there are rising demands on service delivery. My research challenges the positivist, realist and objective approach of enacting change in the NHS. Throughout my inquiry, there was no predetermined solution that if you do this or take this step, you will get that.

These are transcripts extracted from audio-recorded reflections of two co-inquirers about their use of this research approach:

> *It always felt that changes were imposed on us through a theoretical manner with no reference to impact on real operational practice. Through our discussions here, we've been able to deeply understand the root cause of some of our tricky issues and it seems to boil down to lack of respect of each other's viewpoint, especially amongst our areas of disciplines. Now, I fully appreciate our varied perspectives. As I move away from my silo-ed view of the system, this has helped me to stop finger pointing at others.*
>
> – Specialist Nurse co-inquirer at Cycle 5, May 2016

> *In our practice today, nursing as a science is more apparent … we've become accustomed to fire-fighting on operational effectiveness rather than engaging with patients and colleagues. I welcomed this as an opportunity for me to take control of my individual practice, reflect on my actions, take hold of myself, acknowledge and support the weaknesses and strengths in others, and keep*

the art in me continuously burning. This refined my practice at theatre pre-assessment clinics; rather than focussing purely on speaking to patients on operative procedures and post-recovery care, I started to connect with patients on a human level, getting to know them, inquiring about their feelings, acknowledging any discomfort and anxiety whilst addressing any apprehensions, any concerns raised. It moved from transactional interactions to building trust and relationship with patients at pre-assessment clinics. This subtle change in practice reduced patients' complaints and improved patients' experience.

– Clinical Governance Lead co-inquirer at Cycle 5, May 2016

My action research in NWL evidences that sustainable culture change could take place in the NHS through the human dimensions of being reflective and relational in our practices. As practitioner–inquirers, our experience, empathy and understanding of each other were the catalysts that led to a learning culture.

2. A response to leaders across NWL NHS organisations saying that they had no space in which they could discuss their common experiences and concerns in a safe, focussed manner without fear of blame and shame.

The findings of my research suggest that creating communicative spaces for listening to staff and patients is vital to dealing with deep-seated issues. Such spaces enabled us as practitioners to engage in a meaningful way that was democratic, in order to develop knowledge. Through our communicative action, we shared perspectives and considered interpretations of others to try to come to an understanding of shared meanings. This was our local practice within the NWL NHS community, which contributed to situational knowing.

Co-inquirers and I developed and owned the change process. We stayed with our experiences, engaging in dialogue, and became shaped by the learning process, though our social experience in everyday interactions and conversations. Co-inquirers and I felt that the richness in this research is the integration of the voices of a multidisciplinary workforce, which are inherent in everyday practice. Whilst these were initially perceived as competing perspectives, the process provided an opportunity for marginalised staff groups to be listened to, share stories that were normally left unsaid and become socially visible.

For the teams within my local community of NWL NHS organisations where my research was rooted, my research evidences that improvements were made to patient care through allowing space and time to listen and reflect and a learning culture to act on ideas.

My research explored and experienced what it feels like to be in the process of constructing relational leadership. It responds to several calls by scholars (Bradbury & Lichtenstein, 2000; Ospina & Sorenson, 2006; Uhl-Bien, 2006) on the need for leadership studies to be conducted through participatory methods of research and on the need to understand the relational (social) processes by which leadership emerges and operates. Reitz (2015) noted that nowhere had she found scholars asking the question, "What is it like to be within relations where leadership is being constructed?" My research has made a contribution to academic literature by evidencing what it takes to be in spaces where relational leadership is constructed.

I believe this thesis has endeavoured to capture the emotional rollercoaster of anxiety, excitement, struggle, messiness and warmth and the dynamics we experienced in this leadership space in NWL. It includes the invisible threads that connect actors engaged in the leadership process as part of the reality being studied.

3. An understanding of the impact of race, voice and power in personal and organisational life. The acknowledgement of the influence race, voice and power had on my life has developed me as an individual and enabled me to be the change I want to see in the world in my various roles as a wife, mother, daughter, patient, researcher, black leader and practitioner.

I am fortunate to have experienced being at the receiving end of my change practice and change interventions. This provided me with a first-hand experience of how change theory is lived out and how it translates into and manifests in my daily work and that of others.

With my race, gender and background, I bring a unique contribution to research on voice and power in NWL NHS leadership practices. This is particularly relevant, as I work in a setting in which 41% of the NHS workforce are from minority ethnic backgrounds (Kline, 2014). My subjectivity is therefore an important part of understanding the implications of my practitioner research.

Through my inquiry experience I have come to see how current challenges around race equality issues have not improved (Kings Fund, 2018) despite mandated national

policies and standards. I suggest that the debate needs to be about the ways in which the voices of BAME staff participate and are heard in the system, and on how we move forward in connection together, while caring for the wellbeing of our BAME staff and patients. From my viewpoint, it is only through inviting the views of this group so that we gain a shared understanding of the complexities of race that we can start to learn and make sustainable changes in the system. In doing this, we may live more fully connected and relationally as individuals and as a collective that values each other, without the expectations that individuals from BAME backgrounds should 'fit in'.

My inquiry has served to magnify my own notion and my unjustified fears and hopes about my future as a black female leader.

I hope that sharing my voice in this domain may be insightful to others beyond myself. In saying this, I have shared insights from this research in discussions at NHS Confederation events in 2017 and 2018 through the NHS BMS Leadership Network to provoke different, more inclusive, conversations in the NHS as a whole, so that it can become a genuine and equal opportunities employer.

4. Contributing to new knowledge on using CI as a participatory method for organisational culture change in NWL NHS organisations. Keogh (2013) states that patient and staff focus groups were the most powerful method of "getting under the skin" of organisational culture, rather than a technical exercise involving rigid tick-box criteria. Both Francis (2013) and Keogh (2013) highlighted the validity of accepting qualitative evidence, in particular patient and staff stories, as a valid source of information about what happens in healthcare. This paved the way for reconsidering the methods of conceptualising, improving and evaluating culture change, beyond the accepted norm of instrumental methods or tools.

At the time my inquiry was conducted, there was national focus on improving patient safety practices. My research came at an opportune time when there was a drive and willingness for practitioners to engage collaboratively across organisational boundaries to improve leadership and cultural patient safety practices. I took advantage of the timing and the interest from leaders to try something different with practitioners in exploring what could be done differently to improve leadership and cultural patient safety practices.

I feel that CI is a good approach for conducting research with each other and not on or about one another. I did experience some limitations on my use of CI within my inquiry

context, which included underestimating how difficult it is for anyone in the NHS context to understand and adjust to this style of thinking about change. Through my experience, I learned that there is an ownership and leadership issue in CI. Some of the co-inquirers did not see that initiating anything was down to them.

We experienced different ways of knowing. From an extended epistemology lens, I came to realise that my co-inquirers were more interested in practical knowing and some forms of presentational knowing (stories of our experience on the focus of the group). Whilst I also valued such forms of knowing, as they are paramount in seeing the change on the ground, my interest was also in propositional knowing from my doctorate academic standpoint. This illustrates the inequality between researcher and other co-inquirers. While my use of CI has stimulated social action for change within specific teams in NWL NHS organisations, the drawbacks experienced in my practice of CI highlight to me that CI is not for everyone.

My CI approach to health care, with the active participation of patients, carers and representatives as co-inquirers, is unique, based on evidence from McVicar, Munn-Giddings and Abu-Helil's (2012) bibliometric review of published UK healthcare action research studies.

This is a co-inquirer's audio-recorded reflections on their use of this research approach:

> *They just interacted with me effortlessly. It has been a good contact which them and us patients. It is such a good feeling when you are not seen as just a number. We all really felt taken care of. It gave us confidence to also engage and enrol other patients and carers in participating to make a change to the system.*
>
> – Patient co-inquirer at Cycle 5, May 2016

My approach of fully engaging patients and carers as active partners has allowed all stakeholders to engage in new ways of relating, which has been valuable in applying new learning as new ideas unfolded in reality. Co-inquirers were actively involved in sense-making throughout the process, they were involved individually and as a collective to analyse data, which helped to represent a multiplicity of views and interpretations.

A distinct attribute of my CI in comparison to other CIs in health care (Fieldhouse & Onyett, 2012), which consisted of groups which lacked clout or influence to move

forward in implementing the proposed changes, was that my CI group comprised staff with the highest level of organisational influence, whilst also engaging and including a diverse set of practitioners across the hierarchical structures in the SIGs. The engagement style across both groups was a mix of top-down and bottom-up approaches. Our practice developed as new ideas were tried out and the experiential learning unfolded in reality, as opposed to the learning being a theoretical solution to complex issues of patient safety and leadership practices.

5. Authorship. From the review of published UK healthcare action research studies (McVicar, Munn-Giddings & Abu-Helil, 2012), authorship was predominantly dominated by university academics, despite participating practitioners playing significant roles in the whole research process. I view this lack of authorship by practitioners as lack of ownership by practitioners or patients/carers, which is contrary to the inclusive principle of action research. Being a practitioner in a doctoral research capacity and a leader in the system in which my research was conducted, I was able to effect change. My inquiry output, including the corresponding changes in individual and professional practice, has been owned by co-inquirers, with co-inquirers proactively acknowledging the contribution with evidence in Appendix 8 that highlights the impact that this research has had on their practice.

My doctoral inquiry has thus contributed to practice and knowledge in the fields of healthcare management, organisational change, leadership, patient safety, quality improvement, co-operative inquiry and academia. My hope is that this research will have an impact on organisations and practitioners, in showing how to create spaces for reflection, action, collaboration and learning that benefit society at large.

6.2. My reflections

I have used my research questions and the context of my inquiry as the lens through which I interpret all research materials. To recap, the research questions are:

- How can I develop a deeper understanding of the patterns of relating in both my personal and my professional life in the NHS?
- How can we develop more effective relational ways of working, involving multidisciplinary colleagues and patients, in order to improve leadership practice and patient safety?
- What approaches and methods can be used to create sustainable cultural change in the NHS?

Based on my research paradigm and my ontological position, my research process has been deliberately emergent; my inquiry questions changed, following my practical experience of being a patient during childbirth, when I witnessed safety alarm bells in the hospital where I was a leader. My understanding of the issues evolved and deepened, and my relationships changed as my practice shifted over time.

To allow a blend of perspectives in my inquiry, the research methods used were practical, collaborative, time-efficient, engaging and affordable to undertake within the resources available for sustainable cultural change in patient safety and leadership practices across NWL NHS organisations.

To aid with sense-making in my research, I step back to reflect on the following:

- What I did and the resources employed
- What worked?
- What were my challenges and what would I do differently next time?

What I did and the resources employed

My doctoral inquiry happened in my own context through determination, dedication and discipline. At the same time, it taught me to slow down, to cultivate acts of purposeful reflection and to dwell on questions. At times, these seemingly different energies connect at the heart of what I care about, especially in my passion and purpose of improving the lives of patients and the lives of the underprivileged at large.

Owning my own ontological and epistemological position and with the use of an action-based approach to learning and research, I conducted a practitioner inquiry into my personal life and professional practice, in participation with others, to find practical solutions to issues that we face in our everyday lives.

Using an autoethnographical approach, I inquired into my personal life. This made me realise that I was going to work without owning or authenticity in my voice and power. This then led to my curiosity on the patterns of relating in the NHS from my personal experience of being a patient and a leader within my context. This raised the realisation and acknowledgement of the uniqueness of my voice, with the lens of a woman of Nigerian descent, and the importance of stories of the lived experience of others and myself. I started to become aware of acknowledging what it takes to be in touch with

myself, which led to meaning-making in my inner self and an interest in reaching out to others.

As a practitioner–inquirer; I was keen to adopt an action-based approach to learning and research, with the use of CI as my method to reach out to others, so that I could engage proactively with practitioners, patients and carers who were keen to effect change in leadership and patient safety practices. It enabled me to undertake research "with people rather than on people" (Heron, 1996). My method helped to locate the meaning of experience for myself, and also drove me into a shared research position. To share collaboratively an inquiry experience with my colleagues created a sense of shared ownership, in return for learning together in this inquiry to co-transform our practices

During the time of my research, my role was Director of Programmes, Change and Performance Management, where I have responsibility for initiating improvement programmes that addressed the current issues faced in the healthcare system. This included the implementation of action plans as a consequence of the recommendations from the UK government-commissioned reviews, which became a priority for each NWL NHS organisation. My interaction with executive colleagues in each of those organisations highlighted areas within their action plans that related to culture change in practices, and a sense that such change could gain value from collaborative working across organisational boundaries.

