Large Scale Change – NHS Mobilisation

June 2010

NHS Institute for Innovation and Improvement

The NHS Institute for Innovation and Improvement was established in 2005 with the clear purpose and mission to support the transformation of the NHS, through innovation, improvement and the adoption of best practice. The NHS Institute's vision is to be an innovative and pioneering centre for healthcare improvement, building energy and enthusiasm for evidence-based change in England. The NHS Institute aims to promote learning from and to the NHS, encompassing both a national and global audience. The strategy to achieve this is by the creation and proliferation of inventive, clinically-led and tested practical ideas which have the ability to transform the way the NHS works: building skills and capability for continuous improvement and supporting leaders to drive real and lasting change.

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Executive Summary

The NHS Institute for Innovation and Improvement is championing the spread of activity to support the cost and quality agenda across the NHS, captured in the Quality, Innovation, Productivity and Prevention (QIPP) goals. The Institute has been undertaking work to understand how social movement theory could provide insights into how to reconnect the QIPP message to the core values of staff and create a 'contagious commitment' to rapidly increasing quality and driving down costs. This report summarises the findings from a project which the NHS Institute commissioned from the Institute for Employment Studies.

The purpose of the project was to identify a new 'framework' to address quality and cost in the NHS and to identify what messages would best resonate with staff to enable them to implement change to support QIPP.

The project involved:

- a literature review into the intrinsic values that are important to NHS staff and the prospects for harnessing them into a social movement for change (see Appendix 2)

- 16 different occupational focus groups on eight sites using an appreciative inquiry approach. These groups explored deeply held values among staff and their congruence with NHS values, experiences which generated feelings of personal fulfilment in the workplace and their views on messages about QIPP which would resonate with them. These findings were then used to structure ideas about how the cost/quality agenda could be framed to create energy and inspire all NHS staff to action.

This report is structured around a visual summary of the social movement literature shown in Figure 1. This provides an overview of how a social movement for change might develop or be orchestrated to achieve desired outcomes such as service improvement and reduction of waste and duplication of activities. It consists of a number of elements which support mobilisation and a number of factors which can hinder the process. These are:

- A persuasive frame for the message which resonates with staff's personal values can provide the initial impetus for engagement, but may be undermined by a managerial bias if no credible front line staff are championing the message.

- Generation of a collective identity through using peer champions and activists at workplace level which may inspire staff to get involved in QIPP activities, but may be undermined if there is no means of participation in decision-making and influencing the organisation of work and delivery of services at local level.

- Mobilisation supported by commitment from senior managers to act on suggestions for innovation but which may be undermined if no change results, leading to apathy and disillusionment among front line staff.

Figure 1: The process of staff mobilisation for change - from values to outcomes

Congruence   Champions/activists   Org support/leadership
Involvement   Peers   Participatory structures
Empowering   Stories   Quick wins

PERSUASIVE FRAME ☺   COLLECTIVE IDENTITY ☺   CO-ORDINATED ☺

Values ⟶ Identity ⟶ Mobilisation ⟶ Outcomes

PASSIVE RECIPIENTS ☹   NON-CONVERSION ☹   EROSION ☹

Elite bias   No invitation   Negative consequences
Orchestrated   No means   Disillusionment
Cynicism   Hierarchy/silos

The report is intended to be flexible to cater for readers who might want to use it in different ways. Key findings from the literature, the views of staff in the AI groups and the key messaging implications are grouped together under each of the headings in Chapters 2, 3 and 4. Short stories where individuals have been able to make a difference at a local level and gained a strong sense of personal fulfilment in the process are interspersed throughout these chapters. A summary of all the messaging implications is provided in Chapter 5.

What does the research say about staff values?

There was significant commonality in values across all occupational groups of employees who took part in the inquiry groups. Staff reported that the opportunity to care for patients, teamwork, professionalism, opportunities for involvement and contribution to decision-making, use of skills and opportunities to specialise and progress were key sources of fulfilment in their roles which tapped into their personal values.

What are the implications for messaging to mobilise staff in support of the QIPP agenda?

Analysis of the major findings from the inquiry groups generated a number of principles for framing messages to mobilise staff for QIPP.

Principle 1: Messages need to value and recognise staff – 'record and celebrate success' to avoid reinventing the wheel and stress the positive to counter a climate of messaging around 'what not to do'.

Principle 2: Involve staff in creating messages and include 'bottom up' examples of how to shape service.

Principle 3: Make messages simple and limit their number to make QIPP activities more memorable and easier to grasp.

Principle 4: Messages should be realistic and open the door for action, acknowledging organisational constraints and promoting small changes which can make a big difference, to enable QIPP to gain traction on the ground.

The messenger and means of communication

Face-to-face communication with individuals whom staff trust is the most powerful means of engaging and mobilising staff through opportunities for emotional engagement and interaction and especially important to convince people at lower levels in organisations that their contribution is valued. Credible clinical leaders and peers may be very important in engaging staff as powerful change agents.

Each Trust should have the responsibility to come up with its own ideas about QIPP messaging. Local campaigns do need to make sure they connect local vision with the NHS as one organisation and the NHS constitution as the overriding point of identity.

Content of the message - it's all about the patient…

Real-life stories about patient care and outcomes are most engaging to staff.

- Messages about delivering service you would want to have as a user are most powerful – 'improving cost and quality enable us to give care we'd like to receive'.
- The QIPP currency should primarily be about patient experience, not about money, though it is recognised that the two are connected.
- Preserving free access to, and equity in, health care provision are powerful motivating values that resonate with all staff. Connecting cost saving measures to these principles may make them easier for staff to support.

…and improving patient care will benefit staff too

- Messages around how QIPP will make the working lives of staff easier for each other will enable staff to see the win:win of the agenda.
- Breaking down messages about large budgetary savings into smaller meaningful ones about savings per employee or per team, expressed in non-monetary units, eg operations, patients or staff, would make the scale of the QIPP challenge more comprehensible and accessible.

Empowering and supporting staff to act

Messages about reasons for engaging with QIPP which connect the agenda with staff's core values and a prognostic frame for the future of the NHS will serve to mobilise staff emotions and intentions. Staff need to believe that support is available to enable them to embed QIPP in their daily work and provision of services at a local level. Messages about *why* to act will be insufficient to mobilise staff without

messages to convince them that structures and mechanisms are available to implement their ideas.

■ Messages should illustrate the support that staff will receive to 'make a difference' such as how spaces and mechanisms are available and being used to enable staff to contribute. Messages should include endorsement and recognition from colleagues *as well as* managers for participation.

■ Messages should stress that the hearts and minds of decision-makers are receptive to any and all suggestions for innovation.

■ Messages need to challenge inertia and risk aversion which staff identified as likely blockers or excuses for inactivity. Messages that 'It's OK to take a controlled risk' and 'doing nothing is not acceptable' could be powerful calls to challenge passivity.

Building on a common and distinctive future identity

■ Messages which connect the big vision with local context generate a sense of inspiring possibilities for staff – 'we are the biggest organisation in Europe but the most personal'.

■ Messages which illustrate personal connection between staff as employees and service users is emotive and inspires action – 'it's the only organisation that touches everyone's lives'.

■ Messages which connect the contribution of 'your daily role in the big jigsaw puzzle' to a larger purpose around the future of the NHS inspire staff to focus on their shared long-term goals.

Framing QIPP as an opportunity to challenge the wider system

For individuals with potential to be 'change agents', stressing the challenge of implementing QIPP will be motivating.

■ Messages about 'bucking the system' will resonate with staff who perceive themselves as innovators.

■ Messages that QIPP is an opportunity to 'make the system simple' for patients and staff will resonate with staff who are frustrated by bureaucratic complexity.

Framing QIPP in the language of struggle as a call to arms

■ Messages could generate a sense of solidarity among staff in helping to 'fight for the cause' and defending the NHS' reputation

■ QIPP messages could stress the public sector ethos of NHS and ask staff to collaborate to preserve its characteristics of equity of access to free healthcare and play on avoidance of compromising its core principles.

Messages for the public and public health around collaboration between staff and patients could contribute to a sense of mutual responsibility for health outcomes.

A few messages to avoid are those which use language around productivity, targets and auditing, and commercial language which undermines the public service ethos. The term 'QIPP' does not resonate with most staff and 'prevention' is especially difficult to interpret for those in non-clinical functions.

Segmenting messages to ensure they include staff in support roles through promoting personal development through QIPP activities and showing the indirect

impact of support functions on patient care is important to make this staff group feel equally valued compared to clinical staff.

1   Introduction

In order to meet the challenges that lie ahead in times of financial constraint, it will be important that staff across the NHS both hear and respond to the Quality, Innovation, Productivity and Prevention (QIPP) agenda. While the message has spread quickly, there is less evidence that the awareness has led to 'significant improvements in the system at the pace we require' (Bevan, 2010).[1]

The NHS Institute believes that social movement theory could provide insights into how to reconnect the QIPP message to the core values of staff and create a 'contagious commitment' to rapidly increasing quality and driving down costs.

The Institute for Employment Studies (IES) has reviewed the published literature (Appendix 2) on the intrinsic values that are important to NHS staff and the prospects for harnessing them into a social movement for change. We have also carried out 16 different occupational focus groups on eight sites using an appreciative inquiry approach to surface deeply held values. The workforce segments covered were:

- nurses and midwives
- allied health professionals including paramedics and physiotherapists
- administrative staff
- clinical and non-clinical managers
- ancillary staff
- executive team.

From these we have identified short stories where individuals have been able to make a difference at a local level by improving services to patients or colleagues and gained a strong sense of personal fulfilment in the process, which resulted in a sense of empowerment and strengthened commitment to their work. We hope that these will resonate with other staff and send the message that each person can make a difference, no matter what their role.

1.1 Overview of the report

This report is structured around a visual summary of the social movement literature (Figure 1.1) which provides an overview of how a social movement for change might develop or be orchestrated to achieve desired outcomes such as service improvement, reduction of waste and duplication of activities.

The literature suggests that the momentum originates in **deeply held values** which may be under threat or be re-awakened by a **persuasive frame** that stirs the emotions. During the recent passage of the US healthcare bill, for example, when many Americans warned of the dangers of an NHS style service, there was a widespread outpouring of support in the UK in defence of the principles of the NHS and pride in what it has achieved. People began to **identify** with the messages (through newspaper articles and television interviews). Staff remember why they first joined the NHS, the public recall the historical fight for its existence and there is a shared sense of indignation that a great British institution is under attack. Some, who

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[1]   Bevan H (2010), How do we mobilise the NHS leadership community and workforce at scale for cost and quality improvement?: A call to action, a provocation and a proposed way forward. NHS Institute.

felt strongly, **mobilised** by writing to newspapers and telling stories of their own positive experiences.

Figure 1.1: From values to outcomes

Congruence	Champions/activists	Org support/leadership
Involvement	Peers	Participatory structures
Empowering	Stories	Quick wins

PERSUASIVE FRAME ☺ COLLECTIVE IDENTITY ☺ CO-ORDINATED ☺

Values ⟶ Identity ⟶ Mobilisation ⟶ Outcomes

PASSIVE RECIPIENTS ☹ NON-CONVERSION ☹ EROSION ☹

Elite bias	No invitation	Negative consequences
Orchestrated	No means	Disillusionment
Cynicism	Hierarchy/silos	

During the journey from values to outcomes, there are factors that build momentum (above) and those that slow or stall momentum (below). The various sections of this report contain key research data 📖, outputs from Inquiry Groups 👫 and stories, to illustrate the various stages of this journey. The concluding chapter summarises the implications for messaging:

- Chapter 2 – Values
- Chapter 3 – Identity
- Chapter 4 – Mobilisation
- Chapter 5 – Messages.

The appendices contain summary mindmaps of contributors to personal fulfilment and the complete version of the accompanying literature review.

2   Values

Congruence   Champions/activists   Org support/leadership
Involvement   Peers   Participatory structures
Empowering   Stories   Quick wins

PERSUASIVE FRAME ☺   COLLECTIVE IDENTITY ☺   CO-ORDINATED ☺

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Social movement theory suggests that people identify with a cause when it resonates with their identities, ideologies and experiences. Messages must therefore tap into those deeply held values so that they create a **persuasive frame** that will empower them to take action**.**

This first section of the report examines some of the literature on values and motivators in the NHS and the outputs from the appreciative inquiry groups with different workforce segments. Summaries of workforce groups by clinical, non-clinical, clinical and non-clinical managers, senior and executives teams are attached as Appendix 1. As participants recounted stories of when they had felt most fulfilled during their NHS careers we discussed some of their key motivators and underpinning values and heard why they had first joined the NHS.

2.1 Values and motivators by job role

📖   Broadly speaking the evidence suggests that staff enjoy working for the NHS. Surveys of staff show relatively high levels of job satisfaction (CQC, 2009; Fielden & Whiting, 2007) and a view that NHS careers are rewarding: 91 per cent of NHS staff agreed with the statement, 'I've got a worthwhile job that makes a difference to patients' (Ipsos Mori/DoH, 2008). This job satisfaction appears to stem particularly from the intrinsically satisfying nature of NHS work.

'Public service motivation' may also be a powerful source of energy within the NHS. This is defined as 'the motivation of people who feel a sense of duty or responsibility for contributing to the welfare of others and to the common good of the community or society' (Horton, 2008).

Nurses and Allied Health Professionals

The first two groups of staff we consider are nurses and allied health professionals (AHPs).

