The lived reality and meaning of Lean Thinking for nurses and nursing at an NHS Hospitals Trust

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Thesis submitted to the University of Nottingham
for the degree of Doctor of Philosophy
July 2017

Abstract

Lean Thinking (Lean) is a management philosophy originating from the Toyota automobile manufacturing company in Japan. Lean has been widely adopted in the United Kingdom (UK) National Health Service (NHS) as a panacea for addressing challenges that threaten its sustainability. Attempts to evaluate the outcomes of Lean implementation, in order to assess its claims to improve efficiency, quality and safety, have proved challenging owing to ambiguity surrounding the definition of Lean, differences in approaches to, and the poor quality of literature reporting, implementation. Lean continues to be adopted in healthcare regardless however, and a body of literature considering the consequences of Lean more broadly, is suggestive of implementation holding other, far-reaching implications.

In attempting to transform healthcare culture and the way in which work is physically and socially structured, managed, organised and delivered, Lean can be understood as a socio-cultural intervention, holding the potential to transform the socio-cultural milieu of healthcare practice. There is, however, a dearth of research considering the nature of this transformation, the interaction between Lean and the socio-cultural context of practice, healthcare professionals' experiences, understandings and interpretations of implementation, and the implications that it holds for them. This is especially true in the context of Lean applied to nursing. Theoretically, owing to its managerialist associations, Lean presents challenges to essential facets of nursing as a profession, its socio-cultural foundations and identity. Other 'empowering' characteristics of Lean philosophy however, are congruent with increasing autonomy and control over practice, associated with nursing's professional agenda. Lean implementation can therefore be conceived of as representing both a challenge to, and as proffering opportunities for, the nursing profession.

Underpinned by feminist philosophy and employing an ethnographic methodology, the thesis explores the lived reality of Lean implementation for nurses working in three settings at an NHS Hospitals Trust, and its meaning for nursing's professional project, identity and mandate. The lived reality of Lean is conceptualised as a game played between the Trust and nurses, for power and control over nursing practice. The organisational rationale for, and mechanisms of, exercising power under the guise of Lean are explored, together with the nursing response, incorporating strategies to preserve the socio-cultural *status quo* and protect nursing knowledge, autonomy and practice.

The notions of 'power' and 'holistic, person-centred theory' are employed as conceptual vehicles, through which the lived reality of Lean and its meaning for nursing, are critically explored and understood. The traditional 'powerless' depiction and 'project' of nursing, are challenged in light of empirical findings. The positioning of Lean as a contemporary scapegoat for a theory-practice nexus, and the role of antagonising factors intrinsic to nursing itself, are considered. The utility and feasibility of the nursing project and identity, predicated on a holistic, person-centred model, is also questioned. In this context, the notion of 'organisational collaboration work' is introduced, and advanced as a recommendation of the thesis, as a potential means of extending nursing's mandate, to better meet the needs of organisations, patients and nurses in contemporary healthcare.

Conference presentations

Field-Richards, S.E. (2013). Lean on me; nurses' emotional work and labour in Lean times. Oral presentation. British Sociological Association Medical Sociology Annual Conference.

Field-Richards, S.E. (2013). Lost amidst Lean? A critical analysis of the implications of crisis-driven change for the profession of nursing. Oral presentation. 11th Conference of the European Sociological Association, 'Crisis, Critique and Change'.

Field-Richards, S.E. (2014). The Trust-Nurse Game in the context of organisational change. Oral presentation. 8th International Conference on Healthcare Systems and Global Business Issues.

Acknowledgements

To my supervisors, Drs Stephen Timmons and Hannah Noke: Thank you for providing me with the opportunity to pursue doctoral study. I am extremely grateful for your guidance and feedback, especially during the final stages of writing-up, and for your understanding when life has thrown a few curveballs my way.

To Professor Jo Lymn: Thank you for your support and understanding whilst I have been writing-up this thesis and for setting me on the road to an academic career.

To Dr Holly Blake: Thank you for encouraging me to apply for a doctoral studentship.

To the research participants: Thank you for agreeing to take part in this research, for welcoming me into your world and for answering my endless questions!

To Mrs Need, Liz and Mary Walker: Three inspiring women who have had a huge impact on my life in very different ways. Mrs Need - 'To what extent are Anthony and Cleopatra diametrically opposed?' has a lot to answer for! Thank you for fostering a love of language and critical thinking. Liz - thank you for teaching me how to manage that thinking! Mary - thank you for showing me what nursing is and can be.

To Pusscatine: My four-legged 'assistant' and study-buddy!

To Lucy and Ben: Thank you for the much needed joviality of Sunday Supper, at the end of the many long weekends of studying.

To Mum and Dad: Well, this officially marks the end of 'the perpetual student' (I promise!). Thank you for your support, for being so patient through all these years of education and for allowing and trusting me, to find and go my own way. I hope it starts to make a bit more sense now.

To Ollie: I'm sorry for the things that we haven't been able to do together over the last few years, and for all of the things that I haven't been able to help with. Thank you for being so amazingly supportive, patient and understanding. Thank you for your level-headedness, Yorkshire-isms and for intuitively knowing when Chinese take-aways, chicken wings and treks to the pub have been in order! The future starts here.

To Granny: I'm so sorry that you couldn't be here with me to see the end of this journey. I know that you would be proud of your Sarah Sal.

To Granny and Ollie: This one's for you.

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List of abbreviations

ASAP	As soon as possible
BPR	Business Process Reengineering
CQC	Care Quality Commission
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMAIC	Define-Measure-Analyse-Improve-Control
FBI	Federal Bureau of Investigation
Int	Interview
LBI	Lean-based initiative
Lean	Lean Thinking
MNursSci	Master of Nursing Science
NHS	National Health Service
NHSIII	NHS Institute for Innovation and Improvement
NMC	Nursing and Midwifery Council
NPM	New Public Management
Obs	Observation
PDP	Polka-Dot Police
PDSA	Plan-Do-Study-Act
PIS	Participant Information Sheet
RMI	Resource Management Initiative
TNG	Trust-Nurse Game
TPS	Toyota Production System

TQM	Total Quality Management
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Chapter 1. Introduction to the thesis

1.1 Introduction

This introductory chapter provides a synopsis of the thesis, followed by a reflexive account of aspects of the researcher's personal and professional background, which 'situate' the researcher in relation to the research and contextualise its genesis and the underlying motivations for study. An outline of the structure of the thesis is then provided.

1.2 Thesis synopsis

This thesis provides an account of the lived reality of the implementation of a management philosophy called Lean Thinking (Lean), and its meaning for nursing and nurses, working in three settings at a National Health Service (NHS) Hospitals Trust, in the United Kingdom (UK).

Lean is a management philosophy originating from the Toyota automobile manufacturing company in Japan (Womack, Jones and Roos, 1990). Lean has been widely adopted in the UK NHS as a panacea for addressing challenges that threaten its sustainability, including financial deficits, low staff morale and motivation, patient safety and care quality issues, and capacity constraints (Jones and Mitchell, 2006, Jones and Filochowski, 2006). Attempts to evaluate the outcomes of Lean implementation, in order to assess its claims to improve efficiency, quality and safety, have proved challenging however. This is due to ambiguity surrounding the definition of Lean, differences in approaches to, and the poor quality of literature reporting, implementation (e.g. Brandao de Souza, 2009, Radnor, Holweg and Waring, 2012, Mazzocato, Savage, Brommels et al, 2010). Despite this, Lean continues to be adopted in healthcare and a body of literature considering the consequences of Lean more broadly, is suggestive of implementation holding far-reaching implications for healthcare professionals (e.g. Waring and Bishop, 2010, Holden, 2011).

The thesis addresses gaps in knowledge surrounding Lean in healthcare, by considering healthcare professionals' experiences, understandings and interpretations of Lean implementation – specifically, those of nurses – and its implications for nursing. In conceiving of Lean as a socio-cultural intervention (e.g. Andersen, Røvik and Ingebrigtsen, 2014, Byrne and Fiume, 2005), holding the potential to transform the socio-cultural milieu in which care is provided (e.g. Waring and Bishop, 2010, Holden 2011), the thesis is attentive to the way in which Lean interacts with the socio-cultural context of nursing practice, nurses' experiences, understandings and interpretations of this process, and the implications that it holds for them and for the nursing profession more broadly. It provides a theoretical account of the interaction between Lean and nursing as, on the one hand, a manifestation of a 'managerialism versus professionalism' dyad (Noordegraaf, 2011), which challenges nursing as a profession, its socio-cultural foundations and identity. On the other hand, Lean implementation can be conceived of as representing an empowering process (e.g. Poksinska, 2010, Jones and Mitchell, 2006), consistent with increasing autonomy and control over practice, thus proffering opportunities for nurses and the professional project (Larson, 1977) of nursing. The socio-cultural notions of 'power' and 'holistic, person-centred theory' are central to the nature of this theoretical interaction and as such, these concepts are employed in the thesis as vehicles, through which the lived reality of Lean and its meaning for the nursing professional project and identity, are critically explored and understood.

The thesis adopts a qualitative approach and is underpinned by feminist philosophical influences. These influences are reflected in the character of the ethnographic methodology adopted for the empirical work, on which the thesis is based. The thesis' findings depict the lived reality of Lean implementation as a game, played between the NHS Hospitals Trust (the Trust) and nurses, for power and control over nursing practice. The findings chapter explores insights from nurses' accounts and enactments surrounding the organisational rationale for, and mechanisms of, exercising power under the guise of Lean, together with the

nursing response, incorporating strategies to preserve the socio-cultural *status quo*, and protect nursing knowledge, autonomy and practice.

Particular attention is devoted to critical analyses of the role of 'power', informed by a Foucauldian perspective, and 'holistic, person-centred theory', in influencing the nature of nurses' lived reality, and its meaning for nursing. The thesis argues that rather than constituting a 'professional' defence as a function of the 'managerialism versus professionalism' dyad, the nursing response within the game that characterised the lived reality of Lean, was predicated on the objective of an identity project, of the 'good nurse'. It is suggested that the nature of the nursing project as one of identity, rather than profession, was mediated by a double jeopardy, in terms of challenges presented to nursing identity - by Lean implementation, in conjunction with the influence of contemporary disparaging media portrayals of nurses. The thesis also highlights the status of nurses as active oppositional agents within the game, and as a corollary, challenges traditional views surrounding a state of powerlessness in nursing (e.g. Manojlovich, 2007). Explanations are provided however, as to how a 'powerless' self-understanding and identity might be maintained, through a self-fulfilling prophecy, and a situation of 'lose-lose' stalemate, within the game characterising nurses' lived reality of Lean implementation. Regarding the role of 'holistic, person-centred theory' in influencing the nature of nurses' lived reality, critical insight is provided into the nursing praxis process, and it is suggested that Lean might be understood as a contemporary scapegoat for a theory-practice gap (e.g. Hewison and Wildman, 1996), and antagonising factors intrinsic to nursing itself. The utility and benefit of holistic, person-centred theory as a basis for the nursing project and identity, for nurses' wellbeing, relationships with organisations, and degree of influence in the healthcare arena, is also questioned (e.g. Dingwall and Allen, 2001, Maben, Latter and Macleod Clark, 2007).

In identifying the meaning of Lean for nursing, the implications of the thesis suggest that Lean brings critical issues associated with nursing identity to the fore, which are in turn often intimately entwined with issues of power. It is argued that holistic, person-centred theory, upon which the nursing project and identity is predicated, should be approached more critically and candidly, and that a reconceptualisation of the nursing mandate might be considered, in order for it to better meet the needs of nurses, organisations and the changing reality of contemporary healthcare (e.g. Allen, 2004b, 2014, Maben et al, 2007). In addition to addressing issues of identity associated with holistic, person-centred theory, it is suggested that a reformulated nursing mandate might also promote a more empowered identity, thus addressing issues of identity associated with 'powerlessness'. This may in turn foster more productive relationships with organisations, and increased nurse participation in shaping organisational change processes. In this context, the notion of 'organisational collaboration work' is introduced as a tentative recommendation of the thesis, and its potential contribution to contemporary debates surrounding reformulation of the nursing mandate is outlined. Some suggestions are made as to how pre-registration nursing education might support and assist in realising the agenda of organisational collaboration work, within a reformulated nursing mandate.

The penultimate chapter of the thesis identifies its contributions to knowledge, in the areas of nursing, the sociology of professions, and Lean and operations management literatures. At its broadest level, the thesis contributes to the pursuit of a more comprehensive and critical evaluation of Lean in healthcare, and makes an early, empirical and theoretical contribution to the study of Lean applied to the context of nursing. Additional contributions of the thesis coalesce around insights concerning: how nurses appear to make sense of and interpret organisational change processes, the state, process and outcomes of nursing empowerment, critical analyses of the nursing theory-practice nexus, project, identity and mandate, and a post-professional approach (Burns, 2007) to the study of the professions and their projects in the arena of contemporary healthcare. The chapter also identifies the thesis' limitations, and suggests that

contributions to knowledge should be viewed in this context. Normative criteria, proposed as standards by which the thesis could be judged, are also discussed in relation to the thesis.

1.3 Situating the researcher inside and outside of the story - who she is and where she came from

During the course of reading the thesis, it will become clear that 'who' the researcher is, and 'where' they come from, in the sense of their individual background, are considered to be important philosophical and methodological facets of the research process. In the methodology chapter (Chapter 3), reflecting feminist philosophical influences, it is emphasised how this background (contributing to what is referred to as the researcher's 'situatedness' and 'positionality'), affects decision-making and choices during the research process; how and what a researcher 'sees', and the knowledge they have access to, in the research setting; their particular and partial perspective, and how they understand, analyse and interpret situations, observations, participant narratives and events. These things in turn influence and shape the knowledge construction process, the nature of knowledge arrived, and the knowledge presented as the outcome of research. Providing an account of the researcher's background, as part of a reflexive process - which makes transparent the researcher's influence within the research process, and how knowledge presented was arrived at and came to be - is therefore considered to be important in assisting the reader to contextualise and critically appraise the knowledge claims of research. At the outset of the thesis therefore, this section delineates some of the researcher's personal and professional characteristics which might be considered to have influenced the development, shape, direction and conduct of research, and the genesis and nature of knowledge which is presented in the thesis. In recognition of the potentially infinite and indeterminate number and nature of characteristics which confer to determine one's 'situatedness' however, this section aims to provide a précis of those which might be deemed most relevant and influential.

1.3.1 Researcher background and research inception

I graduated from the Master of Nursing Science (MNursSci) Degree awarded by the University of Nottingham, and qualified as a nurse, in July 2009. I left 'the academy' instilled with an optimistic sense that it was an 'age of opportunity' for nursing as a profession and for individual nurses, in terms of diversifying roles and career options, and increasing influence within the healthcare arena.

I commenced my first post as a Staff Nurse in Post-Anaesthetic Care in August 2009, where I worked for a year. I was keen to develop personally and professionally, and also wished to influence clinical practice and the development of nursing at the Trust within which I worked, more broadly. To this end, I completed training courses, clinical work packages and qualifications, and I volunteered for specialist 'Link Nurse', staff representative, audit and practice development roles. It was through one of these roles, that of 'Change Champion', that I first encountered Lean Thinking proper. As a student nurse, I had been briefly involved with the early stages of implementing a Lean initiative called the Productive Ward on a clinical placement, but was not, at that point, aware of its Lean origins. Informed by introductory events and consultation meetings, I interpreted Lean as a Trust project, embarked upon to improve job satisfaction, workplace wellness and absenteeism, through listening to staff ideas as to how the working environment, their work tasks and working life generally, could be made 'better'. I also saw the potential that Lean held to make clinical work more productive, releasing time that could then be spent caring for patients and saving Trust money, which could be reinvested in improving the quality of patient care.

I facilitated, and contributed to, several changes to ways of working in Post-Anaesthetic Care during the time I held the 'Change Champion' role. I felt that I was making a meaningful contribution to improving nursing practice and patient care. I felt recognised and encouraged by managers and senior staff at the Trust, which prior to undertaking the role, I had not. After a period of time however, the role started to become more challenging in terms of the investment of time that was required to plan and implement increasingly complex and broad

changes. Clinical workload during shifts dictated that I dedicate much of my personal time to fulfilling the role and I often came into work on days off and worked on projects at home during weekends and periods of annual leave. I did not consider this to be inherently problematic, but I had also begun to encounter animosity from some colleagues surrounding my involvement in roles lying outside the boundaries of clinical work. I found this frustrating, disappointing and perplexing, since I felt that I was investing my personal time in projects for 'Us' as a nursing group, and the same opportunities had been equally available to others, but they had chosen to decline involvement. I was also surprised at the level of pessimism that I encountered regarding the implementation of what I saw to be policies and projects which could be beneficial to nurses, patients and the organisation more broadly. This experience fostered an interest in nurses' perspectives surrounding organisational change and practice development processes. During my MNursSci course, I had been particularly interested in elements of modules concerning the social, cultural and organisational contexts in which nursing is practiced. These influences coalesced to stimulate an interest in the socio-cultural influences upon nurses' experiences, understandings and interpretations of organisational change.

At this time, I also found that I was increasingly missing the intellectual challenge that academic nursing studies had offered. I had begun to explore opportunities for undertaking NHS funded doctoral study, with a view to ultimately pursuing a clinical academic career. I was told at an early stage however, that funding was not available and that seconded study could not be supported due to staff shortages. Subsequently, I felt an increasing sense of disillusionment regarding what I had previously considered to be an 'age of opportunity' in, and for, nursing. Shortly after this, I left clinical practice, following a successful application for a Research Assistant position. Around 18 months later, I applied for a doctoral studentship that I had seen advertised, focusing broadly on Lean Thinking in healthcare, which was funded by Nottingham University Business School and the School of Health Sciences. It is from the research completed in fulfilment of this studentship, that this thesis stems.

I hope that through this thesis, and my future academic work, I will be able to contribute meaningfully to the nursing milieu of research, policy, practice, theory and education, for the benefit of nursing, nurses, organisations and patient care alike.

1.4 Structure of the thesis

The next chapter of the thesis, Chapter 2, presents a critical review of theoretical and empirical literature relevant to Lean implementation in healthcare, and Lean applied to the context of nursing. The concept of 'Lean Thinking' is introduced, and literature pertaining to its application in healthcare and the UK NHS, is described. Gaps in knowledge and understanding surrounding Lean in healthcare are identified and arguments are presented in support of the need to address them. Further, the focus of the thesis on Lean implementation in the context of nursing is introduced and located within a theoretical context. Arguments which frame and support the rationale for the focus of the thesis are presented. The centrality of the notions of 'power' and 'holistic, person-centred theory' to the thesis is described, a Foucauldian approach to understanding power is introduced, and the potential insufficiency of a binary approach to understanding complex phenomena, is identified. The chapter concludes with the identification of the thesis' research aim and objectives.

Chapter 3 of the thesis is devoted to elucidating the methodology employed to meet the aim and objectives of research. The thesis' ethnographic approach and methods are identified, and the qualitative approach and feminist philosophical assumptions underpinning them, are delineated, together with the implications that they hold for the thesis. An account of the study setting, participants, sampling strategy, data collection and analysis, together with ethical considerations relevant to the study, is also provided.

Chapter 4 presents the empirical findings of the thesis, which provide an account of the lived reality and meaning of Lean implementation for nurses and nursing in the study setting. They also present a depiction of the nature of the socio-

cultural interaction between Lean and nursing, broadly addressing the thesis' primary research objective. The findings are structured in accordance with four themes, which are located more broadly in the context of an overarching metaphor, of a game played between the Trust and nurses, for power and control over nursing practice. The four themes narrate the story of the game 'at play' in the study setting, with the first three themes being devoted to exploring insights from nurses' narratives and enactments, surrounding the Trust 'side' of the game, and the final theme, to the nursing response to Lean implementation.

Chapter 5 constitutes the first of two discussion chapters. It considers the research findings in light of the first of the thesis' research questions. As such, it focuses on exploring 'power', informed by a Foucauldian approach, as an aspect of the socio-cultural interaction between Lean and nursing, from both the analytical angle of the account of the lived reality and meaning of Lean presented in the findings, in addition to a more critical perspective, informed by extant theory, literatures and empirical work. Attention is devoted to critical analyses of the nature and role of 'power', in influencing the nature of the lived reality and meaning of Lean implementation for nurses and nursing, contributing to the overarching aim of research. Insights into the ramifications of power relations within the lived reality of Lean implementation, for the nursing professional project and identity, relevant to the final research question, are also provided.

Chapter 6, the second of the discussion chapters, addresses the thesis' second research question and considers the nature of the interaction between Lean and holistic, person-centred nursing theory, and the way in which the translation of nursing theory into practice can be understood, in the context of Lean implementation. Arguments are located within, and contribute to, contemporary debates and critiques within wider literature surrounding the nursing praxis process. Insights surrounding the ramifications of these understandings for the professional project and identity of nurses and nursing, relevant to the thesis' final research question, are also provided. Mirroring the approach adopted in the first discussion chapter, Chapter 6 considers the

research question from both the analytical angle of the account of the lived reality and meaning of Lean presented in the findings, in addition to providing a more critical exploration, informed by extant theory, literatures and empirical work, contributing further to the aim of research.

Chapter 7 of the thesis draws upon insights presented in the findings and discussion chapters, in considering the meaning of Lean for nursing, in the form of its implications for the professional project and identity of nurses and nursing. In this way, the chapter attends to the thesis' final research question. Informed by the implications presented, and supported by wider literature, the chapter culminates with a tentative recommendation, holding relevance for nursing policy, practice, theory and education.

Chapter 8 identifies some of the broad contributions of the thesis to knowledge. Insights stemming from the thesis are located in the context of literatures introduced in the literature review and discussion chapters, concerning nursing, the sociology of professions, and Lean and operations management. The way in which the thesis contributes to and extends knowledge in these areas, is identified. Some limitations of the thesis are also identified, within which context the contributions of the thesis should be viewed. Finally, normative criteria, proposed as standards by which the thesis could be judged, are discussed in relation to the thesis.

Chapter 9 concludes the thesis and summarises the content presented in each of the thesis chapters.

1.5 Summary and conclusion

This introductory chapter has provided a synopsis of the thesis and a reflexive account of aspects of the researcher's personal and professional background, which 'situate' the researcher in relation to the research, and which might be considered to have influenced the genesis and nature of knowledge presented in the thesis. It has also contextualised the research in terms of the underlying

motivations for study and an outline of the structure of the thesis has been provided.

Chapter 2. Literature review

2.1 Introduction

The literature review chapter introduces and describes the concept of 'Lean Thinking' (Lean). It maps the landscape in terms of existing literature surrounding its application in healthcare and in the United Kingdom (UK) National Health Service (NHS). This literature is critically reviewed and some gaps in the empirical research, current knowledge and understanding surrounding Lean in healthcare, are identified. Arguments are presented to support the need to address the identified knowledge gaps.

The specific focus of the thesis on Lean implementation in the context of nursing is then introduced, and literatures are identified which locate 'Lean and nursing' within a theoretical context. Arguments are presented which frame and support the rationale for the focus of the thesis. The centrality of the notions of 'power' and 'holistic, person-centred theory' to the thesis is described, a Foucauldian approach to understanding power is introduced, and the potential insufficiency of a binary approach to understanding complex phenomena, is identified. The thesis' research aim and objectives are presented at the end of the chapter.

2.2 Lean Thinking

The concept of 'Lean Thinking' originates from and describes the production methods developed by Taiichi Ohno, at the automobile manufacturing company Toyota, following the Second World War. The Toyota Production System was considered to be 'Lean' due to its lesser use (posited as half or less) of resource input, for increased output (in terms of quality, number and variety), as compared to mass production methods (Womack, Jones and Roos, 1990). As Womack and Jones (2003:15) explain, 'Lean thinking is *lean* because it provides a way to do more and more with less and less - less human effort, less equipment, less time, and less space - while coming closer and closer to providing customers with exactly what they want'.

Lean was so named by John Krafcik, a researcher working on the International Motor Vehicle Program concerning 'the future of the automobile' (Womack et al, 1990:ii). Lean was explicated by Womack et al (1990) in the seminal text 'The Machine That Changed the World'. The authors argued that the principles, techniques and logic that comprise Lean, could be extrapolated outside of the context of the Japanese automobile industry. They argued for the universal utility of Lean across industries and geographic boundaries, and considered the spread of Lean beyond its origins to be both inevitable and necessary. They prophesised that ultimately, Lean would transform the way in which people work, think and live.

Lean has since been applied world-wide, across diverse industries. It has relatively recently been adopted as a management philosophy and process improvement methodology in public services, including healthcare (Radnor, Walley, Stephens et al, 2006).

2.2.1 The principles of Lean

Womack et al (1990) did not provide a definition of Lean. Despite widespread adoption, Lean as a concept remains inconsistently defined within the literature, and it has not been applied in a standardised way, either outside or within healthcare (Petterson, 2009, Radnor, Holweg and Waring, 2012, Mazzocato, Savage, Brommels et al, 2010, Brandao de Souza, 2009, Tragardh and Lindberg, 2004, Papadopoulos and Merali, 2008). Commonly however, it is depicted as a process, characterised by the five principles which guide implementation (Womack and Jones, 2003):

1. Specify **value** as it is defined by the **customer.**
2. Identify the actions involved in the **value stream** that produce the end product, and **remove waste** (steps that do not add value).
3. **Create flow** in the value stream through consideration of the production process in its entirety. Isolated departments become product teams who perform **standardised work.**

4. Arrange production in accordance with **pull** generated by customer demand, rather than pushing products towards the customer.

5. **Strive for perfection**, continuously, endlessly, radically and incrementally.

2.2.2 Lean tools and techniques

Lean is associated with specific terminology and a variety of tools, methods and techniques which assist with implementation. Some examples of Lean tools are provided in Figure 1. Radnor (2010) suggests that the use of Lean tools within public services is associated with three purposes:

1. **Assessment** of organisational level processes e.g. process mapping and value stream mapping tools.

2. **Improvement** and support of processes e.g. 5 Ss tool.

3. **Monitoring** and measurement of the impact and improvement of processes e.g. benchmarking, visual management tools.

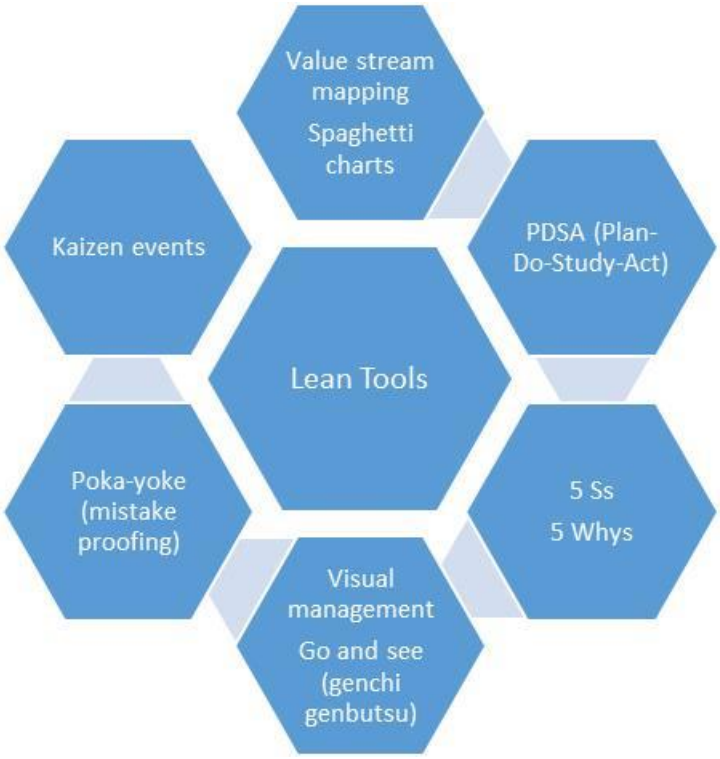

Figure 1. Examples of Lean tools. Informed by Sayer and Williams (2007).

2.2.3 Empowerment; the philosophy and culture of Lean

As a process improvement methodology, Lean is composed of more than a set of principles and tools to improve efficiency. It is underpinned by a Lean philosophy which emphasises the importance of creating a Lean culture which empowers front-line workers and fosters striving for continuous improvement (e.g. Radnor and Walley, 2008, Emiliani, 2011, Poksinska, 2010). In the context of Lean, the central notion of 'empowerment', refers to respecting front-line workers as experts in directing the change process (e.g. Jones and Mitchell, 2006). Changes should be organically-driven 'bottom-up', by committed and involved front-line workers. Workers define, participate in, and take responsibility for and ownership of change, rather than it being imposed or mandated by managers from the 'top-down'. This requires investment in employee development and the fostering of creativity, initiative and innovation (Poksinska, 2010). There is no vertically aligned hierarchy of power within the Lean working environment, which must be viewed as a shared and seamless whole-system. Whole processes are considered in the context of the entire system, as opposed to 'departmental silos' considering isolated parts of a process (Jones and Mitchell, 2006:7).

The adoption of Lean as a holistic approach incorporating its philosophy, as opposed to application as a 'tool-kit' of techniques, is considered to be imperative for its sustainability and success (Radnor and Walley, 2006, 2008, Seddon and O'Donovan, 2009, Womack et al, 1990, Liker and Morgan, 2006, Andersen, Røvik and Ingebrigtsen, 2014). Indeed Emiliani (2011:5) identifies 'Continuous Improvement' and 'Respect for People' as *the* two key principles of Lean, whereby application neglecting the latter is deemed 'Fake Lean'. Similarly, White, Wells and Butterworth (2013:97) argue that it is staff empowerment which 'unleashes the true potential of Lean transformation'. Conversely, a 'tool-kit' approach to implementation can lead to the demoralisation and alienation of staff (Seddon and O'Donovan, 2009, Liker and Morgan, 2006).

Summated, Lean principles, tools, philosophy and culture, are represented by the Toyota Production System (TPS) 'house', or 'House of Lean', depicted in

Figure 2. As Roszell (2013) explains, a Lean organisation is built upon foundations of standardised work processes, performed at a pace which minimises waiting and waste. Resting upon this foundation are two pillars; built-in-quality and delivery of the correct products at the correct time, throughout the organisation. Lean philosophy, emphasising respect for the front-line technical core workers, and their ability to reduce waste and improve continuously, occupies the central position within the model. The roof represents the goal of attainment of the outcomes of best cost, quality, delivery and safety.

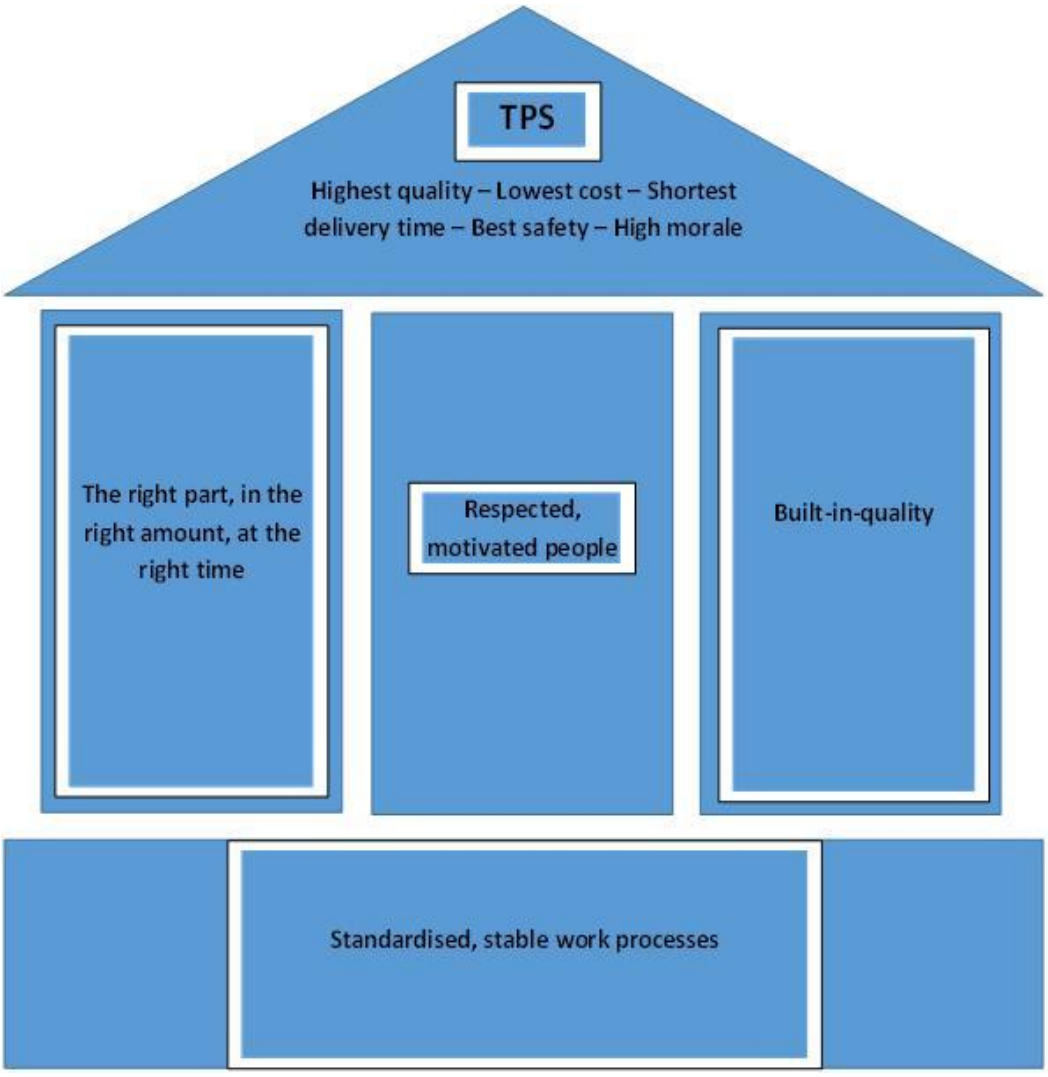

Figure 2. The Toyota Production System (TPS) House. Adapted from Sayer and Williams (2007).

2.3 Lean in healthcare

Of specific relevance to this thesis, is the relatively recent adoption of Lean in healthcare, where it is thought to have first appeared in 2001 (Radnor et al, 2012, Radnor and Osborne, 2013). The principles of Lean identified in 2.2.1 have been adapted to the healthcare context by the NHS Institute for Innovation and Improvement (NHSIII) (2007), and examples are provided in Figure 3. By applying these principles, quality of patient care is said to be enhanced through the improvement of flow and the elimination of waste within the patient journey (*ibid.*).

Lean principles and implications for healthcare
1. Specify value • Defined by the patient, carer and other 'customers' • Value as activities which improve patient wellbeing, care, health and experience • Identifying what patients do and do not value. For example, treatment by the right person, in the right place, at the right time, with high standards of safe care, rather than processes delaying discharge/care, rescheduling of appointments
2. Identify the value stream • The entire patient journey from start to finish. Core actions and components needed to deliver and add value to patient care • Identifying value-adding steps which improve quality for patients. Exposing and removing steps which do not (waste) • Designing better ways of working (without waste, duplication, delay)
3. Make the process flow • Align processes to facilitate smooth flow of information and patients • Removing waste e.g. queuing, multiple referrals, obstacles preventing quickest, safest flow of care • Standardisation of processes and procedures ensures clarity of staff roles, increases visibility of problems, assists in implementing improvements, reduces variation, saves times and allows more work to be performed with the same resources
4. Allow customers to generate pull • Creating pull within the patient journey. Each step pulls people, materials, skills, services and information as needed • Care delivered in response to demand using necessary resources. Resource allocation matched to pull. For example, ward telephones Operating Department for patient, rather than waiting for a request which does not take into consideration resources available (pushing patient to ward)
5. Pursue perfection • Continuously amend and develop processes to pursue the patient ideal - completion of treatment and care with best outcome, without error, on time, without delay • Further eliminate waste, continuously searching for improved ways of increasing value

Figure 3. Lean principles and implications for healthcare. Adapted from NHSIII (2007).

Similarly, seven types of 'Lean waste', originally identified by Womack and Jones (2003), have been modified by the NHSIII (2007, 2008), with examples relevant to healthcare, as identified below. It is thought that by removal of these 'wastes', healthcare professionals' time can be used more productively and efficiently, time savings can be redirected towards patient care activities and patient experience can be improved. Waste is defined as anything above the minimum amount of staff time, space and equipment, which is required to add value to the service or product.

1. **Overproduction**. Producing more than is required. Stems from inappropriate activities or completing tasks 'just in case'. E.g. referrals and tests.

2. **Inventory**. Refers to the storage of excess stock due to unreliable supply, or patients waiting in queues. E.g. waiting lists, over-stocked store cupboards.

3. **Waiting**. Work processes hindered owing to waiting for information, equipment or people. E.g. waiting for patients, prescriptions prior to discharge, test results, physicians to discharge patients.

4. **Transportation**. Unnecessary movement of materials or patients due to the physical arrangement and location of departments, professionals and equipment. E.g. moving a patient from the ward to a physiotherapy department or discharge ward, centralised storage areas instead of storage at the location where the resources are used, walking to the opposite end of the ward to answer the telephone.

5. **Defects**. Repeating work due to faults or incorrect information. E.g. incorrect labelling of tests requiring that they be repeated, medication and patient safety errors, readmission following failed discharge.

6. **Staff movement**. Unnecessary searching, walking and travel. E.g. as a result of poor workplace layout, organisation and design or equipment not being returned to correct place.

7. **Over processing**. Performance of unnecessary processing which does not add value. E.g. collecting patient details multiple times, duplicating information, repeated patient clerking.

NHS Improvement (2015:19, 20) add two further wastes to the seven identified above. The first is the 'waste' of unused staff creativity, potential and skills utilisation. This stems from the failure to consult and listen to staff in the identification of issues, solutions and decision making, where involving them could improve recruitment, retention and morale. This waste also includes highly skilled staff undertaking jobs that are not reflective of their skill, such as 'band 8 staff routinely performing band 3 duties'. The second additional 'waste' is 'automating an already inefficient process', which serves only to automate waste. For example, the purchasing of costly equipment or computer systems which hinder overall process flow, resulting in poor, but expensive, processes.

Ultimately, Lean healthcare is seen as a means of providing 'better care to more people using less resource' (Young and McClean, 2009:309). According to NHSIII (2007:4), it 'identifies the least wasteful way to provide better, safer healthcare to your patients – with no delays'. Lean improves the efficiency, productivity and reliability of healthcare, and more specifically, NHSIII (2007) suggest that Lean can reduce mortality, length of stay, waiting times, waste, costs and delays. It can also improve safety, the quality of patient care, patient experience and staff morale.

2.3.1 Lean in the context of the UK NHS

Modern healthcare organisations are challenged to provide accessible, affordable, high quality, safe and cost effective care, in the context of an ageing society, increasing demand for services and constrained financial conditions (Poksinska, 2010). In the United Kingdom, Lean has been proposed as a panacea for sustainably addressing contemporary challenges facing the NHS; financial deficits, low staff morale and motivation, patient safety issues, capacity constraints, increasing demand for services and poor quality care (Jones and

Mitchell, 2006, Jones and Filochowski, 2006). Through its focus on whole-systems change and continuous quality improvement, Lean has been dubbed a 'refreshing antidote' to the 'artificially imposed metrics' of targets, benchmarks and traditional performance management, with its reactive focus on the solution of immediate problems in the short-term, using a 'slash-and-burn cost-cutting' approach (Jones and Mitchell, 2006:2,3,16). Although the implementation of Lean as a reaction to top-down political and financial drivers is considered 'an anathema to the true vision of Lean' (Radnor and Osborne, 2013:273), the financial crisis within the NHS and policy highlighting the 'efficiency agenda', can be seen to be a major driving force behind its adoption (Radnor et al, 2012:364, Radnor and Walley, 2008, Radnor and Osborne, 2013). Following the Gershon (2004:3) report, for example, which aimed to provide a 'robust framework for analysis and delivery' of efficiency savings, the Operational Efficiency Programme (HM Treasury, 2009) explicitly recommended the use of Lean. The UK government have since invested £50 million in Lean healthcare initiatives (Robert, Morrow, Maben et al, 2011). A more comprehensive account of the origins and rise of managerialism, and the subsequent emergence of Lean, within the NHS, is provided in section 2.4.1.

2.3.2 The Productive Ward: Releasing Time to Care

The Productive Ward series, developed by the NHSIII in 2007, is thought to serve as the most prominent Lean example in the NHS (Waring and Bishop, 2010, Radnor et al, 2012). The Productive Ward recognises the ward as the basic, foundational work unit of the whole hospital system (Bloodworth, 2011). Through the identification and elimination of waste, it aims to improve the safety, reliability, quality and efficiency of care, and in doing so, release time for nurses to spend directly caring for patients (NHSIII, 2009). It also purports to empower nurses and allow them to 'regain control of their ward and the care they provide' (*ibid.*:12).

The Productive Ward consists of a series of modules, each focusing on a different ward process, which are worked through by staff at ward level (NHSIII, 2012a). These are depicted in Figure 4 as the Productive Ward House (NHSIII, 2015a).

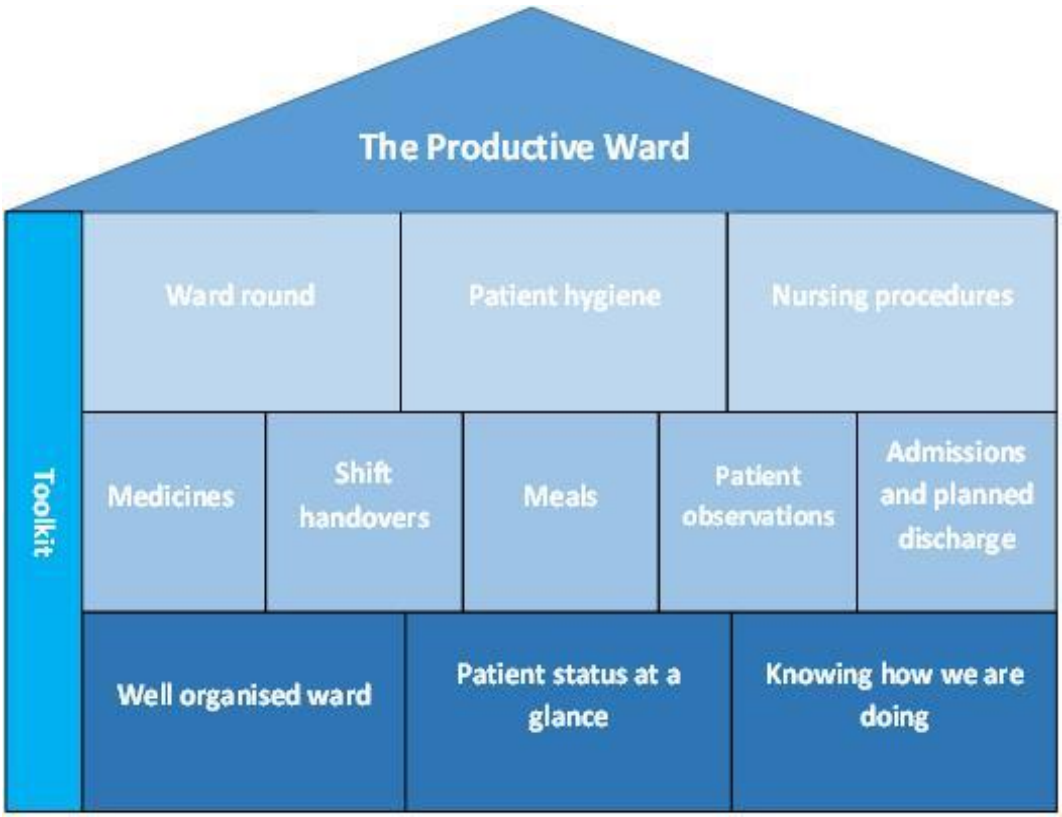

Figure 4. The Productive Ward House. Adapted from NHSIII (2015a).

The individual modules are explained in more detail in Figure 5. The NHSIII (2012b) have expanded the Productive Ward programme to other settings as part of a Productive Series, which includes The Productive Community Hospital, The Productive Operating Theatre and Productive General Practice. The Productive Series, incorporating the Productive Ward, assists NHS Trusts to meet Care Quality Commission care standards and contributes to meeting governmental aims of Quality, Improvement, Productivity and Prevention (QIPP). Its implementation by 2013 across all NHS settings was a QIPP goal, supported by the Prime Minister, David Cameron (*ibid.*). The NHSIII 'closed' in March 2013 and the Productive Ward is now supported by NHS Improving Quality, and Delivery Partners (NHSIII, 2015b).

Productive Ward Modules
'Knowing how we are doing', 'Well organised ward' and 'Patient status at a glance' are foundation modules which provide a grounding for subsequent process modules and in principles of improvement. The toolkit module provides a guide to Productive Ward tools, which support implementation.
Knowing How we are Doing: Involves the development of ward-based measures to assist teams in making informed decisions. **Well Organised Ward:** Involves making ward areas work for staff, rather than staff having to work around the ward areas. **Patient Status at a Glance**: Focuses on information which improves patient flow, experience and communication. **Meals:** Focuses on reducing time spent on the physical delivery of meals, allowing more time for assisting with eating and ensuring patient nutritional assessment is proactive. **Medicines:** Focuses on ensuring that medicine rounds do not conflict with other ward processes and on reducing staff interruptions and preparing in advance. **Admission and Planned Discharge:** Focuses on the planning of admission and discharge processes to avoid rushing. Involves instigating support and social services to facilitate discharge at the appropriate point in a patient's journey. **Shift Handovers:** Focuses on reducing time spent on handover activities, ensuring the appropriateness of information to be handed over and that it is easy to understand and remember. **Patient Hygiene:** Focuses on ensuring patient dignity through the delivery of responsive, clean and safe care. **Patient Observation:** Focuses on improving the standard of patient observations undertaken, through ensuring accuracy and appropriate action based on results. **Nursing Procedures:** Focuses on improving supporting processes for nursing procedures to promote consistency, better patient experience and achievement of standards aspired to by the Trust. **Ward Round:** Focuses on ensuring clarity of outcomes and planning resulting from ward rounds, and making the ward round more consistent and quicker.

Figure 5. Productive Ward modules. Adapted from NHSIII (2012a).

2.3.3 The picture of Lean in healthcare

The application of Lean to healthcare is growing at a fast pace; it is increasingly adopted, adapted and has become progressively more widespread (Burgess and Radnor, 2013, D'Andreamatteo, Ianni and Lega, 2015). Correspondingly, there has been an increase in literature reporting Lean healthcare applications in the UK (Brandao de Souza, 2009). Lean has been applied in areas as diverse as phlebotomy, radiology, laboratory test quality and operations, emergency rooms, autopsy services, operating rooms, pathology, pharmacy and in clinics (Roszell, 2013, Brandao de Souza, 2009). D'Andreamatteo et al (2015:1197) identify the Emergency Department and Operating Theatres as 'pioneer departments' and common sites for Lean implementation, with reports of implementation in these settings accounting for more than half of the studies included in their comprehensive review of Lean in healthcare. With regards to the Productive Ward specifically, in 2011, Robert et al (2011) indicated that the Productive Ward was being rapidly adopted within the NHS, with between 74-100% of acute hospitals in each Strategic Health Authority having downloaded materials from the NHSIII website or purchased supporting packages.

The nature of implementation

Radnor et al (2012) suggest that the nature of Lean implementation in healthcare has been variable in terms of its scope and approach. They note ambiguity surrounding Lean in terms of its definition, purpose and application, but an overall tendency towards application in pocketed areas of organisations, rather than to the organisational system as a whole. Despite cautions surrounding application as a 'tool-kit', identified in section 2.2.3, Lean has tended to be implemented narrowly in the form of operational tools in isolated departments, rather than as a more encompassing continuous improvement philosophy applied system-wide (Radnor et al, 2012, Radnor and Walley, 2006, 2008, White et al, 2013, Brandao de Souza, 2009, D'Andreamatteo et al, 2015, Burgess and Radnor, 2013). The holistic philosophy and culture of Lean is often subsumed under its technical tools, which has contributed to this narrowing of

organisational reach and limitation to isolated departments (Mazzocato et al, 2010). Radnor et al (2012:369) suggest that this approach leads to a 'glass-ceiling of implementation' whereby small improvements are made (and remade) without addressing deeper issues and causes, precluding system-wide improvement.

These observations reflect Radnor et al's (2006:20) distinction between two models of Lean implementation prevalent within healthcare; the rapid improvement approach, offering 'a more tangible version of Lean' and by contrast, the less common full implementation approach encompassing Lean philosophy, or 'true Lean'. The benefits and limitations associated with each approach are summarised in Figure 6. Burgess and Radnor (2013:229) argue that there are at least five discernible approaches to Lean implementation in English hospitals, identified below. They emphasise however, that there is a trend towards increasingly systematic approaches to implementation, with Lean being incorporated into organisation-wide programmes and organisational strategy.

1. The Tentative approach. Staff are in the process of contemplating Lean, tendering for the support of external management consultancy for piloting and implementation of small projects.

2. The Productive Ward Only approach. Staff are involved in the implementation of the Productive Ward but this is the only evidence of Lean implementation.

3. The Few Projects approach. Lean methods and principles are used by staff to underpin projects which relate to certain pathways or functions within the organisation.

4. The Programme approach. Lean principles are referred to by Trust managers as underpinning programmes, which are expected to last for between one and five years.

5. The Systemic approach. Embedding Lean principles within the Trust as a whole is referred to in Trust reports, to foster Lean becoming 'the way we do things around here'. Lean training for all staff is emphasised.

Rapid Improvement Approach		**Full Implementation Approach**	
Strengths	***Weaknesses***	***Strengths***	***Weaknesses***
• Focus on tangible objectives • Immediate benefits • Less challenge presented to management style • Resistance to change diminished owing to intensive approach • Low time and cost investment • Impact on service quality is immediate	• Not all staff affected • Involvement is partial • Lack of visibility overall • All improvement possibilities not covered • Simpler, shorter projects only • May not assist with embedding a culture of continuous improvement	• Complete cultural shift • Improvement potential massive • Sustainability of change • Whole-system change • Changes can be linked with organisational strategy	• Implementation presents larger challenge • Project timescale longer • Achievement of main results slower • Potential for resistance greater • More problematic fit with existing styles of management • Can lose sight of direction in which implementation is heading

Figure 6. Strengths and weaknesses associated with rapid improvement and full implementation approaches to Lean implementation. Adapted from Radnor et al, (2006).

Notwithstanding the above, there are a small number of Lean exemplars cited in the literature. Radnor and Osborne (2013:271) identify two hospitals considered to exemplify a 'truly programmatic approach to Lean'; the UK Royal Bolton Hospital as reported by Fillingham (2008), and in America, the Virginia Mason Hospital, reported by Bohmer and Ferlins (2006). Burgess and Radnor (2013) add Flinders in Australia (Ben-Tovim, Bassham, Bolch et al, 2007) to these seminal examples. Brandao de Souza (2009) and D'Andreamatteo et al (2015) conclude however, that Lean is yet to be implemented in a system-wide fashion in healthcare, across organisational boundaries and remains at an early developmental stage as compared to the automobile industry. This concurs with Spear's (2005:Website page) assertion that no organisation has institutionalised Lean to the extent and level of Toyota. He suggests that 'So far, no one can point to a single hospital and say, "There is the Toyota of health care."'

The impact of Lean in healthcare

Attempts to collate and interpret the outcomes of implementation, in order to assess Lean's impact, in terms of its claims to improve efficiency, quality and safety, have proved challenging, owing to the ambiguity surrounding the definition of Lean, differences in approaches to implementation and the poor quality of the literature reporting Lean studies.

Reflecting Emiliani's (2011:5) notion of 'Fake Lean', Brandao de Souza (2009:131) questions the validity of case studies within the Lean literature, suggesting that many 'are branded as lean without the appropriate level of integrity. These applications are typically very naive but are called lean because they use one or two lean principles'. Roszell (2013:28) similarly notes the various degrees, stages, extents and magnitudes of Lean presence, diffusion and penetration reported as 'Lean' in healthcare organisations, and problematises the lack of 'Leanness benchmarks'. The lack of uniformity in the way that Lean is defined and conceptualised theoretically, has therefore led to ambiguity surrounding not only what Lean is (as a concept), but also what is Lean and what is not (as an application) (D'Andreamatteo et al, 2015). This is further complicated by an

emphasis on the importance of adapting Lean to local context for successful implementation (Poksinska, 2010). Hamilton, Verrall, Maben et al (2014:2), for example, implore that 'One size does not fit all' and that implementation should be adapted in accordance with an appreciation of the uniqueness of discrete contexts. Since different contexts within healthcare demand different approaches, there is essentially 'no single correct way of implementing Lean in healthcare' (Poksinska, 2010:324).

Mazzocato et al (2010) suggest that Lean studies overwhelmingly report success and positive outcomes, but neglect discussion of the constraints and limitations surrounding implementation and study designs themselves, leading them to suspect a publication bias. Similarly, Holden (2011:265) highlights 'methodological, practical, and theoretic concerns', including the absence of 'null or negative patient care effects' and D'Andreamatteo et al (2015) suggest that thus far, the Lean literature has been built specifically upon success cases; sustainability, weaknesses of Lean, negative cases and critical appraisal are neglected, overlooked and underestimated themes. Interrogating the reported 'benefits' and 'successes' themselves, Radnor and Osborne (2013:275) argue that they stem primarily from organisations having addressed prior poor design of services, systems and processes, rather than rigorously applied Lean. It has therefore proved relatively simple to identity and remove waste, and in this way, the benefits reported in the literature represent 'the low hanging fruit (and windfalls!)' of organisational change. They caution that continuation of this approach, limited to correcting prior design faults, will lead to Lean becoming a 'failed theory' in healthcare.

Mazzocato et al (2010) contest that within studies of Lean, methodologies are often unstated, unclear, lack transparency and whilst time and cost savings are reported, it is unclear how these savings are reinvested and whether they indeed contribute to improved quality of care. Similarly, authors suggest that 'studies of lean often lack explicitly stated and appropriate research designs, statistical tests, and outcome measures' (Mazzocato, Holden, Brommels et al, 2012:5, DelliFraine, Langabeer and Nembhard, 2010). There appears to be

disproportionate number of speculative works (Brandao de Souza, 2009, D'Andreamatteo et al, 2015, Poksinska, 2010) and others suggest that the majority of Lean in healthcare literature lacks rigour, is developmental and descriptive by nature (Radnor and Walley, 2008, Joosten, Bongers and Janssen, 2009).

Looking to the literature surrounding the Productive Ward, a similar picture emerges. There is concern surrounding a lack of evaluation, research (empirical, theoretical and experimental), and reliable sources of evidence, a dearth of consistent measures of impact, a potential positive report bias towards favourable outcomes, lack of consideration of sustainability and the association between released time and patient outcomes, and the requirement is identified to supplement local evaluations with 'larger scale evaluative research' (Morrow, Robert, Maben et al, 2012, Burston, Chaboyer, Wallis et al, 2011:2493, Wright and McSherry, 2013, 2014, White and Waldron, 2014, White, Wells and Butterworth, 2014). Indeed, the volume of grey literature and papers which anecdotally report the procedural 'story' of local implementation in practitioner journals, from the perspective of ward managers or programme leaders, is striking and has been noted by several authors (e.g. Wright and McSherry, 2013, 2014, White and Waldron, 2014, White et al, 2014). These articles tend to be orientated towards other leaders and take a discursive, celebratory, experiential, advisory form, but lack empirical basis (e.g. Armitage and Higham, 2011, Blakemore, 2009, Bloodworth, 2009, 2011, Allsopp, Faruqi, Gascoigne et al, 2009, Foster, Gordon and McSherry, 2009, Lennard, 2012). The following extract from Smith and Rudd (2010:48) perhaps typifies this literature:

'Pride in the ward has increased and the ward atmosphere is much more positive. The level of staff sickness has reduced to less than 1% in most months, the number of complaints has fallen and feedback from people coming into the ward is generally more positive. The ward is cleaner, calmer and more organised, and students who have returned to the area feel that the ward is better organised and that staff morale is high. Implementing the productive ward initiative has had a positive effect on team members and patient care on the ward.'

In their review of Productive Ward literature, Wright and McSherry (2013:1368) conclude that whilst there appears to be a trend towards 'Productive euphoria' and evidence indicating the success of the Productive Ward in terms of improvements for staff and patients, the development of a robust evidence base indicating long-term sustainability and impact remains in its infancy. They suggest that quality improvements and cost benefits require evidencing through consistent and reliable data capture and evaluation, to justify continued investment. Similarly, White and Waldron (2014) argue that the literature pertaining to the Productive Ward does not provide credence to its marketing claims. White et al (2014) suggest that the Productive Ward lacks credibility and robust evidence of financial savings, sustained quality improvements, benefits to the well-being of employees, and positive impact on patient experience, as promised by the Productive Ward, is yet to materialise. Wright and McSherry (2014) implore that future research must demonstrate whether the Productive Ward does indeed release time for direct patient care, how released time is reinvested, and how any time that is released and redirected towards patient care translates into outcomes which are meaningful for patients.

Overall, whilst Lean appears to have been successfully applied in many healthcare contexts, other literature presented has suggested that the field is not at a sufficiently developed stage to allow a comprehensive assessment of impact (Mazzocato et al, 2010). Although Lean in healthcare appears to hold promise, evaluations of system-wide approaches to Lean are lacking, and evaluations are limited to quasi-anecdotal reports of narrow applications; a 'state of art' which impedes generalisation, and findings do not allow for a conclusion to be drawn surrounding the impacts of Lean in healthcare, beyond a 'bandwagon effect' (D'Andreamatteo et al, 2015:1204, 1206). Owing to the poor empirical rigour of research surrounding Lean in healthcare, the extent to which it is meeting its claimed potential to address NHS challenges is unclear, and many questions surrounding its effect on patient outcomes remain (Holden, 2011). It seems that much work remains in order to substantiate and verify Lean's claims and propositions relating to its positive contribution to the

improvement of healthcare and there is a need to critique, evidence and more rigorously evaluate the potential and impact of Lean healthcare (Radnor and Walley, 2008, Joosten et al, 2009, Brandao de Souza, 2009, D'Andreamatteo et al, 2015, Poksinska, 2010). It remains to be seen therefore whether Lean in healthcare constitutes an 'unfilled promise' (Radnor et al, 2012:364).

2.3.4 The Lean transformation of the nature of healthcare work

Despite cautions surrounding current approaches to application and the uncertainty surrounding desired financial and patient outcomes, Lean continues to be adopted in healthcare 'regardless'. Beyond debates and research focusing on the efficacy of Lean in healthcare, a smaller body of research, which considers the consequences of Lean more broadly and holistically, suggests that its application may hold other far-reaching implications, for healthcare professionals and the nature of healthcare work.

As a process innovation, the implementation of Lean entails massive organisational change and holds the potential to transform the way in which care processes and healthcare work are physically and socially structured, managed, organised and delivered (Waring and Bishop, 2010, Robert et al, 2011, Papadopoulos and Merali, 2008, Mazzocato et al, 2012). Jones and Mitchell (2006:21, 20) categorically state that Lean in healthcare, is 'about changing the way people work' and involves changing 'people's jobs...significantly. And for ever'. Figure 7 summarises some of the Lean-driven changes to healthcare professionals' work, which have been documented in studies to date.

Lean-driven changes to healthcare professionals' work
• Re-arrangement and re-organisation of the structure of the physical working environment • Introduction, explication and formalisation of new job characteristics, roles and responsibilities, and staff re-assignment • Changes to staff education and training • Introduction of meetings and project rooms for purposes of Lean implementation • Introduction of new (standardised) policies, procedures, guidelines and check lists • Changes to shift start and finish times • Changes to team structures • Changes to technologies, tools, equipment, communication systems, and data monitoring and collection • New processes e.g. rapid assessments, triage and fast-tracking, process-mapping

Figure 7. Summary of Lean-driven changes to healthcare professionals' work. Informed by Mazzocato et al (2012), Holden (2011), Drotz and Poksinska (2014), Waring and Bishop (2010).

2.3.5 The socio-cultural transformation accompanying changes to healthcare work

Ulhassan, Westerlund, Thor et al (2014), Holden (2011) and Joosten et al (2009) posit that the technical components of Lean which promote direct changes to work structure, processes, design, climate and environment, interact with and affect social elements and dynamics in the work setting. In the sense that it impacts upon social processes and functioning in the working environment, Lean can be understood as a socio-technical system and a social intervention (Shah and Ward, 2007, Andersen et al, 2014). Waring and Bishop (2010:1332) suggest that Lean profoundly impacts the way in which healthcare is socially organised and 'has the potential to transform the social organisation of healthcare work'. They identify the introduction of new terminology, customs and routines, the redesign of traditional ways of working and the reconfiguration, differentiation and re-stratification of professional roles and boundaries, as examples of the social effects of Lean. Ulhassan et al (2014) found that Lean impacted upon

teamwork and group functioning, and Holden (2011) suggests that social effects may include changes in social standing due to involvement, empowerment and degree of control over work tasks, and importantly he expects that these social effects on staff will subsequently affect job satisfaction and patient care outcomes, which could suffer or improve as a result.

Further, as demonstrated by Byrne and Fiume (2005) in Figure 8, Lean can be considered 'countercultural' in healthcare, in that it explicitly aims to challenge and change traditional ways of working and the culture of the NHS (Drotz and Poksinska, 2014:177). Extending Andersen et al's (2014) classification of Lean as a social intervention, Lean can also therefore be considered a socio-cultural intervention, with the potential to transform the cultural milieu in which healthcare professionals practice.

Comparison of traditional healthcare and Lean culture	
Traditional healthcare culture	**Lean culture**
• Arranged in function silos • Managers direct • Benchmarking to justify not improving: being 'just as good' • Blaming people • Individual rewards • The supplier is enemy • Guarding information • Volume lowers costs • Internal focus • Expert-driven	• Arranged in interdisciplinary teams • Managers teach and enable • Seeking ultimate performance: the absence of waste • Performing root cause analysis • Groups share in rewards • The supplier is ally • Sharing information • Removing waste lowers costs • Focus on customer • Process-driven

Figure 8. Comparison of traditional healthcare culture and Lean culture. Adapted from Byrne and Fiume (2005).