With my lived childbirth experience of being a patient, when I witnessed safety alarm bells in the hospital where I was a leader, I was fired up as a doctoral practitioner–inquirer to inquire into sustainable culture change in leadership practices and its link to patient safety. My research curiosity became aroused, as I engaged with colleagues on their challenges to effect culture change, as recommended by the government-commissioned reports.

With the renewed national focus on improving patient safety practices, the partnership organisations (such as my organisation – ICHP) were expected to be the driving force to support local organisations within their geographical boundaries to implement improvement initiatives across organisational boundaries. These were to support achievement of the recommendation from the Berwick (2013) review that the NHS should become a learning organisation that engages, empowers and hears patients and carers at all times, with leaders creating and supporting the capability for learning.

As I became mindful of owning and leveraging my own power, I crafted an innovative initiative and requested funding of £250,000, supported with the approval from CEOs across all NWL NHS organisations, to establish FoS (my co-operative inquiry group) in 2014. This led to the creation of safe communicative spaces for individuals to listen in a non-judgemental way, shares our stories, reflect on our individual and collective practices, triangulate and sense-check data, weave and acknowledge our diversity of voices, sense-make, and construct new meanings with shared understanding.

It was not just the national mandate and funding that made it happen, but equally important was the willingness and keen interest from local leaders to collaborate with patient representatives. They wanted to explore alternative forms of transformational learning that could be built into daily practice and to explore their own experiences as leaders to create sustainable improvements.

What worked?

My practice-based inquiry placed me at the centre of the change that I aspired to see in the NHS. I became the subject of my own research and change efforts, with a lived experience of being a patient, practitioner, researcher and participant on FoS that has made me experience being at the receiving end of my own practice and change intervention. I deliberately chose to consume the medicine I prescribed to colleagues, including taking the risk of exposing myself to the experience and the side effects of what I prescribed.

I had first-hand experience of how change theory is lived out and how it translates into and manifests in my daily work and that of others – how change really happens (or not!). This provided an unusual opportunity to experience along with others what it takes to challenge myself in changing mindsets and the barriers to change.

From my first-person inquiry and my experience of self-reflective practice, I have come to value the importance of not forgetting self as an individual and giving conscious attention to self. As such, my experience of ‘knowing self’ and the development of self has led to developing meaningful social relationship with others.

The use of my adopted and refined framework (Figure 3) on knowledge justification helped to provide my research with a claim for validity. Using the framework to test and apply the change ideas through agreed methodologies to areas of concern in our daily lives has enabled us to make the improvements needed in leadership and patient safety practices.

Using CI as a participatory method for research helped us to perceive self as an individual and revealed the meanings of our experiences. We stayed with people's experiences, engaging in dialogue and the learning process with no blame or finger pointing. There was no predetermined mechanical solution that if you do this or take this step, you will get that. In establishing my CI, the outcome was not pre-judged.

Co-inquirers (participants in the inquiry with me) reported that inquiring into their own sense of self, purpose and feelings towards work activities was stimulating, producing growing levels of confidence in how they saw themselves relating to others in work-related activities. Co-inquirers remarked on the intensity and treasured communicative space created by the CI process. The quality of relationships between participants noticeably deepened over the action and reflection cycles. The stories in this thesis exhibit the high levels of trust within the group and the readiness to be vulnerable with colleagues. We experienced new patterns of relating in the NHS that evoked new ways of engagement between colleagues, patient/carers and me. Our outputs were achievable through interactive and humanistic approaches.

Having an unusual opportunity to hold both an insider and an outsider inquiry position was valuable. As an outsider action researcher, I had the privilege of distancing and detaching myself from the settings to view and assess things critically. My detachment from the insider role enabled me to be more reflective, attentive and reasonable in challenging and confronting the insider practitioners' approach to change.

My doctoral research challenged the dominant ways of knowing in the healthcare sector, which are based on positivist rationality with facts and information, prediction, control and statistical analysis of manipulated variables. Leadership is relational, reflective and evocative, and cannot be understood and improved on purely through objective knowing, based on intellect and theoretical knowing. My research methodology was a move from abstraction / technical rationality to a real-world active participative process. It provided space for creativity, uncertainty, messiness and reflection in action between others and myself, and produced the results described in chapter 6.1 and Appendix 8.

What were my challenges and what would I do differently next time?

To learn to live with the ambiguity of action research and CI was not something which we found easy. We were not particularly welcoming to it, so to say. This potentially speaks to the heart of what we needed to learn in terms of voicing ideas and feelings in

an at times challenging situation, not knowing how we would be received, by each other or in the organisation. As co-inquirers, we needed to learn to be comfortable with risk taking. More clarity in articulation of the aims, rules of engagement and personal expectations of FoS seems to have been needed, as it was not fully understood in practice by all co-inquirers, yet we started to learn about it through the inquiry itself. While feeling responsible for much of it, I also needed to let go of some of my own risk-defences. I had to tweak specific elements of the method with diligent crafting for my context, so that the research could realise its powerful potential of human flourishing and sustainable organisational transformation.

The creation of communicative spaces was not without its challenges. Establishing the spaces seemed an interruption to what practitioners were used to doing. In opening the communicative spaces, I experienced a pattern that was evident in my SIG at the initial stages. The pattern for three of the five co-inquirers in my SIG was to think: “I am going to the wider CI group session. I need to present something, so I need to make some slides; I need to provide a progress update report, because that’s what we are required to do”, as they stated in the audio-recording during the third of the five cycles.

I found that I needed to help co-inquirers simply to lay all that down. Saying, “No, we don’t need to do a presentation. You don’t need a poster” etc., I had to assure them that it was fine just to turn up and have a conversation. It was difficult for them as clinicians and managers in our busy NHS world to understand and adjust to this style of learning.

Connecting into people’s experience in order to start a new conversation is vital, but, with hindsight, we could have buttressed the importance of communication amongst each other and the value of appreciating each other’s experiences. What participants had needed to realise from the outset was that we were ‘convening’ different conversations with people in different parts of the system that have an interest in patient safety and a stake in delivering quality care. What we were doing was to provide a channel to allow really interesting creative conversations that we hoped would generate something, so that people would want to do things differently. It is a tricky balance to hold: some people perceive a conversation in the forum as simply a chat and have no expectation that the purpose of that conversation is to effect action.

As the research journey deepened, we gradually took the props of communicating through presentations, PowerPoint slides and reports away, but, if we had taken them all away at the beginning, we may have left participants unable to engage at all. With the practitioners being from an action-oriented background, they felt the need and

urgency for practical action. It was challenging for participants to adjust to the principle of just pausing to stop and reflect.

In addition, I found it a challenge to define the terms and come to a shared understanding of what is or is not relational leadership practice. This was something co-inquirers gave little, if any, attention to. It was not a practice that came naturally to individuals in our busy pressurised daily working lives of interacting with patients, carers and colleagues. Whilst there are definitions of the meaning of relational leadership practices, co-inquirers found it initially difficult to practicalise these. After conceptualising it, they had to step fully out of the busy environment to experience it, during reflection and inquiry sessions on what it really meant. As we progressed through our inquiry cycles, co-inquirers became relaxed about interacting differently and had renewed interest in knowing the other and confidence to challenge others.

Once co-inquirers started practising in a different way in their individual organisations, shifting the practice of teammates was not particularly easy. It was recognised that there was a need to provide 'permission' before catalysing changes perceived to be outside the individual role's remit or to participate in learning or work on improvement initiatives, including carving out time and space to dedicate to a theme/objective.

This reflection raises for me the question of "How should someone else undertake similar research?" From my experience, what such individual needs to do is to very cleverly and carefully construct a community with inquiry interest around political and financial imperatives, as I was able to do. My inquiry was emergent, based on what co-inquirers and I defined as a useful outcome for us. Any organisational situation at a specific time comprises mandated national agendas including particular practitioners with their own individual and unique shared histories. As such, it is Ideal to stand back from the details, look at the systemic dynamics and work carefully and politically astutely with others in order to inquire into themes that are meaningful to people within a system that is local, timely and specific.

Apart from all learning and understanding, I also have to acknowledge my own limitations. I learned that what I perceive and understand is only a tiny piece of the social environment I am acting in. Hence, I have endeavoured to be tentative in my claims and make conclusions based purely on evidence from data available from co-inquirers and me. In addition, I sense that the use of autoethnography has aided in emphasising the social character of our relationships as NHS practitioners.

Reflection on quality and validity

Action researchers advocate that their research should be judged by their own criteria, such as authenticity (Bassey, 1999) – those standards of judgement that are the living values people bring to their own lives (Whitehead, 2000). I am of the view that action research should be judged on its contribution in the situational context – the validity of my research is in my view established by the impact it had in my context and the context of the co-inquirers.

At the start of this thesis, I stated that what followed would be stories about my personal and professional development, and I developed those standards, building on the action research knowledge base (chapter 2.5) to appraise the quality and validity of my research. At this point, it is to these criteria that I return.

Did my inquiry contribute to the flourishing of self and other individuals and the flourishing of the healthcare system? My doctoral journey has indeed been an immensely fulfilling, rewarding and satisfying experience. I have experienced feeling, thinking and behaving differently. It has been new learning, a nonlinear progression and transformation from one state to another. Does it seem over-assured … perhaps – but I speak unequivocally from my heart.

How do I know what I just stated? My inquiry into race has conveyed new perspectives, learning which we identified in the inquiry group on the influence one's background and upbringing has in early socialisation of adolescents going through education and into the workplace. Those conversations have had a deep impact on me, noticing how others in their upbringing are told (or see) from an early age that they can achieve, no matter what the barriers or perceived barriers are. It seems to be almost a given for some people to be able to achieve their potential, while seen from a different perspective that is not always so.

I came to see how I have grown accustomed to having a position of significant social status, with which comes a degree of positional power and a voice to be listened to. I exercise those qualities and attributes in this UK society as well. I was raised by my parents and taught how to succeed in an international context, unlike many people of similar race who may not have been imbued with the values of confidence and taking control, irrespective of colour or any other perceived disadvantage.

All of these stories make me who I am. As I conducted reflective inquiry into this, it raised the other streams of my formative years that have made me into who I am. This

is where my sense of self comes from. My race and biculturalism (co-existing in two distinct cultures) including being able to taste my own medicine offers me a tenuous balance between two cultural worlds, something which I only grew more aware of when engaging in inquiry with others from the same race and a different background. My learnings on this doctoral journey have created the advantage of me seeing things differently as an 'outsider within'. And I feel fortunate to have been able to access the knowledge of the insider through the critical lens of an outsider at the same time.

Being an insider provides the opportunity for change, with my audacity in risking consuming my own medicine and experiencing the side effects. Becoming a patient provided me with the first-hand experience to recognise that there is indeed an issue around leadership practices and patient safety culture which need to be improved upon.

My experience of acknowledging my own power during this doctoral journey of learning to articulate my ideas and living them out has not just strengthened my sense of self as an individual, but even more so in interaction with others. For it also made me become more aware of the power people perceive in me, including how I employ the power and my agency in the service of organisational change. The groundwork in establishing the FoS CI group can surely be attributed to being aware of owning my power and putting it to good use.

A collaborative way of applying power, in my view, offers positive ways of expressing power that create the possibility of improved and equitable relationships amongst individuals and can lead to sustainable change. My experience of positive change in improving care through initiatives from our FoS CI group has been that, if power is expressed through 'power to' 'power with' and 'power within', that will result in win–win situations in which both the individual and the system benefit.

From our FoS CI, co-inquirers and I recognised that culture is a complex construct, of which the creation and transmission of sustainable culture change is done by leaders, managers and other organisational members through constructive challenge, ongoing negotiation of processes, persuasion and reflection of behaviours through engagement with others.