    📖   Most frequently, nursing and AHP staff cite the opportunity to work with and help patients as the best part of their job. Conversely, stress, pressure, high workloads and understaffing often top lists of the worst things about working for the NHS, particularly because it reduces the amount of time staff can spend with patients (Arnold et al., 2003). Nurses and AHPs working outside the NHS identify the slower pace of work in the private sector as a key reason not to work for the NHS. Another aspect of this is a desire to be allowed to 'get on with the job' of caring for patients. Muller et al. (2008) discuss how nurses in NHS Direct call centres often express opposition to the strict structuring of their work, such as restrictions on how long they can spend talking to callers. While seeing the utility of a framework for talking to callers, nurses tend to want greater discretion over the way they handle calls.

Nurses

    📖   Fielden & Whiting (2007) find that nurses have a high level of job satisfaction despite the fact that the NHS is not always delivering the things that staff define as most important to job satisfaction.

👪   Inquiry group participants' stories identified several common themes:

- **A sense of camaraderie**: people spoke warmly of colleagues and their support in a way that was beyond just good teamwork. At one time 'it felt like a family'.

- **Pride**: nurses want to feel pride in their job and feel they have done their best in every situation. Achieving a team award in recognition of success was also a source of pride.

- **A sense of vocation**: many nurses had always wanted to care for people and alleviate pain and feel that nursing is rooted in a strong public service ethos.

- **Teamwork**: it is important to the role that 'everyone worked together, including patients'.

- **Professionalism**: nurses enjoy using all the skills acquired through rigorous training and these include 'caring qualities as well as the analytical qualities'.

- **Meaningful work**: nurses value variety in tasks, autonomy in choice of how work is undertaken and having time to care.

- **Trust support**: it is important for nurses to know they will receive support from their Trust which may include financial backing for innovations and public recognition for good work.

- **Public confidence**: nurses value the confidence of the public and believe negative publicity results in a perception that hospital is an unsafe place.

- **Making a difference**: nurses described how they often achieve good outcomes from negative or crisis events and value the opportunities to support families. Where incidents do not have happy outcomes, there was satisfaction from knowing 'you did everything you could'.

- **Feeling valued**: nurses appreciate symbols of thanks, acknowledgement from patients such as flowers and letters.

- **NHS values**: nurses strongly believe that NHS values should centre around people not money.

- **Equity and fairness**: they value a health service that is free to all and which reflects the diversity of patients.

The story below illustrates several of these values.

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Making a difference

This story relates to coronary care and bereavement training. The patient arrested on the way back from treatment. There was pressure on the/most senior staff member present, who felt overwhelmed at having to deal with the family including distressed children. The nurse felt she did not have full control of the situation. She accompanied the family to view the deceased patient and found the ward staff had made a real effort to lay out the patient. She recalled it as 'a spiritual moment'. The arrangements that had been made in the other ward gave a sense of calm with flowers and soft lighting. Later one of the children asked her if she would go with them to see the [dead] grandparent. She felt a great sense of relief that the other nurses had done so well. She mentioned the effort they had made, their consideration, dignity and respect they had given the patient. She felt 'this was the essence of true nursing'. The family were grateful for staff compassion despite their bereavement and sent flowers to the staff and a letter from the children.

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Allied Health Professionals

    The motivations of nurses and AHPs do not overlap entirely. For example, a slight concern amongst AHPs (physiotherapists and radiographers) is a lack of recognition for their role. Both qualified (Fielden & Whiting, 2007) and trainee (Arnold et al., 2003) AHPs express concerns that they are less valued within the NHS, particularly compared to nurses.

    The inquiry groups reflect some of this concern in their desire for greater integration and a sense of knowing what happens to the patient when they leave their care. The multi-disciplinary element of their role and the need for recognition from peers were therefore important in their stories of personal fulfilment:

- Saving lives and making a difference through good patient care and outcomes.
- Recognition from peers for expertise and a job well done.
- Teamworking among colleagues with a complementary mix of skills.
- Multi-disciplinary service delivery with more integration and streamlining of services.
- Professional courtesy from other medical staff.
- Flexibility within the scope of the job to respond to patient needs.
- Seeing a job through and knowing patient outcomes.
- Professionalism and building experience and confidence.
- Successful completion of medical tasks and the intrinsic satisfaction from proving technical competence.
- High-trust management-staff relations which allows discretion and responsibility to deliver services well.
- Career and personal development, self-fulfilment.

Ancillary services

👥 Staff in ancillary services add that staff well being is also of value and staff should not feel awkward about using aftercare services to alleviate stress as it impacts on patient safety and care.

- Patient safety and well-being.
- Staff safety and well-being which has an impact on patient care.
- Using skills and building confidence to gain a sense of achievement.
- Joint working with social services.
- A good balance between quality and quantity in patient care.
- Patient feedback.

Administrators

👥 Staff in non-clinical roles also value team spirit and want to contribute to patient well-being through:

- Team spirit, mutual respect and working with competent colleagues and a professional team.
- Pride from gaining recognition for good work.
- Challenge and opportunity for personal development, building transferable skills and having stretching goals.
- Involvement with other staff groups in order to understand how their work connects with that of others.
- Getting positive feedback and good communication from managers which makes them feel valued.
- Saving costs.
- Autonomy, discretion and responsibility over how work is carried out.
- Being able to see how work in a support function contributes to patients' well-being.

Clinical and non-clinical managers

📖 There are much higher degrees of engagement and advocacy of the NHS amongst managers (Ipsos Mori/DoH, 2008; Robinson, Perryman and Hayday, 2004). Furthermore, these more positive attitudes increase with seniority (Ipsos Mori/DoH, 2008). Merali (2005) notes that despite the apparent perceptions amongst the public and, indeed, clinicians that NHS managers are excessively concerned with money and form filling at the expense of patient care, many managers do in fact have strongly altruistic values.

👥 Clinicians in the inquiry groups who are also managers find the 'them and us' perception produces conflicting emotions. Managers have similar values to other groups but have an additional desire to influence change through their role. Themes from their stories include:

- caring for patients: making a difference through helping people and saving lives
- variety of work

- professional development and opportunities for continuous learning
- career progression in a variety of specialisms and the opportunity to change track
- support from managers and more senior staff
- teamwork and strong mutually supportive relationships with colleagues/peers
- recognition that they are doing a good job through positive feedback
- freedom to innovate and try new ways of working
- open communications between teams
- the ability to influence and effect change in a collaborative way.

Executive team

👫👫 Themes of fulfilment for the executive teams reflect their broader responsibilities for the whole Trust and beyond through:

- embedding a culture of service improvement and quality in a positive can-do culture
- internalising the meaning of QIPP without the jargon
- improving patient care, listening to patients and staff, stories of success from patients
- working innovatively beyond rules and structures
- improving productivity through advanced care planning
- supporting staff, empowering them and receiving feedback, recognise and appreciate staff efforts, building trust across the organisation
- embedding fairness, openness and transparency
- ensuring patients are the main focus
- promoting good teamwork at all levels
- responsibility for public money
- leadership development – role modelling effective behaviours, working collaboratively within the Trust and beyond.

The executive team stand out as having the most distinctive set of values compared to the other groups but, in spite of the difference in roles, levels and focus there is a good deal of commonality in the things that matter to NHS staff. When feeling most fulfilled staff identified:

- teamwork
- communication
- recognition (none of the examples were financial – all were about managers saying 'well done' and 'thank you' – especially important in non-patient care roles – or letters and messages from patients)
- opportunities to learn/use skills.

Reminders of anchor values around working for the NHS

Bevan (2010) suggests that it is impossible to 'mobilise at scale by appealing to people's self-interests: *'what's in it for me?'* This was challenged somewhat by staff

who highlighted the importance of messages that would demonstrate benefits of QIPP for staff as well as patients. Some of the factors they cited as being important to them about working for the NHS are:

- job security and a secure future, including a good pension
- good working conditions, particularly flexible working arrangements
- good training and professional development opportunities
- a safe working environment
- good career prospects with structured career pathways
- ability to use one's full range of skills in a variety of work
- doing useful and meaningful work
- being supported by management
- access and feeling able to use services, eg counselling, occupational health.

These factors are supplemented by reasons why people chose to join the NHS which included:

- (pride in) feeling you can make a personal difference
- 'delivering something worth getting out of bed for'
- giving a genuine public service 'available to everyone regardless of means'
- opportunities to specialise and change career track
- opportunity for flexible working and work-life balance
- job security and a good pension.

This means that the messages developed to inspire staff to implement the QIPP agenda must be consistent with, and supportive of, these values. The **opportunity to use and develop skills**, the **availability of management support** and a sense of doing **meaningful work to contribute to a safe working environment** are three factors which seem likely to be important for framing QIPP messages.

2.2   A persuasive frame ☺

In order to harness these values, social movement theory suggests that a persuasive frame is needed to connect with people 'in a way that makes them pay attention' (Bibby et al., 2009). This frame must be seen as **empowering** so that it paves the way for action. To avoid the 'elite bias' discussed later, the messages should **involve** people and their real stories to create a compelling narrative that ensures **congruence** between the organisational vision and employees' deeply held values.

📖   'Framing' moves away from the rational, utilitarian models of change based on an instrumental understanding of motivation, to a direct appeal to personal beliefs through emotive engagement. It has been described as the 'single most important aspect of social movement theory' (Bibby et al., 2009). Benford and Snow (2000) describe it as 'meaning construction', which works by increasing the salience of the message through tapping into beliefs that people already hold, increasing the likelihood of them taking action. Bevan (2010) suggests that there is a need for 'higher level framing that focuses on mission and core purpose'.

👪   Staff want to see easy connections between QIPP, the values of their organisation and the values of the NHS Constitution. They say there is a need for a clear vision/purpose around patient care, working smarter and having a clear idea of

service to be delivered. They also want to understand the true financial position of their Trust and understand how QIPP might tackle it. To make QIPP meaningful, they feel it should be presented in a more concrete way, being specific about the type of positive outcomes expected by broad roles, including those in support roles so that all staff feel that QIPP relates to them. For example, how 'prevention' is relevant to staff working in roles without patient contact such as administration.

2.2.1 Empowering

One of the key messages from the inquiry groups is that staff want to 'make a difference'. A persuasive frame must therefore be one that is enabling, rooted in real experiences from a variety of workplaces which are recognisable to staff and setting the scene for action through making the possibilities for change plausible.

'Engage people by providing 'bottom up' examples of how to shape services.'

Staff suggest that messages about how relatively small things can make a big difference are empowering as they encourage staff to contribute in lots of small ways in their daily routines. As one participant said,

'If everyone could save £2 a day per head the financial problems would be solved.'

2.2.2 Involvement

The key underlying driver of employee engagement in the NHS is 'feeling valued and involved' (Robinson et al., 2004). Involvement comes from being given the opportunity to contribute to decision-making, have one's views taken seriously and shape how work is organised and services are delivered. It depends on good communication mechanisms being put in place and used effectively by managers at all levels of NHS organisations.

Inquiry group participants consistently asked for their voices to be heard and their contributions to be taken seriously, with opportunities for upward communication from staff to managers, rather than solely downwards from managers to staff: 'listen to us', 'stop threatening us', 'listen to the public'. From a practical perspective staff feel they know what to do to improve services. They feel that many unintended consequences from management targets and solutions could be foreseen if staff on the front line were regularly consulted or actively involved in decision making.

One group described another importance of being involved, to help them take ownership of organisational changes:

'As part of the strategy the management gave the opportunity for everybody to be involved, which made people more likely to own and be part of it.'

Involvement was also felt to be vital to gain momentum:

'Be inclusive, ask the whole organisation for input otherwise people will use hierarchy in decision-making to justify inertia.'

Various non-clinical staff groups also expressed their desire not to feel 'peripheral' or secondary to staff who had patient contact. All groups want to feel an integral part of the whole system and understand how they contribute to the bigger picture of positive outcomes for patients and NHS organisations.

2.2.3 Congruence

📖 Employee involvement in decision making is also more likely to lead to the development of value congruence with employers (Ren, 2009). There is, however, evidence from recent surveys that staff are no longer identifying with NHS values.

- Only 27 per cent spoke positively about the NHS 'as it is now' although 42 per cent spoke highly of 'what the NHS stands for' (Ipsos Mori/DoH, 2008).

- Only 52 per cent of staff understand the national vision for the NHS (CQC, 2009).

- Only 50 per cent of staff feel their Trust communicates its aims clearly (CQC, 2009).

- The lowest score given to the NHS in a public survey by the Reputation Institute (2010) relates to having 'a clear vision for the future'.

This illustrates that more attention needs to be given to communicating the core *future* purpose of the NHS and its constituent organisations in a way that connects with deeply held staff beliefs about what the NHS should be. It is striking that even at a local level, staff do not necessarily feel they understand the goals of their Trust. There is potential for the QIPP agenda to fill this space because it offers a means of connecting local and national visions to the NHS constitution.

👫 Nurses feel that it is important that management and staff share the same vision for the NHS; that it is not a 'business' and does not lose sight of caring for patients. This could be demonstrated by more meaningful and flexible targets and less emphasis on throughput and budgets. This will involve staff consultation in development of goals and targets to avoid unanticipated consequences. These were highlighted earlier as a source of frustration to staff if they undermined goals of service improvement.

The illustration below from one group of nurses suggests that value congruence promotes innovation through staff confidence in being able to challenge, make suggestions and instigate change.

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Value Congruence

At Winchester and Eastleigh NHS Trust, nurses identify strongly with their own Trust's values and believe that all staff would know what the values were if asked. They take pride in the reputation of the Trust, believe that staff views are heard and have confidence that the Trust can 'make things happen'. This alignment of values encourages a culture of innovation where nurses feel able to question, take new ideas forward and 'sell them' to others and spread learning.

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2.3 Passive recipients ☹

The first set of challenges in using social movement for change relate to the possibility that people do not identify with the frame and remain passive recipients of the message. Firstly, this might occur because it is seen as a traditional 'top down' communication with an **elite bias** which does not connect with the personal values of individuals. Secondly, the processes may seem too **orchestrated** with little room for employee involvement in shaping the change, or worse, token employee involvement where they give up time to take part in consultations with seemingly no outcomes or pre-determined outcomes. Finally, the frame may require persistence to overcome suspicion and residual **cynicism** from previous initiatives.