2.3.6 Healthcare professionals' experiences of Lean transformation

Although the potential for Lean to transform the nature of healthcare professionals' work and the socio-cultural milieu in which it is provided have been identified, there is a relative dearth of research within the Lean evaluation literature, which considers the nature of this transformation, healthcare professionals' experiences, understandings and interpretations of Lean implementation, and the implications that it holds for them at an individual and professional level (Holden, 2011, Holden, Eriksson, Andreasson et al, 2015, Mazzocato et al, 2010, Robert et al, 2011). Aside from some recent studies (e.g. Moffatt, 2013, Timmons, Coffey and Vezyridis, 2014, Waring and Bishop, 2010, Holden et al, 2015, Drotz and Poksinska, 2014), when healthcare professionals' experiences, understandings and interpretations have been considered, it has tended to be in an anecdotal, implied and indirect way (Holden 2011, Mazzocato et al, 2010). It appears that the focus on respect for employees within Lean philosophy has not been reflected in the priorities of the evaluation literature. The short- and long-term implications of Lean-driven changes for healthcare professionals, and its significance for them and their work, remains relatively underexplored. Morrow et al (2012) and Pokinska (2010) suggest that further evidence surrounding the impact and implications of Lean for staff, and their experiences of implementation, is both necessary and important, as additional but relatively neglected outcomes, which should be used to contribute to the evaluation of Lean in healthcare.

2.3.7 The call for a socio-cultural approach to the study of healthcare professionals' experiences and interpretations of Lean

In the two preceding sections, the potential of Lean to transform the socio-cultural context in which healthcare is practiced has been identified, and also that healthcare professionals' experiences, understandings and interpretations of this transformation are poorly documented. Further to this, it is argued that in considering healthcare professionals' experiences and interpretations, the socio-cultural context itself, into which Lean is introduced, should be afforded

equal empirical attention, since this context forms an important reference point, which influences how Lean is experienced and understood. The existing socio-cultural milieu acts as an interpretive context and backdrop, against which Lean is made sense of and attributed meaning. Indeed, drawing on a Technology in Practice approach, Waring and Bishop (2010:1334) suggest that Lean encompasses 'interpretative flexibility' and is imbued with cultural and social meaning. Actors interact to translate and interpret Lean in accordance with the prevailing beliefs and values of the socio-cultural setting. It is therefore suggested that in order to understand and explain, rather than simply describe, healthcare professionals' experiences, understandings and interpretations of Lean, reference should be made and due attention paid, to the socio-cultural back-drop, against which Lean is interpreted.

Such an approach also allows for consideration of the way in which Lean interacts with the socio-cultural context of clinical practice, a theoretical and critical understanding of which is currently neglected within the literature (Waring and Bishop, 2010). Examining the way in which Lean works (or does not work) in interaction with the socio-cultural context to which it is applied, avoids descriptive, static reports of implementation and outcome (Mazzocato et al, 2010, Papadopoulos and Merali, 2008). It allows for an analysis of the process of Lean implementation, and the mechanisms and dynamics underpinning the trajectories of Lean, which is neglected within the literature, which tends to favour an isolated focus upon outcome (Papadopoulos and Merali, 2008, Drotz and Poksinska, 2014). The potential for this interaction to give rise to significant, unanticipated and enduring consequences, or what Wilson (2014:8) terms 'Dysfunctional emergent properties', makes such an exploration timely, in terms of contributing towards a more comprehensive, encompassing and balanced approach to the evaluation of Lean in healthcare.

2.3.8 Taking a 'step back' in order to 'step forward'

Research considering healthcare professionals' experiences, understandings and interpretations of Lean implementation from a socio-cultural perspective, would contribute to a more comprehensive and balanced evaluation of Lean in healthcare, in terms of considering human processes, costs and benefits amidst 'hard' outcomes alone. This would seem essential in order to ascertain, and intervene to prevent, any unanticipated, deleterious consequences for healthcare professionals, at the professional and individual level, and for organisations and patient care. Ill effects for professionals could influence their quality of working life, staff recruitment, retention, sickness and absence rates, and ultimately organisational functioning and the quality of patient care provided. Indeed, the NHSIII (2010:6) suggest that 'the rapid spread of 'good' ideas can be damaging in the longer-term' if the wider impact upon patients and staff is not considered, and Joosten et al (2009), that it must be ensured that the central focus of Lean on customer value and reducing waste does not occur at the expense of staff well-being, satisfaction and working conditions.

Considering the consequences and outcomes of Lean implementation for, and informed by the experiences and interpretations of, healthcare professionals, would allow assessments surrounding the *desirability* of Lean in healthcare to be made, to augment the focus within the literature upon (improving) the viability, feasibility and sustainability of implementation. That is, it appears that the Lean literature overwhelmingly adopts an uncritical, *a priori* standpoint, that 'properly' or 'successfully' implemented, Lean is necessarily desirable and beneficial in healthcare, thus uncritically conforming to Lean rhetoric and the prevailing orthodox view. Such an approach would seem premature however, in light of the dearth of literature regarding healthcare professionals' experiences and understandings of Lean, and the implications and consequences that implementation holds for them, their work, organisations and patient care. Papadopoulos and Merali (2008) advance a similar critique and emphasise that Lean research has tended to focus on complexities associated with implementation and factors thought to be important for success (e.g. staff

engagement and alignment with policy), rather than whether Lean is desirable *per se*. There would seem to be a requirement for research therefore, which takes a step forward in the evaluation of Lean in healthcare, by taking a step back. That is, a commitment to understanding healthcare professionals' experiences and interpretations surrounding Lean, and its implications and consequences, would allow for assessments as to the desirability of Lean in healthcare to be made, rather than simply whether it is feasible or effective, to which existing research tends to be limited. This critical 'step back' would simultaneously represent a 'step forward', in advancing a more comprehensive evaluation of Lean in healthcare.

Thus far, the literature review has focused on critically reviewing literature concerning the application of Lean in healthcare. The requirement for an increased research emphasis on socio-culturally informed understandings of the experiences and interpretations of healthcare professionals surrounding Lean implementation has been identified, and arguments supporting the importance of this agenda have been presented. The remainder of the literature review focuses on Lean implementation in the context of the healthcare professional group with which the thesis is concerned - that of nursing. A rationale is provided for this focus on Lean applied to the context of nursing, and nurses' experiences and interpretations of implementation, and literatures are identified which place the potential interaction between Lean and nursing within a theoretical context.

2.4 Lean applied to the context of nursing

It is suggested that consideration of Lean applied to the context of nursing, and nurses' experiences and interpretations of implementation, is especially important, since there are some characteristics particular to the profession, which mean that Lean may interact with nursing in a specific way, and hold specific implications for nurses and nursing, in terms of the opportunities and challenges that Lean presents to the profession.

Nurses are by far the largest professional group working in UK healthcare (NHS Information Centre, 2011) and have been described as the NHS's 'lifeblood' (Adams, Beasley, Bernhauser et al, 2010:14). Due to their numerical over representation, and their front-line role as providers of the highest proportion of the direct patient care that Lean attempts to transform (Antrobus, 1997, Laschinger, Finegan, Shamian et al, 2001), Lean implementation in healthcare might be said to impact nursing 'most', in a disproportionate way as compared to other professional groups. In order to comprehensively assess the feasibility and desirability of Lean in healthcare, any gains in efficiency should be balanced with implications for nurses and nursing, which long-term, may also affect patient care. Additionally, owing to their number and location at the interface between organisational Lean implementation and patient care provision, the 'success' and sustainability of Lean-driven change might also be seen to rely, to a large extent, on the degree to which the nursing workforce engage with initiatives. In occupying this 'gate-keeping' role, nursing engagement might be considered a *sine qua non* for sustainable change, and understanding nurses' experiences and interpretations of implementation would therefore also seem important, from this organisational and operations management point of view.

The potentially considerable impact of Lean upon nurses and their work, and their essential role in the implementation and sustainability of Lean, have been identified. Despite this, literature searches of the databases PubMed, ProQuest and EBSCO Host (Cinahl Plus with Full Text), first performed in May 2012 and updated periodically until July 2015, suggest that the application of Lean to nursing, and the experiences, understandings and interpretations of front-line clinical nurses surrounding implementation, have yet to be comprehensively considered theoretically or empirically. The details and results of searches are presented in Appendix 1.

In the absence of theoretical literature considering the interaction between Lean and nursing, the following sections consider the conceptual relationship between the two entities, as a means of contextualising the focus of the thesis. Theoretically, the relationship between Lean and nursing might be socio-

culturally conceived of as representing, in part, an interaction between managerialism and professionalism. The sections of 2.4.1 and 2.4.2 which follow, explicate this conception, and section 2.4.3 considers the implications that Lean, interpreted in this way, may hold for the profession of nursing. Beyond managerialist associations, additional characteristics of Lean are also highlighted in section 2.4.4, which suggest that overall, the application of Lean to nursing may present both a challenge to and opportunities for nursing.

2.4.1 The managerialist ideology underpinning Lean, and its origins and rise in the NHS

Lean thinking is underpinned by, and contributes to, the ideology and practice of managerialism in healthcare (Waring and Bishop, 2010, Pitschas, 2004, Kollberg, Dahlgaard and Brehmer, 2007). Tsui and Cheung (2004) identify eight implications of managerialism for human services. Adapted for the context of healthcare, these can be summarised as follows:

1. **The patient is seen as the customer rather than as a consumer**. Definitions of service quality are therefore determined by the patient.

2. **Managers, rather than front-line healthcare professionals, hold power and control operations,** since it is assumed that effective management allows increased efficiency through cost-reduction. Staff implement the decisions and plans of the manager. Staff are managerialised and marginalised in the managerialist era.

3. **Healthcare staff are viewed as employees rather than professionals or experts**. Professional autonomy and expertise is not respected and staff are expected to perform managerial, bureaucratic tasks as part of their role (e.g. audits and performance appraisals). Their work becomes a job, rather than a career.

4. **The knowledge of management rather than of professionals is dominant** and new jargon, management roles and measures are created.

Management technology guides action, and performance and quality are improved using managerial skills.

5. **Decision making is in accordance with commercial principles and market value, in pursuit of organisational profit, rather than for the benefit of the patient**. Society is seen not as a community with common goals but as a market composed of competing interests. Market share and maximisation of profits are of paramount importance.

6. **Efficiency (ratio of output to input) is the measure of staff and organisational performance.** Effectiveness, or the extent to which a service meets its goals, is less emphasised. Managers count rather than judge, measure rather than think, and are concerned with cost rather than cause.

7. **Relationships are characterised by contracts and cash, rather than concern and care**. They are task-orientated, time limited, short-term, obligatory and legal entities.

8. **Quality, as indicated by standards, is emphasised and measured quantitatively.** It is equated with documentation and standardisation. Healthcare professionals are expected to spend time away from direct patient care to complete paperwork. The defining standards of quality are hard to apply to human services, since they omit elements of processes which are unquantifiable.

Business-style managerialist doctrines were emphasised and introduced into public services by the New Public Management (NPM) approach to bureaucratic reform, prevalent from the late 1970's (Hood, 1991). Drawing on the work of Butler (1992:1), Traynor (1999:9) suggests that at this time, private sector practices, with their connotations of efficiency, were consulted in order to provide solutions to problems associated with the NHS, including the 'heavy influence' of bureaucracy, an absence of patient choice and incentives for efficiency and innovation, 'the restrictive practices of powerful professions' and

a ‘deadening reliance’ on government funding. As a consequence, discourses of the market, competition and managerialism, originating from industry, began to enter into the public sector. In 1983, Sir Roy Griffiths, then Managing Director and Deputy Chairman of the supermarket chain Sainsbury’s, was asked by the Conservative government to lead an inquiry into the management of the NHS (Traynor, 1999, Edwards and Fall, 2005).

The Griffiths Report

The outcome of Griffith’s management inquiry, the Griffiths Report (Department of Health and Social Security [DHSS], 1983), was critical of consensus management within the NHS and the lack of management accountability, performance orientation, and the absence of concern for the views of healthcare consumers (Harrison, 1994). By way of summarising the findings of the inquiry, Edwards and Fall (2005:19) quote Cliff Graham (a member of the inquiry team) thus: ‘In short, if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge’. The rise, growth and institutionalisation of managerialism within the NHS, is commonly attributed to the Griffiths Report, which advocated a general management approach drawing on private sector methods and experience, philosophies of business, market principles, and promoted more pluralistic patterns of finance and care provision (Lewis, 2014, Cox, 2003, Hewison and Wildman, 1996, Parkin, 1995, Day and Klein, 1983, Klein, 2006). Improvements in the quality and intensity of managerial intervention and organisational restructuring, were viewed as solutions to the economic and social pressures associated with the NHS, and through the explicit measurements of outcomes and costs, it was proposed that the efficiency of resource use could be improved and expenditure contained, at a time of underfunding, increasing demand, escalating costs and expected future increases in costs associated with medical innovations, technologies and advances (Day and Klein, 1983, Hewison and Wildman, 1996, Cox, 2003). Implemented through a managerial hierarchy, an identified individual was to

become responsible for planning, setting targets, implementing, monitoring and controlling performance, at every organisational level (Cox, 2003).

Cox (2003:108) explains that the Griffiths Report represented an ideological move from health service administration focusing on the needs of professionals, to general management, who adopted responsibility for service delivery and implemented strict control over performance, and manual and professional labour costs. As part of a 'cultural and organizational revolution', the report adopted an 'industrial-style authority' whereby financial accountants and general managers played a progressively significant role in the control and production of healthcare, and a sensitivity to the satisfaction of the consumer featured as a recurring theme.

'The philosopher's stone of efficiency' (Klein, 2006:106)

In the years following the Griffiths Report, New Right government policy became increasingly shaped and driven by the 'productivity imperative' (Klein, 2006:105), which was viewed as a potential solution to the problems of meeting increasing demands upon the NHS - as a consequence of an ageing population and technological change, and on the other hand, the government's commitment to containing the increase in public expenditure, owing to financial constraint resulting from 'an ailing economy' (Klein, 2006:105, Harrison, 1994). As Klein (2006:106) notes, it was thought that the 'philosopher's stone of efficiency' offered a formula allowing a constrained NHS budget to be combined with the expansion of services, to be achieved through better management. Following the Griffiths Report, a sequence of 'top-down' reforms were introduced by the New Right government, which can be subsumed under the umbrella of NPM. These reforms, through their emphasis upon the 'productivity imperative' (Klein, 2006:105), and 'efficiency agenda' (Radnor et al, 2012:364) as solutions to the challenges facing the NHS, acted as precursors to the adoption of a plethora of process improvement methodologies within the NHS, derived from industry, including Total Quality Management (TQM), Business Process Reengineering (BPR), Plan Do Study Act (PDSA), Six Sigma, and of significance to this thesis, Lean

Thinking. An overview of these process improvement methodologies, which can be considered the 'Continuous Process Improvement Cousins' of Lean (Sayer and Williams, 2007:22), is provided in Appendix 2.

The Resource Management Initiative

Among the NPM reforms introduced by the New Right government, was the Resource Management Initiative (RMI) of 1986 (DHSS, 1986). The RMI constituted a resource management approach focused on the achievement and demonstration of measurable 'improvements in patient care through better use of all the hospital's resources' (Mills, 1987). Iedema, Braithwaite, Jorm et al (2005:256) identify four aspects of the RMI as: 'strategies to improve quality of care; the involvement of clinicians in operational management; better provision of information to improve the use of resources; and improved control of resources through better resource management and allocation.' The RMI aimed to 'establish the effect on the quality and quantity of patient care when clinicians were fully involved in the management of their hospitals, supported by information from computerised databases on the resources used to treat individual patients' (Edwards and Fall, 2005:42). Fundamentally therefore, it sought to fully involve clinicians in the process of management, through accounting-focused management decision-making (Broadbent, Laughlin, Read, 1991, Mills, 1987). Responsibility for resources used was transferred to those who were responsible for allocating them, making professionals 'managerially responsible for their actions' (Broadbent et al, 1991:17). For clinicians, patient care had previously constituted an implicit but separate issue, decoupled from resource implications and issues of resourcing (*ibid*.). This therefore represented a fundamental change from clinicians' use of their professional autonomy to fulfil their principal responsibility towards patient care, towards patient care within resource limitations *(ibid*.). The RMI might therefore be interpreted as a means of calling autonomous professionals to account and managerial control of professional activity (Traynor, 1999).

The internal market

The introduction of an internal market to the NHS was recommended in the Enthoven Report (Enthoven, 1985), concerning Reflections on the Management of the NHS (Edwards and Fall, 2005). As Mays, Dixon and Jones (2011) explain, the internal market was introduced into the NHS in 1991, following the publication of the white paper 'Working for Patients' (Department of Health, 1989). Such market-like incentives were 'intended to motivate improvements in efficiency and patient responsiveness while maintaining a tax-financed system that provided universal free access to health services'. As a consequence of the introduction of the internal market, the roles of NHS providers and purchasers of healthcare were separated. Regarding secondary care, acute hospitals became 'Trusts', free from District Health Authority (DHA) control. DHA's were financed in accordance with the healthcare needs of their local population, and were able to purchase services from providers, whether from the public, voluntary or private sector. Trust funding became based on their ability to secure contracts for providing services for a DHA at a price which was negotiated locally. Since purchasers could 'shop around' for their required services (Klein, 2006:163), and Trusts must in effect 'compete for 'business'' (Glasby, 2017:37), it was envisaged that theoretically, the internal market would incentivise providers to improve efficiency, customer responsiveness, standards and reduce costs - maximise quality, whilst minimising cost - in order to ensure their viability (Traynor, 1999, Mays et al, 2011, Glasby, 2017).

New Labour targets

Mays et al (2011) explain that reforms to the NHS continued in the years following the change to a New Labour government in 1997, albeit with a different focus – on collaboration, in place of competition. Although 'claiming to abolish the internal market' the separation of providers and purchasers of services remained (*ibid.*:4). The terminology 'commissioning' replaced 'purchasing' however, reflecting a movement away from simply the buying of existing services of providers, towards the development of 'new and better

services' through working in collaboration with providers, in order to 'improve their ability to meet the needs of the local population' (*ibid.*:4).

Drawing on the work of Stevens (2004), Mays et al (2011) identify that health policy became focused upon standardising care provision across providers and securing national quality targets and standards. As a consequence, two regulatory organisations were introduced – the National Institute for Clinical Excellence (now the National Institute for Health and Clinical Excellence) and the Commission for Health Improvement (now the Care Quality Commission), alongside National Service Frameworks, which articulated what 'good' services relevant to a particular patient group or condition, looked like, according to evidence and professional consensus. The Commission for Health Improvement assessed the performance of NHS institutions, awarding them 'star ratings' ranging from zero ('failing') to three stars ('excellent'), indicating to the public the standard to which a Trust was performing (Whitfield, Pritchard, Latchmore, 2005:10). The National Institute for Clinical Excellence was to assess the cost and clinical-effectiveness of treatments, in order to determine which should be available to patients through the NHS (*ibid*.).

As Mays et al (2011) further explain, from the year 2000, the Labour government embarked upon a plan for investment and reform (Department of Health, 2000), which saw an increase in the NHS budget. In order to ensure that investment delivered the results desired however, and reflecting a recognition that the setting of targets and their enforcement had likely reached a ceiling of impact, once again, emphasis was placed upon market-like competition, to promote efficiency of resource use and customer expectations, overall ensuring that investment delivered performance improvements (Stevens, 2004). Subsequent policy and reform built upon this market element, with the aims of 'improving quality of care, improving patient experience, improving value for money, and reducing inequality' (Mays et al, 2011:8). Whitfield et al (2005) identify that patients were provided with a choice as to which hospital they received their treatment from and the private sector was encouraged to assume a greater role in services provision to NHS patients. This period also saw the introduction of

Foundation Trusts, which were accountable to 'members' (elected governors, patients, residents and NHS staff) and independent from the Department of Health (*ibid.*). Further 'Payment by Results' (Department of Health, 2005) was introduced as a method of resource allocation, whereby, in accordance with a national tariff for procedures and operations, hospitals received a standard price for care provided to patients. Those which attracted more patients therefore in turn received more income (*ibid.*). Whitfield et al (2005:11) suggest however, that whilst competition was reintroduced, 'co-operative ventures' to increase efficiency and improve standards were also emphasised. Clinical networks, for example, which drew together doctors and specialists from several institutions were established, in order to ensure the best use of limited and specialist, resources, were established, and other voluntary associations, or 'collaboratives' were set up as a means of sharing best practice and techniques for fostering improvement. New Labour reforms can therefore be considered to have been characterised by a 'mixture of competition and collaboration' (*ibid.*:11).

The Gershon Review and Operational Efficiency Programme

In 2004, the Gershon Review (Gershon, 2004:3), which aimed to provide a 'robust framework for analysis and delivery' of efficiency savings, identified key efficiencies within the departments of the public sector, to deliver £20 billion savings annually in public spending by 2007/08. The review focused on ways in which resources could be released to the front-line, by 'recycling' resources released via identified efficiencies, and enhancing 'the productive time of front-line staff' (e.g. through the use of para-professionals to prevent the need for clinicians to deviate from their core activities, and support from Information Computer Technology systems) (*ibid*.:23). The report recommended that a 'culture of efficiency' be promoted in the public sector, in order to 'facilitate the delivery of proposed efficiency savings', and a role for efficiency experts, or 'specialist change agents', to provide advice surrounding implementation of efficiency programmes, was proposed (ibid.:20, 32).

Having met and exceeded the efficiency targets set out in the Gershon (2004) review, in 2009, The Treasury published their report relating to operational efficiency within the public sector (HM Treasury, 2009). The report suggested that the public sector should seek to emulate the drive towards efficiency found within the private sector, in order to ensure the survival and improvement of front-line services amidst a climate of economic hardship. The report acknowledged that the restructuring and redesign of services may be required in order to deliver the efficiency savings envisaged as a result of implementing its recommendations. It emphasised limiting the role of central government to that of a strategic driver in the efficiency process, and enabling devolved services to collaborate, lead and manage change on a local level in a way which best met local priorities. Key to this vision was incentivising, engaging, empowering and capturing the ideas of staff working on the front-line of service delivery, regarding ways in which services could be made more efficient and better meet the needs of local people. It was therefore proposed that the expertise of front-line staff could be used to enhance the efficiency of service delivery. The report also emphasised the centrality of adopting and locally adapting examples of good practice and removing barriers presented by bureaucracy, regulation and inspection (though limiting the role of government), in the creation of an environment in which innovation led by front-line staff could prosper. The role of leaders, managers and senior managers were also highlighted as central in the creation of an innovation-led culture.

The report examined the potential for efficiency savings within five areas of the public sector, and within the area of 'local incentives and empowerment', it explicitly recommended the adoption of continuous improvement methodologies across the public sector, and Lean was specifically identified (HM Treasury, 2009:69). The government have since invested £50 million in Lean healthcare initiatives (Robert et al, 2011).

Summary

The arrival of managerialism in the NHS in the late 1970s, in response to the government looking to the private sector and industry for approaches and practices as solutions to the problems and challenges facing the NHS, gave rise to a series of reforms characterised by NPM, which can be seen as drivers of the adoption of Lean Thinking, and other process improvement methodologies, including TQM, BPR, PDSA, 6 Sigma, in public services. These 'Continuous Process Improvement Cousins' of Lean (Sayer and Williams, 2007:22), are described in Appendix 2.

Having described the managerialist ideology underpinning Lean, and its origins and rise in the NHS as a precursor to the adoption of Lean in healthcare, the next section introduces the ideology underpinning contemporary nursing practice and its claims to status as a profession.

2.4.2 The ideology of 'New Nursing' and holistic, person-centred theory

The ideology of 'New Nursing' was central to reforms of nursing education and training outlined in Project 2000 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC], 1986) in the 1980's (Beardshaw and Robinson, 1990). New Nursing was a multi-faceted and complex movement, designed to re-orientate the basis and principles of nursing practice (Beardshaw and Robinson, 1990). It represented a move away from influences of rationality and classical science, and the consideration that this entailed of human beings as orderly, predictable, machine-like and measurable, since this was considered to lead to a dehumanising, fragmented and reductionist approach to care (Benner and Wrubel, 1989 in Antrobus, 1997). Traditionally, task- and functionally-oriented approaches to care prevailed, underpinned by a bureaucratic, authoritarian and hierarchical model of organisation. Care was fragmented and organised ritualistically in accordance with fixed routine, rather than tailored to the individual needs of patients (Beardshaw and Robinson, 1990).

The ideology of New Nursing challenged the traditional value-system of nursing. Whereas the task-centric model emphasised physicality and was reductionist and mechanistic by nature, the ideology of New Nursing emphasised humanistic, holistic, person-centred and individualist perspectives, allowing for a reflective, multi-focal consideration of the biological, psychological, cultural, spiritual and social needs of patients (Wells, 1999, Beardshaw and Robinson, 1990, Fitzpatrick and Redfern, 1999, Leininger, 1988). A comparison of traditional, and New Nursing person-centred, models of nursing, is provided in Figure 9. Influential nurse theorists and philosophies contributing to the caring frameworks and values of New Nursing which underpin contemporary practice, include:

- Humanistic philosophy and constructs in the work of Paterson and Zderad (1976).
- An emphasis upon the therapeutic relationship fostered by the work of Peplau (1952).
- An experiential, aesthetic and intuitive epistemology, provided by the work of Benner and Tanner (1987).
- The Roper, Logan, Tierney (1985) model of nursing introduced a means of individualising and personalising the nursing process.

Informed by Antrobus (1997) and Beardshaw and Robinson (1990).

Comparison of traditional and person-centred models of nursing	
Task-oriented nursing	**Person-centred nursing**
• Nursing tasks include housekeeping (e.g. stocking and supplies, linen, catering), clerical and administrative duties • Nursing competence is underpinned by the ability to undertake a variety of tasks, with emphasis placed on getting by and coping • Nurses supervise 'basic care', which is delegated to non-qualified staff • The patient is a passive recipient of routinised care • Care is characterised by fragmentation, routine and ritual • Emphasis is placed on a biomedical model, illness and dependence	• Nurses plan, implement and evaluate care based on the individual needs of patients • Nursing competence is underpinned by the fulfilment of the therapeutic role as an independent practitioner, caring for individual patients • Nurses plan and deliver 'basic care', with the assistance of other staff • The patient is an active partner in planning for individual needs nurses • Care is characterised by a holistic, critical and questioning approach to care provision • Emphasis is placed on a holistic model, health and independence

Figure 9. Comparison of traditional and person-centred models of nursing. Adapted from Beardshaw and Robinson (1990).

Nursing as an art and science

New Nursing introduced the notion of the nurse as a 'knowledgeable doer' (UKCC, 1986 in Beardshaw and Robinson, 1990:19). This was intended to convey the amalgamation of the duality of theoretical knowledge and practical skill in nursing (Drennan and Hyde, 2009). Through a holistic approach, it recognised nurses as both scientifically knowledgeable and technically skilled in the affective, humanistic and interpersonal art of caring (Antrobus, 1997, Morrison and Cowley, 1999, Finkelman and Kenner, 2013). It was envisaged that individualised, tailored care be achieved by a skilled, therapeutic clinician, using a systematic approach based on scientific knowledge of best practice (Beardshaw and Robinson, 1990).

The ideology of New Nursing plays a prominent role in nursing's claims to status as a profession. Before this is considered further however, a brief background to nursing's place within the professional paradigm is provided.

The sociology of professions and the professional status of nursing

The meaning of the term 'profession' and its defining characteristics, are widely, and historically, debated (Parkin, 1995, Burns, 2007, Porter, 1992, Liaschenko and Peter, 2004). The status of nursing as a profession, and indeed whether it is a desirable or relevant aspiration, is similarly contested (Salvage, 1985, 1988, Abbott and Meerabeau, 1998, Porter, 1992, Liaschenko and Peter, 2004, Antrobus, 1997, Willetts and Clarke, 2014). In terms of its social positioning, nursing has been variously understood as a profession, an occupation, a discipline, a calling, a vocation, a practice, a quasi-profession, semi-profession, bureau-profession, or 'an adjunct to a gendered concept of profession' (e.g. Antrobus, 1997:452, Turner, 1995, Etzioni, 1969, Abbott and Meerabeau, 1998, Wilkinson and Miers, 1999, Liaschenko and Peter, 2004). Salvage (2003:13) argues that nursing has 'always inhabited a rather uncomfortable social space somewhere between the 'true' (i.e. male-dominated, powerful, elitist) professions like medicine and law, proletarian occupations like domestic work and health care assistants, and unpaid 'women's work' in the family home.'

Although the place of nursing on the profession-non-profession continuum (Burns, 2007) is contested, the intention here is not to debate the supporting and undermining factors for nursing's professional status. Rather, it is to consider ways in which nursing has strived to secure professional status. This can be considered nursing's 'occupational strategy' (Salvage, 1988:517) for appropriating 'the honorific title' of profession (Porter, 1992:720), or, what Larson (1977:5) would term, the 'professional project' of nursing.

New Nursing and the professional project

Nursing's strategies for occupational advancement and increased power have been based on functionalist, trait depictions of the archetypal or *de facto* profession, which have served as a template or 'well-trodden pathway' for professionalisation (Abbott and Meerabeau, 1998, Porter, 1992, Burns, 1997, Parkin, 1995:562). Two key, interrelated elements have served as central foci for nursing efforts; autonomy and control over work organisation and content, and a defined knowledge base, with associated training and education. Commenting on the relation between the two, Parkin (1995:562) suggests that 'professionalization is a political process and issues of power and control are central to it'. Expert, specialised knowledge affords power arising from a situation of dependency, which in turn confers autonomy. He continues to say, that in order to obtain the Weberian notion of social closure, control mechanisms such as the restriction of educational opportunities and entry criteria must be applied, in order to enhance status through scarcity value. This mirrors Larson's (1977) ideas underpinning the notion of the professional project, whereby through the construction and control of an expertise market, professionals are able to legitimise their authority and assert the inclusionary boundaries of the group. Education systems function to monopolise expertise through the grouping of experts, the identification and perpetuation of a unique body of knowledge, and formation of criteria in order to control, license and regulate professional 'goods' and entry requirements.

The ideology of New Nursing has been interpreted as representing 'an explicitly professionalising strategy, designed to give trained nurses a distinct sphere of influence within health care and greater autonomy in their work' (Beardshaw and Robinson, 1990:19, Salvage, 1990). Using this ideology, nursing has sought to demarcate its unique body of knowledge and distinctive contribution to patient care, arguing that the 'synthesis of the art of caring and the empiricism of science distinguishes nursing from other health professions' (Shaw, 1993 in Parkin 1995:563, Beardshaw and Robinson, 1990). The idea of nursing as caring therefore lies at the heart of its professional project, its claims to status as a

profession and is considered its boundary feature which establishes and legitimises it as a recognised profession (Norman and Cowley, 1999a, Leininger, 1988, Salvage, 1990).

With regard to educational components of the professional project, Project 2000 (UKCC, 1986) saw nursing enter the academy. It conveyed a vision of autonomy, assertiveness and independence for nurses, conferred via the development of expertise through formalised training (Beardshaw and Robinson, 1990, Antrobus, 1997). This was seen as a way in which core professional values could be fostered and reinforced, and an 'academic currency' could be secured through diploma level training (Meerabeau, 1998:87). The rise of nursing theory and conceptual models, the drive for academic credibility and emphasis upon autonomous, independent practitioners, can be interpreted as part of nursing's strategy for professional advancement, inhering the possibility of autonomy and a defined body of knowledge (Traynor, 1999, Parkin, 1995).

The concepts of professional identity and identity work

Allen (2014) suggests that the notions of individualised, person-centred, holistic care, upon which nursing's professional project relies, are central to the professional identity of nurses. Drawing on the work of Schein (1978), Ibarra (1999) conceptualises professional identity as embodying the motives, experiences, attributes, values and beliefs that one uses to define their occupational role. It is associated with the common understandings, culture, roles, beliefs and ideals of a given professional group and is produced and reproduced through professional socialisation processes, for example, during professional education and training (Evetts, 2013, Briggs, 2007). In short, professional identity might be described as professionals' understanding of 'who they are', 'what they do' and 'what one stands for', which is reflected in how they 'present themselves to the world' (Pratt, Rockmann and Kaufmann, 2006:259, Trede and McEwen, 2012:30, Owens, 2006:206). The notion of 'identity work' can be employed to describe the processes and means by which

professionals shape, influence and manage their identity, for example through their talk and action (Watson, 2008).

Thus far, the conceptual underpinnings of Lean and nursing have been identified, in terms of the managerialist ideology of Lean, and nursing's caring, professional ideology. The following sections of 2.4.3 identify some potential implications, in the form of conflicts and challenges that Lean may present to nursing, resulting from the interaction between these two ideologies. Some additional affordances of Lean are then considered in section 2.4.4, which suggest that Lean may simultaneously present opportunities for the nursing profession.

2.4.3 The potential for conflict between Lean and nursing

Owing to its managerialist underpinnings, Lean can be seen to hold the potential to conflict with nursing. This section summaries some of the challenges and consequences of managerialism for nursing that can be identified within the nursing literature. Overwhelmingly, this scholarship presents an understanding of managerialism as detrimental to nursing practice, culture, the professional project and identity of nursing, and as catalysing a pervasive discontinuity between holistic nursing theory and its materialisation in clinical practice - commonly referred to as the nursing theory-practice gap (e.g. Hewison and Wildman, 1996). This depiction can be seen to reflect the focus upon the oppositional 'managerialism versus professionalism' theme within wider sociological literature, which views managerialism as inherently threatening to professionalism (Noordegraaf, 2011).

Challenges to the nature of nursing as caring

Nursing in the context of managerialism might be seen to represent the meeting of two disparate and competing ideologies. The potential for conflict is made visible when key facets underpinning New Nursing and managerialism are explicated and compared, as presented in Figure 10.

Comparison of managerialist and nursing ideology	
Managerialist ideology	**Nursing ideology**
Emphasises the: • Measurable Demonstrable Tangible • Reductionist • Objective • Scientific • Standardised • Task-oriented Fragmented • Mechanistic Quality as turnover, cost effectiveness	Emphasises the: • Tacit Aesthetic • Holistic • Subjective • Art and science • Individualised • Person-centred • Humanistic Quality as best experience

Figure 10. Comparison of managerialist and nursing ideology. Informed by Davies (1995), Antrobus (1997), Rankin and Campbell (2006), Morrison and Cowley (1999), Wells (1999), Bolton (2004), Leininger (1988), Fitzpatrick and Redfern (1999), Finkelman and Kenner (2013), Drennan and Hyde (2009) and Bergen (1999).

The often diametric opposition of these features has led authors to deem managerialism as antithetical to caring in a plethora of ways, and as creating a disjuncture for nurses between the agendas of caring and efficiency (Rankin and Campbell, 2006). It is suggested that the reductionist, performance-oriented, scientific-rational focus and mode of knowing of managerialism 'does not fit' with a contemporary nursing ideology for practice within a holistic, humanistic, intuitive and aesthetic framework (Antrobus, 1997:451). Managerialism challenges, diverts time and attention away from, and marginalises care beyond that which is conducive to measurement and quantitative outcome measures, rendering it invisible and contributing to a theory-practice gap (Rankin and Campbell, 2006, Bergen, 1999, Davies, 1995, Hewison and Wildman, 1996). As a corollary, it is argued that nursing risks becoming weakened by a subsumption of

caring under managerialist ideology, where only classifiable, measurable scientific skills are legitimised (Morrison and Cowley, 1999).

Threats to nursing knowledge and autonomy

Rankin and Campbell (2006:174) advance the argument that 'knowing' is socially organised and 'never neutral'. They contend that in the context of managerialism, the status of knowledge is assessed against dominant managerialist interpretive frameworks, which serve to authorise certain forms of knowledge and subjugate others. Managerialism conceptually frames and defines what can be legitimately known and what counts as knowledge, in 'scientized' and objectified terms, delegitimising the experiential, tacit and embodied knowledge of nurses (*ibid.*:170). Since this process does not recognise or examine power relations and knowledge disjunctures, the legitimacy of managerial knowledge and its unassailability is perpetuated, creating an 'ideological circularity' (*ibid.*:181). This 'circularity of knowing' not only marginalises and colonises traditional nursing ways of knowing, but also rationalises managerial intervention upon nursing work, and functions to organise and regulate nursing practice for organisational purposes (*ibid.*:171). The authors suggest that through the absorption and actioning of the ruling ideological practices and ideals of managerialism, nurses' clinical judgement and autonomy is undermined and their action, thinking and subjectivity is restructured and dominated. Similarly, Bolton (2004) identifies arguments surrounding managerialist discourses functioning as devices of normative control, and the potential for bureaucratisation, with its emphasis upon targets, measurement, audits and standardised protocols, to exert control over nursing work, encroach upon, and threaten nurses' professional autonomy.

Renegotiation of jurisdictional boundaries (Abbott, 1988) and nursing the organisation

Rankin and Campbell (2006) observe that within the managerialist milieu, nurses are becoming enrolled into ruling relations, purposes and practices, which are reconstituting their actions, knowledge and are ultimately eroding nursing. They argue that the 'efficiency' perspective of managerialism reorders, reforms and remakes nursing work. Similarly, others suggest that the agenda of management dictates nurses' clinical work boundaries, parameters and redefines divisions of labour, with nurses adopting managerial responsibilities and perspectives beyond their clinical work (Wells, 1999, Parkin, 1995). This challenge to nursing's traditional jurisdictional boundaries (Abbott, 1988), Rankin and Campbell (2006:172) suggest, is symptomatic of a reorganisation of nurses' consciousness away from their traditional standpoint of caring, towards the 'professional duty to nurse the organization.'

Challenges to the culture, professional project and identity of nursing

In sum, the challenges presented by managerialism to nursing's caring ideology, practices, knowledge, autonomy and jurisdictional boundaries, can be interpreted as threatening the essential facets of the professional project, identity and culture of nursing. Wells (1999:68) argues, for example, that a preoccupation of managerialism has been to colonise, change and influence facets of nursing philosophy, culture and 'weltangschaung' - nursing's shared set of values, beliefs, attitudes, language, traditions, behaviours, rules and ways of working - to the ends of meeting managerial goals, such as increased efficiency and cost-effectiveness. This changes and shapes the context in which nurses work, from which their professional identity and self-image is drawn. In turn, this can lead to the refashioning of traditional values, understandings and roles, stimulating 'role and value ambiguity', as nurses attempt to negotiate managerial, target-oriented responsibilities, with those more traditionally located within the parameters of their clinical tradition (*ibid.*:57). Drawing on the work of Porter (1992), Wells (1999:71) further suggests that those concerned

with the professionalisation of nursing through developing autonomy, will inevitably see managerialism as threatening, challenging, 'anti-professional' and incompatible with the nursing professional project. It has been similarly argued that the challenges to autonomy presented by the bureaucratisation of nursing work, can lead to de-skilling and the proletarianisation of nursing (Bolton, 2004). Likewise, Parkin (1995) identifies the effects of managerialism as eroding nursing authority, status and autonomy, and equates these sequelae with notions of deprofessionalisation. Since the idea of nursing as caring lies at the heart of its claims to professional status and constitutes its unique boundary feature, in stifling the expression of caring in practice, managerialism can be seen to present a further challenge to the professional project of nursing (Norman and Cowley, 1999b).

This section has outlined some potentially deleterious professional implications of Lean for nursing, stemming from its association with managerialism. Notwithstanding this perspective, when considered in the context of its wider culture and philosophy, as introduced in section 2.2.3, Lean can be seen to be comprised of some additional characteristics, which might be considered to proffer opportunities, and hold positive affordances, for the nursing profession.

2.4.4 Lean and nursing; an age of opportunity?

Owing to a variety of social, cultural and educational factors, nursing is traditionally depicted as a subjugated and disempowered professional group, which continues to hold low status within the healthcare professional hierarchy (e.g. Manojlovich, 2007, Smith, 1992, Davies, 1995, Kuokkanen and Leino-Kilpi, 2000, Wilkinson and Miers, 1999, Sparrow and Robinson, 1994, Antrobus, 1997, Hewison, 1999). It can be recalled from section 2.2.3, that Lean however, aims to realign traditional organisational hierarchies of power, foregrounds respect for front-line workers' knowledge and expertise, and emphasises employee empowerment, autonomy and increased control over work and care processes. These affordances can be seen to be congruent with the professionalising aims of the nursing professional project described in section 2.4.2. The offerings of

Lean in terms of challenging established social structures and processes, the presentation of the potential for re-negotiations of status, professional power and empowerment, may therefore hold opportunities for nursing and their professional project, and are particularly poignant for nursing as a subjugated profession.

It has been identified, in section 2.4.3, that managerialist elements of Lean may challenge the theory and practice of holistic, person-centred caring lying at the heart of nursing culture, their professional project and identity, and antagonise a theory-practice gap. Paradoxically however, the increased autonomy and control over practice proffered by Lean, identified in the preceding paragraph, may allow nurses to mitigate against this, and ensure that the direction of organisational change is congruent with, supports and enhances, the implementation of holistic theory in practice. Additionally, it can be recalled from section 2.3.2, that Lean-driven productivity improvements are purported to increase the amount of time that nurses can contribute to directly caring for patients, thus allowing for the enactment of the caring theory upon which the nursing professional project and identity rely. At a more individual level, it could be anticipated that these affordances might contribute to improved job satisfaction, workplace wellbeing, retention, and sickness and absence rates. Indeed, the empowerment of nurses, as promoted by Lean, is associated with increased work satisfaction, reduced levels of job strain and burnout, and improved job commitment, benefitting the organisation, employee and patient care alike (Laschinger et al, 2001, Laschinger, Finegan, Shamian et al, 2003, Pineau Stam, Laschinger, Regan et al, 2015, Kuokkanen, Leino-Kilpi and Katajisto, 2003). Lean can therefore be seen to offer opportunities for nursing, in terms of increasing professional autonomy, control, power and supporting the implementation of holistic theory, holding positive implications for nursing's professional project.

2.5 The research agenda

Given the potential challenges and opportunities presented by Lean to nurses and nursing which have been identified in the literature review thus far, and the dearth of literature exploring Lean implementation in the context of nursing, there would appear to be a need to empirically consider Lean applied to the context of nursing, and front-line nurses' experiences, understandings and interpretations of implementation, as part of the critical assessment and evaluation of the impact and desirability of Lean in healthcare.

The concepts of power and holistic, person-centred theory have formed central themes in conceptualising the potential socio-cultural interaction between Lean and nursing in this literature review, in terms of the opportunities and challenges that Lean may present in relation to the culture, professional project and identity of nursing. It is therefore suggested that power and holistic, person-centred theory constitute sensitising, orientating concepts and vehicles, through which nurses' experiences, understandings and interpretations of Lean can be explored and understood, and implications for the professional project and identity of nursing, considered. Drawing on Lukes' (1974) application of Gallie's (1955-6:169) terminology, power can however, be considered an 'essentially contested concept', and in the remaining sections of the literature review, a means of conceptualising and approaching the issue of power in considering the application of Lean to nursing, and nurses' experiences and interpretations surrounding implementation, is explicated.

2.5.1 The power of Lean

Although the issue of power features as a pivotal concept within Lean philosophy, and is key to the opportunities that Lean may hold for nursing, it appears to be approached in a somewhat uncritical and simplistic way by proponents of Lean and within Lean theory itself. This critique might also be said to apply to the treatment of the issue of power in the literature identified concerning nursing in the context of managerialism. In both cases, power, as a

concept, receives scant attention, is adopted unproblematically, and in practice, is depicted as functioning in a deterministic, linear way. Further, Lean theory implies, somewhat axiomatically, that 'empowerment' is a desirable, positive and progressive outcome, and presumes that in creating the structural preconditions for empowerment (Laschinger et al, 2001), such a state will follow as a matter of course, apparently neglecting any complexity of process. As identified at the start of section 2.2, Lean is also considered by its proponents to be universally applicable. Overall, the Lean approach to the issue of power denies the specificity of the context of, and potential socio-cultural influences on, implementation, sustainability and outcome. Foucault's work on power however, can be seen to challenge and problematise the Lean depiction, and provides a way of approaching the issue of power in a more critical and comprehensive way. Some key aspects of Foucault's conception of power are described in the next section.

2.5.2 A Foucauldian approach to understanding power

A theory of power?

Foucault (2003a:6) is sceptical of totalising 'all-encompassing and global theories'. His understanding of power does not therefore equate with a theory of 'what' power is *per se*. Indeed, he suggests that 'power as such does not exist' and there is no 'unique form of a great Power', in a universal, realist sense (Foucault, 1982:786, 1978:98). He argues that the question 'What is power?' denies the 'extremely complex configuration of realities', and the context-specific, disparate nature of the local effects of power (Foucault, 1982:786, Foucault, 1978). Instead of speaking of a unitary power therefore, Foucault speaks of powers in the plural (Foucault, 2003a, 2003b, 1982).

Foucault (1982) maintains that power can only be exercised over free subjects. Without freedom, physical relations of constraint and determination, rather than power, ensue. Owing to the agency of the subject, when 'faced with a relationship of power, a whole field of responses, reactions, results, and possible

inventions may open up' (*ibid.*:789). The effects of power at the point of application are therefore contextually specific, and studying power involves being attentive to the essentially local, particular and discontinuous character of the critique (Foucault, 2003a). Foucault (2003a:6) suggests that this resembles 'a sort of autonomous and noncentralized theoretical production, or in other words a theoretical production that does not need a visa from some common regime to establish its validity'.

Rather than providing a theory of power, it is therefore perhaps more accurate to say that Foucault offers a methodology for analysing power, or the 'how of power'; its mechanism, its relationships, its apparatuses and the effects of its exercise through action (Foucault, 2003c:24, 2003a). Foucault (1982:786) attempts a critical exploration of the thematics of power, seeking to answer 'The little question' of 'What happens?', in a way which avoids a 'fraudulent' ontology of power.

Power as games of strategy

For Foucault (1978:95), power has a 'strictly relational character' and when Foucault (1997:292, 298) speaks of power, he speaks of relations of power; 'a relationship in which one person tries to control the conduct of the other', combined with the 'strategies by which individuals try to direct and control the conduct of others'. The 'how' of power must therefore be understood through the analysis of the mobile and multiple social relations and the strategies of control, which constitute and perpetuate it (Foucault, 1978). Foucault (1997:298) asserts that 'Power is games of strategy' and accordingly, in his explorations, he employs the language and imagery of struggles and tactics, battles and wars, of adversaries, armies, oppositions and 'dividing lines' of confrontations (e.g. Foucault, 2003a:7, 2003b, 1982). Foucault (2003c:29) maintains that power is not 'held' within these relationships by individuals or groups, but rather, it is something which is exercised through action:

'Power must, I think, be analyzed as something that circulates, or rather as something that functions only when it is part of a chain. It is never localized here or there, it is never in the hands of some, and it is never appropriated in the way that wealth or a commodity can be appropriated. Power functions. Power is exercised through networks, and individuals do not simply circulate in those networks; they are in a position to both submit to and exercise this power. They are never the inert or consenting targets of power; they are always its relays.'

Power and knowledge

Foucault sees power and knowledge as inextricably linked and mutually reinforcing within relations of power. Knowledge equates with, is an effect of, and perpetuates power, and *vice versa*. He suggests that 'Between techniques of knowledge and strategies of power, there is no exteriority' (Foucault, 1978:98). Power-knowledge relationships constitute the 'matrices of transformations' within relations of power (*ibid.*:99). An implication of the association between knowledge and power, is that power relationships should be analysed in a critical way, and in an ascending, rather than descending fashion (Foucault, 2003c). That is, Foucault sees studying power using a descending approach, from the perspective of the institution, as inherently problematic. This is because he sees the mechanisms through which power is operationalised by institutions, as designed to serve a self-preserving function. A descending approach to analysing power presents the risk of 'deciphering functions which are essentially reproductive' of the power relations studied, and constitutes 'seeking the explanation and the origin of the former in the latter, that is to say, finally, to explain power to power' (Foucault, 1982:791). Foucault (1982:780, 791) therefore suggests that 'one must analyze institutions from the standpoint of power relations, rather than vice versa' and from 'outside' the 'point of view of its internal rationality'.

Further, for Foucault (2000, 1978:100, 102), power, discourse and knowledge (savoir) are inextricably linked; 'it is in discourse that power and knowledge are joined together'. Drawing on knowledge, discourse can serve simultaneously as

an effect, a transmitter, a producer, a reinforcer, and an instrument of power. Within the power relations of a given social setting, there exists an unstable and complex interaction of a 'polyvalence of discourses' and these serve strategic and tactical functions in relation to the exercise of power. Discourse can also function as a practice of self-formation in the construction of identities (Foucault, 1997).

Studying power at the local level

Foucault (2003a:7,9) suggests that when approached in an ascending way, local knowledges, which 'functional arrangements or systematic organizations are designed to mask', can be desubjugated, reactivated and insurrected 'against the centralizing power-effects that are bound up with the institutionalization and workings of any scientific discourse organized in a society'. Local knowledge lying fallow at the margins, deemed unqualified, naive, 'insufficiently elaborated' and inferior, makes visible, and allows for a critical analysis of, power relations (*ibid.*:7). Studying power at local level becomes 'a way of playing local, discontinuous, disqualified, or nonlegitimized knowledges off against the unitary theoretical instance that claims to be able to filter them, organize them into a hierarchy, organize them in the name of a true body of knowledge' (*ibid.*:9). This allows these knowledges to be set free, 'to enable them to oppose and struggle against the coercion of a unitary, formal, and scientific theoretical discourse' (*ibid.*:10).

Intention at the point of application

Foucault suggests that the study of power should take effects at the margins, rather than intentions underlying power, as its focus. Power should be understood through studying it at its point of application, through 'looking at its extremities, at its outer limits at the point where it becomes capillary', at the point of its 'most regional forms' (Foucault, 2003c:27). Foucault (1978:95) acknowledges that 'Power relations are imbued, through and through, with calculation: there is no power that is exercised without a series of aims and

objectives.' However, he suggests that in analysing power, intention should be analysed at the point where it meets real practices, 'the procedures of subjugation', or the external face of power; 'the point where it relates directly and immediately to what we might, very provisionally, call its object, its target, its field of application, or, in other words, the places where it implants itself and produces its real effects' (Foucault, 2003c:27, 28). In analysing the 'rationality of power' therefore, one must not consider the 'headquarters that presides over its rationality', but rather, analyse the tactics, logic and aims which are clear, decipherable and 'explicit at the restricted level where they are inscribed (the local cynicism of power)' (Foucault, 1978:95).

It can be seen from this explication that Foucault's work challenges the simplistic conception of power contained within accounts of Lean, and nursing in the context of managerialism, and suggests that power is a dynamic and highly complex phenomenon. In exploring and understanding issues of power in the context of Lean implementation, and nurses' experiences, understandings and intrepretations of this, Foucault's work points to the importance of considering the local manifestation of the processes of power, and power relations should be acknowledged and explored.

2.5.3 Towards understanding beyond binaries

Foucault's relational understanding of power, together with the identification of *both* potential challenges and opportunities presented by Lean to nursing, suggests that a binary approach to understanding, is likely to be insufficient for exploring and understanding issues of power in the context of Lean and nursing. Inherent within conventional accounts of nursing and managerialism, is the dichotomisation of professionalism-managerialism, power-powerlessness, nursing ideology-managerialist ideology, for example, but such dualistic constructions can be seen to constrain, narrow and artificially simplify explorations of phenomena (Manojlovich, 2007, Thomas and Davies, 2005). An approach to understanding which looks beyond and beneath diametric opposition and either/or scenarios however, allows for the accommodation of

both/and scenarios, fostering greater nuance and a more holistic understanding, within which contradiction, complexity, tension, contingency and the relational nature of phenomena can be acknowledged (Thomas and Davies, 2005, Fagerström and Bergbom, 2010).

2.6 Summary of gaps in knowledge surrounding Lean implementation in healthcare

The literature review has identified several gaps in knowledge surrounding Lean in healthcare, relevant to the direction of the thesis. Informed by the conceptualisation of Lean as a socio-cultural intervention, the potential for Lean to transform the nature of healthcare professionals' work and the socio-cultural milieu in which it is provided, has been described. Gaps in understanding have been identified however, surrounding the nature of this transformation, healthcare professionals' experiences, understandings and interpretations of Lean implementation, and the implications that it holds for them at individual and professional levels. Further, it has been suggested that in order to understand and explain healthcare professionals' experiences, understandings and interpretations, due attention should be paid to the socio-cultural back-drop, against which Lean is interpreted. This would allow for gaps in knowledge to be addressed, surrounding the way in which Lean interacts with the socio-cultural context of clinical practice, and the process of implementation, in terms of the mechanisms underpinning Lean outcomes and trajectories.

Regarding the specific focus of the thesis on nursing and nurses, the need for research considering Lean applied to the context of nursing, and front-line clinical nurses' experiences, understandings and interpretations of implementation, has been identified, in order to contribute to a more critical and comprehensive evaluation of the impact and desirability of Lean in healthcare. The notions of power and holistic, person-centred theory, formed central themes in conceptualising the theoretical, socio-cultural interaction between Lean and nursing, and in identifying potential implications for the nursing professional project and identity, in terms of opportunities and challenges

presented by Lean. As such, it has been suggested that these concepts hold utility as vehicles through which nurses' experiences, understandings and interpretations of Lean, and its implications for nursing, can be explored. In the next section, informed by these gaps in understanding, the thesis' research aim and objectives are presented.

2.7 Research aim and objectives

The following research aim and objectives are informed by the socio-culturally oriented gaps in knowledge surrounding Lean implementation in healthcare, and reflect the utility of power and holistic, person-centred theory as concepts of relevance, in considering Lean implementation in the context of nursing. They are supported by the rationale that has been presented, highlighting the importance of research considering healthcare professionals' experiences, interpretations and understandings of Lean implementation, and more specifically, those of nurses as individual actors, and the implications that Lean holds for nursing as a professional entity.

Research aim

The aim of research was to explore the lived reality and meaning of Lean Thinking for nursing and nurses working in three settings at an NHS Hospitals Trust.

Research objectives

In order to address the aim of research, a broad primary objective was formulated, from which stemmed three more specific secondary objectives. The primary research objective was:

- To explore the socio-cultural interaction between Lean and nursing

The more specific, secondary research objectives, were to address the research questions:

- How can power and power relationships be understood in the context of Lean and nursing?
- How does Lean interact with holistic, person-centred theory and how can the translation of nursing theory into practice (the praxis process) be understood in the context of Lean implementation?
- What ramifications do power relationships in the context of Lean, and its interaction with holistic, person-centred theory, hold for the professional project and identity of nurses and nursing, to which the notions of power and holistic theory are central?

2.8 Summary and conclusion

This chapter has introduced the concept of Lean Thinking, and existing literature relating to its application in healthcare, and within the UK NHS, has been critically reviewed. Gaps in knowledge and understanding surrounding Lean in healthcare have been identified and arguments have been presented to support the need to address them.

The focus of the thesis on Lean implementation in the context of nursing has been introduced and a rationale has been provided for this focus. The potential interaction between Lean and nursing has been located within a theoretical context, and challenges and opportunities presented to nursing as a profession by Lean, have been described. The concepts of 'power' and 'holistic, person-centred theory' have been identified as holding utility for exploring the socio-cultural interaction between Lean and nursing, and the implications that Lean holds for the professional project and identity of nursing. The treatment of the concept of 'power' within Lean theory has been critiqued, the Foucauldian approach to understanding power, employed in the thesis, has been introduced, and the potential insufficiency of a binary approach to understanding complex phenomena, has been identified. The thesis' research aim and objectives have been presented, informed by the gaps in knowledge identified in the literature review.

Chapter 3. Research Methodology and Methods

3.1 Introduction

This chapter of the thesis describes the ethnographic methodology and methods which were adopted to address the aim and objectives of research. The qualitative approach and feminist philosophical influences underpinning the research methodology, and their implications for the research and thesis, are delineated. The chapter also provides an account of the study setting, participants, sampling strategy, data collection and analysis, and the role of the researcher in the research process, together with ethical considerations relevant to the study.

3.2 Connecting research philosophy, methodology and methods

Research methodology refers to the 'theory and analysis of how research should proceed' (Harding, 1987:2). It can be seen as a conceptual bridge between the philosophical assumptions underpinning the research and the methods of data collection (Hesse-Biber and Leavy, 2011). Philosophically, epistemological assumptions are reflected in one's theoretical and methodological approach to research and delineation allows for the scrutiny and defence of the research process as a credible form of inquiry (Crotty, 1998). They provide criteria for assessing the adequacy of the research's 'truth claims', and explication ensures that criteria are congruent and consistent with underlying assumptions, in order to avoid 'talking past' each other (Sandberg, 2005:42, Grix, 2010). Epistemology is concerned with 'the theory of knowledge' and is traditionally driven by the questions 'What is knowledge?', 'What can we know?' and 'How do we know what we know?' (Greco, 1999:1). In addition to concerning the adequacy of and strategies for justifying knowledge claims, feminist interpretations of epistemology, upon which this thesis draws, include questions such as 'whose knowledge?', 'who is it that knows?', 'who can be a 'knower'?' and 'what can she know?' (Harding, 1991:xiii, Grasswick, 2004:85, Harding, 1987:3, Code, 1991:xv).

Ontology and epistemology are inextricably linked and together provide the foundations upon which methodology is built (Grix, 2010). That is, where 'ontology involves the philosophy of reality, epistemology addresses how we come to know that reality while methodology identifies the particular practices used to attain knowledge of it' (Krauss, 2005:758-9). Epistemology and ontology are therefore often discussed in a related fashion rather than in a conceptually distinct way (Crotty, 1998). Reflecting this confluence, these philosophical assumptions are discussed in tandem in the sections which follow.

The research reported in this thesis is grounded in the qualitative paradigm and underpinned by feminist philosophical influences. An ethnographic methodology was employed to address the aim and objectives of research. Before describing the nature of the ethnographic approach adopted and contextualising the decision to employ this methodology, the qualitative approach and feminist philosophical influences underpinning and permeating the research are explicated, in order to identify how issues of 'knowledge' and 'reality' are conceived of and approached in the thesis. The implications and consequences that the feminist philosophical influences hold for the research and thesis – for how the thesis' knowledge claims should be approached and understood, the place of criticality in the thesis, and the normative criteria by which the knowledge claims of the thesis might be judged – are also identified. The adoption of feminist philosophy is then justified and a qualification relating to the way in which a feminist approach was adopted in the research, together with supporting arguments, is introduced.

3.3 The qualitative research paradigm and feminist philosophical influences

A qualitative approach was considered appropriate to address the aim of research, since such an approach seeks to:

'Study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them'

(Denzin and Lincoln, 1998:3)

Accordingly, in the context of this research, the 'things' of nurses and nursing were studied in their three 'natural' hospital ward settings, in order to explore the lived reality of the 'phenomenon' of Lean implementation, and understand and interpret the meanings that it held for nurses and nursing. Consistent with the qualitative focus, the research was concerned with the 'reality' of Lean implementation and the meanings that it held, as socially constructed, subjectively experienced - or 'lived' - and multiple, in nature (Denzin and Lincoln, 2008). 'The' lived reality and meaning of Lean implementation was therefore conceived of, and approached as, essentially plural in nature and the possibility of *the* single, 'objective' understanding, corresponding with *the* single, objective 'reality' and meaning of Lean implementation, 'out there' to be discovered, in a realist sense, was rejected. It was therefore acknowledged that the thesis provides but one account of the lived reality and meaning of Lean implementation for nurses and nursing, and the term 'lived reality' was used to denote and distinguish the research focus on the 'reality' of Lean as subjectively experienced by nurses, as opposed to a focus on a realist 'objective' reality of Lean.

The qualitative approach adopted was influenced by feminist philosophical assumptions regarding the nature of knowledge and social reality. Consistent with the aim of research and the qualitative approach, feminist research emphasises and is committed to exploring 'what is going on' in participants' lives, their experiences and understandings of phenomena, and the meanings with which they are attributed (Letherby, 2003:6, Hesse-Biber, 2007, Leavy, 2011). Feminist research begins with, and is grounded in, the experiences, interpretations and understandings of participants, which are respected, valued, upheld and taken 'seriously' in the research process (Letherby, 2003:62).

In the sections which follow, feminist critiques of traditional epistemology are introduced and the feminist responses informing the thesis, are outlined. The way in which these influences were adopted, and the implications that they held for the research process and thesis, are identified.

3.3.1 The feminist rejection of traditional epistemology

Feminists have explored the relationship between gender, knowledge and knowing and the relationship between power and knowledge (Garry and Pearsall, 1996a). Feminists argue that epistemology, as traditionally conceived of, represents 'an exclusively masculine perspective on human knowledge (by way of content, acquisition, methodology and application)', which serves to perpetuate and reinforce 'the long-standing denigration and oppression of women by men' (Pinnick, Koertge and Almeder, 2003:1). Feminist philosophers have highlighted the near exclusion of women historically from the philosophical canon and their negative depiction where they are considered within it (e.g. Witt, 2004, Antony, 2002). In addition, they claim that normative philosophical concepts such as objectivity and reason are gendered through their placement in opposition to 'whatever a given philosopher associates with women and the feminine' (Witt, 2004:1). They argue that in this way, what has been allowed to pass as knowledge in 'epistemology proper' (Alcoff and Potter, 1993:1) has been 'policed by philosophers codifying cognitive canon law' (Haraway, 1988:575).

Descartes as 'the main foil' (Longino, 1999:331)

Descartes is commonly considered to be the founding father of the traditional epistemological project (e.g. Bonjour, 2010, Berger, 2003, Longino, 1999). The feminist rejection of Descartes' unified 'first philosophy', which answered the central questions and concerns of epistemology (Kornblith, 1999:159), can be seen to reflect a more encompassing rejection of epistemology proper and its 'pivotal ideas' (Code, 1991:314). Bordo (1987:5), for example, provides a critical interpretation of Cartesian foundationalism, rationalism and epistemic objectivity. In her thematic deconstruction of the *Meditations*, she argues that rather than providing enduringly applicable philosophical insights into the human condition, Descartes' dilemmas and solutions are better considered as contextually situated, historical and cultural products; responses to the prevailing chaotic and unstable circumstances of his time. She interprets rationalism as symbolic of 'flight from the feminine', organic world, towards a

'modern scientific universe of purity, clarity and objectivity', where knowledge is conceptualised as a certain, absolute and masculine entity. Descartes' dualisms of self-world and subject-object are interpreted as attempts to transcend the maternal world and its feminine values. Feminists have also argued that within such binary oppositions, a hierarchy exists whereby the 'masculine' component or entity is contrasted, preferred and placed in a dominant position to the opposed 'female' entity, and that these oppositions have served to assist in justifying and perpetuating subordination within androgenic philosophy (Garry and Pearsall, 1996b).