I have started to appreciate power as a fluid and unembodied phenomenon, which can be expressed, shared and created by individuals in multiple ways. My initial negative view and experience of power was of it being something used to exercise control over

others in situations where the individual is socialised not to challenge. The learning on how to shift those situations has evolved during my inquiry journey into a view and experience of power as something that can also to be exerted for positive action.

We learned how as healthcare professionals we unconsciously exclude the patient in discussions relating to their care. Through our CI inquiry, we learned to stay with people's experiences, communicate clearly and listen carefully in order to build mutual understanding.

Did we manage to inquire collaboratively and undertake a worthwhile practice-based inquiry? Undoubtedly, would be my primary response, although on second thoughts there are nuances here which I reflected on in chapter 5 when highlighting that, at times, I did feel responsible for the overall research. The joint perspective, combined with my research, was perceived to contribute to our understanding of social life, and how our human understanding of and perspective on our processes have made an impact in improving our practices.
Initiating my CI following my personal health experience, whilst being a leader in the healthcare system, revealed to me that there was a deep yearning in many practitioners to explore our own experience as leaders. We undertook this inquiry to improve our practice and were determined to improve the quality of care for our patients. FoS provided the opportunity really to explore what needed to change in the way health professionals, patients and families relate to one another, and to work out how we all can take collective responsibility for patient safety.

Our FoS initiative was not a fantasised 'new world' for the NWL healthcare system, but rather it created a new platform, a new communicative space – a common ground where constructive dialogue, empathy and respect could exist amongst formerly fragmented healthcare practitioners and patients. The space was a real-life connection to the worlds outside.

Did my inquiry create learning that translates into change in personal and professional lives? I hope there is ample evidence in this thesis, in the transcripts of our meetings and in the stories of our learning to validate the claim that, at an individual level, we created and took opportunities for transformational learning: learning that was then built into our daily practice as we engaged in our different ways with the demands of delivering a quality service in the complex healthcare system.

My inquiry challenged me to go beyond my comfort zone, engaged me in a series of monologues and dialogues and pushed me to read, meditate, write, imagine and create. It has given me more confidence to express my beliefs and the structure behind them. Doing so, I grew my voice and started to explore how I can use the roles I am given to voice and address the concerns in NHS, in a way that can be received.

As we cycled through the phases of reflection and action, we developed healthy human interactions in face-to-face sessions and we gathered knowledge through resonance and empathy, the type of in-depth knowing that is almost impossible to put into words. The knowledge gathered through learning from the experiences of participants with diverse perspectives is highly valuable.

Is my inquiry strongly grounded to progress bodies of ideas and theories that exemplify relevance and rhetorical force? I believe my research is embedded in a theoretical grounding that includes deepening my clarity of thinking and critical sense-making as I worked and discussed with co-inquirers.

My contribution to knowledge is in the area of what some researchers (Bradbury & Lichtenstein, 2000; Ospina & Sorenson, 2006; Uhl-Bien, 2006) have alluded to as relational/collaborative leadership making a change to organisations. Though it is good for such ideas to have been promulgated in previous literature as theory, I have undertaken the practical reality. I have stopped and listened and practised it in reality, despite the presence of constraints in the system.

Our practice in reality highlighted to us that leadership in complex systems should not just occur in specific individuals or internal teams, but across the multidisciplinary workforce through networks that span beyond organisational boundaries. Individuals within such systems need to meet each other where they are – in their daily realities – with an understanding that knowing occurs through engagement in each other's worlds. Our experience of relational practice / collective leadership led to a form of change that cannot be 'teachable' but needs to be experienced through cycles of action, reflection, meaning-making and experimentation. Our conversations, negotiating and renegotiating the meaning of our experiences via storying, have led to the change in leadership that emerged during the research process.

A personal reflection

Fifteen years ago, I could not comprehend why certain people would decide to sacrifice a highly lucrative job for one with a reduced income or earning power. An investment

banker becomes a kindergarten teacher, a doctor turns gardener, a lawyer turns missionary worker. It all seemed strange to me.

In the past few years whilst undertaking my research, I have come to understand and appreciate why people choose to follow their passion towards attaining fulfilment in life. Success and fulfilment in life to me come from being proud of myself, knowing I have done the right thing in making a positive contribution to my life and the society in which I exist. It is the achievement of something I have desired, whilst pursuing my own unique path.

My spiritual ontological belief of being blessed through helping the weak, oppressed and needy influences my thinking and practice to live and act according to the word of God.

> *Defend the weak and the fatherless; uphold the cause of the poor and the oppressed.*
> *Rescue the weak and the needy; deliver them from the hand of the wicked.*
>
> The Book of Psalms, Chapter 82, verses 3 – 4
> (The New International Bible)

The scripture quoted above is a guiding light and a constant reminder to me to do as much as I can to improve the wellbeing of my fellow human beings.

In my personal life, it has led to the birth of Heritage Outreach (www.heritageoutreach.org), a charity I founded in Nigeria to fulfil the goal of making my contribution towards reducing inequality amongst children. To me, this charity organisation is the vehicle that allows me to act according to our collective beliefs about caring for children in distress, defending the fatherless, the needy and the oppressed through an orphanage.

In my professional life, I chose to transition from highly paid interim consultant roles to become a full-time substantive NHS staff member with reduced income, and to undertake this doctoral research in order to enable me to follow my passion and conviction that I could make a positive impact through cultural change to patient safety and leadership practices, thus improving quality of care,

Undertaking this research has been both life enhancing and life changing, and at times took over my life completely.

> *"I'm left here making sense of my research data, juggling two children going to swimming lessons, music lessons and football practices, keeping up with homework, enrolment to holiday kids club, reconciling arguments, keeping up with the housework, shopping, cooking meals, learning piano, professional work commitments, overseeing and sorting out the governance of the orphanage in Nigeria"* – I paused as I struggled to keep control of my emotions – *"... and in the midst of all of these pressures I endeavour to meet my husband's expectations of a loving wife".*
>
> Personal Journal, September 2017

This excerpt from my journal highlights moments in my personal life during my doctoral journey.

The journey contained within this thesis was not at all easy. At times, I have felt very vulnerable and have seen others in that space as well. I compare it at times as a mixed bag of warmth, anxiety, hope and messiness in understanding the complex relational spaces. In my personal reflections, I questioned whether I was strong enough to continue at certain times during my doctoral journey, as I came to realise that being on the inside trying to effect change can be emotionally and physically draining, a challenge that leaders have to be up for. At different times during the journey, I questioned whether I was strong enough for the challenge.

As I found during my experience of childbirth, reflection got me into embodiment, being present and showing up as a leader/patient. My learning during my research moved me from being a detached leader who treats the system as something that is distant with no personal linkage to someone who treats it as something that had become real and personal with other practitioners, patients and carers.

When my practice changed to become fully reflective, stuff happened and I got stressed. It was challenging and difficult to be faced with particular colleagues who tend to use intellectual acuity with no respect for relational practice or emotional intelligence. As I tried to introduce something that was radically and culturally different, such as leaders being reflective and trying to work across boundaries, it was draining. It was difficult to challenge people's behaviours, as it had real personal perils.

In reflecting on my research, I have experienced that initiating a non-conventional approach to organisational cultural change has not been easy. I have come to appreciate the immeasurable value of relationships, including the value of SiG

initiatives born from within, conceived through discussions amongst multidisciplinary individuals, and owned by such individuals and teams.

As I cycled through various events illustrated throughout this thesis, I regularly reflected on them as they have unsurprisingly changed the person that I am and the way that my practice is viewed. They have tested my priorities, values and beliefs.

For my doctoral research, I chose to go down from the seemingly solid 'high ground' of manageable leadership, patient safety issues and technical-based policies and recommendations into the messiness of the 'swampy lowlands' (Schön, 1983). As a practitioner, I chose the swampy lowlands as my habitat of inquiry to immerse myself in, muddling through the clearly unarticulated issues that are real around me. My experience, experiments and innovation with practitioners have led to profound transformation of myself / my being which I think, from feedback in my second-person inquiry, has also led to a transformation in my practice.

Of particular interest to me is the connection between claims to knowledge and the resulting change in practice that they lead to. Whilst the output of my inquiry is acceptable to co-inquirers and has led to practice changes in local settings across NWL NHS organisations (evidenced in Appendix 8), some doubts arise on the value of the claims when presented as public knowledge in public settings.

At the final stage of my research, the accusation of being too definitive on inquiry claims haunted me, when questioned on the accuracy of claims of improvement achieved in professional practice as the output of my doctoral inquiry. In my practice of critical subjectivity (Reason, 1994), I would often ask myself – what counts? who decides what counts? how does it count? and for whom does it count? These questions are embedded throughout my thesis. Over time, I started to see how, in the tacit areas of my knowing, potential sits in me to engage in a non-judgmental way with those complex dilemmas and aspects of practice that cannot be entirely rationalised.

Being an 'in-between' researcher, where I shifted from being an insider action researcher from within an organisation to being an outsider looking into an organisation, I was able to evaluate critically my inquiry and understand practice objectively, as others sees it from an outsider lens; subjectively, as a person involved see it from an insider lens; and dialectically, as a participant/observer sees it.

Each cycle of my inquiry has evolved and brought out a dynamic interaction of experience, personal reflection, shared understanding of realities, co-creation of

meanings and testing of ideas from different lenses of diverse groups of multidisciplinary professionals, all influencing one another in unpredicted ways. My inquiry took place in an eco-system that is very specific, political and relational.

As I reflect on the outcomes of my inquiry, I feel a sense of pride in my personal development over the past six years, the growth I have made in myself in acknowledging my full being and the impact it has had on my interaction and relationship with my family, friends, trustees on my charity board and my professional colleagues. I am mostly proud of the improvements made to the way service delivery has improved in specific areas in NWL (evidenced in Appendix 7) which is enabling the delivery of high-quality patient care and patient experience through development of leadership and patient safety practices. I acknowledge, of course, that other factors in the local systems might have influenced the achievement of some measureable outcomes, but those involved certainly attributed at least part of the change to FoS.

"Ronke, the political manoeuvrings you did in your research to achieve the outcomes and the manoeuvring you continue to do in your professional practice could be invisible to you, as based on your persona – it tends to happen naturally" my supervisor remarked following my Viva in May 2018.

My doctoral research helped to create a very strong case for the need for collective leadership and relational practice which requires leaders to be more reflective in their own practice. I was doing this myself, and what I have endeavoured to describe here in my thesis is how I tried to do it from the inside, how difficult that was and what got in the way of doing it.

6.3. Recommendations for further research

My hope is that, perhaps, the work we did may inspire other leaders to examine their own actions by being self-reflective as well, and to take the risk of exposing themselves by being partakers of their own change interventions, experiencing the effects of the change on themselves and others in practice.

I have found that research into sustainable culture change in the NHS should be specific to its local context, which includes the leadership practices present, priorities in the local system and behaviours of external key stakeholders. The outcomes achieved in my research were as a result of the factors present in my local system, and FoS provided us with an opportunity to explore sustainable culture change within our local NWL system, which made this research worthwhile.

A question along this line of thought for further research could be to explore whether similar outcomes are replicable in other NHS organisational contexts in other regions across the UK, using similar methods. How can other NHS organisations become learning organisations that genuinely seek to reflect, act and collaborate for healthcare delivery improvement?

I have come to the view that national mandated improvement recommendations, whilst being helpful guides, are not solutions in themselves, without local practitioners taking ownership for implementing them. But is that really valid? This might be an interesting question for further action research.

I recommend that future practitioner research into sustainable cultural change through relational collective leadership practices evaluates other interventions that involve a leader who is strictly an insider in their NHS organisation or a junior member of staff in an NHS organisation with a mandate to inquire with other junior colleagues, exploring whether that produces similar outcomes.

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APPENDIX 1: R&D APPROVAL LETTER

From: Roper, Gary C [mailto:gary.roper@imperial.ac.uk]
Sent: 06 November 2015 12:15
To: Ronke Akerele <Ronke.Akerele@imperialcollegehealthpartners.com>
Subject: Research Doctorate Ethics Query

Dear Ronke

Thank you for the discussion on your proposed doctorate project with me.