2.3.1 Elite bias

📖   Critics of the framing approach suggest it can focus too much on the role of elites (Benford, 1997; Ganz, 2001), regarding it as a form of persuasion particularly when used in political communication (Nelson, Oxley and Clawson, 1997). The frame becomes a message projected at employees without asking them for input. This is dangerous because it assumes managerial and staff values will be congruent and we have seen earlier that senior managers, in particular, may express their values slightly differently from other staff, even if all are working to common goals. Some of the key messages from the literature are:

- Managers need to beware of projecting their own motivations onto medical staff (Keller & Aiken, 2008).

- There are higher degrees of engagement and ambassadorial orientation towards promoting the organisation among managers which increases with seniority (Robinson et al., 2004).

- People are affected by their view of the messenger so someone with a dislike of government interventions may be less likely to listen to messages that are perceived to come from the 'government' (Nolan et al., 2010).

This means that gaining the backing of champions who are credible to staff for promoting and implementing of the QIPP message is important to its success. This may involve developing small pools of champions across different staff groups, given the diversity of occupations in NHS workplaces.

👪   Participants in one group see the existing culture and management style in their service as male dominated in senior and operations management positions and too 'top heavy' with a steep hierarchy. This tends to 'infantilise' staff which leads to employees not taking ownership of change. Possibilities for change, therefore, feel limited because of the narrow focus on targets which tend to be operational and ignore the need for fundamental building blocks of good communication and staff management to enable staff to embrace and drive change.

2.3.2 Orchestrated

📖   The literature identifies two approaches to social movements in organisations. The first are oppositional and emergent as in 'traditional' social movements (Zald and Berger, 1978). The second are management-instigated 'orchestrated social movements' which have less emphasis on struggle, conflict and overturning the status quo, but focus instead on co-ordinated and purposeful change in pursuit of goals for the organisation. The danger for QIPP as a social movement is that it risks becoming over-orchestrated with a top down cascaded message that fails to resonate with staff and fails to generate a groundswell of support. This implies a need to create spaces in which relatively informal interest groups can come together to define the goals and methods for implementing changes to support QIPP. Orchestration is required in the form of 'organising for impact' (Bibby et al., 2009) but not as a pre-determined, top down blueprint for change.

👪   Top down communication is seen as problematic to learning and participants see a need for regular feedback and bottom up communication so that the whole system learns. Some of the key messages from the Inquiry Groups to ensure the QIPP message is not simply seen as 'orchestrated' and 'top down' are:

- Most participants in roles with patient contact do not recognise 'QIPP' – it may need to be embedded in other more familiar messages.

- People do not want to be overwhelmed with QIPP messages – just a few short and simple ones to avoid initiative fatigue.
- Messages should be linked to familiar concepts that staff respect. For example, the Productive Ward programme is well-regarded and could be linked to QIPP.

2.3.3 Cynicism

Another reason why staff may remain 'passive recipients' is what participants describe as a 'deeply-entrenched resistance to change among those who have worked in the NHS for a long time' or a sense of 'initiative fatigue'. They suggest that staff need to feel that:

- the message is about change that leads to genuine outcomes
- QIPP is not simply re-inventing the wheel
- the culture of continuous improvement (that has started to take roots in the NHS) will not be hijacked by the cost savings agenda (ie continuous improvement does not always result in cost savings and efficiency gains).

After initial cynicism to this study in one group, the appreciative approach enabled participants to engage and when they reconvened into a whole group they all reported recalling good memories, feeling positive through reminding them why they joined and have stayed with the NHS, generating a sense of warmth and enthusiasm. They felt it was a welcome change to focus on the positive aspects of their roles. Approaches such as appreciative inquiry could therefore provide an excellent means of staff involvement.

3   Identity

Congruence   Champions/activists   Org support/leadership
Involvement   Peers   Participatory structures
Empowering   Stories   Quick wins

PERSUASIVE FRAME ☺   COLLECTIVE IDENTITY ☺   CO-ORDINATED ☺

Values ⟶   Identity ⟶   Mobilisation ⟶ Outcomes

PASSIVE RECIPIENTS ☹   NON-CONVERSION ☹   EROSION ☹

Elite bias   No invitation   Negative consequences
Orchestrated   No means   Disillusionment
Cynicism   Hierarchy/silos

A precursor to mobilisation is a sense of identity with the 'frame' which develops into **collective identity** as others are called to action. Collective identity is fostered through sharing **stories**, comparing beliefs and experiences with **peers** and seeing the message lived by **activists/champions**.

3.1   Developing collective identity ☺

Developing a shared sense of identity around a set of values is central to building social movements. Through the 'framing' process individuals develop a shared understanding of the issues and what action needs to be taken.

     One of the key challenges for the NHS is that people have different understandings of what it means to be committed to, or identify with, the NHS (CQC, 2009).

- Professions have a greater loyalty to their profession than the NHS (Robinson et al., 2004).

- However professions can be incubators of public service motivation (Panday & Stazyk, 2008).

And

- Feeling valued and involved is the key driver of employee engagement in the NHS (Robinson et al., 2004).

     Team work and a sense of camaraderie is a deeply held value expressed by many of the inquiry groups. Stories feature times when teams had 'pulled together' to respond to a crisis. Inter-departmental interaction and multi-disciplinary teamwork are

particularly highly valued, accompanied by mutual respect and recognition. Participants also value working with similarly public-spirited people who share their values.

One group explicitly stated that recruiting people according to their attitude to teamwork and then developing technical skills was more desirable than the other way round.

We have also seen that it helps to create a sense of identity where staff are able to see the bigger picture and how they contribute, eg ambulance personnel receiving information about a patient's progress.

While we know that staff identify with their teams, professional groups, a multi-disciplinary team, a service, or their employing organisation, inquiry group participants spoke of the need for a 'more integrated and seamless service'. The QIPP message may need to 'hook' staff into a broader NHS-wide collective identity.

Inquiry group participants suggest some key messages to build collective identity with the NHS as a whole:

- Connect the big vision with the local context: 'We are the biggest organisation in Europe but the most personal'.

- Staff are users and employees: 'it's the only organisation that touches everyone's lives from "cradle to grave".'

- Messages should encompass the whole organisation and show how each individual can contribute.

- Messages should show how learning can be shared and spread across a service.

- Help people to understand the contribution of their 'daily role in the big jigsaw puzzle' and how 'everyone has a place and role to play'.

- Help to 'fight for the cause' and defend the NHS' reputation.

- Take pride in the work and professionalism of all NHS staff.

- Highlight how the size and diversity of the NHS provides opportunities to grow and develop.

3.1.1 Stories

  Ganz (2001) advocates storytelling in preference to framing, where collective identities are developed as people tell their own stories and actively make sense of change. Overly positive stories, however, that fail to reflect real difficulties may generate 'anti-stories' amongst staff (Denning, 2004).

  Inquiry group participants suggest using examples of how staff have helped to shape the service and introduce innovation as well as patient stories to bring to life issues of quality and patient experience.

The following story is an example of successfully balancing rules and listening to the patient's voice to achieve a better experience for the patient and a better outcome for the ward.

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Listening to patient voice

A 65-year old man with long-term advanced degenerative condition was admitted in hospital with breathing problems. He did not know that his condition was so serious and that he had little time left to live. The consultant and his team had to inform the

patient of the seriousness of his condition. After the initial shock the patient said that he wanted to go home. However, because of the seriousness of his situation, according to the hospital rules he could not be discharged. The consultant listened to the patient voice and used his authority and license to act to circumvent rules, use procedures in a more flexible way and decided to make use of the End of Life Care Programme for the patient who was able to go home, where until he died, he received good patient care. In doing so, the consultant had to work collaboratively both with the ward team and the patient/family. By using the system innovatively and going beyond structures, he was able to both free up capacity in the ward and satisfy the patient's wishes without compromising the quality or care.

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3.1.2 Peers

Teams and multi-disciplinary teams are an important aspect of delivering healthcare. The following story of interdependence illustrates a moment of personal fulfilment for an inquiry group participant.

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Personal value and satisfaction from teamwork in a tough situation

One member of staff was working with colleagues in a newly formed team which faced a situation where a patient had self-harmed and was a danger to himself and others. Staff quickly martialled colleagues from different specialisms to treat the patient and contain the situation. The incident was successfully contained with no further injury because the staff followed the crisis procedure like clockwork and the staff derived a sense of pride from using their professional expertise to play their parts. Although the patient was seriously injured, the member of staff reported that the experience had built trust among team members, the team was now fully-fledged and she felt she was playing her full role in the team as a result.

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📖 It is unsurprising therefore that Dolan et al. (2010) says that peer effects are very strong in influencing behaviour change. He suggests that we are strongly influenced by what others do through the effects of social norms that can develop and spread rapidly, describing this as 'contagious behaviour'. In a professional setting, peer group behaviour is particularly important as employees look to work colleagues to help make sense of changes they see occurring (Rousseau & Tijoriwala, 1999). Peer groups, however, may simply reinforce the status quo unless they are able to identify with a champion or activist from the same or similar group.

3.1.3 Champions and activists

📖 Social movements, therefore, require activists but the literature suggests that it matters who the activists are (Kleiner, 2008). There is a need to engage champions from diverse demographic and behavioural backgrounds. Dolan et al. (2010) suggests that people from lower socioeconomic groups in particular are more sensitive to the characteristics of the messenger.

Many of the informal stories and sense-making take place in staff rooms or outside the formal structures of change in 'free spaces' (Couto, 1993). These are inaccessible to management control and activists have an important role in helping shape these stories and reinforcing the change message by providing cues for new behaviours.

👪　　Several inquiry group participants identified particular individuals who had been instrumental in taking the decision to make an innovation. These were often clinical staff who had decided to challenge the status quo in the interest of serving patients better. It is evident that patient care serves as a powerful message to act among potential champions of change.

3.2　Non-conversion ☹

There is a danger that although staff identify with the message, this will not result in action because they are either **non invited** to do anything different or take part or they feel they have **no means** of making a contribution. Staff may feel disenfranchised by **hierarchical systems** or constrained by **silos** which do not allow them to cross into another profession's territory.

📖　　Non-conversion occurs when sympathisers are not properly mobilised (Oegema & Klandermans, 1994) because individuals are not asked to participate or may not have the necessary authority to make improvements. Dolan et al. (2010) also suggest that people tend to work on a 'default' setting and 'go with the flow of pre-set options' in the absence of making an active choice. This implies that initially staff may need a clear invitation (the 'empowering' message referred to earlier in this report) to get started with small but 'quick wins'.

3.2.1 No invitation, means or connection to purpose

📖　　Currently, however, although 70 per cent of staff feel they can make suggestions about how to improve performance only, 54 per cent feel they can make improvements a reality (CQC, 2009).

👪　　Participants show that staff are highly motivated by 'making a difference', but some of their stories suggest that they achieve change *in spite of* the organisation rather than *because* of it.

> *'It takes so long for good ideas to feed through, you never see the results. It takes too long, it's too bureaucratic, so things do not get done.'*

Staff also need to know how to contribute:

> *'We have to make all elements of QIPP meaningful to non-clinical staff, we know to know what am I supposed to be preventing?'*

Staff need to receive a clear invitation to make changes and to understand their role. Stories of personal fulfilment often contained some element of satisfaction that there was absolute clarity of objectives around the event staff described. In recalling these incidents, staff sometimes reflected that these experiences were exceptional rather than usual because management skills in setting out organisational vision and mission were not always good, or simply because organisational processes and procedures 'got in the way' of the basic goal. Some staff feel that there is a need to provide managers with high level interpersonal skills, staff engagement skills, communication and straight talking skills for having difficult conversations.

3.2.2 Hierarchy/silos

👪　　Inquiry group participants are full of ideas and suggestions of how to improve services. They are often frustrated by systems or silos that do not capture this knowledge or allow them to try new things, often resulting in duplication of effort and resources. Some of their comments and suggestions are included below:

- The service has already developed effective solutions but due to the fragmented structure of the NHS they are not being used more widely.
- QIPP should encourage and recognise 'pockets' of innovation and systemic thinking. To do this, managers need to break down barriers between departments and professions within the NHS.
- Messages should stress that all staff groups and organisations across the NHS should work together including hospitals, GPs and physiotherapy services.
- We all work together for the good of the patient so we should not be up against barriers between departments and wards all the time. Let's talk about what works for all of us.
- There is a lack of system integration across the NHS.
- There is sometimes a feeling of 'them' and 'us' between clinicians and managers and 'for someone who is both a clinician and a manager this can generate conflicting emotions'.

The importance of breaking down silos is illustrated in the story below.

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Cutting across silos

A miner was involved in a terrible pit accident and the nurse physio was able to follow the patient from the initial trauma situation to full recovery. This meant establishing a good rapport with the patient and working together not only with the rest of the medical team, eg paramedics, orthopaedic surgeon, consultants/doctors, but also with the patient and his family, friends and fellow miners in the local mining community. Working in a multi-disciplinary team ensured that all aspects of patient care were addressed. Providing physiotherapy in an integrated way with the rest of the treatment helped speed up recovery and allowed the patient to leave hospital sooner (with physiotherapy continuing at home) which suited both his wishes and made a hospital bed available more quickly, thus saving costs and allowing the NHS to help another patient in need of such a bed.