3.3.2 Feminist epistemology – the situatedness and interdependence of knowers, and the ontological parity of subject-object

Whilst feminists have rejected the 'mainstream' epistemic project (Adam, 1998:58), their response, in the form of developing an alternative, feminist epistemology, has not followed a linear, definitive path and encompasses vast and deep difference, variation and disagreement (Griffiths, 1995, Grasswick, 2004, Tuana, 2001). Indeed, it may be more accurate to refer to their response as plural 'feminist epistemologies' (Alcoff and Potter, 1993:1). Harding (1986a, 1986b:649) categorises feminist solutions as empiricist, standpoint or postmodern but subsequently notes that these categories are and '*should* be unstable'. It is generally accepted that feminists alter and add to these lines of thought (Hoffman, 2001a), that they overlap and interrelate (Grasswick, 2009), and should not be regarded as separate, incompatible or opposed (Hoffman, 2001b).

The feminist philosophy underpinning the thesis was informed by several perspectives, based around the epistemological themes identified by Longino (1999). Longino (1999:331) introduces the concept of *embodiment* as a feminist response to binary opposition, challenge to knowledge *a priori* (Alcoff and Potter, 1993) and identifies three consequences stemming from the embodiment of the knowing subject; the 'situatedness of the knower', the

'interdependence of knowers' and the 'ontological parity of subject and object'. These consequences are described in turn in the next three sections.

Situatedness of the knower

'Through our bodies, we behold and know each other and ourselves, the world around us, and the heavens above us'. Our corporeal 'bodies influence what and how we know.'

(Shuford, 2010:5, 7)

Feminists argue that we are not abstracted 'brains in vats', as analytical philosophy depicts (Griffiths, 1988). Using the metaphor of vision, Haraway (1988:581) argues that knowledge cannot be construed as 'seeing everything from nowhere', an illusion which she terms 'the god trick'. Unable to transcend our earthly bodies, we are at any one time located physically, historically, socially, politically and linguistically and therefore our view (and knowledge) is located, partial, specific and changing rather than disembodied, transcendent, universal, infinite and fixed (Haraway, 1988, Tuana, 2001). A knowers' existential condition of embodiment and situatedness requires that epistemic subjects be regarded not as homogenous and generic but as different and similar simultaneously across and within contexts, according to their experiences, values, culture and social practices - these factors influence embodiment's many meanings and the construction of knowledge (Shuford, 2010).

Interdependence of knowers

Code (1991:4-5) contests the conception of knowledge as an outcome of individual knowers' efforts, arguing instead, that knowledge is socially constructed. She rejects the Cartesian depiction of the knower contained in the standard 'S knows that P' proposition on several grounds, one of which concerns the knower as a 'self-sufficient and solitary individual' in the epistemic project. The knowledge project *a priori,* she argues, neglects both the knower's embodiment and their relations with other knowing subjects. Similarly,

Grasswick (2004:88) suggests that such an individualistic depiction, an 'atomistic view of knowers...abstracted from their social relations', fails to acknowledge inter-subjective power relations and the role of knowledge communities in shaping knowledge. In proposing a model of 'individuals-in-communities', she provides an account of the role of both individuals and communities in knowledge production; individuals possess epistemic agency but power relations can affect its exercise. Subjects are therefore situated, *socially* within communities and knowledge is interactive as well as socially constructed.

Ontological parity of subject-object

Feminists reject the detachment of the subject and object of knowledge which stems from the prerequisite of objectivity in the process of producing 'valid' and 'true' knowledge (England, 1994, Usher, 1997a). They see the subject and object as continuous and contest the desire for, and possibility of, neutrality and impartiality within the research process, since such a stance denies and undermines both the subject and objects' essential embodiment and situatedness, requires a position of transcendence and assumes the possibility of seeing 'everything from nowhere' (Haraway, 1988:581, England, 1994, Shuford, 2010, Usher, 1997a). Feminists argue that traditionally, the researcher assumes a position of dominance and power over passive objects of research (Grasswick, 2004), who, in their treatment as 'mere mines of information' rather than embodied people, are exploited by the researcher, 'the neutral collector of 'facts'' (England, 1994:82). In response to their objections, feminists have developed a 'morally responsible' alternative 'that gives what is due to all parties' (Stanley and Wise, 1993:200), which is outlined in the next section.

3.3.3 Feminist epistemology - co-construction, representation, power relations and reflexivity in the research process

In response to their critique of objectivity, and reflecting their arguments surrounding the situatedness and interdependence of knowers, and the ontological parity of subject-object, feminists emphasise the active role of the

researcher during the knowledge production process (Stanley and Wise, 1993) and the genesis and status of knowledge as co-constructed, by the researcher and participants, rather than 'discovered' by the researcher. This acknowledgement of knowledge as co-constructed in turn relates to, and holds implications for, feminist notions of representation, power relations and reflexivity in the research process, which are explicated over the course of the next three sections.

Co-construction

Rather than operating under a 'veil of objectivist neutrality' (England, 1994:83), documenting 'facts' *about* the 'other', feminists argue that researchers construct knowledge *with* participants as part of an inter-subjective, dialogic process, which fosters an understanding of phenomena, which is reflective of and recognises the researcher's active role in the knowledge production process, and historical and contextual specificity (Usher, 1997a, England, 1994, Stanley and Wise, 1993). Necessarily and inevitably, both the researcher and participants structure, influence, play a role and are therefore implicated in, the dialogical knowledge production process, and whether this is explicitly acknowledged by the researcher or otherwise (England, 1994).

As England (1994:84) argues, researchers 'do not parachute into the field with empty heads and a few pencils or a tape-recorder in our pockets ready to record the 'facts''. Rather, in accordance with feminist epistemological principles, a researcher's situatedness and positionality impact upon and filter how and what they 'see' in the research setting, their particular and always partial perspective, and how they understand, analyse and interpret situations, observations, participant narratives and events. Further, active choices made by the researcher during the research process also influence the nature and genesis of knowledge co-constructed. These include, for example, decisions surrounding research questions, the approach to data collection incorporating the status and role played by the researcher, together with the questions that they ask and nature of interactions with participants, and choices surrounding the approach

to data analysis (Usher, 1997a). In writing up and reporting findings, the researcher makes further decisions as to which findings to present and how, and selects particular supporting quotations and observations, which influence what is presented as knowledge. Knowledge is not therefore 'discovered' by the researcher through an 'objective' process of extracting 'facts' from participants in the research setting, corresponding with a 'reality' in a realist sense - researchers are implicated in the construction of the knowledge that they produce and present. Knowledge is therefore co-constructed, through the input and influences of both the researcher and participants.

Regarding the role of participants in the co-construction of knowledge, feminists firstly argue that the understandings and experiences of phenomena that participants communicate to the researcher, should not be construed as constituting an unmediated, direct knowledge of a social 'reality', in a realist sense, for documentation by the researcher (Usher, 1997b). Participant knowledge is a necessarily subjective, partial, never complete, *interpretation* of phenomena, influenced by their situatedness, positionality and the specific subjectivity that this confers, which influences how the social world is 'viewed', experienced and interpreted, not a passive and unmediated reflection of a social 'reality' itself (*ibid*.). Secondly, the information that participants share with the researcher should be viewed as situated and partial accounts, or stories, of their understandings and experience, which they have chosen to share and disclose. The nature of these partial stories is influenced by factors including the questions asked by the researcher to elicit narratives, aspects of the researcher's situatedness and 'who' they are in relation to participants, the nature of interactions with participants and the status and role that they occupy during fieldwork. The information voiced by participants does not therefore 'represent' a complete and unmediated correspondence with their understandings, interpretations and experiences of phenomena, and these factors influence the nature of the co-constructed knowledge arrived at, its status and the claims which can be made surrounding it.

Further, when combined with the influence of the researcher in the co-construction of knowledge – in terms of their role in interpreting and analysing participant accounts according to their partial and situated view, and the active decisions made surrounding the content and structure of information which is presented as findings – findings become the researcher's (partial and situated) account of participants' (partial and situated) accounts and enactments, of their understandings and experiences of phenomena. This demonstrates and reflects how knowledge production constitutes a collaborative endeavour – a co-construction of the partial perspectives and insights of the researcher and participants regarding social phenomena, reflecting their respective influences in the genesis of an account of it (Usher, 1997a). For these reasons, whether recognised or otherwise, findings are considered, necessarily and inevitably, to be 'an account of the 'betweenness'' of participants' and researchers' partial perspectives (England, 1994:87). Since the possibility of a researcher objectively discovering 'facts' corresponding with a given social reality, in a realist sense, is considered to be 'completely mythical', the feminist acknowledgement of the co-construction of knowledge holds the implication that different(ly situated) researchers and participants would likely arrive at different(ly co-constructed) knowledge and present a different(ly situated) account of the same phenomena (*ibid.*:85).

Representation

As a consequence of the philosophical acknowledgement and conceptualisation of the genesis and status of knowledge as co-constructed, feminists argue that research findings do not constitute, and should not be claimed or construed as, a mirror-image 'representation' of participants' experience and understandings of phenomena (England, 1994), or that they reflect a social reality, in a realist sense, in a mirror-image way. Although qualitative research findings may aim and claim to 'represent' the perspective of participants, their lived reality, or give 'voice' to their understandings, experiences of and meanings surrounding phenomena, in accordance with feminist philosophy, this, necessarily and

inevitably, can only be pursued, achieved and claimed to the extent that, and insofar as, it is acknowledged and recognised that, more accurately, findings constitute the researcher's (partial and situated) account, of the (partial and situated) accounts of participants' experiences and understandings, reflecting their respective influences in the co-construction of knowledge. As Fonow and Cook (2005) argue, the outcome of any research endeavour is not a reflection, but a construction of, what participants' 'reality' is about.

Feminist arguments pertaining to this caveat concerning the representative potential and status of research, which stems from the acknowledgement of the co-construction of knowledge, in turn entails implications for feminist concerns surrounding power relations in the research process.

Power relations in the research process

Section 3.3.2 identified that feminists are critical of traditional power relations in the research process, wherein the researcher assumes a position of dominance and power over passive objects of research, who, in their treatment as 'mere mines of information' rather than embodied people, are exploited by the researcher 'the neutral collector of 'facts'' (England, 1994:82). As a consequence of this critique, feminists are attentive towards the inter-subjective power relations implicated in the co-construction of knowledge (Grasswick, 2004, England, 1994). Since, and although, it is acknowledged that power relations cannot be eliminated, feminists suggest that researchers should be cognisant of and attend to issues of power in the research process (England, 1994, Harding and Norberg, 2005). To this end, though committed to exploring the experiences, interpretations and understandings of participants (e.g. Letherby, 2003, Hesse-Biber, 2007), firstly, researchers should *acknowledge* that they cannot aim and claim to truly 'represent' participants and their experiences and understandings of phenomena, and that rather, necessarily and inevitably, findings constitute the researcher's (partial and situated) account, of the (partial and situated) accounts of participants' experiences and understandings of phenomena, reflecting their respective influences in the co-construction of

knowledge. Owing to their role in the co-construction and presentation of knowledge, researchers should *recognise* their influence in this process, *acknowledge* that the knowledge that they present is one, *partial and situated* understanding of, not 'the truth' about, phenomena, and accept *responsibility* for the *partial and situated* knowledge that they have *allowed* to come to the fore and have *chosen* to report (England, 1994, Ramazanoğlu and Holland, 2002, Usher, 1997a). Secondly, feminists suggest that researchers positioning themselves in a role as learner and supplicant within the research process, and acknowledgment of reliance upon participants' greater knowledge of phenomena to guide fieldwork, can assist in preventing exploitation by a 'neutral collector of 'facts'' (England, 1994:82, Usher, 1997a).

Reflexivity

Reflexivity is considered by feminists to be a means through which the researcher can acknowledge and make transparent their role in the co-construction of knowledge and accept responsibility for the partial and situated knowledge that they bring to the fore, as part of demonstrating attention to power relations in the research process (England, 1994, Ramazanoğlu and Holland, 2002). Reflexivity considers 'the relationship between the process and the product' (Letherby, 2003:62) and allows the researcher to describe and account for decisions and choices made during the research process, influenced by their situatedness, and make transparent the process through which the co-constructed knowledge presented as findings was arrived at. Reflexivity might be considered, for example, in relation to an account of aspects of the researcher's biographical situatedness, the philosophical and methodological assumptions underpinning the research, formulation of research questions, their approach to data collection and analysis and the status and role that they occupied during fieldwork – all of which are influenced by the researcher's situatedness and in turn influence the nature of and way in which co-constructed knowledge was arrived at (Usher, 1997a, England, 1994).

The principles of co-construction and reflexivity are not understood as means of acknowledging the 'problem' of 'distorting' and 'contaminating' researcher 'bias' in a positivistic sense however, hampering the pursuit and discovery of objective 'truth' corresponding with a 'reality' in a realist sense, by the researcher (Usher, 1997b:35, 1997a:53, England, 1994:81). Rather, in acknowledging that knowledge is inherently co-constructed, rather than 'discovered', reflexivity is understood as a resource (Usher, 1997b), a means of making transparent, and accounting for, how the co-constructed knowledge presented as findings – always informed by both the participants' and the researcher's situatedness, partial perspectives and the researcher's active choices made during the research process - was constructed, arrived at and came to be. In turn, reflexivity can contribute to the process of critically appraising the knowledge claims of research, which is central to the normative criteria by which the thesis might be judged, outlined further in section 3.4.3, by making transparent how the position of the researcher and participants may have influenced the genesis and nature of the account of phenomena that is co-constructed through, and presented as an outcome of, the research process.

3.4 Implications of feminist epistemology for the research and thesis

Section 3.3 described the feminist epistemology underpinning the thesis, and the co-construction of knowledge, issues of representation and power within it, and reflexivity, were identified as some of the philosophical implications of adopting a feminist epistemological perspective. The methodological implications that feminist epistemology held for the research process are described and reflected in the remaining sections of this chapter, namely, the specific nature of the ethnographic approach adopted (including the role of theory within it) (section 3.6.2), the way in which research methods were utilised (section 3.7), the role of the researcher in fieldwork (section 3.9.4), and the approach to data analysis (section 3.10). This section summarises the implications that the feminist philosophical influences described, hold for how the knowledge claims of the thesis should be approached and understood, the role and place of criticality in

the thesis, and the normative criteria by which the knowledge claims of the thesis could be judged.

3.4.1 Implications for knowledge claims

In section 2.7 of Chapter 2 the overall aim of research was introduced as 'to explore the lived reality and meaning of Lean Thinking for nursing and nurses working in three settings at an NHS Hospitals Trust'. At the start of section 3.3, it was identified that, consistent with the qualitative foundations underpinning the thesis, the research was concerned with the 'reality' of Lean implementation and the meanings that it held, as socially constructed, subjectively experienced - or 'lived' - and multiple, in nature (Denzin and Lincoln, 2008). 'The' lived reality and meaning of Lean implementation was therefore conceived of and approached as essentially plural in nature and the possibility of *the* single 'objective' understanding of *the* single 'reality' and meaning of Lean implementation 'out there' to be discovered, in a realist sense, was rejected. It was therefore acknowledged that the thesis provides but one account of the lived reality and meaning of Lean implementation for nurses and nursing, and the term 'lived reality' was used to denote and distinguish the research focus on the 'reality' of Lean as subjectively experienced by nurses, as opposed to a focus on a realist 'objective' reality of Lean. Also at the start of section 3.3, consistent with the qualitative focus, the feminist commitment to exploring and grounding research in participants' experiences, interpretations and understandings of phenomena, and respecting, valuing, upholding and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62), was identified.

When combined with the feminist philosophical assumptions underpinning the thesis, described in sections 3.3.2 and 3.3.3 however, some further qualifiers apply to the thesis' knowledge claims surrounding 'the lived reality and meaning of Lean for nurses and nursing'. As an implication of the feminist principles of situated and partial knowledge, the ontological parity of subject-object, co-construction and representation, though the research was committed to exploring the experiences, interpretations and understandings of participants,

consistent with a feminist approach, the findings of the thesis are not presented as, or claimed to constitute, a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, it is acknowledged that, more accurately, necessarily and inevitably, the thesis and its findings constitute *one* (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge. 'The' lived reality and meaning of Lean implementation, should be conceived of and approached as essentially plural in nature, and the knowledge presented in the thesis surrounding 'the' 'lived reality' and meaning of Lean implementation is but one partial, situated, co-constructed understanding, informed by the partial and situated perspectives and insights of the researcher and participants, reflecting their respective influences in the genesis of an account of it (Usher, 1997a).

In the remainder of the thesis, in the interests of avoiding repetition and fragmentation of the text, references to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should therefore be understood in the context of, and as subject to, this philosophical clarification and qualification.

3.4.2 Implications for the role and place of criticality in the thesis

The nature of the presentation of findings in the findings chapter (Chapter 4) reflects the feminist commitment to exploring and grounding research in participants' experiences, interpretations and understandings of phenomena, and respecting, valuing, upholding and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62). This commitment is maintained through presenting and exploring participants' experiences, interpretations and understandings surrounding Lean implementation, before approaching them more critically in the discussion chapters (Chapters 5 and 6). It has at the same time been recognised in section 3.3.3 however, that research findings do not constitute a mirror-image reflection or representation of

participants' understandings and experiences of phenomena. Rather, as identified in the preceding section, more accurately, and necessarily and inevitably, the findings of this thesis constitute the researcher's (partial and situated) account, of participants' (partial and situated) accounts and enactments, surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge. This approach to the place of criticality in the thesis was also informed by, and reflects, the researcher's adoption of the role of learner and supplicant within the research process, and their acknowledgment of reliance upon participants' greater knowledge of phenomena, as a means of assisting in attending to power relations within the research process (identified in section 3.3.3) (England, 1994, Usher, 1997a).

Upholding the feminist commitment to respecting (the researcher's account of) participants' (accounts and enactments surrounding their) understandings and experiences of phenomena, does not however preclude the researcher then adopting a more critical stance and approach towards the account that has been presented as findings. Acknowledging that the way in which individuals are situated and positioned influences what they 'see', their partial perspective, and their understandings and interpretations of phenomena (and that all knowledge is situated and partial as a consequence), creates a space for multiple perspectives regarding the same phenomena, or a plurality of perspectives. In the discussion chapters therefore, (the researcher's account of) participants' partial and situated accounts and enactments presented in the findings, is located in a broader context, forms the basis for further analysis and interpretation, and is approached from a more critical perspective, informed by extant theory, empirical work and literatures. This might be considered as the researcher's *critical* account of the (researcher's account of the) accounts and enactments of participants. This is not however, to devalue, undermine, disrespect, claim 'authority' over, delegitimise or declare 'wrong' (the researcher's account of) participants' (accounts of their) experiences and understandings. It is rather to present an additional, differently situated, partial

account. Indeed, feminists argue that at the same time as taking the experiences and understandings of participants 'seriously', researcher's should also take their own partial and situated perspective 'seriously', informed by academic theoretical preparation and sensitivity, and use it to make sense of, interpret, analyse and understand participants' experience, thus connecting experience to understanding (Letherby, 2003, drawing on the work of Cain, 1986 and Maynard, 1994). This recognises the 'academic mode' or facet of knowledge production, whereby 'experiential knowledge' is transformed into 'academic discourse' (Letherby, 2003:78).

Further, feminists acknowledge that 'Those who conduct the investigations and generate knowledge are also complicit in the processes through which knowledge is re-produced' Woodward (2008:16). To present an understanding of a culture is also to authorise and 'actively intervene in its (re)production', and the reinscription and reproduction of discourses (Walker, 1997:4). If participant's accounts are considered as mirror-image 'representations' of 'reality' and are not approached critically, the researcher may (unwittingly) legitimate and perpetuate oppressive power relations, discourses and 'forms of cultural oppression' (Street, 1992:12, Walker, 1997). A more critical approach therefore affords the potential to question, agitate and disturb understandings, and 'interrupt certain containments' and reproductive complicity (Childers, Rhee and Daza, 2013). Although potentially reproducing dominant discourses, the researcher can also therefore participate in the creation of discourses (Walker, 1997), for which they should accept responsibility, as described in section 3.3.3.

Reflecting a balance between, and the taking of both (the researcher's account of) participants' (accounts and enactments of their) experiences and understandings, and the more critically situated and partial perspective of the researcher, 'seriously', the discussion chapters (Chapters 5 and 6) interrogate the findings in light of the secondary research objectives, considered from both the analytical angle of the account presented in the findings, in addition to a more critical analysis and interpretation informed by extant theory, literatures and empirical work. This more critical exploration, in light of and situating

findings in, the broader context of theory, literatures and empirical work, allowed for the broader meaning of Lean for nurses and nursing to be explored, and demonstrates a further 'layer' in the process of the co-construction of knowledge – beyond the findings as a co-construction, the knowledge presented in the thesis overall also constitutes a co-construction between the researcher and participants, through the presentation of the researcher's additional, more critical interpretation.

3.4.3 Normative criteria

It can be recalled from the start of section 3.2, that identification of one's epistemological assumptions allows for the establishment of consistent criteria for assessing the adequacy of research's 'truth claims', and for the scrutiny and defence of the research process as a credible form of inquiry (Crotty, 1998, Sandberg, 2005, Grix, 2010). From the analysis presented thus far, it can be seen that feminist epistemology constitutes more than a theory of knowledge; it provides researchers with guidance as to standards and procedures within the knowledge construction process (Stanley and Wise, 1993). This normative dimension prescribes 'how we can know better' (Grasswick, 2004:89) and the following criteria are proposed by feminists as standards by which the knowledge claims of the thesis could be judged.

Plurality and critical interaction

Whilst the feminist rejection of a realist conception of 'truth', in favour of a plurality of 'knowing' perspectives (Longino, 2002) might imply epistemological relativism, feminists have been keen to defend against the charge that 'anything goes' (Heikes, 2004:315, Code, 1991). Indeed Haraway (1988:584) suggests that 'relativism is a way of being nowhere while claiming to be everywhere equally'. It is 'the perfect mirror twin of totalization in the ideologies of objectivity; both deny the stakes in location, embodiment, and partial perspective'.

Haraway (1988:584, 585) argues that the feminist insistence upon situated and partial knowledges, and the possibility of critical conversation and inquiry, or 'critical knowledges', which this confers, offers an alternative to 'easy relativisms'. Such criticality 'requires more than acknowledged and self-critical partiality' (*ibid.*:585) by the researcher however, and is reliant upon seeking alternative perspectives and points of view 'which can never be known in advance' from others (*ibid.:585*). Feminists therefore suggest that the requirement for knowledge claims to be subject to critical appraisal be retained and critical scrutiny, dialogue, discourse and interaction, within and across, inside and outside, epistemic communities, from a variety of differently situated, partial perspectives and points of view, can be employed as a solution to 'the problem of the slippery nature of competing knowledges' (Longino, 2002, Woodward, 2008:23). Such critical interaction can therefore assist in determining the epistemic authority of the knowledge claims of research, avoiding 'a simple pluralism' and 'a version of the impartiality ideal that allows all stories equal rhetorical space' (Woodward, 2008, Longino, 2002, Tuana, 2001:8).

Conceiving of a research account as one motivated version, or construction of persons and events, which should be subject to critical analytical inquiry (Stanley and Wise, 1993), and a researcher accepting, and making a 'modest claim' to situated, partial, fallible, limited, provisional and incomplete knowledge, therefore 'opens the door' to contestation and interaction with differently situated others (Ferree, 2008:15), not in pursuit of 'truth', but of a plurality of differently situated perspectives (Usher 1997a). This acknowledges the constraints of a researcher's own critical consciousness, in accordance with the limitations of their situatedness and partiality, informed by their experience, skills and knowledge (Ramazanoğlu and Holland, 2002:119), and offers research out to 'be interrogated from a stance that accepts that no perspective is producing disinterested knowledge', with each holding a particular position within relations of power (Usher 1997a:52). Such critical conversation is

considered a means of occupying the middle ground between the polarities of relativism and realism (Haraway, 1988).

The role of reflexivity

Reflexivity can be considered to act as a 'route' into, and resource within, the process of critically appraising the knowledge claims of research, by making transparent how the position of the researcher and participants may have influenced the genesis and nature of the account of phenomena that is co-constructed through, and presented as an outcome of, the research process. Reflexive acknowledgement in relation to (for example) aspects of the researcher's biographical situatedness, the philosophical and methodological assumptions underpinning the research, approach to data collection and analysis, and the status and role occupied during fieldwork, allows others to assess and appraise how the partial research account itself is situated and how it came to be (Woodward, 2008:28). Reflexivity can therefore be considered as 'an invitation to other voices to challenge the researcher's knowledge claims and conceptions of power…reflexivity opens up possibilities for negotiation over what knowledge claims are made, for whom, why and within what frame of reference' (Ramazanoğlu and Holland, 2002:119). Instead of attempting to 'construct general standards of valid knowledge acquisition' one is therefore attentive to 'analyses of contexts of inquiry' (Tuana, 2001:5), asking 'what conditions facilitated the development' of the knowledge presented (Usher, 1997a:49). These processes of reflexivity and critical appraisal also contribute to the feminist attentiveness to power relations in the research process, identified in section 3.3.3, involving researchers accepting responsibility for the partial and situated knowledge that they bring to the fore (England, 1994, Ramazanoğlu and Holland, 2002).

The 'bias paradox' (Antony, 1993:188)

Regarding feminism itself, it is acknowledged that some feminists simultaneously advocate multiple truths *but* the primacy of women's knowledge, and that this has led to criticism regarding the 'bias paradox' within this argument (Antony, 1993:188). That is, 'how to have *simultaneously* an account of radical historical contingency for all knowledge claims and knowing subjects, a critical practice for recognising our own 'semiotic technologies' for making meanings, *and* a no-nonsense commitment to faithful accounts of the real world' (Haraway, 1988:579). With Usher (1997a:49, 51) however, it is argued that in acknowledging the feminist principle that 'knowledges must be reflexive in coming to understand their own self-development as knowledges', feminism should consider itself in the same light, and 'must therefore accept its own status as context-specific, the product of socio-economic and historical movements. It has no more claim to speak *the* truth than any other discourse but must own up to its own points of view, specific aims, desires and political position within power relations'. Similarly, Ferree (2008:15) argues that feminists 'have no monopoly on insight or ability to find the one correct analysis…since they are not the only actors engaged in contests over meanings, resources and power.' It is argued therefore that feminist theory does not therefore purport to offer 'the truth' in the absence of socio-political and historical contingencies, rather it offers a self-reflexive claim, which itself should be subject to interrogation.

3.5 The feminist focus on power and marginalised knowledges – consistency and expansion

This final section focusing on the philosophical assumptions underpinning the research, justifies the decision to adopt a feminist philosophical approach. A qualification surrounding the way in which the feminist approach was adopted in the research is identified, together with arguments which lend support to the legitimacy and feasibility of the adaptation, within the boundaries of a feminist approach.

3.5.1 The focus on power and marginalised knowledges consistent with and afforded by feminist philosophy

The adoption of a feminist philosophical approach was considered to be justified and appropriate owing to the research's focus on the concept of *power* in exploring the lived reality and meaning of Lean implementation for *nurses*, who are traditionally depicted as a *subjugated* professional group, and whose *knowledge* surrounding Lean implementation was *marginalised* in the Lean literature. This focus on power and the marginalised knowledge of a subjugated professional group, is consistent with the central concerns and focus of feminist philosophy, which was therefore considered to constitute an appropriate philosophical approach.

The sensitivity towards the concept of power afforded by feminist epistemology, was considered to be valuable for the thesis as (as identified in section 2.5 of the literature review chapter), the concept of power formed a central theme in conceptualising the potential socio-cultural interaction between Lean and nursing, in terms of the opportunities and challenges that might be presented in relation to the culture, professional project and identity of nursing. It was therefore argued that power constituted a sensitising, orientating concept and vehicle through which nurses' experiences, understandings and interpretations of Lean could be explored and understood, and implications for the professional project and identity of nursing considered. As a corollary of this, consistent with the feminist focus on power, exploring power relations in the context of Lean and nursing formed the focus of one of the secondary research objectives (identified in section 2.7 of the literature review chapter).

Relatedly, and also conducive to the concerns of feminist epistemology, the thesis aimed to explore Lean in the context of nursing, which (as identified in section 2.4.4 of the literature review chapter) is traditionally depicted as a disempowered, subjugated professional group, *and* (as identified in section 2.4 of the literature review chapter) whose experiences, understandings and interpretations of Lean were yet to be comprehensively explored – nursing knowledge constituted marginalised knowledge within the Lean literature.

Researching the experiences and knowledges of a subjugated professional group, and contributing marginalised knowledge to the knowledge gap within literature surrounding Lean in healthcare, were also considered to be consistent with the adoption of a feminist philosophical approach.

Owing to these parallels between the central concerns and focus of feminist philosophy and the thesis' research, the adoption of a feminist philosophical approach was considered to be appropriate and justified.

3.5.2 Feminism and power beyond gender – expanding the gender lens

Although the research reported in this thesis is underpinned by feminist philosophical influences, which stem from a critique of power and knowledge centred around the relationship between gender, knowledge and knowing (Garry and Pearsall, 1996a), emphasise the salience of gender epistemically, and foreground gender as an analytic category (Janack, 2017), the research did not commit to and seek to pursue and privilege, a specifically gendered line of analysis in exploring power in the context of Lean implementation, or analyse power relations operating specifically along the axis of gender (Alcoff and Potter, 1993). Rather, feminist philosophical influences and principles were employed to underpin and guide a broader exploration and analysis of power relations, extending beyond a focus solely on gender, which reflected an understanding of power as multiplicitous in its manifestations, guises and forms. A more generic orientation to the concept of power was therefore adopted and the feminist concern for gendered power relations, and the analytical 'gender lens' (Tuana, 2001), were expanded towards a more inclusive, multi-focal, 'power lens', where gender was considered to be but one of many potential axis of power along which power relations can be aligned.

This broadening of the 'gender lens' accommodated and allowed for a wider consideration and attentiveness towards issues of power, supported by and compatible with the broader, more encompassing and less specific conception of power offered by Foucault, which was adopted by the thesis (introduced in

section 2.5.2 of the literature review chapter), and was consistent with the generality of the thesis' secondary research objective which foregrounded an exploration of power and power relations, rather than specifically gendered power relations (identified in section 2.7 of the literature review chapter). Whilst both feminist epistemology and Foucault offer critiques of power and knowledge, Foucault's analyses concern power more broadly and are not confined solely to consideration of the role of gender in power and knowledge. As identified in section 2.5.2 of the literature review chapter, instead of speaking of power in a unitary and universal way, Foucault speaks of powers, and power relations, in the plural (Foucault, 2003a, 2003b, 1982). He argues that conceiving of, and studying, power in a monolithic way, denies the complex and context-specific nature of the essentially local, particular and discontinuous effects of power (Foucault, 2003a), and that power analyses should be concerned with the mobile and multiple social relations and strategies of control, which constitute and perpetuate it (Foucault, 1978). In adopting a Foucauldian conception of power, one is therefore attentive to forms of power and power relations in the multiple, which act in unique ways, their relative interplay and their unique context-specific manifestation and effect. Further, in suggesting that power is relational and 'something that circulates…it is never localized here or there' and that individuals 'are in a position to both submit to and exercise this power', adopting a Foucauldian (2003c:29) conception of power relations in the plural, allows for consideration that nurses can simultaneously be oppressors and oppressed within the same, and between different, situations, rather than power operating in a unidirectional and linear way. In adopting a Foucauldian conception of power therefore, the research proceeded in accordance with a non-linear, multi-directional conception, which acknowledged its multiple forms and guises. Power as an analytical concept was broadly conceived of and exploration and analyses did not explicitly foreground any single 'category' or manifestation of power.

Support for the expansion of the gender lens within a feminist approach

Two lines of thought and argument can be drawn upon to lend support to the legitimacy and feasibility of adopting feminist philosophy and adapting the feminist gender lens towards a more encompassing power lens, *within* the boundaries of a feminist approach.

Firstly, in response to internal and external critique[1], contemporary feminists are broadening their analytical focus, and recognise and are attentive to, issues, axes and relations of power, beyond those defined by gender. In broadening their focus and agenda beyond 'gender as the primary axis of oppression' (Alcoff and Potter, 1993:3) and its place at the centre of analyses (Visweswaran, 1997), they are becoming more sensitive towards and accommodating of other, multiple, intersecting aspects of situatedness and positionality, which act as categories and markers of 'difference', and function as sites within the matrix of oppressions along which power can operate (Hill-Collins, 1990, Visweswaran, 1997, Maynard, 2001, Davis and Craven, 2016, Ferree, 2008, Gopaldas and Fischer, 2012). Markers of 'difference' which have contributed to, and have been incorporated as topics and subjects within, the intersectional broadening of the theoretical and analytical frameworks for feminist power analyses, include race, sexuality, class, ethnicity, age, disability, geographical location, historical

[1] For example, Allen (2011) summarises critiques surrounding feminist approaches to, and conceptions of, power which assume single-axis frameworks and treat the categories of (for example) gender and race as mutually exclusive. Critiques argue that such an approach distorts and neglects to capture experiences of women who are subject to multiple, simultaneous, and intersecting forms of oppression. Relatedly, questions have been raised surrounding gender as an essentialised, homogenous and unified category, which, when conceptualised as such, it has been argued, neglects ways in which individuals are multiply situated and positioned, and does not account for the differing experiences of differently located women, in terms of, for example, class and race (Ferree, 2008, Childers, Rhee and Daza, 2013, Maynard, 2001, Martin, 1982). Thirdly, arguments have be presented which criticise the primacy of the feminist notion that the 'struggle against gender oppression is primary' despite, and regardless of, other aspects of difference and situatedness (McNay, 1992:7), and similarly, that the focus on gender may subsume and obscure other forms of difference, which are equally fundamental and pertinent to analyses of power (Visweswaran, 1997, Martin, 1982, McNay, 1992).

context, language, religion, ablebodiedness, generation and geographical origin (Maynard, 2001, Allen, 2011, Hill-Collins, 1990, Ramazanoğlu and Holland, 2002, Davis and Craven, 2016). This wider feminist focus guided by concepts of 'diversity' and 'difference', with their implications of multiplicity, complexity, irreducibility and plurality (Maynard, 2001, Ferree, 2008), demonstrate how feminist power analyses are no longer confined to gendered power relations alone, and intersectionality is broadening and 'stretching' the parameters of 'what counts' as feminist research and what it may become (Visweswaran, 1997:597, Ferree, 2008). Gender has therefore become but one entry point of many, for analyses of power in all its forms and complexity, considered to be legitimate in feminist research (Visweswaran, 1997). Thus, it is in accordance with this direction of thinking, in the vein of this broader conception of feminist analyses, that it is argued that feminist philosophy can legitimately and feasibly underpin, accommodate and be considered consistent with, research which focuses on power relations beyond those of gender, in exploring the lived reality and meaning of Lean implementation for nurses.

Another means of articulating support for the legitimacy and feasibility of expanding the gender agenda *within* the boundaries of a feminist approach can be found in arguments advanced by Childers, Rhee and Daza (2013:507), in their paper discussing the 'Promiscuous (use of) feminist methodologies' for 'research beyond gender'. Guided by questions including 'what does it mean to claim a feminist position…?', 'what counts' as feminism and feminist research? and can 'feminist' research 'focus on subjects beyond gender and still be considered "feminist"?' (*ibid.*:507, 512), they discuss the potential, and advocate for, the legitimacy of expanding the centres, margins and boundaries of feminist research, in order to extend 'feminism beyond the limits of gender analysis' (*ibid.*:519). They argue that philosophical insights stemming from the feminist critique of traditional (male-dominated) epistemology can be extended and applied to guide research with a focus 'beyond gender' (*ibid.*:507), with which other feminist commentators can also be seen to agree (e.g. Grasswick, 2009), and that research that focuses on issues of power beyond the parameters of

gender should not be 'pushed out' or 're-categorized' (*ibid.*:511). Drawing on the work of Sandoval (2000), they suggest that when translated and confined to gendered issues and gender only, rather than a methodological and theoretical approach 'in its own right', feminist methodology is underanalysed and misrecognised, and that conflating the method, theory and practice of feminist methodology with the category of 'women' is a problem which limits the evolution of 'feminist' research which is not dependent on gender.

The authors therefore seek to challenge the discursive construction of feminism within gendered terms, which circumscribes feminism to within a gendered 'ontological boundary' (*ibid.*:511). They propose and conceptualise 'promiscuity' and 'promiscuous feminist methodology' as a means of exceeding, and working against and within, the bounded mainstream discursive practices and discourses surrounding 'what "counts" as feminist' (*ibid.*:513, 514). Embracing a promiscuous feminist analytical lens, they suggest, avoids feminism becoming hegemonic and exclusive, offers new possible futures for research and allows for an 'unfixed becoming of feminist methodology' (*ibid.*:514). Further, they suggest that promiscuous feminism is in keeping with, and reflects, characteristics of the project of feminism itself. For example, although traditionally discursively articulated and 'defined in opposition to male-dominated epistemologies' and around gender as an analytical concept, feminist theory is itself complex, heterogenous, variegated, sometimes conflicting and seeks to both centre and problematise categories of analysis (*ibid.*:510). Similarly, they consider the disruption of convention, challenging the 'notion of a canon' (Visweswaran, 1994:39) and working within, across and beyond boundaries, as a legacy and essence of feminism. Inspired by Patti Lather and others, they suggest that, with respect to feminist methodology, they were taught to 'keep the centre unsettled', '"do it and trouble it simultaneously"' and '"work within and against"' (Childers et al, 2013:513). This, they argue, 'incites new imagination' through 'Pushing the edges of scholarship' from engaging in 'respectful critique of our feminisms' (*ibid:*516, 517).

Further to these arguments, although this research did not adopt the feminist analytical gender lens, it was underpinned by, incorporates, displays and reflects, other distinguishing features and characteristics of feminist research (*ibid.*). These include the feminist emphasis upon the issue of power and power relations, the marginalised knowledges of subjugated groups and a critical approach to knowledge production (*ibid.*). Further, the thesis adopts feminist philosophical assumptions regarding the nature of knowledge, reality, and reflects the related implications of embodiment, situatedness, partiality, the interdependence of knowers, the ontological parity of subject-object, the co-construction of knowledge, representation, attentiveness to power relations in the research process, reflexivity and feminist normative criteria (Childers et al, 2013, Davis and Craven, 2016). It is at the level of these philosophical and methodological features and values, that claims to consistency within a feminist approach are further made and justified (Longino, 1999, Harding, 1987).

Although the research reported in this thesis did not commit to and privilege a specifically gendered line of analysis in exploring power relations in the context of Lean implementation, this section has presented two arguments in support of the legitimacy and feasibility of adopting feminist philosophy, and adapting the feminist gender lens towards a more encompassing power lens, *within* the boundaries of a feminist approach. It has also presented features of the research which further demonstrate how, although not focusing on gender, the research displays other distinguishing and defining characteristics of a feminist approach, and therefore maintains consistency with the feminist approach to research, adopted by the thesis.

3.6 Ethnographic methodology

The thesis employed an ethnographic methodology, in order to meet the aim and objectives of research. Ethnographic methodology however, does not constitute a singular, unified approach or set of methods. Rather, it describes a congeries of perspectives, stylistic variations and data gathering techniques (Jessor, 1996, Boyle, 1994). The specific nature of the ethnographic approach

that was adopted in this research is described in section 3.6.2, where some key features are highlighted, which demonstrate how the approach was consistent with addressing the aim and socio-culturally focused objectives of research, and with the feminist philosophical assumptions underpinning the thesis. The concept of culture, which is central to ethnographic methodology, is first described.

3.6.1 The concept of culture

The concept of culture, which is central to ethnographic methodology, can be considered 'that complex whole which includes knowledge, belief, art, morals, law, customs, and any other capabilities and habits acquired by man as a member of society' (Tylor, 1871:1). Culture is a shared, collective phenomenon, which is socially learnt and transmitted (Peoples and Bailey, 2012). Comprised of the inter-related components depicted in Figure 11, culture is integrated with and reliant upon the social, and vice versa (Elliott, 2014). Simplistically, it can be represented by the instructive verbs of 'everything that people *have*, *think* and *do* as members of a society' (Ferrano and Andreatta, 2012:29).

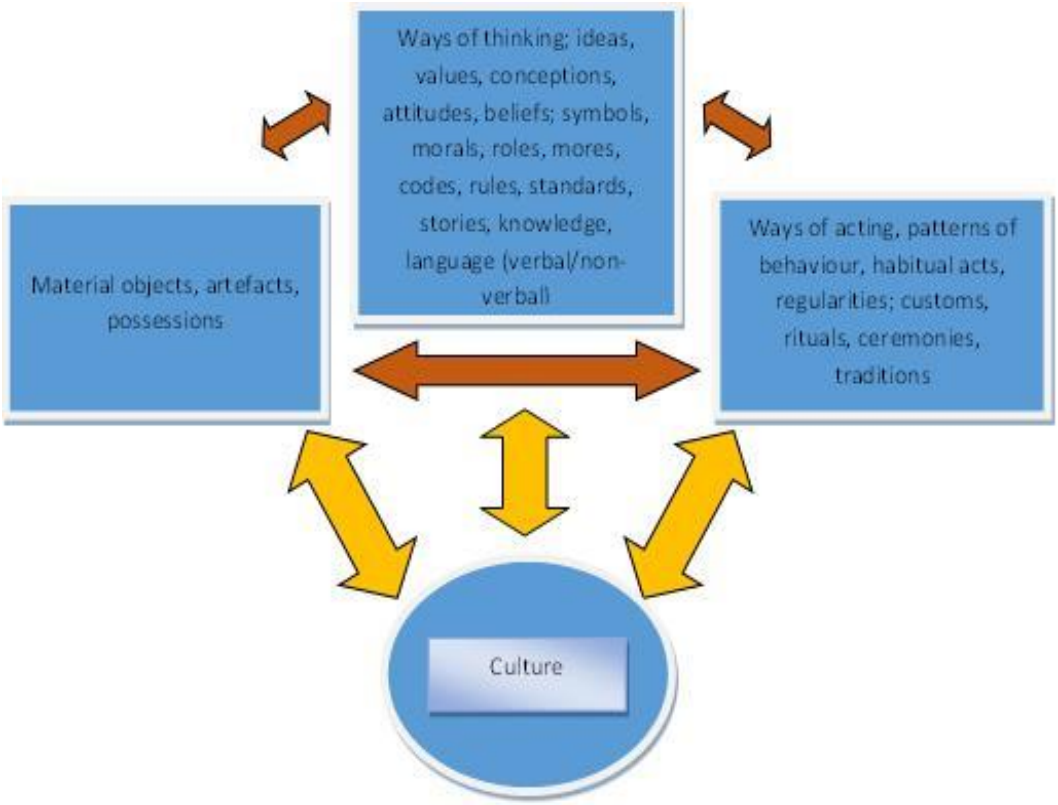

Figure 11. The interrelated components of culture. Adapted from Ferrano and Andreatta, (2012), using Kendall (2010), Tischler (2011) and Peoples and Bailey (2012).

3.6.2 The ethnographic approach

Since ethnographic methodology does not constitute a singular, unified approach to research and can be employed in different ways, this section highlights some key features of the specific ethnographic approach that was adopted to meet the aim and objectives of research, which demonstrate how the approach was consistent with addressing the aim and socio-culturally focused objectives of research, and with the feminist philosophical assumptions underpinning the thesis.

Ethnography and feminist assumptions

An ethnography, meaning 'writing culture', a 'description of folk', or 'portrait of the people', aims to provide 'a holistic understanding of how individuals in different cultures...make sense of their lived reality' (Hesse-Biber and Leavy, 2011:193, Boyle, 1994:161, Lipson, 1994:339). The interpretation and understanding of cultural meaning is of central importance to this endeavour (Jessor, 1996, Hesse-Biber and Leavy, 2011, Aull Davies, 2008). An ethnography seeks to look beyond describing what is said and done in a study setting, towards providing an understanding of how responses and events observed are mediated *culturally,* through attempting to understand what phenomena mean to participants (Boyle, 1994, Leininger, 1967). This focus upon culture, lived reality and meaning within ethnographic methodology, was considered to be consistent with meeting the aim and objectives of research, to which these concepts were also central, and the qualitative foundations and feminist philosophy underpinning the research.

Consistent with the qualitative focus on the 'reality' of Lean implementation and the meanings that it held, as socially constructed, subjectively experienced - or 'lived' - and multiple in nature (Denzin and Lincoln, 2008), ethnographers suggest that the social world is defined by a kaleidoscope of understandings, interpretations, actors and interests, and a cacophony of voices and discourses, and is therefore messy, contingent, changing, contested and phenomenally complex (Schatz, 2009, Adler and Adler, 1998, Altheide and Johnson, 1998). In accordance with this ontology, consistent with feminist philosophy, researchers emphasise that an ethnography does not constitute an objective, static, complete picture of social reality (Muecke, 1994, Schatz, 2009).

Reflecting feminist epistemology, ethnographic knowledge can be considered to be co-constructed through an inter-subjective, dynamic interaction between the researcher and participants, and positionality dictates that knowledge is partial in accordance with the unique values, stance and awareness of its co-creators (Muecke, 1994, Schatz, 2009, Tedlock, 2003, Mills and Morton, 2013). Ethnographers also suggest that the researcher is a part of the culture that they

are attempting to understand, and that the way in which knowledge is 'acquired, organised, and interpreted is relevant to *what* the claims are' (Altheide and Johnson, 1998:284, Tedlock, 2003, Boyle, 1994). When combined with the notion that all knowledge is partial and perspectival, ethnographers argue that it is therefore the responsibility of the researcher to make their situatedness, or 'where the author is coming from' transparent (Lodico, Spaulding and Voegtle, 2006, Altheide and Johnson, 1998:294) and the research process through which knowledge was gained should be subject to reflexive consideration and analysis, in order to assist with the critical appraisal of the knowledge presented (Altheide and Johnson, 1998, Tedlock, 2003, Boyle, 1994).

In addition to these consistencies between feminist and ethnographic assumptions surrounding the knowledge production process, contemporary ethnographic methodological literature also reflects an acknowledgement of other feminist principles and concerns that were identified in section 3.3. It is recognised, for example, that ethnographic research raises fundamental issues surrounding power and knowledge (Light, 2010) and drawing on the work of various authors, Molloy, Walker, Lakeman et al (2015) provide an account of changes which have occurred within ethnographic methodological thinking since the 1970s, wherein feminism is cited as one of the influences having driven these developments. They suggest that there has been a shift in ethnography characterised by critique and critical reflection surrounding the production of ethnographic knowledge, and a movement away from empiricist ideas. Previous ideas regarding the 'ethnographic ideal' (*ibid.*:18) of an objective, neutral researcher producing data which reflected the perspective of the 'other' have been questioned, and the presumption that data constitutes a 'rendered reality' (*ibid.*:18), exact and unfiltered by the researcher's interpretive schema or values has been challenged. The authors suggest that for many, no longer can it be presumed that the ethnographic researcher delivers an uncontested, objective account of the experience of the 'other'. Further, they identify that in the 1980s, issues and questions of gender, ethnicity and class within ethnographies were highlighted, and arguments arose for the incorporation of reflexivity within the

production of research, and writing which is cognisant of the relationship between the researcher and participants. These concerns reflected a 'crisis of representation' reflecting questions surrounding how the social sciences could unproblematically represent social reality (*ibid.*:19). Regarding the conceptualisations of the concept of culture, Molloy et al (2015) explain that the indeterminacy of cultural analysis was emphasised and culture became viewed as emergent, temporal and contested. This challenged the idea that culture presents a discoverable, coherent 'whole' that can be reflected 'as it really is' by a researcher with impartial detachment (*ibid.*:20). The idea of a 'correct', single interpretation of reality could not any longer be assumed, since 'facts' and their interpretation were considered to be produced from one's interpretive stance, precluding the possibility of the establishment of any 'form of unchallenged authority or truth (*ibid.*:19). Notions of objectivity, reliability and validity therefore became problematic and the ethnographer's intellectual authority, and any 'claims to authority' were judged to be false (*ibid.*:19).

This account demonstrates how contemporary conceptions of ethnographic methodology and culture are consistent with feminist philosophical principles surrounding the critique of objectivity, the co-construction of knowledge, situatedness, partial perspective and concerns surrounding representation, authority, power relations and reflexivity in the research process (described in section 3.3.3). When combined with its focus on the concepts of lived reality, culture and meaning, consistent with the research aim and objectives, the adoption of ethnographic methodology was considered to be an appropriate for the research.

The role of theory in the ethnographic approach adopted

Although it is acknowledged that the place and role of theory within ethnographic methodology can differ, this section describes how issues of theory were approached within the specific ethnographic approach adopted by this research, guided by an abductive approach to theory development (Blaikie,

2010), which was consistent with the feminist influences underpinning the research.

Regarding the role of theory within the ethnographic approach adopted, the research did not foreground any particular theory *a priori* in attempting to understand the lived reality and meaning of Lean for nurses and nursing. Rather, theories as to 'what is going on' (Hesse-Biber and Leavy, 2011:215) in the study setting, were empirically grounded and developed, guided by an abductive approach, as outlined by Blaikie (2010). Reflecting the aim of research - to explore the lived reality and meaning of Lean Thinking *for nursing and nurses* (informed by the knowledge gap within Lean in healthcare literature, surrounding *nurses'* experiences, understandings and interpretations of Lean implementation) - and underpinned by the feminist commitment to exploring and grounding research in *participants'* experiences, interpretations and understandings of phenomena (insofar as is possible, according to feminist caveats concerning co-construction and representation), respecting and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62), this involved seeking to understand the lived reality and meaning of Lean for nurses in the study setting from the 'bottom-up', and ethnographic fieldwork proceeded in an 'open' fashion. This contrasted with a deductive approach, foregrounding and imposing researcher theory from the outset, which Hesse-Biber and Leavy (2011:202) and Muecke (1994) suggest holds the potential to constrain insights and unwittingly exclude what is most important and culturally relevant to participants within a study setting.

The conceptualisation of the potential interaction between Lean and nursing, power, and research objectives regarding power and nursing theory, introduced in the literature review chapter, served contextualising, sensitising, orienting and guiding roles, and were broadly and flexibly conceived of (Hesse-Biber and Leavy, 2011, Wolcott, 2005). Issues, ideas and themes that appeared significant for participants and to their concerns, served to guide and refine interviews, interactions and observations, akin to a funnelling process (Hesse-Biber and Leavy, 2011, Adler and Adler, 1998). Socio-cultural interpretations and

theoretical ideas as to ways in which nurses' lived reality could be understood, were grounded in and abstracted from participants' empirical accounts and enactments of their 'everyday' understandings and experiences, and continued to evolve during the course of the fieldwork, as observations, interviews and analysis progressed.

This 'bottom-up' approach was also informed by feminist concerns surrounding power relations in the research process, whereby (as identified in section 3.3.3), feminists suggest that the researcher positioning themselves in a role as a learner and supplicant within the research process, and acknowledgment of reliance upon participants' greater knowledge of phenomena to guide fieldwork, can assist in preventing exploitation by a 'neutral collector of 'facts'' (England, 1994:82, Usher, 1997a).

Although the ethnographic approach adopted did not foreground any particular theory *a priori,* reflecting the feminist principles of situatedness and positionality (identified in section 3.3.3), the impossibility of the researcher as a *tabula rasa*, existing in an intellectual vacuum was also acknowledged (Schatz, 2009). That is, reflecting feminist principles, the abductive approach recognises that a researcher's intellectual and theoretical training are aspects of the researcher's situatedness and positionality, which influence and filter how and what one 'sees', asks, 'hears' and is attentive to in the research setting, their particular and always partial perspective, and how they understand, analyse and interpret situations, observations, participant narratives and events (Timmermans and Tavory, 2012). The abductive approach therefore acknowledges that although not explicit in terms of guiding fieldwork, a researcher's theoretical sensitivities therefore inevitably influence theory development and the co-construction of knowledge, rather than theory 'emerging' from fieldwork in a truly inductive way. Within the abductive approach, consistent with feminist philosophy, 'nontheoretical work' is therefore considered to be a 'myth' and a theory-free inductive approach as 'theory-engine is philosophically untenable' (*ibid.*:181).

3.7 Methods

One's research methods can be considered as the chosen 'techniques for gathering evidence' (Harding, 1987:2). The methods of observation and semi-structured interview were selected as the methods to meet the aim and objectives of research. This section describes why these methods were chosen and how they were utilised in a way which was congruent with the research's methodology and underpinning philosophy. Whilst this section focuses on theoretical rationale, practical details, for example, in terms of the number of interviews, and hours of observation undertaken in the study setting, are described in the sections of 3.9, which provide an account of data collection.

3.7.1 The complementarity of observation and interview

Observation and interview constitute archetypal ethnographic methods (Aull Davies, 2008) and were therefore considered to be consistent with the ethnographic methodology of the research. Although both observations and interviews contributed to exploring the lived reality and meaning of Lean for nurses and nursing, interviews with individual nurses afforded a more individual focus, elucidating nurses' individual accounts surrounding the lived reality and meaning of Lean for *nurses*. Observations afforded a broader focus on the lived reality and meaning of Lean within the broader context of *nursing*, as a collective, socio-cultural phenomenon, and allowed the researcher to explore what participants 'did' (their enactments), in addition to what they 'said'. Consistent with the ethnographic methodology and socio-culturally focused research objective, observations also provided a 'route' and 'access' into the socio-cultural milieu of nursing practice, which formed an interpretive context within which nurses' lived reality, the processes by which they appeared to make sense of, and attribute meaning to Lean, and the interaction between Lean and nursing, could be located. This socio-cultural interpretive context therefore acted as a back-drop which assisted with understanding and explaining, rather than simply describing, nurses' accounts and enactments surrounding the lived reality and meaning of Lean, and provided insight into its meaning for nursing.

3.7.2 Theoretical aspects of interviews

Feminists consider semi-structured interviews to be a valuable method for exploring participants' lived reality (Hesse-Biber, 2007). They allow insight into participants' subjective experience of, and understandings and interpretations surrounding, phenomena and the meanings with which they are attributed (whilst acknowledging the feminist caveats surrounding co-construction and representation identified in section 3.3.3) (*ibid*.). Semi-structured interviews were therefore considered to be a method consistent with the aim of research, the qualitative foundations, and feminist commitments underpinning the research.

Interviews were approached, and proceeded, in a way which was congruent with feminist philosophy. Reflecting feminist concerns, a reflexive awareness of the inter-subjective power relations implicated in the co-construction of knowledge (Grasswick, 2004, England, 1994), was maintained during interviews with participants. I positioned myself as a learner, or supplicant, acknowledging participants' greater knowledge surrounding the lived reality and meaning of Lean, which (as identified in section 3.3.3), feminists suggest can assist in reducing the 'dominance' of the researcher over 'passive objects' of research and their treatment as 'mere mines of information', exploited by a 'neutral collector of 'facts'' (Grasswick, 2004, England, 1994:82, Usher, 1997a). The approach taken was also consistent with the feminist commitment to exploring *participants'* experiences, interpretations and understandings of phenomena (insofar as this is possible, in accordance with feminist provisos surrounding co-construction and representation), and respecting and upholding, taking them 'seriously' in the research process (Letherby, 2003:62).

Accordingly, interviews were semi-structured, proceeded in an open fashion, and participants were encouraged to discuss issues which appeared relevant to their understandings and experiences. Discussions were facilitated by the use of a topic guide but this was followed flexibly and contained a list of broad areas and questions informed by observations and developing areas of analytical interest. Examples of topics explored included: participants' nursing background

and the reasons why they had chosen to become nurses and work in their speciality; their experiences, understandings and interpretations of Productive Ward implementation, its impact and relationship to other LBIs, nursing priorities and values; the relationship between notions of productivity, efficiency, financial agendas and caring; and ideas of 'crisis' within the NHS. Although the researcher wanted 'to know 'a something'', questions were approached flexibly and were of an open nature (Hesse-Biber, 2007). Non-verbal communication (for example, nodding and the maintenance of eye-contact), verbal affirmations, prompts and probes (for example 'I see', 'uh-huh'), and requests for illustrative examples were used to encourage narrative and elaboration on topics (*ibid.*:127). Hand written notes were made, which served as reminders of potential avenues for exploration later in the interview, during subsequent interviews and to record any initial ideas as to themes and theoretical connections.

The interview serves an example of the way in which feminists see knowledge as co-constructed by the researcher and participants (*ibid.*), and demonstrates how knowledge produced cannot be considered to be a mirror-image 'representation' of participants' experiences and understandings of phenomena. For example, during interviews, the questions and the way in which they are asked, and the researcher's interpretation of responses informing subsequent questions, influence and frame participants' answers and the information that that they share during the interview, which in turn influences what becomes research 'findings' (Letherby, 2003). The way in which the researcher is situated in relation to participants (in relation to age, gender, ethnicity, occupational background, for example), also influences the information that participants share, the nature of their accounts of phenomena and the knowledge that the researcher has 'access' to (Hesse-Biber, 2007). The influence of the positionality and situatedness of the researcher 'vis-à-vis' participants (*ibid.*:139), is therefore reflexively discussed further in sections 3.9.4 and 3.9.5, in relation to the role of the researcher during fieldwork.

3.7.3 Theoretical aspects of observations

Observations were not intended as a means of triangulating or confirming the 'truth value' of events, accounts and meanings expressed in interviews, but rather, they attempted to capture the meaning of events as they naturally occurred (bringing meaning to life), and taken-for-granted, tacit knowledge, outside of participants' awareness, that could not be articulated in interviews (Hodgson, 2000). Tacicity lies in the realm between meaning and action, captures the experience implicated in behaviour and assists in the understanding of meaning (Altheide and Johnson, 1998). It is contextual, unarticulated and is reflected in silences, tone, nods and humour, reflecting the inadequacy and insufficiency of language to communicate complex meaning (*ibid.*). Observations were therefore considered to be a means of enhancing the level of nuance in understanding the lived reality and meaning of Lean, beyond that which could be developed through undertaking interviews alone.

Overall, the scope of observations was initially general and broad, but became more focused as sensitivity was developed towards the events and concerns that appeared significant in understanding the lived reality and meaning of Lean implementation (Emerson, Fretz and Shaw, 1995). During a single observation period however, observations could often be both broad and specific in nature. When sitting at the 'Nurses' Station', for example, the researcher could observe general activity, interactions and nurses 'toing and froing' around areas of the ward. These broad observations assisted the researcher in developing contextual understanding, surrounding the socio-cultural milieu of the ward, its routines, rituals, rules and practices. When nurses joined the researcher in sitting at the 'Nurses' Station' however, more specific conversations surrounding Lean implementation could then take place. Conversely, specific observations, such as reviewing ward metrics on 'Performance Boards', or blank examples of Lean nursing documentation, could evolve into more broad observations, as the researcher became involved in general interactions with nurses.

Guided by Emerson et al (1995), fieldnotes were recorded contemporaneously, and interactions in a verbatim way, as far as was possible, in order to capture,

preserve and inscribe observations, insights, experiences and discourses in the setting. The format of fieldnotes did not follow a pre-defined, static structure, but variously incorporated notes focusing on:

1. Practical orientation: time, date, location and degree of participation.
2. Impressionistic and descriptive orientation: sensory information, movement, activities, atmosphere, events, tone, mood, artefacts.
3. People orientation: people and behaviour, interactions, language, anecdotes, roles.
4. Analytical orientation: how could this be interpreted? What does it mean? What is going on? Why is it important? How does this relate to the aim and objectives of research?
5. Reflexive orientation: feelings and emotions of the researcher, precursors and antecedents.
6. Future orientation: what do I want to ask/say? What new questions arise from these observations? What should be the focus of the next observations?

A reflexive account and discussion surrounding the specific role occupied and level of participation during fieldwork, together with associated ethical considerations, are provided in section 3.9.4.

3.7.4 The role of material artefacts in the research process

As Hammersley and Atkinson (2007:137) explain, in a study setting, participants' talk and actions do not occur in a vacuum. In addition to social actors, study settings are populated by 'things' of various sorts, and participants 'do things' not only with words, but also with these 'things'. Ethnographers consider these 'things', that is, material artefacts, to constitute integral elements of the socio-cultural world, and the way in which everyday life is organised and performed within it. Hammersley and Atkinson (2007) continue to say that artefacts both

contribute to the creation of, and result from - that is, they are shaped by and are shaping of - the socio-cultural world under study. Artefacts are therefore imbued with socio-cultural significance and can be considered as 'visible expressions' and embodiments of a culture, which are symbolic of, and communicate cultural meaning (Gagliardi, 1992a:3, Hammersley and Atkinson, 2007, Rosen, 2000). Artefacts 'speak' – they constitute communication systems through which participants themselves communicate and act (Gagliardi, 1992b:vi). They are 'clues' as to aspects and themes of a culture, and 'emblems' of participants' socially constructed reality, which reflect their 'cultural quiddity' (*ibid.*:viii, vii, vi). As a corollary of this, artefacts constitute a symbolic resource for the ethnographer - they form part of the ethnographer's toolkit, or palette of sensitivities, in the study setting (Gagliardi, 1992b, Nicolini, 2009), and assist with the exploration of the culture under study and the development of understanding of its meaning systems. The ethnographer's gaze should therefore attend to material artefacts, and 'they should be incorporated into the fabric of ethnographic inquiry, just as they contribute to the fabric of social life' (Hammersley and Atkinson, 2007:137).

Reflecting their centrality to ethnographic inquiry, artefacts present in the study setting formed an important resource during the research process. They informed and contributed to the preparatory, fieldwork and analytical phases of research, and as such, artefacts feature in this, the thesis' methodology chapter, in addition to the findings chapter (Chapter 4), and the first of the discussion chapters (Chapter 5). The next section of this chapter reports how, during the scoping and preparatory stages of the research process, organisational artefacts relevant to Lean implementation, such as official organisational strategy documents, formal reports and posters, displays and leaflets were read. Given the variability associated with the nature of Lean implementation in healthcare, reported in section 2.3.3 of the literature review chapter, it was thought important to clarify (for the researcher, ahead of fieldwork, and for descriptive purposes in the thesis) the specific nature of Lean implementation in the study setting, and 'what' exactly was studied, in terms of how Lean was formally,

explicitly and locally defined. Although it was acknowledged that these organisational artefacts reflected and projected a particular, 'officialised' version of Lean, as it was constructed and articulated by the Trust at the organisational level (Trust discourse surrounding Lean), in this preparatory phase of research, artefacts served a pragmatic, informative, orientating, situating and contextualising function (Hammersley and Atkinson, 2007, Gagliardi, 1992). They provided an 'entry point' into the Lean programme in the study setting, and their content contributed to informing and promoting a preliminary working understanding of and insight into, the specific nature, shape, form of, and purposes and expectations surrounding, Lean at the Trust. This information also contributed to the formation of a broader context and frame of reference within which fieldwork observations could be located and understood, and a backdrop for the thesis' findings (Hammersely and Atkinson, 2007).