From your description and the outline you provided I would class the primary focus of your research as evaluating a learning programme to assess viability and learning outcomes. This type of activity would fall under the areas of evaluation and audit as opposed to active research.

With this in mind you will not require any additional ethics approvals for your area of study.

Please treat this email as my formal assessment of your project requirements.

Best wishes

Gary

Gary Roper
Head of Regulatory Compliance
AHSC Joint Research Compliance Office
Imperial College London and
Imperial College Healthcare NHS Trust
510C
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London
W6 8RF

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APPENDIX 2: RESEARCH PARTICIPATION LETTER

Ronke Akerele
Doctorate in Organisational Change DProf candidate
Tel: +44 7807 167 371
ronke.akerele@imperialcollegehealthpartners.com

Research Overview

Many health outcomes continue to improve rapidly through new and more effective treatments. At the same time harm to patients remains a serious concern in all healthcare systems. Healthcare carries an inherent risk of harm which must be continually reduced but cannot be eradicated. The task of developing new and more effective treatments must be complemented by an understanding of how to continuously improve healthcare and to build safer systems.
In his recent review, commissioned by the UK Government, Don Berwick and his expert group made a number of recommendations for the achievement of a safe healthcare system.
The core philosophy of the report was summarised as:
"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end. Place the quality of patient care, especially patient safety, above all other aims. Engage, empower, and hear patients and carers at all times. Foster wholeheartedly the growth and development of all staff, including their ability and support to improve the processes in which they work. Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge".
In response to the above report, a programme has been established for leaders and patient representatives across North West London health system aimed at enabling a system-wide approach to organisational and cultural change with regards to patient safety. This programme fosters a culture of continual learning where participants will be to build skills and knowledge about safety improvement, create space and time to work on safety issues, and provide opportunities for shared learning and innovation.

Against this background, this inquiry intends to explore how participants on the programme apply the strategies learnt to enrich the culture around patient safety in their respective organisations irrespective of financial mandates. It will explore the art of enabling people to claim the necessary power to drive cultural change in quality and safety.
This inquiry further zooms into how the programme will empower participants to improve the understanding and practices of their colleagues to become fully committed to improvement of patient safety culture within their respective organisations.

This inquiry will use an action research approach that seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions of pressing concern to people and more generally the flourishing of the individual and their communities.
It uses a practitioner participative intervention that will enable change through involvement, understanding of self, participants, stakeholders and organisations via reflection on action, research, observations and triangulation of data from different sources.

Invitation
You are being invited to take participate in this research because you are involved in the innovative programme.
We believe that your knowledge and experience on the programme is valuable and relevant to this research project.
This research has been approved by Ashridge Business School Research Ethics Committee. The research will be carried out in accordance with the Ashridge Business School Code of Practice for Research.

Participation and Potential Benefits
Your participation is entirely voluntary. You are free to choose not to participate.
The main benefit of taking part in the study is that you will have an opportunity as a participant to describe in detail how the programme has supported in motivating you on your understanding of the practices to improve patient safety culture and to reflect upon your development throughout the process.
We will analyse and feedback insights concerning participants perspectives on the role of the programme in facilitating safer system, the barriers and enablers in creating and embracing new innovations where healthcare organisations will act as learning organisations and continually listen to patients about issues of safety and care.
The perspective you contribute to the research will be represented in published findings and might be used to inform NHS policy and practise.
There are no anticipated risks associated with taking part in this study.

Confidentiality
All reasonable means will be used to ensure the anonymity of research participants. Data collected during this research will be treated as strictly confidential. All data collected from participants will be anonymised in any published work; the names of individuals will be removed and replaced with generic job roles. Where you have agreed to the use of verbatim quotations your job role will be used as an identifier, but you will not be named.
All personal data will be handled in compliance with the Data Protection Act (1998).

Contact
If you would like further information about this study please contact Ronke Akerele on ronke.akerele@imperialcollegehealthpartners.com or +44 7807 167 371.

APPENDIX 3: RESEARCH CONSENT FORM

Ronke Akerele
Doctorate in Organisational Change DProf candidate
Tel: +44 7807 167 371
ronke.akerele@imperialcollegehealthpartners.com

Participant Consent Form

Please initial box

1. I confirm that I have read and understand the information sheet for the research and I have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and I am free to withdraw without being penalised or disadvantaged in any way.	☐
3. I understand that sections of my recorded comments and transcript text may be looked at by responsible individuals from Ashridge Business School. I give permission for these individuals to access this data as relevant to this research.	☐
4. If audio recordings are used, I give permission for my spoken responses to questions asked as part of the study to be recorded and I understand that any audiotape material of me will be used solely for research purposes and will be destroyed on completion of your research.	☐
5. I understand that this consent form will be kept separate from the data and that the researchers will maintain my anonymity throughout the project, including in publication.	☐
6. I agree to take participate in the research.	☐

Name of Participant (Printed) **Date** **Signature**

Name of Researcher (Printed **Date** **Signature**

APPENDIX 4: FOS LETTER OF INVITATION

10 Gre
London
Tel: 02C
www.imperialcollegehealthp

18 August 2014

Dear [insert CEO's name]

Patient Safety Collaborative for North West London
The Foundations of Safety: Invitation to nominate participants

Delivering safe care to patients is a priority for all leaders in healthcare. Our understanding of factors contributing towards building a safe healthcare environment continues to grow. Risk of harm to patients in our care persists and often this harm is avoidable. We know that a strong culture of safety based on listening and learning is a key factor in minimising the risk of harm. Board leadership that is visibly committed to improvement and enabling staff to openly share safety information are key foundations of such a culture.

Through Imperial College Healthcare Partners (ICHP), North West London (NWL) Boards have committed to co-designing an approach to supporting a system-wide patient safety culture as part of ICHP's Patient Safety Programme. This programme will be aligned with the National Patient Safety Collaborative that are about to be launched on the basis of the recommendations of the Francis and Berwick reports. This approach, titled 'The Foundations of Safety', will offer a series of forums for your nominated Board executives, non-executives, senior leaders, commissioners and patient representatives. Participants will be able to foster shared learning and innovation to deliver organisational and cultural change for their respective Boards and their organisations.

In accordance with recommendations your nominated representatives made to us over a series of co-design sessions and meetings, ICHP is commissioning a consultancy specialised in the delivery of customized executive leadership programmes to produce and facilitate delivery of the forum. In respect of the expertise that already exists within NWL leaders, there will be a non-didactic approach to learning, which will draw on expertise and experience from within the sector, from other sectors as well as internationally. The form and content of these forums will be developed through co-design between the consultancy and a sub-set of participants. Resource will be available over the course of the forums to support participants who wish to develop particular initiatives in their own organisations.

We expect 'The Foundations of Safety' to launch in **October 2014.** I am writing to invite you to nominate two to three senior leaders from your Board or wider organisation, capable of leading and delivering this programme on your behalf. I encourage you to think carefully when considering your nominees and select two dynamic leaders who embody the values of your Board and who can confidently lead on delivering organisational culture change. The success of the Foundations of Safety will depend on its membership. I would be grateful if your nominees would provide a brief summary of their role and interests which will be shared with other members of the forum. Nominees will be contacted shortly afterwards by Daniel Elkins, Lead for the Foundations of Safety for an informal discussion. Please send your list of two nominees by **Friday 5th September to:**

Ref: Foundation nominees
ea@imperialcollegehealthpartners.com

Please note, NHS England and NHS Improving Quality (NHSIQ) continue to work on patient safety at a national level to deliver the commitment to a national response to the Francis and Berwick reports. All organisations will be expected to join the Collaboratives for Safety that will be established under this initiative. This programme of work will incorporate most, if not all, of the requirements expected to form part of the National Patient Safety Collaboratives. ICHP and those involved in this Programme have been key influencers on the national developments and ICHP wish to continue taking a leading role and informing and influencing the national agenda.
This is an exciting opportunity to not only develop patient safety at a local level, but to simultaneously contribute to the emergence of a new national patient safety landscape.

Yours sincerely,

Dr Adrian R Bull
Managing Director
Imperial College Health Partners

APPENDIX 5: FOS CO-OPERATIVE INQUIRY PROCESS

Theme	Main Activities	Timeframe
Doing the groundwork	Gathered leadership development requirements and co-creation of FoS with NWL leaders Obtained sign-off from NWL NHS Trust CEOs and Chairs Procured a provider to support with FoS	May 2014 to Dec 2014
Forming the group	Letter of nomination to CEOs and Chairs to nominate appropriate colleagues in their respective organisations. Recruitment of patient champions to participate in FoS Letter of invitation to all nominated participants Briefings for all potential participants	Oct 2014 to Mar 2015
Creating a safe space	Engaging with Ashridge Consultants as facilitators Engaging with committed participants to agree rules	Jan 2015 to Sept 2016
Inquiry Cycle 1	Creation of sub-groups (SIGs) Agreed plan of actions and frequency of SIG meetings Undertook data gathering with wider colleagues	Mar 2015 to July 2015
Inquiry Cycle 2	Reflected on Cycle 1 experience Analysed data gathered Reviewed with co-researchers and reflected on findings	July 2015 to Sep 2015
Inquiry Cycle 3	Reflected on Cycle 1 and 2 experience Sense-making amongst participants on role and commitment to FoS Regroup and refine inquiry questions Present and socialise data gathered with colleagues Reflect on feedback and agree next steps	Oct 2015 to Jan 2016
Inquiry Cycle 4	Cycling through the phases of the inquiry	Jan 2016 to May 2016
Inquiry Cycle 5	Cycling through the phases of the inquiry	June 2016 to Sept 2016

APPENDIX 6: SERIOUS INCIDENT

Below is an excerpt of a Serious Incident (SI) meeting I attended, which I illustrated as stated in Chapter 3.2.

Mr Smith (Surgical Consultant), Dr Jacobs (Acute Medicine Trainee Doctor) Ruth Abrams (Nurse) have been invited to join Julie Brooks (Head of Quality and Governance), Nina Patel (Quality and Safety Nurse) and Maureen Daal (Head of Performance Management) at the SUI Meeting.

The purpose of this specific meeting is to review an SUI case of wrongful insertion of a nasogastric tube (NG tube) to the lungs instead of the stomach that resulted in the death of a patient.

On a Friday evening, Dr S. had undergone a long day of over 14 hours' work and, on his final patient for the day, he inserted an NG tube for Sally P. (a patient) who was nil by mouth following a surgical operation.

On completion of the procedure, Dr S. went home for the night and Sally P. was discharged to a recovery ward for monitoring.

Dr J. got a handover on arrival for the night shift and did a ward round in the early hours of the morning, after the Friday-night pressure had subsided from influx of patients in the accident and emergency unit, where he had been called to urgently assist with two deteriorating patients. Despite being fairly junior, he had to manage alone as his Registrar (next grade down from a consultant) was assisting with an emergency operation and was unreachable.

R. A. (Nurse) had the responsibility for reviewing and monitoring Sally P.
'Is it okay to feed Sally P. through the NG tube?' asked R. A. (Nurse), as she was slightly concerned she could not remove fluid from the tube.

'Of course, it's okay to feed her. Mr S. inserted it and he would have inserted it spot-on. His expertise is unquestionable', responded Dr J.

R. A. thereafter fed Sally P. One of R. A.'s colleagues had called in sick and she was looking after 12 patients instead of 8 and was finding it difficult to review her patients as frequently as she would normally. A few hours later, one of the health care assistants reported to her deterioration in Sally P.'s observations.

On further review in the day, Sally P.'s health did not seem to improve, and R. A. highlighted her concerns and informed Dr J., who requested an X-ray on Sally P.

The X-ray was performed and the result was reported in the system, flagging an error of mistaken insertion of tube in the lungs rather than stomach. Whilst the X-ray report was waiting on the system to be viewed, Sally P. was continually fed.

Being a weekend with limited clinical cover on site, both Dr J. and R. A. were working to their limits, and beyond the recommended hours and patient-to-nurse ratio.