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4   Mobilisation

Congruence   Champions/activists   Org support/leadership
Involvement   Peers   Participatory structures
Empowering   Stories   Quick wins

PERSUASIVE FRAME ☺   COLLECTIVE IDENTITY ☺   CO-ORDINATED ☺

Values ⟶   Identity ⟶   Mobilisation ⟶ Outcomes

PASSIVE RECIPIENTS ☹   NON-CONVERSION ☹   EROSION ☹

Elite bias   No invitation   Negative consequences
Orchestrated   No means   Disillusionment
Cynicism   Hierarchy/silos

The previous section highlighted some of the dangers of arousing enthusiasm which is not converted into action. This section of the report looks firstly at how to mobilise volunteers successfully.

4.1 Co-ordination ☺

Developing a collective identity is not in itself sufficient to ensure mobilisation. No matter how favourably disposed people are to change they need practical **organisational support** to enact changes (Keller and Aiken, 2008), they need some **participatory structures** to keep them involved and they need to see some **quick wins** to build momentum.

4.1.1 Organisational support/leadership

📖   One of the difficulties in providing genuine organisational support is that many clinical leaders and non-clinical managers do not fundamentally believe that it is possible to deliver lower cost through higher quality (QIPP Communications research report, 2009). This makes it difficult to role-model the required behaviours and disempowers staff.

👪   Support identified by inquiry group participants comes in various forms; providing structures that make it easy to try new ways of working and strong but empowering leadership. They need:

■   Permission to try: the message should be that 'it's OK to take a controlled risk' and 'doing nothing is not acceptable'.

- To feel that they can personally contribute to making QIPP a reality.
- Leaders who live and breathe NHS/QIPP values/standards, consult with staff and listen to feedback.

The following story illustrates a simple innovation by a member of staff based on her observation and experience, which was implemented with full support of the Trust. It was embedded in a regular system and has proved itself sustainable over many years, reducing litigation and providing safer care.

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Introducing innovation – 'fresh eyes'

In 2003 a risk management midwife from Winchester & Eastleigh NHS Trust saw that there was the potential for reducing the risk of misinterpretation of foetal heart rate traces in labour (Cardiotocographs CTG).

Careful monitoring of the foetal heart rate and uterine pattern is an important part of midwifery and obstetric care. She realised that it was much safer to have another colleague's (midwifery or obstetric) opinion of a CTG trace. Following a 'near miss' incident in 2003 she introduced a new approach to CTG interpretation in the maternity service called 'fresh eyes' which ensures that all CTGs in labour are reviewed by another midwife every hour to ensure correct CTG interpretation. Both reviewers must agree with the classification of the CTG before signing in the obstetric notes using the DR C BRAVADO label which is an aide-memoire for CTG interpretation.

The 'fresh eyes' process was introduced in June 2003, so all midwives used this approach when reviewing any CTGs including all antenatal CTG assessments. If the two midwives do not agree with the CTG classification then a senior obstetrician is informed for the woman to have an obstetric review.

The introduction of this important change to practice at no additional cost was easily introduced to the staff whilst reducing the risk of error and, as some of the biggest litigation claims nationally are related to maternity care, this dual review of CTG's has improved patient safety.

This 'fresh eyes' approach CTG interpretation has been sustainable and with many obstetricians, new midwives and midwifery students having come through the maternity unit since 2003 the practice has undoubtedly spread to other maternity services.

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Supportive systems such as Productive Ward also release time and space to improve service and quality. The following story illustrates how a nurse was able to spend time with a family to achieve a good outcome from a tragedy.

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Time to care

A 19-year old was involved in a terrible motor-bike accident and was admitted to hospital with severe brain damage where he was shortly pronounced brain-dead. The nurse had to help the patient's family both cope with the loss of their son but also suggest to them that they might want to consider donating his organs. She spent an enormous amount of time talking to and supporting the family who agreed to organ donation. In order to proceed a whole inter-disciplinary team was mobilised and the nurse had to work with consultants/surgeons, intensive care nurses, transplant co-

ordinator, paramedics, at the same time as supporting and consoling the patient's family. Since securing organs is very difficult, this was a good outcome; the death of a young person acquired some meaning and another person was helped to live.

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4.1.2 Participatory structures

📖   We know that involvement is a key driver of employee engagement in the NHS (Robinson et al., 2004). Ren (2009) suggests that employees are more likely to develop value congruence with their employers if they are allowed to participate in decision making. While storytelling and communication foster public service values, 'empowering and participatory work structures' are important in really getting staff involved (Paarlberg, Perry & Hondegham, 2008). Social movements are seen to be more successful where rank and file members have an influence over the movement's strategy (Ganz, 2000).

👥   The following story highlights the value of being involved in discussing ideas for saving cost and sharing learning.

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Forum for sharing

Since May 2009 senior PAs hold monthly meetings in order to discuss common concerns, share good practice and agree on new /better ways of working and liaising together. After a few months, this initiative was extended, so that now there is a bi-monthly Senior Administrators Meeting (SAM). These meetings have been very useful platforms for discussion among senior admin staff who usually do not have such opportunities for exchanging views and ideas, for identifying new or better ways of working and ensuring that these are implemented by administrators in a consistent way, for cascading information to the rest of the administrative staff, for networking, etc. At the moment, led by the locality manager they use these meetings to identify efficiency gains and cost savings in back office operations. For example, they have already decided to forego refreshments at meetings paid by the NHS, they are looking at mobile working (since each person sitting on a desk costs £9,000 to the NHS), etc.

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In another forum staff have come together to design a tool to allow information sharing between Trusts.

Purpose through participation in collaborative working

In one setting, staff have come together to design an online tool which allows Trusts to benchmark and share information about performance indicators. One member of staff working in a professional administrative role described the buzz of working with a multi-disciplinary team including clinicians and support staff, IT specialists, communication specialists and senior corporate managers. All inputs were valued to ensure that the tool met the needs of the community of NHS staff it is intended to serve. Chief Executives at a number of Trusts started to use the data and gave positive feedback. This gave an enormous sense of satisfaction to the individual who could see how their work had contributed to the success of the project.

4.1.3 Quick wins

📖   'Quick wins' (Bevan & Plsek, 2009) are early, small (or big) examples of successful change, which may not be of major significance in the long-term, but help to generate positive feelings about change among staff. They build momentum and confidence that individuals can make a difference.

Some of the stories in this report are about small changes that have made early contributions to service improvement and cost reduction that encourage staff to continue. *'Once we have our initial successes, the process will gather momentum and begin to snowball'* (Alinsky, 1972).

The following story though shows how responding to an immediate problem through a 'quick win' resulted in a longer-term service innovation.

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Innovations in improved patient care with reduced staffing

One Trust experienced a high turnover of consultants in an outpatient department. This was regularly leading to staff shortages and cancellations of clinics, which left the staff feeling demoralised because they could not provide the service patients needed. A service manager decided to take a risk by introducing an interim service to patients who had found their appointment with a consultant was cancelled. This was a nurse-led clinic to provide patients with an opportunity to discuss their condition with a supportive experienced professional. The feedback from patients through the service users' forum was overwhelming and this convinced the Trust to make the service permanent. It also led to a re-organisation of consultant staffing which proved more efficient to the Trust, while nurses reported greater satisfaction at being able to spend time with individual patients providing one to one care.

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4.2 Erosion ☹

Support for social movements can erode as quickly as it builds when people experience negative consequences from taking part. The psychological contract research highlights the consequences of breaking promises and failing to meet staff expectations. This can cause staff to withdraw discretionary behaviours on which innovation in particular depends, when it requires staff to go beyond the content of their job description. As we move from the rational into the emotional sphere of effecting change, we find a loss of support when people see **negative consequences** either for patients or staff, they experience **disillusionment** which may ultimately lead to **conflict**.

4.2.1 Negative consequences

Negative consequences can be in various forms. We identified fears from inquiry group participants that the system would not support action, there may be personal adverse outcomes and too much re-organisation and red-tape.

No support from the system

Stories like the one below illustrate how individual initiative means that people often have to work outside the system in order to provide good service but that this kind of good practice is reliant on individual goodwill which cannot be spread or sustained.

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Waste is built into the system

One physio received a telephone call regarding an immobile patient who had been discharged from hospital in a wheelchair with no support or equipment to get her back on her feet. The family was going to complain as the patient had been independent before coming into hospital and it looked as though she would be left immobile for up to a week. The physio rearranged his work to go out to the patient and soon she was smiling and proud to be walking.

The temporary receptionist who had taken the call played an important role and worked with him to reschedule other jobs after the manager had said that they 'do not run an emergency service'.

The physiotherapist's action prevented a complaint and also prevented the patient, who had an infection, getting worse. He was, however, hampered by the system for supplying equipment such as zimmer frames.

One of the reasons was that different sites had differing policies regarding the re-use of equipment. At some sites within the trust there was a 'loan shop' where equipment such as zimmer frames and crutches were returned, cleaned, stored and re-issued. At another site within the group, if such equipment was returned, it was thrown away.

Some of the problems identified included the fact that responsibility for purchasing and distribution of the equipment lay in different departments. A second barrier to re-use was the fact that someone would need to be responsible for the loan process, and the money to employ such a person would come out of a different budget than that for equipment purchase. It was viewed as easier to continue to buy new equipment to replace the equipment given out than to employ someone to undertake the organisation of the loan process (and there was thought to be an additional issue around storage room). A major stumbling block was that fact that while there was a budget to pay for replacement of these significant items, this money could not be transferred to employ someone in this role.

However, these challenges had clearly been overcome at other sites within the group. The staff suggest that one way forward would be for a social enterprise company to be set up to be responsible for the loan, return, cleaning and storage of re-usable equipment.

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Adverse personal outcomes

📖   Stress, pressure, high workloads and understaffing top the lists of the worst things about working for the NHS (Arnold et al., 2003). These factors are important because efforts to bring about change which involve innovation or attempts to improve productivity usually involve initial additional work in the early phases of change. Staff must therefore be thoroughly convinced of the ultimate benefits of change to be willing to embark on a short-term increase in effort for long-term gain.

👥   Staff well-being is an important anchor value for staff. Being healthy through a reasonable work-life balance, having new challenges and job variety as well as having a voice and management support are part of personal fulfilment and their long-term absence is likely to result in 'erosion' of support. Staff may perceive that insufficient backing is available to help them achieve change.

Recognition and use of professional skills raises self-esteem, while not feeling valued leads to disengagement.

Staff also see a need for reassurance that management will support them 'instead of always believing the public'. This is linked to the need for better management skills in dealing with mistakes/clinical incidents.

Too much re-organisation and red tape

ᛘᛉᛘ Inquiry group participants feel that in the past too much re-organisation has had a negative impact on efficiency and that fewer and more targeted interventions would contribute better to QIPP. Frequent local restructuring was noted at a number of sites and staff felt that regular organisational restructuring diverted energy and attention from delivering services. They also felt this kind of change inhibited building of relationships and trust which are needed to mobilise staff to work together effectively. Additionally, if QIPP entails the need for more information being generated to feed management data requirements, then there should be an explanation to staff why it is required and how it will be used.

4.2.2 Disillusionment

No change

NHS initiatives may face initial suspicion because many staff have experienced or participated in previous projects which have not delivered any change. Overcoming disillusionment by creating a compelling case for why QIPP will be different from other initiatives is therefore an important part of the messaging process.

📖 The literature warns:

- Where there are no concrete improvements from change people become disillusioned (Rousseau & Tijoriwala, 1999).

- Doctors feel patient expectations can be too high due to politicians' extravagant promises (Smith, 2001).

ᛘᛉᛘ At the start of the inquiry groups many participants expressed cynicism because they had taken part in other forums with no obvious outcomes.

Managing expectations therefore becomes very important. One group of clinical and non-clinical managers suggest being careful not to raise unrealistic expectations. They suggested it would be helpful simply to present the current difficult situation in a factual way, appeal to staff's core values in the NHS ethos and the need for all to do what they can to preserve its unique character, emphasising aspects of free access, equity, fairness and good patient care for all.

As one group said, 'staff have been through too many 'Big Bang' approaches in promoting other initiatives that have not delivered all that was expected of them'.

5 Messaging

The core purpose of this project is to identify messages that tap into the deeply held values of staff and encourage them to mobilise behind the QIPP agenda. This will support the transformation of QIPP from an aspiration to a movement for change across NHS organisations which will deliver cost-effective safety and quality improvements for patients. This section sets out to examine inquiry group participants' ideas about messages that will appeal or not appeal to them and draws out the implications for spreading messages about QIPP.

The project has revealed a number of dilemmas in 'orchestrating' a social movement within an organisation rather than in society. It needs to reconcile several opposing tendencies:

■ Be both organised **and** spontaneous.

■ Be top down **and** bottom up.

Our inquiry groups identified further dilemmas:

■ Must benefit patients **and** staff.

■ Needs both actions **and** words.

The QIPP dilemma is:

■ To reconcile quality **and** productivity.

The messages we have extracted from the project seek on the one hand to pay attention to the need to maintain a balance between these opposing forces where this will generate most possibilities for change, but also to use the opposing concepts as forces to motivate change, whenever there is a lack of equilibrium between some of these principles.

5.1 Core principles to underpin messages

Needs to value and recognise staff – messages must 'record and celebrate success'

■ Messages should show that the NHS values/appreciates its staff.

■ Messages should use examples of staff building on already good practice to avoid the sense that QIPP is reinventing the wheel and to recognise existing good work.

■ Messages must be positive because inquiry group participants felt that too many NHS messages are negative and about what not to do. As one group put it: 'we need to stress the positive on a daily basis'.

■ Messages should recognise that it is the goodwill of NHS staff that makes the NHS work.

Involve staff in creating messages

■ Messages should be inclusive to ensure they resonate with all staff groups.

■ 'Bottom up' examples are needed of how to shape the service.

Make messages simple and limit their number

■ A few short and simple messages would make QIPP activities more memorable and easier to grasp – messages should be 'fewer, more focused/crisper, more intelligent and consistent'.