During the fieldwork phase of research, artefacts were attended to during, and formed an important part of, observations. Attention was paid to the artefacts themselves and the way in which nurses interacted with and referred to them in their talk and behaviour. They are referred to throughout the analysis presented in the findings chapter (Chapter 4), as symbols of and vehicles for exploring, deconstructing and disentangling aspects of the lived reality and meaning of Lean for nurses and nursing, in the study setting. The organisational artefacts mentioned in section 3.8.1, which contributed to informing a working understanding of the 'officialised' version of Lean ahead of fieldwork (some of which were also present on the study wards during fieldwork), are also referred to in the findings as reference points of contrast or corroboration, in the context of their relationship to nursing narratives and observations surrounding the lived reality and meaning of Lean, at the level of application (Hammersley and Atkinson, 2007).

In the first of the discussion chapters (Chapter 5), the organisational artefacts informing the preparatory phase of research, and referred to in the findings chapter, are approached more critically. They contribute to an analysis of the nature and function of the 'officialised' version of Lean, as constructed and

articulated through Trust discourse, in the context of power relations in the study setting, which is informed by aspects of (the researcher's account of) nurses' narratives and enactments surrounding the lived reality and meaning of Lean presented in the findings, and approached from a Foucauldian perspective.

3.8 Study design

3.8.1 The research setting

The research setting was a large NHS Hospitals Trust located in the United Kingdom. Three purposively sampled wards were studied across two of the Trust's hospital sites; the ethnography was therefore multi-sited. The study wards specialised in oncology (Ward 1), neurology and neurosurgery (Ward 2) and palliative care (Ward 3). In what follows, a 'picture' of Lean in the research setting is presented, followed by the rationale underpinning the purposive selection of the three study wards.

The picture of Lean in the research setting

In section 2.3.3 of the literature review chapter, the variability of the nature of Lean implementation in healthcare was identified. The following sections are therefore dedicated to describing the specific nature of Lean in the research setting, in order to clarify exactly 'what' was studied. The description provided is derived from the content of organisational artefacts - formal Trust documentation pertaining to the Trust's Lean programme - and personal communication with Lean programme leaders, which occurred before fieldwork commenced, and which are described in more detail in the final sub-section of this section ('Lean-based initiatives and Lean philosophy'). The documents are unreferenced and the Lean programme is referred to by the pseudonym 'Working With You', in order to protect the anonymity of the research setting.

Levels of Lean in the study setting

In the study setting, Lean implementation could be identified as existing at two levels; at ward level and at organisational level. The Trust had adopted the 'Productive Ward' in 2009 and it had since been implemented in all ward areas across the organisation. Also in 2009, a wider, bespoke, Trust-wide, continuous improvement programme, called 'Working With You', explicitly based upon Lean principles, had been introduced at the Trust. In accordance with Burgess and Radnor's (2013:229) typology of Lean implementation approaches in healthcare, identified in section 2.3.3 of the literature review chapter, the Trust's approach could be classified as 'systemic' implementation - the most comprehensive approach within the typology - since the Trust were attempting to embed Lean principles organisation-wide, as 'the way we do things around here'.

Trust level Lean; Working With You

Working With You was introduced in response to challenges that the Trust faced, with regards to staff morale and motivation, under-achievement in relation to performance targets, and financial pressures. Reflecting Lean philosophy, Trust documents identified the key aims of the programme as:

- To reduce cost and improve efficiency through the redesign of ways of working, the elimination of waste and reduction of unwarranted variation.
- To establish and embed a continuous improvement culture, involving commitment to transformational change and long-term quality improvement to clinical practice, safety, and staff and patient experience, in order to promote a caring, thoughtful organisation. Safety, quality and financial savings are equally emphasised.
- To engage, empower and involve the maximum number of staff as is possible in change projects, and share best practice and information to promote awareness and learning.

Working With You was introduced as a framework, organisational philosophy and infrastructure, to support and build on, Productive Ward implementation, applying and extending principles to an all-encompassing, whole-system, 'Productive Hospital'. Working With You also encompassed discrete projects, focused at system, speciality/departmental and patient pathway levels.

Ward level Lean; the Productive Ward and other Lean-based initiatives

The Productive Ward represented a tangible, ward level manifestation, of a Lean initiative falling under the auspices of Working With You. At the time of research, numerous other ward level improvement initiatives had been, or were in the process of being, implemented, based on the Lean philosophy, principles and techniques underpinning Working With You and the Productive Ward. This research focused on Lean generically, as it was comprised of collectively by the various Trust initiatives, as these formed interrelated rather than discrete projects. Indeed, although identifying initiatives by name at times, participants often spoke of change and its consequences more broadly, in an overarching way, rather than making stark distinctions and contrasts between projects. Similarly, initiatives were explicitly linked to the Productive Ward and/or Working With You by some nurses and not by others. Initiatives are therefore referred to generically in the thesis as Lean-based initiatives (LBIs), rather than by specific names, which also serves to protect the anonymity of the study setting, as projects had often been assigned bespoke names by the Trust.

At the start of fieldwork, the purpose of the research was introduced to participants as a study to explore nurses' perceptions and experiences of an efficiency, quality and safety improvement programme at the Trust, which was reiterated in the Participant Information Sheet. The Productive Ward was initially used to contextualise and ground the research in conversations with nurses, as it appeared that this was the Lean project with which nurses were most familiar and had had most experience. This perhaps reflected the status of the Productive Ward as the most prominent Lean example in healthcare nationally (Waring and Bishop, 2010, Radnor, Holweg and Waring, 2012).

Management, dissemination and translation of ward level Lean

The Director of Nursing at the Trust oversaw the management of ward level Lean projects and members of the Trust corporate nursing team had been assigned 'Project Leads' for different initiatives. 'Project Nurses', who were also members of the corporate nursing team, were each assigned named wards, for which they were responsible in terms of overseeing and supporting project implementation at ward level. Training, project updates and new project launches were delivered by Project Leads and Project Nurses at meetings attended by Ward Managers or Deputy Ward Managers. Ward Managers were then responsible for cascading information to their staff on their individual wards.

Lean-based initiatives and Lean philosophy

During initial scoping stages of the research process, and as part of negotiating access to the study wards, a prolonged period of time was spent in the Trust's hospitals. During this period, organisational artefacts relevant to Lean implementation, such as official organisational strategy documents, reports and LBI posters, displays and leaflets, were read. LBI dissemination, staff consultation, engagement and training events, together with formal project meetings, were attended and discussions took place with individuals including a Directorate Clinical Lead, Project Nurse, Productive Ward Project Lead and the Working With You Programme Director. From these activities and communications, a strong emphasis upon the empowerment component of Lean philosophy could be gleaned. In the context of this Trust, empowerment was associated with respecting front-line workers as knowledgeable experts in the change process, encouraging their participation in, and ownership of, projects, working together with them to explore their ideas, and keeping Trust promises surrounding the implementation of ideas.

3.8.2 Purposive sampling of the study wards and negotiating access

Careful consideration was paid to the selection of the three wards for study, which were purposively sampled for 'variation' in accordance with three characteristics. These were: the status of the settings as 'less typically researched' within the Lean in healthcare literature, the 'high-touch' nature of nursing care required in the settings, and 'natural variation' in terms of local engagement with, and perceived 'success' of, Lean implementation. The decision to situate the study within three different settings (a multi-sited ethnography) was also deliberate. The rationale guiding the sampling of wards according to these features, and for a multi-sited ethnography, is described over the course of the next four sections.

The selection and negotiation of access to the study wards was undertaken in conjunction with the Productive Ward Project Lead at the Trust. Permission to study each individual ward was granted from the relevant Ward Manager (Acting Ward Manager in one case, owing to long-term absence of the Ward Manager), following meetings explaining the nature of the research and the involvements of staff. The research was supported by the Director of Nursing and Working With You Programme Director, and approval from the Trust Research and Innovation Department was gained.

Variation 1. Less typically researched settings

Lean research in the arena of healthcare has been more concentrated in the settings of the Operating Department (O.D.) and Emergency Department (E.D.) (Mazzocato, Savage, Brommels et al, 2010, Holden, 2011). Whilst Lean principles are purported to be generic and universally applicable (Womack, Jones and Roos, 1990), it has been suggested that Lean implementation may entail context-specific considerations, and be more or less amendable to some clinical contexts than others (Holden, Eriksson, Andreasson et al, 2015, Mazzocato, Thor, Bäckman et al, 2014). Holden et al (2015) suggest that Lean may be more conducive to areas which are characterised by high acuity, high volume, fast-

pace and which are highly inter-dependent, such as the O.D. and E.D. Further, Radnor and Osborne (2013) posit that there may be service delivery circumstances in which Lean is ineffective or inappropriate.

Characteristics of the three wards selected for study, varied from those of the O.D. and E.D., in terms of patient length of stay, degree of process orientation, volume of patients cared for and patient through-put, for example. In selecting less typically researched settings, which varied in nature from those most researched, it was thought that the research could contribute to explorations of the role of contextual difference and variability in the process and outcomes of Lean implementation, in turn contributing to a more comprehensive understanding of Lean's universality claims in healthcare (Holden et al, 2015).

Variation 2. 'High-touch' settings

Study wards were purposively selected for their nature as particularly 'high-touch' nursing settings. In the chosen specialities, it was thought that interpersonal and psychosocial aspects of holistic nursing theory and practice may be especially required and emphasised. Norms and values surrounding the 'art' of nursing and humanistic aspects of care may be afforded particular weighting within the balance between high-touch 'care' and biomedically oriented, high-tech 'cure' (Leininger, 1988). It was thought therefore, that the potential challenges presented by Lean to nursing as holistic, person-centred caring, described in the literature review, may be more pronounced and visible in these settings. This situated the study wards as 'information-rich' (Sandelowski, 2000:338) for the purposes of exploring the lived reality and meaning of Lean for nurses, as the research aim, and addressing the socio-culturally oriented research objectives, particularly those focusing on nursing theory in the context of Lean implementation.

Variation 3. Natural variation associated with aspects of Lean implementation

The third variation guiding the purposive sampling of the study wards, pertained to the settings' 'natural' contextual variability in relation to aspects of Lean implementation:

- Although Working With You had been implemented Trust-wide, with associated Lean philosophy and ward level projects, departmental level projects had commenced in relation to Ward 1's speciality only.
- Ward 2 had acted as a pilot ward for Productive Ward implementation. This ward had therefore had more 'experience' of this initiative than Wards 1 and 3 at the time of research, and had received more input and 'attention' from the Trust surrounding implementation and evaluation.
- The Trust Productive Ward Project Lead, considered Ward 1 to be enthusiastic about change projects. Ward 2 was reported to initially engage well with initiatives but did not always sustain the momentum of change, and Ward 3 was deemed not to have engaged well with change initiatives. This provided a spectrum of 'engagement', which the Project Lead thought reflected the general picture of implementation across the Trust.

It was not intended that these contextual differences would be used as a basis for cross-setting comparative exploration *per se*. Rather, if significant differences in the lived reality and meaning of Lean between the study wards became apparent in the early stages of fieldwork, it was intended that these variations would be afforded increased analytical attention as fieldwork progressed.

A multi-sited ethnography

The decision to study three settings was informed by the tendency in research considering Lean implementation in healthcare, to limit the remit of study to single departments (Mazzocato et al, 2014, Holden et al, 2015, D'Andreamatteo, Ianni, Lega, 2015). A multi-sited ethnography provided the opportunity (as, and if, applicable) to explore variability, diversity and commonality in the lived reality and meaning of Lean across ward settings, and the potential influence of local contextual and socio-cultural factors on Lean's manifestation. A multi-sited ethnography therefore afforded the research the potential to capture both unique and common manifestations of meaning across phenomenally varied locations, which represented 'unusual' and 'uncommon', rather than 'typical', cases of Lean implementation (Sandelowski, 2000:338).

3.8.3 Participants

Participants were Registered Nurses employed by the Trust, working on the three study wards. Collectively, the wards employed a complement of 68 nurses. Observations focused on nurses of all bands; Staff Nurses (Band 5), Deputy Ward Managers (Band 6) and Ward Managers (Band 7). Interview participants were five Staff Nurses and two Ward Managers. All interview participants were female.

Initially, it was not intended that Ward Managers form part of the study sample, as it was thought that they served an organisationally-oriented role in the context of Lean implementation, as drivers of implementation at local level. It was thought that the lived reality and meaning of Lean implementation might therefore differ for Ward Managers and clinically-oriented 'front-line' Band 5 and 6 nurses, respectively. During early observations however, it transpired that Ward Managers did not appear to closely identify with their organisationally-affiliated Lean role. Regarding matters of Lean, they seemed to identify more closely with a clinical nursing, rather than an organisational, managerial complement, and shared in the Band 5 and 6 nurses' 'front-line' experiences and

understandings of Lean. For this reason, the decision was taken to include Band 7 nurses in the study sample. It was decided however, that if significant differences became apparent, between the experiences, understandings and interpretations of Ward Managers and Band 5 and 6 nurses, this would be given further analytical attention, in order to inform a decision as to whether, and how, to incorporate the Ward Manager perspective in the research. This situation did not arise however and Ward Managers' views are presented alongside those of Band 5 and 6 nurses in the findings.

3.9 Data collection and ethical cognisance

This section details aspects of data collection, which took place over a period of seven months in 2013. In order to avoid repetition, identification of ethical issues and how they were addressed (e.g. associated with recruitment, informed consent, the nature of observations), are interspersed throughout the account which follows, rather than described in a separate section.

3.9.1 Sampling of participants, recruitment and consent

Participants were approached following the receipt of favourable ethical approval from the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee (reference: F10012013 SNMP 12126). Sampling for both observations and interviews was opportunistic and voluntary. Participants on each of the three study wards were initially approached in groups at shift handover meetings. The purpose of the study was introduced as to explore nurses' perceptions and experiences of an efficiency, quality and safety improvement programme at the Trust, and nurses were informed of all aspects pertaining to participation. Participant Information Sheets were distributed and the opportunity to ask questions was provided. It was explained to nurses that entry into the study was entirely voluntary, that they could withdraw from the study at any time without giving reason, and that their position at the Trust would not be affected by their decision to participate in the study, or otherwise. Nurses were told that if they chose not to participate in

observations, this did not preclude participation in interviews if they wished, and *vice versa*. Participants were advised that although their participation in the study would be kept confidential, if they were to disclose information which the researcher felt presented a risk to the participant or others, it may be necessary to report this to appropriate persons. Participants were also informed that the findings of the study would be reported as part of a doctoral research project, and that anonymised direct quotations from interviews and observations, together with anonymised descriptions of their observed actions and activities, might be used to help explain and provide examples of findings, in reports, presentations and academic publications.

Recruitment and consent; observations

If nurses did not wish to participate in observations, they were advised during the introductory visit that they should 'opt out' by informing the Ward Manager, the researcher directly, or via the postal, telephone or email contact details included on the Participant Information Sheet (PIS). This process was also detailed and reiterated in the PIS, alongside the information described above, and a supply of PISs was left on the wards. At the start of the first data collection visit, the researcher again attended the handover meeting for the relevant shift on which observations were due to commence and nurses were provided with a further opportunity to 'opt out' of observations. Consent to participate in observations was therefore implied by nurses not choosing to 'opt out'.

Subsequent observation visits were prearranged with Ward Managers (the Acting Ward Manager on Ward 1), who were asked to inform nurses during their handover meeting, of the researcher's presence that day, and provide the opportunity to 'opt out'. During observation periods, posters incorporating a photograph of the researcher and advising of researcher presence were displayed in ward areas, providing further opportunity for nurses to 'opt out', by informing the Ward Manager or researcher. If nurses chose not to participate in observations, this did not preclude participation in interviews, and *vice versa*.

Prior to observing individual nurses, verbal consent was obtained where possible. No nurse chose to 'opt out' of observations during the period of fieldwork.

Recruitment and consent; interviews

During observation periods, participants were reminded that interviews would be taking place on the ward over the coming months. Nurses were again invited to read the PIS detailing what participation would involve and were provided with the opportunity to ask questions. Nurses were advised that the interview would last up to one hour, that it would take place on the ward at a time convenient to them, and that it would be audio-recorded, in order to aid the researcher's recall of the discussion. Nurses who indicated a willingness to participate in an interview provided written informed consent prior to the start of their interview, having had at least 24 hours to consider participation and ask questions.

3.9.2 Interviews

The theoretical rationale for adopting the method of interviews, together with details as to how they were utilised in a way consistent with the feminist philosophy underpinning the research, were provided in section 3.7.2. This section focuses on more practical details associated with interviews. A total of seven semi-structured interviews were undertaken with nurses (five Staff Nurses and two Ward Managers. All female.), which lasted an average of 23 minutes. Interviews took place at a time during a participants' shift when clinical duties allowed, and in a private location on the ward, for example, in the ward office or relatives' room when vacant. Interviews were audio-recorded and subsequently transcribed verbatim and anonymised.

Fewer interviews were undertaken than was anticipated, owing to several factors associated with interview recruitment. Firstly, after fieldwork had commenced, the Acting Ward Manager on Ward 1 preferred that data collection

focus upon observations only, owing to nurses' clinical workload and the time that participation in an interview would consume, away from their allocated patient area. They also did not wish for nurses to participate in interviews during their break times or outside of their allotted shift times, with which the researcher agreed. Band 5 and 6 nurses on Ward 1 were not therefore invited to participate in interviews and as a corollary, only one interview was undertaken on this ward, with the Ward Manager (following their return to work after a period of absence, as identified in section 3.8.2). Although disappointing, this was not considered to be methodologically problematic, since similar discussions could take place, and questions could be asked of nurses during observation periods, albeit in a less formal and more fragmented way. One nurse on Ward 1 had however been especially keen to participate in an interview, from which they were now precluded. Ethically, it was felt important to comply with the wishes of the Acting Ward Manager, but also provide the Staff Nurse with the opportunity to express their thoughts, opinions and contribute to the research, as they desired. As a compromise, interview questions were asked across the span of an observation period, in an *ad hoc* way, as and when the participant was available to converse, and responses were recorded in fieldnotes.

Secondly, on Wards 2 and 3, owing to nurses' workload, coupled with its unpredictable nature, it was difficult to allocate time for interviews, or arrange them in advance. Nurses were asked whether it would be helpful for the researcher to attend the ward during night and weekend shifts, but owing to reduced staffing levels at these times, participants suggested that still, little time would be available. Again, this was not considered to be problematic as informal discussions could take place during observation periods.

Relatedly, it can be noted that the interviews that did take place were relatively short in duration, lasting an average of 23 minutes. This too was due to time constraints associated with nurses' clinical workload and interviews were curtailed in accordance with the requirements of nurses' ward work.

3.9.3 Observations

The theoretical rationale for adopting the method of observation, and the nature of observations, were identified in section 3.7.3. This section focuses on more practical details associated with observations. The next section provides a reflexive account and discussion surrounding the specific role occupied, and level of participation during fieldwork, together with associated ethical considerations. A total of 119 hours of observation were undertaken in the study setting over a period of seven months in 2013. Participants on each ward were observed for up to four hours per week over the period of study. Observations took place during morning and afternoon shifts, Monday to Friday. The seven month duration of fieldwork was considered adequate with regards to yielding a nuanced insight into the lived reality and meaning of Lean for nurses and nursing. At the close of fieldwork, it was felt that a point of saturation had been reached whereby new insights were few, rich insight and understanding had been developed in relation to the research aim and objectives, and researcher questions were becoming exhausted (Blaikie, 2010).

Observations focused on nurses and nursing activities that did not involve the provision of direct patient care, so as to protect patient privacy, dignity and confidentiality. Patient involvement in observations was therefore incidental only, owing to their presence on the ward during observation periods, and data was not collected regarding patients, carers or relatives. Posters were displayed in ward areas advising patients and relatives that a researcher was observing nurses. The posters incorporated a photograph of the researcher and advised that if patients and relatives did not wish the researcher to observe in their vicinity, they should inform a member of staff or the researcher. Before observations commenced in a patient area, patients were also verbally informed of researcher presence for the purpose of observing nurses and the opportunity was provided for patients to voice any objections. No patient or relative raised any concerns or objections during fieldwork.

3.9.4 A reflexive account of the role of the researcher in fieldwork

In accordance with the feminist influences underpinning the research (identified in section 3.3.3), it was acknowledged that the researcher's situatedness, and active choices and decisions made during the research process, influence and shape the nature and genesis of knowledge which is co-constructed with participants through the research process, and presented as 'findings'. The role that the researcher plays during fieldwork was identified as one such decision and factor influencing the co-construction of knowledge. It was also identified that through reflexivity, the researcher should acknowledge and make transparent their role in the co-construction of knowledge, and accept responsibility for the partial and situated knowledge that they bring to the fore. Reflexivity allows the researcher to describe and account for decisions and choices made during the research process, influenced by their situatedness, and make transparent the process through which the co-constructed knowledge presented as findings was arrived at, contributing to the process of, and allowing for, the critical appraisal of the knowledge claims of research, which was identified as central to the normative criteria by which the thesis might be judged.

To this end, this section provides a reflexive account of the role that the researcher played during fieldwork. In doing so, it draws upon Allen's (2004a) ethnomethodologically informed framework, to provide a more rigorous reflexive account of positioning, which is underpinned by a theoretically informed and empirically substantiated treatment of social interaction in the research setting.

Insider-outsider, participant-observer

As Allen (2004a) explains, classically, the reportage of the role of the researcher in ethnographic fieldwork concerns their status in relation to the insider-outsider dialectic and participant-observer continuum (Gold, 1958). Within this orthodox practice, the insider-outsider dialectic is discussed in relation to the advantages

and disadvantages that each position confers, and how these are managed, from a realist perspective. This involves considering the influence of the status adopted upon the ideal of objectivity within the research process (e.g. the objectivity of observations and observer effects), or conversely, upon the aim of 'getting closer' to participants in order to foster 'true' understanding (Allen, 2004a, Hesse-Biber and Leavy, 2011).

It can be recalled from section 3.3.3 however, that the feminist philosophical influences underpinning the research, consider research findings as a co-constructed understanding, informed by the situated, partial perspectives and reflecting the influences of, the researcher and participants in the knowledge construction process – they necessarily and inevitably constitute the researcher's (partial and situated) account of participants' (partial and situated) accounts and enactments, of their understandings and experiences of phenomena, reflecting their respective influences in the co-construction of knowledge. This contrasts with the realist agenda of documenting objective reality, through the pursuit of objectivity as an ideal in the research process, involving detachment and the creation of distance from participants during fieldwork. It also deviates from the possibility of, and ambition to, 'represent' participants' experiences and understandings of phenomena, through 'getting close' to participants, in order for the researcher to experience and understand their lived reality as they do. A reflexive account of the researcher's role during the fieldwork of this study therefore requires the adoption of an alternative approach.

Allen (2004a) recognises that rather than being determined *a priori*, the researcher's insider-outsider status is variable and socially accomplished, through social interaction, practices and processes. Her framework turns attention away from essentialist statements of status, towards reflexive accounts of positioning which consider how status and identity are achieved, negotiated, managed and maintained through social practices and processes in the research setting. Gold's (1958) traditional continuum of participation is also relevant, since the researcher's actions or 'mode of participation in the research

field' (Allen, 2004a:19) constitutes one of the ways in which insider-outsider identity is achieved. The researcher's transient status on the participant-observer continuum will therefore be described in what follows, in conjunction with, and in relation to, a reflexive insider-outsider exposition. As in the findings chapter, names assigned to participant quotations in the following account are pseudonyms.

The presentation of a 'dual-identity'

Across the three study settings, I presented myself as an 'outsider' to the organisation, with an 'insider' nursing background. My role as an 'outsider' researcher was overt and my nursing 'insider' identity was disclosed to participants from the outset. The development and maintenance of this 'dual-identity' as both an 'insider' and 'outsider' was considered important for the reasons outlined in the two sections which follow. The third section details how I attempted to forge and maintain the presentation of this identity and finally, issues that arose in relation to this process are recalled.

Rationale for presentation of an 'insider' identity

I was aware from my experiences as a Staff Nurse, that requests from individuals 'outside' the nursing group, for nursing opinions and views, and the rationale that underpinned the appeal, could be met with suspicion. They could be interpreted as contributing to a self-serving organisational agenda, which paid 'lip-service' to nursing involvement, 'ticked a box' in managerial policy, but had no meaningful implications in, or for, nursing practice. As an 'outsider' researcher therefore, I recognised the potential for ambiguity surrounding my request for nurses' perceptions and the rationale driving my research. Given the 'genuine' intention of my research aim; to explore the lived reality and meaning of Lean *for nurses and nursing*, I felt it important to attempt to address the potential for scepticism and misinterpretation associated with 'outsider' requests for information, through emphasising my 'insider' nurse status.

Rationale for presentation of an 'outsider' identity

Given the emphasis of the research upon organisational change initiatives, I felt that presenting myself as an 'outsider' to the organisation may lessen the potential for misinterpretation surrounding the purpose of my observations; as for the purposes of internal evaluation, project compliance audits, or nursing clinical practice appraisal, for example. Therefore, whilst wanting to present myself as an 'insider' to the nursing group, I wanted to further clarify the issue of affiliation through presenting my status and identity as an 'outsider' to the organisation in which participants worked.

I also wished to consciously maintain an 'outsider' facet of researcher identity to the nursing group, for ethical and safety reasons. In terms of research ethics, I thought it important that participants disclosed only information which they would be happy to be used for the purposes of research. I thought that maintaining my identity as an 'outsider' to the nursing group may assist in ensuring this, and serve as a reminder that participants could raise questions or objections regarding observations at any time (Emerson et al, 1995). In terms of safety, I thought it important that I was not mistaken for an 'insider' clinician, in order to ensure that I was not depended on to intervene, should a medical emergency arise.

Finally, I was anxious to maintain an 'outsider' identity as a means of avoiding being considered to be 'lazy' or 'not pulling my weight', in the sense that I spent much time apparently 'sitting around' during fieldwork, rather than sharing in physical 'insider' nursing work. I was aware of the existence of cultural values in nursing surrounding 'the workload approach' of 'getting the job done' (Melia, 1984:138) and negative judgements towards those who 'shirk' the physical work (Maben, Latter and Macleod Clark, 2006). My presentation as an 'outsider' to the nursing group was therefore important to me personally, as a marker of my being 'exempt' from clinical work, thus limiting the potential for negative judgement.

The shaping and negotiation of a 'dual-identity'

In order to create and maintain my 'outsider' identity and prevent the potential for 'mistaken identity', rather than wearing a clinical uniform which would symbolically confer membership of the nursing group (Timmons and East, 2011:1041), I dressed in smart-casual clothes and ensured that my University identity badge was worn at all times. I also hand-wrote fieldnotes overtly and in 'real-time' to remind participants that my presence on the ward was for the purposes of 'outsider' research (Emerson et al, 1995).

In order to promote my status as an 'insider' to the nursing group however, I was keen to explain the nurse-centric rationale underpinning the study, at the outset of fieldwork. I identified the lack of evidence surrounding nurses' perceptions and experiences of Lean and the importance of ascertaining implications for nurses and nursing, in order to contribute to the evaluation of Lean implementation in healthcare. I wanted to communicate that the research was intended to be *about* 'them' as nurses, *for* 'them' as nurses, and for nursing more broadly. I thought that disclosing my 'insider' status as a nurse myself would help to explain and support the genuineness of my intentions, as 'one of them', with shared nursing interests at heart. This practice of emphasising common interest and solidarity could be understood in Putnam's (2000:23) terms as a form of 'bonding and bridging' social capital – bonding me as an 'insider' to the nursing group and strengthening in-group identity, whilst simultaneously bridging my 'outsider' researcher identity with that of the 'insider' nurse, with both functioning as kinds of sociological glue.

Having laid the foundations for my 'insider' identity, since I was aware of the value of physical work in nursing culture (Maben et al, 2006, Melia, 1984), I offered to share in the work of the ward as a currency for fostering further acceptance and rapport. This was albeit in the limited way that was possible, as dictated by my official status as an organisational 'outsider', and the ethical boundaries of my participatory role as a researcher, confined to non-clinical tasks. My level of participation/observation on each ward varied and similarly, my place on the participation-observation continuum varied at any given time,

according to the nature of activities taking place in the study setting (Dewalt and Dewalt, 2002). Examples of activities in which I participated included the 'fetching and carrying' of resources between areas of the hospital, accompanying nurses on 'errands' and arranging flowers and thank you cards on the reception desk. This participation also served to ease some of my personal anxiety around 'being in the way' and being 'lazy'. Additionally, I ensured that I 'spoke the same language' as nurses and shared nursing stories from my time as a Staff Nurse, in order to communicate my understanding of the realities of nursing, 'insider' nursing values and identity (Bowles, 1995, Eastman, 1985). At other times, I located myself at a central 'Nurses' Station', where interactions could be observed and listened to, with no or very little direct involvement from myself.

The ambiguity of identity; insider, outsider, nurse-researcher, spy

Although I have outlined my intentions regarding the presentation of my insider-outsider status and identity during fieldwork, as Allen (2004a:22) notes, 'we are not free to make our identities in any which way we choose'. This final section therefore turns to recalling some issues that arose during fieldwork, which influenced the negotiation of my insider-outsider identity and status 'in practice'.

During early stages of fieldwork, I encountered some ambiguity and scepticism regarding my status and affiliation. My identity, intentions and the purposes of me being on the ward were comprehensively probed by participants. Nurses were interested in aspects of my situatedness; personal background, where I lived, future career ambitions and why I was interested in Lean implementation, for example. I was asked whether I was a nurse, an 'academic' or whether I was 'from the Trust', the two former categories being articulated as mutually exclusive. Despite attempts to explain my status as an 'outsider' to the organisation, some nurses appeared cautious, were hesitant, and talked in a self-conscious manner. From a dramaturgical perspective (Goffman, 1959), it seemed that, before answering my questions, nurses were first attempting to

assess the audience to whom their performance was directed, in terms of affiliation, in order to gauge the most appropriate way in which to manage their impression and potentially, which facets to accentuate or supress. It appeared that participants thought it conceivable that I was akin to an organisational spy, with some nurses attempting to confirm this conclusively: 'Are you one of those people that's really high up in management and is watching what we're doing? Are you?' (Katrina. Ward 3.). As a consequence of this, participants ensured that they explained situations where negative judgements regarding their professional practice might be made. One participant, for example, implored: 'That's a doctor that's left that like that by the way' (Tabby. Ward 2.), referring to a computer screen that had not yet been logged out of. In other instances, participants appeared protective of each other in my presence, by urging each other to be 'professional, be professional' (Elizabeth. Ward 2.), reminding colleagues that they were being observed.

At this stage, it seemed that neither aspect of my dual-identity was successful in its presentation. Neither my status as 'insider' to the nursing group, nor 'outsider' to the organisation was accepted. As fieldwork progressed however, and participants became more familiar with my presence and questioning, they appeared to become more accepting of my identity as a nurse 'insider' and organisational 'outsider'.

For a minority of participants, it seemed unlikely that I would ever be considered an 'insider' to the nursing group, and I felt that this might relate to my status as a non-clinical, academic (nurse) researcher. Participants joked that I had time during my working day to eat lunch, that my day's work constituted the few hours that I spent observing on the ward, and when writing fieldnotes, it was suggested that I was colouring in a colouring book. It seemed that through this humour, participants were drawing attention to the stark contrast between my working day as an academic nurse, and their working day as clinical practitioners. This was reminiscent of my experience as a student nurse, where I had encountered negative opinions surrounding the academisation of nursing, and students being 'too posh to wash' and 'too clever to care' (Scott, 2004:581),

indicating a mutual exclusivity between the mind-work and body-work of nursing, and the primacy of the status of the latter in the work hierarchy and division of labour, within nursing culture. By warrant of my status as an academic (nurse) researcher, unable to participate in the busy clinical work of the ward, it seemed that I was precluded from being accepted as a 'proper' nurse 'insider', in the eyes of some nurses.

By the end of fieldwork, I felt that issues of affiliation had been resolved in the minds of the majority of participants and that overall, I occupied a status concurrently as a 'marginal insider' and 'trusted outsider'. Questions as to 'who' I was and 'what' I was doing had subsided. I overheard a participant introduce me to another nurse who had been on annual leave by saying 'she's observing, but not in a scary way' (Ruth. Ward 1.), suggesting that I was no longer interpreted to be an organisational spy. Further, participants began to mock their own prior trepidation and hesitancy regarding my presence, and potential for me being an organisational spy. This was typically acted out by participants pretending to write in the way that I was doing whilst recording fieldnotes, and simultaneously narrating out loud what I could potentially be writing. For example: 'She's writing about us again - "Does no work, swears like hell" [pretending to write].' (Emily, Ward 2.). The idea of 'researcher as spy' was also humourised more directly, through assigning 'spy' to me as a nickname. This name was seemingly used by nurses in a subversive way, to ironicise prior assumptions and indicate that they accepted that I was in fact, quite the opposite as an organisational 'outsider' and nursing 'insider'. I was greeted for example, at the start of visits with: 'Ey up spy, you alright?' (Emily, Ward 2.), to which I responded: 'I should get that put on my name badge really shouldn't I?', since it had become common to be greeted like this. The assignment of this sarcastic nickname could be interpreted as a marker of inclusion and group membership, cementing my status as an 'insider' (Nicholson, 2006). Also symbolic of acceptance, I also became included in 'backstage' social conversation (Goffman, 1959:114). In turn, these things made me *feel* accepted, within the 'insider' group.

3.9.5 The role of the (insider) researcher and the potential for collusion and complicity

In section 3.3.3, reflecting the feminist epistemological principle of co-construction, it was acknowledged that, as part of their active role in the knowledge production process, the status and role that the researcher occupies during fieldwork influences the genesis and nature of knowledge that is co-constructed by the researcher and participants (Stanley and Wise, 1993, Usher, 1997a). Aspects of the researcher's situatedness and 'who' they are, together with the active choices that they make during the research process, influence the researcher's insider-outsider status and role, which in turn influences the information that participants share with the researcher and the nature of their accounts of and behaviours displayed surrounding, phenomena. Similarly, the researcher's situatedness impacts upon and filters how and what they 'see' in the research setting, their particular and always partial perspective, and how they understand, analyse and interpret situations, observations, participant narratives and events. These factors inform the feminist assertion that findings do not 'represent' a complete and unmediated correspondence with participants' understandings, interpretations and experiences of phenomena and instead reflect the influence of both the researcher and participant in the genesis and nature of the co-constructed knowledge arrived at. As also identified in the previous section (section 3.9.4), the researcher should therefore identify and provide an account of the role and status that they occupied during fieldwork as part of the reflexive process, in order to make transparent the process through which co-constructed knowledge presented as findings was arrived at, and how their role may be implicated in the nature of co-constructed knowledge presented, in turn assisting readers with the critical appraisal of research. This section therefore specifically considers how the 'insider' 'nurse' facet of my situatedness and status during fieldwork, identified in section 3.9.4, may have been implicated in the genesis and nature of the co-constructed knowledge that is presented in the thesis.

Identifying the potential for collusion

Owing, and in response, to the insider nurse aspect of my situatedness and status occupied during fieldwork, it was recognised that nurses may reveal certain things surrounding their culture and the lived reality and meaning of Lean, at the expense of others. It was acknowledged that narratives and behaviours of a particular nature might be elicited and this key aspect of my situatedness would therefore influence the knowledge that I had 'access' to during fieldwork (England, 1994, Woodward, 2008). More specifically, owing to this shared facet of situatedness, or 'ontological complicity', between myself and participants, the potential existed for nurses to construct and communicate accounts, and display behaviours, which colluded and were complicit with my nursing sensibilities (Woodward, 2008:3). It might be suggested, for example, that nurses' accounts and enactments may have particularly emphasised understandings and experiences of Lean implementation and a version of their culture, which placed and portrayed them in a 'favourable' light in a nursing context. Similarly, accounts might be expected to be less contentious, challenging or critical of the dominant discourses, rhetoric and ideology of nursing, through which both they and I were educationally and professionally socialised and enculturated. Participants may have articulated their accounts in such way as to seem acceptable to a fellow nurse, with shared professional history, thus providing mutually socio-culturally acceptable versions and accounts of phenomena.

Further, since researcher interpretation, their partial perspective and what they 'see' in the study setting is influenced by their situatedness (in this case as an insider nurse), the potential also exists for the (insider) researcher to collude with participants' accounts of phenomena. That is, since the researcher possesses the means to enter in to, and collude in, nursing culture and is also partially constituted by the 'myths and practices' of nursing and its discursive regimes (Woodward, 2008:28), the researcher may conceive of and accept the information that participants share with the researcher uncritically, as 'transparent reflections or representations of their experience' (Woodward,

2012:61). Inherent within the potential collusion of (nurse) participants with the (nurse) researcher, and in turn, the collusion of the researcher with participants, owing to their insider status (mutual collusion), is the implication that the knowledge co-constructed through research, may simply and uncritically propagate, reproduce, reify and reiterate mutually socio-culturally acceptable accounts and versions of phenomena, and normative, hegemonic nursing discourses and subject positions (Woodward, 2012). Woodward (2008:16) therefore argues that 'Those who conduct the investigations and generate knowledge are also complicit in the processes through which knowledge is re-produced'. To present an understanding of a culture is also to authorise and 'actively intervene in its (re)production', and in participating in the reinscription and reproduction of discourses (Walker, 1997:4), Street (1992:12) and Walker (1997) argue that the researcher may (unwittingly) legitimate and perpetuate oppressive power relations, discourses and 'forms of cultural oppression'.

'Addressing' the issue of collusion

Although the potential for collusion and complicity associated with my insider status, and the reproduction of dominant discourses and power relations, is acknowledged, the 'outsider researcher' (or '*marginal* insider') facet of my 'dual-identity' maintained during fieldwork (described in section 3.9.4), may have to some extent 'balanced' the nature of accounts that nurses constructed and provided, and reduced the potential for nurses' collusion with me. In addition, although sharing a nursing educational and professional socialisation background with participants, the researcher facet of my situatedness was associated with educational and professional training, emphasising theoretical preparation and skills of critical analysis, which afford a 'view' of nursing within a broader theoretical and critical context. This may therefore have 'balanced' the nursing socialisation aspect of my situatedness and created a degree of 'distance' from my nursing identity, mitigating against my collusion with their accounts and enactments. Although a nurse, I was also 'otherwise' situated as an academic researcher. I was at once the same and 'different to' nurses, and through

maintaining the critical distance that this affords, the potential exists to question, agitate and disturb understandings, and 'interrupt certain containments' and reproductive complicity (Childers et al, 2013:516). Although potentially reproducing dominant discourses, the researcher can also therefore participate in the creation of discourses (Walker, 1997). This is supported by the adoption of feminist assumptions which held the implication that information that participants shared was not conceived of as constituting 'transparent reflections or representations of their experience' (Woodward, 2012:61), which, as identified above, can lead to collusion. Instead, as identified in section 3.3.3, they were viewed as situated and partial accounts, or stories, of their understandings and experiences, which they chose to share and disclose, the nature of which being influenced by factors including the researcher's insider-outsider status occupied during fieldwork. As identified in section 3.4.2 describing the role and place of criticality in the thesis, (the researcher's account of) nurses' accounts and enactments are therefore approached critically in the discussion chapters (Chapters 5 and 6) of the thesis, and are analysed in relation to theory, extant literatures and empirical work, reflecting the academic preparation associated with the 'researcher' aspect of my situatedness.

Finally, in accordance with the feminist philosophy underpinning the thesis, although the issue of potential collusion and complicity associated with 'insider' research, implicated in the co-construction of knowledge, requires reflexive acknowledgement and consideration, it is not conceptualised as a 'problematic' issue *per se*. The principles of feminist epistemology conceptualise *all* knowledge, necessarily and inevitably, as situated, partial and co-constructed in accordance with the influences and situatedness of the researcher and participants. Since it cannot be otherwise, one's insider (or equally, outsider) status will always therefore be implicated in the co-construction of knowledge, alongside the myriad other aspects which confer to determine the situated nature of knowledge. In this way, Woodward (2008:28) argues that feminist approaches 'have a great deal to offer when addressing strategies for resolving some of the methodological problems that have emerged out of the tensions

between the inside and the outside...'. She suggests that explicitly acknowledging the partial nature of knowledge, the situatedness of the researcher and pointing 'to the necessary inclusion, whatever research methods are adopted, of a situated perspective', creates a space for and affords a 'route' into the critical consideration of how the position of the researcher and participants may have influenced the genesis and nature of the account of phenomena that is co-constructed through the research process (*ibid.*:26, 28). Through reflexive acknowledgement of aspects of situatedness, one can then assess and appraise how the partial research account itself is situated and how it came to be. This is not conceptualised as a means of acknowledged 'bias' in a positivistic sense, hampering the pursuit of objective 'truth' or 'to devalue the research, but to situate the knowledge so produced and acknowledge its partiality' (*ibid.*:29). In acknowledging the philosophical 'given' of the partial and situated nature of knowledge, the methodological issue and priority therefore becomes the necessity for the reflexive acknowledgement of how the research account is situated, and recognition that it constitutes but one, partial, situated, incomplete account of phenomena.

3.9.6 Data storage

In accordance with the stipulations of the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee, study data were treated confidentially. Computer held data was stored securely, with access restricted by user identifier and password, and hard copies of data were stored in a locked cabinet. All participant names presented in the thesis are pseudonyms.

3.10 Data analysis

Data analysis began during the data collection phase of research. During observations and interviews, notes were made as to analytical and theoretical ideas, reminders, linkages, topics and features of the data. This process continued when transcribing fieldnotes and audio-recorded interviews.

Following the transcribing of data, more formal data analysis commenced, guided and informed by the principles of thematic analysis, identified by Braun and Clarke (2006), which were utilised in a way consistent with the feminist philosophical assumptions underpinning the research. In order to describe the way in which data were analysed in a comprehensible way, in what follows, the process of thematic analysis is divided into six phases. In reality however, as is characteristic of thematic analysis, it should be noted that analysis did not proceed in a rigid and linear fashion; the stages were used flexibly, recursively and overlapped (*ibid.*).

3.10.1 Thematic analysis

According to Braun and Clarke (2006:82), thematic analysis is a theoretically flexible method of data analysis, which aims to identify, analyse and report patterns (or themes) within and across data. A theme 'captures something important about the data' and represents a repeated pattern of meaning or response. Thematic analysis is a research tool which can provide a complex, detailed and rich account of data and contributes to methodological transparency and rigour within the analytical process. It can therefore assist with the reflexive process, as highlighted in feminist philosophy, as a means through which the researcher can describe and account for decisions and choices made during the research process, acknowledging and making transparent their role in influencing the genesis and nature of co-constructed knowledge arrived at. Indeed, Braun and Clarke (2006) also suggest that the specific nature of the thematic analysis performed is determined by a number of choices made by the researcher, and these should be explicitly identified as part of the reflexive process.

To this end, in this research, a 'bottom-up', data-driven strategy to analysing data and identifying themes was adopted, and socio-cultural interpretations and theoretical ideas were grounded in, abstracted and developed from the empirical data. This approach was informed by and reflected the research aim - to explore the lived reality and meaning of Lean Thinking *for nursing and nurses*,

and feminist commitments, firstly, to exploring and grounding research in *participants'* experiences, interpretations and understandings of phenomena (insofar as is possible, according to feminist caveats concerning co-construction and representation), respecting and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62), and secondly to the positioning of the researcher as learner or supplicant in the research process (England, 1994, Usher, 1997a). This approach was also consistent with the place of criticality, theory and the abductive approach within the research process, described in sections 3.4.2 and 3.6.2 respectively.

As a corollary of adopting a 'bottom-up', data-driven strategy, data analysis was not approached in a way driven by any particular theory *a priori*, in a deductive fashion, nor was it directed by a pre-formulated coding framework, or the specific research objectives. It is not suggested however, that themes 'emerged' passively, or were 'discovered', since, reflecting the feminist arguments surrounding the role of the researcher in the co-construction of knowledge and implications that this has for the impossibility of 'representing' participants' understandings and experiences (identified in section 3.3.3), the *active* role of the researcher in *identifying* themes within the data and their eventual *selection* for reportage, is acknowledged (Braun and Clarke, 2006). That is, the identification of themes is not a 'theory-free' process - it is necessarily an analytical and interpretive process influenced by the researcher's situatedness, which includes their analytical and theoretical sensitivities, reflecting the co-constructed, partial and perspectival nature of knowledge production (Stanley and Wise, 1993, Schatz, 2009, Altheide and Johnson, 1998, Timmermans and Tavory, 2012).

The six phases of thematic analysis undertaken, based on those identified by Braun and Clarke (2006), are described in the remainder of this section. Titles of the phases have been adapted to reflect the specific way in which they applied to this research.

Phase 1: Immersion in the data corpus

Transcribed interviews and fieldnotes were read through several times in their entirety, at both semantic and latent levels, in order to increase familiarity with data. Notes regarding potential codes, themes, ideas and interpretations were made.

Phase 2: Deconstruction through coding

The data corpus was then re-read and formally coded by hand on a sentence by sentence basis. Coding was data-driven and both semantic and latent level codes, of a general and specific nature, were assigned to data and further analytic ideas and interpretations were recorded. Attention was therefore paid to surface, explicit meanings contained within participants' narratives and actions, in addition to potential underlying socio-cultural conceptualisations, ideas and assumptions, which appeared to inform the semantic data.

Phase 3. Construction of themes

Codes were reviewed in light of the overarching aim of research, and the question: 'Does this code help me to describe, understand or explain the lived reality and meaning of Lean?' was asked in relation to the codes. This process assisted in deciding which codes were apparently less central or relevant to the aim of research. Retained codes could be categorised at the broadest level into those relevant to the 'opinions of initiatives' and those relevant to 'documentation'. Quotations and data extracts relevant to these categories were compiled in computerised documents. These documents were then analysed, annotated and interrogated for themes, their linkages, commonalities, differences, interplay and inter-relationships. Examples of themes identified at this stage of analysis included:

- Productivity
- Volunteerism
- Surveillance
- Feigned compliance
- Humour
- Accountability

- Busyness
- Work ethic
- Mistrust
- Types of knowledge and knowing
- Box-ticking
- Standardisation
- Ideas of identity, difference and uniqueness
- 'Good nurse', 'Bad nurse'
- The business of caring
- The media
- Resistance
- Rule-making and rule-breaking
- Sanction
- The personal cost of caring
- Shifting responsibility
- 'Them' and 'Us'

Phase 4. Reconstruction through consideration of the story

Having analytically deconstructed the data corpus, a process of reconstruction was then embarked upon in order to ascertain, make sense of, and interpret, what themes, in sum, said about the lived reality and meaning of Lean for nurses and nursing, and how it could be understood. This involved taking a 'step back' from the data and considering what was presented by the data beyond a selection of themes. This process was facilitated by asking further questions such as:

What is the overarching story, picture and message presented by these themes?

What is the meta-narrative which unites, cements and contextualises individual themes, making them coherent?

What illuminates and enlivens the experiences and narratives captured within the themes?

The outcome of Phase 4 was the conception of a game, played between nurses and the hospitals Trust (the Trust), for power and control over nursing practice. This game is introduced and described proper in the introduction to the findings, in Chapter 4 (section 4.1.1).

Phase 5. Refining and aligning the themes of the story

Once the meta-narrative of a game, played between nurses and the Trust, had been conceptualised, themes were reconsidered and reviewed with a particular focus on the way in which they contributed to the overarching story of the game, as a conceptualisation of the lived reality and meaning of Lean for nurses. This process assisted in refining the themes for presentation in the findings of the thesis, and the aspect of the game that they captured.

Phase 6. Structuring the analytic narrative

The final phase of data analysis involved grouping themes, the creation of subthemes and organising and structuring them in a way which allowed the game to be articulated and communicated in the thesis. This also involved the selection of quotations and data extracts to support and illustrate the descriptive and analytic narrative which would 'tell the story' of the game. The outcome of this final phase in terms of themes and subthemes, and the analysis process as a whole, is presented in the findings chapter (Chapter 4).

This process of structuring the analytic narrative and the selection of quotations and data extracts, together with the reviewing and refining of codes and themes for presentation in the thesis, as described in Phases 3 and 5, can be seen as examples of how decisions made by the researcher in the research process, influence the co-construction of knowledge and what is presented as findings, as argued within feminist philosophy.

3.10.2 Approach to addressing the aim and objectives of research

The six phase data analysis outlined in the previous section, culminated in the conception and articulation of a game, as an overarching conceptualisation of the lived reality and meaning of Lean for nurses, and a broad depiction of the socio-cultural interaction between Lean and nursing. The findings stemming from this analysis therefore broadly addressed the aim of research and primary

research objective identified in the literature review chapter, and are presented in the findings chapter (Chapter 4).

Following the six phase analytical process, attention turned to consideration of the socio-culturally focused secondary research objectives. Although the conceptual foci of these objectives - power and nursing theory - permeate the findings relating to the game, at this later stage, the 'story' of the game was approached specifically with these research objectives in mind. They were effectively imposed upon the data and the game was interrogated in light of the research questions exploring: how power and power relationships could be understood within the game, the nature and role of the interaction between Lean and nursing theory within that lived reality, and the ramifications of these things for the professional project and identity of nurses and nursing. Whereas the six phase analysis focused upon exploring, and producing the researcher's interpretive account of nurses' accounts and enactments surrounding the lived reality and meaning of Lean, this secondary process was intended to further develop the exploration and analysis of the account of nurses' lived reality presented in the findings, through a more critical analysis and interpretation, guided by, and in relation to extant theory, literatures and empirical work. By situating findings in, and critically exploring them in light of, the broader context of theory, literatures and empirical work, the broader meaning of Lean for nurses and nursing could be explored. This secondary process therefore further contributed to addressing the overall aim of research, in addition to the primary and secondary research objectives. In the chapters which follow, the six phase data analysis forms the basis for the findings chapter (Chapter 4). Based on these findings, the discussion chapters (Chapters 5 and 6), reflect the secondary process, exploring the nature and role of power relations and nursing theory within the lived reality of Lean, considered from both the analytical angle of the account presented in the findings, in addition to a more critical perspective informed by extant theory, literatures and empirical work. Drawing on the insights presented in the findings and discussion chapters, the implications and recommendation of the thesis chapter (Chapter 7), considers the meaning of

Lean for nurses and nursing, in terms of their professional project and identity, and as such, attends to the final research objective.

This process reflected, and was consistent with, the role and place of criticality in the research process, informed by feminist rationale, identified in section 3.4.2, which also formed an aspect of 'addressing' the issue of collusion in section 3.9.5. That is, it reflected the balance between, and the taking of both, (the researcher's account of) participants' (accounts and enactments of their) experiences and understandings, and the more critically situated and partial perspective of the researcher, 'seriously' in the research and knowledge production process. This demonstrates a further 'layer' in the process of the co-construction of knowledge – beyond the findings as a co-construction, the knowledge presented in the thesis overall also constitutes a co-construction between the researcher and participants, through the presentation of the researcher's additional, more critical interpretation.

3.11 Summary and conclusion

This chapter of the thesis has described the ethnographic methodology and methods which were adopted to address the aim and objectives of research, and the qualitative foundations and feminist philosophical assumptions which underpinned this research methodology. It has described the setting in which the study took place, the participants that were involved and ethical considerations relevant to the study. An account of data collection and analysis has been provided, together with the role of the researcher within these processes. The next chapter of the thesis reports the research findings.

Chapter 4. Findings

4.1 Introduction to the findings

This chapter presents the findings of the thesis, in relation to the overarching research aim, of exploring the lived reality and meaning of Lean Thinking (Lean) for nurses and nursing in the study setting. The findings also provide a depiction of the nature of the socio-cultural interaction between Lean and nursing, thus broadly addressing the primary research objective. The findings are structured and articulated through the presentation of four themes:

Theme 1. An outbreak of MRSA (Mistrust, Responsibilisation, Surveillance and Accountability)

Theme 2. Paradigms of productivity

Theme 3. Lean-ing on caring

Theme 4. The politic of resistance; waging the nursing defence

These four themes are located more broadly in the context of an over-arching metaphor, of the 'Trust-Nurse Game', which is introduced and explicated in the next section.

Section 3.4.2 of the methodology chapter identified the implications that the feminist philosophical influences underpinning the thesis held for the role and place of criticality in the thesis. Accordingly, the nature of the presentation of findings in this chapter reflects the feminist commitment to exploring and grounding research in participants' experiences, interpretations and understandings of phenomena, and respecting, valuing, upholding and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62). It also reflects the researcher's adoption of the role of learner and supplicant within the research process, and their acknowledgment of reliance upon participants' greater knowledge of phenomena, as a means of assisting in attending to power relations within the research process (identified in section

3.3.3 of the methodology chapter) (England, 1994, Usher, 1997a). These feminist commitments are maintained in this chapter, through presenting and exploring participants' experiences, interpretations and understandings surrounding Lean implementation, before approaching them more critically in the discussion chapters (Chapters 5 and 6).

Section 3.4.1 of the methodology chapter also identified the implications that the feminist philosophical influences underpinning the research held for how the thesis' knowledge claims should be approached and understood. Accordingly, although the research was committed to exploring the experiences, interpretations and understandings of participants, the findings in this chapter are not presented as, or claimed to constitute, a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, more accurately, necessarily and inevitably, the findings constitute *one* (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge.

In this chapter therefore, in the interests of avoiding repetition and fragmentation of the text, references to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should be understood in the context of, and as subject to, this philosophical clarification and qualification.

4.1.1 The Trust-Nurse Game as an orientating and organising metaphor

The findings chapter employs the overarching metaphor of the 'Trust-Nurse Game' (TNG), as a conceptualisation of the lived reality and meaning of Lean for nurses in the study setting.

The four themes of the findings narrate the story of the TNG 'at play', which, more specifically resembled a 'Tug-of-War' between nurses and the NHS Hospitals Trust (the Trust) within which they worked, for power and control over nursing practice. The first three themes of the findings explore insights from nurses' narratives and enactments relevant to the Trust 'side' of the game; the

basis and rationale for the Trust's introduction of Lean-based initiatives (LBIs), the agenda that they were designed to fulfil, and the conceptions of productivity and caring that were perpetuated by LBI implementation. As such, the first three themes of the findings represent the 'pulling force', on the part of the Trust players, within the 'Tug-of-War' characterising the TNG, played for the control of nursing practice. The fourth and final theme of the findings explores the 'other side' of the TNG and focuses on the nursing response to LBI introduction by the Trust.

The conception of nurses' lived reality as resembling a game played by, and between, nurses and the Trust, stemmed from the data analysis process described in section 3.10 of the methodology chapter, and is therefore empirically grounded in participants' accounts and enactments. The naming of the game as the 'Trust-Nurse Game' was however inspired by, and holds resonance with, the work of Stein (1967), surrounding the 'Dr/Nurse Game'. Stein (1967) employs this 'game model' to depict and describe the interaction between doctors and nurses, in their negotiations and management of inter-professional relationships and boundaries, wherein the notion of power forms a prominent influence. The presentation of nurses' lived reality in accordance with a game model also reflects the influence of the work of Foucault, presented in section 2.5.2 of the literature review chapter, who conceives of the enactment of power relations as 'games of strategy' (Foucault, 1997:298).

4.1.2 Reporting conventions

Participant quotations derived from observations and interviews are included in this chapter in order to enhance transparency in the research process by illustrating the findings presented, and displaying and demonstrating examples of the basis upon which researcher interpretations were made (Boyle, 1994). Quotations are presented in quotation marks ('xxx') and are italicised ('*xxx*'). At the end of each quotation, the participant to whom the quotation is attributed is identified in the form of a pseudonym name, presented inside square brackets ([e.g. Tabby]). The decision to refer to nurses in the findings as 'participants',

rather than 'subject', was informed by the feminist influences underpinning the research (described in section 3.3.3), and was intended to reflect their 'participation' in the co-construction of knowledge (Leavy, 2011). Similarly, the decision to use pseudonym names, rather than participant numbers was intended to reflect the acknowledgement of participants as embodied, heterogeneous individuals, and depict and respect them as such, rather than objectified research 'subjects' and 'mines of information' (England, 1994:82), in turn reflecting an awareness and attentiveness to power relations in the research process.

Ward numbers are used to anonymise the names of the three study wards upon which participants worked (Wards 1, 2 and 3). Ward 1 corresponds to the speciality of oncology, Ward 2 to the speciality of neurology and neurosurgery, and Ward 3 to the speciality of palliative care. At the end of quotations, the ward number corresponding to the ward upon which the participant worked, is also identified, alongside whether the quotation was derived from observation (abbreviated to 'Obs') or an interview (abbreviated to 'Int') ([e.g. Tabby. Obs. Ward 2.]).

Within quotations, non-italicised words in square brackets ([xxx]) indicate a substitution or addition by the researcher, for example, for the purposes of providing contextual details relevant to the quotation, or explicating a specialised or abbreviated term used by the participant, to facilitate reader understanding. Footnotes are included to provide further explanations or details where necessary. The use of three full-stops (…) indicates that words have been omitted from quotations, for the purposes of succinctness.

Where quotations form part of conversations between participants, text in square brackets at the start of the conversation provides the context in which it took place (if necessary). Participant details (pseudonym, whether the quotation is derived from observation or interview, ward number) are presented in square brackets at the start of the quotation.

4.2 Theme 1. An outbreak of MRSA (Mistrust, Responsibilisation, Surveillance and Accountability)

This first theme of the findings explores the lived reality and meaning of Lean, in terms of the relationship between LBIs and notions of Mistrust, Responsibilisation, Surveillance and Accountability (MRSA). It describes nurses' depictions as to the intentions, motivations and rationale underpinning the Trust's introduction of LBIs. As such, it represents the establishment of the 'pulling force' on the part of the Trust players within the 'Tug-of-War' which characterised the TNG, played for power and control over nursing practice. This theme therefore 'sets the stage' in terms of cultivating insights into the basis for the evolution and enactment of the TNG, and the premises upon which the nurses' response, presented in Theme 4 of the findings, appeared to be predicated.

4.2.1 Mistrust

This section introduces nurses' claims surrounding the introduction of LBIs, as tantamount to Trust accusations of an insufficiency of productivity and caring within nursing practice. It identifies how the voluminous, mandatory and standardised nature of LBI documentation had come to be described by participants as symbolic of the Trust's lack of trust in nurses' clinical judgement and professional knowledge. Nurses often related these ideas to vilifying national media discourses, surrounding the role of nurses in the failings in care identified by the Mid Staffordshire NHS Trust Francis Inquiry (Francis, 2013), which appeared to reify their sentiments. Owing to these associations, on an individual level, LBIs were identified as a systematic form of sanction for the hypothetical 'bad nurse'. On an organisational level, driven by media scrutiny surrounding the quality of healthcare and requirements of the Care Quality Commission (CQC), nurses reported feeling that through LBIs, they were becoming enrolled to fulfil Trust objectives relating to the visibility of taking positive action towards the 'improvement' of standards within nursing care.

Doubt, dictation and documentation

Organisational artefacts read during the preparatory phase of research (described in section 3.8.1 of the methodology chapter) and present in the study setting, suggested that 'The Productive Ward; Releasing Time to Care' had served as a semantic template for the Trust's naming of other LBIs and the framing of their remit. Project titles heading Trust issued posters and leaflets describing LBIs for example, often incorporated and positioned terms associated with 'productivity' adjacent to those related to 'caring', and this had not gone unnoticed by nurses. These titles, ostensibly communicating organisational priorities and commitments to improving productivity and caring processes, appeared to be imbued with a hue of negative meaning, which radiated from the walls of the ward. Far from representing an 'innocent' statement of intent, nurses suggested that LBI titles were tantamount to the Trust implying a wanting in terms of both their productivity and caring practices, and it was from this interpretation that nurses appeared to infer the Trust's rationale behind LBI introduction. It appeared that project titles had become a rubric for naming, framing and shaming and were read as a professional insult, which simultaneously spoke to and criticised nurses' professional core and central tenets of their practice.

'I mean the word 'productive', is, doesn't really sit very erm happily in the sense of…it sort of implies unproductive.' [Jemima. Int. Ward 2.]

'The Productive Ward's just another idea that isn't suited to some wards. It isn't suited to ours. I don't think we get criticised for not caring.' [Beatrix. Obs. Ward 2.]

Participants suggested that as a consequence of LBI introduction, the administrative demands of their role had increased exponentially, far surpassing a ceiling of benefit for fulfilling nursing functions. The nursing 'documentation ritual', which could be observed during fieldwork, to meet these administrative demands, was accompanied by a host of signifiers and symbols, and its

performance was not spatially or temporally confined to a certain place or time on the wards. Although discrete rooms on the wards were designated as offices, these tended to be occupied by doctors, other healthcare professionals and the Ward Managers, and nurses 'doing the writing' were sprawled across the wards. Although some sat at the Nurses' Station, which incorporated a designated desk area and chairs, the nature of this space belied its name indicating dedicated nursing ownership. Rather, it appeared that this site constituted a shared, communal space, often occupied by other staff, limiting the room available and holding the implication that nurses could be frequently interrupted, by colleagues, relatives and administrative staff, when sat here. In such instances, nurses could be observed to create 'impromptu', temporary sites for performance of their documentation ritual, sometimes dragging a patient bedside table to a space in a patient bay, collecting a plastic chair from the 'stack' available for relatives during visiting hours, in the process. They created 'desks' though resting on low dividing 'walls' at the end of patient bays, or by lifting one knee to lean on whilst standing, or wrote 'on the fly' standing up with files and folders pressed into and held vertically against walls. Others sat at a table or desk area at the end of patient bays, enacting their ritual whilst retaining an 'overview' of and 'keeping an eye' on their patients.

Several 'accessory' behavioural signs accompanied the explicit, physical 'writing' element of the documentation ritual. These included the chewing of pen tops, red marks on participants' elbows and cheeks, from resting their elbow on the table to cradle their chin in their hand whilst writing. Nurses flexed and stretched their fingers periodically and crossed and uncrossed their legs restlessly, as they flicked back and forth through the pages of documentation, assigning and scribbling their signature in the process.