Sally P. became increasingly unwell and R. A. increasingly became concerned about her health and then remembered the X-ray report was awaiting review. She contacted Dr J., who was about to finish his shift, to review the X-ray

report. They looked for the report in the system. They discovered two reports for Sally P., with one X-ray performed just after surgery.

It then occurred to them that Mr S. had requested an X-ray following the insertion of the NG tube in theatre. This had not been handed over by the nurses in recovery to the ward nurses or, if it had, it was to the nurses from the previous shift, who had not mentioned any specific handover from the recovery area. Nor had Mr S. communicated this to Dr J., and it was unclear whether Mr S. had spoken to the Registrar, who then had to rush off to theatre.

The alarm bells went off and efforts were made to reinsert the tube. Unfortunately Sally P. died within 24 hours as a result of severe pneumonia caused by wrong insertion of the NG tube.

As this was an adverse event, an incident report should have been completed, ideally by the clinician or team involved in the patient's care. In this instance, the report took a few weeks following the event to be completed but met the deadline on timescales for completion.

On narration of the events that led to Sally P.'s death, J. B. enquired further from all three clinicians (Mr S., Dr J. and R. A.) about their adherence to all the quality-related procedures expected to be followed in treatment of Sally P. whilst N. P. informed them of the consequences of the adverse event and likely next steps which could include an inquest.

M. D. enquired further on the clinicians' view of their performance levels over the period of the event and informed them of the data on the organisation's performance, including workforce and operational levels during the period of the incident.

The above story is not intended to question the proficiencies of the individuals involved in patient care or management of the system, but to provide a synopsis of discussions at an SUI meeting.

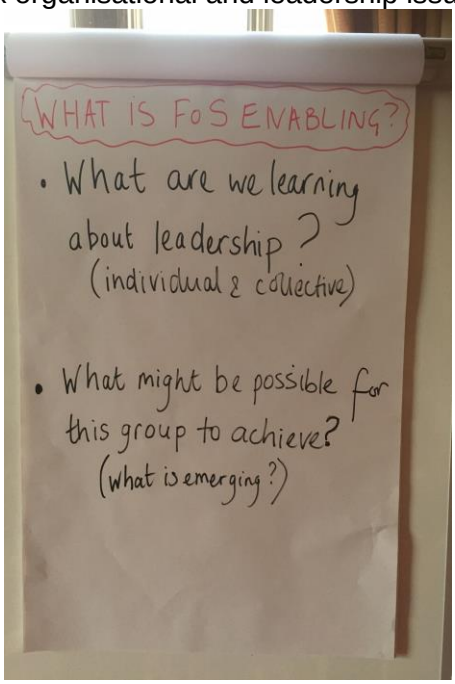
R. A. completed the report, though she was accused in underground whispers of whistle blowing on Dr J. Dr J. did not seem to have the courage to complete the report or, as murmured on the corridors, 'the balls' to identify Mr S. – a renowned senior consultant – in the report as inserting the tube incorrectly.

Meanwhile, Dr J. found it hard to continue to work, became withdrawn from his colleagues, found it difficult to sleep and had thoughts of giving up surgery. He felt responsible for not checking the first X-ray that had not been handed over and assuming that the NG tube was safe to use. He had not received a handover from his boss and had not wished to call Mr S. at home after the theatre list to check whether there were outstanding issues, as Mr S. had a somewhat fiercesome reputation and he had felt too junior to be calling the Boss at home to check about an NG tube. That evening the Registrar had been in theatre and so he had felt isolated and unable to ask the Registrar to ring Mr S. instead.

As a participant of such meetings, we are all equally to blame for embedding a culture of fear that is target driven, in which I question clinicians knowingly about aspects of the systems that contributed to the failure in delivery of high quality care which in most cases are beyond their control.

APPENDIX 7: FOS MID-CYCLE PARTICIPANT REFLECTION

By lunchtime, questions (snapshot in flipchart below) emerged about finding one's own agency with others and seeing one's role as leader and in our understanding that patient safety is a complex organisational and leadership issue.



The exploration of these questions was done through a fish bowl activity, which led to rich conversations amongst participants and further explorations that evolved throughout the sessions. Below are remarks from participants in response to the questions.

'I think for me it's the importance of listening to others and I found this really beneficial for me in coming away from the workplace and to hear from others across the sector on what leadership means to them. I was talking to Sally, when we went for our walk earlier, on attending previous leadership programs with theories plus models, and how this is different with regards to interacting with a leadership community in learning about leadership through sharing of our experiences. Sometimes it's reinforcing to self with regards to what you value whilst exposing you to new thoughts and ideas on how others approach leadership. I am finding it really, really very valuable.
Really, it's about listening to others and also finding time for myself with regards to reflecting on my own leadership skills. The workplace is so busy and sometimes you just don't take time in the work place to reflect on how you are putting your leadership skills into practice and what that means to the people around you. So, for myself, it is knowing to take some time to reflect, not just in this forum but outside as well, to engage with others who want to think and talk about leadership. The SIG group has really helped me with regards to listening to others in that small group around their thoughts and taking those on-board and accepting what others have got to say with regards to what fits into your own values'. Joanne – Deputy Director of Nursing and Governance.

'As commissioners, it is on how we share and learn about leadership skills on the commissioning side of things but also on how we work with our providers and not have a form of divide, because we all want the same thing. I suppose it's looking at what I have learnt over time and sharing it, as well as hearing individual perspectives on how we can do things differently because of the impact it is having and how it can perhaps be done in a different way. As some of us are in a small team in the workplace, it's about how we can develop and empower them to be asking the right questions.
Bridging the divide is about the quality of the relationship you can have and the basis on which the foundations are laid. It's about not being an expert and understanding where patient safety sits and how do we do it together. It could require some leadership, but actually people have to understand that we have some principles because if you are from the provider arm it's easy to think commissioners don't understand but actually it's where our skills come from, particularly those of us with a nursing background. It is how we do it in partnership as opposed to, this is the way it's got to be done, including the skills and tools that we use'. Maureen – Deputy Director for Quality and Patient Safety.

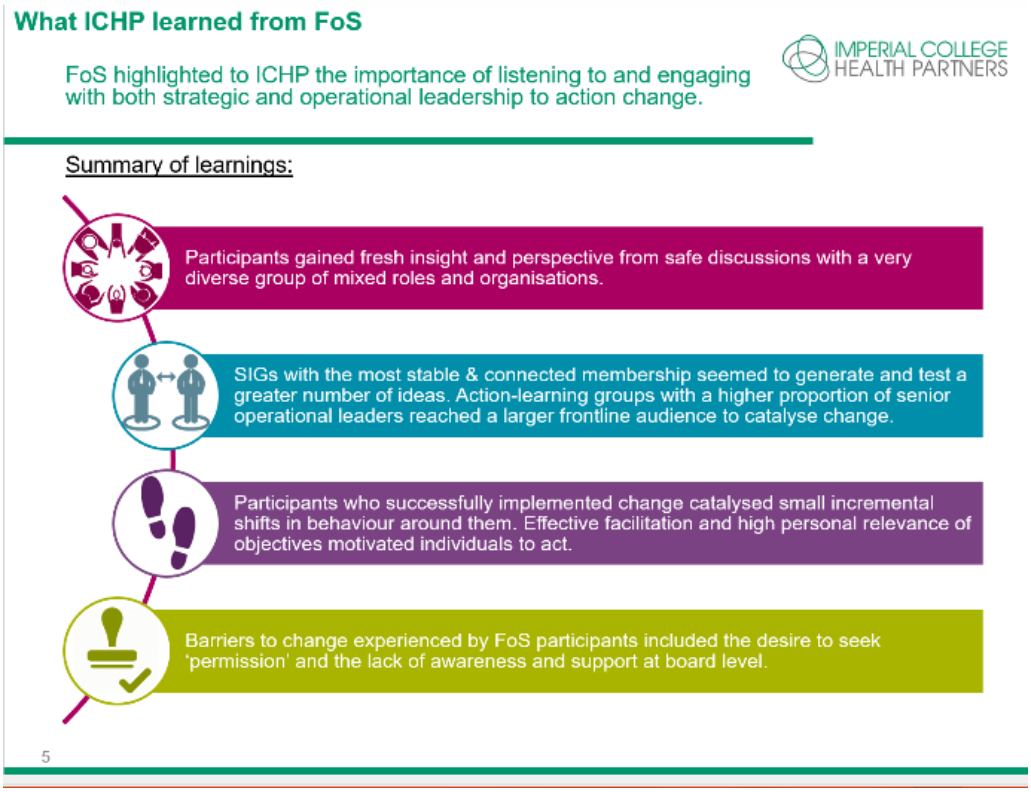
'I have learned that leadership is incredibly difficult when you want to bring about the change we are talking about here. It is a complete change in mind-set. I want my clinical colleagues to be more involved and I've found it difficult whilst having difficult conversations. I am bringing about change by actually acting it out myself to some extent and that's really difficult when you are sort of inspired here but then you go back to your organisation when you feel undervalued in the firefighting you are doing in terms of your day job. I think I have got to be stronger or something like that word when I go back to my organisation to deliver something I've benefitted from in this FoS programme'. Claire – Anaesthetist/ Clinical Director of Quality and Safety.

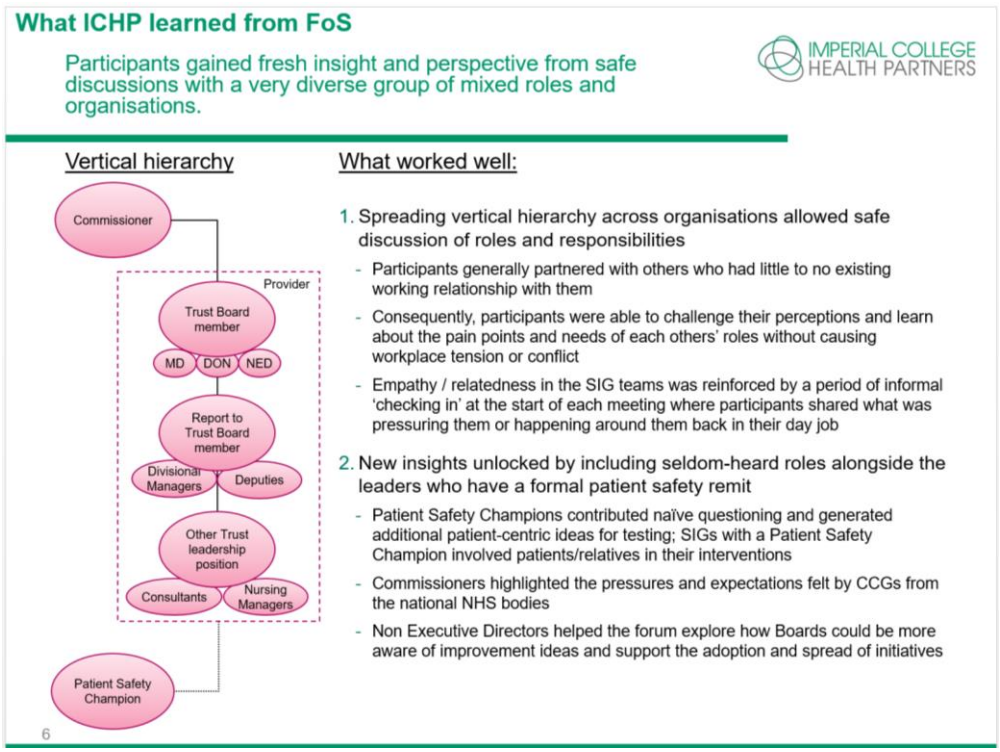
'I think it's becoming clear that's it is a collective responsibility, as we've just heard that said in lots of different ways. There is a lot of responsibility in actually being in a leadership role. We have to be strong enough to carry some burden and protect the people that we are trying to grow from below. During the walk earlier, we were standing under the shade of the oak tree and we were talking about actually putting our arms around the people who need to be able to do these new things and that's the bit I think is most important in terms of translating it from this rather grandiose environment that we are in – this very precious and privileged environment – to talk and learn about it. Taking it back is to put our arms around and create this protective cover around the people that we are working with and to enable them to feel that they are leading things and not take the ownership of leadership as something that sits up there but something that actually disseminates throughout the team'. Ronald – Medical Director

'I have found the experiential learning valuable. It emphasises that communication is really very important and listening to others and actually myself in terms of what changes I have to make in patient safety has been something I have been reflecting on deeply. With the inner listening to myself, I've managed to grow in strength and the resilience within is coming out. This is combined with understanding that the more I listen to people and myself in a given situation, the greater the understanding of where people come from. Towards achieving a common goal, I can see more clearly other people's perspectives which helps to put the arm around people as Ronald mentions to deliver good quality care to patients'. Nina – Consultant Physician.