Messages should be realistic and open the door for action

■ Open acknowledgement of any organisational constraints and framing QIPP within this context will make the agenda realistic.

■ Messages about small changes making a big difference are empowering.

■ Messages about genuine proven outcomes for patients and staff will enable QIPP to gain traction on the ground.

■ Building on the culture of continuous improvement that has started to take root in the NHS without overwhelming it with the cost saving agenda would create a spirit of optimism that makes implementation seem possible.

5.2   The messenger and means of communication

■ Face-to-face communication with individuals whom staff trust is the most powerful means of engaging and mobilising staff through opportunities for emotional engagement and interaction. For people at lower levels in organisations, it is important to engage them face-to-face to explain initiatives and convince them that their contribution is valued, otherwise they may fail to engage with top down change. This will require some thought about how best to free up time for discussions in clinical settings. Inquiry group participants felt strongly that relying too much on emails and posters for communication would not mobilise staff in sufficient numbers and sufficiently quickly.

■ Credible clinical leaders and peers may be very important in engaging staff as we have seen that the identity of the messenger can influence staff reception of the message. While senior and line manager support to implement change is important, other staff may be more powerful as change agents because management messages take time to cascade and are not always perceived as credible.

■ Each Trust should have the responsibility to come up with its own ideas about QIPP messaging. Inquiry group participants felt weary of national campaigns and the need to connect QIPP messages with their immediate work means that message formulation may be better undertaken at local level. Local campaigns do need to make sure they connect local vision with the NHS as one organisation and the NHS constitution as its overriding point of identity. There is potential for organisations such as the NHS Institute to offer support to individual trusts to enable them to frame messages that encompass the national and local agendas with individual values.

■ An incremental, 'chipping away' approach is more likely to yield long-term results than a 'big bang' approach in promoting QIPP. Staff are slightly suspicious of 'big bang' approaches because they do not always deliver on expectations. In order to achieve rapid change using this approach, it implies that numerous small scale activities will be needed. This needs care and some resources to maximise the likelihood of achieving wide scale change quickly.

5.3 Content of the message

It's all about the patient…

Real-life stories about patient care and outcomes are most engaging to staff. The appreciative inquiry groups consistently found these stories generated most interest and questions from staff about how the initiatives worked and 'how could we make this happen in our service?'

■ Messages about delivering service you would want to have as a user are most powerful – 'improving cost and quality enable us to give care we'd like to receive'.

■ Messages about using QIPP to 'make a human connection' and enable provision of 'compassionate care' are deeply emotive end goals which tap into the core values of staff.

■ Messages which stress that QIPP will improve the patient experience and make a difference could reference previous successes. The Productive Ward programme was mentioned as an example which QIPP could build on because its focus was on improving patient care and work organisation. This will also avoid the perception that QIPP is reinventing the wheel.

■ The QIPP currency should primarily be about patient experience, not about money, though it is recognised that the two are connected. This involves defining the level of quality that is deliverable to manage both staff and public expectations and staff felt this was a key principle to make QIPP credible.

■ Preserving free access to, and equity in, health care provision are powerful motivating values that resonate with all staff. Connecting cost saving measures to these principles may make them easier for staff to support.

■ Messages about the wider impact of QIPP may create resonances with staff as service users. It was striking that a number of inquiry group participants had seen the effects that inefficient services had had on their families' experiences of health care. These could include messages around 'saving my money as a tax payer' by managing resources well and 'enabling my family to access health care faster' through providing more efficient services.

…and improving patient care will benefit staff too

■ Messages around how QIPP will make the working lives of staff easier for each other will enable staff to see the win:win of the agenda.

■ Messages around how QIPP activity could protect job security through greater efficiency will concentrate staff attention in a time of financial pressures.

■ Freeing up staff so they can give individual care is appealing, but must not result in a perceived unmanageable volume of patients to care for.

■ Breaking down messages about large budgetary savings into smaller meaningful ones about savings per employee or per team, expressed in non-monetary units, eg operations, patients or staff, would make the scale of the QIPP challenge more comprehensible and accessible.

Empowering and supporting staff to act

Messages about reasons for engaging with QIPP which connect the agenda with staff's core values and a prognostic frame for the future of the NHS will serve to mobilise staff emotions and intentions. But it is very clear from the appreciative inquiry groups that staff need to believe that support is available to enable them to

embed QIPP in their daily work and provision of services at a local level. A number of participants felt that messages about *why* to act were insufficient to mobilise them without messages to convince them that structures and mechanisms were available to implement their ideas.

■ Messages should illustrate the support that staff will receive to 'make a difference'. This includes messages about how spaces and mechanisms are available and being used which will enable staff to contribute and stories of how staff suggestions have been implemented. Messages should include endorsement and recognition from colleagues *as well as* managers for participation.

■ Messages should stress that the hearts and minds of decision-makers are receptive to any and all suggestions for innovation. This is because staff felt strongly that ideas were often quashed in the early stages, reflecting that 'The answer to everything isn't "no'' and asking "how much will it cost?" should not be the initial response to every staff suggestion'.

■ Messages need to challenge inertia and risk aversion which staff identified as likely blockers or excuses for inactivity. Messages that 'It's OK to take a controlled risk' and 'doing nothing is not acceptable' could be powerful calls to challenge passivity. These need to be backed up with reassurance that hierarchical decision-making will support innovation which is pursued with controlled risks.

■ Messages which help staff understand that QIPP is about the overall approach to delivering services may be useful. Those most familiar with QIPP stressed that to enhance the prospects of embedding QIPP, staff would need to understand it as 'a *culture*, not a *project*'. Avoiding the sense of a project with a finite timespan could draw on messaging undertaken with long-term ongoing initiatives around infection control.

Building on a common and distinctive future identity

■ Messages which connect the big vision with local context generates a sense of inspiring possibilities for staff - 'We are the biggest organisation in Europe but the most personal'. This message also stresses one of the unique features of the NHS and the staff who participated in this project liked the idea of promoting what makes the NHS 'different' from other organisations.

■ Messages which illustrate personal connection between staff as employees and service users is emotive and inspires action – 'it's the only organisation that touches everyone's lives'.

■ Messages which connect the contribution of 'your daily role in the big jigsaw puzzle' to a larger purpose around the future of the NHS inspire staff to focus on their shared long-term goals. Staff suggested that this vision might stress financial viability and freedom from debt as a vision in which 'everyone has a place and role to play'.

■ Messages about the future should show the NHS at what staff recognise as its best including a public service ethos; excellent patient care; highly professional and committed staff; strong teamwork; scope at work for personal growth.

Framing QIPP as an opportunity to challenge the wider system

Some individuals within the inquiry groups identified that some staff in their organisations have the potential to be 'change agents'. For these individuals, stressing the challenge of implementing QIPP will be motivating.

- Messages about 'bucking the system' will resonate with staff who perceive themselves as innovators.
- Messages that QIPP is an opportunity to 'make the system simple' for patients and staff will resonate with staff who are frustrated by bureaucratic complexity.
- Messages about making 'joined up thinking' and services happen could appeal to staff who work in multi-disciplinary teams and work areas which span the boundaries of organisations.

Framing QIPP in the language of struggle as a call to arms

The QIPP agenda and aspirations for large scale mobilisation lie within organisations, rather than in the more conflictual social movements that take place in society. However, borrowing some of the language of conflict and self-defence can be appealing to staff in galvanising them to protect NHS interests.

- Messages could generate a sense of solidarity among staff in helping to 'fight for the cause' and defending the NHS' reputation.
- QIPP messages could stress the public sector ethos of the NHS and ask staff to collaborate to preserve its characteristics of equity of access to free healthcare and play on avoidance of compromising its core principles.

Messages for the public and public health

Some key themes emerged around collaboration between staff and patients to improve patient health outcomes and contribute to a sense of mutual responsibility for healthcare.

- Messages about how patient self-care and appropriate use of services can contribute to improved outcomes would provide staff with a sense of support and reassurance they are not solely accountable for patient outcomes.
- Messages which seek and gain positive patient feedback about innovations implemented to support QIPP could be drawn on to formulate inspiring QIPP messages for staff.
- Messages which distinguish between 'prevention' in a public health context and an organisational context would help NHS staff in secondary care settings understand how the 'prevention' element of the QIPP agenda relates to their work.

5.4   A few messages to avoid…

We noted earlier that the focus of messages should be positive, but it is also worth noting some of the key findings that staff reported were either less important or simply unattractive in inspiring their commitment to QIPP.

- The language around productivity does not appeal to staff and neither do any messages which evoke targets and auditing. Staff strongly stressed the view that 'we're not making widgets'.
- Avoid business language. This would undermine the public service ethos which is one of the key reasons why many staff joined the NHS and which underpin their personal values. Commercial language would annoy staff who believe that the NHS should not be run like a business.
- Some staff, in particular AHP staff, do not feel a 'moral obligation' to work for the NHS and there is some evidence that potential recruits and former staff are irritated by attempts to play on feelings of moral obligations in recruitment

campaigns (Arnold et al., 2006). Therefore messages which appeal to a sense of duty should be avoided.

■ Most inquiry group participants in roles with patient contact or junior management and administrative roles do not recognise the acronym 'QIPP'. It could be better embedded in other more familiar concepts, eg Releasing Time to Care.

5.5   Segmenting the message

We have looked at general messages that hold true for all staff but this section highlights the main differences found between staff roles within the NHS. Most of the staff engaged in patient contact roles had a sufficient commonality of interests for shared messages to be appropriate. The group which required most nuanced messages were those in support roles.

5.6   Admin, clerical and corporate non-management roles

■ Some staff, especially those in roles which have less scope for influencing direct patient care, are keen to have opportunities to stretch themselves beyond the confines of their current job. Messages that taking on challenges related to embedding QIPP can shape individual learning and provide opportunities for personal growth could appeal to this group.

■ Messages about patient stories to which non-clinical staff efforts have indirectly contributed could be extremely powerful methods for making this staff group feel valued. There is a need to demonstrate that this group is equally valued compared to medical staff.

■ QIPP messages for admin and clerical staff need to help explain how the principles relate to their work, eg to answer the question of 'what am I supposed to be preventing?'

■ Examples of QIPP activity need to be concrete and specific about the type of positive outcomes achieved by staff in support roles.

Appendix 1: Workforce Groups

Figure A1.1: Clinical and non-clinical managers

Mind map centred on **Personal Fulfilment** with the following branches:

NHS as employer
- large availability of diverse jobs
- NHS size/scope/diversity is most appealing
- job security
- good pay & conditions, pension

Ability to influence & effect change
- able to introduce new ways of doing things
- change things in a systematic but also collaborative way
- becoming the leader one always wanted to have
- Confidence to start again / introduce new things
- motivate team & make things happen

Prof/careet devt
- excellent prof dev opportunities across NHS
- plenty of stretch opportunities
- structured career progression
- ability to move both within the Trust & across the NHS in the UK
- able to train for something completely new

Relationships with patients
- developing good relationships with patients & their families/friends
- dealing with life & death situation
- validation of everything one has worked and trained for
- patient care
- making a difference
- gratitude from patients
- active listening skills to patient voice

Job satisfaction
- work variety & diversity
- doing something worthwhile
- having a supportive manager
- better without bureaucracy/rules
- fulfilment of long-term goal
- confirmation of one's ability by being promoted, thanked by patients
- work autonomy and flexibility

Teamwork
- strong, mutually-supportive relationships with colleagues/peers
- ensuring good team spirit in ward/operating theatre
- feeling of "them & us" between clinicians & mgt
- great diversity of staff

Recognition
- that one is doing a good job by line manager & peers
- positive feedback not just when things go wrong
- tariff structure prevents appreciation of cost savings achieved

Support
- from line manager & senior people
- freedom to try new things
- open communications
- address the 'silos' culture
- being thanked
- not afraid to approach line mgr with a problem

Figure A1.2: Clinical staff

Personal Fulfilment

Professionalisation of nursing
- strong professional identity
- structured career pathways

Job content
- great variety of work
- great autonomy of work
- but need to look at workload
- less admin/audit tasks y
- apply skills acquired through rigorous training
  - stretch & build confidence
  - continuous learning

Supportive management
- encouragement for prof & career devt
- understanding pressures nurses work under
- allowing flexibility in how they do their job
- stronger leadership skills at ward sister level
- two-way communication
- permission to question

Mgmnt & staff share same vision -NHS is not a business
- more meaningful/flexible targets, or flexible implementation of them
- not to lose sight of what NHS is here for: caring for patients
- more emphasis on "what is good for patients" & less on throughput, budgets

Sense of fulfilling one's vocation for caring for people
- helping people at their most vulnerable
- freedom to treat patients differently according to their needs
- saving lives
- best for patients without tension bet quality of care & productivity
- alleviating pain

Pride in Trust values
- reputation in community
- knowing the stakeholders
- alignment with staff values

Recognition
- letters, flowers from patients
- manager appreciation
- team/individual awards
- improvements in public perception/confidence

Pride in working for NHS
- proud to work in public sector
- NHS is free to all
- diversity of patients
- Sense of equity/fairness
- life and death
- example to the rest of the world
- an employee & a user of service
- Unique service
- NHS values centre around people, not money

Strong teamwork
- good colleagues who all pull together
- but.. better integration of teams/services needed
- working in multi-disciplinary teams

Good terms & conditions
- good pension
- job security
- flexible hours & family friendly policies
- but "performance management is weak

Figure A1.3: Non-clinical staff

A mind map with central node "Personal Fulfilment" (red) connected to:

- **Job satisfaction** (yellow):
  - work at their best
  - work diversity
  - having an overview
  - role autonomy

- **NHS ethos** (yellow):
  - working in a caring environment
  - Value public service ethos
  - focus on quality patient care
  - pride in working for NHS
  - Like comprehensive nature of NHS
  - support for equality & diversity regarding patients