The emphasis on standardisation within Lean principles (identified in section 2.2 of the literature review chapter), was reflected in the organisational artefacts informing the preparatory phase of fieldwork, and on the wards, organisational artefacts such as standard operating procedures, protocols and documentation could be seen. In addition to participants suggesting that LBI introduction had

increased the administrative demands of their role, they explained how they considered the standardisation which accompanied paper-based bureaucracy, to be unnecessary, and this appeared to reinforce their suggestions as to Trust doubt surrounding their productivity and caring practices. Participants implied that the uniformity of LBI documentation was purposively directive and paternalistic, leaving little margin for the exercise of clinical judgement, or enactment of professional autonomy. They seemed keen to demonstrate the nature of their documentation to support their assertions, and urged for me to look through pre-prepared documentation packs with them during our discussions, which had been compiled ahead of time in preparation for new patient admissions. The charts, boxes and pre-printed lines populating these pages appeared faded and 'wonky' in their orientation, accompanied by printing ink blotting, splodges and smudges, suggesting that they had been both hurriedly (or apathetically) photocopied and reproduced many times. Indicating the thickness of the paperwork pile with their index finger and thumb, participants thumbed through these documents in order to illustrate to me how LBI projects and documentation variously instructed nurses as to *what* they must do, *how* it must be done, *when* it was required, the *frequency* with which it must be performed, and in some cases, for what *duration*. Accounting for the *why* of this authoritarianism, nurses implored that standardised LBIs were indicative of the Trust's attempt to control their practice, spurred by doubt surrounding, a lack of trust in, and diminished respect for, their professional knowledge, expertise, initiative and skill. Nurses' identification of the mandatory status of LBIs, implemented *'from above'* [Camilla. Int. Ward 3.], appeared to intensify these suspicions of mistrust. Akin to diktats, it seemed that LBIs had come to symbolise an inanimate form of control, operationalised via the dictation of care activities and removal of professional autonomy. Consequently, nurses described feeling personally patronised, insulted and frustrated, and professionally devalued and undermined.

'They don't let you use your, you know, initiative. I mean, you've trained to be a nurse, you've got skills. You want to use your intuition. You're not allowed to use those, you've got to tick the box and I find that quite frustrating.' [Milly. Int. Ward 3.]

'It's ridiculous. Every day, we have to do falls assessments on unconscious patients, pressure ulcer assessments on patients walking around. We're not allowed to use our initiative anymore.' [Anna. Obs. Ward 2.]

'I think with nursing too, we're not trusted…We don't get trusted with anything.' [Margaret. Obs. Ward 2.]

The way in which nurses described interpreting the Trust rationale underpinning the introduction of LBIs, as an attempt to control their practice, directly contrasted with organisational rhetoric concerning the engagement and empowerment aims of the Working With You project and LBIs, contained in the organisational artefacts read, and insights gleaned from the training and consultation events attended, as part of the preparatory phase of fieldwork, as described in section 3.8.1 of the methodology chapter.

Sanction

Participants related their pronouncements surrounding the Trust's mistrust of nurses, and the subsequent attempt to control practice through LBIs, to wider contemporary media discourse following breaches of care identified in the Francis Inquiry (Francis, 2013), at Mid Staffordshire NHS Foundation Trust. These events seemed to weigh heavily in participants' consciousness and were referred to in a self-conscious way, sometimes almost apologetically and ashamedly, with participants looking downwards or lowering the volume of speech when they were discussed, and more defensively at other times. From this discourse, participants referred to the emergence of the imagery of the deviant 'bad nurse', which they argued was perpetuated by disparaging media reportage surrounding the nursing profession. They maintained that this image

was gaining prominence as a connotation of the image of nursing within societal consciousness. When combined with the increase in scrutiny of practice from the CQC, nurses suggested that the introduction of LBIs could be explained as a consequence of the Trust having to be *'seen to be doing things'* [Camilla. Int. Ward 3.], regarding the instigation of remedial action to improve the accountability and quality of nursing care. This was depicted as an organisational exercise in restoring public faith and allaying social concern, through remedying the unproductive and uncaring 'bad nurse', via the control and dictation of nursing practice.

'It's all changes. I think a lot of it's quite hard going on the nurses…It's all the CQC with Mid Staffs and that.' [Poppy. Obs. Ward 3.]

'It's very much a paperwork exercise, it's not actually to do with patient care and it's a tick box so ***they*** *can say to whoever "We've done this, we've done this.".'* [Milly. Int. Ward 3.]

'The way the media treat it…it's only since the Francis report…and the [name of newspaper] *is the culprit…we've been erm demonised and it is the horrible nurses, the uncaring nurses, the uncompassionate nurses.'* [Jemima. Int. Ward 2]

Nurses acknowledged a positive function of LBI documentation in principle, in terms of its potential to make visible and expose the 'bad nurse' providing poor standards of care. The system-wide, non-discriminatory approach to LBI implementation however, was identified as an unwarranted, collective, blanket punitive measure, imposed upon nursing in its entirety, owing to the actions of a 'bad nurse' minority.

'I think obviously it's accountability, um, which is good um…I suppose it, in a way, it would be more highlighted that they're not doing a lot of the stuff that they should be um, but then also for the people that do work really hard, it's just more and more paperwork and I'm pretty much sick of it to be honest.' [Camilla. Int. Ward 3.]

Overall, nurses reported feeling that LBIs served on behalf of, and for the benefit of, the Trust - as a means of control and sanction, for the purposes of corporate accountability and organisational objectives, rather than for the end of patient care *per se*. Nurses described their predicament as untrusted automatons, and their descriptions of the Trust-nurse relationship resembled and invoked the imagery of a puppet and ventriloquist puppeteer.

'I mean nursing's very different to what I thought it'd be…I didn't think we'd be so swamped down with documentation that repeats itself…I had visions that I'd be sitting there holding patients' hands and, and making a real difference to their quality of life…I had visions more that I'd have the voice to be able to implement what they needed more, but actually my voice is just used to implement what the Trust needs, not the patients.' [Lucy. Int. Ward 2.]

'We're subject to these policies and we're just to act them out really.' [Kathy. Obs. Ward 3]

4.2.2 Surveillance (of surveillance); LBI or FBI[2]?

The previous section identified nurses' arguments surrounding ways in which LBIs functioned for Trust prerogative. Participants suggested that implementation simultaneously constituted a mechanism of control through the dictation of practice, a means of enhancing the visibility of efforts to improve nursing care quality, and a mode of sanction for the 'bad nurse'.

Additionally, the way in which nurses described the mandating of patient care in accordance with standardised LBIs, could be seen to resemble a form of Trust surveillance of person and practice - an attempted exercise in omniscience, in order to achieve total cognisance and control of nursing activities. Participants identified additional, secondary mechanisms of surveillance, which potentially

[2] The Federal Bureau of Investigation (FBI). A national American intelligence-driven security and law enforcement organisation. The FBI employ specialist intelligence and surveillance agents, responsible for collecting, analysing and disseminating intelligence data, as part of surveillance operations. Information from: http://www.fbi.gov/about-us and https://www.fbijobs.gov/explore-careers/ps-investigative.asp.

had the effect of coercively promoting compliance with LBIs, as the primary form of surveillance. This 'surveillance of surveillance' could be observed to manifest in three ways; through auditing activities, via inter-collegial scrutiny, and by direct, officialised observation by Trust project nurses, nick-named by participants as the 'Polka-Dot Police' (PDP).

The Polka-Dot Police

The 'Polka-Dot-Police' (PDP) is a pseudonym for the nickname that nurses assigned to Trust Project Nurses, which was derived from characteristics of their nursing uniform. Their official function was to support the implementation of LBIs across the wards within the Trust. They observed and audited nursing practice, and were responsible for conducting 'time and motion studies', for example. These involved shadowing nurses and counting the number of steps taken during care processes, as a baseline for evaluating motion saved following the introduction of LBIs.

Nurses appeared to be acutely aware of and sensitive towards, the presence of the PDP when they visited the wards. The arrival of the PDP, for example, was accompanied by a number of observable changes in nurses' behaviour, which appeared to act as a chain of signifiers in communicating, warning and alerting other nurses to the PDP's presence. On first glimpsing the PDP, nurses responded by turning their heads, glancing at each other 'knowingly', and gaining and fixing eye contact momentarily, sometimes with a slight nod of the head or widening of the eyes, before continuing with their nursing tasks. Other participants physically visited colleagues' bays to verbally inform them of the PDP's arrival.

Subsequently, the rhythm and routine of the ward appeared interrupted and nurses could be observed to commence 'spot checking' rituals - of the patient bay for which they were responsible and of their person. In their bay, equipment associated with an LBI focusing on hourly rounding was adjusted to ensure a more prominent position or angle, and any 'clutter' (unused cutlery,

food wrappers, spare dressings, for example) was cleared from the surrounding area. During personal 'spot checks', nurses hastily raised their hands to pinch their earlobes and pat their neckline to ensure compliance with the Trust 'no jewellery' uniform policy. Indeed, having initially mistaken me for a clinician, I was asked by the PDP during one visit to remove my watch, to comply with the Trust's 'bare below the elbows' infection control policy, which I duly did. When I recalled this to one of the participants, they joked sarcastically 'Why don't you just strip naked!' [Emily. Obs. Ward 2.], seemingly trivialising the nature of these requests. As a consequence, I too sometimes found myself self-consciously performing the spot-checking ritual at the start of future visits.

Nurses continued about their work around and about the PDP, the world of the ward revolving around them, with participants glancing across to 'clock' and check their location sporadically, and the PDP appearing as the 'elephant in the room'. Participants walked past the PDP when they sat at the Nurses' Station holding their head in the direction of travel, as if in an attempt to make themselves inconspicuous, and at other times extended their neck to peer momentarily over the desk, as though attempting to gain advanced knowledge or reassurance regarding what and whose documentation was being reviewed. During this time, nurses did not engage in the social conversations that sometimes accompanied their informal meetings at the Nurses' Station during shifts, but migrated back when the PDP moved to patient bays. When the PDP retreated to the ward doctor's or Ward Manager's office, nurses' 'knowing' glances and 'warning behaviour' tentatively and temporarily ceased. When they left the ward, a palpable sense of tension was relieved, and the wards reverted back to their previous rhythm and routine.

Inter-collegial scrutiny and informal social control

Nurses explained that they were required by the Trust to audit LBI documentation for the purposes of ascertaining levels of compliance, which could be deciphered at the level of individual nurses or at ward level, by summating results to provide a calculation of overall ward adherence. Ward

results were displayed on 'Performance Boards' in the clinical area and submitted to the Trust for review. Similarly, participants explained how, in accordance with an LBI focusing on accountability, when handing over care at the end of a shift, oncoming nurses were required to examine a portfolio of documentation. They were to ensure that it had been completed satisfactorily by the outgoing staff member, then record a signature to indicate that this procedure, and the transfer of accountability, had occurred. This procedure was reinforced by an organisational artefact in the ward area - an A3 size poster incorporating the Trust logo and LBI logo, together with an algorithm presented in the form of a flow chart, identifying the procedure which should be followed. During these processes of 'surveillance of surveillance', nurses could be seen to act as devolved agents of the Trust, and were responsible for the surveillance of compliance with LBIs, as the primary form of surveillance of practice, 'from within'.

Beyond ascertaining conformity, these processes of self- and peer-surveillance may have acted as informal mechanisms of social control at individual and ward level. Care which had not been completed as prescribed by LBIs, was made evident and tangible 'at a glance'. This potentially promoted and incentivised adherence to LBIs as the primary form of surveillance, through the threat of sanction, peer-judgement and labelling as a 'bad nurse' or 'bad ward', should inadequacies be 'exposed' by these processes. Nurses seemed acutely aware of the potential for them to 'expose' any shortcomings in colleagues' practice through this apparent peer-surveillance function of LBIs, with participants smiling apologetically to each other in a resigned fashion, before starting the review of documentation associated with the new accountability handover LBI, for example. The threat presented by this secondary layer of surveillance therefore might be interpreted as an organisational procedure to reinforce the efficacy of, and compliance with LBIs, as the primary form of surveillance of professionals and their practice.

'[We complete] *audits to say that we've done what we should do, or we haven't done this, or we haven't done that…a lot of it is looking at paperwork and making sure that things have been done properly…we're the ones that are expected to do that.'* [Jessie. Int. Ward 1.]

'It's about making sure that everything's done perfectly. So there's less trust because it's more trackable.' [Margaret. Obs. Ward 2.]

4.2.3 Accountability and *'passing down the blame'* [Beth. Obs. Ward 3.]

Beyond controlling practice and promoting conformity, nurses related the surveillance associated with LBIs to a Trust prerogative to identify and apportion blame for error or inadequate completion of LBI dictated care, on an individual rather than organisational basis. Nurses suggested that the surveillance functions of LBIs acted to scaffold and support the shifting of accountability and responsibility from the organisation to the individual, which participants contrasted with Trust rhetoric surrounding an organisational commitment to a *'no-blame culture'* [Margaret. Obs. Ward 2.].

Although nurses appeared to concur that documentation could be valuable in terms of identifying the 'bad nurse', they also expressed concern that Trust surveillance procedures did not allow for an appreciation and understanding of the context in which care took place. They suggested that often, reasons and explanations as to why LBI documentation, procedures or care, might not have been completed, related to the care context, rather than individual oversights or failings. They contested for example, that *'missed stuff'* [Suzie. Obs. Ward 1.] did not usually indicate forgotten tasks, rather, that the high nursing workload dictated that they prioritise some aspects of care, leaving others uncompleted. Nurses explained that this (mis)attribution of causality to individual failings, rather than the organisational system or care environment, could lead to the 'mistaken' identification of an individual as a 'bad nurse'. This apparent neglect of concern for understanding the context in which care was (not) provided, appeared to have fostered a sense of injustice amongst participants and

galvanised their assertions as to LBIs representing the Trust's preoccupation with blame, rather than 'genuine' quality and safety improvement, as espoused in LBI organisational artefacts and mirrored in the consultation and training events attended during the preparatory phase of fieldwork.

'*They were doing a Root Cause Analysis on a man here…He had a fall; why? She needed to ensure the* [physiological vital signs recordings] *were done via the correct procedure. And what begrudges me about Root Cause Analysis and nursing documentation, is that there's not enough looking at if a procedure isn't followed, why it's not followed…They're not interested about the circumstances why it's not happening, so what nurses were prioritising at that time. It's just bare facts, not what was going on on the ward at the time.'* [Jeremy. Obs. Ward 3.]

'It's all about accountability…It's blatantly to flag up people who regularly don't update stuff. It's not out of choice, you don't look at, "Oh, this [nutrition assessment is] *due" and decide "Don't do that"*.' [Margaret. Obs. Ward 2.]

4.2.4 Responsibilisation and expected voluntarism

Paradoxically, although nurses reported feelings of mistrust in relation to their clinical practice, they suggested that LBIs had fostered proliferation within the nursing role, in terms of remit and responsibility. Many additions were however of a non-clinical nature and this appeared to inform nurses' arguments that such activities, lying outside of the traditional nursing remit, sat more appropriately and comfortably within the organisational remit of the Trust. In this way, it appeared that LBIs had come to represent an increasing agitation and displacement of boundaries between Trust and nursing remits, roles and responsibilities. The expansion of nurses' administrative and surveillance responsibilities, and the shift from organisational, towards individual accountability and responsibility, for example, have been described. Participants presented other examples however, of ways in which LBIs were moulding the nursing role in further, more tangible ways.

Participants identified how LBI projects required that they adopt additional roles which, in turn, ascribed specific responsibilities to individuals. These included, for example, the 'Productive Ward Lead for Personal Hygiene' and the 'Productive Ward Lead for Mealtimes'. Participants also described the investment of time required for 'front-loading' projects in terms of their introduction, instalment, implementation and integration into practice. They suggested that the increased demand that these activities and roles placed on their time, had not been recognised by the Trust however; participants' clinical workload remained unchanged and protected time away from their clinical duties had not been provided. Indeed, I observed that nurses sometimes continued working on a voluntary basis after their shift had ended, which they argued was a consequence of LBI introduction, and was necessary in order to ensure the completion of clinical tasks, bureaucratic demands, coupled with additional LBI roles. In failing to acknowledge and compensate for the time commitment required for LBIs, there was a sense that voluntarism had become expected by the Trust.

'Umm, I think there's a lot of umm, other roles that they're sort of putting on people and I've got my own role…but I think you kind of, sometimes can get taken away from your actual job um and not be given those extra hours to do infection control or you know, [documentation associated with an LBI]*…I prefer just to look after the patients…Sounds really lazy, but I just don't want to be staying late just to be filling in audits and things.'* [Camilla. Int. Ward 3.]

'Since [name of LBI]*, 90% of the time, no one's left on time. Our shift finishes at 8 and we've been leaving at 8.30…it just takes so long*.' [Mavis. Obs. Ward 3.]

'We've got [name of LBI] *now, that's, that's new and that's eating into our time…And then you're finding you're still getting off after when you finish. Not massively long after but it's significant when you've got to go home and come back again after a long-day and then be on another long-day, it does affect you mentally I think.'* [Mary. Int. Ward 3.]

The need for voluntarism to ensure the completion of documentation before leaving at the end of a shift, appeared to be reinforced by a mantra of nurses' professional socialisation: 'if it hasn't been recorded, it hasn't been done'[3]. This could be heard to be recalled by nurses to colleagues as a justificatory response at the start of a new shift, when 'remnant nurses' from the previous shift remained on the ward to complete their documentation, or when nurses delayed their breaks, and were questioned by colleagues as to 'why' they were still on the ward. Given that these 'remnant nurses' could overtly and explicitly be seen to be completing documentation however, the questioning of 'why' they were still on the ward by colleagues, appeared to serve a rhetorical function, perhaps demonstrating their awareness (and concern), for the remnant nurse who remained on a voluntary basis to complete their work after their shift had ended.

4.3 Theme 2. Paradigms of productivity

The first theme of the findings explored the lived reality of Lean implementation, in terms of the relationship between LBIs and notions of Mistrust, Responsibilisation, Surveillance and Accountability (MRSA). This second theme of the findings explores the lived reality of Lean, in terms of insights from nurses' accounts and enactments surrounding the nature of the Trust's conception of productivity, the purpose that it served, and the agenda that it contributed to, informed by their experiences of LBI implementation. Insights surrounding nurses' own conceptions of productivity, and its purpose and place within nursing culture, are also explored. Within the metaphor of the 'Tug-of-War' for control of nursing practice that characterised the TNG, this theme again represents part of the Trust effort and provides further insight into the premises

[3] Variations of words to this effect can be seen in nursing professional literature and guidance, for the purposes of communicating the legal importance of record keeping to professional practice (e.g. Andrews and St Aubyn, 2015, Bird, 2012, Glasper, 2011, Thomas and Snelling, 2017). These discussions are often linked to the Nursing and Midwifery Council (NMC) (the regulating body of nursing) Code of Conduct (NMC, 2015:1) which articulates 'professional standards of practice and behaviour' to which nurses must commit and uphold, in which record keeping features prominently.

upon which the nursing response, detailed in Theme 4, appeared to be predicated.

4.3.1 'Productivity' as a point of unity?

Lean appeared to occupy a differential existence in the study setting. It quickly became apparent that opinions that nurses reported concerning Lean 'in theory' differed from, and were somewhat more positive than, those surrounding LBIs 'in practice'. When discussing the notion of 'productivity', which underpinned LBIs 'in theory', participants made two conceptual associations: 'productivity as releasing time' and 'productivity as releasing money'.

Productivity as releasing time; 'less toing and froing' [Alice. Int. Ward 2.]*, 'stocking up'* [Mavis. Obs. Ward 3.] *and 'being tidy'* [Mary. Obs. Ward 3.]

The Lean inspired 'productive pursuits' of reducing motion, improving work organisation and environmental re-design, were reported to be congruent with improving the quality of nursing care. In their talk, participants made a positive connection between the concepts of productivity and caring, which hinged upon the identified potential for productivity improvements to increase time available for engaging in direct patient care. It was this positive association between productivity and caring, which appeared to allow participants to conceive of 'productivity as releasing time' as amenable to nursing, and being productive as a central facet of the 'good nurse'. Amidst nurses' contentions surrounding LBIs 'in practice', reported in Theme 1, the parity of emphasis placed upon 'productivity' by both the Trust and nurses, seemed to form a rare point of cohesion, uniting their agendas.

'So you're not spending lots of time looking for things. Everything's in, where it should be. We all know where we can find things so we're not spending hours looking for one thing, walking all the way up the ward to find something else…So it's supposed to make your job very, a lot easier, so that you then have time, that time that you were spending looking for things, you're actually supposed to have

that time to, to look after patients…So I think the principle is really, really good.' [Jessie. Int. Ward 1.]

Productivity as releasing money; the business of caring

The notion of productivity underpinning LBIs also appeared to hold a corporate, 'business' connotation for nurses. Participants associated 'productivity as releasing money' with the business of caring, articulated as the need to contain financial costs and rationalise care at the Trust, and within the National Health Service (NHS) more broadly. This financial agenda that nurses associated with 'productivity as releasing money' underpinning LBIs, was reflected in the organisational artefacts informing the preparatory phase of fieldwork, identified in section 3.8.1 – Working With You had been introduced (in part) in response to financial pressures, to reduce costs and improve efficiency.

Whilst the acceptability of 'productivity as releasing time' appeared to form a point of consensus amongst participants, their reports as to legitimacy of the 'business of caring' as a nursing responsibility and concern, in terms of making proactive efforts to improve productivity through reducing financial waste, were not as uniform. Most nurses demonstrated an awareness of financial costs attached to the equipment and resources that they used on a daily basis however, regardless of their apparent opinions as to the palatability of 'productivity as releasing money' to nursing.

'I think I'm quite aware of money, of using things, more when it comes to using syringes and dressings…We use this stuff called [Intravenous Immunoglobulin] *and it's £20,000 a course. I'm always aware of that.'* [Margaret. Obs. Ward 2.]

Within nurses' narratives, opinions expressed surrounding the amenability of the business of caring to nursing pivoted upon ideas as to the impact that the business of caring had upon quality of patient care - at the point of delivery, or for one nurse, at national level. These opinions fell within three variations. Two groups of nurses employed the notion of caring as it pertained to the level of the

individual patient. Nurses in the first of these groups seemed unable to forge a positive link between 'business' and 'caring'. Rather, they connected reducing financial waste with patients 'going without'. They subsequently disregarded the business of caring as a nursing agenda, which they rationalised through recourse to prioritising the quality of patient care at an individual level. The vigour with which these participants denounced the business of caring suggested that although it may be of concern to the Trust, it was antithetical to caring and the characteristics of the 'good nurse'. For this group of participants, it appeared that 'productivity as releasing money' was a redundant concept in the context of nursing and could equate with the notion of the 'bad nurse'.

[Researcher]: *'Do you ever think about finances?'*

[Suzie. Obs. Ward 1.]: '*Finances? No, you do what you do don't you. I don't know how much stuff costs. Some of the dressings in the cupboards have got stickers with the costs on but I don't know what they cost. You care because you care don't you, you don't come into the profession to think about cutting money and saving costs.'*

'If we need it, then we need it and I will argue with anybody that kind of says "Actually do you really need that?"...When I'm working on the ward, I don't think "I can't do this for this patient because it costs such and such an amount of money". If patients need it, then they need it, and if we've got it, then we'll give it…it doesn't come into the equation.' [Jessie. Int. Ward 1.]

The second group of nurses acknowledged the business of caring as an important contemporary issue, and as something that they 'should', and did, attend to. They reported engaging with the financial agenda however, only so long as it did not impact upon the quality of patient care at individual level. At the point where negative implications for quality of care were identified, these nurses withdrew from contributing to the concerns of the business of caring. This group of nurses therefore made a positive but fragile connection between financial issues and the notion of caring. These narratives suggested that the

'good nurse' heeded and contributed to the 'productivity as releasing money' agenda, but only up until the point at which it may start to conflict with nursing as caring.

'I am conscious of, sort of, the amount of linen and waste that we have um, but, if somebody needs something, they can have it pretty much. I don't, I wouldn't not give it to [patients] *because of the cost. Like some of our drugs are really expensive, I wouldn't think "Ooh let's try this first"…Um, it is in my mind but um, only on quite a small level I think.'* [Camilla. Int. Ward 3.]

Although these nurses did not always articulate the rationale underpinning their sense that they 'should' attend to reducing financial waste, some acknowledged the role that nurses could play in rationalising healthcare. Others however, identified it as a duty, informed by pro-social logics and principles of ethical consumerism. Still others related the agenda to a personal philosophy of 'waste not' vested by contemporary times of austerity, which had diffused from their personal to professional life.

'It's not just the crisis in the NHS, it's the economic crisis worldwide. Everything's having to rationalise resources. In my private life, I have to think "Can I afford that and that?"…But everyone's aware that resources are finite. You naturally tend not to be wasteful if you can. It spills over from your private life, it happens as you would normally.' [Elizabeth. Obs. Ward 2.]

The final variation in opinions reported surrounding the 'fit' between nursing and the business of caring, took the form of a 'deviant case'. One nurse made a positive association between 'productivity as releasing money' and caring, at a societal level. They alluded to the notion of equality in healthcare provision: nurses' proactive attempts to reduce financial waste could release money, to increase the total 'amount' of healthcare available, allowing 'more' patients to be cared for by the health service, spreading finite resources more 'equally' across society. This participant appeared to feel that 'productivity as releasing money' could therefore be amenable to nursing, in the sense that through

promoting equality, it positively contributed to caring at a societal level. This association was fragile however. As per the second group of participants, agreement with the business of caring was caveated by the consequences that 'productivity as releasing money' could have, for the quality of patient care at an individual level. The envisaged population level benefits of engaging with the business of caring, appeared only to be valid therefore, in a nursing sense, if efforts to reduce financial waste did not compromise the quality of care for individual patients. This nurse identified an industrial and mechanistic approach to patient throughput, turnover and care, as one way in which quality of care could be compromised as a corollary of the business of caring.

'It's about how to save money…I think every day, with everything we do…if this dressing's cheaper than that dressing, but they do the same thing, then you should always be using the cheaper dressing, because otherwise, somebody's not going to get the dressing at all down the road…We are aware of the cost of equipment, of resources…I think that you have to be productive…but I think patients feel like they are on a conveyor belt of productivity; "Get them in, get them out", "Oh, you want the bed, quick, that's why you're rushing me out isn't it?" and you're then having to sit down and say "I'm not rushing you out. If you don't want to go then you can stay. If you need more support I can arrange that for you"…It kind of, it flips the way that you look at it, if that makes sense.' [Lucy. Int. Ward 2.]

This logic essentially represented the attempt to balance (and reconcile tension within) the relationship between the principles of *equity* (the prioritisation and allocation of financial resources according to individual needs) and *equality* (as described above), in healthcare provision. For this nurse, it seemed that the mediating factor which determined which principle was ultimately prioritised, was the *quality* of nursing care received by individual patients. This nurse acknowledged the Trust's organisational emphasis on population level equality, which she suggested underpinned LBIs, but this could conflict with the nursing emphasis upon equity. It appeared therefore that equality was supported until

the need for an equitable approach became apparent, driven by nursing conceptions of quality in the caring process. For this participant therefore, the 'good nurse' considered issues of equality and social justice.

Overall, the 'releasing time' connotation of 'productivity' underpinning LBIs appeared to have been received more favourably by nurses than its 'releasing money' association, owing to the positive, tangible correlation, made between releasing time, and quality of nursing care. This synonymity between 'productivity as releasing time' and nursing, seemingly allowed nurses to cognitively *'tailor it to nursing meaning'* [Milly. Int. Ward 3.], and conceive of productivity positively. This stood in contrast to the apparent tension and dissonance which could ensue when nurses described the relationship between 'productivity as releasing money', and the potentially negative effects of reducing financial costs, on the immediate quality of patient care. Although nurses indicated an acceptance that 'productivity as releasing money' could be amenable to nursing, this was only to the extent that it did not impact upon the quality of individual patient care; they appeared to prioritise nursing values of equity and quality of care, over organisational values of equality and quantity of care. Nurses therefore seemed less able to reconcile the business of caring with nursing, since 'productivity as releasing money' could be detrimental to their caring agenda.

4.3.2 Creating the right image; the busyness of caring as the sight and sound of nursing productivity

The previous section described the associations that participants made between the notion of productivity underpinning LBIs, and releasing time and money. The 'productivity as releasing time' synergy appeared significant in nursing culture, beyond its affiliation with LBIs however. The notion of productivity, acknowledgement of its value as a means of releasing time, and the subsequent association between productivity and caring, appeared to be embedded within the socio-cultural work ethic of the 'good nurse', outside of any LBI-driven

influence. This may go some way in explaining participants' apparent receptivity to this principle of Lean 'in theory'.

'In practice', during fieldwork, the 'busyness of caring' appeared to constitute a practical means through which nurses could achieve 'productivity as releasing time' and increase the amount of time available for caring. This was beyond the LBI-derived activities of reducing motion, improving work organisation, and environmental re-design. Busyness also appeared to serve socio-cultural functions - it acted as a nursing form, technique or strategy for ensuring, enacting and demonstrating the 'productivity' that was central to the presentation and identification as a 'good nurse'. It appeared socio-culturally important for nurses to display and enact busyness as the embodiment and incarnation of 'productivity' and the 'good nurse'.

During fieldwork observations, nurses artfully created, and verbally narrated, an image of nursing productivity, premised upon the cultural notion of busyness. Strategies employed to physically demonstrate busyness often equated with speed and *'the quickest way'* [Alice. Int. Ward 2.]. They included nurses walking thought the ward at an ultra-fast pace whilst swinging the arms purposefully, multi-tasking by concurrently holding a phone to each ear, and walking down the ward loudly calling colleagues' names to request assistance. One nurse employed the acronym *'AASAP'* [Sybil. Obs. Ward 2.], when ASAP (as soon as possible) would apparently not suffice. Others added completed tasks to their nursing 'to do' lists, making their productivity and busyness tangible to the self and to others, when periodically reviewed with colleagues. 'Busyness' was also evident in nurses' talk, and self-talk, contributing to a 'busyness' narrative, or stream of consciousness.

[Talking to self regarding break time]*'*[I've had] *10 minutes but it's enough to keep me going until 12. I'll do a handover to* [colleague] *and* [colleague] *quick quick, then I'll do a ward handover, then I'll do a bedside handover.'* [Winnie. Obs. Ward 1.]

[Researcher offered chair to nurse] *'Oh no, it's ok, I never sit down. I don't have time to sit down.'* [Then continued to work standing up at the desk for some time] [Delia. Obs. Ward 1.]

It was also commonplace throughout fieldwork visits, to hear participants narrate 'martyr stories' relating to ways in which they prioritised patients' needs over their own, for example, through voluntarism, not taking breaks and waiting for several hours before going to the toilet, which reinforced their illustrations of busyness. Being a busy martyr, and creating time for patient care, by putting patient need before one's own, appeared to be a socio-culturally desirable trait, associated with the 'good nurse'.

'I did a shift [during the school holidays]*…but I've got a bad back. It was so bad the other day, it was killing me, I could have cried.'* [Suzie. Obs. Ward 1.]

The notion of busyness was also incorporated into nurses' humour surrounding their socio-cultural work ethic, and depicted an association between the absence of busyness and the 'bad nurse'. Sarcasm, irony and teasing could be heard surrounding intimations of 'laziness', and by association, the 'bad nurse'.

[A nurse's name had been omitted from the break allocations white board.]

[John. Obs. Ward 3.]: *'Why isn't* [Peter] *allowed a break?'*

[Katrina. Obs. Ward 3.]: *'Because he's not worked hard enough!*'

[Peter. Obs. Ward 3.]: *'I've had one this week, that's enough for anybody!'*

[Kathy. Obs. Ward 3.]: *'Why are you on every computer* [Jeremy]*?'*

[Jeremy. Obs. Ward 3.]: *'Because I'm the only one that's doing any chuffing work!'*

[Kathy. Obs. Ward 3]: *'On eBay!'*

This may also have served as an informal means of socialisation, behavioural regulation and cultural reinforcement, premised on the potential for public ridicule and exposure, should an individual not confirm to the socio-culturally accepted nursing work ethic. Indeed nurses were quick to identify individuals who did not conform to accepted work standards; those who were *'not…so hot on things'* [Alice. Int. Ward 2.], those who *'weren't doing the assessments as much as they should be'* [Mary. Int. Ward 3.], that were *'bone idle'* [Poppy. Obs. Ward 3.] or were one of *'a few lazy staff nurses'* [Camilla. Int. Ward 3.]. Participants' narrations surrounding the busy martyr therefore may have served to 'stave off' this potential to be labelled as 'lazy' by peers.

Demonstrations of 'busyness' could be observed to become increasingly frequent, frantic and pronounced in response to certain environmental cues, which corresponded with changes and fluctuations in the events occurring on the ward. These cues could therefore be interpreted as symbolic indicators, predictors of and precursors to increased busyness behaviours. During apparently 'quieter' periods, which corresponded with a slower 'tempo' of the pace of nursing activity, the steady and repetitive bings and bongs, hisses and hums, of electronic medical equipment (oxygen delivery systems, intravenous infusion pumps, nebulisers, for example) were audible and provided a backdrop to the conversations and work of the ward. When these sounds could be heard, they contributed a sense of calm and comfort to the atmosphere of the ward, indicating the absence of emergency and 'problems' generally. The faint sound of multiple patient radios, carrying a jumbled sound of music, flowing from different bays and rooms on the wards could be heard, as could patient call bells (used by patients to indicate a request for nursing assistance) in steady succession, making audible patient need. The sound of a call bell corresponded with the illumination of red lights on the ceiling of central ward corridors and above room doors, indicating the location of the requesting patient and guiding the nurse to their destination. Nurses entered and exited the bays, carrying with them plastic gloves and aprons, and pushing commodes on wheels, symbolic of the nursing work to be performed. Their shoes squeaked rhythmically as they

walked, indicating their pace, perhaps providing advanced notice and reassurance to patients that they were soon to arrive. When the telephone rang, this was for a short duration, as it was promptly answered by ward administrators or nurses in an efficient manner. When together at the Nurses' Station, patient thank you cards, newly added to the ward notice board, or standing proudly propped up at the nurses' station, would be read, and nurses reflected, reminisced and shared memories of nursing past, whilst wishing patients and their relatives well in the future.

If a nurse pointed out their awareness of the 'quietness' or 'lull' in the days' busyness, other participants reprimanded them jokingly, and reminded the 'offending' person of what could be interpreted as a nursing superstition – it appeared that the utterance of the word 'quiet' was believed to provoke and preclude a sudden increase in the busyness of the ward, akin to 'tempting fate'. It was therefore preferred that it instead be referred as 'the Q word' in nursing parlance, in order to avoid 'jinxing' the remainder of the days' shift. I too was reprimanded by participants on one occasion, when I made such an observation regarding the atmosphere on the ward compared to the previous day, for 'forgetting' the superstitious connotations of the 'quiet' word that I had used.

Environmental cues and events which appeared to act as precursors to increased busyness behaviours included 'flurries' in patient admissions and discharges; 'peak times' for patient care provision, such as first thing in the morning when patients required assistance with washing and dressing; patients returning from, or requiring assistance with preparation for theatre; the start of a meal service and relative visiting time. These events were accompanied by a tangible change in the tempo of ward activity and its sights, sounds and smells. At meal times, the smell of hot food wafted through the ward for example, which later mingled with relative's perfumes. Patient call bells became more constant, the ceilings illuminating with several lights at once and as one was silenced, another quickly took over in succession. The ward doorbell could also be heard as relatives arrived at the ward door and waited for a nurse to let them in using their electronic key card, or requested permission via a crackling intercom system for

entry. At the nurses' station, telephones were left ringing, as nurses rushed past with their hot red faces and their plastic aprons sucked to their uniforms with the pace of their progress down the ward. In the afternoons, on days where administrators had worked 'early' shifts and had gone home, or when there was no administrative support on the ward, this gatekeeping and security function became a nursing responsibility. When I arrived on the wards during such times, the wait at the door could often be long, as I duly heeded and abided by requests on laminated signs to press the doorbell or intercom button only once and await entry. As I stood at the entrance to Ward 2 on such occasions, anonymous blue flashes of nurses' uniforms frequently streaked past glass panels on the door, providing a glimpse of the 'inside' busy ward world awaiting me. It seemed that during these times of busyness, some nurses became alive, as though thriving on the adrenaline of the situation. Others however reacted differently in their demeanour, appearing flustered and appealing to colleagues for assistance. At times, they appeared to spin in circles – first walking one way, then turning around in the opposite direction after just a few steps, as though changing their mind about which task to prioritise next.

During these flurries of busyness, nurses could be interpreted as seamlessly morphing into a Jack (or Jill) of all trades. They donned the role of domestic staff clearing up spillages, catering staff serving meals, administrative staff answering phones, security staff and gatekeepers answering doorbells, porters transporting urgent medical samples and patients, stock checkers and shelf stackers, auditors and student teachers.

As periods of busyness began to subside, so too did the patient call bells. The bings, bongs, hisses and hums of medical equipment once again became calmingly audible. Nurses de-robed from their aprons and congregated at the Nurses' Station. Some began completing their nursing documentation, recording the events of their busyness, or called to colleagues that they were going 'on break'.

4.3.3 Productivity in practice; the Sisyphean task of the (counter) Productive Ward

It has thus far been identified that nurses appeared to consider 'productivity as releasing time' to be amenable to caring 'in theory', as part of both LBIs and nursing culture more broadly, as was, to a flexible extent 'productivity as releasing money'. 'In practice' however, it appeared that participants had come to interpret LBIs, somewhat ironically, as a counterproductive pursuit. Rather than improving productivity, as articulated within the rhetoric of organisational artefacts informing preparatory work (described in section 3.8.1), many projects were reported by nurses to have yielded polar opposite consequences and their narratives suggested that not only did LBIs fail to improve productivity, worse, they could act against productive working and decrease productivity overall.

Nurses attributed this situation to being a ramification of the dis-integration and lack of coherence between the LBI projects, and between LBIs and other Trust policies and procedures. Participants described instances in which the Trust had vetoed nurses' productive changes owing to their conflict with pre-existing policies relating to infection control, fire safety and estates, waste and medicines management, for example. It appeared that rather than fostering progressive change and forward momentum, nurses had come to consider implementation of LBIs as a retrogressive exercise, which ensured the maintenance of a state of stasis. Participants explained that owing to the rapidity of pace at which LBIs were introduced, changes had also worked to subsume one another. This was because newer projects either contradicted and quashed prior ones, or they competed with and decentralised others, through a renewed and more currently pressing focus. Accordingly, in these instances, it could be seen that the net dual effect relevant to productivity, was that the time invested by nurses in projects was rendered unproductive, and productivity gains themselves became obsolete through further changing of the productive practice. Summarising the situation, one nurse was heard to exclaim *'It makes a mockery of the Productive Ward!'* [Mavis. Obs. Ward 3.]. A further example of the way in which LBIs were

reported to be counterproductive, in terms of consuming rather than releasing time to care, is explored in section 4.4.1 of Theme 3.

'*I mean, the idea of Productive Ward is great, but as I say, in my opinion, the erm initiatives that have come in since then have sort of nullified any effect…the Trust have introduced initiatives that have taken away all of that time that was erm, saved…I've had battles and all sorts because of the different ways of doing things, again, the Waste Management policy is just completely opposite to how Productive Ward would erm work.'* [Jemima. Int. Ward 2.]

'A lot of things were done for Productive Ward and it would still be here had it not been superseded by other initiatives…for example the way we did meals, we were told we couldn't do that. Things like the way the sluice was done, it was then changed. The way you used to do gloves and aprons. All these things were impeded by overarching initiatives. We had lots implemented which are now superseded, and they're not as, productive, should we say.' [Elizabeth. Obs. Ward 2.]

Productive priorities

Nurses suggested that there had been some benefits accompanying LBI implementation, such as the allocation of finances for ward storage facilities and equipment, and one participant mentioned an increased staff complement. Overwhelmingly however, nurses reported that LBIs focused on the productivity priorities of the Trust, which were often at variance with those of nurses. Participants implored that LBIs 'productivised' the wrong things and neglected the nursing agenda. They identified their desire, for example, for a *'general overhaul of the paperwork'* [Milly. Int. Ward 3.], in terms of a reduction in volume and the replacement of standardised documentation with that *'tailored'* [Beth. Obs. Ward 3.] to their speciality and their patients' needs. However nurses argued that LBIs had not only circumnavigated the issue of paperwork, but had exacerbated the situation by increasing the administrative load.

'I think it needs to incorporate more things like paperwork…re-evaluating the level of paperwork that's required and how it could be specialised and condensed to different areas. I think they're trying to have a one size fits all set of policies and you can't have a single set of paperwork that's going to do the job for everyone. If individual areas had the power to design their own stuff, it would reduce what was needed.' [Mavis. Obs. Ward 3.]

The Trust's commitment to financial investment in the Working With You programme could be identified in the organisational artefacts which contributed to the preparatory phase of fieldwork (identified in section 3.8.1). The allocation of financial resources by the Trust was criticised by nurses however, on the grounds of concentrating on larger, more ambitious projects, at the expense of investment in basic and fundamental equipment needed for the provision of nursing care. On Ward 2, for example, the sluice had recently be re-designed and re-fitted, but it was suggested that small-scale resource purchases would have yielded a greater reduction in wasted time and motion, since nurses spent a great deal of time 'searching and seeking' these scarce resources.

'For two wards, we've got one hoist…and one [machine for measuring lung function]. *We use spoons to crush tablets as there's no tablet crusher, then they're taken away for meals so we can't crush them. One* [glucose monitoring equipment] *box for 28 patients…We've got three keys for four bays…the* [controlled drug] *cupboard isn't big enough…we've got the slowest computers in the world.'* [Tabby. Obs. Ward 2.]

Indeed, these 'searching and seeking' behaviours were readily apparent during observation periods. Participants visited other wards to borrow or reclaim equipment, or called out to colleagues to locate resources, with a frustrated growl and flapping of the arms when equipment was not in the correct location, owing to it being already in use. During some shifts, a nurse who was 'extra to the numbers' (extra to the number of nurses working on a shift who were assigned specific bays of patients) would be assigned as a 'runner' or 'floater'

and their allocated role was to assist other nurses with 'odd jobs' as need arose, which included these 'searching and seeking' activities. I came to interpret this 'job' as a 'sponge role', with the occupier tasked with 'soaking up' these and other aspects of workload which appeared to be influenced by wider organisational issues associated with productivity. In this sense, nurses 'soaked up' these wider productivity issues, which 'trickled down' to the 'sponge role'.

4.4 Theme 3. Lean-ing on caring

The second theme of the findings explored the lived reality of Lean implementation in terms of insights from nurses' accounts and enactments surrounding the nature of Trust productivity, the purpose it served and the agenda that it contributed to, informed by their experiences of LBI implementation. Insights surrounding nurses' own conceptions of productivity, and its purpose and place within nursing culture, were also explored.

The third theme of the findings explores the lived reality of Lean implementation for nurses and nursing, in terms of the relationship between LBIs and the nature of nursing as caring, together with the consequences that LBIs were reported to hold for nursing as caring. In the context of the TNG for control of nursing practice, this is the final theme exploring Trust efforts within the 'Tug-of-War', before progressing to consider the nursing response in Theme 4.

4.4.1 The Productive Ward; Consuming Time to Care

The findings presented in section 4.3.1 of Theme 2, identified that the concept of 'productivity as releasing time' underpinning LBIs, was reported to be congruent with nursing. This association was reliant upon the connection that participants made between the identified capacity for productivity to release time, which could subsequently increase that which was available for caring. It appeared to be this link, between productivity and caring, that cemented LBIs 'in theory' as being amenable to nursing. Nurses' accounts of their experiences of the (counter) Productive Ward 'in practice' however were also described, in section

4.3.3 and nurses' suggestions that not only did LBIs fail to improve productivity, but they frequently, and actively, decreased it, were explored.

As a corollary of this, this section focuses on nurses' accounts of their experiences as to how 'in practice', 'productivity as releasing time' did not materialise, and their suggestions as to how in actuality, LBIs had the converse effect. These accounts demonstrate how the release of time available for caring, envisaged in nurses' theoretical presuppositions, mirrored in organisational artefacts, and upon which the congruence between LBIs and nursing appeared to be based, was not deemed to have occurred. 'In practice' therefore, LBIs were reported by participants to be incongruent with nursing and participants expressed doubt surrounding the validity of both the 'productive' and 'releasing time' components of the Trust's rhetoric and rationale for LBI introduction 'in practice', despite these being espoused as positive premises underpinning LBIs 'in theory'.

Drowning in documentation

LBI implementation was reported to have *'taken more time than it's released'* [Lucy. Int. Ward 2.], and as a consequence of consuming time, nurses argued that LBIs consumed opportunities for direct patient contact and caring more broadly. Participants' principle contention related to the increased and excessive volume of LBI documentation. Nurses suggested that time devoted to the completion of paperwork directly consumed time available for, and physically redirected them away from, clinically-oriented, interpersonal and relational aspects of nursing care.

'So we're filling all of these forms in, we're ticking all of the boxes to say "Yes we've done a risk assessment. Yes, we've done a falls assessment" but we're not actually looking after that patient whilst that's, so you can tick as many boxes as you want and do as many risk assessments as you want. Down on paper, we're looking after them, but actually we're not spending time with them.' [Alice. Int. Ward 2.]

'You're having to write so much you that don't have the time to do it. You spend so much time writing about it, you don't have time to do it. We're drowning here.' [Ruth. Obs. Ward 1.]

'I think we're losing lots of palliative care, what's actually important, which is supporting families and patients. That [tender loving care]*, we're pulled away to do paperwork.'* [Beth. Obs. Ward 3.]

Nurses protested that the standardisation of documentation compounded the consumption of time to care. Owing to the inability to tailor paperwork, nurses maintained that significant proportions were irrelevant, inappropriate and unnecessary, in terms of the individual wards' nursing speciality and the clinical requirements of patients for whom they cared. In such instances, the completion of paperwork and tasks became labelled as counterproductive in terms of achieving nursing goals and releasing time to care, as nurses argued that they were performing tasks and completing documentation unnecessarily owing to Trust command, rather than clinical requirement.

'By trying to bring one standardised one size fits all set, it's crippling nurses, and doctors probably, from doing the job that's important.' [Mavis. Obs. Ward 3.]

'I feel like some of the things that we're made to do isn't really appropriate and it's not really taking into account our patients…I don't think we should be measuring people's arms and weighing them. I think purely just asking them and assessing them, how they are, they're probably not going to be eating and drinking much. As long as it's always offered. Just things like that, I just think it needs to be more relevant for each ward.' [Camilla. Int. Ward 3.]

Dupery, trickery, artifice and pretence

Further to questioning the validity of the 'releasing time' component of LBIs 'in practice', participants expressed doubt surrounding the adjunct of 'releasing time *to care*' within the Trust's LBI pledge, mirrored in organisational artefacts. Nurses described how in rare instances where time had been released, it was

appropriated by the Trust and directed away from caring, towards fulfilling Trust aims and objectives. They argued that in addition to the administrative load of LBIs consuming time and diverting them from opportunities to care, the volume of paperwork meant that where any time had been released through LBI implementation, it was absorbed through meeting the bureaucratic demands of LBIs. This was to the extent that nurses had renamed the Productive Ward initiative *'Releasing Time to do Paperwork, Releasing Time to do Audit.'* [Jemima. Int. Ward 2.].

Similarly, nurses explained how the additional roles and responsibilities associated with LBIs, described in section 4.2.4 of Theme 1, not only consumed time for caring, but that the Trust had justified their introduction through drawing on the logic that time released through LBIs *could*, and *should*, be allocated to fulfilling these duties. This was identified as problematic since a) the envisaged productivity gains in terms of releasing time, had apparently failed to materialise - time that *could* be spent fulfilling these roles had not been released, and b) nurses argued that LBI roles did not focus on 'care' in a nursing sense. Any time released which *should* be spent fulfilling these roles, therefore rendered Trust rhetoric and 'releasing time *to care*' a misnomer.

'[The Trust are] *saying "Oh you've got the time now, you should be doing this and you should be doing that". Well actually, you've said that in that time, I should be there doing this and that, you're adding more and more paperwork to my workload.'* [Lucy. Int. Ward 2.]

'Releasing time to care for the patients is what it originally came out as. That time that you were spending looking for things, you're actually supposed to have that time to, to look after patients. However in reality, it just means you've got more time to do more jobs. So it doesn't release you the time to sit by the beds or anything like that.' [Jessie. Int. Ward 1.]

Overall, nurses' narratives suggested that LBIs had resulted in either no net gain, or a negative balance, in terms of time available for caring. Since the congruence of LBIs with nursing appeared to be dependent upon its association with releasing time, and time to care, 'in practice', participants suggested that LBIs were not conductive to either caring or nursing. LBIs were presented as antithetical to the Trust's pledge at the inception of LBIs as 'releasing time to care'.

Nurses articulated their feelings that under the guise of LBIs, and the accompanying promise of releasing time to care, the Trust had attempted to capitalise upon the subsequent nursing engagement that this could foster, in attempt to trick them into engaging with LBIs, for alternative, Trust ends. They reported feeling that 'in practice', the Trust had contorted the meaning of LBIs 'in theory'. Rather than 'productivity as releasing time' to spend on caring, it was argued that the Trust had translated its meaning to equate with working harder and faster to achieve more, often for Trust, rather than nurse or patient, benefit. Consequently, nurses described feeling misled by the Trust who, they suggested, had used LBIs akin to a duping mechanism.

'They're pushing me to work harder. Pushing me to achieve more with all these different care plans and so on. But am I more productive? I suppose from what point of view really, do you know what I mean?' [Kathy. Obs. Ward 3.]

'*It's why we all want to be a nurse, we want to sit with patients, we all want to make a difference. We want to talk to them, we want to have that but, so I think when you're saying we're going to give you the time to do that, you think "brilliant", but then they put more and more and more on top of it. So, actually if I've got to do all this paperwork and I've got to do all this* [name of LBI] *stuff, and I've got to do all this filing and organising, and sorting of stuff to do it, then it's lost its balance.'* [Lucy. Int. Ward 2.]

4.4.2 Standardisation, diversity and difference; *'You can't put a set routine on* [nursing]*…it's not like that'* [Harriet. Obs. Ward 1.]

Insights from nurses' narratives surrounding the relationship between standardised LBI documentation and care processes, and suspicions of mistrust and surveillance, were discussed in sections 4.2.1 and 4.2.2 of Theme 1. Nurses' arguments regarding the inability to tailor standardised care processes to patient need, as a consumer of time to care, have also been identified, in the previous section of this theme (section 4.4.1). This section outlines further contentions raised by participants with respect to standardisation, in terms of the relationship between standardisation and notions of 'difference'.

'All wards are quite different' [Lucy. Int. Ward 2.]*; the uniqueness of speciality, patient characteristics and needs*

Participants argued that standardised approaches to care did not take account of, and undermined, 'difference' in terms of the specific nature of patient need within their speciality. Nurses narrated allegories of atrocity, or 'atrocity stories' (e.g. see Allen, 2001), in order to illustrate and emphasise ways in which standardisation was inappropriate and detrimental to patient care on their ward, owing to the inability to tailor care processes in accordance with these differences. These concerns appeared to be most prominent amongst participants working in the palliative care setting.

'[The Trust] *brought* [hourly rounding LBI equipment] *on, which, down here, we don't use, use them anymore. I think they were totally inappropriate. We go to our patients more than once an hour anyway and the fact you've got people who are terminally ill, maybe only have days to live and you have* [an hourly rounding LBI] *counting down the rest of their time. I think that's very, I don't think like that. That was my main bug bear with it; that people were sitting here and "Oh, you've got one hour down". You know, I didn't think it was appropriate.'* [Milly. Int. Ward 3.]

'Like the eating and drinking care plan. We have to do it for people that are dying. It's a waste if ink. It's a Trust thing. This probably isn't relevant to some places but here, here we should have a bit of give or take…Working in palliative care, we had our own kind of rules. Now we weigh people, [complete nutritional screening tools]*, every week. It shows them their decline in black and white. Showing them how much weight they've lost; not top of my priorities really.'* [Beth. Obs. Ward 3.]

Flexibility of the nursing process

Participants also contrasted the rigidity and structure of LBIs with the flexibility and fluidity required in the nursing care process more broadly. It appeared that LBIs had come to represent a lack of appreciation of, and attempted to oversimplify and boundary, the complex, encompassing and continuous nature of nursing. Nurses described the need to individualise, tailor and craft the care process in accordance with the changeability of the ward environment, staffing levels, and as the needs and dependency levels of patients dictated.

'Our patients are here for palliative care issues and they shouldn't be treated as a ward. We should just be able to just tailor it daily to how we need to…Because sometimes, I think, you don't want to be in a situation where you have a structure, you have to do this by this point, this point, this point, 'cuz that's not really very caring, not very caring for the patients.' [Milly. Int. Ward 3.]

We're different and unique; 'we definitely have our thing' [Ruth. Obs. Ward 1.]

Nurses appeared at pains to emphasise the uniqueness of their ward setting, in terms of their patients, clinical skills, ways of working, and the nature of working and caring relationships. This could be considered as a reference to the uniqueness of their ward culture, but this sense of uniqueness could also be identified as a cultural value in itself. Nurses' pronouncements of their uniqueness appeared integral to their sense of professional pride and identity, and seemed to be enmeshed within and contribute towards, their ward culture.

This cultural value of uniqueness was observed to be transmitted as part of the early socialisation process of student nurses, with a mentor stating during orientation and induction the mantra: *'Every ward is different.'* [Laura. Obs. Ward 2.]. Nurses appeared proud of their difference, with another nurse stating: *'We are who we are and there's no point hiding it.'* [Lucy. Obs. Ward 2.]. In contrast to this observed sense of uniqueness, nurses described how the characteristic standardisation of LBIs assumed and promoted uniformity between wards. They suggested that the Trust's insistence, via standardisation, that *'this is how every ward's going to do it'*, made it *'really difficult to try and fit everything around what everybody else does'* [Lucy. Int. Ward 2.]. As a social effect, it appeared that LBIs acted to devalue and undermine nurses' sense of identity, individuality, difference and cultural heterogeneity. In this way, it seemed that participants had come to regard standardisation as a symptom of the Trust's lack of understanding, recognition and appreciation of the uniqueness of their ward, both in terms of patient need and nursing culture.

'We just want it back to how it used to be really. Like, just tailored for paperwork instead of how the Trust does it...I think we used to be quite special here, we had a good reputation…we're less ['palliative care-ey'] *now.'* [Beth. Obs. Ward 3.]

Nurses' sense of uniqueness also appeared to manifest at a more individual level, through the ways in which participants were observed to 'personalise the professional'. Nurses could be observed to adorn 'professional' aspects of themselves with various 'personal' artefacts, which might be interpreted as symbolic expressions of their individual 'nurse' and 'personal' identity, within the generic, organisationally prescribed boundaries of Trust 'professional' nursing uniform policy. Some participants decorated their Trust issued identity card with stickers, for example, or suspended them on lanyards bearing the name of a charity or external organisation. Others decorated lanyards with charity pin badges, demonstrating their affiliation with that entity (and perhaps also the 'good nurse' who donates to charity). 'Personalising the professional' was also expressed through the different styles, designs and colours of nurses' fob

watches and their surrounds, notepads and pens. Similarly, whilst required to wear black shoes, nurses showed each other their patterned and brightly coloured socks, which could not immediately be seen underneath their Trust issued nursing uniform trousers. When I arrived for fieldwork visits, nurses would also comment on 'personal' aspects of my appearance or belongings - my handbag, cardigan or shoes, for example, and ask where I bought them from. Participants' comments to each other regarding these 'personalised' aspects of the 'professional', appeared to serve a cohesive and bonding socio-cultural function, in that more 'personal' conversations regarding aspects of their life outside of the working environment could be stimulated, in turn introducing 'personal' facets to 'professional' working relationships, thus 'personalising' the 'professional' further.

Through 'personalising the professional', as a more individual manifestation of nurses' sense of uniqueness, it appeared that nurses were carving out a space for expression of a 'personal' identity within organisational and professional confines, and negotiating the boundary between the realms of the personal, and the organisational professional.

4.4.3 'Versions' of caring

Nurses suggested that LBIs exemplified and promoted a specific conceptualisation of, and approach to, caring. This 'Trust version' of caring was depicted as presenting a challenge to the 'nurse version', predicated on a holistic and person-centred model. Alongside nurses reporting that LBIs consumed time and reduced opportunities for nurse caring, the competing 'Trust version' of care which nurses identified as encapsulated within LBI projects, appeared to be interpreted as a challenge to the nature of nursing as caring, central to nursing culture and the good nurse, itself.

The 'Trust version' of caring was presented by participants as standing in direct contrast to nursing caring. The 'Trust version' was defined by a standardised (rather than individualised) approach to care delivery. It promoted task-oriented

(rather than person-centred) practice, and measurable, objective, quantifiable and biomedical (rather than intuitive, subjective, qualitative, holistic) aspects of care and forms of knowledge, were deemed to be indicators of quality. Nurses contested that the 'Trust version' of caring was largely antithetical to their person-centred and holistic version, which they associated with the 'good nurse'. The ways in which participants presented LBIs as exemplifying these aspects of the 'Trust version' of caring, are considered in the following sections.

Metrics, ticks and task-oriented care

The standardised documentation of LBIs was said to foster a task-oriented approach to caring, which undermined nurses' person-centred approach. Participants reported feeling that the Trust judged their value and 'worth' as nurses, in accordance with the tasks of corporate caring, as dictated by documentation.

'Patient-centred care. I believe in that really strongly, especially in an area like this…The Trust want me to approach this in a certain way, and do certain things a certain way round. When I make patients fit around what my nursing tasks are, not what patients want, it's not beneficial to them and my stress levels go up. But when you deal with what the patient needed at that time, I enjoy my job…To me and maybe the era I was trained in, the whole thing is about patient-centred care.' [Jeremy. Obs. Ward 3]

'I'm judged as a nurse not on how I care for [patients]*, speak to them, but how I fill out paperwork.'* [Lucy. Obs. Ward 2.]

Conversely, the provision of holistic, person-centred care appeared central to participants' notion of the 'good nurse', and nurses seemed to judge themselves (and each other) in accordance with the extent to which this was achieved. Nurses reiterated how 'successful caring' and 'proper care' involved attending to and meeting holistic needs, beyond the physical, and this was described in an encompassing and absolute way. The 'good nurse' successfully addressed *all*

needs, *all* jobs and completed *everything* that they had aimed to achieve during their shift. The 'good nurse' provided total, holistic care and ensured the time to do (and demonstrate) this through 'productivity as releasing time' and 'busyness', as described in section 4.3.2 of Theme 2.

'It's important that [caring is] *done properly…really make sure that you're addressing everyone's needs, not just their physical needs or medical needs…*[also] *psychosocial wellbeing, including the families', really making sure you can give everything to that patient that they really need, not just saying "Oh, well, we've done their medicine today then that's them ticked, that's them done."'* [Milly. Int. Ward 3.]

'I would like to think that all day, everybody was clean, everybody was happy, everybody was well fed, everybody was well medicated…yeah, so they'd had all the analgesia that they needed, at the time that they'd immediately requested it…Um, so yeah, if I went home and thought…I'd had a good day, I feel like a good nurse, would probably be an efficient nurse-that I'd got everything that I set out to do, done.' [Lucy. Int. Ward 2.]

It appeared that overall, nurses felt that LBIs fostered a disequilibrium in practice which was weighted towards the 'Trust version' of caring, and this was compounded by the reinvestment of any released time into addressing organisational caring priorities, as described in section 4.4.1 of this theme. Given the finite nature of time available during a given shift, and the necessity to attend to documentation and the physical tasks that corporate caring dictated, nurses explained that attending to the relational, holistic care, associated with the 'good nurse', was challenging at best, and impossible at worst. They suggested that ultimately, this could involve compromising the achievement of their holistic model of caring.

'*Well I, I feel it's, you're sort of fighting a losing battle sometimes with all these new documents and paperwork, you have to move patients two hourly. Now all of my patients need moving two hourly. It's physically trying to get to do*

that…you know, and I've got to do this paperwork so you're fighting to do that, but I want to be spending time with them, which I feel is more important, but if I haven't done the paperwork then I'm penalised.' [Milly. Int. Ward 3.]

'All our other things that we need to do paperwork-wise…you feel like it's impacting on patient care sometimes. And I also feel that in our area where we work here, be it palliative care, I don't feel like I'm giving proper palliative care because you have to keep all the paperwork up to date. *And I think it loses its philosophy of care sometimes on here.'* [Mary. Int. Ward 3.]

One nurse did however, remonstrate and reconcile a potentially positive link between the tasks of nursing and caring. She explained that although LBIs did not release time for relational aspects of care, they could support nurses in performing more tasks for patients which contributed to caring overall. She suggested that this affiliation between tasks and caring was not always readily apparent or recognised by nurses however, including herself:

'In some respects [the Productive Ward] *does take away from the nursing point of view, because it, it can become very task-orientated erm, and it would be lovely if it was based around the nursing…And I suppose in some respects it is…but I think we don't always make that link of how it does improve our nursing care…In some respects they're kind of at two different lengths...they're miles apart. But then in others they do actually, they, they marry…and* [if] *we thought of it differently…When you say 'releasing time to care', a lot of people, like I said earlier (and it's, it's the wrong way, thing to say really isn't it, it gives you time to sit by the bedside), but in actual fact, it gives you more time to do* ***more things*** *for that patient, so it's a different way of looking at things, when you think about it.'* [Jessie. Int. Ward 1.]

Epistemological disconnects; ways of knowing for caring

Nurses' contentions regarding standardisation as neglecting 'difference' at the level of the specific nature of patient need, according to speciality, were described earlier in this theme, in section 4.4.2. Similar contentions also applied at the level of the individual patient within a speciality. Participants suggested that the standardisation accompanying LBIs was inadequate in terms of enabling nurses to meet the needs of patients in a person-centred and individualised way, and that this was also hindered by the nature of knowledge that was promoted through LBIs.

Nurses' narratives depicted epistemological conflict surrounding the paradigms of knowledge prioritised by the 'Trust version' of caring and the 'nurse version' respectively. Nurses emphasised qualitative, subjective, holistic, individualised and tacit characteristics of knowledge, whereas they argued that the Trust emphasised quantitative, objective, standardised and metricised elements, as evidenced by LBI documentation, the indiscriminate implementation of initiatives, and the impetus upon auditing of care for statistical yield. Nurses suggested that their way of knowing for caring was essential for them to 'know the patient', which allowed them to care for patients holistically, beyond providing physical, physiological and biomedical care.

Nurses reported that 'knowing the patient' in terms of their subjective, unique and personal idiosyncrasies, preferences, psychosocial needs and routines, was an important precondition for, and characteristic of, the holistic caring of the 'good nurse'. This subjective, patient-centred knowledge, was identified as complementary to that which was objective, clinical and biomedically oriented. 'Knowing the patient' appeared in this way to be an essential component in comprehending the *'full picture'* [Poppy. Obs. Ward 3.].