- Transcribed from Cycle 3 reflection session, October 2015

APPENDIX 8: FOS EVALUATION AND IMPACT





What ICHP learned from FoS

Participants who successfully implemented change catalysed small incremental shifts in behaviour around them.

Effective facilitation and high personal relevance of objectives motivated individuals to act.

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What worked well:

1. Alignment of group objectives with personal passions and the role of operational leaders
   - It worked well to allow participants to choose their own area of interest for SIGs: participants felt energized by a common purpose and objective, but they still had the freedom to tailor actions to be relevant to their role (and organisational priorities)
   - Most participants contributed to their SIG in a way specific to their job, and supported by the other members (i.e. in shaping / progressing their idea), rather than as a group endeavour around their theme
2. Gaining confidence and trust from small and simple successes
   - Participants who achieved change within the programme's duration tried small scale initiatives within the remit of their day job with the people (direct reports / peers) they interact with day-to-day. Examples:
     - Seeking input and listening to other roles in their organisation
     - Increasing transparency / sharing insight / sharing data
     - Starting new structures or processes for team work / discussion
   - These activities had a noticeable impact on behaviour, culture, and communication quality; which in turn improved the morale of those involved

FoS Change Model

3. Effective facilitation to support progressive testing and learning
   - Examples of effective facilitation techniques:
     - Push participants to grow & nurture individuals' ideas expansively
     - Seek constructive feedback from other perspectives (experts or different roles/organisation types in the SIG)
     - Record actions suggested by each individual and informally hold members to account by reminding them of things they said they would or would like to do

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What we would do differently if we were to do FoS again

We asked participants for feedback and received several ideas for improvement, especially regarding executive support, clear aims & rules, and exploiting the network long-term.

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Suggestions from participants:

1. Articulate clearly the aims, objectives, and personal expectations of the FoS programme
2. Attempt to achieve a more stable membership or greater attendance at meetings
   - Churn at some of the face-to-face SIG meetings hindered establishment of new networks
3. Ensure that the "rules of engagement" are always clear and adhered to
   - Particularly important when mixing roles spanning the reporting / governance hierarchy
4. Gain wide breadth of support & sponsorship from executive directors in all partner organisations
5. Consider balance of investment into long-term thought leadership development versus short-term projects to tackle immediate NHS safety challenges
   - Project ideas emerging from thought leadership may require investment to take forwards
6. Exploit the power of the networks / connections forged beyond the life of the FoS programme

Collaborative Care

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Exam Question: How can we collaborate across the interfaces between acute, community, and beyond for better patient safety?

Achievements	• Explored how to create the conditions for more collaborative care within Ealing Hospital (specifically the endocrinology ward), the community Diabetology service, and primary care • Surveyed 131 staff, patients, and relatives to assess patient safety culture and priorities; facilitated patient focus groups and 8 one to one patient interviews • Expanded the Hospital at Night team handover meeting to include all acute medical, surgical, anaesthetic, and bed management teams • Standardised handovers using SBAR[1] structure and introduced a ward round proforma to empower junior doctors • Established a monthly Junior Doctor Forum to provide a platform to discuss safety concerns and design quality improvement projects • Tested reducing restrictions on patient visiting hours at Ealing hospital • Designed a framework (the 3 C's) to summarise the approach of Collaborative Care
Conclusions	• Staff priorities for patient safety improvement were communication (>30%) and teamworking and a structured approach (>20%) • 100% of 26 junior doctors and 94% of new FY1s felt they could make safety improvements, but 70% were unsure of how they could do it • Staff involvement was maximised via broad multi-channel awareness building: systematic emails, walk rounds by the Deputy DON, presentations, and lunchtime group discussions
Impact	• Improved quality and safety-focus of communication between staff and with patients / relatives • Empowered junior doctors to act on safety improvement ideas and boosted team morale • Using the learning from the programme, a delegate was empowered to use proactive participation to engage her team in positive culture change which led to the team winning an annual
Remaining Work	• Evaluate the changes made to handovers • Continue to explore Collaborative Care in practice at Ealing Hospital and across patient pathways in primary and secondary care

14 [1] Situation, Background, Assessment, and Recommendations

Measurement

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Exam Question: How do we develop patient safety measures?

Achievements	• Promoted safety huddles in theatres and wards with the development of templates to support discussions using appropriate information (using the Measurement and Monitoring Framework) • Implemented leadership walk-rounds at Hillingdon Hospital to encourage board members to gain safety information from frontline staff • Engaged junior doctors and band 5/6 nurses in safety information and created a data-driven daily safe staffing briefing at Northwick Park Hospital • Developed fishbone analysis in mental health safety at West London Mental Health Trust • Evaluated "Beautiful Information" to discuss how safety data could be displayed appropriately to promote improvement behaviours
Conclusions	• Safety information needs to be relevant at the individual or team level – and the Measurement and Monitoring Framework can be adapted usefully as a template • Data and measurement can alter behaviours not always in the right / expected way • The key is to develop measurements and data that promotes appropriate safety focussed behaviours
Impact	• Increased understanding of root causes and human factors in mental health safety incidents • Changed the nature of discussions about nurse staffing levels in Northwick Park hospital and reduced agency spend by 30% • Increased the frequency and changed the content of discussions about safety at Hillingdon hospital
Remaining Work	• Maintain and improve upon the initiatives tested so far • Implement "Beautiful Information" in up to 4 Trusts • Develop team focused (or individual consultant) information accounts based on the Measurement and Monitoring Framework and populate with data for personal appraisal • Adapt a computerised database to analyse safety incidents from CNWL to other care settings / organisations as a learning information system

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Board Culture

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Exam Question: What can we do to help Boards to ask patient safety questions and help them achieve patient safety culture?

Achievements[1]	• Created a better understanding of where patient safety sits in the London North West Trust governance structures; helped the Executive team and the Board to explore the question of "How do you see your role with regards to patient safety?" • Steered the Board's practice in Hillingdon hospital from paper-driven to substantive; reviewed the Quality Strategy, structures, and flow of information; helped fellow NEDs to think about what questions to raise at the Board and tested a template developed by the Measurement SIG • Provided clinical input to open up reflective discussions about patient safety in CNWL's Executive team; engaged clinicians in patient safety thinking in a variety of ways • Influenced personal approach to the Quality agenda at Chelsea & Westminster • Continued working with GPs and lay people across the CWHEE CCGs on how to respond well to bad news and learn from incidents in order to hold everyone accountable for their learning • Organised an event for Provider CEOs and CCG Chairs to connect them to the experience and learning of the FoS participants
Conclusions	• The best way of leading change at Board level is locally and individually by Board members, and to engage the SIG as a source of support, reflection, and learning • NEDs appreciated the commissioners' deep knowledge of tools and safety concepts, this informal sharing helped point out what resources are out there and where to access them
Impact	• Guided Executive teams to consider their role in patient safety and have effective conversations about patient safety • Prompted Non-Executive Directors to ask different questions at board / committee meetings
Remaining Work	• Continuing influencing conversations at Board and Sub-Committee level • Explore how Boards could or should support the initiatives from other SIGs • Explore if newly appointed NEDs would benefit from an onboarding pack that shares patient safety resources and explains the potency of the NED role

10 *1.It has been difficult to track achievements of this SIG due to the fluidity of the membership*

Staff Safety

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Exam Question: What makes frontline staff feel safe at work?

Achievements	• Distributed a questionnaire to ~30 frontline staff, Band 5/6 nurses and HCAs, to gather anonymous inputs about staff safety • Held focus groups with ~12 frontline staff to gain understanding of what makes frontline staff feel safe; the results led to the group thinking about handover processes, how bank and agency staff are used, and how permanent staff are deployed (e.g. trading off skill level with familiarity) • Launched a HCA forum at Royal Marsden hospital • Reviewed literature e.g. human factors, air industry, intelligent kindness, and bright spots • Drafted a care bundle for other leaders to repeat the learning locally
Conclusions	• Emotional safety is perceived as most significant to frontline staff, surprisingly more so than physical safety • A 'team' culture is important: when staff know and trust their colleagues, they feel safer – it is a team effort and they know they can rely on their colleagues; when staff work with strangers, teamwork is more challenging • The rules about safe staffing (e.g. skill mix) can work against safety by removing familiarity within ward teams and with patients • Line management has a big impact on confidence and culture of teams • Shared purpose, appreciative inquiry, active listening, and avoidance of analysis/judgement encourages story-tellers to open up and build the foundation for more difficult conversations • Open and honest relationships between Providers and CCGs is important for improvement
Impact	• Changed each participant's own leadership within their organisation: they were prompted to ask different questions and take different decisions, particularly with support workers • HCA forum supported HCAs to: design visual aids to improve fluid balance of patients; write a Go-To Guide to help induct new HCAs to Horder Ward; design a patient poster about mobility • Influenced priorities for Quality Account, 2016/17 priority is staff engagement
Remaining Work	• Spread adoption of the care bundle to other organisations and departments to enable more leaders to understand what will help their staff feel safe

Patient Involvement

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Exam Question: How can patients, relatives and the public be part of co-creating safer care?

Achievements	• Designed 3 events as part of the Sign Up 2 Safety campaign at Hillingdon hospital to honour the campaign commitment to engage, hear, and empower patients and the public in making patient care safer • Launched Sign up to Safety (June 2015) where: patient safety processes / structures / equipment were showcased to the public; staff were made aware of improvement initiatives in progress; and 40 patients and relatives were surveyed about patient safety, project involvement, and what could be improved • Held Patient Involvement workshop (October 2015) to: hear patients' experience of care; discuss how to reduce harm and prevent error; and draft what a Patient Safety Champion role could look like • Held Staff Involvement workshop (November 2015) • Published a paper in the BMJ about how to progress the involvement of patients and the public in healthcare improvement
Conclusions	• Despite Sign Up 2 Safety having collaboration as a central focus, not all of the Patient Safety Champions were aware of the campaign and it was not clear how to get involved • It was more successful to target patients / relatives waiting in A&E than those entering or exiting the main hospital entrance • Patients surveyed believe their feedback makes a difference to safety and they would like to be more involved, including in specific projects • Diversity in the workshop was widened by targeting voluntary groups with a diverse population
Impact	• Hillingdon hospital's Sign Up 2 Safety campaign effectively heard strong patient voices and role modelled best practice engagement
Remaining Work	• Explore means to recruit, support, and develop Patient Champions and attract senior sponsor • Identify opportunities for Patient Champions to become involved at Hillingdon and Chelsea & Westminster Hospitals e.g. joining leadership walk-arounds, safety committee • Test the involvement of patients, relatives, and staff in the improvement of a clinical pathway using co-production methodology

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Repository & Dissemination

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Exam Question: What are the key factors in successful dissemination and adoption?