- **NHS as employer** (yellow):
  - job stability
  - flexibility re where& when they work
  - good pension scheme
  - good terms & conditions
  - job evaluation - structured pay bands
  - professional development
  - career progression
  - reasonable pay
  - competency-based job

- **Challenge, Reward, Satisfaction** (yellow):
  - turning negatives to positives
  - a tremendous learning opportunity
  - being given responsibility/ ownership for a project

- **Recognition, Respect & Support** (yellow):
  - more could be done by NHS as a whole
  - line manager showing trust in one's abilities
  - feeling valued
    - good work noticed
    - Chief Exec takes an interest
    - "NHS does not value admin staff's services"

- **Teamwork** (yellow):
  - close working relationships with colleagues
    - family atmosphere
    - professional team
    - team effort
  - forum for staff action views/ideas

Figure A1.4: Senior and Executive Teams

A mind map centred on **Personal Fulfilment** with the following branches:

NHS as employer
- flexibility
- good terms and conditions
- professional development

NHS ethos
- public service values
- NHS focus on quality of patient care
- support for equality and diversity

Teamwork
- strong teamwork both at exec & senior management level
- "We are all singing from the same hymn sheet"
- sharing patient stories with non-clinical colleagues so that they are all better informed
- ensuring that both clinical & non-clinical managers have patients as their main focus
- ensuring good teamwork at all levels

Supporting staff
- ensuring staff feel supported during these challenging times
- positive feedback from staff
- listening to, empowering, & enabling both individuals & teams
- visibly recognise & appreciate staff, i.e. stress positives
- open & honest dialogue with staff re required changes from the start
- deal with difficult issues in a transparent & equitable way
- build trust between them & staff

Improving Patient care
- having authority to ensure that the best is done for patients, even if outcome is death
- listening to patients & staff
- listening to patient voice so that they can make informed choices
- working innovatively beyond rules & structures
- improving productivity through advanced care planning
- QIPP should be seen as ROI of public money and to the public
- irrespective of changes, need to ensure that NHS retains its patient-centric focus

Progress in embedding improvement & quality culture
- Capability Training being cascaded
- internalised meaning of QIPP
- too much re-organisation, need tor continuity & time to embed change
- promoting a "positive/can do" culture within organisation
- money saved / efficiency gains should be seen (& communicated to staff) as an enabler to improve patient care even more

Leadership Development
- modelling effective leader behaviour re QIPP
- executive coaching, incl. coaching based on appraisal results
- 360 degree appraisal re leader behaviour
- Key attributes: clear vision, listening, communicating, learning, engaging, acting, influencing, leading care
- need skills to work more collaboratively & in an integrated way both within the trust & beyond
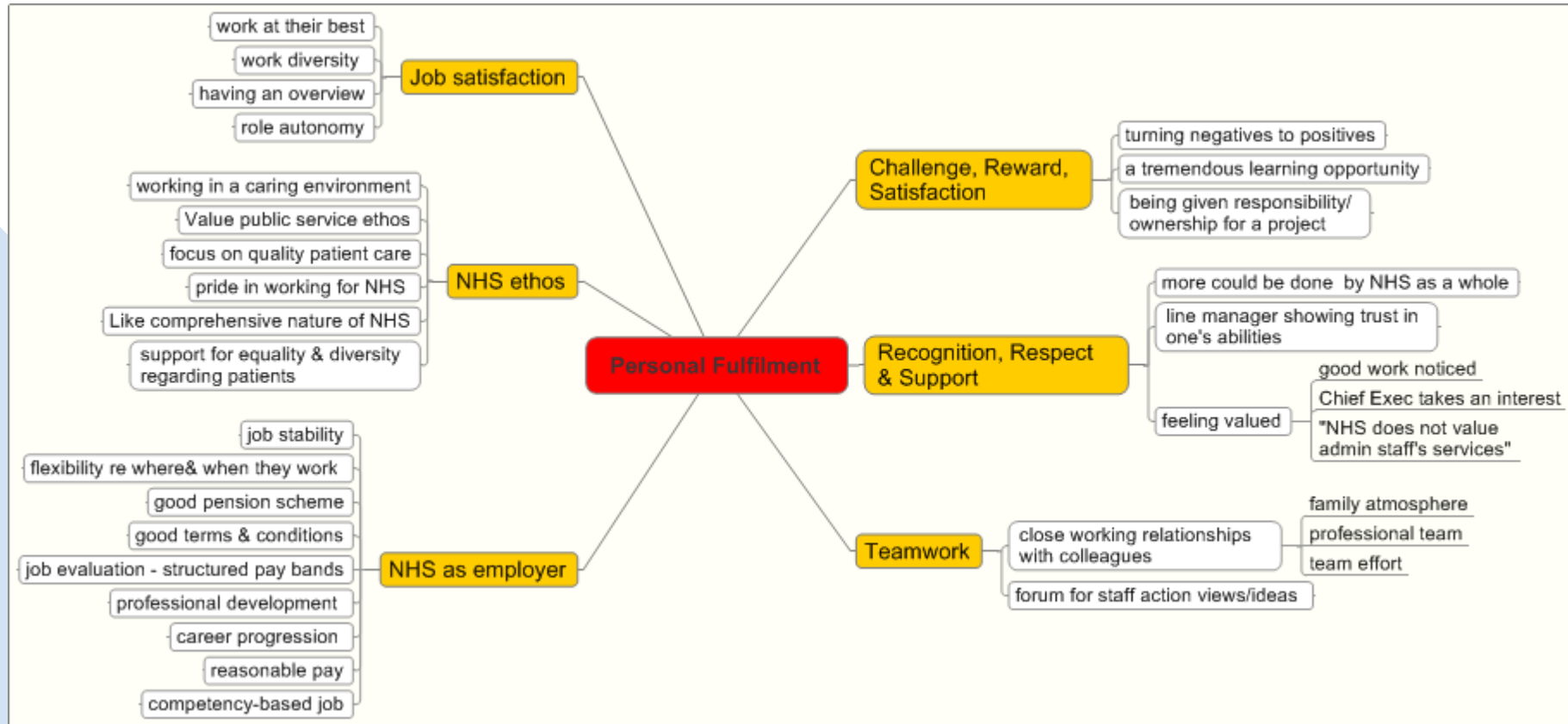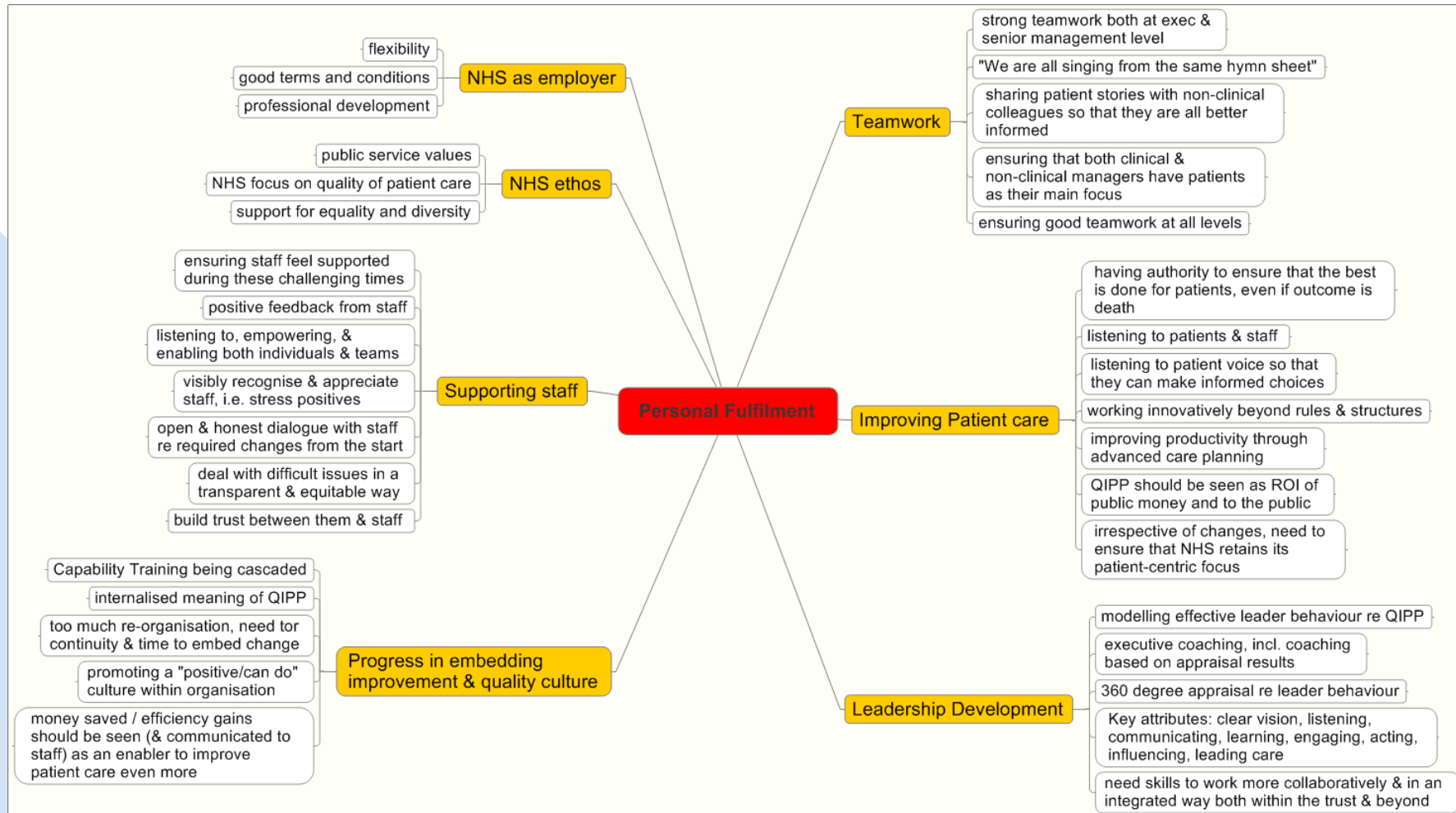
Appendix 2: Literature Review

Introduction

This literature review has been commissioned as part of a study for the NHS Institute for Innovation and Improvement into how best to mobilise staff to achieve large scale change to support the Quality, Innovation, Productivity and Prevention (QIPP) agenda. It addresses two main areas of literature. First it examines the concept of social movements, their purpose, how the idea can be applied in organisational settings, how people can be engaged in support of social movements and why such movements succeed or fail. Second, it examines the bases for staff motivations and engagement in the NHS, looking in particular at values which drive individual behaviour, because connecting with these values is an important success factor for mobilising staff to achieve change.

What are social movements?

Social movements are a prominent part of modern societies. The activities inspired by social movements frequently make the evening news bulletins or the pages of newspapers whether this is pro-democracy demonstrators in Iran, environmental campaigners on the roof of the Houses of Parliament or the political organising activities of anti-Nazi groups in Barking and Dagenham. The significance of social movements goes beyond their ability to draw attention to themselves because they play a key role in societal change (Crossley, 2002). Social movements have had a hand in some of the defining moments in modern history such as the end of segregation in America and the collapse of Communism in eastern Europe.

Precise definitions of social movements vary, but certain general features can be identified. The NHS institute describes social movements as 'A voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity' (Bibby et al., 2009). This identifies many of the key features of social movements, it marks them out as different from other more 'transitory' forms of collective action such as riots by pointing up the place of co-ordination and commitment to achieving (or preventing) some kind of specific change. It also emphasises the voluntary nature of social movements. People do not participate in movements through external compulsion but because they believe in the movement's cause. Other definitions of social movements also emphasise the importance of conflict and contention in social movements (Crossley, 2002). Many social movements, particularly those which garner most attention, emerge from groups who see themselves as oppressed or marginalised and wish to raise their status. This leads to the observation that conflict of some kind is likely to play a part in most social movements, even if it does not appear in physical form. Overall, social movements are more likely to share a 'family resemblance' than a 'fixed essence' (Crossley, 2002). This flexibility offers possibilities for harnessing and applying the idea in a range of societal contexts, including within organisational structures.

Social movements and organisations

Social movements are usually depicted as forces for change in wider society. The major social movements of historical fame – the Civil Rights movement, the environmental movement, the labour movement, Solidarity and other movements in former Communist countries all emphatically depend on group participation. Organisations are often considered as important tools through which social

movements can further their aims: examples include trade unions, political parties and faith-based groups. There is less work which considers social movements *within* organisations themselves as much focus to date has been on social movements in wider society. While organisations have some similarities and function in similar ways to society, with management representing the 'government' and ordinary staff the 'people' (Zald & Berger, 1978), there is a different formal and legal relationship between employees and staff. Nonetheless, a number of authors have applied social movement thinking to organisations and there is evidence that interest in this area is growing (Zald, 2005).

Broadly we can find two approaches to social movements within organisations. The first are oppositional or emergent movements similar to the 'classic' social movements (Zald & Berger, 1978) and the second are management instigated 'orchestrated social movements' which resemble traditional social movements in form rather than content. Orchestrated social movements 'look' like social movements in that they seek to mobilise large numbers of people around a cause for change. However, orchestrated social movements are not characterised by struggle and conflict (Strang & Jung, 2002). 'Orchestration' can be compatible with the idea of a social movement because social movement theorists have frequently acknowledged a mixture of organisation and spontaneity in social movements (Ganz, 2000; Scokpol, Ganz & Munson, 2000; McCarthy & Zald, 1977). Given its greater relevance to the subject of organisational change, the focus here will be on orchestrated social movements. The idea of using social movement thinking to improve levels of quality and productivity in line with the QIPP agenda is a prime example of an orchestrated social movement. The impetus for implementing change is likely to come from managers, along with a broad outline of what needs to be done but, rather than relying on traditional 'programmatic' models of change, the hope is that staff throughout the NHS will become mobilised and proactively seek out ways to implement the change.