'It's so much better knowing your bay [of patients]*. You know them so much…How do you know your patients are getting poorly if the* [physiological observations] *aren't showing it? When you've spent 12 hours there, you know your patient's getting poorly, that something's not right.'* [Laura. Obs. Ward 2.]

'You need to know…the little personal things. So I can relate back to relatives again too and say they've got their normal habits back. With [medical condition affecting speech]*, they can't always express what they'd like done, the little things they do at home. It's nice to carry on that care because it gives them a sense of comfort in an environment that they're not used to, away from their family and home…I need to get to know them, the personal touch.'* [Beatrix. Obs. Ward 2.]

Participants explained that 'knowing the patient' was nurtured through time spent caring for the patient and 'knowledge-pooling' between nurses. It was suggested that the nursing handover at the start of shifts constituted a key juncture at which this knowledge could be shared, built upon and transferred to promote continuity of individualised care.

'I start with the patient's name, how old they are, past medical history, diagnosis, [describes multiple neurological aspects of nursing care]…*It's trying to cover every aspect of the 12 Activities of Daily Living but in our method…the basics, what you need to know to start your shift. He won't have a shave today, he has one every other day…The personal things. His wife comes in every lunch time so that she can feed him…'* [Beatrix. Obs. Ward 2]

LBIs were reported to consume time and opportunities for 'being with' the patient in order to develop this knowledge however, and had influenced the handover process too. Participants explained that this LBI project aimed to 'productivise' the nursing handover through standardising and condensing the communication of information and transfer of accountability between shifts. Although adequately addressing biomedical aspects of care, nurses argued that the new LBI algorithm did not allow time, or scope, to transfer nursing knowledge surrounding 'knowing the patient'. Consequently, nursing ways of knowing for caring appeared to be demoted and subsumed under ways of knowing prioritised in the 'Trust version' of caring, which was imposed, promoted and perpetuated through this LBI.

After coming out of their formal handover meeting, nurses could be observed to regroup informally, where they stood, huddled together and continued to talk, scribbling notes on paper folded to the pocket size of their uniform, as they conversed. When I later questioned participants as to the purpose of this 'huddling ritual', they explained that whilst some conversations in this context were to 'catch up' with colleagues that they may not have worked with recently, since the implementation of the new LBI handover, these 'huddles' had also evolved as an opportunity to transfer nursing knowledge surrounding 'knowing the patient', to compensate for the lack of scope for this in the new formal LBI handover that had just taken place. In effect therefore, it appeared that rather than 'productivising' the nursing handover by standardising and condensing information transferred, as suggested in associated organisational artefacts, the LBI handover had in practice, 'shifted' the transfer of information considered peripheral or surplus to requirements within the LBI algorithm, to within the domain of a new, second, informal ritual, outside the formal and official handover arena.

Corporate caring and 'actually' caring; demarcations of type

It was common practice and parlance for nurses to employ the use of an adverb to prefix words that related to 'caring':

*'**Successfully** cared for'* [Mary. Int. Ward 3.]

*'**Actually** care'* [Laura. Obs. Ward 2.]

*'**Proper** palliative care'* [Mary. Int. Ward 3.]

When making statements such as these, nurses stressed the adverb in their intonation and further emphasised the stress placed on the word by nodding or leaning their head forwards and wrinkling their facial expression. The use of adverbs as prefixes appeared to be a considered and deliberate linguistic construction, which pragmatically, served an orientating and clarifying function. The addition of a prefix intimated an insufficiency in employing the 'caring' word

alone, and given the epistemological disconnects that nurses depicted between nurse and Trust ways of knowing and their 'versions' of caring, the use and nature of these adverbs might be interpreted as an attempt by participants to clarify their use of the word 'caring'. That is, to denote their subscription to the 'nurse version' of caring and portray the 'genuine' use of the 'caring' word, demarcating it from its usage in the organisational and corporate environment, where it was associated with a different meaning. The addition of a prefix may therefore have allowed nurses to take (re)ownership of the concept of caring and communicate the meaning it held for them, in the context of nursing.

The Trust and nurse versions of caring described by nurses, together with their respective indicators of nursing care quality, held resonance with, and were exemplified visually by two artefacts present in the ward environment. On ward 'Performance Boards', as introduced in section 4.2.2, nursing care was represented by crosses and ticks, numbers and percentages, graphs, pie charts and colour coded headings identifying different areas of nursing practice, against which nurses were assessed and audited by the Trust (for example infection control, nutrition and hydration, and pressure area care). Nursing appeared visually 'stripped back' and 'laid bare', reduced and condensed to its discrete composite processes, ticks and tasks, which participants suggested were characteristic of the Trust version of caring.

By contrast, another board, displaying patient and relative 'thank you' cards, appeared to embody 'the good nurse' and the nurse version of caring. This second board might also be interpreted as a nursing Performance Board, but one which defined and captured nursing 'performance' in a different way. Here, ticks, tasks and numbers were replaced by greetings cards depicting flowers, animals, teddy bears and poems. Graphs, charts and crosses indicating achievement were replaced with gifts of chocolates, biscuits, sweets and flowers which had accompanied the cards, as tokens and gestures of appreciation.

It appeared that little nursing attention was devoted to the Trust Performance Boards. Audit results were not always updated and I did not observe nurses reviewing their results. By contrast, nurses appeared proud of their thank you

cards. When new cards arrived at the nurses' station, they were read by nurses and (as reported in 4.3.2) often provoked discussion and reflection. When moving them to the notice board for display, despite there being no more 'clear' room, old cards were not removed. Rather, new cards were layered on top of old, which might be interpreted as indicating the value of the cards within nursing culture, as representations of (enduring and accumulating) 'performance' in a nursing sense, and as a barometer by which the 'good nurse' could be measured. These visible esteem indicators appeared in contrast to the 'wipe clean' impermanency of the crosses and ticks written on laminated sheets and whiteboards, that nurses argued were used by the Trust to judge their value and worth. This thank you card display of the 'good nurse' may also have served as a visual retort, to counteract Trust accusations that participants were uncaring 'bad nurses', which they suggested had informed the introduction of LBIs, catalysed by media portrayals of nurses following the Mid Staffordshire Inquiry (Francis, 2013) (as reported in 4.2.1 of Theme 1). Despite nurses' contentions surrounding the difficulties associated with fulfilling the nurse version of caring in the context of Lean implementation, this thank you card display also served to demonstrate and make tangible patient and relative satisfaction with, and gratitude for, the quality of nursing care provided.

4.4.4 Lean on me; the personal cost of Lean-ing on caring

This final section of Theme 3 considers the implications that nurses suggested the lived reality of Lean implementation, as presented thus far, held for their affective wellbeing.

Exasperation with a no-win situation; 'we're on our knees' [Jemima. Int. Ward 2.]

Nurses described feeling that they were embroiled in a no-win situation when it came to meeting the many demands of LBIs associated with the 'Trust version' of caring, in conjunction with their holistic and person-centred 'nurse version' of

caring. Participants reported feeling that they were *'always constantly kind of pulled'* [Jessie. Int. Ward 1.] between Trust and nursing priorities.

'If you don't do that stuff, they get on you back and if you don't do that stuff, they get on your back....It's the workload on top [of caring]*. But we are, we can't do it any faster. You see, this is how it is.'* [Estelle. Obs. Ward 3.]

As reported in section 4.4.3 of this theme, nurses suggested that this tension could result in the compromise of their holistic model of care, since the Trust 'judged' nurses in accordance with the corporate metrics, ticks and tasks of caring. The use of the word 'just' in participants' narratives, together with the audible emphasis that was placed on it, accompanied by shakes of the head and heavy sighs, communicated their frustration and exasperation with this situation, in which they appeared to feel unable to provide what they saw, simply and uncomplicatedly, to be fundamental and foundational elements of nursing care.

*'…**just** to sit with the patient...**just** give them care…**just** spending some time with them.'* [Milly. Int. Ward 3.]

*'…and you **just** want to give, you know, quality end of life care.'* [Mary. Int. Ward 3.]

*'…every nurse or you know, **just** wants to do a good job. You want to do a good job for your patients.'* [Alice. Int. Ward 2.]

The concurrent, competing demands and conflicting priorities identified by participants as inherent within the lived reality of Lean implementation appeared to hold other emotional repercussions for nurses. Participants reported feelings of guilt associated with being unable to care holistically for patients, for causing patients discomfort when performing LBI interventions which were considered to be unnecessary, and for handing over uncompleted aspects of care to nurses on the next shift. Some participants reported working

voluntarily after their shift had ended in an attempt to allay this guilt, which they said could in turn create tension outside of work, with family members.

'We've got to do it and when you're doing an admission, the booklet is just ginormous of everything you have to fill in. And it's like, whilst you're filling in all that paperwork that has to be done within x amount of hours, your buzzers are going off, people want pain relief, people want to talk to you, you know, there's lots of reasons why they want you...you can hear them but you've got to fill in all this paperwork and you feel bad and um, out of guilt I guess, you don't, you stay until it's done. And your patient's getting tired and you've still got to be saying "Can I do this? Can I do that?"' [Camilla. Int. Ward 3.]

'I mean, my husband's a [tradesman] *and he'll say "I thought you were supposed to be home at 8?" He doesn't understand that you can't just down tools and leave.'* [Jessie. Obs. Ward 1.]

Guilt could also be identified as stemming from a reliance upon the good will of relatives for the provision of care, and having to apologise for inadequacies which gave rise to the situation. Participants also demonstrated an awareness that patients sometimes refrained from asking for assistance in an attempt to ease the burden on nurses.

'We had a patient who we couldn't one-to-one nurse, but he really needed that…the family said that they were willing to stay with him 24 hours a day; could they have a side room?...I had to go and apologise to that family and say "I'm really sorry that we can't actually do our job, but thank you for saying that you will do it", do you know what I mean? And it's awful because you feel so guilty. The patient's coming to hospital…and we can't actually look after them.' [Jessie. Int. Ward 1.]

The 'bad nurse', the media and the knock-on effects of a thankless task

The emotions that nurses reported experiencing associated with the conflicts apparent within the lived reality of Lean implementation, appeared to be compounded by their awareness of negative media portrayals of the 'bad nurse', as reported in section 4.2.1 of Theme 1. A mixture of resilience and resignation to this situation could be discerned amongst participants.

'If you're just reading it every day, and some of the stories are horrific, don't get me wrong, they are horrific, but it, it just makes you think, you know, a few decades ago, nurses were angels, you know, and never a bad word was said about them and that's probably wrong because there are people obviously that take advantage of whatever, but the constant slating, it does make you kind of sometimes think 'Well why do I bother?'' [Alice. Int. Ward 2.]

'Nursing has its challenges but it always has its challenges. Morale's low with all the press nurse-bashing at moment, but we're resilient people. The proof is in the pudding of what you do every day. You have your ups and downs but you keep coming back. But it is difficult sometimes when you've got the likes of the [name of newspaper].*'* [Elizabeth. Obs. Ward 2.]

'Everyday, you turn on the news and there's something else saying that, you know, saying that this, nurses this, doctors that, it's very hard to, to want to come to work and keep up-beat when all you're getting, you know, is negative feedback…The media certainly don't help things…I don't think the people think that write these stories, they don't realise what they're doing and how it affects people. They should come and spend a day, you know, seeing practice and I find that very difficult.' [Milly. Int. Ward 3.]

Overall, the situation had prompted several nurses to reflect upon the *'sad state of affairs'* [Mavis. Obs. Ward 3.] that they felt represented contemporary nursing. Participants suggested that the physical and emotional strain that they were experiencing was not only personally significant, but could also adversely influence the quality of care that they provided.

'*Physically, the workload is very umm, it's very hard as well umm, and obviously it's quite emotionally draining here, umm…it's very hard.'* [Milly. Int. Ward 3.]

'If you're stressed out because you're having to do tonnes of paperwork tonnes of this, tonnes of that and look after your patients, I think that's, has a massive effect on people's attitudes and, and the way they see their jobs and eventually the way they do their jobs.' [Jemima. Int. Ward 2.]

4.5 Theme 4. Waging the nursing defence; the politic of resistance

In the first three themes of the findings, the lived reality of Lean implementation for nurses, in relation to notions of mistrust, responsibilisation, surveillance and accountability, was explored. Nurses' narratives and enactments surrounding the nature of Trust productivity and the agenda that it served, and the effects of Lean implementation on, and the consequences that it held for, the nature of nursing as caring, were also explored. Nurses' depictions of LBIs as a vehicle employed by the Trust, in order to establish, enforce and legitimate control over nursing practice, for the purpose of serving organisational needs, priorities, aims and objectives, were described. In this way, the first three themes 'set the stage' for the establishment of the TNG and presented aspects of nurses' accounts and enactments which related to the Trust side, or 'pull', within the 'Tug-of-War' for power and control over nursing practice.

This final theme of the findings explores the lived reality of Lean implementation, in terms of the nature of the nursing response to Trust antagonisms identified in the first three themes of the findings. In this sense, the theme represents the nursing 'counter-pull', or retaliation, in the 'Tug-of-War' of the TNG, for power and control over nursing practice. The theme explores the modes, means and mechanisms which appeared to be employed by nurses to negotiate resistance towards LBIs, and the Trust imposition on, and control over, practice, that they were reported to entail. It considers the rationale underpinning these strategies of resistance and discourses which nurses used to justify their course of action.

4.5.1 The dilemma of defence and (non-provocative) mechanisms of resistance

Although nurses' accounts depicted LBIs as largely inimical to nursing ideology and culture in their accounts, it can be recalled from Theme 1, that implementation was mandated by the Trust and enforced by mechanisms of surveillance. On the face of it, this might be seen to create a dilemma for nurses, involving two potential, but perhaps equally unpalatable, courses of action. Participants suggested that implementing and complying with LBI projects required that they compromise their nursing values and ideology, but non-compliance and resistance, to preserve the nursing *status quo*, held the potential for judgement as a 'bad nurse' and sanction by the Trust.

In what might be interpreted as their attempt to negotiate this compliance-resistance dilemma, nurses were observed to enlist strategies which enabled them, paradoxically, to comply with LBI projects and avoid Trust sanction, whilst simultaneously defending the nursing *status quo,* in terms of the sanctities of nursing values, practice, knowledge and culture.

Accepting whilst rejecting; symbolic compliance as covert resistance

Despite the multitude of contentions that nurses reported surrounding LBIs, overt objection in the form of approaching the Trust, or open refusal to comply with project implementation, was not identified. Rather, nurses' resistance to implementation could be observed to exist in more covert, subtle and nuanced forms. Indeed, at the outset of fieldwork, substantial elements of LBIs appeared *prima facie* to have been adopted and integrated into nursing practice. This was consistent with the impression and 'expectation' that I had formed surrounding implementation on the wards, during the preparatory phase of fieldwork, informed by organisational artefacts, and meetings, training and consultation events attended, as described in section 3.8.1 of the methodology chapter. As fieldwork progressed however, it became apparent that overwhelmingly, compliance with projects manifested at a somewhat superficial and symbolic level. It transpired, for example, that titled LBI roles had been embraced in

name, but were reported to have resulted in little sustained change to nursing practice. Similarly, the display of organisational artefacts, such as posters describing LBIs within the ward environment, implied allegiance and identification with the LBI 'cause'. When asked to explain or expand upon their content however, nurses appeared disinterested and apparently struggled to articulate and communicate the salient messages contained within them. On Ward 2, such Trust issued LBI 'propaganda' was ripped and unkempt in appearance. This presented in stark visual contrast to the framed and acrylic glazed posters depicting nursing principles, and intensified the tatty appearance of the Trust issued information. It appeared that the amount of project information that nurses were expected to read and display, had led to feelings of frustration and fatigue.

[Talking to colleague] *'Who's going to read that?...Put* [the LBI poster] *up wherever you'd like...Wherever you like. I shall endeavour to read that next week* [said sarcastically].' [Ruth. Obs. Ward 1.]

Overall, it seemed that nurses displayed posters but did not engage with them in a meaningful way, and their display constituted a form of feigned compliance with LBI initiatives. Similarly, boxsets providing guidance for Productive Ward module implementation, which had been issued to the wards by the Trust, had been consigned to cluttered back corners of shelves, already heavy with the weight of obsolete lever arch files, books, Trust policies and other organisational artefacts.

As identified in 4.4.3 of Theme 3, it was observed that organisational artefacts such as 'Performance Boards' displaying the wards' audit results, had not always been kept up to date and nurses appeared to struggle to decipher the meaning of graphs and statistical representations of their care. As I stood looking at these boards, passing nurses made a sideways glance towards me, then continued walking with their heads down, aloofly dismissing requests made to them to explain data, retorting, for example: *'Ask the management'* [Charlotte. Obs. Ward 1.], whilst shrugging their shoulders. Although numerical representations

of care were displayed as prescribed by LBIs, they appeared to hold limited significance and meaning for nurses. Being part of the 'Trust version' of caring described in section 4.4.3 of Theme 3, they were instead identified as a concern *'for the hierarchy'* [Suzie. Obs. Ward 1.].

[Explaining her comprehension of performance metrics] *'All I know is that we do these ones every night. We fill in our little boxes'.* [Beth. Obs. Ward 3.]

As a further form of symbolic compliance, other LBIs were observed to be adhered to in a partial, transient and *ad hoc* manner. Demonstrating token engagement with projects, part of the Productive Ward focused on patient meal times, and required that a bell be rung to indicate the commencement of meal service. During observations however, the bell was rung as directed on a few occasions only, and on one occasion, was accompanied by a distant cry from a nurse joking 'last orders at the bar!'. Similarly, temporary, or situational compliance in the form of brief behaviour change could be observed when the Polka-Dot Police visited the ward:

[Emily. Obs. Ward 2.]: *'*[Anna], *will you walk down, come with me to do this? The* [Polka-Dot Police are] *on the ward and we need to make it at least look like you're coming to* [name of bay] *to do this.'*

[Anna. Obs. Ward 2.]: *'Yeah sure.'*

The shifting of handover information surrounding 'knowing the patient' to a new additional 'handover huddle' ritual, owing to the lack of opportunity during the LBI handover, as reported in section 4.4.3 of Theme 3, serves as a further example of this. Forming an anomalous case closer to 'true compliance' however, one LBI activity appeared more sustained; the organisation, placement and labelling of equipment in stock rooms. This pragmatic LBI activity was perhaps more acceptable to nurses as it was associated with *'making life a bit easier'* [Jemima. Int. Ward 2.], and *'stocking up'* [Mavis. Obs. Ward 3.] and *'being tidy'* [Mary. Obs. Ward 3.] were consistent with 'productivity as releasing

time', underpinning nurses' positive pronouncements of Lean 'in theory', reported in section 4.3.1 of Theme 2.

Meaningless rituals; box ticking and 'jumping through hoops' [Ruth. Obs. Ward 1.]

Nurses reported completing LBI documentation, but not always in the way intended by the Trust, nor did the standardised procedures that it dictated guide care absolutely. The completion of documentation was depicted as a nugatory box-ticking exercise. It appeared to be a meaningless ritual, in which the documented 'reality', reflecting corporate caring, was considered to bear scant resemblance to the realities of nursing caring practice. Rather than documentation contributing to, or reflecting the realities of the caring process in any meaningful way therefore, it was suggested that *'it just puts it in boxes'* [Camilla. Int. Ward 3.]. By complying with box-ticking as a meaningless ritual however, nurses could demonstrate compliance with LBIs, thus avoiding the potential for Trust sanction. Where documentation contributed to the metrics displayed on 'Performance Boards', since nurses seemed to struggle to interpret their meaning, this presented as an exercise in *'jumping through hoops'* [Ruth. Obs. Ward. 1] to meet Trust directives. Whilst box-ticking was hitting the (Trust) target, it appeared to be missing the (nursing) point.

'It's purely just filling in boxes…It's purely just paper, that's all it is, in a folder but we've got to do it.' [Camilla. Int. Ward 3.]

'It's pointless…I don't see the point, they just take up space in a folder. We use falls and nutrition because we have to…If you're writing a care plan, you need to write it yourself. They're just there to tick boxes.' [Margaret. Obs. Ward 2.]

It is important to note that no nurse stated that they engaged in the practice of box-ticking to indicate care provision, in the absence of such care having being provided. Rather, retrospective and post-hoc completion of documentation, for example, was suggested, in relation to an hourly rounding LBI, where nurses

might '*fill 4 or 5 hours out in one go'* [Beth. Obs. Ward 2.]. This was caveated with the insistence however, that care *had* been performed, but time had simply not allowed for the completion of the documentation to indicate this, at the time. It was intimated that the demands placed upon nurses by documentation, and the meaninglessness of tick-box corporate care, might encourage such behaviour on other wards however, where in relation to care plans for example, nurses might '*just sign them'* [Margaret. Obs. Ward 2.].

Rule-making, rule-breaking and exceptions to the rule

Nurses were observed to employ rule-making and rule-breaking, which appeared to act as an additional mechanism to negotiate LBI compliance and resistance. Rules associated with LBIs appeared contested, fragile and ephemeral. Participants identified instances in which they flexibly interpreted rules, particularly in circumstances where standardised LBI instructions were not commensurate with their clinical judgement regarding patient need and best interests.

'If you're tip-toeing in on the 2 hours, every 2 hours for the [night time phase of the hourly rounding LBI] *to make sure, then umm is that such a good idea if somebody was going home the next day? I'd probably sneak, if they were in a side-room, I'd probably have a quick look through, make sure they were OK.'* [Lucy. Int. Ward 2.]

The vetoing of nurse-led productive changes by the Trust, was identified in section 4.3.3 of Theme 2. On Ward 2, nurses described having independently taken measures to reduce duplication inherent within nursing documentation, prior to LBI implementation. Participants argued that the subsequent introduction of LBI paperwork had acted to sabotage their efforts however. In response to Trust actions, participants described rule-breaking surrounding their continued use of some ward-specific, rather than standardised LBI documentation, which they rationalised professionally and clinically, through recourse to it better suiting the needs of nurses and patients.

'We've managed to hold onto what documentation we can to, so that our documentation is less repetitive than the rest of the Trust's. That's, we're not technically supposed to be doing that but, hey ho, when they change it.' [Jemima. Int. Ward 2.]

On Ward 3, underpinned by ideas of difference and uniqueness described in section 4.2.2 of Theme 3, there was some debate as to whether the remit and jurisdiction of all Trust rules extended to their speciality. Nurses appeared unsure as to whether their ward qualified for special dispensation and exemption or conversely, whether they were bound to abide by all Trust rules. Informal transmission by rumour and hear-say could be identified as an instigator and perpetuator of much of the ambiguity, inconsistency and doubt. Participants appeared hesitant when discussing rules, tending to start and finish their sentences with caveats:

'*There seems to be an understanding that actually* [describes dispensation from Trust rules]*…as far as I'm aware.'* [Mavis. Obs. Ward 3.]

'There's a lot of talk that we don't have to do these rules because we're separate but it's not. We're part of the Trust so we're bound by these rules. There's exceptions to every rule but…' [Milly. Obs. Ward 3.]

This ambiguity could be observed to create a flexible, interpretive space which could be used by nurses to justify rule-breaking in cases where rules were not strictly followed. Further, where a nurses' clinical judgement as to individual patient need deviated from standardised rules dictated by LBIs, it seemed that participants adhered to local, informal and unwritten rules to ensure that individualised care was received. Such behaviours were simultaneously *sub rosa* and open secrets, in that they were not formally and overtly acknowledged as 'standard practice', but appeared tacitly approved of and performed by nurses.

'[Patients at the] *end of life don't fit the criteria for a catheter. We have to, not make stuff up, it can't be comfort, it has to be for skin integrity. It's too medical now. You have to make up these rules to fit the paperwork.'* [Beth. Obs. Ward 3.]

Nurses' rule-making and rule-breaking appeared to be morally informed by the consequentialist principle that the 'ends justify the means'. Nurses reported that it was important that individualised palliative care needs were met, and in instances where rules precluded this, their rule-making and breaking was justified to this end. Nurses' actions were also rationalised through appeals to the nursing principles of advocacy and acting in a patients' best interest. Consequently, the making and breaking of LBI rules as appropriate, appeared to be associated with the 'good nurse'. It could be seen however, that adhering to these professional principles involved the potential compromise of the self, in terms of breaking organisational rules, which could potentially expose the individual to reprimand. As a further characteristic of the 'good nurse', this reiterates the way in which the 'good nurse' prioritised the needs of patients before their own, as identified in section 4.3.2 of Theme 2. Within the speciality of palliative care, the compromise of the self for patient benefit appeared particularly culturally significant, perhaps owing to the sanctity of achieving a 'good death' within palliative care ideology. In reconciling their rule-breaking, two participants conversed:

[Mavis. Obs. Ward 3.]: *'You have to think who you're doing it for, yourself or the patient.'*

[Beth. Obs. Ward 3.]: *'Yeah, they're at the end of their life and you want to do whatever it takes.'*

4.5.2 Defence against 'bad nurse' accusations; 'we're different' and 'we do it anyway'

It can be recalled from section 4.2.1 of Theme 1, that nurses appeared to interpret the introduction of LBIs by the Trust as an accusation that they were unproductive and uncaring. They suggested that LBIs had been implemented in an attempt to remedy the unproductive and uncaring 'bad nurse'. In turn, this interpretation appeared to be informed and reified by the disparaging media portrayal of nurses following the Mid Staffordshire Inquiry (Francis, 2013).

Nurses could be observed to have developed strategies which appeared to directly defend against this 'bad nurse' accusation, and in turn, the need for LBI implementation as a remedy to improve productivity and caring in nursing practice. Serving to counteract Trust accusations of unproductivity and insufficiency of caring, nurses verbally asserted words to the effect of 'we do it anyway'.

'We're doing it anyway. You'd always look at a cannula before you give anything through it. You always look at someone's skin when you turn people.' [Ruth. Obs. Ward 1.]

'It's fine in theory but in practice you're always caring for your patients anyway, especially in this environment.' [Mavis. Obs. Ward 3.]

Since nurses maintained that LBIs had been introduced as a generic and blanket measure to remedy the 'bad nurse', their claims to 'we're different' described in section 4.4.2 of Theme 2, became relevant in these instances also. Nurses suggested that whilst LBIs may be necessary on other wards, they were not necessary in their speciality, because they were 'different', in that they weren't 'bad nurses', because they did it 'anyway'. It appeared that engaging with LBIs would therefore be akin to admitting deficits in practice in terms of productivity and caring, thus legitimating Trust accusations as to the 'bad nurse'.

'Um, I just think maybe if they spoke to everybody, um, we don't need [the hourly rounding LBI]. *We don't need it here. I don't know about other wards but here, we're always in the bays, we know how, what everybody's up to. Maybe on a really busy ward, it might work for them…you know, it's different.'* [Camilla. Int. Ward 3.]

'On this ward…I am assured that erm all of these patients are cared for 24/7, I, do you know what I mean? I don't think we need [the hourly rounding LBI]*…if they work in other areas, that's great, but it's embarrassing that you say you've got patients who don't see a nurse for hours.'* [Jemima. Int. Ward 2.]

Additionally, nurses physically demonstrated their assertion that they 'did it anyway' through their busyness, as introduced in section 4.3.2 of Theme 2, which further served to counteract Trust accusations. It seemed that demonstrations of busyness therefore performed a dual outward and inwardly facing function. They served to demonstrate busyness to the Trust, to counteract accusations of the unproductive 'bad nurse', whilst simultaneously demonstrating busyness to colleagues, to conform to the cultural work ethic of the 'good nurse'. The display of, and apparent pride imbued within, patient and relative thank you cards, reported in section 4.4.3 of Theme 3, might also be considered a visual means of defending against bad nurse accusations, by demonstrating that they were 'good' nurses, with cards acting as a visual retort, paying physical and visual testament to the fact that they were 'different' and 'did it anyway'. In what could be interpreted as an attempt to demonstrate that they 'did it anyway' to the Trust in a more formal way, Ward 2 had in the past volunteered themselves to pilot the Productive Ward before system-wide implementation. This opportunity appeared to have allowed nurses to 'prove' that they were 'different' to the unproductive 'bad nurse' and that the requirement for LBIs was therefore obsolete on their ward.

'I mean I applied basically, to get into the pilot of Productive Ward…It was sort of devil's advocate really, I thought, you know, if we're not working to maximum efficiency, you show me how. So it was sort of a little bit tongue in cheek, my application…We'd done a lot of erm sort of, work together to try and minimise things that waste time and anyway…to my mind, we were working productively already…ours was far higher than erm any of the previous pilots, to the point where they questioned our methodology then said "You must be making a mistake."' [Jemima. Int. Ward 2.]

4.5.3 *'Put an apron on'* [Kathy. Obs. Ward 2]; the disparate ontologies of professional life-worlds

In section 4.4.3 of Theme 3, the epistemological disconnects contained within nurses' narratives surrounding Trust and nurse 'versions' of caring were described. Further, participants implied that the Trust and nurses occupied separate ontological worlds, defined not only by disparate paradigms of knowledge, but by differing realities, which corresponded with each 'way of knowing'. Nurses' apparent sensitivity to these discrete ontologies manifested in their talk in a way which implied dualistic constructions, including 'Them and Us' and 'Our World, Their World'. These polarities could be interpreted as being used by participants, to assist in the demarcation of boundaries between the Trust and nurses, their corresponding responsibilities and concerns, and to dissociate themselves discursively from the remit of the Trust. Nurses' appeals to the disparate ontologies of professional life-worlds served broadly, as a more encompassing and over-arching justification, for other strategies of resistance to LBIs.

*'You get on with your daily job don't you. You're in the centre of things. It's too difficult to see around the bubble. People that are trying to manage things are in their own world. It's hard to see what all that c**p is about.'* [Daniel. Obs. Ward 2.]

Participants suggested that LBIs had been designed and devised by the occupants of the 'Trust world', removed from the realities of nursing practice. Nurses appealed to the Trust to 'visit' their reality of LBI implementation 'in practice', by putting *'an apron on'* [Kathy. Obs. Ward 3.], which appeared to be symbolic of practical nursing work, rather than experiencing it 'in theory', from their world *'behind a desk'* [Beatrix. Obs. Ward 2.]. These appeals served to highlight the misfit between the 'Trust world' and LBIs 'in theory', and the world of nursing and LBIs 'in practice'.

'If they just came down here…I mean where do you get the time to do two hourly turns? I suppose it's because we don't know them and they don't know us.' [Estelle. Obs. Ward 3.]

'They keep arguing, sorry, they keep telling us, that erm [the hourly rounding LBI] *actually saves you time but see, I don't get that and I've asked them to come and work a shift and tell us how it does.'* [Jemima. Int. Ward 2.]

4.5.4 Humour, sarcasm and bonding resistance

Nurses could be observed to use humour, sarcasm and irony directed at LBIs or the Trust, as jovial and 'safe' forms of resistance, which also communicated a more earnest subtext. Their statements of opinion surrounding LBIs were often phrased and structured in the form of rhetorical questions, rather than categorical statements. This appeared to serve to invite consideration of, and highlight, the irony associated with how LBIs functioned 'in practice', whilst implicitly communicating negative opinions. Participants framed these questions in such a way as to promote seemingly self-evident and unequivocal answers. In doing so, they illuminated, interrogated and emphasised what they identified as the logical fallacies and inconsistencies vested between LBIs 'in theory' and 'in practice'. Strengthening this process, participants appropriated the lexicon and principles of LBIs themselves, to question the integrity of, and subvert, Trust logic. Examples of the 'faulty logic' that participants highlighted included identifying how 'productive' initiatives were in fact unproductive (reported in

section 4.3.3 of Theme 2), how LBIs consumed rather than released time to care (described in section 4.4.1 of Theme 3) and how changes designed to improve safety could in fact act as antecedents to safety incidents.

'In actual fact, the, the paperwork that we do for patient safety actually takes us away from keeping that patient safe! How does that make sense?' [Jessie. Int. Ward 1.]

'How is that productive and releasing time to care?' [Mavis. Obs. Ward 3.]

'Productive? All this writing we have to do?' [Kathy. Obs. Ward 2.]

'[The paperwork is] *so superfluous that it's laughable. It's a standing joke, we laugh at the level of repetition…If you've written it once, why do you need to write it in five other different places?'* [Mavis. Obs. Ward 3.]

Nurses could be heard to use sarcasm to mock the corporate prerogative, and question the validity and challenge the authority of, the 'Trust version' of caring. In the case of audit questions, nurses provided wry and apathetic retorts which could be heard to contain a critical double discourse; responses simultaneously discredited and criticised two things. Firstly, they intimated the worthlessness and invalid nature of questions in terms of 'truly' establishing nurses' levels of knowledge and assessing caring in practice. Secondly, answers mocked the inference that participants maintained underpinned audit questions; that they were 'bad nurses'. At a more pragmatic level, the provision of derisory answers appeared to serve to allow nurses to demonstrate compliance with the audit activity, but limit their engagement to a somewhat cursory level.

[Elizabeth. Obs. Ward 2.]: *'Do you know the procedure to follow should a staff member get an inoculation-contamination injury?*'

[Jemima. Obs. Ward 2.]: [Did not stop or look up from paperwork] '*Yes.'*

[Elizabeth. Obs. Ward 2.]: *'Do you perform* [personal] *hygiene daily?'*

[Kitty. Obs. Ward 2.]: [Said sarcastically] *'No, I like to let a layer of* [filth] *build up.'*

Similar techniques and devices were employed, which emphasised nurses' contentions as to the differences between, and the mundane nature of, the 'Trust world', and the realities of the 'nursing world' 'in practice'. Organisational artefacts such as corporate documents, metrics, and Trust allocations of time and money were dismissed, devalued and discredited.

[Describing the corporate nursing and midwifery annual plans and reports] *'Oh, how exciting. I bet someone was so excited when they got the job to do that. I mean, how many hours would it have taken to have written those?..I mean, imagine sitting down and reading all that. And the cost, if they've gone to every ward, and nobody'll read them.'* [Kathy. Obs. Ward 3.]

'I resent that if we don't meet stupid targets for stupid things like the [LBI 'Performance Boards']*, you know, not having the weight on the back of the* [physiological observations] *chart. It could be in five other places but because of that we're a bad ward and it's like "Well how does that work?" You know, and erm, and we're always like falling down on turn charts and stuff and yet we have one of the lowest rates of pressure sores.'* [Alice. Int. Ward 2.]

Socio-cultural effects

The apparatus of sarcasm and humour could be interpreted to have served several socio-cultural functions. In addition to constituting a form of resistance to Trust imposition on a collective basis, it audibly *demonstrated* individual resistance to colleagues, and in turn, allegiance to the cultural nursing group. Further, it appeared that humour and sarcasm served a bonding function, promoting social solidarity and reinforcing nursing cultural values. Scoffing at LBIs and jibes at the Trust appeared to constitute 'in' jokes, which were comprehended across the cultural collective. The renaming of the 'Working With You' project as *'Working For Who?'*[4] [e.g. Delia. Obs. Ward 1], served as a notable example. Finally, in addition to reinforcing nursing values and concerns, the 'threat' of potential mocking may also have served to promote socio-cultural

[4] Quotation adapted to reflect the pseudonym assigned to the Trust project.

conformity, and strengthen the defence against the incorporation of corporate caring into nursing culture, by curtailing the potential for nurses to engage with LBIs. That is, resistance towards LBIs may have been strengthened through the threat of potential mockery, should an individual not conform to nursing resistance. Indeed the potential for such intra-group regulation and informal social control was implicit where individuals were teased for conformity, with the suggestion that they were fawning upon and ingratiating themselves to the Trust.

[Speaking to colleague regarding a piece of Trust documentation] *'Are you laminating that?! That's good of you! I just put one up there and in the off-duty!'* [Kitty. Obs. Ward 2.]

4.6 Summary and conclusion

This chapter has presented the thesis' empirical findings, in relation to the overarching research aim, of exploring the lived reality and meaning of Lean for nurses and nursing in the study setting. It has also provided a depiction of the nature of the socio-cultural interaction between Lean and nursing. The chapter has therefore broadly addressed the thesis' research aim and primary research objective.

The findings have depicted the lived reality of Lean implementation as a game, played between the Trust and nurses, for power and control over nursing practice. The four themes of the findings have narrated the story of this Trust-Nurse Game 'at play' in the study setting. The first three themes were devoted to exploring insights from nurses' narratives and enactments relevant to the Trust 'side' of the game; the organisational rationale for, and mechanisms of, exercising power under the guise of Lean. The final theme explored the nursing response to Lean implementation, incorporating strategies which appeared to preserve the socio-cultural *status quo* and protect nursing knowledge, autonomy and practice. The next chapter of the thesis forms the first of two discussion chapters, and focuses on how power and power relationships can be understood

in the context of nurses' lived reality of Lean implementation, and the ramifications that this holds, for the professional project and identity of nurses and nursing.

Chapter 5. Discussion. Understanding power and power relationships in the Trust-Nurse Game

5.1 Introduction

The preceding chapter explored the nature of the socio-cultural interaction between Lean Thinking (Lean) and nursing, and the Trust-Nurse Game (TNG) was presented as a conceptualisation of the lived reality and meaning of Lean implementation for nurses and nursing. The TNG was depicted as a 'Tug-of-War' between nurses and the Hospitals Trust (the Trust) in which participants worked, for power and control over nursing practice. Participants' contentions surrounding ways in which the Trust attempted to exert and secure control over their practice under the guise of Lean, were presented, and the rationale that nurses identified as underpinning these attempts, was also described. The final theme analysed the ways in which nurses appeared to defend against Trust attempts to control their practice in the TNG, in order to protect the nursing socio-cultural *status quo*.

This first of two discussion chapters, explores the research findings that have been presented, in light of the first socio-culturally focused research question identified in the literature review chapter, which is reproduced below. As such, it explores power as a specific aspect of the socio-cultural interaction between Lean and nursing. In doing so, it seeks to provide a more comprehensive and critical exploration of nurses' lived reality, and insight into the broader meaning of Lean for nurses and nursing, contributing further to the aim of research. Further, insights into the ramifications of this analysis for the professional project and identity of nurses and nursing, relevant to the final research question, also reproduced below, are considered.

- How can power and power relationships be understood in the context of Lean and nursing?

- What ramifications do power relationships in the context of Lean, and its interaction with holistic, person-centred theory, hold for the professional project and identity of nurses and nursing, to which the notions of power and holistic theory are central?

In section 3.4.2 of the methodology chapter, the role and place of criticality within the thesis was identified. Accordingly, the nature of the presentation of the findings in the findings chapter, reflected feminist commitments, which included exploring and grounding research in participants' experiences, interpretations and understandings of phenomena, and respecting, valuing, upholding and taking them 'seriously' in the research process (e.g. Hesse-Biber, 2007, Letherby, 2003:62). This was maintained in the findings chapter through presenting and exploring participants' experiences, interpretations and understandings surrounding Lean implementation, before approaching them more critically (in the discussion chapters). It was at the same time acknowledged however, that the findings presented did not constitute, a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, more accurately, necessarily and inevitably, the findings, forming the basis for this discussion chapter, constituted one (the researcher's partial and situated) account, of participants' (multiple, partial and situated) accounts and enactments, surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge. In this chapter therefore, references to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should therefore be understood in the context of, and as subject to, this philosophical clarification and qualification.

The nature of this discussion chapter reflects the principle, also identified in section 3.4.2 of the methodology chapter, that upholding the feminist commitment to respecting (the researcher's account of) participants' (accounts and enactments surrounding their) understandings and experiences of phenomena, does not preclude the researcher then adopting a more critical

stance and approach towards the account that has been presented as findings. This discussion chapter therefore approaches (the researcher's account of) participants' partial and situated accounts and enactments presented in the findings, from a more critical perspective, informed by extant theory, empirical work and literatures. It presents the researcher's critical account of the (researcher's account of the) accounts and enactments of participants surrounding the lived reality and meaning of Lean.

In this chapter, the findings are explored in light of the secondary research objectives, considered from both the analytical angle of the account presented in the findings, in addition to a more critical analysis and interpretation, informed by extant theory, literatures and empirical work. This more critical exploration, in light of, and situating findings in, the broader context of theory, literatures and empirical work, allows for the broader meaning of Lean for nurses and nursing to be explored, and demonstrates a further 'layer' in the process of the co-construction of knowledge – beyond the findings as a co-construction, the knowledge presented in the thesis overall also constitutes a co-construction between the researcher and participants, through the presentation of the researcher's additional, more critical interpretation. This approach to addressing the research objectives therefore reflects a balance between, and the taking of both, (the researcher's account of) participants' (accounts and enactments of their) experiences and understandings, and the more critically situated and partial perspective of the researcher, 'seriously' (Letherby, 2003:62), supported by the feminist rationale identified in section 3.4.2 of the methodology chapter.

Firstly, in section 5.2, the chapter employs a Foucauldian framework, in order to provide an understanding of power, and analyse power relations 'at play', within the TNG, predicated on (the researcher's account of) nurses' accounts and enactments presented in the themes of the findings chapter. A more critical stance is then adopted towards this portrayal of power relations, in section 5.3 and this analysis further explores, and provides a more comprehensive understanding of, the complexity of power relations 'at play' within the TNG.

5.2 A Foucauldian analysis of the Trust-Nurse Game

A Foucauldian approach to understanding power and power relationships was introduced in section 2.5.2 of the literature review chapter. In the sections which follow, a Foucauldian framework is employed to critically analyse and explore the issue of power within nurses' lived reality, and power relations manifest within the TNG.

In 'The Subject and Power', Foucault (1982:792) outlines some specific components to consider when analysing power relations. These five components; the system of differentiations, types of objectives, means of bringing power relations into being, the institutionalisation of control, and degrees of rationalisation, guide the following analysis of power relations 'at play' within the TNG. The first four components are addressed in this section and the fifth is addressed later in the discussion, in section 5.3.

5.2.1 The system of differentiations in the Trust-Nurse Game

Foucault first draws attention to consideration of differentiations which occur within, result from, and condition all power relationships, allowing action upon that of others.

Laying the foundations for the Trust-Nurse Game; differentiations of 'Them and Us'

The system of differentiations constructed and contained within nurses' narratives, could be seen to play a significant role in establishing and perpetuating the oppositional nature of power relations within the TNG. Demarcations between 'Them' and 'Us', reported in section 4.5.3 of Theme 4 of the findings, invoked a binary form of thinking and foundation upon which Trust and nurse 'players' were cognitively separated into opposing 'teams'. Within their 'discourses of difference', nurses depicted 'The Trust' as an anonymous, amorphic and abstract entity. This nebulous and disembodied presentation, perhaps assisted nurses in cognitively demarcating and reifying boundaries

between themselves and the Trust 'other'. The Trust 'Them' became faceless, remote and removed, perhaps serving to bond identification with the recognisable and familiar nursing 'Us' collectivity (Jenkins, 2008).

Participants' differentiations between 'Them' and 'Us' were predicated on their narratives which implied the existence of fundamental disparities between the ways of knowing and the nature of life-worlds, associated with the Trust and nurses respectively, which underpinned their different 'versions' of caring, values and priorities. Accordingly, nurses demarcated boundaries with respect to the division of labour and each party's remit and responsibilities within the locale. Participants argued that Lean implementation reflected the agenda of the Trust, and they furnished the Trust's espoused rationale for the introduction of Lean-based initiatives (LBIs), with sceptical assumptions and doubt, influenced by negative contemporary media reporting surrounding the nursing profession. This perhaps served to perpetuate the oppositional and polarised framing of 'Them' and 'Us', as the basis upon which a 'Tug-of-War' for power and control over nursing practice, could proceed. Traynor (1999:141) similarly identifies the construction of 'us-them' dualisms by nurses, as a means of dichotomising the priorities and values of nurses and management.

The Trust-Nurse Game and the managerialism-professionalism dyad

From a traditional sociology of professions perspective, nurses' articulations of 'Them' and 'Us', and the TNG more broadly, could be interpreted as a function of the interaction between managerialist ideology and nursing's professional ideology, described in sections 2.4.1 and 2.4.2 of the literature review chapter. More specifically, they could be interpreted as a manifestation of the 'mangerialism versus professionalism' dyad, within which managerialism is viewed as inherently threatening to professionalism (Noordegraaf, 2011), as outlined in section 2.4.3 of the literature review chapter. The TNG resembled a 'Tug-of-War' for power and control over nursing practice, within which nurses attempted to resist managerialist imposition upon their practice, to the ends of upholding their professional autonomy, defending their professional knowledge,

and the jurisdictional boundaries (Abbott, 1988) of the nursing profession. On this interpretation, the TNG becomes a form of boundary work (Fournier, 2000), and the nursing response, a function of their professional project (Larson, 1977). Control of practice was resisted in order to protect and maintain the knowledge and autonomy upon which the status of nursing as a profession is predicated, thus protecting the professional status of nursing itself.

Two problematics associated with this reading can be identified however, in light of the empirical evidence. Firstly, there was little evidence to support the nursing response in the TNG as a 'professional' defence and a 'professional' struggle. The assumption that the game was played by nurses on behalf of, and as representative of, nursing at the level of 'profession' appeared erroneous. Secondly, and relatedly, if nurses' actions did not constitute a 'professional' defence *per se*, the relevance of the notion of the 'professional project', as traditionally conceived of, also becomes problematic. Indeed evidence existed to support an alternative theorisation of the nurses' project in the context of Lean implementation.

The first problematic will now be expanded upon and a potential explanation for the marginalisation of the 'professional' in the context of these findings is provided. The second problematic is addressed in section 5.2.2, which explores the 'types of objectives' within the power relations of the TNG.

Internal differentiation and identification; from the professional to the individual

Turning to the first problematic, rather than being engaged in a defence at the global level of 'profession', the nursing defence appeared to manifest at a far more individual level. There was little evidence to suggest that the 'Us' with which nurses identified, was primarily a reference to a cohesive and united professional group. Rather, in addition to the macro-level differentiation of 'Them' and 'Us', nurses constructed micro-level differentiations internal to the nursing group itself. On each ward, protestations of 'we're different' (reported in section 4.4.2 of Theme 2 of the findings), portrayed a splintered and

disintegrated nursing group at the Trust. Similar to the findings of Halford and Leonard (2003) surrounding ward territoriality as a source of distinct identities, these protestations emphasised participants' notions of separateness from 'other' nurses on 'other' wards. Clinical specialities were presented as fractured and fragmented nursing silos, and ironically, Trust attempts to reduce silo-style thinking through Lean implementation, appeared to have perpetuated and reinforced ideas of difference and uniqueness amongst nurses. Although notions of uniqueness and boundary work, associated with the professional project, can be identified within this analysis, they applied at ward level and served to fragment the nursing group, rather than applying at the level of profession, serving to unite, distinguish and demarcate a professional group.

The 'Us' identification that transpired amongst nurses within the TNG, therefore manifested at a discrete and local socio-cultural ward level. It was nurses' sense of uniqueness that was central to their sense of pride, identity and culture, rather than a professional association. Nurses did not articulate their lived reality as a shared professional struggle, and 'profession' was marginal as a category of identification. Instead, their 'repertoires of identification' (Jenkins, 2008:27) were situated, and focused on the 'good nurse' and 'nursing' at a local, individual ward level. In effect, the three study wards presented corresponding but separate TNGs, representing a 'Tug-of-War' between (and on behalf of) nurses and nursing at ward level, and the Trust, as opposed to between (and on behalf of) the nursing 'profession' and the Trust. It is acknowledged that the transposition of a broad professional project might be *expected* to manifest at a local level, as a localised version of the nursing project, involving individual level 'professional' nurses, as part of the wider 'professional' agenda. However, within the localised and contextualised dynamic of these findings, a local version of the 'professional' project, involving 'professional' nurse actors, was not alluded to and did not transpire.

It is suggested therefore that the concept of 'profession' constitutes too high a level of analytical abstraction in terms of identification, for the participants in this study, and as a basis upon which the nursing defence in the TNG can be

explained. Whilst providing useful insights, it is argued that a sociology of professions-based interpretation of power relations within the TNG, lacks the analytical resources to develop a sufficiently specific, sensitive and contextualised understanding of the lived reality of Lean for nurses in this study.

5.2.2 Types of objectives[5] in the Trust-Nurse Game

Nurse objectives; theorising the professional (identity) project in the context of Lean

This section addresses the second, related problematic associated with interpreting the TNG as a function of the 'managerialism versus professionalism' dyad. Whilst nurses appeared to be engaged in a process of protecting and defending knowledge, autonomy, practice and jurisdictional boundaries within the TNG, it has been argued that this did not constitute a 'professional' defence *per se*. The related notion of the 'professional project' as traditionally conceived of, as a basis for explaining the objectives of the nursing response within the TNG, therefore becomes problematic, and its relevance in terms of these findings, questionable. That is, without the notion of 'profession', one is left with only a 'project'. Logically, this then begs the question 'What was the objective of the nursing defence?'

Evidence existed to support an alternative theorisation of the nurses' project in the context of Lean implementation. It appeared that the objective of the nursing defence of knowledge, practice and culture within the TNG, related to the identity of the 'good nurse', rather than a 'professional' agenda. The nature of this identity project will now be outlined, followed by a potential explanation as to why nurses identified more closely with the notion of the 'good nurse', than that of 'profession'.

[5] Foucault does not use the word 'objectives' in the strict sense of 'how aims are met'. Rather, this stage of analysing power more closely resembles an analysis of the 'aims' themselves. Objectives in the true sense are considered by Foucault in the later stage 'means of bringing power relations into being.' This discussion of objectives within the TNG therefore incorporates an analysis of aims. Objectives stemming from the aims of the TNG are discussed later in 'means of bringing power relations into being'.

A project without a profession; the identity project of nurses

The identity project of nurses in the context of Lean appeared to be comprised of two elements. The first, their identity work (Watson, 2008) surrounding the *direct* defence of the 'good nurse' identity and the second, their identity work surrounding the *indirect* defence of this identity. These two components of the identity project are now considered in turn.

The first element - the direct defence of the 'good nurse' identity, appeared to be achieved via two mutually reinforcing strategies. Strategy one involved participants saying and showing that they were not '*bad* nurses', for example, through their protestations of 'we're different' and 'we do it anyway', reported in section 4.5.2 of Theme 4 of the findings. Strategy two focused on demonstrating characteristics and behaviours associated with the '*good* nurse', for example, through narrating martyr stories and enacting busyness, identified in section 4.3.2 of Theme 2 of the findings. Combined, these strategies functioned as a 'two-pronged' defence; portrayals of the 'good nurse' served to undermine myths and counteract Trust and media accusations as to their identity of the 'bad nurse', reported in section 4.2.1 of Theme 1 of the findings. Conversely, defence against the 'bad nurse' served to reify their identity as the 'good nurse'. Their demonstrations of productivity through busyness, for example, served simultaneously to promote their identity as a 'good nurse' and counteract accusations of unproductivity associated with the 'bad nurse'.

The second component of the identity project of the 'good nurse' focused on the defence of the 'good nurse' identity *indirectly*. This involved the more concrete strategies that nurses appeared to employ to resist imposition of the 'Trust version' of caring, which was inimical to the nursing ideology underpinning the characteristics and caveats of the 'good nurse' identity. Strategies included not engaging with LBI roles, posters and metrics, box-ticking and rule-breaking, as reported in section 4.5.1 of Theme 4 of the findings. These strategies of resistance acted to limit the impact of Lean upon, and Trust power and control over, nurses' knowledge, practice and culture. By protecting practice congruent with the 'nurse version' of caring and their identity, nurses indirectly defended

the identity of the 'good nurse'. Additionally, and ironically, although nurses argued that the Trust had introduced LBIs in order to control practice as a remedy for the 'bad nurse', it was suggested that they fostered an approach to caring which promoted 'bad nurse' practices. These strategies of resistance therefore also functioned to indirectly defend the 'good nurse' identity, by preventing LBI implementation, which held the potential to mould participants into 'bad nurses'. In resisting the 'Trust version' of caring as part of this indirect defence, it seemed that nurses therefore simultaneously attempted to protect and retain practice to defend the 'good nurse', and prevent changes in order to defend against 'bad nurse' practices, and the identity that this would confer.

Finally, resistant discourses could be seen to unite the direct and indirect components of identity work identified above, within the nursing identity project. Resistant discourses accompanied nurses' concrete and action-oriented strategies of resistance which were associated with the indirect defence the 'good nurse' identity. These discourses formed, framed and contained nurses' repertoires of rationalisation for resisting Trust imposition upon their practice, and were broadly predicated upon narrative concerning the antithetical nature of the 'Trust version' of caring and LBIs, to the holistic and person-centred 'nurse version' of caring underpinning the notion of the 'good nurse', reported in section 4.4.3 of Theme 3 of the findings. These articulations required that nurses identify and describe care associated with the 'good nurse' in the process, as only then could contrasts be drawn with the 'Trust version' of caring, disparities highlighted, and resistance rationalised. This process therefore afforded nurses the opportunity to reaffirm and reify the 'good nurse' identity directly, as per the objective of the first component of their identity work. Resistant discourses accompanying more concrete strategies of resistance, associated with the indirect defence of the 'good nurse', therefore allowed nurses to directly 'say and show' characteristics of the 'good nurse', their disdain for characteristics of 'bad nurse' practice, thus reifying the direct defence of the 'good nurse' identity.

Overall therefore, within the TNG, nurses' resistance could be conceived of as serving a dual purpose. It served not only a negative, oppositional function, but also a productive and generative one (Foucault, 1988, Thomas and Davies, 2005), in terms of contributing to the identity project of the 'good nurse'. Drawing on analyses by Thomas and Davies (2005), who consider the identity project of professionals amidst New Public Management, resistant discourse opened a discursive, recursive and rhetorical space, which proffered the opportunity for the performance of identity work, impression management (Goffman, 1959) and the positive portrayal and reification of the nursing self, in accordance with the ideological model and scripts underpinning the construction of the 'good nurse' identity. Condemnation of the 'Trust version' of caring served strategically to emphasise selected, contrasting elements of their own identity. Person-centred, individualised, holistic care, busyness, the martyr who puts 'service before self' (Halford and Leonard, 2003:207)[6], for example, were central sources and symbols within their construction of the 'good nurse' identity, which were drawn upon and emphasised. Nurses therefore appeared to employ Lean as a resource within their identity project, to portray, assert and reify their 'good nurse' identity, whilst simultaneously subverting and rhetorically dismissing potential 'other' ways of classifying them, namely, as the 'bad nurse' (Traynor, 1999).

Further, nurse and Trust 'versions' of caring could be seen to stand 'for a specific frame of reference', characterised by the 'good' and 'bad nurse' respectively (*ibid.*:143). The synonymity invoked between the 'nurse version' of caring and the 'good nurse', and the 'Trust version' of caring as paralleling the 'bad nurse', therefore introduced a moral dimension to nurses' identity work. The process of rhetorically contrasting 'versions' of caring and the moral 'good' and 'bad' nurse associations that each conferred, might be viewed as a dualistic device, through which nurses could narrate 'moral tales', allowing them to construct a 'moral identity' through normative discourse, present themselves as morally astute, and establish their 'moral adequacy' as the 'good nurse' (Traynor, 1999,

[6] Narratives of 'self-sacrifice' and 'vocabularies of complaint', have similarly been noted by other authors as prevalent characteristics within nurses' talk, contributing to a 'culture of martyrdom' in nursing (Traynor and Evans, 2014:192, 197, Turner, 1995:149).

Holdsworth and Robinson, 2008:1086, Phillips, Amos, Ritchie et al, 2007:553, Baruch, 1981:276). This discourse could therefore be interpreted as serving as an active, constitutive practice of the self and self-formation (Foucault, 1997), introducing a (re)moralising agenda within the nursing identity project, which was perhaps all the more poignant in light of nurses' awareness of contemporary media 'bad nurse' portrayals of nursing (Traynor, 2007, 2014).

Professional project to identity project; the role of the media, spoiled identity, plodding on and ploughing through

This section turns to providing a potential explanation as to why nurses appeared to identify more closely with the local notion of the 'good nurse', than a global one of 'profession', as a category of identification. The explanation also provides insight into the impetus for the specific nature of their project as one of identity, and one which was morally imbued.

Firstly, it is posited that the apparent marginalisation of 'profession', in favour of the more discrete 'good nurse' category of identification, was influenced by the media context surrounding the 'bad nurse'. It can be recalled from section 4.2.1 of Theme 1 of the findings, that the media milieu and its pillorying of nurses appeared to fuel nurses' sentiments surrounding the rationale for the introduction of LBIs, as accusations of sub-standard care and unproductivity, a form of generic sanction for the 'bad nurse' and, as justifying (in the eyes of the Trust) the introduction of strategies to control nursing practice, and be 'seen to be doing things', surrounding improving quality of care. These ideas appeared to catalyse the response of nurses within the TNG and in this way, the media seemed to constitute integral contextual factor, which was woven into the web of how nurses made sense of and interpreted Lean implementation, and their resulting actions. It was a factor lying beyond Lean implementation itself, within, and driving the TNG. The previous section identified how this context appeared to inform nurses' identity work within the identity project of the 'good nurse'. In terms of the marginal relevance of the notion of 'profession', in favour of that of the 'good nurse', it is suggested that it was in response to the double jeopardy

presented by the concurrent challenges to their identity by the media and Trust, that their project became one of identity, of the 'good nurse', serving a defensive and restorative function, grounded at a personal level. Nurses could be interpreted as attempting to differentiate and distance themselves individually from an association with a 'professional' group castigated by the media, and dissociate themselves personally from the 'spoiled identity' (Goffman, 1963: publication title) of the 'bad nurse'. Their protestations that 'we're different' can be seen to echo this interpretation.

The relocation of the nursing project to within the personal realm perhaps also brought manipulation of the nursing image, in terms of identity management and 'face-work' (Goffman, 1955:213), to within individuals' control, at a time when the nursing professional image seemed particularly outside of their control. This 'abandonment' of the notion of profession may have acted as an individual level defence of the 'good nurse' identity, and assisted in promoting the resolution of dissonance stemming from a media fuelled 'identity crisis'.

Further, the notion of survival may assist in explaining the modesty of the nursing identity project, in terms of nurses' preoccupation with and aspirations to the 'good nurse', in contrast to the professionalising agenda more broadly. A meta-narrative of nurses' discourse depicted their quotidian toil, tension and struggle, surrounding the completion of patient care in accordance with (and attempts to reconcile) both Trust and nurse 'versions' of caring (reported in sections 4.4.3 and 4.4.4 of Theme 3 of the findings). Their concerns appeared to be immediate and pragmatically orientated, surrounding 'getting the job done' and completing patient care, amidst competing operational pressures. 'Plodding on and ploughing through', combined with the need to defend local culture, practice and identity, appeared a far cry from the ambition associated with a professionalising agenda. This resonates with the premises of Maslow's (1943) model of the Hierarchy of Needs. Nurses' 'basic' or fundamental needs were unmet, which perhaps precluded them from pursuing the more 'self-actualising' agenda of professionalisation. The challenges that nurses articulated, for example, in terms of the availability of essential resources, time to care and

enacting the 'nurse version' of caring associated with the 'good nurse', perhaps made it unlikely that they would identify with a professionalising agenda, and strive for higher and more abstract 'self-actualising' agendas associated with the profession. It is suggested that withdrawal from a 'professional identity' was mediated by the more pressing requirement to 'get the job done' amidst operational pressures and ensure the survival of the essence of nursing, in terms of the 'nurse version' of caring. Their project was one of the 'good nurse', protecting culture at local level, meeting immediate patient need, temporally located in the 'here and now'. It centred around prevention, protection and maintenance of identity, practice and culture, rather than forward-looking professional agendas, as higher order affairs. For these participants, the professionalising agenda appeared too far abstracted from the constraints encountered within their lived reality. On a daily basis, it was this; their situated individual experience, and aspirations to the 'good nurse' in the eyes of patients, colleagues and themselves, that appeared to constitute their preoccupation - a far more modest project than lofty aspirations to legitimising status, enhance nursing and the professional agenda more broadly.

Trust objectives within the Trust-Nurse Game

Nurses' contentions surrounding Trust objectives of control within the TNG have been described as part of the preceding analysis. Further to this, a distinction can be made between the espoused objectives contained within Trust rhetoric surrounding LBIs 'in theory' (of nursing involvement, participation, increased nursing control over practice, improved productivity and the release of time to care), and nurses' narratives surrounding Trust objectives 'in practice', underpinned by a more 'hidden agenda' (of control of nursing practice, as a form of sanction and remedy for the 'bad nurse', and to fulfil the Trust 'version' of caring and corporate agendas and priorities). In the TNG, nurses appeared to translate the objectives espoused by the Trust 'in theory', sceptically. Through analysis of the Trust's tactics, logic and aims at the level where they were inscribed, nurses determined a quite different 'rationality of power' from that

espoused by the Trust (Foucault, 1978:95). The way in which Lean appeared to be interpreted by nurses 'in practice' demonstrates that the effects of the Trust's exercise of power was not necessarily related to Trust intention, or Lean 'in theory', in a linear way (Foucault, 2003c). Owing to the freedom of subjects, the effect of power in relation to Trust intention was unpredictable, as Trust intentions of empowerment through Lean 'in theory', were interpreted and translated differently 'in practice', as those of disempowerment and control.

5.2.3 Means of bringing power relations into being and the institutionalisation of control

This section combines the third and fourth of Foucault's components for analysing power relations. It considers the mechanisms employed by the Trust to exercise power and control over nursing practice, employing Foucauldian notions of governmentality and discourse.

Trust mechanisms of power and control; Lean as a dynamic of governmentality

Nurses' contentions as to the way in which Lean was utilised by the Trust within the TNG in attempt to exercise power and control over their practice, could be seen to resemble a dynamic of governmentality. As a technology of power, LBIs were used to 'determine the conduct of individuals and submit them to certain ends or domination' and as a technology of the self, they influenced 'how an individual acts upon himself', or the 'conduct of conduct' (Foucault, 1988:18, 19, Gordon, 1991:2). Theme 1 of the findings (section 4.2.2) identified how the lived reality of Lean implementation appeared to involve the surveillance (and surveillance of surveillance) of nurses and practice, as a Trust disciplinary and regulatory mechanism (Foucault, 1995), which was operationalised by mandatory LBI implementation, standardisation, audit and direct observation by the Polka-Dot-Police. Further, nurses' surveillance of each other 'from within' can be interpreted as a form of self-governance, with a shifting emphasis upon the promotion of individual nurses as responsible for self-surveillance. Trust mechanisms of promoting self-surveillance were reliant upon exploiting the

individualising gaze and 'normalising judgement' of aspirations towards being the 'good nurse', manifested against a backdrop of media discourse and nurses' culturally socialised work ethic of 'busyness' (*ibid.*:192). Together with hierarchicalised surveillance, this potentially acted to increase bodily productivity and work efficiency to avoid the labelling of the 'lazy nurse' (*ibid.*). In his observations regarding Bentham's panoptician - the 'panoptic modality of power' - Foucault (1995:221, 203, 217) notes that self-surveillance ensures a permanency of the effects of power, a 'perpetual victory' operationalised and automated through nurses' 'intersecting gazes' of self-surveillance. Further, Foucault (1995: 201, 202-203) observes that in such situations, individuals become 'caught up in a power situation of which they are themselves the bearers'. In assuming responsibility for, and participating in, the 'constraints of power; he [*sic*] makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection.'