Achievements	• Convened or joined events where successful safety initiatives were shared & discussed

Conclusions	• Organisations come to address critical patient safety issues not knowing of good work already done even by other NW London partners (not to mention nationally/internationally)
	• There is huge repetition/duplication from everyone synthesizing & prioritising best practices (from case studies etc.), there is opportunity for synergy, but centralising this activity is too onerous
	  ○ It's a huge workload to create, maintain, and update a NW London best practice repository
	  ○ A repository might stifle local innovation, serendipity, and unanticipated breakthroughs
	• Top down impositions of statements of best practice are unlikely to gain traction
	  ○ To change their ways of working, people need to understand what is being asked of them, the rationale/evidence for it, and to see the benefits arising from it
	• Dissemination is less about connecting people with a challenge with those who have a solution, and more about finding where the process of solving the challenge is happening and starting a dialogue about what can be learnt
	  ○ Real insights & sense of agency can be gained simply by giving staff the opportunity to meet to share the initiatives they've developed / are developing in response to a common purpose
	  ○ Holding high quality informal conversations to establish trust & confidence are critical factors that underpin long-term collaboration
	• Adoption & spread of a new practice is unlikely unless it has:
	  ○ A clear need and alignment with strategic plans of that organisation – the regulatory framework influences "urgent vs important" prioritisation
	  ○ Support & sponsorship up the hierarchy
	  ○ Systematic incorporation into the process of care, routine operational procedures, and performance reporting (but beware the over-reliance on procedures that stops staff thinking)

Remaining Work	• The conclusions from this SIG will be used as a crucial input when ICHP sets its priorities and workplan for the next 6 to 18 months in Jan 2017

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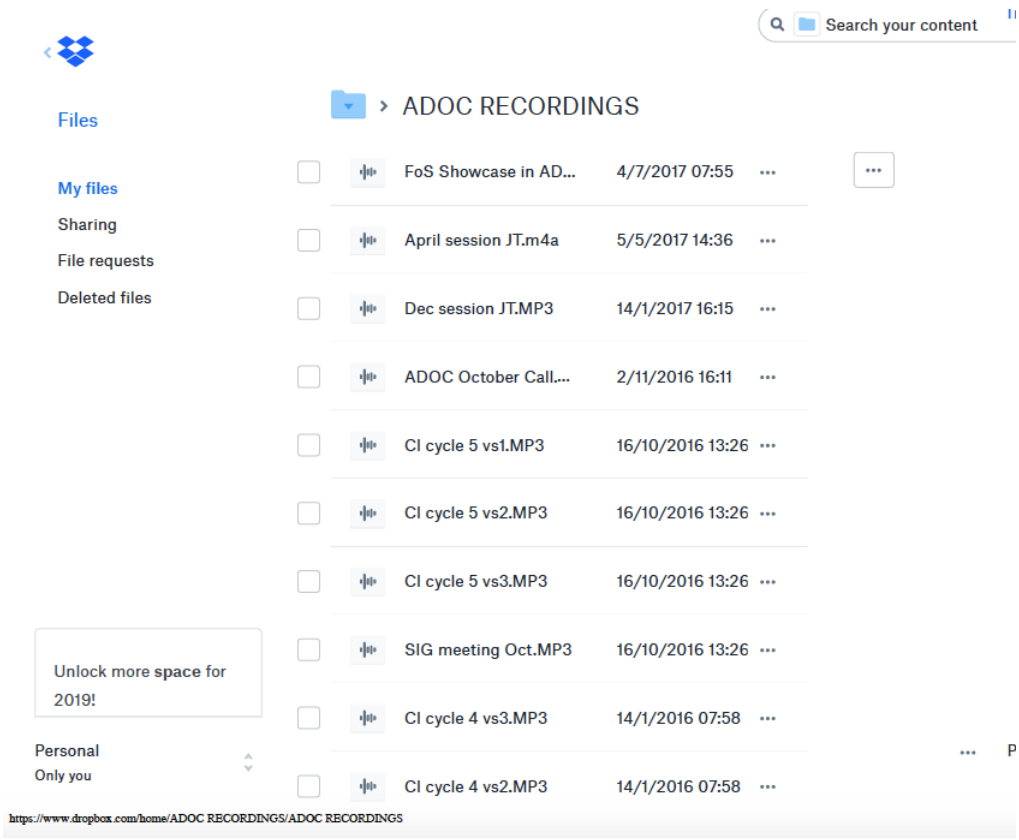
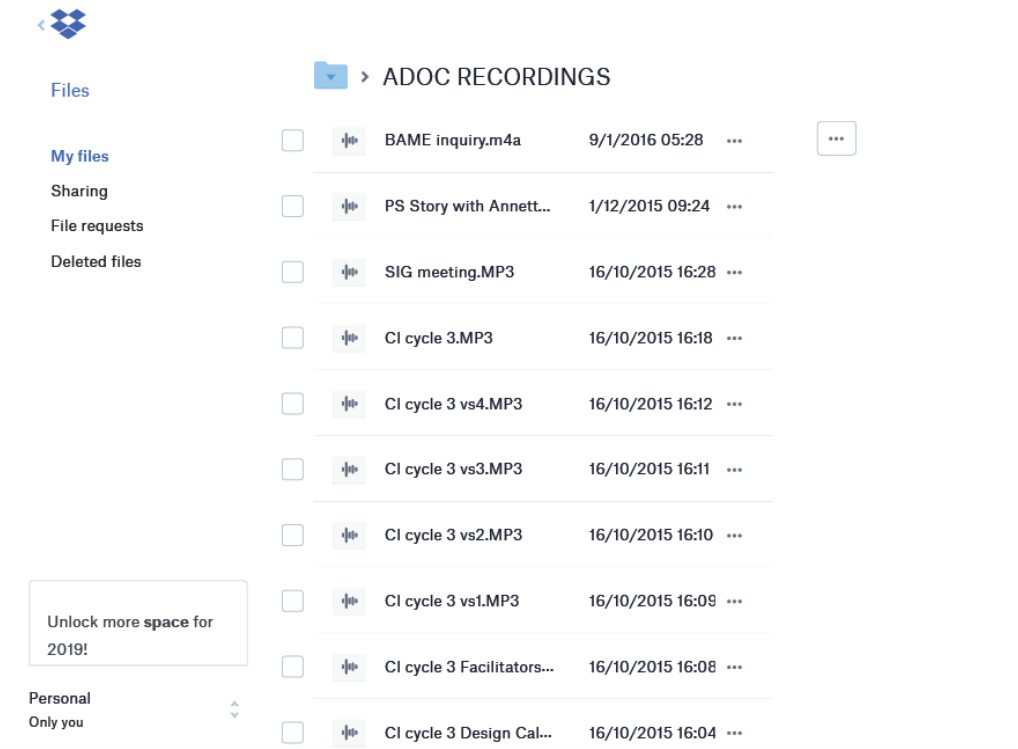
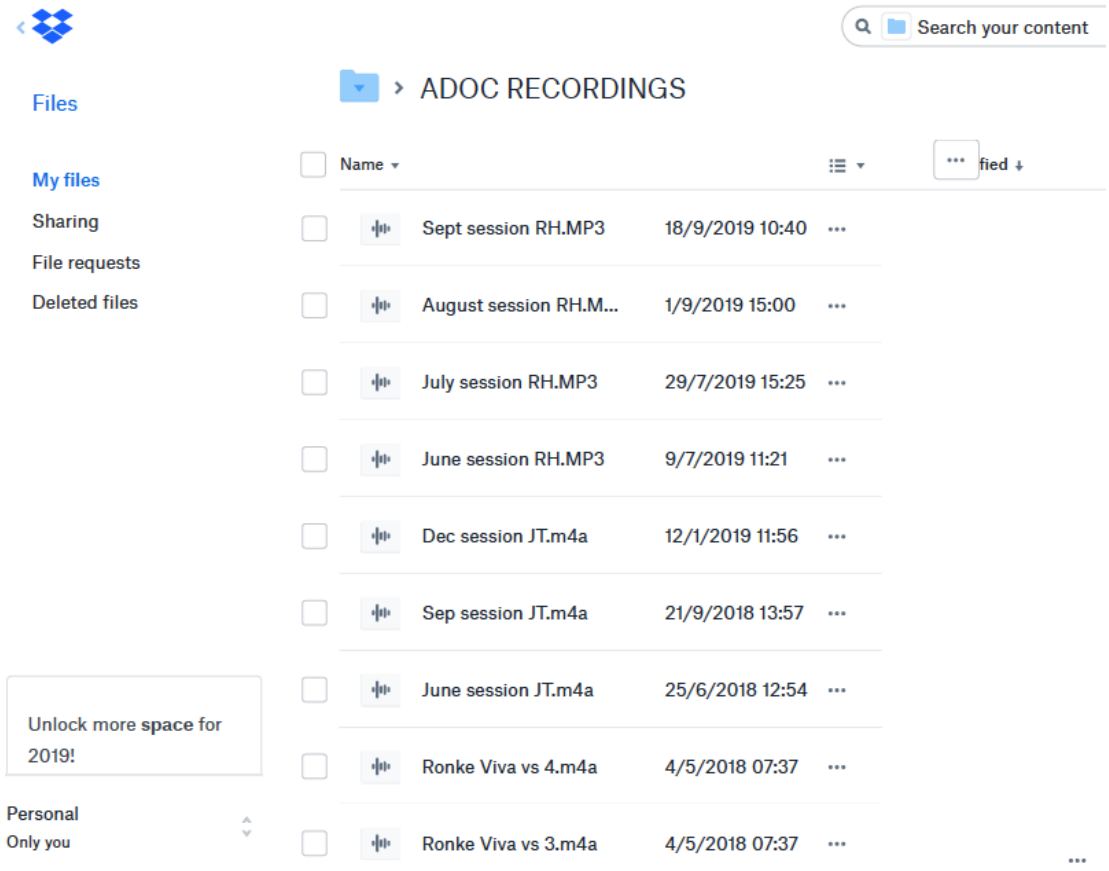
APPENDIX 9: RESEARCH DATA