Why are orchestrated social movements important to organisational change?

Change may be instigated by organisational leaders but it requires the action of everyone within the organisation to make plans happen. Effective change can only really occur when people are persuaded by the case for change and motivated to implement the spirit as well as the letter of change. This depends on the extent to which the change message connects with the personal values of the individuals involved. Social movement theory provides the concept of 'framing' as a method to achieve these aims.

Framing is one of the key aspects of social movement thinking and one that is particularly important in orchestrated social movements. The NHS Institute's own literature on social movements describes framing as 'the single most important aspect of social movement thinking' (Bibby et al., 2009). Benford & Snow (2000) describe framing as a process of 'meaning construction' by which groups and individuals make sense of the world. The relevance of framing to social movements is that it allows participants to develop shared understandings of the problems faced by the group and, furthermore, to assess what actions to take and why. In terms of the psychological processes underlying framing, it is described as a different form of persuasion to, for example, belief change (Nelson, Oxley & Clawson, 1997). Rather than providing people with new pieces of information, framing works by increasing the salience or highlighting information or beliefs that people already hold: it involves looking at the same situation or problem and focusing on different aspects of it which will create a greater sense of engagement and commitment to the cause. So in the context of a social movement amongst an oppressed people, where subjection may encourage feelings of despondency, worthlessness and resignation, a different frame

might emphasise injustices, acts of heroism and the moral worth of the oppressed. In the context of the QIPP agenda, instead of emphasising the need to reduce costs and improve productivity which conjure up images of financial stringency, control and auditing, messages might appeal instead to the possibility of improving services by reducing waste, which conjures up images of opportunities for improved patient care and freeing up resources.

Framing entered into social movement scholarship due to a dissatisfaction with the 'resource mobilisation' theories of social movements. These tended to assume that social movements were simply rational, utilitarian and almost mechanical responses by individuals with shared 'objective' material interests. In contrast, framing emphasises the way social movement actors interpret situations as problems requiring action and focuses more on the role of values and emotional motivations in social movements. At its strongest this suggests social movements involve the creation of 'collective identity' that creates a bond between participants that goes deeper than any material interests they may have. These kind of shared understandings can help develop a collective identity amongst social movement participants. This not only helps motivate and mobilise people but also informs tactical and strategic decisions and can be a powerful outcome in building trust to help implement further change (Poletta & Jasper, 2001).

The centrality of values and emotional arguments to the framing perspective explains its appeal to exponents of change management. Recent developments in change management have emphasised that overly rational models of organisational change tend to fail (Keller & Aiken, 2008; Rock & Scwhartz, 2006; Denning, 2004). Instead, modern theories of change management highlight the importance of the emotional, interpretive and apparently 'irrational' factors that are required to generate organisational change.

Barriers to orchestrated social movements

While the generation of collective identity through framing is widely considered to be a necessary element of a social movement, this is not sufficient to ensure mobilisation. Effective communication of the movement's aims does not guarantee participation and many social movement theorists and practitioners have emphasised the importance of the practical side of mobilisation. The main barriers are non-conversion and erosion of participants, choice of inappropriate activists, failure to involve participants in framing key messages to engage them and failure to involve people in decision-making to engage them fully with implementing change. We now explore each of these issues in turn.

For example, Oegema & Klandermans (1994) discuss two ways in which those sympathetic to a social movement may not become active: non-conversion and erosion. Non-conversion happens when sympathisers are not mobilised because no one asks for their involvement or explains how to participate. Erosion, on the other hand, happens when active members of a movement experience negative consequences from their participation and withdraw their effort.

These considerations are echoed in the literature on change management. The problem of non-conversion chimes with the argument that 'good intentions' are not enough. No matter how favourably disposed individuals are to the change programme, more often than not they will need practical, organisational support to enact changes (Keller and Aiken, 2008). Equally, the principal of erosion has parallels with the finding that an individual's opinion of a change programme may alter over time and become negative if promised benefits do not emerge (Rousseau & Tijoriwala, 1999). In the initial stages of change the reasons for the change matter most because people will be either enthused by, or apathetic about, the change

depending on how appealing its messages are to them. However, over time staff will increasingly base their opinion of organisational changes on the presence or absence of concrete improvements resulting from the change (Rousseau & Tijoriwala, 1999). As part of the QIPP agenda, this explains the importance of 'quick wins' (Bevan & Plsek, 2009). These early, small examples of successful change may not be of major significance in the long-term, but help to generate positive feelings about change among staff. However, to prevent erosion of support in the longer-term, the QIPP agenda has to be able to provide the promised improvements to quality and productivity which in turn need to improve the work situation of staff. Without this, disillusionment may set in and support for the changes may wane.

In traditional social movements, practical mobilisation requires activists. For example, Saul Alinsky's efforts to organise poor inner city communities in America relied on 'organizers [going] out into the neighbourhoods, ringing doorbells, starting book clubs and building trust through gatherings in churches and homes' (Kleiner, 2008). Furthermore, it mattered who the activists were. When organising the black community in Rochester, for example, Alinsky put a premium on finding leaders from within the black community and avoided using sympathetic white people from outside. Alinsky was concerned that white activists would appear as 'colonialists' to the black community (Kleiner, 2008). In the context of organisational change, this 'activist' role might be what is sometimes described as a 'change champion' – key individuals who push change forward, bringing others on board and maintaining good working relationships and morale when difficulties arise (Chruciel, 2008). Therefore within an organisation it is important to ensure that such 'activists' are recruited from frontline staff and that change champions are not perceived as the 'agents' of management. However, the recruitment of 'activists' alone does not guarantee the mobilisation of staff. No matter how well connected and respected the change champions are, some change programmes still may not find favour with staff if they perceive the change as unfavourable (Keller & Aiken, 2008). It is important, therefore, to understand that mobilisation and framing are inextricably linked; a frame that is not supported by practical mobilisation will be weak and unpersuasive while mobilisation in the absence of a persuasive frame is likely to be futile.

The framing approach to social movements has a number of other potential pitfalls. The most pressing is the possibility of an elite or leadership bias. This is a tendency to place too much importance on the leadership of social movements and ignoring or downplaying the role of 'grass roots' participants. While leadership is undeniably important in social movements, a movement cannot exist without an active and engaged mass of participants. Critics of the framing approach in the social movement literature suggest it can focus too much on the role of elites in social movements (Benford, 1997; Ganz, 2001). Authors who discuss framing sometimes appear to assume that movement organisers simply create a 'package' that is then fed to a largely passive audience who do not contribute to the content of the frame (Ganz, 2001). Indeed, political communication scholars often define framing as a form of persuasion particularly favoured by elites (Nelson, Oxley & Clawson, 1997). When trying to apply social movement theory practically as part of an organisational change programme, the risk is that managers will spend a great deal of time developing a frame which they believe will resonate with their employees without ever actually asking their employees for their input into the message. In terms of an orchestrated social movement, we risk giving the orchestration primacy over the movement.

Ganz himself advocates 'storytelling' as a preferable concept to framing because it implies a much more collaborative process where stories and, by extension, collective identities are developed by everyone involved in the movement. Keller & Aiken (2008) also touch on this point in relation to change management. They argue

that change will be more likely to occur if employees are allowed to tell their own story and suggest a number of ways of doing this; for example, through mass online discussion forums. The NHS Institute has already looked at the possibilities of using technology to provide new opportunities for staff engagement (Wilson & Casey, 2007) and is currently examining the potential value to the NHS of staff using social media. While such technologies are not an alternative to more 'traditional' forms of interaction they do offer additional possibilities for staff to interact with their managers and each other.

It is clear from the literature, however, that this point goes further. Employees are not simply passive recipients of management messages with which they either agree or disagree. Even if they are not 'invited' to tell their own story, they are active 'sensemakers' (Weick et al., 1995), storytellers in their own right and alert to messages from non-management sources. Particularly at times of change, individuals will be actively trying to make sense of what is happening around them, using multiple sources of information so messages from leaders may be just one of many they use (Rousseau & Tijoriwala, 1999; Weick et al., 1995). Employees will be actively seeking out sources of data that can help them explain the change they see occurring and in particular they will turn to informal sources such as their work colleagues (Rousseau & Tijoriwala, 1999). Furthermore, it is important to note that while employees may well be invited to collaborate with managers in storytelling, they will also be developing stories with each other outside of the structures of the change programme. The effect of the attitudes of employees' work colleagues on their own attitudes to change are considerable (Rousseau & Tijoriwala, 1999; Strang & Jung, 2002). This is because social movement stories develop above all in 'free spaces' (Couto, 1993). The stories employees tell in the staff room or on the ward after the meeting has finished are probably more important than the stories they tell in the meeting. It is not appropriate to suggest that management try and control their employees' free spaces, but those leading change do need to be alert to these issues. In particular, this again highlights the importance of having 'activists', who are prepared to advocate the change and encourage others to participate, at all levels of the organisation. While managers cannot effectively contribute to stories told in free spaces, activists may be able to use their influence to shape how employees interpret and respond to these sources of information. However, this will only be possible if activists are not seen as management agents.

Lastly, framing may not be the only, or even the best way to create a set of shared values within an organisation. For example, it has been argued that employees are most likely to develop value congruence with their employers if they are allowed to participate in decision making within the firm (Ren, 2009). Others note that storytelling and communication help to foster public service values in the public sector but argue that 'empowering and participatory work structures' are also important (Paarlberg, Perry & Hondegham, 2008). This kind of participation goes deeper than simply being invited to tell a story about change; rather it implies genuine involvement in decisions about the goals and direction of the organisation. This suggests that it may not be possible for an organisation to rely solely on communication methods to generate shared values, it may be equally important to involve staff directly in the decision making process. This theme is also developed in social movement theory, where movements tend to be more successful where grass roots participants have an influence over the movement's strategy (Ganz, 2000). This is an important point. In the context of QIPP it has been suggested that while the NHS has the will to change and plenty of ideas about what needs to be done, the 'weak link' is in execution, hence the interest in using social movement theory to mobilise staff around the proposed changes (Bevan & Plsek, 2009). However, if participation in decision making is critical to the success of the movement for change, it may be that more attention needs to be paid to how staff can participate in the

development of ideas about change and decisions about the overall direction of change in the NHS.

Oppositional & emergent social movements and organisational change

While the notion of 'orchestrated social movements' are more relevant to change management it is worth looking at the lessons from oppositional organisational social movements identified by Zald & Berger (1978) and Barry, Berg & Chandler (2008). Zald & Berger identify three kinds of social movements that can occur within organisations:

- **Coup d'etats** involve senior members of an organisation forcing out and replacing the organisation's leader or leaders. Examples include sudden replacement of CEOs. Typically coup d'etats do not lead to radical change in an organisation.

- **Bureaucratic insurgency** occurs when small or medium sized groups of middle managers or frontline staff attempt to bring about fundamental change, typically when a course of action has specifically been blocked or ignored by senior managers. An example of this is the development of helicopter gunships by middle ranking officers in the US army against the wishes of senior officials.

- **Mass Movements** are large scale protests by lower ranking members of an organisation against those at the top of the organisation. They bear some similarities to bureaucratic insurgencies but are generally larger, more confrontational and more visible where insurgencies tend to hide themselves from senior managers. The student protests of the 1960s against their universities are good examples of such movements.

Due to the fact that coup d'etats tend not to result in large scale change they are perhaps the least interesting of the three for the purposes of this project. Bureaucratic insurgencies and mass movements are more relevant because of the scale of change they seek and sometimes achieve. They are made up of what Kleiner (2008) might describe as 'heretics'. These are people who have identified something they want to change in their organisation and decided to attempt a radical reconfiguration. The key difference between these emergent social movements and the 'orchestrated' social movements discussed above is their point of origin. Orchestrated social movements are instigated by the management of the organisation, while emergent movements come from lower down the organisational hierarchy. Emergent movements tend to be characterised as more democratic and at less risk from problems of elite bias associated with orchestrated social movements. Additionally, emergent movements can be expected to be more 'radical' and oppositional in their approach because they are typically instigated by 'heretics'.

While it has been argued that the change programme associated with the QIPP agenda is best described as an orchestrated social movement, it is also important to note that changes instigated at senior levels can have the effect of stimulating emergent, grass roots movements within an organisation (Wheatley & Freize, 2007). In the context of change, staff will develop their own understandings and tell their own stories about what is happening. It is conceivable that these stories will develop into an alternative movement to the one instigated under QIPP but also that staff interest could be steered and harnessed productively in the interests of QIPP.

There are a number of ways in which managers might deal with an emergent movement in their organisation. An obvious temptation might be to try to eliminate it by suppressing it or buying its members off; however, it is also possible to attempt some form of partnership with the movement. If this latter strategy is to be effective, it is important that managers do not try to excessively 'control' the movement but rather give it space and resources to develop, because overt interference risks undermining

emergent movements (Wheatley & Freize, 2007). What managers choose to do will be determined at least partly by the nature of the movement that emerges. Although many authors have emphasised the benefits of emergent movements in organisations (Wheatley & Freize, 2007; Barry, Berg & Chandler, 2008; Kleiner, 2008), it should not be assumed that such movements will inevitably have a positive effect on an organisation. Organisational 'heretics' are not always in the right and sometimes not engaging with the movement might be the best course of action for the organisation (Kleiner. 2008).

It is impossible to know in advance what kind of emergent movement QIPP might spark. It may be that staff perceive the changes as threatening and mobilise against it, alternatively a movement may emerge that seeks to go beyond the prescriptions of change laid out by QIPP to seek more radical methods for improving productivity and performance. If it is the latter, NHS managers may have to take a step back and allow the movement to experiment and develop, accepting that change is happening even though it is not taking the form they initially envisaged.