A further means of Trust exercise of power could be identified in the standardisation of practice, policies and procedures of LBIs, which objectified nurses' 'docile bodies' and rendered them analysable, improvable, manipulable and transformable (*ibid.*:135). Such an 'administration of bodies and the calculated management of life', Foucault (1978:140) terms 'bio-power'. Nurses' descriptions of Trust productivity as making them work harder, faster and more, are reticent of a 'power…centred on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls' (*ibid.*:139). The self-governance of this docile body contributes to one's own subjugation.

The institutionalisation of control through Lean discourse as 'the power which is to be seized' (Foucault, 1981:53)

In section 3.8.1 of the methodology chapter, organisational artefacts and activities which informed a working understanding of the 'official' version of Lean, as articulated by the Trust at organisational level (Trust discourse surrounding Lean), ahead of fieldwork, were identified. The organisational artefacts contributing to this preparatory phase of research were also referred to throughout the findings, as artefacts also present on the study wards during fieldwork, or as reference points of contrast or corroboration, in relation to nurses' narratives and enactments surrounding the lived reality and meaning of Lean, at the level of application (Hammersley and Atkinson, 2007).

Nurses' sentiments as to the Trust's 'dual' objectives 'in theory' and 'in practice', within the TNG have been described in section 5.2.2 of this chapter. Informed by the activities and organisational artefacts utilised in the research process (identified in section 3.8.1 of the methodology chapter), as described above, this section explores the construction of Trust discourse, which communicated the espoused objectives of Lean implementation, and how the same discourse might simultaneously be interpreted as functioning to secure control over nursing practice, as the 'hidden' Trust objective. In doing so, it draws upon nurses' depictions as to Trust use of Lean as a duping mechanism (described in section 4.4.1 of Theme 3 of the findings), exploring how the power of discourse surrounding Lean and its 'tactical productivity' (Foucault, 1978:102), could have functioned in this way. First, the structure and nature of Trust discourse is considered, followed by a more critical consideration, in terms of its use as a mechanism of exercising power and control over nursing practice.

As part of the process of the legitimation of Lean, through the promises of improving productivity and releasing time to care, the Trust appealed to nursing ideology, culture and values. This created the vision of a legitimate organisational agenda, which was strategically aligned with the concerns of nursing. Through internal organisational marketing and communication (for example, posters, leaflets, displays, reports, staff consultation, engagement and

training events, and nursing strategy documents, informing preparatory and fieldwork stages of research, the Trust articulated operational benefits of productivity, including making nursing work easier, less stressful, less wasteful, and as releasing time to care. On an interpersonal level, the Trust emphasised relational aspects of Lean philosophy, including involvement, participation, investing in staff, the importance of a learning organisation, increased nursing control over their practice, a bottom-up approach to change involving listening to ideas, and epistemic and ontological appeals to respecting the knowledge and expertise of front-line workers, and the value of their empirical experiences. 'Individuality' was appealed to in a triadic way; on a personal (we value you as a person; your ideas), professional (we value you as a nurse; your front-line clinical knowledge and experiences) and organisational level (we value you as an employee; we invest in you). In contrast with the nursing differentiations of 'Them' and 'Us' therefore, in their emphasis upon the values of caring underpinning LBIs, the Trust appeared to attempt to dissolve cultural cliques underpinning a 'Them' and 'Us' culture, towards the creation of a unified organisational value system and foundation, upon which a cohesive organisational identity and culture of 'We' could be built. Discourse was used in a deferential sense by the Trust, to emphasise the value of nursing knowledge in attempt to *em*power rather than to *dis*empower. To the extent that nurses agreed with Lean 'in theory', the Trust were successful in 'winning' the minds of nurses.

With nurses' contentions surrounding 'hidden' objectives in mind however, this account could be interpreted concurrently as an attempt to secure control over nursing practice, through the exploitation of the power of discourse. Since it was posited to benefit patient care, nurses' working lives and their degree of control over their practice, paradoxically, the Trust might be said to have used the rhetoric of Lean as a persuasive device, a form of 'covert control', harnessing the power of emancipatory discourse to encourage nursing engagement, and ultimately, as a mechanism to exercise power and control over nursing practice. As their raison d'etre, the incorporation of 'caring' within Trust discourse

surrounding Lean, and the blending of nursing and organisational logics, might be interpreted as an attempt on the part of the Trust to encourage nursing engagement and complicity (Rankin and Campbell, 2006, van den Broek, Boselie and Paauwe, 2014). Lean was aligned with the caring concerns of nurses, which 'in theory', made Lean difficult for nurses to reject, since rejection would, by association, simultaneously constitute a rejection of nursing concerns. Nurses' own knowledge was employed therefore, to reduce the power of nurses to object.

Once complicity had been secured, the Trust were reported to have implemented their 'version' of caring, in the form of Lean, and in doing so, nurses suggested that the Trust were attempting to exercise power and control over nursing practice. Trust rhetoric could therefore be seen to constitute a discursive practice, which strategically drew upon and was constructed around, the power inherent within the notion of 'caring', in order to exercise power and control over nursing practice. In effect, nursing ways of knowing might be interpreted to have been used against nurses, akin to a pawn within the TNG, to entice them into engaging with Lean. The meaning of 'caring' was then contorted in accordance with, and subsumed under, the Trust 'version' of caring and ways of knowing, for the achievement of Trust objectives. Within the TNG therefore, to the extent that they agreed with Lean 'in theory', nurses appeared to have in essence, fallen victim to the power conferred by their own knowledge that had been wielded through Trust discourse. Similarly, participatory elements of Lean, parcelled and packaged as 'empowering', might be seen as an attempt to secure 'government through freedom', embroiling nurses in their own subjugation (Rose, 1999:xxiii in Gallagher, 2008:402).

In accordance with a Foucauldian governmentality perspective, several specific rationalities and technologies of government (Miller and Rose, 1990, Bröckling, Krasmann and Lemke, 2011, Lemke, 2002, 2007) could be identified within Trust discourse, which in turn could be seen to function to encourage, and responsibilise, nursing engagement with Lean, in order to exercise power and control over nursing practice, and fulfil organisational agendas and objectives.

'Rationalities' of government can be considered as 'ways of thinking that render reality conceivable and thus manageable, which is to say subject to calculation and transformation' (Bröckling, Krasmann and Lemke, 2011:11). They provide 'cognitive and normative maps that open up spaces of government which are intrinsically linked to truth', and which enable action upon 'governed reality' (Lemke, 2007:48). They are comprised of reasoning which 'defines the telos of action' of government, creating and establishing discursive fields in which the exercise of power appears 'rational' and is 'rationalised' (Lemke, 2002:53, 2007). They articulate the programmes and aspirations of government, the basis and terms of its legitimacy, and conceptions of its means and ends (Miller and Rose, 1990). 'Technologies' of government can be considered as the symbolic and material practices, mechanisms, devices, measures, instruments and techniques, which make it possible to shape, guide and control the actions and decisions of individuals, 'in order to achieve specific objectives' (Bröckling, Krasmann and Lemke, 2011, Lemke, 2007:50). They instrumentalise, deploy and operationalise rationalities of government, enabling governmental action upon its targets, thus translating the 'thought' of rationality 'into the domain of reality' (Miller and Rose, 1990:8)

Whilst Lean can be viewed as a rationality of government itself, and Trust discourse a technology of government, *within* Trust discourse, there could be seen discrete rationalities and technologies of government, which could serve to encourage, and responsibilise, the engagement of nurses with the rationality of Lean overall, in order to exercise power and control over nursing practice, and fulfil organisational agendas and objectives. Discrete technologies of government within Trust discourse included appeals to nursing ideology, culture and values, through promises of improving productivity and releasing time to care, utilising a discourse of caring, a discourse of empowerment, autonomy and control, and discourses highlighting individual and professional respect, expertise and competence. These discrete discourses could be seen to appeal to different aspects of nursing professional ideology and in sum, Trust discourse might therefore be interpreted as reflecting a discourse of professionalism

(Evetts, 2011, Fournier, 1999). 'Professionalism' can be considered a discrete rationality of government, and Trust use of a discourse of professionalism, as a technology of government, functioning overall to operationalise the rationality of Lean more broadly, through encouraging and responsibilising nursing engagement, in order to exercise power and control over nursing practice, and fulfil organisational agendas and objectives. Indeed Evetts (2011) argues that organisations are increasingly utilising a discourse of professionalism as a means of controlling professionals, for the purposes of meeting organisational objectives. She suggests that in appealing to professional ideological values and priorities, such as autonomy, competence, expertise, empowerment and dedication to service provision, the discourse of professionalism is used by organisations to simultaneously engage and 'tempt' professionals, whilst constructing and delineating 'appropriate' 'professional' conduct, and inculcating professional responsibility and duty, consistent with meeting organisational objectives (*ibid.:*408). Through appropriation of professional ideology, a discourse of professionalism can therefore be used as an instrument of employee control, in attempts to reorganise, rationalise, control and contain professionals and their work, towards performance and output measures, standardisation, audit, quality and control, characteristic of organisational control, whereby professional values are used to promote efficient and effective organisational management (*ibid.*).

Drawing on the work of Foucault and other authors, Fournier (1999:281) similarly suggests that professional discourse can serve as a disciplinary mechanism, allowing organisational 'control at a distance'. Through exploiting the indeterminacy associated with the meaning of professionalism and articulating it in a way that constructs, delineates and defines the 'suitable' and 'appropriate' work conducts and identities of the 'professional' worker, a discourse of professionalism responsibilises professionals towards engaging with the organisational agenda (*ibid.*:290). As Fournier (1999:304) explains, 'Once the discourse of professionalism pervades organisational life, it becomes difficult for employees not to align themselves with it, or not to constitute themselves as

'professional' for not doing so would mean being marked as 'unprofessional''. Professionalism is therefore viewed as a rationality, and associated discourse, a technology, which can be employed by organisations as a mechanism of discipline and control, through articulating 'appropriate' professional conduct, which is consistent with, and aligned to, organisational objectives.

Further, Fournier (1999:281, 283) suggests that this government of autonomous labour 'at a distance' in turn reflects a liberal rationality of government whereby professionals, through appeals to autonomy and empowerment within the discourse of professionalism, 'are constituted as autonomous subjects' who are encouraged, and have a responsibility to, 'exercise their freedom in appropriate ways'. Discipline is therefore achieved 'through constitution of free-willed subjects', or technologies of the self (*ibid.*:283). Fournier's (1999) analysis suggests that Trust appeals to empowerment, when combined with appeals to valuing the individual and their expertise, could be interpreted as an attempt to control work through affording employees increased autonomy, which mobilises their potential for self-actualisation and innovation, and is in turn aligned with the objectives of the organisation. As a means of controlling work, autonomy therefore becomes responsibilised through constituting employees as 'empowered' and autonomous agents, and defining the parameters within which employees' autonomy and power are to be exercised. Fournier refers to this process as 'the autonomisation of conduct' (*ibid.*293).

'Where there is power, there is resistance' (Foucault, 1978:95): resistance to the institutionalisation of Lean discourse

Notwithstanding the above, nurses appeared to resist the institutionalisation of Trust discourse, through their construction of an alternative, 'reverse' discourse surrounding the Trust's 'hidden' objectives within the TNG. Indeed whilst discourse functions to produce, transmit and reinforce power, Foucault (1978:101) suggests that the process is unstable and complex. Discourse can also expose power and in doing so, serve an undermining function. It can therefore make power fragile, opening a space for 'a point of resistance and a

starting point for an opposing strategy' or '"reverse" discourse', making it possible to challenge and thwart the mechanisms through which power is exercised. Discourse therefore constitutes a 'means of escape' (Foucault, 1982:794) from prevailing forms characterising power relations, and underlines the unpredictable and non-linear transposition of aims and objectives into practice.

Nurses challenged the Trust's 'discourse of truth' (Foucault, 1978:97) with a competing discourse surrounding their contentions as to the rationale for Lean implementation. 'In practice', nurses identified Lean as a duping mechanism, designed to encourage and maintain their engagement with LBIs, in order to control their practice, to serve Trust ends – in effect 'seeing through' the discourse of professionalism (Evetts, 2001, Fournier, 1999). Drawing on the work of Thomas and Davies (2005:683), nurses could be seen to exercise their agency through contesting and re-writing the meaning of the Trust's discourse of productivity, participation and caring. They challenged its hegemonic status as a 'discourse of truth' (Foucault, 1978:97) by exploiting the contradictions that they observed between the theory and practice of Lean, through their (re)interpretive work, which served to destabilise and weaken Trust discourse and agitate power relations. Trust discourse was translated, redefined and transformed from one of empowerment, to one of control, against the media backdrop as a contextual condition. In reformulating the meaning of Lean as part of their resistance, its shape and form was mediated by nurses' agency, and formed a precursor to more concrete resistant behaviour. Through redefining the meaning of Lean as antithetical to the concerns of nursing, nurses could rationalise and legitimise their resistance to implementation, allowing for defence of their identity, culture and practice.

5.3 A critical approach to understanding power relations in the TNG

In the discussion thus far, a Foucauldian framework has been employed to provide an understanding of power and analyse the power relations 'at play' within the TNG. This analysis was predicated on the (researcher's account of) participants' accounts and enactments surrounding the way in which the Trust controlled and exercised power over nursing practice through LBI implementation, which was presented in the findings chapter. The remainder of the discussion adopts a more critical stance towards and reconsiders this understanding of power and portrayal of power relations 'at play' in the TNG, as means of further exploring how power relations can be understood. Firstly, it identifies the binary opposition of 'power-powerlessness', as characteristic of nurses' presentation of power relations in the TNG. This pairing is then critically examined in order to show how these conceptual components presented in an 'either/or' scenario, can be interpreted as co-existing in a 'both/and' fashion (Fagerström and Bergbom, 2010). This approach to understanding was introduced in section 2.5.3 of the literature review chapter, and seeks to look beyond binary opposition, in order to foster greater nuance in the understanding of phenomena. Factors within the lived reality of Lean implementation which may have contributed to sustaining the 'power-powerlessness' binary, and its consequences for the TNG, are also considered. Overall, the sections which follow contribute to a more comprehensive understanding of the complexity of power relationships at play within the TNG.

5.3.1 Power in powerlessness

Nurses' presentation and ordering of the power relationships within the TNG was characterised by the binary opposition of 'power-powerlessness'. It was seen in the themes of the findings how, within the lived reality of Lean implementation, nurses presented themselves as subject to Trust imposition upon their practice, and as occupying a position of powerlessness in relation to the Trust, who exercised power and control over their practice through LBIs. In their various actions, discourses, mechanisms and strategies of (covert)

resistance however, nurses could be seen to mould and limit the impact of Lean upon their practice, and the extent to which the Trust held power and control over it, and them. Nurses featured as covert, but active, oppositional agents within the TNG. Although participants did not identify their response to LBIs in this way, their resistance could be seen as the exercise of control and power over their practice, and over the extent of imposition by the Trust. Through their strategies and discourses of resistance, nurses acted as 'street-level bureaucrats' (Lipsky, 2010:xvii, Hewison, 1999). They exercised discretion and control over the praxis process; over the way in which Lean was interpreted and translated from Trust theory, to nursing practice. This appeared to influence not only how the lived reality of Lean was experienced, but the shape and form of Lean itself; what Lean *became*. Nurses could therefore be interpreted to have exercised control through their resistance, exercised power from their position of 'powerlessness', and through their covert resistance, simultaneously demonstrated compliance and resistance. As a corollary, rather than existing as binaries, there could be seen to exist degrees of Trust control and nursing resistance to such control, both compliance and resistance to LBI implementation, and nursing power and powerlessness. Neither control nor resistance, compliance nor resistance, power or powerlessness was absolute, complete or static within the TNG. Rather, these 'states' were fluid, existing in 'degrees', and were transiently and flexibly negotiated by nurses along continuums. Whilst nurses' lived reality of Lean presented in the findings was defined *ipso facto* by a binary experience of power-powerlessness, it is argued that such a rigid presentation fails to capture and illuminate the complexity and nuance inherent within the power relations of the TNG, that could be observed at this more latent level.

In the sections that follow, a potential explanation as to why nurses continued to present themselves as powerless, despite the exercise of control over their practice in the form of resistance, is provided. That is, how the power-powerlessness binary was maintained. The consequences stemming from

nurses' apparent self-understanding of powerlessness, and the implications they hold for understandings of power relations within the TNG, are also considered.

Powerlessness; the power in the patter

Nurses did not appear to conceive of the functional capacity of their strategies of resistance, or attach connotations of power. They presented themselves as powerless, despite their exercise of control over their practice. An explanation for the adoption of this 'powerless' subject position, and the persistence and maintenance of the power-powerlessness binary, might be found in the idea of a socio-historically constructed and socio-culturally imposed subjugated identity.

It is suggested that the 'patter of powerlessness' presented by nurses, constituted a socio-culturally rehearsed discourse. Their narratives, socialised and enculturated, might be said to have evolved from the internalisation of traditional socio-historical accounts of the subjugated and 'powerless' status of nursing, identified in section 2.4.4 of the literature review chapter. Nurses may have interpreted their resistant actions in line with the internalisation of the patter of powerlessness; they considered themselves to be power*less*, therefore they did not interpret their actions as power*ful*. The ramifications of this 'powerlessness' subject position and a subjugated identity, for the maintenance of notions of Trust power and nurse powerlessness, and for the TNG, are described in the next two sections.

The self-fulfilling prophecy as a pathology of powerlessness

The binary of power-powerlessness within nurses' lived reality of Lean implementation was predicated upon, and maintained by, their interpretation as to the power of the Trust and the powerlessness of nurses. Further, the power of the Trust was seen to be causally related to the powerlessness of nurses; nurses appeared to consider themselves to be powerless *because of* the power of the Trust, in terms of control over their practice through LBI implementation. It is suggested however, that not only did nurses exercise power, but that their

apparent *self-understanding* of powerlessness might have constituted a self-fulfilling prophecy, *beyond* the exercise of Trust power and control as a causal mechanism. That is, their understanding of themselves as powerlessness gave rise to a chain of events involving actions and interpretations which ultimately served to reinforce their 'powerlessness'. This is in contrast to the view of powerlessness as originating from the Trust exercising power over nursing practice. The processes through which the self-fulfilling prophecy of powerlessness may have operated, are now described.

It is suggested that nurses' self-understanding and presentation of powerlessness, contributed to a self-fulfilling prophecy, as an alternative to the view of powerlessness as stemming exclusively from Trust control of nursing practice. Despite the 'espoused' Lean rhetoric surrounding nurse participation and involvement in organisational change, nurses positioned themselves as powerless in the face of Trust implementation of Lean. Informed by, and coherent with, their self-understanding of powerlessness, nurses appeared to reinterpret Lean implementation sceptically, as harbouring 'hidden' objectives, as a mechanism of control, accusation and punishment, and as a consequence, oppositional power relations were formed and nurses resisted implementation as part of their identity project of the 'good nurse'. On this reading, which resonates with Traynor's (2013), and Traynor and Evans' (2014), observations surrounding narratives of victimhood in nursing, through these discourses, nurses reified Lean as threatening, and reproduced their disempowered locale, by emphasising their lack of control and power (Thomas and Davies, 2005). On a more pragmatic level, these sceptical interpretations, influenced by nurses' self-understanding of powerlessness, appeared to inform nurses' subsequent (covert) resistance, and precluded the potential for nursing participation and influence, in shaping and moulding the organisational change process, and harnessing the increased control over their practice and 'empowerment' that this might confer. It could also be posited that nurses' resistance was influenced by the potential threat that the participatory processes of Lean presented to their self-understanding of powerlessness itself. Powerlessness was a secure

identity, it was 'what nurses knew' and it was perhaps therefore defended (and perpetuated) through resistance to Lean and its 'empowering' facets, in order to prevent anxiety associated with the uncertainty and destabilisation of this cultural self-understanding (Menzies, 1960, Traynor, 2013, Traynor and Evans, 2014).

In each of these cases, the lived reality of established power relations within the TNG, based on nurses' interpretations of Trust power and nurse powerlessness, is reproduced. As a consequence, nurses' prophecy of powerlessness is fulfilled and their self-understanding of powerlessness, reinforced. In the process, nurses' conception of their powerlessness as being causally related to Trust imposition upon their practice, are also perpetuated, despite this 'powerlessness' being influenced by their own self-understanding, sceptical interpretations surrounding, and resistance to, Lean implementation and its 'empowering' processes.

The subjugated identity, covert resistance and 'lose-lose' stalemate

It can be recalled from Theme 4 of the findings, that despite nurses' multitude of contentions surrounding LBIs, overt objection in the form of approaching the Trust, or open refusal to comply with project implementation, was not identified. Rather, nurses' resistance existed in more covert forms. The covert nature of nurses' resistance could be considered a second consequence of nurses' internalisation of a subjugated identity, which too holds implications for understanding power relations in the TNG. In the nursing literature, an incongruence between the caring role of nurses and the concepts of 'power', 'conflict' and 'assertiveness' is noted (e.g. Falk Rafael, 1996). It is suggested that covert resistance provided nurses with an approach which simultaneously allowed them to resist Trust imposition upon their practice, but in a non-confrontational way, avoiding the requirement for overt objection and potential conflict. Consonant with the subjugated identity, such an approach could be considered a socio-culturally sanctioned, 'appropriate', 'safe' and enculturated means of resisting; a response congruent with nursing professional (gender)

roles, expectations and stereotypes of subservience and subjugation (Smith, 1992, Walsh and Ford, 1989, Valentine, 1995).

Within the TNG, nurses' covert resistance could, in many ways, be viewed as an effective means, at least in the short term, of realising the apparent objectives of their defence – the prevention of Trust imposition upon their practice in order to maintain the socio-cultural *status quo*, as part of their identity project of the 'good nurse'. In concealing the 'state' of resistance, Trust awareness of nurses' opposition might be said to be kept to a minimum. The meaningless ritual of 'box-ticking' associated with LBI documentation, for example (reported in section 4.5.1 of Theme 4 of the findings), indicated to the Trust that LBIs had been successfully implemented and sustained as intended. In turn, since the Trust were likely to have then assumed that they had achieved their change management goals, the requirement for further intervention (and imposition) was negated. On the part of nurses, the influence of LBIs upon their practice and cultural milieu was therefore limited, albeit requiring the continuous performance of practices and rituals of resistance, in order to maintain this steady state. In this sense, through nurses' covert actions, the Trust achieved a 'fictitious' or 'cosmetic' power over nursing practice, which functioned to 'stunt' its further exercise. Through the mirage of power created by covert resistance, nurses created the appearance of a positive-sum, or 'win-win' outcome within the TNG. Indeed, Foucault's (1978:86) work supports this as a 'tactical reason' for the 'devious and supple mechanisms of power' that coalesced to form covert resistance. He suggests that the success of power relies upon its ability to 'mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms'. Nurses' covert resistance characterising their defence within the TNG, could therefore be seen not only to mediate compliance-resistance, control-resistance and power-powerlessness binaries, through influencing the *effects* of the exercise of power, it could also be seen to influence the *exercise* of power itself 'at the source'. Through influencing the appearance of the 'potency' of the Trust's exercise of power, nurses regulated the Trust's assessment of the requirement for further exercise of power through LBIs.

The long-term effectiveness of covert strategies for managing power relations in the TNG, in terms of achieving the nursing objective - of defence of nursing knowledge, practice and identity - however, is questionable. Covert resistance could be considered akin to 'treading water' or 'fire-fighting'. Through covert resistance, a steady state was maintained within the TNG, with regards to power relations consonant with a subjugated identity, and the limitation of the influence of LBIs on nursing practice. This steady state however, failed to address nurses' apparent underlying contentions associated with Lean implementation in an overt and productive way, and acted to preclude nurses' 'empowerment', in terms of participating in shaping the nature of organisational change. Despite their covert resistance, nurses also reported that they remained unable to practice in accordance with the holistic and person-centred ideals of the 'nurse version' of caring.

Influenced by the covert nature of nurses' resistance, informed by a subjugated identity, it appeared that the steady state of the TNG was one of stalemate. Nurses' appeared reluctant to either resist further, more overtly, comply with, or influence the future nature of, Lean implementation. Patient care existed within the 'Tug-of-War' of the TNG, in a liminal state, between Trust and nurse 'versions' of caring, neither of which were complete. LBI implementation continued however, and in line with the 'rules' of the TNG, continued Trust implementation required continued nursing resistance, and the TNG, together with its manifest power relations, were perpetuated and set in motion, 'full circle'. In this way, nurse' interpretations surrounding the power relations of the TNG become increasingly entrenched and institutionalised, by the enactment and 'continuous play' of the TNG, which became a 'lose-lose' game. Neither the Trust nor nurses achieved their 'version' of caring or objectives as an outcome of the TNG, when played in accordance with the socio-cultural 'rules' which appeared to have come to construct and define its reality.

5.3.2 'Degrees of rationalisation' (Foucault, 1982:792)

In the preceding section, the potential influence of the internalisation of a subjugated identity, on the covert nature of nurses' resistance within the TNG, was described. The repercussions that nurses' covert resistance held for the maintenance of power relations of the TNG were also identified. This final section of the chapter returns briefly to the Foucauldian framework that was used to analyse power relations in the TNG, in section 5.2. It considers the fifth and final of Foucault's (Foucault, 1982:792) components; 'degrees of rationalisation'. In doing so, three more pragmatic explanations are offered, beyond the internalisation of a subjugated identity, for the covert nature of nurses' resistance, and their seeming reluctance to participate more overtly, in the potentially 'empowering' process of shaping organisational change. These factors might be seen to coalesce with those that have been identified throughout the course of the chapter, in influencing the nature of power relations in the TNG.

Foucault (1982:792) asserts that the nature of the means of exercising power is influenced by 'degrees of rationalisation', and is adjusted in accordance with situation specific factors, such as a calculation as to the potential effectiveness of the attempt at exercising power ('the certainty of the results'), and the weighing up of cost (economic or social), incurred by resistance. The apparent internal differentiation of the nursing group, which resulted in a lack of a cohesive nursing 'Us', might suggest that nurses were unaware that other wards held similar concerns surrounding LBIs, and were responding and resisting in similar ways. Indeed, the spatial separation of nurses between wards perhaps meant that inter-ward nursing interaction was minimal. Drawing on Clegg's (1989:221) analysis of Mann's (1986:7) notion of 'organisational outflanking', absence of knowledge regarding the existence of analogous 'powerless agencies with whom one might construct an alliance', perhaps ensured that resistance was uncoordinated and confined to a series of ward islands of resistance. In their assessment of the likelihood of successful resistance, nurses may therefore have anticipated a lone fight, and assessed the feasibility of the success of overt

resistance, as slim. Further, the temporal organisation of ward work, divided into shifts, may have meant that on any one ward, at any one time, the whole ward staff complement could not discuss LBIs as a collective *'en masse'*, further fracturing the potential for the discussion and staging of any overt, cohesive, and concerted resistance effort.

Secondly, in the findings chapter (section 4.4.3 of Theme 3), nurses' depictions of their quotidian struggle to meet the demands of LBIs and the respective Trust and nurse 'versions' of caring, within the lived reality of Lean implementation, were described. The negative impact that they suggested this had on their affective wellbeing was also identified (section 4.4.4 of Theme 3). Accordingly, nurses may have assessed that they had limited physical and emotional capacity to engage in more overt resistant forms, and commit to more participatory roles and processes within organisational change. Covert resistance may have been assessed as requiring less expenditure, in terms of the physical and emotional effort and resources needed, to preserve the *status quo*. Maslow's (1943) Hierarchy of Needs, which was introduced in section 5.2.2 of this chapter, might again hold utility here. That is, it might be thought unlikely that nurses would strive for the more 'self-actualising' agenda of empowerment, amidst the more fundamental and pragmatic challenges that they encountered on a daily basis, associated with the lived reality of Lean implementation.

Finally, it was also seen in the findings chapter (section 4.4.4 of Theme 3), how nurses' emotionality associated with the lived reality of lean implementation, appeared to be compounded by contemporary media scrutiny surrounding the 'bad nurse'. The media context might therefore have intensified nurses' feelings as to their limited capacity to engage with overt forms of resistance and participatory processes. Further, media reporting surrounding the 'bad nurse' may also have acted to decrease the likelihood of nurses engaging with the risk-taking and responsibility accompanying overt resistance and participation in nurse-led organisational change.

Overall, these explanations, or 'degrees of rationalisation' (Foucault, 1982:792) associated with the cost and potential effectiveness of resistance, would suggest

that within the lived reality of Lean implementation, nurses lacked adequate structural and psychological resources necessary for engaging in more overt forms of resistance, and with participatory, potentially empowering, organisational change processes (Laschinger, Finegan, Shamian et al, 2001).

5.4 Conclusion and summary

This first of two discussion chapters has considered the research findings in light of the first of the thesis' socio-culturally focused research questions. As such, informed by a Foucauldian approach, it has explored 'power' as an aspect of the socio-cultural interaction between Lean and nursing, approached from two analytical angles – in accordance with the account presented in the findings (the researcher's account of the accounts and enactments of participants surrounding the lived reality and meaning of Lean), in addition to a more critically situated, partial perspective of the researcher – reflecting a balance between, and taking, both accounts 'seriously', informed by feminist rationale (Letherby, 2003:62). Attention has been devoted to critical analyses of the nature and role of 'power', in influencing the nature of the lived reality and meaning of Lean implementation for nurses and nursing, contributing to the overarching aim of research. Insights into the ramifications of power relations within the lived reality of Lean, for the nursing professional project and identity, relevant to the final research question, have also been provided.

Among the arguments presented in this chapter, it has been contended that rather than representing a 'professional' defence as a function of the 'managerialism versus professionalism' dyad, the nursing response within the game that characterised the lived reality of Lean, was predicated on the objective of an identity project, of the 'good nurse'. It was suggested that the nature of the nursing project as one of identity, rather than profession, was mediated by a double jeopardy, in terms of challenges presented to nursing identity - by Lean implementation, in conjunction with the influence of contemporary disparaging media portrayals of nurses. The status of nurses as active oppositional agents within this game has also been highlighted, thus

challenging traditional views surrounding a state of powerlessness in nursing. Explanations have been provided, as to how a 'powerless' self-understanding and identity might have been maintained however, through a self-fulfilling prophecy, and a situation of 'lose-lose' stalemate, within the game characterising nurses' lived reality of Lean implementation.

Chapter 6. Discussion. The theory-practice gap in the context of the Trust-Nurse Game; locating Lean and the role of nursing factors

6.1 Introduction

The previous discussion chapter explored research findings in light of the first research question identified in the literature review, concerning power and power relationships, as specific aspects of the socio-cultural interaction between Lean Thinking (Lean) and nursing. It also explored the ramifications of power relationships within the Trust-Nurse Game (TNG) for the professional project and identity of nurses and nursing. In doing so, it provided a critical exploration of nurses' lived reality, and insight into the broader meaning of Lean implementation for nurses and nursing, contributing to the overall aim of research. This second discussion chapter addresses the second of the research questions identified in the literature review:

- How does Lean interact with holistic, person-centred theory and how can the translation of nursing theory into practice (the praxis process) be understood in the context of Lean implementation?

From this discussion, insights relevant to the theory related component of the final research question, reproduced below, are also provided, which are developed further in the next chapter of the thesis.

- What ramifications do power relationships in the context of Lean, and its interaction with holistic, person-centred theory, hold for the professional project and identity of nurses and nursing, to which the notions of power and holistic theory are central?

Mirroring the approach adopted in the previous discussion chapter, and the associated feminist rationale, derived from the role and place of criticality in the thesis (identified in section 3.4.2 of the methodology chapter), this chapter approaches the research questions from two analytical angles. Firstly, they are

considered from the analytical angle of the account presented in the findings (the researcher's partial and situated account, of the partial and situated accounts and enactments of participants, surrounding the lived reality and meaning of Lean). This account is then critically explored, informed by extant theory, empirical work and literatures, and additional arguments are put forward. These arguments are located within and contribute to, contemporary debates and critiques within the wider literature surrounding the nursing praxis process. Finally, the implications for the TNG, of these alternative ways of conceptualising and interrogating the praxis process in the context of Lean implementation, are considered. This chapter therefore offers a more critical and comprehensive exploration and interpretation of nurses' lived reality, and insight into the broader meaning of Lean for nurses and nursing, contributing further to the overarching aim of research, and demonstrates a further 'layer' in the process of the co-construction of knowledge – beyond the findings as a co-construction, the knowledge presented in the thesis overall also constitutes a co-construction between the researcher and participants, through the presentation of the researcher's additional, more critical interpretation. This approach to addressing the research objectives, reflects a balance between, and the taking of both, (the researcher's account of) participants' (accounts and enactments of their) experiences and understandings, and the more critically situated, partial perspective of the researcher, 'seriously', supported by the feminist rationale identified in section 3.4.2 of the methodology chapter (Letherby, 2003:62).

As in the previous discussion chapter, references to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should be understood in the context of, and as subject to, the feminist philosophical clarification and qualification - that the findings presented in the findings chapter, forming the basis of this discussion, did not constitute, a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, more accurately, necessarily and inevitably, the findings constituted one (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived

reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge.

6.2 The account presented in the findings: The lived reality of Lean as a manifestation of the theory-practice nexus

In Theme 3 of the findings chapter (section 4.4.3), it was described how within the TNG, holistic, person-centred theory underpinned the 'nurse version' of caring, nursing culture and the identity of the 'good nurse'. Nurses argued that Lean implementation promoted and orientated their work towards the 'Trust version' of caring and the metrics, ticks and tasks that this entailed however. Nurses described feeling unable to enact and fulfil their holistic and person-centred model of caring, since Lean implementation detracted from, consumed time for, and prevented, the provision of the 'nurse version' of caring. Echoing other findings (e.g. Daykin and Clarke, 2000), section 4.4.4 of Theme 3 identified the negative emotional feelings that nurses' described experiencing as a consequence of their inability to implement and realise their aspirational, holistic ideals in practice. They could be understood as 'compromised idealists' who found it demoralising to be unable to implement holistic ideals, or as 'crushed idealists', experiencing exhaustion and burn out (Maben, Latter and Macleod Clark, 2007:107).

Overall, nurses contested that the 'Trust version' of caring was antithetical to their holistic, person-centred aims and that Lean implementation challenged nursing knowledge, culture, and the practice and identity of the 'good nurse'. Using various strategies, reported in Theme 4 of the findings chapter, nurses appeared to (covertly) resist Lean implementation in order to defend these nursing facets, as part of the TNG. Nurses' subscription to holistic, person-centred ideology could therefore be considered an additional factor, coalescing with nurses' self-understanding of powerlessness (described in section 5.3.1 of the previous discussion chapter), in underpinning the oppositional nature of power relations in the TNG, and nurses' resistance towards Lean

implementation, which acted to preclude their involvement in participatory and 'empowering' processes of Lean.

The nursing thesis that can be derived from this lived reality, and which appeared to underpin nurses' resistance in the TNG, is that Lean is incongruent with holistic, person-centred nursing theory and prevents its translation into practice. This essentially depicts participants' experience as a manifestation of the enduring and pervasive nursing theory-practice nexus, within which Lean is placed as the antagonist. This resonates with the picture presented in the literature review chapter surrounding nursing in the context of managerialism. In section 2.4.3, managerialism was identified as contributing to the theory-practice gap and challenging nursing identity, by presenting a set of values which fundamentally conflicted with those of nursing, and prevented their materialisation in practice.

Whilst not discrediting or devaluing the (researcher's account of) participants' (accounts and enactments of their) experiences and understandings, viewed from a more critical angle, other empirical evidence presented in the findings chapter is suggestive of unacknowledged factors intrinsic to nursing itself, beyond Lean, as antagonising the theory-practice gap, and stifling the holistic praxis process. This challenges the apparent assumption underpinning nurses' resistance in the TNG, that Lean was solely responsible for the theory-practice gap experienced, and implicates nursing issues as contributors, in the process. This also suggests therefore, that nursing factors contributed to the negative emotional effects which arose as a consequence of the theory-practice gap that nurses described. In the sections that follow, two such nursing influences which could be identified from the findings, are highlighted; the nature of nursing theory itself and the role of aspects of nursing culture.

6.3 The (f)utility of holistic, person-centred theory

In this section, it is argued that the nature of holistic, person-centred nursing theory itself, contributed to the theory-practice gap identified by nurses, beyond the influence of Lean. This suggests that nurses' construction of the theory-practice gap, causally attributed to Lean alone, may be partially, an ill-posed problem, and that the apparent basis of their resistance in the TNG was perhaps therefore exaggerated.

6.3.1 Aspirational ideology and the 'ideal-real dichotomy' (Maben, Latter and Macleod Clark, 2006:475)

Beyond the influence of Lean, the idealistic nature of holistic, person-centred theory appeared to contribute to the theory-practice gap articulated by nurses, which rationalised their actions within the TNG. In section 4.4.3 of the findings, it was identified how nurses conceived of holistic, person-centred care in an all-encompassing and absolute fashion. It involved addressing 'all' patient needs and that nurses give and do 'everything' for those in their care, 'all' of the time.

These conceptions of holistic, person-centred care are mirrored in the findings of other studies (e.g. Jackson, 2005, Maben et al, 2006). They also reflect a theme within the wider nursing literature, which questions the degree to which the ideology and expectations surrounding holistic, person-centred care, are realistic and feasible in practice (Dingwall and Allen, 2001, Maben et al, 2007). Hewison and Wildman (1996:757, 759) for example, suggest that this nursing theory encourages 'an idealized view of…the putative role of the nurse' and an 'approach to practice that can never be realized'. Similarly, Dingwall and Allen (2001:64) brand holistic emotion work an 'occupational myth' and Melia (1984) argues that holistic, person-centred care is representative of a quest for an idealised nursing grail.

The empirical findings from this study, in conjunction with these supporting arguments, suggest that the idealistic nature of nursing theory, may render it a self-defeating prophecy, making a gap between nursing theory and practice

inevitable and ineluctable. That is, somewhat paradoxically, the idealism inherent within nursing theory itself, hinders the ability to realise the model in practice. This holds the implication that although nurses in this study attributed the theory-practice gap to Lean implementation, and were therefore reluctant to engage, nursing theory itself might be said to have antagonised the theory-practice gap experienced, in an analogous way. Within their construction of the theory-practice gap, which featured as a central component of their rationale for resistance within the TNG, nurses perhaps overestimated the influence of Lean implementation and underestimated the influence of their own guiding theoretical model of care.

Further, although participants attributed the theory-practice gap, and its emotional consequences, to Lean implementation, the argument presented above suggests that these negative effects might equally be ascribed to a theory-practice gap arising from an infeasible theoretical model of nursing itself. This reflects literature questioning the utility and benefit to nurses of holistic, person-centred theory, as a depiction of nursing practice. In promoting perfection rather than adequacy, holistic, person-centred theory might be said to do nurses a disservice, in setting them up to fail in their efforts from the outset and making them feel inadequate, by moulding unrealistic expectations of practice and requirements in order to achieve the status of a 'good nurse' (Dingwall and Allen, 2001, Hewison and Wildman, 1996, Clifford, 1995, Maben et al, 2007). A nursing professional, or identity, project predicated on unrealistic holistic, person-centred theory, would seem likely to be futile, resulting in negative emotional implications. Beyond the influence of Lean therefore, a theory-practice gap driven by a futile theoretical model of practice, might be said to be potentially detrimental to nurses' wellbeing, sense of identity, morale and workforce retention (Maben et al, 2006, Clifford, 1995, Maben et al, 2007).

6.4 Nursing 'work' and covert cultural rules

The previous section identified nursing theory itself as a potential contributor to the theory-practice gap, which appeared to catalyse nurses' resistance in the TNG, beyond the influence of Lean. This section presents a second unacknowledged factor intrinsic to nursing drawn from the study findings, which could be observed to contribute to this theory-practice gap, again outside of Lean's influence.

The emphasis that Lean placed upon the practical, material and physical tasks of caring was cited by participants as one of the major reasons that Lean antagonised a theory-practice gap, since this impetus was considered to be antithetical to holistic, person-centred theory, and a hindrance to its realisation in practice. These findings were reported in section 4.4.3 of Theme 3 of the findings chapter. Despite their overt denigration of Lean's task-orientation, paradoxically, other study findings suggested that task completion and the work ethic of 'getting the work done', was in fact highly valued by nurses. In section 4.3.2 of Theme 2 of the findings chapter, it was documented how physically demonstrating busyness and narrating productivity, appeared to be integral elements of being and displaying the 'good nurse' and the associated work ethic. Proficiency and sufficiency in these activities avoided negative peer judgement, chastisement and labelling as a 'bad', 'lazy' nurse. Task completion was significant as a barometer for productivity, and provided a vehicle for its tangible enactment, conferring conformity to the cultural work ethic of the 'good nurse'.

These findings implied the existence of an array of covert socialised values and rules within nursing culture, which emphasised the importance of a 'task and time' orientation to practice (Kitson, Muntlin Athlin and Conroy, 2014). Immersed and enmeshed within the social fabric and apparatus of the ward (May, 1992), they formed a 'second set', co-existing as an alternative value-system, alongside more overt and formalised values emphasising holistic care. Thus, a disparity and 'systemic tension' could be detected between 'the way things are talked about around here', emphasising 'being with' patients and

denouncing tasks, and 'the way things are done around here', emphasising the 'doing' of nursing work as manual and physical (Kitson et al, 2014:336).

If the task focus of Lean implementation conflicts with the nursing holistic model of care, and mediates a theory-practice gap, as nurses suggested, this covert nursing culture emphasising nursing tasks, can be seen to antagonise the theory-practice gap in the very same way that nurses implied of Lean. Based on their own logic, nurses could therefore be thought of as both holding and hindering their holistic values. Beyond Lean therefore, this is an additional factor, inimical to nursing culture itself, which could be seen to contribute to the theory-practice gap reported by nurses in this study.

Such a 'split subjectivity' (Traynor, 1999:147), or competing discourse, surrounding the value of holistic, person-centred care in theory, but veneration of a task-orientation in practice, has been identified as a nursing-derived source of the theory-practice gap in other studies. A similar 'hidden reality' incorporating covert rules was found by Maben et al (2006:470), for example. Within the work hierarchy, the 'real work' of nursing was considered to be physical, of which the 'good nurse' undertook a fair share or risked labelling as 'lazy'. Melia (1984:138) too describes the existence of, and discrepancies between, 'two versions of nursing, each with its own rationality' in clinical practice. Although an idealised, ideological 'version' of nursing was promoted in education, the service 'version' occurring on a day-to-day basis emphasised values surrounding 'the workload approach' of 'getting the job done', which was promoted through occupational socialisation and reinforced by social pressure and expectations. Both of these studies, together with work by Mooney (2007) and Daykin and Clarke (2000), identify that contrary to the ethos of holistic, person-centred care, more psychosocially-oriented elements of caring, such as sitting and conversing with patients, were not seen to constitute 'real work' and tasks were esteemed within the division of labour. Further, despite participants espousing the importance of holistic, person-centred theory, Porter and Ryan (1996) and Maben et al (2006) observed that a preoccupation with the perfunctory and expeditious completion of nursing tasks, was driven by the

notion that failing to complete the nursing work was an indicator of inefficiency and deficiency.

The parallel emphasis placed on tasks by Lean and within nursing culture alike, suggests that Lean was more socio-culturally amenable to, and compatible with, the realities of nursing practice '*in situ*' and the work ethic of the 'good nurse', than was acknowledged by participants. The reluctance to acknowledge this task-focused similitude, might be accounted for by the differential emphasis placed upon, and symbolic meaning attributed to, psychosocial, relational, affective and expressive aspects of care on the one hand, and the devaluing, denouncing and divesting of manual, task-oriented, instrumental 'body work', on the other, within holistic ideology (Liaschenko and Peter, 2004:493, Clifford, 1995). Participants were perhaps reluctant to acknowledge 'task and time' values (Kitson et al, 2014), owing to the near cultural taboo of verbalising the salience of the task work of nursing. Professing allegiance to the relic of task-oriented, rather than person-centred, care might have entailed the risk of labelling as a 'bad nurse'. Within the TNG, this denigration of tasks may have therefore precluded nurses from exploring and recognising potential benefits of Lean, from the outset.

6.5 Lean as scapegoat and the holistic identity monopoly

The arguments presented in the preceding sections provide an alternative way of conceptualising the praxis process in the context of Lean implementation. They suggest that factors intrinsic to nursing potentially contributed to the theory-practice gap (and the resulting negative emotional implications) identified by participants. These nursing factors were not acknowledged by participants however, and the theory-practice gap was attributed to organisational implementation of Lean, which served to rationalise nurses' resistance in the TNG.

It could be argued that this isolated focus on Lean implementation as stifling the holistic praxis process, acted to divert, detract attention from, and mask, the

contribution of issues endemic to nursing as antecedents to the theory-practice gap identified. Lean could perhaps therefore be understood as acting as a contemporary scapegoat, in accounting for the perennial theory-practice gap, and properties inimical to nursing itself. In turn, in acting as a scapegoat, Lean might be seen to serve a useful function in terms of preserving and protecting nurses' self-understanding and identity, based on holistic nursing theory. Within the TNG, participants unanimously and uncritically subscribed to the ideology of holistic, person-centred care, as a means of articulating the identity of the 'good nurse', as part of their identity project (introduced in section 5.2.2 of the previous discussion chapter). It appeared to represent a monopoly in terms of nurses' self-understanding. This socio-culturally rehearsed script, upon which nurses' appeared reliant for their self-understanding, was employed as a rhetorical discourse and device, to articulate, defend and persuade of the 'good nurse' identity (Daykin and Clarke, 2000, Dewar and Nolan, 2013, Hewison, 1999).

Since holistic theory seemingly monopolised nurses' self-understanding, and other default positions appeared unavailable to them, protecting and defending this ideology from scrutiny might be inferred to be especially important, in preventing potential challenges to nurses' identity. To this end, scapegoating Lean for the theory-practice gap, could be interpreted as a means of externalising causality, deflecting the critical gaze, thus avoiding the subjection of holistic theory (and their identity) to critical examination. In turn, the potential exposure of any shortcomings and contributions of nursing factors, to the theory-practice gap and its negative emotional consequences, is avoided. Scapegoating Lean therefore might be considered a collusive defence mechanism; an adaptive technique against anxiety (Menzies, 1960), ensuring an imperviousness to any shortcomings. At a time when nurses' considered their identity to be subject to increasing external challenge, incorporating this deflective and protective work within their identity project, might seem all the more imperative. Ironically therefore, whilst participants suggested that Lean

challenged their 'good nurse' identity, Lean could also be interpreted as being woven into the work of nurses' identity project, as a mechanism of defence.

6.6 The influence of nursing theory within the Trust-Nurse Game

Nurses' resistance in the TNG appeared to be predicated upon their pronouncement that Lean prevented the implementation of their holistic model of care in practice; Lean antagonised a gap between holistic theory and nursing practice. Alternative evidence and arguments have been presented, which suggest that factors intrinsic to nursing also contributed to the establishment and perpetuation of the theory-practice gap that nurses observed. The theory-practice nexus was more complex than a simple causal attribution to Lean; nursing factors were also implicated, but were perhaps masked through Lean acting as a scapegoat for these influences. With regard to the TNG, this holds the implication that a central premise upon which nurses' resistance was founded, was potentially overstated, and to some degree, misplaced. In addition, the preceding analysis has suggested that ultimately, the TNG may have been predicated on the nursing defence of an unrealistic and infeasible identity, which in turn, could be seen to contribute negatively to nurses' morale and wellbeing. Further, as identified in section 6.2, nurses' subscription to (infeasible) holistic, person-centred theory appeared to influence the oppositional nature of power relations in the TNG and nurses' resistance, which precluded engagement with participatory and 'empowering' processes of Lean. Holistic ideology therefore might be seen to act as a disempowering and constraining force, which ostensibly prevented nurses from capitalising upon any opportunities and benefits in terms of increasing control over, and shaping the nature of, organisational change, patient care and clinical practice.

6.7 Summary and conclusion

This chapter has addressed the thesis' second research question concerning the nature of the interaction between Lean and holistic, person-centred nursing theory, and the way in which the translation of nursing theory into practice can be understood, in the context of Lean implementation. Insights surrounding the ramifications of these understandings, for the professional project and identity of nurses and nursing, relevant to the thesis' final research question, have also provided. Arguments have been located within, and contribute to, contemporary debates and critiques within wider literature surrounding the nursing praxis process. In considering the research questions from two analytical angles - in accordance with the account presented in the findings (the researcher's account of the accounts and enactments of participants surrounding the lived reality and meaning of Lean), in addition to a more critically situated, partial perspective of the researcher - a more critical exploration of nurses' lived reality and its meaning for nurses and nursing, has been provided, contributing further to the aim of research. This approach has also reflected the maintenance of a balance between, and the taking of both accounts 'seriously', informed by the feminist rationale (Letherby, 2003:62).

In this chapter, it has been suggested that Lean might be understood as a contemporary scapegoat for the perennial nursing theory-practice gap, and antagonising factors intrinsic to nursing itself. The utility and benefit of holistic, person-centred theory as a basis for the nursing project and identity, for nurses' wellbeing, and degree of 'empowerment' and influence in the healthcare arena, has also been questioned.

Chapter 7. Implications and a recommendation of the thesis: The meaning of Lean for nursing

7.1 Introduction

This chapter of the thesis draws upon the insights presented in the findings and discussion chapters, in considering the meaning of Lean Thinking (Lean) for nursing, in the form of its implications for the profession. In this way, the chapter further attends to the final research question reproduced below, and the overarching aim of research.

- What ramifications do power relationships in the context of Lean, and its interaction with holistic, person-centred theory, hold for the professional project and identity of nurses and nursing, to which the notions of power and holistic theory are central?

Informed by the implications presented and supported by wider literature, the chapter culminates with a tentative recommendation, holding relevance for nursing policy, practice, theory and education.

Although the implications and recommendation of the thesis are derived from the specific context of this research, they resonate with, and are relevant to, some concerns of nursing more broadly. By locating the issues raised in this chapter within contemporary theoretical, conceptual and practical nursing debates, it is suggested that the research may hold utility and pertinence beyond the confines of the study setting (Lewis and Ritchie, 2003). The chapter draws upon and contributes to these existing conversations, by illustrating their application to the specific empirical context of, and insights offered by, the thesis.

As in previous chapters, references in this chapter to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should be understood in the context of, and as subject to, the feminist philosophical clarification and qualification - that findings did not constitute, a mirror-image

reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, more accurately, necessarily and inevitably, the findings constituted one (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge.

7.2 The meaning of Lean for nursing: Issues of identity

The preceding chapters have described and critically analysed nurses' lived reality of Lean implementation, characterised by the Trust-Nurse Game (TNG) - a 'Tug of War' between nurses and the Hospitals Trust (the Trust), for power and control over nursing practice. Particular attention has been paid to the power relations inherent within the TNG (Chapter 5), and the role and nature of Lean's interaction with holistic, person-centred nursing theory, within that lived reality (Chapter 6). A number of potential implications for nursing can be derived from these analyses, which are presented as the meaning of Lean for nurses and nursing. In particular, it is suggested that Lean implementation brings critical issues associated with nursing identity to the fore, which are in turn, often intimately entwined with issues of power. Two issues surrounding nursing identity, illuminated by Lean, are identified and expanded on in what follows, as implications of Lean for nursing.

7.2.1 Implication one. Reconsidering the nursing mandate (Allen, 2004b, 2014)[7] and identity predicated on holistic, person-centred theory

The analysis presented in Chapter 6 questioned the utility and benefit of holistic, person-centred theory as a basis for the nursing project and identity - for collaborative relationships with organisations, participation in 'empowering'

[7] Allen (2004b:271, 2014) employs Hughes' (1984) concept of the occupational 'mandate' in her writings, to refer to nursing's occupational remit or niche - 'the claims that the occupation makes about its contribution to society that distinguishes it from other groups', together with nursing ideals and culture. The nursing mandate, predicated on holistic, person-centred theory, therefore underpins both nursing's project and identity.

change processes, and for nurses' wellbeing. The likely futility of the holistic agenda underpinning the project and identity of the 'good nurse' was described, and the theory-practice nexus to which this contributed, appeared to result in negative consequences for nurses' wellbeing. It was suggested that Lean acted as a scapegoat for the theory-practice schism however, and masked problems intrinsic to nursing theory. Wider literature was identified which also questioned the utility and benefit of holistic theory for the nursing project and identity, premised on analogous observations of futility and negative wellbeing issues.

With regard to the influence of holistic theory on the nature of power relations within the TNG, nurses' resistance appeared to be underpinned by their pronouncement of the challenge that Lean presented to holistic, person-centred care, and therefore their culture and identity. Although likely to be futile regardless of Lean implementation, nurses' unanimous and uncritical subscription to holistic theory appeared to catalyse the oppositional nature of power relations in the TNG, and nurses' subsequent resistance. In the process, engagement with 'empowering' elements of Lean was precluded, with holistic theory acting to constrain the potential for increased nursing control and influence over organisational change, clinical practice and patient care.

These observations summarise some of the disbenefits identified in this study, of a preoccupation with holistic theory as the basis for the nursing project and identity, for relationships with organisations, influencing change processes and nurses' wellbeing. They might be seen to add to a growing body of critical commentary, which questions the 'fitness to practice' of holistic theory, as a basis for the nursing mandate more broadly, in the evolving nursing landscape. With the authors of this literature, it is argued that holistic theory as the cornerstone of the nursing mandate, should be approached more critically and candidly. It is further argued that a redefinition and reconceptualisation of the nursing mandate might be considered, in order for it to address and better meet the needs of nurses, organisations and the changing reality of nursing in contemporary healthcare (e.g. Dingwall and Allen, 2001, Allen, 2004b, 2014, Maben, Latter and Macleod Clark, 2007, Clifford, 1995). An extended

envisioning of the potential shape and form of a reconsidered nursing mandate is beyond the scope of this thesis. The final section of this chapter however, aims to contribute in a small way to the reformulation debate and a tentative suggestion, based on the evidence and insights of the thesis, is put forward.

7.2.2 Implication two. The subjugated nursing identity and socio-cultural context of 'empowerment'

Lean highlights a second critical issue associated with nursing identity, which is intertwined with issues of power. This implication is also relevant to contemporary understandings of the state and process of empowerment in nursing, and in the implementation of organisational change.

The analysis of power relations presented in Chapter 5, illuminated the apparent centrality of a self-understanding of powerlessness, to the outcome of attempts to 'empower' a socio-historically subjugated nursing collective. It was suggested that a self-understanding of powerlessness existed within nursing culture, and that the internalisation of a subjugated identity and powerless self-understanding, influenced the scepticism inherent within nurses' accounts and enactments surrounding Lean implementation. This appeared to fuel the oppositional nature of power relations within the TNG and nurses' subsequent resistance, the covert nature of which was consistent with the internalisation of a subjugated identity. As such, nurses did not engage with 'empowering' processes of Lean, denying them of the potential opportunity to increase control over their practice, leading to understandings and notions of powerlessness becoming a self-fulfilling prophecy, and a situation of 'lose-lose' stalemate, within the TNG. This apparent self-understanding of powerlessness in turn therefore hindered the potential for improvements in patient care, nursing practice and organisational functioning, which might have been harnessed through innovation and collaborative working between engaged nurses and the Trust.

These findings summarise some of the detrimental effects of nurses' 'powerless' identity for power relations in the TNG, organisational change and nurses' control over their practice. In addition to addressing issues associated with an identity predicated on holistic theory, a reformulated nursing mandate might focus on addressing these issues associated with 'powerlessness', by promoting a more empowered identity, in order to encourage more positive relationships with organisations and nurse participation in shaping organisational change. The thesis' recommendation, presented in the next section, is consonant with this agenda.

The findings highlighted also hold implications for understandings of the state and process of empowerment in nursing, and within organisational change implementation. The foregoing casts doubt on the sufficiency of a Lean approach to empowerment, in the context of a socio-historically subjugated group, with an apparently persisting self-understanding of powerlessness. Based on the findings of this study, a Lean approach to empowerment does not appear to offer a panacea for issues of (lack of) power in nursing. Paradoxically, this research suggests that Lean first *requires* a pre-existing degree or baseline of empowerment, in terms of a congruent self-understanding or readiness, before further opportunities that it may offer for empowerment can be realised. Whilst Lean might offer structural preconditions and necessary antecedents for empowerment (Laschinger, Finegan, Shamian et al, 2001), it may be inadequate as an approach in isolation, for successfully engaging and involving nurses in shaping organisational change processes, encouraging innovation and enhancing control over, clinical practice. These findings suggest that when approaching the issue of empowerment in the context of nursing, the influence of socio-cultural issues, such as facets of identity, upon its process and outcome, requires special attention. Factors intrinsic to nursing itself appear influential and ironically, may intervene to counteract and mediate against attempts to increase professional power and control. Conceptually, this suggests that in the context of nursing, empowerment should not be considered a certitude, following organisational invitation and presentation of opportunity; power did not appear 'transferrable'

in a straight-forward, linear manner. It may be better depicted as an unpredictable, dynamic and socio-culturally mediated process.

7.3 Reframing the nursing mandate and identity within an organisational context; a tentative recommendation

This section presents a tentative suggestion as to a potential future direction and focus for the nursing mandate and identity, based on the two implications of Lean for nursing presented in section 7.2. This recommendation can be seen as a direct response to calls for a reconceptualisation of the nursing mandate, identified in implication one (section 7.2.1). The specific nature of the recommendation accommodates a focus on the need to promote a more empowered nursing identity, identified in implication two (section 7.2.2).

It is suggested that extending the nursing mandate to incorporate the notion of what is referred to here as 'organisational collaboration work', may offer a means of reframing nursing identity, in a way which is more realistic and feasible, begins to address the theory-practice gap, and is therefore more conductive to nurses' wellbeing, as discussed in implication one. It may also be seen to offer an approach to addressing barriers to nursing empowerment associated with issues of identity. Namely, self-understandings of powerlessness associated with a subjugated identity, identified in implication two. In the context of organisational change, through addressing these issues of identity, which contributed to oppositional power relations and 'lose-lose' stalemate within the TNG, 'organisational collaboration work' may hold the potential to agitate the socio-cultural rules and 'gaming work', by which the TNG was defined, leading to a more 'productive' outcome for nurses, organisations and patients. Encouraging nurse participation in shaping organisational change, through placing 'organisational collaboration work' at the centre of their mandate and identity, may foster more progressive and constructive interactions and conversations between organisations and nurses, maximising the opportunity for (nurse-led) improvements to clinical practice and quality of

patient care, ultimately resulting in better outcomes for nurses, patients and organisations alike.

This recommendation is not presented as a panacea for the plethora of power and identity issues identified in the thesis. The potential challenges which would be associated with incorporating 'organisational collaboration work' into the nursing mandate, are similarly not underestimated. Nevertheless, the suggestion is put forward as a potential contribution, starting point and stimulus for further consideration and development, through research and critical dialogue, within the emerging nursing mandate reformulation debate.

7.3.1 A conceptualisation of 'organisational collaboration work'[8]

The term 'organisational collaboration work' is employed to refer to nurses working synergistically with organisations, towards the identification, negotiation, development and implementation of visions and strategies for organisational change, relevant to the development of nursing practice and quality of patient care. Organisational collaboration work might be seen to represent, and respond to calls for, an extension of the traditional nursing mandate, with its focus on relationships with patients, towards the incorporation of a wider focus upon mutually dependant relationships with organisations (Allen, 2014). This conceptualisation of organisational collaboration work chimes with the direction of thinking of other commentators, who problematise non-collaboration between nurses and organisations, and emphasise the need for increased recognition within the nursing mandate, of the organisational context in which nursing is practiced. This body of work stresses that nurses do not work autonomously or in isolation from the organisations in which they practice and that organisations and nurses are increasingly interdependent. It

[8] Allen (2014:131, 137) introduces the notion of 'organising work' in the context of her empirical work regarding what nurses 'actually do' in healthcare, and as a contribution to the debate surrounding the reformulation of the nursing mandate. 'Organising work' describes the everyday practices inherent within nurses' organisation of care, and achievement and mediation of service delivery. Although both 'organising work' and 'organisational collaboration work' incorporate an organisational component, and are perhaps complementary in character, the notion of 'organisational collaboration work' introduced and advanced in the thesis, differs in its specific focus and nature from 'organising work'.

therefore emphasises the importance of developing and legitimating a focus on co-operation, conversation, partnership and collaborative relationships with organisations, as an essential component of the modern nursing remit (e.g. Allen, 2004b, 2014, Liaschenko and Peter, 2004, Clifford, 1995, Bishop and Scudder, 1991, Norman and Cowley, 1999b, Hewison and Wildman, 1996, Maben et al, 2007).

Working in collaboration with organisations may proffer the opportunity for the development of shared understanding, with regards to the priorities and agendas contained within the different nurse and Trust 'versions' of caring identified by nurses. It is suggested that engaging in the process of organisational collaboration work may assist in the mediation and negotiation of boundaries, between the discrete socio-cultural life-worlds associated with the 'Them' and 'Us' collectives, upon which the oppositional power relations of the TNG appeared to be established. Through working in collaboration, insight into the perspective of the 'other', their responsibilities, challenges and constraints, is offered. In exploring each other's perspectives, a discursive space is created for critical conversation and reflection, and within this space, 'versions' of caring can be overtly articulated and contested (Hewison, 1999). In 'heeding the alternative viewpoint' (Norman and Cowley, 1999b:152), the development of shared understanding, recognition, acceptance, respect and a degree of common ground, may be promoted, incorporating both managerial and nursing values (Hewison and Wildman, 1996). Through this process, nurses play an active role in shaping and influencing the nature and form of organisational change from the outset, forging and ensuring congruence with nursing values and practice.

A wider nursing role incorporating organisational collaboration work, offers the opportunity to challenge, redress and renegotiate the power relations which pervaded the Trust-nurse dyad, within nurses' lived reality of Lean implementation. It offers the potential for a shift in power relations, from those defined by oppositional 'gaming work' and covert resistance, leading to a lose-lose impasse, towards proactive engagement in shaping change and decision-

making, as a more sustainable, long-term solution to (shared) control of nursing practice. Through incorporating organisational collaboration work within the nursing mandate itself, rather than through external organisational 'invitation', the potential for nurses to be 'empowered' through facets of their own work is presented, and the potential for innovation and effecting change is harnessed, to the benefit of patients, nurses and organisations alike.