Audio recording of FoS CI sessions

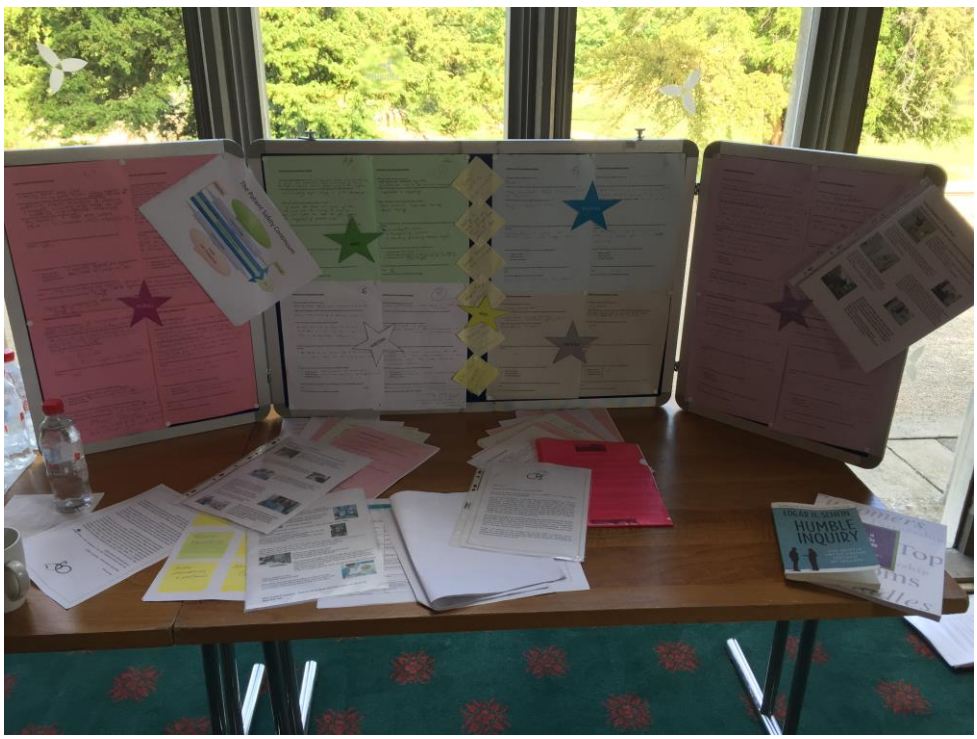


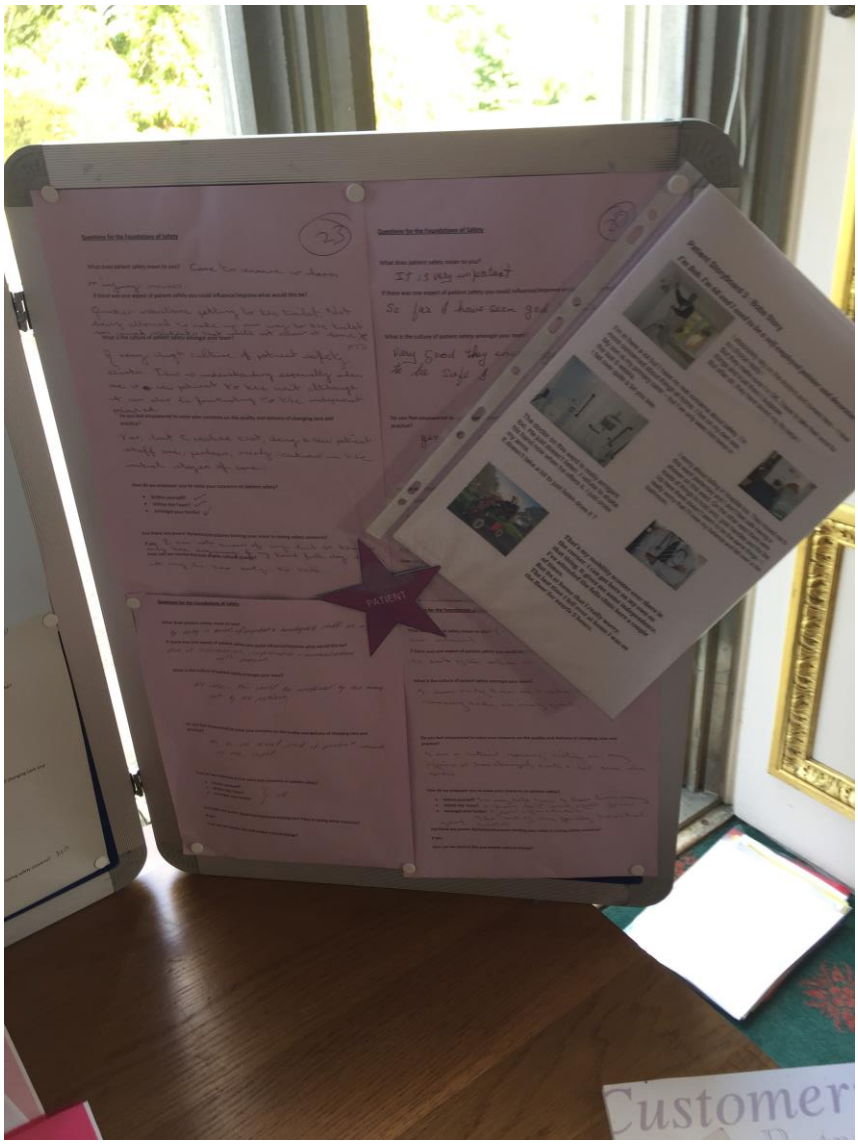


Audio recording of ADOC Process



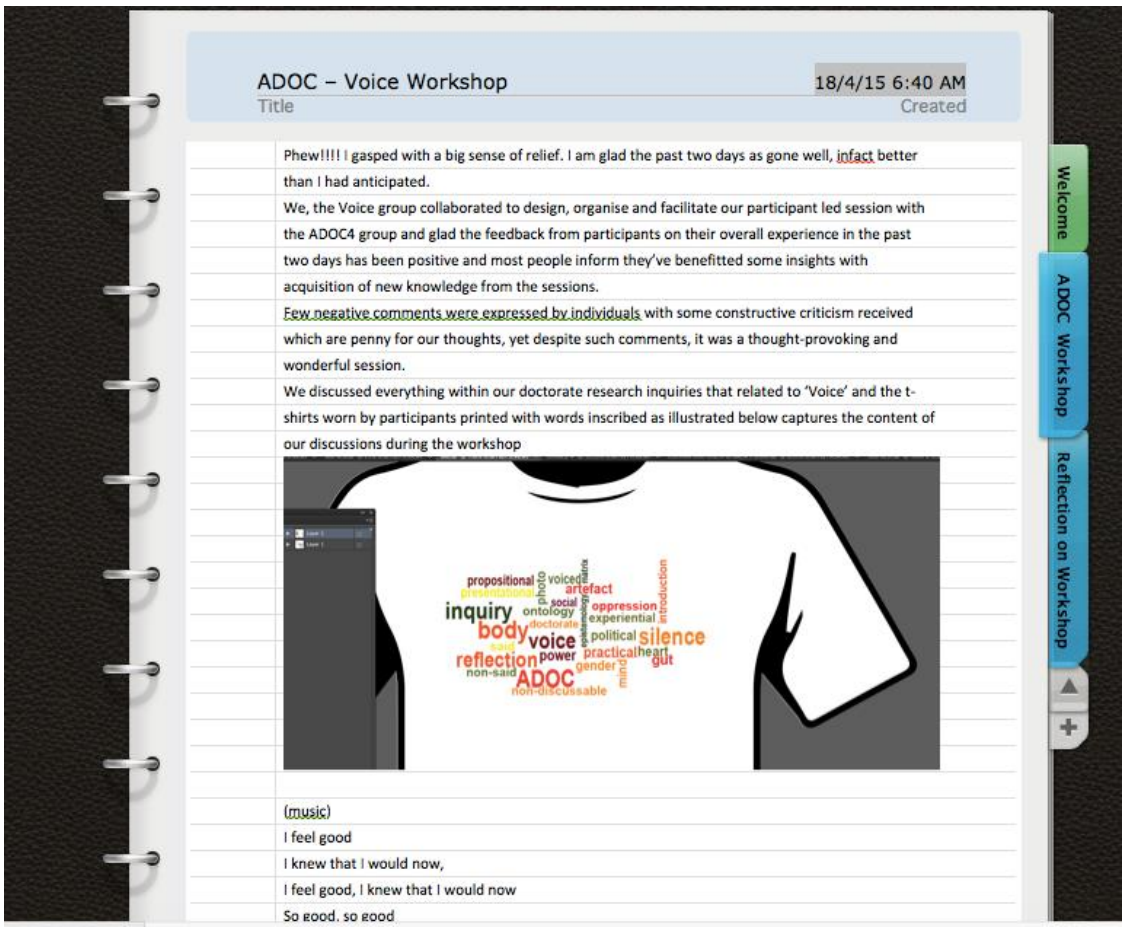
SIG inquiry on Collaborative Care




PATIENT
Customer

Co-inquirers in a FoS cycle of action and reflection sessions

Extract from learning journal



ADOC – Voice Workshop
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Phew!!!! I gasped with a big sense of relief. I am glad the past two days as gone well, infact better than I had anticipated.

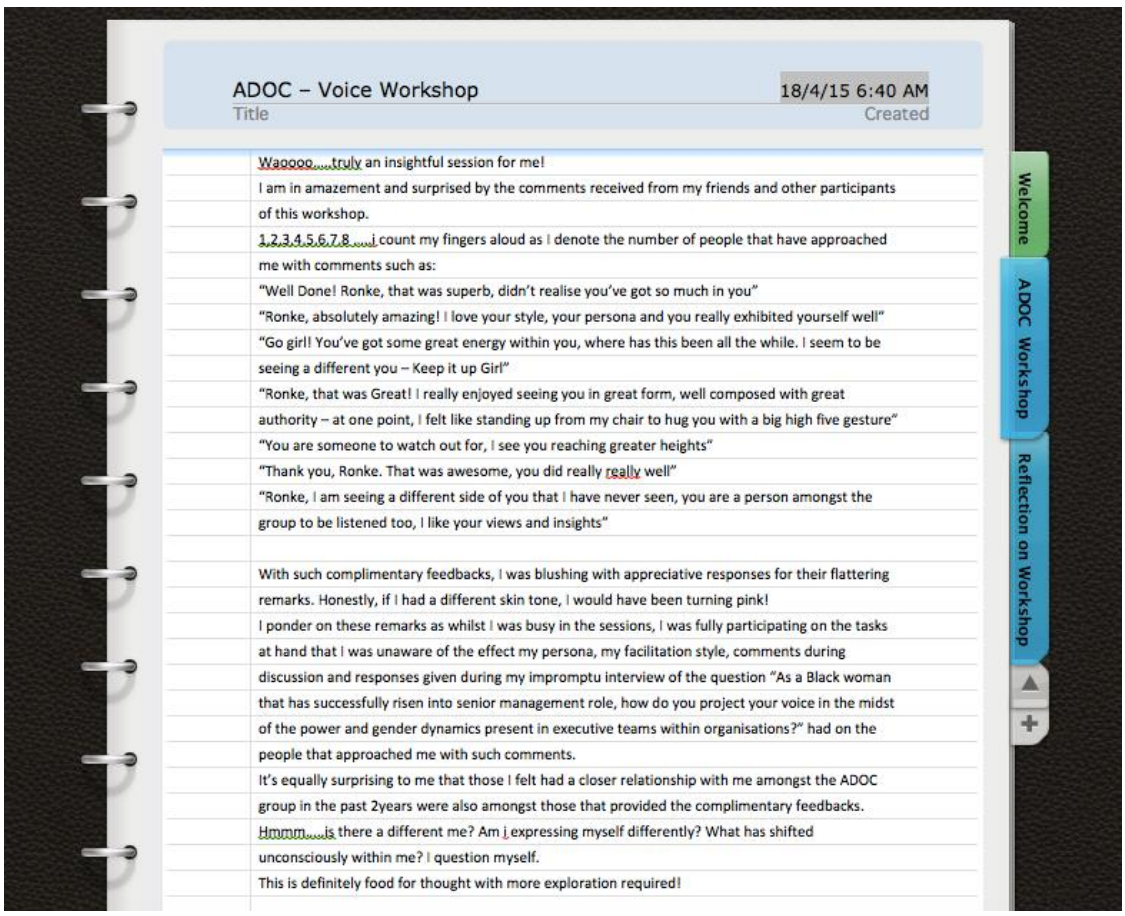
We, the Voice group collaborated to design, organise and facilitate our participant led session with the ADOC4 group and glad the feedback from participants on their overall experience in the past two days has been positive and most people inform they've benefitted some insights with acquisition of new knowledge from the sessions.

Few negative comments were expressed by individuals with some constructive criticism received which are penny for our thoughts, yet despite such comments, it was a thought-provoking and wonderful session.

We discussed everything within our doctorate research inquiries that related to 'Voice' and the t-shirts worn by participants printed with words inscribed as illustrated below captures the content of our discussions during the workshop

(music)
I feel good
I knew that I would now,
I feel good, I knew that I would now
So good, so good

Welcome
ADOC Workshop
Reflection on Workshop



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Wapooo....truly an insightful session for me!

I am in amazement and surprised by the comments received from my friends and other participants of this workshop.

1,2,3,4,5,6,7,8 ....i count my fingers aloud as I denote the number of people that have approached me with comments such as:

"Well Done! Ronke, that was superb, didn't realise you've got so much in you"

"Ronke, absolutely amazing! I love your style, your persona and you really exhibited yourself well"

"Go girl! You've got some great energy within you, where has this been all the while. I seem to be seeing a different you – Keep it up Girl"

"Ronke, that was Great! I really enjoyed seeing you in great form, well composed with great authority – at one point, I felt like standing up from my chair to hug you with a big high five gesture"

"You are someone to watch out for, I see you reaching greater heights"

"Thank you, Ronke. That was awesome, you did really really well"

"Ronke, I am seeing a different side of you that I have never seen, you are a person amongst the group to be listened too, I like your views and insights"

With such complimentary feedbacks, I was blushing with appreciative responses for their flattering remarks. Honestly, if I had a different skin tone, I would have been turning pink!

I ponder on these remarks as whilst I was busy in the sessions, I was fully participating on the tasks at hand that I was unaware of the effect my persona, my facilitation style, comments during discussion and responses given during my impromptu interview of the question "As a Black woman that has successfully risen into senior management role, how do you project your voice in the midst of the power and gender dynamics present in executive teams within organisations?" had on the people that approached me with such comments.

It's equally surprising to me that those I felt had a closer relationship with me amongst the ADOC group in the past 2years were also amongst those that provided the complimentary feedbacks.

Hmmm....is there a different me? Am i expressing myself differently? What has shifted unconsciously within me? I question myself.

This is definitely food for thought with more exploration required!

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Word Count: 69,478 (main text from contents to conclusion p. 7-213)