Motivations and the NHS

We know that framing is an important part of mobilisation which works by highlighting and making salient beliefs already held by individuals and that it is most effective in mobilising people when it taps into their deeply held values. It is important, therefore, to consider what we already know about NHS employees' views of working in the NHS. What makes them want to work in the NHS and how do they feel about the NHS as an institution?

Broader concepts: Public service motivation, the psychological contract and the engagement

There are a number of different frameworks to explain employee motivations, of which the most relevant here are: public service motivation, the psychological contract and engagement.

Public service motivation can be defined as 'the motivation of people who feel a sense of duty or responsibility for contributing to the welfare of others and to the common good of the community or society' (Horton, 2008). It is embodied in ideas such as altruism and pro-social behaviour, indicating a willingness to go beyond contractual requirements of a job. While public service motivation is relatively well developed conceptually, measuring it and judging its effects are more complicated. Nonetheless, some attempts have been made. Gregg et al. (2008), for example, find that individuals in the non-profit caring sector are more likely to donate their labour in the form of unpaid overtime than individuals in the for-profit sector. A review of studies that have attempted to link public service motivation with individual and organisational performance finds mixed evidence (Brewer, 2008). However, it does identify studies which find a link between public service motivation and higher appraisal scores among individuals and between high levels of public service motivation and performance at an organisational level in terms of efficiency, effectiveness and fairness. Public service motivation is potentially, therefore, a powerful source of energy within the NHS which could be tapped by a social movement frame.

The psychological contract is a further useful lens for understanding what affects employee motivation and behaviours in the workplace. In employment relationships, the psychological contract tends to be seen as a set of beliefs held by an employee about the mutual obligations between themselves and their employer (Anderson & Schalk, 1998; Rousseau & Tijoriwala, 1998). These mutual obligations refer to what employers and employees believe is expected of them and what they will get in

return. While certain mutual obligations may be set out formally in the employment contract or in company rule books, they are generally too limited to encompass the full range of obligations that make up the employment relationship (Guest, 1998). Psychological contracts fill the gaps left by formal, written contracts. Because they are built on employees' beliefs, the precise content of a psychological contract will vary between individuals and because these contracts are not formally agreed, employees and employers may differ in their understanding of their mutual obligations. A 'healthy' psychological contract is one where employees and employers believe each party is fulfilling their obligations and is associated with a range of behaviours and attitudes that are beneficial to the organisation. For example, a number of studies have found healthy psychological contracts can result in greater organisational commitment, motivation and job satisfaction along with reduced absence and intention to quit (Guest, 1998). Violations of the psychological contract, however, can have a severely detrimental impact on the employment relationship. The reaction to contract violation goes deeper than feelings of dissatisfaction about a job not meeting expectations. Instead, from the perspective of the employee it implies a 'betrayal' on the part of the employer. This can lead to a fundamental breakdown in trust and respect in the employment relationship (Robinson & Rousseau, 1994).

Robinson, Perryman & Hayday (2004) define engagement as *'a positive attitude held by employees towards the organisation and its values. An engaged employee is aware of business context and works with colleagues to improve performance within the job for the benefit of the organisation'*. It implies a willingness amongst employees to 'go the extra mile' for the sake of the organisation and an ability to understand how their role contributes to the organisational 'bigger picture'. Robinson, Perryman & Hayday (2004) suggest that the key drivers of engagement for employees are feeling valued and involved in the organisation. A number of factors can foster these feelings, for example job satisfaction, being able to develop a career, a co-operative ethos within the organisation as well as satisfactory pay and benefits.

Staff motivation in the NHS

Job satisfaction is often seen as a necessary if not sufficient condition for motivation, people who do not enjoy their jobs are unlikely to be motivated but simply being satisfied with a job does not guarantee motivation. Broadly speaking the evidence suggests that staff enjoy working for the NHS, surveys of staff show relatively high levels of job satisfaction (CQC, 2009; Fielden & Whiting, 2007) and a view that NHS careers are rewarding: 91 per cent of NHS staff agreed with the statement that 'I've got a worthwhile job that makes a difference to patients' (Ipsos Mori/DoH, 2008). Significantly, this job satisfaction appears to stem particularly from the intrinsically satisfying nature of NHS work. For example, Fielden & Whiting (2007) find that nurses have a high level of job satisfaction despite the fact that the NHS is not always delivering additional benefits that staff define as most important to job satisfaction.

Having noted the relatively high levels of job satisfaction within the NHS, it is important to look at what different staff groups within the NHS say about their motivations.

Role Motivation in Nurses & AHPs

Most frequently, nursing and AHP staff cite the opportunity to work with and help patients as the best part of their job. Conversely, stress, pressure, high workloads and understaffing often top lists of the worst things about working for the NHS,

particularly because it reduces the amount of time staff can spend with patients (Arnold et al., 2003). Interestingly, Nurses and AHPs working outside the NHS identify the slower pace of work in the private sector as a key reason not to work for the NHS. Another aspect of this is a desire to be allowed to 'get on with the job' of caring for patients. Muller et al. (2008) discuss how nurses in NHS Direct call centres often express opposition to the strict structuring of their work, for example restrictions on how long they can spend talking to callers. While seeing the utility of a framework for talking to callers, nurses tend to want greater discretion over the way they handle calls.

The motivations of nurses and AHPs do not overlap entirely. For example, a slight concern amongst AHPs (physiotherapists and radiographers) is a lack of recognition for their role. Both qualified (Fielden & Whiting, 2007) and trainee (Arnold et al., 2003) AHPs express concerns that they are less valued within the NHS, particularly compared to nurses.

Role Motivation in Doctors

Amongst doctors, the BMA (2006) found that the most highly regarded professional value by a long distance is competence – doing the job well. This is not quite the same as the findings from the nurses and AHPs which focussed much more on caring for patients. In the BMA survey caring came a fairly distant third. Nonetheless, there still appears to be a strong public service motivation amongst doctors, only a very small minority felt that being a doctor was 'a job like any other'. The majority, while asserting their right to a work-life balance, regarded being a doctor as a 'major commitment'.

However, this sense of commitment and duty is slightly complicated by the fact that a majority of doctors feel that patients' expectations of their abilities are too high. Some blame this particularly on extravagant promises made by politicians which cannot be put into practice on the ground. It is argued that this is a major source of unhappiness amongst doctors and the cause of a great deal of disenchantment with the NHS (Smith, 2001). This perhaps points at a potentially less positive psychological contract amongst doctors.

Commitment to the NHS as an institution

On the question of whether staff have a strong commitment to the NHS as an institution, the evidence is more mixed. Surveys of AHPs (Arnold et al., 2006) suggest that few NHS staff feel a 'moral obligation' to work for the NHS, although those that did tended to be more committed to working for the NHS. Additionally, there is some evidence that both potential recruits to the NHS and former staff were irritated by attempts to play on feelings of moral obligations in recruitment campaigns, suggesting it made the NHS look desperate. It has been suggested that advertising which gives a more 'realistic' picture of working for the NHS would be preferable (Arnold et al., 2003). A similar picture emerges among nurses with fewer than half of nurses being prepared to speak highly of what the NHS stands for and 28 per cent speaking critically of the principles of the NHS (Ipsos Mori/DoH, 2008). However, other surveys have found that AHPs tended to agree that they 'strongly identified with the principles of the NHS'. Furthermore, this was true of those currently working in the NHS *and* those who had left the NHS (Arnold et al., 2006).

The NHS staff survey also indicates a fairly low level of engagement with the NHS as a wider organisation beyond employees' immediate teams. For example, only 52 per cent of staff said they understood the national vision for the NHS and only 50 per cent felt their trust communicated its aims clearly. And while 70 per cent of staff felt they could make suggestions about how their team could improve its performance,

only 54 per cent felt they could make those changes a reality (CQC, 2009). The findings are supported by Ipsos Mori/DoH (2008) which identifies helping staff understand where their role fits in as an area in need of improvement in the NHS.

It should be noted that while these results may appear rather negative, there are difficulties in measuring engagement and commitment to an organisation. People have different understandings of what it means to be committed to or to identify with the NHS (Fielden & Whiting, 2007). This is perhaps corroborated by the high proportions of staff who neither agree or disagree with questions on engagement in the NHS staff survey (CQC, 2009). Finding a way to articulate a broad vision of what it means to identify with the NHS, that can bridge different definitions of 'identification' is likely to be a key task in framing messages related to the QIPP agenda.

The attitudes of NHS staff towards the NHS is shaped by more than their day to day experiences within the NHS. For example, friends and family of staff have an impact on their attitude towards the NHS. Staff whose friends and family are most supportive of them working for the NHS are most likely to want to stay employed by the NHS (Arnold et al., 2006). This adds a further dimension to the earlier observations about the impact of work colleagues on attitudes towards change.

There are much higher degrees of engagement and advocacy of the NHS among managers (Ipsos Mori/DoH, 2008; Robinson, Perryman and Hayday, 2004). Furthermore, these more positive attitudes increase with seniority (Ipsos Mori/DoH, 2008). Merali (2005) notes that despite the apparent perceptions among the public, and indeed, clinicians that NHS managers are excessively concerned with money and form-filling at the expense of patient care, many managers do in fact have strongly altruistic values. However, what is surprising, and extremely significant in the current context, is the gap between the perceptions of medical staff and managers. Nurses, AHPs and doctors tend to be positive about various aspects of their jobs while having mixed feelings about the NHS as an institution, managers are mainly positive about it. This matters in the context of an orchestrated social movement because it indicates a divide that will need to carefully bridged in the framing process. Managers may well be fired up by the romance of the values, ideals and mission of the NHS but it seems that staff, while not entirely unreceptive, do not feel the same way. Managers need to be cautious about projecting their own motivations onto staff (Keller & Aiken, 2008) and realistic about attempting to use framing, storytelling or any other communication device to mould staff into their own image.

Overall, there seems to be more evidence that the values of NHS staff are more oriented towards professional aspects such as caring for patients or competence than towards the NHS as an institution with a unique mission. This is particularly applicable to staff with a high level of patient contact who are more likely to be motivated to provide a high level of patient care (Ipsos Mori/DoH, 2008). Similarly, Robinson, Perryman & Hayday (2004) find that professionals within the NHS have a greater loyalty to their profession than the organisation. From the perspective of *organisational* engagement or commitment this is clearly problematic. However, other writers note that professional commitment can be a powerful source of public service motivation. In this way, professions have been identified as incubators of public service motivation as much as organisations (Pandey & Stazyk, 2008). Consequently, it seems sensible to suggest that frames aimed at emphasising the way change will help clinical staff do their job better, specifically allowing them to focus as much time as possible on patient care, will mobilise most support for change.

Two cautionary points also emerge from the literature. Firstly, it must be noted that although the motivation of staff in the NHS does indicate a high level of intrinsic, public service motivation, extrinsic motivations cannot be ignored (Arnold et al.,

2003, 2006; Fielden & Whiting, 2007). Job security and pensions can be identified as important motivations for working for the NHS (Arnold, 2006) while the level of pay and even the possibility of pay cuts are cited as concerns by AHPs (Arnold, 2003, 2006). Equally, problems establishing an adequate work-life balance underlie concerns about overwork as much as lack of time to care. In the rush to tap into the deeply held values of NHS staff, these more extrinsic factors cannot be ignored. As Keller & Aiken (2008) note, although monetary incentives do not guarantee staff motivation, an absence of such incentives is likely to lead to demotivation. Furthermore, in a change philosophy such as QIPP, with its emphasis on improving quality while cutting costs, there is an obvious and powerful potential for the emergence of a counter frame emerging which would portray the change as being about overworking staff without adequately compensating them for the extra effort. Even if staff accept this counter-frame and perceive changes as primarily economically motivated, this need not prevent mobilisation around the QIPP agenda. Rousseau & Tijoriwala (1999) find that nurses are not necessarily hostile to economic justifications for change, they may still support changes which they believe to be motivated by economic considerations. However, Rousseau & Tijoriwala also note that under these conditions change is less likely to be successful. Arguably this is due to the fact that although nurses understand that financial considerations may necessitate change, they are less enthusiastic about it than when they believe change is aimed at improving patient care. This lack of enthusiasm translates into less effectively implemented change.

The second cautionary point centres on being over enthusiastic in the construction of the frame. Alongside the concern amongst doctors about over expectations amongst patients, Arnold et al. (2003) raise concerns about high expectations of work in the NHS among new and potential recruits, they specifically advocate presenting 'realistic' pictures of NHS life in recruitment campaigns.

In turn this creates two risks. The first is that an overly positive frame or story will lack credibility and the second is that a frame that raises expectations too high may crumble when setbacks occur. Denning (2004) notes how overly positive stories that fail to reflect real difficulties may generate negative 'anti-stories' amongst staff. Stories and frames cannot totally be detached from the real and potentially negative situation staff perceive. On the point of raised expectations, social movements and change programmes inevitably face setbacks. Particularly for social movements, the notion of 'struggle' in the quest for change is important, because if change merely involved a string of easy victories a social movement carries less urgency. If change is framed in an excessively positive manner there is a real risk of disenchantment when things do not go as planned. We have already noted the way that negative initial experiences of participation in change and social movements can lead to a loss of support (Oegema & Klandermans, 1997; Rousseau & Tijoriwala, 1999). We can see this process happening in the US, for example, where the failure of the Obama presidency to live up to the exceptionally high levels of expectation generated by the Obama campaign appears to be leading to disenchantment and backlash amongst the president's supporters (Taibbi, 2009; Washington Post, 2010). Stories need to manage as well as raise expectations about the prospects for change.

Appendix 3: Bibliography

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