A note on the relationship between 'organisational collaboration work' and holistic, person-centred theory

A nursing mandate incorporating organisational collaboration work does not require the abandonment of holistic, person-centred nursing theory. A reconceptualised mandate might retain this theory as an approach to nursing care *in an attenuated form,* which overcomes its limitations of infeasibility and subsequent disillusionment, but allows for the retention of its essential values and principles. This might be understood as a 'rebalancing of principles…rather than a complete rejection of what has gone before' (Maben and Griffiths, 2008:14), or an attempt to seek a balance, between retaining ideals, allowing for a degree of continuity with nurses' self-understanding and promoting acceptability (Allen, 2014), and modifying (or abandoning) them in light of operational shortcomings (Bergen, 1999). This attenuated form might resemble 'formalized caring', as advocated by Clifford (1995:40):

> *'In acknowledging a formalized caring role it is recognized that nurses will…endeavour to meet the needs of the whole person from a humanistic perspective with compassion and empathy…nurses will undertake a caring role with patients and clients during a working day, but set formal parameters on that caring that focus this activity over a given time span. Within this it will be acknowledged that the activity of care giving may be dictated by the resources available which may have an impact on the range of instrumental and effective care nurses are able to give…in acknowledging the formalized nature of this it would allow nurses to identify the boundaries of their contribution to caring in society in a more realistic way.'*

An identity and mandate focusing on organisational collaboration work might be viewed as complementary, and as a contributor to, an attenuated holistic, person-centred approach. For example, organisational collaboration work might be considered as a form of holistic, person-centred 'caring by proxy' (*ibid.*:39). Through the broader and more encompassing focus on influencing the organisational agenda, nurses can ensure that the imperative of a holistic, person-centred approach to care is central to the direction of change and working practices. This may offer a sustainable way to maximise the influence of nursing values upon practice within the organisational context (Maben et al, 2007). Finally, organisational collaboration work might also be understood as an extension of traditional holistic, person-centred care, since it seeks to broaden the nursing focus upon relationships with patients, towards developing relationships with organisations. Extending 'knowing the patient' to 'knowing the organisation', represents a broadening of the nucleus of nurses' cultural values and in this sense, can be considered a form of 'cultural incrementalism' (Gagliardi, 1986:130).

7.3.2 The role of nursing education and training in supporting organisational collaboration work

Through refocusing the nursing mandate towards incorporating organisational collaboration work, nurse-led decision-making and change occupies a central place in the nursing role and self-conception. Organisational collaboration work therefore provides a means of constructing, articulating, developing and operationalising an 'empowered' nursing identity 'from within'. Attempts to promote an 'empowered' nursing identity through organisational collaboration work, and attempts to promote the acceptability of organisational collaboration work itself, might concentrate on initial processes of identity formation, early socialisation and enculturation, at the point of pre-registration nursing education. Indeed, it is envisaged that nursing education would play a key role in normalising, legitimising and cementing organisational collaboration work as a socio-culturally acceptable endeavour, conducive to the identity and

performativity of the 'good nurse', and the 'proper' remit of nursing. It would also be essential to laying more practical foundations, in terms of promoting the development of skills, attitudes, knowledge and confidence, conducive to engaging with the process of organisational collaboration work. The following suggestions might be considered by educators in their curriculum design and pedagogical approach, to normalise organisational collaboration work, and develop such preparedness, amongst pre-registration students.

- Current models of inter-professional and multi-disciplinary learning employed in nursing education, could be extended to incorporate shared modules and learning, with students from business, leadership and management disciplines.

- Student nurses could receive teaching input from organisational managers and dedicated placements could be arranged with individuals and teams working in an organisational management capacity. Educators could consider developing specific competencies relevant to the collaborative agenda, perhaps by extending those that currently relate to ward management, and inter-professional and multi-disciplinary team working.

- Taught modules could incorporate a specific focus on nursing practice within the organisational context and include theories, frameworks and empirical literatures relevant to organisational change, organisational sociology and sociology of the professions. These modules might aim to foster a reflexive and critical awareness of the socio-cultural context in which healthcare is provided and associated issues of power, empowerment and identity within the organisational and change management context.

- This final suggestion contributes more directly to addressing nurses' apparent self-understandings of powerlessness, their subjugated identity, and the subsequent potential for resistance to the 'empowering' processes of organisational collaboration work. Accordingly, an equal

emphasis might be placed within curricula on teaching surrounding the socio-historical origins of nursing, and the contemporary healthcare context, within which there is increasing opportunity for nurses to participate in and shape nursing practice within the organisational context. More specific pedagogical techniques to promote an 'empowered' identity might also be explored, such as 'Theatre of the Oppressed', as applied to the nursing context by Love (2012).

7.4 Summary and conclusion

This chapter has drawn on insights presented in the findings and discussion chapters, in considering the meaning of Lean implementation for nursing, in the forms of its implications for the professional project and identity of nurses and nursing. In this way, it has attended to the thesis' final research question. Informed by the implications presented, a tentative recommendation, holding relevance for nursing policy, practice, theory and education, has been made.

In identifying the meaning of Lean implementation for nursing, it has been argued that Lean brings critical issues associated with nursing identity to the fore, which are in turn often intimately entwined with issues of power. It has been argued that holistic, person-centred theory, on which the nursing project and identity is predicated, should be approached more critically and candidly, and that a reconceptualisation of the nursing mandate might be considered, in order for it to better meet the needs of nurses, organisations and the changing reality of contemporary healthcare. In addition to addressing issues of identity associated with holistic, person-centred theory, it has been suggested that a reformulated nursing mandate might also promote a more empowered identity, thus addressing issues of identity associated with 'powerlessness'. It has been suggested that this in turn, may foster more productive relationships with organisations, and increased nurse participation in shaping organisational change processes. In this context, the notion of 'organisational collaboration work' has been introduced as a tentative recommendation of the thesis, and its potential contribution to contemporary debates surrounding reformulation of

the nursing mandate has been outlined. Some suggestions have been made as to how pre-registration nursing education might support and assist in realising the agenda of organisational collaboration work.

Chapter 8. Contributions and limitations of the thesis

8.1 Introduction

This chapter identifies some of the broad contributions of the thesis to knowledge. Insights stemming from the thesis are located in the context of literatures introduced in the literature review and discussion chapters, concerning nursing, the sociology of professions, and Lean Thinking (Lean) and operations management. The way in which the thesis contributes to and extends knowledge in these areas, is identified. The thesis' contributions to knowledge should be viewed in the context of the limitations of the thesis however, which are also identified. Finally, normative criteria, proposed as standards by which the thesis could be judged, are discussed in relation to the thesis.

As identified in previous chapters, references in this chapter to 'the lived reality and meaning of Lean', 'for nurses/participants', 'nurses' lived reality' *etcetera*, should be understood in the context of, and as subject to, the feminist philosophical clarification and qualification - that findings did not constitute, a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses'. Rather, more accurately, necessarily and inevitably, the findings - which formed the basis of the discussion, and the implications and a recommendation of the thesis, chapters from which the contributions of the thesis identified in this chapter stem - constituted one (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge.

8.2 Contributions of the thesis

8.2.1 Contributions to nursing knowledge

The thesis provides a critical understanding of nursing, and the lived reality of nursing practice, in the context of Lean implementation, as a contemporary

example of an organisational change initiative, predicated on managerialist principles. It provides insight into the way in which issues of power, identity and the broader social context of the media, appear to shape how nurses make sense of, and interpret, organisational change processes, and relationships with the organisation in which they work. The thesis suggests that understandings and notions of powerlessness persist in nursing, with nurses continuing to inhabit a subjugated identity, which can work to counter organisational attempts to 'empower' nurses and lead to 'powerlessness' becoming a self-fulfilling prophecy. Beyond the external influence of managerialism, this therefore highlights the potential role of factors intrinsic to nursing itself in maintaining a position of relative powerlessness within the professional hierarchy. Overall, the thesis suggests that the 'powerless' subject position adopted by nurses, can hinder the implementation of organisational change processes, relationships with organisations and the potential for innovative nurse-led improvements to patient care. These insights in turn contribute to contemporary understandings of the state and process of 'empowerment' in nursing, and outcomes, in the context of a Lean approach. Although Lean may create structural preconditions necessary for empowerment (Laschinger, Finegan, Shamian et al, 2001), the thesis suggests that in the context of nursing, this may not be sufficient, and due attention should be paid to socio-cultural and psychological antecedents, which appear significant in influencing outcomes.

The thesis contributes to nursing knowledge regarding the theory-practice nexus and suggests that although factors external to nursing, such as managerialist influences, are commonly cited as contributory factors (e.g. Hewison and Wildman, 1996, Rankin and Campbell, 2006), there appear to be factors intrinsic to nursing which similarly antagonise the praxis process, including the unrealistic nature of holistic, person-centred theory and aspects of nursing culture associated with work ethic. Further, this research also contributes to a growing body of literature which critically considers the utility and benefit of the nursing mandate and identity, predicated on holistic, person-centred theory, for both nurses and organisations, in the climate of contemporary healthcare (e.g.

Dingwall and Allen, 2001, Maben, Latter and Macleod Clark, 2007). It suggests that nurses' apparent uncritical subscription to holistic ideology can lead to disillusionment, adversely affect their workplace wellbeing, serve to catalyse oppositional relations with organisations, and preclude nursing engagement with participatory and potentially 'empowering' elements of organisational change initiatives. This in turn prevents nursing input into changes to patient care processes, perpetuates understandings and notions of powerlessness and hinders the process of organisational change.

The recommendation of the thesis offers a potential way in which the nursing mandate and identity based on holistic nursing theory, might be reframed within an organisational context. The notion of 'organisational collaboration work' is advanced as a potential means of addressing a nursing subjugated identity as a barrier to 'empowerment', promoting more productive relationships with organisations and nursing involvement in shaping changes to practice, and refocusing the nursing mandate towards one which is perhaps more realistic and achievable. This recommendation can also be seen to respond to a body of literature which calls for an increased recognition within the nursing mandate, of the organisational context in which nurses work in contemporary healthcare (e.g. Allen, 2004b, 2014, Clifford, 1995, Maben et al, 2007). Organisational collaboration work, and associated implications for pre-registration nursing education in support of this agenda, are offered as a starting point and stimulus for further research and critical debate within the nursing arena.

8.2.2 Contributions to the sociology of professions

Understandings of (nursing) professionalism in the context of managerialism

The thesis identifies the way in which, in line with a conventional sociology of professions analysis, media reportage, representations, and public image and understandings, might be interpreted as contemporary 'threats' to professional power and identity, beyond managerialism. Media influences and public image and understanding, may form a fruitful area for further research within the

sociology of professions, as factors to be considered beyond analysing the influences of managerialism on the professions.

The thesis introduces Lean as a modern manifestation of managerialism. It augments conventional understandings of nursing in the context of managerialism and provides a more nuanced, less deterministic account, which depicts nurses as both subject to managerialist influences, and as active, mediating, oppositional agents within organisational change processes. This research demonstrates how nurses can act to shape the form of managerialism implemented, and negotiate its process and outcomes. The recommendation of the thesis, surrounding organisational collaboration work, reflects an attempt to move beyond oppositional understandings of nursing and managerialism, and managerialism and professionalism, in order to consider how nurses might work with managerialist influences, in order to achieve better outcomes for nursing, organisations and patient care. This is consistent with calls from within the sociology of professions literature, for advancing understandings of the *interaction* between managerialism and the professions (e.g. Noordegraaf, 2011, Thomas and Davies, 2005).

With regards to understandings of the nursing professional project in the context of Lean implementation, the thesis suggests that although managerialist influences can seemingly be interpreted by nurses as challenging their culture, knowledge, identity, autonomy and control over practice, this is not necessarily consistent with the notion of de-professionalisation surrounding nursing in the context of managerialism (e.g. Wells, 1999, Bolton, 2004, Parkin, 1995). Nurses in this research did not appear to interpret these challenges as challenges to professionalism *per se*, neither did Lean appear to be interpreted as a means of supporting the professional project of nursing. Rather, in the context of Lean implementation and media influences, nurses appeared to marginalise and dissociate from, rather than defend, the idea of 'profession' itself, which became largely redundant as a category of identification. Nurses' repertoires of identification instead coalesced around 'nursing' and nursing values at a local, situated, ward level. The nursing identity project of the 'good nurse' in the

context of Lean implementation and media influences, supports the utility of a post-professional approach to the sociology of professions, as outlined by Burns (2007:93), and could be located theoretically within this paradigm as a post-professional project. This approach seeks to critically engage with and extend the concept of profession, in order to 'identify what is new about professions, professionalisation and professionalism and account for this theoretically'. Consistent with the findings of the thesis highlighting the apparent importance of the role of both local and wider socio-cultural context, in influencing the nature of the nursing project, a post-professional approach considers the influence of changing contemporary social and cultural factors upon professionals in society. In this sense, it might be described as concerning professional evolution, or the evolution of the profession.

From 'the profession' to professionals

The findings of the thesis surrounding the nursing identity project of the 'good nurse', located at the contextual interface between Lean implementation and media influences, also contribute to knowledge surrounding how the professional project of the nursing elite plays out and is enacted at a local, ward level. They highlight a disparity between the professional project of the nursing elite and front-line nurse workers, who appeared to hold different concerns, ambitions and articulated an alternative identity. Nurses in this study appeared to align themselves more closely with a localised notion, of the 'good nurse', above the 'professional nurse', as promoted and espoused by the nursing elite.

Nurses' identity project, of portraying the 'good nurse', involved protecting nursing culture and practice at local level. It appeared to reflect the necessity to surmount the struggles associated with 'getting the job done' amidst operational pressures, and defend and 'remoralise' their nursing identity, amidst the concurrent challenges that were presented to it, by Lean implementation and negative media portrayals of the profession. This contrasts with the defence of boundaries, knowledge and practice more broadly, for professional status and a professionalising agenda, as a higher order affair. Adding credence to a post-

professional approach to the professions, and a body of literature in nursing studies, the findings of the thesis support the notion that rather than conceiving of nursing as a homogenous professional entity, there exist disparate iterations, segments, fragments, compartments and versions of nursing - different interest groups do not necessarily share the same aspirations, ambitions and concerns, or a united, collective professional ambition (Salvage, 1988, Bowers, 1989, Porter, 1992, Melia, 1984, Liaschenko and Peter, 2004). These findings also support the idea that aspiring to the status of 'profession' is not necessarily a universal norm or ideal (Brykczynska, 1993, Allen, 1998) and demonstrate that there are a variety of forces both from within and from without, to which nursing is subjected, which cause it to 'ebb and flow along the continuum of professionalization' (Parkin, 1995:566). This in turn suggests that the notion of 'profession' is a flexible rather than static category, and, consistent with Parkin's (1995:565) analysis the notion of 'functional deprofessionalization' (Storch and Stinson, 1988), in this study, nurses appeared to reverse their concern for professional status, in favour of a service ideal, highlighting and re-emphasising the caring role and humanising the care process. Nurses in this study seemed to foreground service towards individuals, as presented to them in their everyday reality, over 'the profession' as an abstract entity (Perry, 1993).

Commenting on the sociology of the professions approach more broadly, the findings of the thesis might be used to caution against analytically and theoretically overemphasising 'profession' as a general, impersonal category, at the expense of individual professionals who constitute the front-line technical core (Bergen, 1999, Roszell, 2013). This is again consistent with a post-professional approach, which engages with the performance of professional ideology, change and practice, and as such, is concerned with issues of identity, and individual level interpretations and discourse, in studying the professions (Burns, 2007). Indeed, this study of nursing, manifested in its local context, illustrates that different empirical conclusions can be drawn from macro and micro-level sociological analyses (Lawler, 1991 in Bergen, 1999, Allen, 1998); this thesis challenges the pre-eminence of the value of 'professionalism' as an

analytical and interpretive category, in exploring nursing work at a local level, in the context of organisational change.

8.2.3 Contribution to the Lean and operations management literature

As a critical study of Lean implementation, the thesis responds to calls for, and contributes to the pursuit of, a more comprehensive evaluation of Lean in healthcare, and its implications for healthcare professionals (e.g. Holden, 2011, Morrow, Robert, Maben et al, 2012, Mazzocato, Savage, Brommels et al, 2010, Brandao de Souza, 2009, D'Andreamatteo, Ianni and Lega, 2015). It makes an early, critical contribution to the study of Lean applied to the context of nursing. Further, it provides an empirically-based, theoretical understanding of the process of Lean implementation in healthcare, and how it appears to be translated and interpreted, through reference to the socio-cultural interaction between Lean and the context into which it is introduced (Waring and Bishop, 2010, Papadopoulos and Merali, 2008). In doing so, the thesis also highlights the way in which wider socio-political influences, such as the media, can mediate the way in which nurses appear to make sense of organisational change processes. As a contribution to the implementation science literature more broadly, this reiterates the importance of attending to the socio-cultural context into which organisational change is introduced, and healthcare professionals' experiences, understandings and interpretations, in managing the process of implementation, its sustainability and outcome. In providing an account of the Lean implementation process, its outcomes, and what might be conceived of as 'facilitators' and 'barriers' to implementation and sustainability, the findings of the thesis contribute to and hold further utility for operations management literatures.

8.3 Limitations of the thesis

8.3.1 The 'generalisability' of insights provided by the thesis

The contributions of the thesis which have been identified in the preceding sections, must be viewed in light of the thesis' limitations. It is acknowledged that the concern of the research with the 'reality' of Lean implementation and the meanings that it held, as socially constructed, subjectively experienced - or 'lived' - and multiple, in nature (Denzin and Lincoln, 2008), its status as one small-scale study, located in one NHS Hospitals Trust setting, with opportunistically sampled participants, limits the 'generalisability' of findings and insights in a positivistic sense. However, since the aim of research was to explore the lived reality and meaning of Lean for nursing and nurses at one Trust, and the feminist approach underpinning the thesis is committed to and emphasises exploring and grounding research in participants' experiences and understandings of phenomena and the meanings with which they are attributed (e.g. Letherby, 2003, Hesse-Biber, 2007), this is not considered to be problematic, as a claim to 'generalisation' in a positivist sense was not considered to be a relevant or consistent aim of the research.

Yet, in identifying the contributions of the thesis, it has been suggested that insights stemming from the research hold utility beyond the study setting, and are potentially applicable to knowledge surrounding nursing, the sociology of the professions and organisational change, more broadly. Rather than being suggestive of 'generalisability' in a positivistic sense, this claim is predicated on the adoption of the more appropriate notion of 'theoretical generalisation', as it applies and is utilised within qualitative inquiry (Lewis and Richie, 2003:267). Indeed, the discussions and explorations of research findings, on which the contributions of the thesis are based, have been located in the context of their relationship to wider extant sociological and nursing theory, contemporary debates and literatures. The recommendation of the thesis surrounding 'organisational collaboration work', has been presented as a tentative starting point for further research and theoretical refinement. In this way, the thesis' contributions can be treated as broad theoretical insights or general themes,

which can be extrapolated and explored in other settings and contexts. Rather than claiming to have documented an objective, static 'reality', holding 'true' beyond the study context, the thesis' utility lies at the level of its theoretical contributions, conceptual arguments and explanations, which contribute towards building empirically informed theoretical bodies of knowledge. It is therefore at the level of theory that a form of generalisation might be said to apply (Lewis and Ritchie, 2003). It is recognised however, that, as described in section 3.8.2 of the methodology chapter, the empirical work of the thesis was situated on three wards which were purposively sampled for their nature as 'high-touch' nursing settings, where the holistic and person-centred nature of, and values underpinning, nursing care might be expected to be particularly emphasised. Given the centrality of holistic, person-centred theory to the nature of the lived reality and meaning of Lean for nurses and nursing within this study, the findings of this research may potentially be especially pronounced or exaggerated, as compared to what might have been found in other, more 'high-tech' nursing settings. The weight afforded to the theoretical contributions of the thesis, in terms of their applicability to nurses and nursing more broadly, should therefore be viewed in this context. Similarly, the potential impact of the 'insider' facet of the researcher's situatedness on the nature of the knowledge presented in the thesis, as considered and discussed in section 3.9.5 of Chapter 3, should also be taken into account in critically appraising the knowledge claims of the thesis.

8.3.2 Normative criteria; critical interaction and reflexivity

It can be recalled from section 3.2 of the methodology chapter, that identification of one's epistemological assumptions allows for the establishment of consistent criteria for assessing the adequacy of the research's 'truth claims', and for the scrutiny and defence of the research process as a credible form of inquiry (Crotty, 1998, Sandberg, 2005, Grix, 2010). In sections 3.3 and 3.4 of the methodology chapter, the feminist philosophical assumptions underpinning the research were delineated and normative criteria stemming from feminist

epistemology were proposed as standards by which the knowledge claims of the thesis could be judged.

In section 3.4.3, it was identified that critical interaction, appraisal and conversation within and across, inside and outside, epistemic communities, from a variety of differently situated, partial perspectives and points of view, can offer a potential solution to 'easy relativisms', 'the problem of the slippery nature of competing knowledges', and can assist in determining the epistemic authority of the knowledge claims of research, avoiding 'a simple pluralism' and 'a version of the impartiality ideal that allows all stories equal rhetorical space' (Haraway, 1988:585, Woodward, 2008:23, Longino, 2002, Tuana, 2001:8). The thesis is therefore conceived of as one motivated version, or construction of persons and events, which should be subject to critical analytical inquiry (Stanley and Wise, 1993), and the researcher accepts and makes a 'modest claim' to situated, partial, fallible, limited, provisional and incomplete knowledge, which 'opens the door' to contestation and interaction with differently situated others (Ferree, 2008:15). To this end, throughout the period of doctoral study, the research has been presented to, and discussed with, wider clinical and academic audiences at local, national and international levels. A list of formal oral conference presentations was provided at the start of the thesis. Critical interaction has assisted with developing and refining components of the thesis, and research findings will be disseminated more widely, through the submission of research papers to peer-reviewed journals, further supporting the criterion of critical interaction. Through the doctoral examination process itself, the thesis will be critically appraised by examiners, who are differently situated to the research within a wider epistemic community, and critical interaction and discussion will take place in the *viva voce* examination.

It was also identified in section 3.4.3 that reflexivity acts as a 'route' into, and resource within, the process of contextualising and critically appraising the knowledge claims of research, by making transparent how the co-constructed knowledge - informed by both the participants' and the researcher's situatedness, partial perspectives and the researcher's active choices made

during the research process - was constructed and arrived at. It can also be considered to be part of the feminist attentiveness to power relations in research, involving researchers accepting responsibility for the partial and situated knowledge that they bring to the fore (England, 1994, Ramazanoğlu and Holland, 2002). Reflexivity therefore allows others to assess and appraise how the partial research account itself is situated and how it came to be, and acts as 'an invitation to other voices to challenge the researcher's knowledge claims and conceptions of power…reflexivity opens up possibilities for negotiation over what knowledge claims are made, for whom, why and within what frame of reference' (Woodward, 2008:28, Ramazanoğlu and Holland, 2002:119).

Throughout the thesis, transparency and a reflexive awareness 'vis-a-vis the phenomenon' (Altheide and Johnson, 1998:302) has been maintained, through identifying the approach taken at each stage of the research process and describing and justifying the choices made, in ways consistent with the feminist philosophical assumptions underpinning the research. Reflexivity and transparency have been demonstrated, for example, in relation to: aspects of the researcher's biographical situatedness and positionality (Chapter 1, section 1.3); the rationale informing the formulation of research questions (Chapter 2, section 2.6); the theoretical, philosophical and methodological assumptions underpinning the research (Chapters 2 and 3); the implications of feminist philosophy for the knowledge claims of the thesis and the role and place of criticality within it (Chapter 3, section 3.4) and the ethnographic approach adopted, including the role of theory (Chapter 3, section 3.6.2). Reflexivity and transparency have also been demonstrated in relation to the critical approach to the status and role of the researcher occupied during fieldwork observations (Chapter 3, sections 3.9.3 and 3.9.5) and the approach taken to interviews (Chapter 3, section 3.7.2); the approach to data analysis (Chapter 3, section 3.10) and the limitations of the thesis in this chapter. An awareness of power relations in the research process, and respect for (inevitably and necessarily, the researcher's account of) participant accounts and enactments surrounding the

lived reality and meaning of Lean, has also been demonstrated and interspersed throughout the chapters and sections of the thesis.

Overall, it is acknowledged that although committed to exploring the experiences, interpretations and understandings of participants, rather than constituting a mirror-image reflection or representation of 'the' 'lived reality' and meaning of Lean 'for nurses', more accurately, and necessarily and inevitably, the knowledge presented in the thesis constitutes *one* (the researcher's partial and situated) account of participants' (multiple, partial and situated) accounts and enactments surrounding the lived reality and meaning of Lean, reflecting their respective influences in the co-construction of knowledge. Since feminists conceptualise *all* knowledge as situated, partial and co-constructed in accordance with the influences and situatedness of the researcher and participants, rather than objectively 'discovered', this is not considered to be problematic, as long as this status of knowledge is recognised, it is not claimed otherwise, and the researcher makes transparent how the research itself is situated and how the co-constructed knowledge presented was constructed, arrived at and came to be - through reflexivity, which in turn allows for the critical appraisal of knowledge claims. The account presented in the thesis should therefore be subject to critical appraisal by differently situated others, assisted by the transparent and reflexive accounting which has been maintained throughout the thesis, which explicates how the co-constructed knowledge presented in the thesis was arrived at and came to be.

8.4 Summary and conclusion

This chapter of the thesis has identified some of the broad contributions of the research to knowledge. Insights stemming from the thesis have been located in the context of literatures introduced in the literature review and discussion chapters, concerning nursing, the sociology of professions, and Lean and operations management. The way in which the thesis contributes to and extends knowledge in these areas, has been identified. Limitations of the thesis have also been identified, and it has been suggested that the thesis'

contributions should be viewed within this context. Normative criteria, proposed as standards by which the thesis could be judged, have been discussed in relation to the thesis.

Chapter 9. Conclusion to the thesis

9.1 Introduction

This final chapter concludes the thesis, by way of providing a summary of the content of each of the thesis' chapters.

9.2 Summary of the thesis

The thesis has provided an account of the lived reality of the implementation of a management philosophy called Lean Thinking (Lean), and its meaning for nursing and nurses, working in three settings at a National Health Service (NHS) Hospitals Trust, in the United Kingdom (UK).

Chapter 1 introduced the thesis by way of providing a synopsis of the thesis' content and a reflexive account of aspects of the researcher's situatedness and positionality, which 'situated' the research in relation to the research and contextualised its genesis and the underlying motivations for study. The structure of the thesis was also outlined.

Chapter 2 introduced the concept of 'Lean Thinking' and provided a critical review of theoretical and empirical literature relevant to Lean implementation in healthcare, and its application in the UK NHS. Gaps in knowledge and understanding surrounding Lean in healthcare were identified, and arguments were presented in support of the need to address them. The knowledge gaps most pertinent for the direction of the thesis, were predicated on the conception of Lean as a socio-cultural intervention, holding the potential to transform the socio-cultural milieu of healthcare practice. The dearth of research considering the nature of this transformation, the interaction between Lean and the socio-cultural context of practice, healthcare professionals' and experiences, understandings and interpretations of implementation, and the implications that it holds for them, was highlighted.

The thesis' focus on Lean implementation in the context of nursing was introduced, and arguments which framed and supported the rationale for this

focus, were presented. A theoretical account of the interaction between Lean and nursing was provided as, on the one hand, a manifestation of a 'managerialism versus professionalism' dyad, presenting challenges to essential facets of nursing as a profession, its socio-cultural foundations and identity. On the other hand, it was suggested that Lean implementation could be conceived of as representing an 'empowering' process, consistent with increasing autonomy and control over nursing practice, thus proffering opportunities for nurses and the professional project of nursing. The centrality of the socio-cultural notions of 'power' and 'holistic, person-centred theory', to the nature of this theoretical interaction was highlighted. As such, these concepts were introduced as vehicles employed by the thesis, through which the lived reality of Lean, and its meaning for the nursing professional project and identity, could be critically explored and understood. The treatment of the concept of 'power' within Lean theory was critiqued, the thesis' Foucauldian approach to understanding power was introduced, and the potential insufficiency of a binary approach to understanding complex phenomena, was identified.

The chapter concluded with the identification of the thesis' research aim and objectives. The aim of research was to explore the lived reality and meaning of Lean Thinking for nursing and nurses working in three settings at an NHS Hospitals Trust. The objectives of research were presented, through which the aim of research could be addressed. The broad primary objective of the research was to explore the socio-cultural interaction between Lean and nursing. From this, stemmed three more specific secondary objectives, which were to address the research questions:

- How can power and power relationships be understood in the context of Lean and nursing?
- How does Lean interact with holistic, person-centred theory and how can the translation of nursing theory into practice (the praxis process) be understood in the context of Lean implementation?

- What ramifications do power relationships in the context of Lean, and its interaction with holistic, person-centred theory, hold for the professional project and identity of nurses and nursing, to which the notions of power and holistic theory are central?

Chapter 3 elucidated the methodology which was employed to meet the aim and objectives of research. The qualitative approach and feminist philosophical assumptions underpinning the thesis were identified, together with their implications for the thesis. The thesis' ethnographic methodology and methods were described, and an account of the study setting, sampling strategy, participants, data collection and analysis, together with ethical considerations relevant to the study, was also provided.

Chapter 4 presented the thesis' empirical findings, which provided an account of the lived reality and meaning of Lean implementation for nurses and nursing in the study setting, and depicted the nature of the socio-cultural interaction between Lean and nursing. The findings therefore broadly addressed the research aim and primary research objective.

The lived reality of Lean implementation was conceptualised as a game, played between the Hospitals Trust (the Trust) and nurses, for power and control over nursing practice. The four themes of the findings narrated the story of the game 'at play' in the study setting. The first three themes were devoted to exploring nurses' narratives and enactments surrounding the Trust 'side' of the game; the organisational rationale for, and mechanisms of, exercising power under the guise of Lean. The final theme explored the nursing response to Lean implementation, which appeared to incorporate strategies to preserve the socio-cultural *status quo*, and protect nursing knowledge, autonomy and practice.

Chapter 5 formed the first of two discussion chapters. It considered the research findings in light of the first of the thesis' socio-culturally focused research questions. As such, informed by a Foucauldian approach, it explored 'power' as an aspect of the socio-cultural interaction between Lean and nursing, from both

the analytical angle of the account of the lived reality and meaning of Lean presented in the findings, in addition to a more critical perspective, informed by extant theory, literatures and empirical work. Attention was devoted to critical analyses of the nature and role of 'power', in influencing the nature of the lived reality and meaning of Lean implementation for nurses and nursing, contributing further to the overarching aim of research. Insights into the ramifications of power relations within the lived reality of Lean, for the nursing professional project and identity, relevant to the final research question, were also provided.

Among the arguments presented in the chapter, it was contended that rather than constituting a 'professional' defence as a function of the 'managerialism versus professionalism' dyad, the nursing response within the game that characterised the lived reality of Lean implementation, was predicated on the objective of an identity project, of the 'good nurse'. It was suggested that the nature of the nursing project as one of identity, rather than profession, was mediated by a double jeopardy, in terms of challenges presented to nursing identity, by Lean implementation, in conjunction with the influence of contemporary disparaging media portrayals of nurses. The influence of nurses' quotidian struggle to 'get the job done' amidst operational pressures, was also described. The status of nurses as active oppositional agents within the game was also highlighted, thus challenging traditional views surrounding a state of powerlessness in nursing. Explanations were provided as to how a 'powerless' self-understanding and identity might have been maintained however, through a self-fulfilling prophecy, and a situation of 'lose-lose' stalemate, within the game that characterised nurses' lived reality of Lean implementation.

Chapter 6, the second discussion chapter, addressed the thesis' second research question and considered the nature of the interaction between Lean and holistic, person-centred theory, and the way in which the translation of nursing theory into practice could be understood, in the context of Lean implementation. Insights surrounding the ramifications of these understandings for the professional project and identity of nurses and nursing, relevant to the thesis' final research question, were also provided. Attention was devoted to critical

analyses of the role of nursing theory, in influencing the nature of nurses' lived reality, and its meaning for nursing. Mirroring the approach adopted in the first discussion chapter, the chapter considered the research question from both the analytical angle of the account of the lived reality and meaning of Lean presented in the findings, in addition to providing a more critical exploration, informed by extant theory, literatures and empirical work, contributing further to the aim of research.

Arguments relevant to the nursing praxis process were advanced, including the contention that Lean could be understood as a contemporary scapegoat for a theory-practice gap, and antagonising factors intrinsic to nursing itself. The utility and benefit of holistic, person-centred theory as a basis for the nursing remit and identity, for nurses' wellbeing, relationships with organisations, and degree of influence in the healthcare arena, was also questioned. Arguments were located within, and contributed to, contemporary debates and critiques within wider literature, surrounding the nursing praxis process and nursing's mandate.

Chapter 7 presented the implications, and a recommendation of, the thesis. It drew upon insights presented in the findings and discussion chapters, in considering the meaning of Lean for nursing, in the forms of its implications for the professional project and identity of nurses and nursing. In this way, it attended to the thesis' final research question. Informed by the implications presented, the chapter culminated with a tentative recommendation, holding relevance for nursing policy, practice, theory and education.

In identifying the meaning of Lean implementation for nursing, it was argued that Lean brought critical issues associated with nursing identity to the fore, which were in turn often intimately entwined with issues of power. It was argued that holistic, person-centred theory, upon which the nursing project and identity appeared to be predicated, should be approached more critically and candidly, and that a reconceptualisation of the nursing mandate might be considered, in order for it to better meet the needs of nurses, organisations and the changing reality of contemporary healthcare. In addition to addressing

issues of identity associated with holistic, person-centred theory, it was suggested that a reformulated nursing mandate might also promote a more empowered identity, thus addressing issues of identity associated with 'powerlessness'. It was suggested that in turn, this may foster more productive relationships with organisations, and increased nurse participation in shaping organisational change processes. In this context, the notion of 'organisational collaboration work' was introduced as a recommendation of the thesis, and its potential contribution to contemporary debates surrounding reformulation of the nursing mandate was outlined. Some suggestions were made as to how pre-registration nursing education might support and assist in realising the agenda of organisational collaboration work, within a reformulated nursing mandate.

Chapter 8 identified some of the broad contributions of the thesis to knowledge. Insights stemming from the thesis were located in the context of literatures introduced in the literature review and discussion chapters concerning nursing, the sociology of professions, and Lean and operations management. It was identified that, at its broadest level, the thesis contributes to the pursuit of a more comprehensive and critical evaluation of Lean in healthcare, and makes an early, empirically based, theoretical contribution to the study of Lean implementation in the context of nursing. Further contributions of the thesis were identified, which coalesce around insights concerning: how nurses appear to make sense of and interpret organisational change processes, the state, process and outcomes of nursing empowerment, critical analyses of the nursing theory-practice nexus, identity and mandate, and a post-professional approach to the study of the professions and their projects in the arena of contemporary healthcare. The chapter also identified the thesis' limitations, and suggested that contributions to knowledge should be viewed in this context. Normative criteria, proposed as standards by which the thesis could be judged, were discussed in relation to the thesis.

This final chapter, Chapter 9, has served to conclude the thesis, by way of providing a summary of the content of each of the thesis' chapters.

References

Abbott, A. (1988). *The system of professions. An essay on the division of expert labor.* University of Chicago press: London.

Abbott, P., Meerabeau, L. (1998). *Professionals, professionalization and the caring professions*. In: Abbot, P., Meerabeau, L. (Eds). *The sociology of the caring professions*. 2nd Ed. UCL Press Limited: London. P1-19.

Adam, A. (1998). *Artificial knowing: gender and the thinking machine*. Routledge: London.

Adams, G., Beasley, C., Bernhauser, S., Bharj, K., Carter, P., Chapman, D., Emerton, A., Fradd, E., Griffin, J., et al (2010). *Front line care: the future of nursing and midwifery in England. Report of the prime minister's commission on the future of nursing and midwifery in England 2010.* Available at: http://www.nhshistory.com/nursing%20commission.pdf. Accessed 17/02/12.

Adler, P.A., Adler, P. (1998). *Observational techniques*. In: Denzin, N.K., Lincoln, Y.S. (Eds). *Collecting and interpreting qualitative materials*. SAGE Publications Ltd: London. P79-109.

Alcoff, L., Potter, E. (1993). *When feminisms intersect epistemology*. In: Alcoff, L., Potter, E. (Eds). *Feminist epistemologies*. Routledge: London. P1-14.

Allen, A. (2011). *Feminist perspectives on power*. The Stanford Encyclopedia of Philosophy. Available at: http://plato.stanford.edu/archives/sum2014/entries/feminist-power/. Accessed 25/5/15.

Allen, D. (1998). *Doctor-nurse relationships: accomplishing the skill mix in health care*. In: Abbott, P., Meerabeau, L. (Eds). *The sociology of the caring professions*. 2nd Ed. UCL Press Limited: London. P210-235.

Allen, D. (2001). Narrating nursing jurisdiction: 'atrocity stories' and 'boundary work'. *Symbolic interaction.* 24 **(1)**. P75-103.

Allen, D. (2004a). Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings. *Nursing inquiry*. 11 **(1)**. P14-24.

Allen, D. (2004b). Re-reading nursing and re-writing practice: towards an empirically based reformulation of the nursing mandate. *Nursing inquiry*. 11 **(4)**. P271-283.

Allen, D. (2014). Re-conceptualising holism in the contemporary nursing mandate: from individual to organisational relationships. *Social science and medicine*. 119. P131-138.

Allsopp, P., Faruqi, J., Gascoigne, L., Tennyson, R. (2009). Productive Ward 2: practical advice to facilitators implementing the programme. *Nursing times*. 105 **(25)**. P19-21.

Altheide, D.L., Johnson, J.M. (1998). *Criteria for assessing interpretive validity in qualitative research*. In: Denzin, N.K., Lincoln, Y.S. (Eds). *Collecting and interpreting qualitative materials*. SAGE Publications Ltd: London. P283-312.

Andersen, H., Røvik, K.A., Ingebrigtsen, T. (2014). Lean Thinking in hospitals: is there a cure for the absence of evidence? A systematic review of reviews. *BMJ Open*. 4 **(1)**. P1-8.

Andrews, A., St Aubyn, B. (2015). 'If it's not written down; it didn't happen…'. *Journal of community nursing.* 29 **(5)**. P20-22.

Antony, J. (2006). Six Sigma for Service Processes. *Business process management journal*. 12 **(2)**. P234-238.

Antony, L.M. (1993). *Quine as feminist*: *the radical import of naturalized epistemology*. In: Antony, L.M., Witt, C. (Eds). *A mind of one's own: feminist essays on reason and objectivity.* Westview press: Colorado. P185-226.

Antony, L.M. (2002). *Embodiment and epistemology*. In: Moser, P.K. (Ed). *The Oxford handbook of epistemology*. Oxford University Press: New York. P463-478.

Antrobus, S. (1997). An analysis of nursing in context: the effects of current health policy. *Journal of advanced nursing*. 25 **(3)**. P447-453.

Armitage, C., Higham, P. (2011). The Productive Ward: encouraging teambuilding and innovation. *Nursing management*. 18 **(1).** p28-31.

Aull Davies, C. (2008). *Reflexive ethnography: a guide to researching selves and others*. Routledge: London.

Baruch, G. (1981). Moral tales: parents' stories of encounters with health professions. *Sociology of health and illness*. 3 **(3)**. P275-295.

Beardshaw, V., Robinson, R. (1990). *New for old? Prospects for nursing in the 1990s. Research Report 8.* King's Fund Institute: London.

Benner, P., Tanner, C. (1987). Clinical judgement: how expert nurses use intuition. *American journal of nursing*. 87 **(1)**. P23-31.

Benner, P., Wrubel, J. (1989). *The primacy of caring*. Addison-Wesley: California.

Ben-Tovim, D., Bassham, J., Bolch, D., Martin, M., Dogherty, M., Szwarcbord, M. (2007). Lean Thinking across a hospital: redesigning care at the Flinders Medical Centre. *Australian health review*. 37 **(1)**. P10-16.

Bergen, A. (1999). *Nursing as caring revisited*. In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age*. Blackwell Science Ltd: London. P155-166.

Berger, A. (2003). The Quinean quandary and the indispensability of nonnaturalised epistmemology. *The philosophical forum*. 34 **(3-4)**. P367-382.

Bird, A. (2012). *A guide to case notes and record-keeping*. Available at: https://www.nursinginpractice.com/article/guide-case-notes-and-record-keeping. Accessed 17/07/17.

Bishop, A.H., Scudder, J.R. (1991). *Dialogical care and nursing practice*. In: Chin, P.L. (Ed). *Anthology on caring*. National League for Nursing Press: New York. P17-30.

Blaikie, N. (2010). *Designing social research: the logic of anticipation*. 2nd Ed. Polity Press: Cambridge.

Blakemore, S. (2009). How productive wards can improve patient care. *Nursing management.* 16 **(5)**. P14-18.

Bloodworth, K. (2009). Productive Ward 1: implementing the initiative across a large university teaching hospital. *Nursing times*. 105 **(24)**. P22-25.

Bloodworth, K. (2011). The Productive Ward and the Productive Operating Theatre. *Journal of perioperative practice*. 21 **(3)**. P97-103.

Bohmer, R. M. J., Ferlins, E. M. (2006). *Virginia Mason Medical Center. Case studies*. Harvard Business School: Boston.

Bolton, S.C. (2004). A simple matter of control? NHS hospital nurses and new management. *Journal of management studies*. 41 **(2)**. P317-333.

Bonjour, L. (2010). *Epistemology: classic problems and contemporary responses*. 2nd Ed. Rowman and Littlefield Publishers: Plymouth.

Bordo, S. R. (1987). *The flight to objectivity: essays on cartesianism and culture*. State University of New York Press: Albany.

Bowers, L. (1989). The significance of primary nursing. *Journal of advanced nursing*. 14 **(1)**. P13-19.

Bowles, N. (1995). Story telling: a search for meaning within nursing practice. *Nurse education today*. 15 **(5)**. P365-369.

Boyle, J.S. (1994). *Styles of ethnography*. In: Morse, J.M. (Ed). *Critical issues in qualitative research methods*. SAGE Publications Ltd: London.

Brandao de Souza, L. (2009). Trends and approaches in Lean healthcare. *Leadership in health services*. 22 **(2)** .P121-139.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*. 3 **(2)**. P77-101.

Briggs, A.R.J. (2007). Exploring professional identities: middle leadership in further education colleges. *School leadership and management*. 27 **(5)**. P471-485.

Bröckling, U., Krasmann, S., Lemke, T. (2011). *From Foucault's lectures at the Collège de France to studies of governmentality. An introduction.* In: Bröckling, U., Krasmann, S., Lemke, T. (Eds). *Governmentality: current issues and future challenged.* Routledge: Oxon. P1 - 33.

Brykczynska, G. (1993). *Nursing values: nightmares and nonsense*. In: Jolley, M., Brykczynska, G. (Eds). *Nursing: its hidden agendas*. Edward Arnold: London. P131-158.

Burgess, N., Radnor, Z. (2013). Evaluating Lean in healthcare. *International journal of health care quality assurance.* 23 **(3)**. P220-235.

Burns, E. (2007). Positioning a post-professional approach to studying professions. *New Zealand Sociology.* 22 **(1)**. P69-98.

Burston, S., Chaboyer, W., Wallis, M., Stanfield, J. (2011). A discussion of approaches to transforming care: contemporary strategies to improve patient safety. *Journal of advanced nursing*. 67 **(11)**. P2488-2495.

Butler, J. (1992). *Patients, policies and politics: before and after 'Working for Patients'*. Open University Press: Milton Keynes.

Byrne, A.P., Fiume, O.J. (2005). *Figure 3. Traditional culture vs. Lean culture*. In: Miller, D. (Ed). *Going Lean in healthcare*. Institute for Healthcare Improvement: Cambridge. Available at: http://www.entnet.org/Practice/upload/GoingLeaninHealthCareWhitePaper.pdf . Accessed 20/05/12.

Cain, M. (1986). Realism, feminism, methodology and law. Journal of the sociology of law. 14 (314). P255-267.

Clegg, S.T. (1989). *Frameworks of power*. SAGE Publications Ltd: London.

Clifford, C. (1995). Caring: fitting the concept to nursing practice. *Journal of clinical nursing*. 4 **(1)**. P37-41.

Code, L. (1991). *What can she know? Feminist theory and the construction of knowledge.* Cornell University Press: New York.

Cox, D. (2003). *Health service management - a sociological view: Griffiths and the non-negotiated order of the hospital.* In: Gabe, J., Calnan, M., Bury, M. (Eds). *The sociology of the health service*. Taylor and Francis e-Library. Available at: http://dlx.bookzz.org/genesis/547000/360b79083df6045f51f2180df2936c67/_as/[Michael_Bury_M]_The_Sociology_of_the_Health_Serv(BookZZ.org).pdf. Accessed: 01/02/15.

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process*. SAGE Publications Ltd: London.

D'Andreamatteo, A., Ianni, L., Lega, F. (2015). Lean in healthcare: a comprehensive review. *Health Policy*. 119 **(9)**. P1197-1209.

Davies, C. (1995). *Gender and the professional predicament in nursing*. Open University Press: Buckingham.

Davis, D-A., Craven, C. (2016). *Feminist ethnography: Thinking through methodologies, challenges and possibilities.* Rowman and Littlefield: London.

Day, P., Klein, R. (1983). Two views on the Griffiths report. The mobilisation of consent versus the management of conflict: decoding the Griffiths report. *British medical journal*. 287 **(6407)**. P1813-1816.

Daykin, N., Clarke, B. (2000). 'They'll still get the bodily care'. Discourses of care and relationships between nurses and health care assistants in the NHS. *Sociology of heath and illness.* 22 **(3)**. P349-363.

Dedhia, N. S. (2005). Six Sigma Basics. *Total Quality Management*. 16 **(5)**. P567–574.

DelliFraine, J.L., Langabeer, J.R., Nembhard, I.M. (2010). Assessing the evidence of six sigma and lean in the health care industry. *Quality management in healthcare*. 19 **(3)**. P211-225.

Denzin, N.K., Lincoln, Y.S. (1998). *Entering the field of qualitative research*. In: Denzin, N.K., Lincoln, Y.S. (Eds). *Collecting and interpreting qualitative materials*. SAGE Publications Ltd: London. P1-34.

Denzin, N.K., Lincoln,Y.S. (2008). *Introduction: the discipline and practice of qualitative research.* In: Denzin, N.K., Linsoln, Y.S. (Eds). *Strategies of qualitative enquiry.* 3rd Ed. SAGE Publications: London. P1-44.

Department of Health. (1989). *Working for Patients*. HMSO: London.

Department of Health. (2005). *Payment by Results: Technical guidance for 2004–05*. The Stationery Office: London.

Department of Health and Social Security. (1983). National Health Service management inquiry. HMSO: London.

Department of Health and Social Security. (1986). *Health services management: resource management (management budgeting) in health authorities.* DHSS: London.

Dewalt, K.M., Dewalt, B.R. (2002). *Participant observation. A guide for fieldworkers*. AltaMira Press: California.

Dewar, B., Nolan, M. (2013). Caring about caring: developing a model to implement compassionate relationship centred care in an older people care setting. *International journal of nursing studies*. 50 **(9)**. P1247-1258.

Dingwall, R., Allen, D. (2001). The implications of healthcare reforms for the profession of nursing. *Nursing inquiry*. 8 **(2)**. P 64-74.

Drennan, J., Hyde, A. (2009). The fragmented discourse of the 'knowledgeable doer': nursing academics' and nurse managers' perspectives on a master's education for nurses. *Advances in health sciences education*. 14 **(2)**..P173-186.

Drotz, E., Poksinska, B. (2014). Lean in healthcare from employees' perspectives. *Journal of health organisation and management.* 28 **(2)**. P177-195.

Eastman, C.M. (1985). Establishing social identity through language use. *Journal of language and social psychology.* 4 **(1)**. P1-20.

Edwards, B., Fall, M. (2005). *The executive years of the NHS. The England account 1985 – 2003.* Radcliffe Publishing: Oxford.

Elliott, A. (2014). *The trajectories of social and cultural theory*. In: Elliott, A. (Ed). *Routledge handbook of social and cultural theory*. Routledge: Oxon. P3-19.

Emerson,R.M., Fretz, R.I., Shaw, L.L. (1995). *Writing ethnographic fieldnotes*. University of Chicago Press: Chicago.

Emiliani, B. (2011). *Moving forward faster: the mental evolution from fake Lean to REAL Lean*. The Center for Lean Business Management: Connecticut.

England, K.V.L. (1994). Getting personal: reflexivity, positionality and feminist research. *The professional geographer*. 46 **(1)**. P80-89.

Enthoven, A. (1985). *Enthovan report. Reflections on the management of the NHS: an American looks at the incentives to efficiency in health services management in the UK.* Nuffield trust: London.

Etzioni, A. (1969). *The semi-professions and their organisation*. Free Press: New York.

Evetts, J.. (2011). A new professionalism? Challenges and opportunities. *Current sociology*. 59 **(4)**. P406-422.

Evetts, J. (2013). Professionalism: value and ideology. *Current sociology review*. 61 **(5-6)**. P778-796.

Fagerström, L., Bergbom, I. (2010). The use of Hegelian dialectics in nursing science. *Nursing science quarterly*. 23 **(1)**. P79-84.

Falk Rafael, A.R. (1996). Power and caring: a dialectic in nursing. *Advances in nursing science*. 19 **(1)**. P 3-17.

Ferrano, G., Andreatta, S. (2012). *Cultural anthropology. An applied perspective*. 9th Ed. Wadsworth Cengage Learning: California.

Ferree, M.M. (2005). *Inequality, Intersectionality and the Politics of Discourse: Framing Feminist Alliances.* Available at: http://www.ssc.wisc.edu/~mferree/documents/Inequality&intersect-July08.pdf. Accessed 27/06/17. P1-21.

Fillingham, D. (2008). *Lean healthcare: improving the patient's experience*. Kingsham Press: Chichester.

Finkelman, A., Kenner, C. (2013). *Professional nursing concepts; competencies for quality leadership.* 2nd Ed. Jones and Barlett Publishers: Massachusetts.

Fitzpatrick, J., Redfern, S. (1999). *The organisation of nursing work*. In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age*. Blackwell Science Ltd: London. P103-122.

Fonow, M.M., Cook, J.A. (2005). Feminist methodology: new applications in the academy and public policy. *Signs*. 30 **(4)**. P2211-2236.

Foster, S., Gordon, P., McSherry, W. (2009). Rolling out Productive Ward foundation modules across a hospital trust. *Nursing times*. 105 **(30)**. P28-30.

Foucault (1978). *The history of sexuality. Volume 1: an introduction*. Pantheon Books: New York.

Foucault, M. (1981). *The order of discourse*. In: Young, R. (Ed). *Untying the text: a post-structuralist reader*. Routledge and Kegan Paul: London. P48-78.

Foucault, M. (1982). The subject and power. *Critical inquiry*. 8 **(4)**. P777-795.

Foucault, M. (1988). *Technologies of the self*. In: Martin, L.H., Gutman, H., Hutton, P.H. (Eds). *Technologies of the self. A seminar with Michel Foucault*. The University of Massachusetts Press: Amherst. P16-49.

Foucault, M. (1995). *Discipline and punish. The birth of the prison*. 2nd Ed. Vintage Books: New York.

Foucault, M. (1997). *The ethics of the concern of the self as a practice of freedom*. In: Rabinow, P. (Ed). *Michel Foucault: ethics: subjectivity and truth*. *The essential works of Michel Foucault 1954-1984. Volume one*. The Penguin Press: London. P281-301. P281-301.

Foucault, M. (2000). *The archaeology of knowledge*. Routledge Classics: London.

Foucault, M. (2003a). *7 January 1976*. In: Bertani, M., Fontana, A. (Eds). *Society must be defended. Lectures at the collège de france 1975-76.* Picador: New York. P1-22.

Foucault, M. (2003b). *21 Jan 1976*. In: Bertani, M., Fontana, A. (Eds). *Society must be defended. Lectures at the collège de france 1975-76.* Picador: New York. P43-64.

Foucault, M. (2003c). *14 Jan 1976*. In: Bertani, M., Fontana, A. (Eds). *Society must be defended. Lectures at the collège de france 1975-76.* Picador: New York. P23-42.

Fournier, V. (1999). The appeal to 'professionalism' as a disciplinary mechanism. *The sociological review*. 47 **(2)**. P280-307.

Fournier, V. (2000). *Boundary work and the (un)making of the professions*. In: Malin, N. (Ed). *Professionalism, boundaries and the workplace*. P67-86. Routledge. London.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery office: London.

Gagliardi, P. (1986). The creation and change of organisational cultures: a conceptual framework. *Organisation studies*. 7 **(2)**. P117-134.

Gagliardi, P. (1992a). *Artifacts as pathways and remains of organizational life*. In: Gagliardi, P. (Ed). *Symbols and artifacts. Views of the corporate landscape*. Aldine de Gruyter: New York. P3-38.

Gagliardi, P. (1992b). *Preface*. In: Gagliardi, P. (Ed). *Symbols and artifacts. Views of the corporate landscape.* Aldine de Gruyter: New York. Pv-x.

Gallagher, M. (2008). Foucault, power and participation. *International journal of children's rights*. 16 **(3)**. P395-406.

Gallie, W.B. (1955-1956). Essentially contested concepts. *Proceedings of the Aristotelian Society*. New Series. 56 **(1955-1956)**. P167-198.

Garry, A., Pearsall, M. (1996a). *Theory of knowledge*. In: Garry, A., Pearsall, M. (Eds). *Women, knowledge and reality: explorations in feminist philosophy*. 2nd Ed. Routledge: London. P145-148.

Garry, A., Pearsall, M. (1996b). *Introduction*. In: Garry, A., Pearsall, M. (Eds). *Women, knowledge and reality: explorations in feminist epistemology*. 2nd Ed. Routledge: London. P1-6.

Gershon, P. (2004). *Releasing resources to the front line - independent review of public sector efficiency.* HM Treasury: London. Available at: https://www.education.gov.uk/publications/standard/Budgetsandfinance/Page1/Treasury-Efficiency. Accessed 05/10/11.

Glasby, J. (2017). *Understanding health and social care.* 3rd Ed. Policy Press: Bristol.

Glasper, A. (2011). Improving record keeping: important lessons for nurses. *British journal of nursing.* 20 **(14)**. P886-887.

Goffman, E.G. (1955). On face-work: an analysis of ritual elements in social interaction. *Psychiatry: interpersonal and biological processes*. 18 **(3)**. P213-231.

Goffman, E.G. (1959). *The presentation of self in everyday life*. Penguin books Ltd: Middlesex.

Goffman, E.G. (1963). *Stigma. Notes on the management of spoiled identity*. Penguin Books: Middlesex.

Gold, R.L. (1958). Roles in sociological field obervations. *Social forces*. 36 **(3)**. P217-223.

Gopaldas, A., Fischer, E. (2012). *Beyond gender: intersectionality, culture, and consumer behaviour.* In: Otnes, C.C., Tuncay Zayer, L. (Eds). *Gender, culture, and consumer behaviour*. Routledge: London. P393-410.

Gordon, C. (1991). *Governmental rationality: an introduction*. In: Burchell, G., Gordon, C., Miller, P. (Eds). *The Foucault effect. Studies in governmentality.* University of Chicago Press. Chicago. P1-52.

Grasswick, H.E. (2004). Individuals-in-communities: the search for a feminist model of epistemic subjects. *Hypatia*. 19 **(3)**. P85-120.

Grasswick, H.E. (2009). *Feminist social epistemology*. Stanford Encyclopedia of Philosophy. Available at: http://plato.stanford.edu/archives/spr2009/entries/feminist-social-epistemology/. Accessed 12/01/12.

Greco, J. (1999). *Introduction: what is epistemology?* In: Greco, J., Sosa, E. (Eds). *The Blackwell guide to epistemology.* Blackwell Publishing Ltd: Oxford. P1-32.

Griffiths, M. (1995). *Feminisms and the self: the web of identity*. Routledge: London.

Griffiths, M. (1988). *Feminism, feelings and philosophy*. In: Griffiths, M., Whitford, M. (Eds). *Feminist perspectives in philosophy*. Indiana University Press: Indiana. P131-151.

Grix, J. (2010). *The foundations of research*. 2nd Ed. Palgrave Macmillan: Hampshire.

Halford, S., Leonard, P. (2003). Space and place in the construction and performance of gendered nursing identities. *Journal of advanced nursing*. 42 **(2)**. P201-208.

Hamilton, J., Verrall, T., Maben, J., Griffiths, P., Avis, K., Baker, G.R., Teare, G. (2014). One size does not fit all: a qualitative content analysis of the importance of existing quality improvement capacity in the implementation of Releasing Time to Care: the Productive Ward in Saskatchewan, Canada. *BMC health services research*. 14 **(642)**. P1-14.

Hammersley, M., Atkinson, P. (2007). *Documents and other artefacts, real and virtual*. In: Hammersley, M., Atkinson, P. (Eds). *Ethnography. Principles in practice.* 3rd Ed. Routledge: London. P121-139.

Haraway, D.H. (1988). Situated knowledges: the science question in feminism and the privilege of partial perspective. *Feminist studies.* 14 **(3)**. P575-599.

Harding, S. (1986a). *The science question in feminism*. Cornell University Press: New York.

Harding, S. (1986b). The instability of the analytical categories of feminist theory. *Signs*. 11 **(4)**. P645-664.

Harding, S. (1987). *Is there a feminist method?* In: Harding, S. (Ed). *Feminism and methodology.* Indiana University Press: Indiana.

Harding, S. (1991). *Whose science? Whose knowledge? Thinking from women's lives*. Cornell University Press: New York.

Harding, S., Norberg, K. (2005). New feminist approaches to social science methodologies: an introduction. *Signs.* 30 **(4)**. P2009-2015.

Harrison. S. (1994). *National Health Service management in the 1980s. Policy making on the hoof?* Avebury: Hampshire.

Heikes, D.K. (2004). The bias paradox: why it's not just for feminists anymore. *Synthese*. 138 **(3).** P315-335.

Hesse-Biber, S.N. (2007). *The practice of feminist in-depth interviewing*. In: Hesse-Biber, S.N., Leavy, P.L. (Eds). *Feminist research practice; a primer.* Sage Publications, London. P111-148

Hesse-Biber, S.N., Leavy, P. (2011). *The practice of qualitative research*. 2nd Ed. SAGE Publications Ltd: London.

Hewison, A. (1999). The New Public Management and the New Nursing: related by rhetoric? Some reflections on the policy process and nursing. *Journal of advanced nursing.* 29 **(6)**. P1377-1384.

Hewison, A., Wildman, S. (1996). The theory-practice gap in nursing: a new dimension. *Journal of advanced nursing*. 24 **(4)**. P754-761.

Hill-Collins, P. (1990). *Black feminist epistemology*. In: Calhoun, C. Gerteis, J., Moody, J., Pfaff, S., Virk, I. (Eds) (2007). *Contemporary social theory*. 2nd Ed. Blackwell Publishing: Oxford. P327-336.

HM Treasury. (2009). *Operational Efficiency Programme: final report*. HM Treasury: London. Available at: http://www.bis.gov.uk/assets/biscore/shex/files/oep_final_report_210409_pu728.pdf. Accessed 05/10/11.

Hodgson, I. (2000). *Ethnography and health care: focus on nursing.* Forum: qualitative social research. 1 **(1)**. Art 7. Available at: http://www.qualitative-research.net/index.php/fqs/article/view/1117/2475. Accessed 07/06/12.

Hoffman, J. (2001a). Blind alley: defining feminism. *Politics*. 21 **(3).** P193-199.

Hoffman, J. (2001b). *Gender and sovereignty: feminism, the state and international relations*. Palgrave: Hampshire.

Holden, R.J. (2011). Lean Thinking in Emergency Departments: a critical review. *Annals of emergency medicine*. 57 **(3)**. P265-278.

Holden, R.J., Eriksson, A., Andreasson, J., Williamsson, A., Dellve, L. (2015). Healthcare workers' perceptions of Lean: a context-sensitive, mixed methods study in three Swedish hospitals. *Applied ergonomics*. 47 **(1)**. P181-192.

Holdsworth, C., Robinson, J.E. (2008). 'I'll never let anyone hold the kids while they've got ciggies': moral tales of maternal smoking practices. *Sociology of health and illness*. 30 **(7)**. P1086-1100.

Hood, C. (1991). A public management for all seasons? *Public administration*. 69 **(1)**. P3-19.

Hughes, E.C. (1984). *The sociological eye. Selected papers*. Transaction Books: London.

Ibarra, H. (1999). Provisional selves: experimenting with image and identity in professional adaptation. *Administrative science quarterly*. 44 **(4)**. P764-791.

Iedema, R., Braithwaite, J., Jorm, C., Nugus, P., Whelan, A. (2005). *Clinical governance: complexities and promises.* In: Stanton, P., Willis, E., Young, S. (Eds). *Workplace reform in the healthcare industry*. The Australian experience. Palgrave Macmillan: New York. P253-278.

Jackson, C. (2005). The experience of a good day: a phenomenological study to explain a good day as experienced by a newly qualified RN. *International journal of nursing studies*. 42 **(1)**. P85-95.

Janack, M. (2017). *Feminist philosophy.* Internet Encyclopedia of Philosophy. Available at: http://www.iep.utm.edu/fem-epis/. Accessed 21/06/17.

Jenkins, R. (2008). *Social identity*. 3rd Ed. Routledge: Oxton.

Jessor, R. (1996). *Ethnographic methods in contemporary perspective*. In: Jessor, J., Colby, A., Shweder, R.A. (Eds). *Ethnography and human development: context and meaning in social inquiry*. University of Chicago Press: London. P3-14.

Jones, D., Mitchell, A. (2006). *Lean Thinking for the NHS*. NHS confederation: London. Available at: http://www.leanuk.org/downloads/health/lean_thinking_for_the_nhs_leaflet.pdf. Accessed 17/05/12.

Jones, D.T., Filochowski, J. (2006). Lean healthcare: think yourself thin. *The Health service journal*. 116 **(6000)** suppl. P6-7.

Joosten, T., Bongers, I., Janssen, R. (2009). Application of Lean Thinking to healthcare: issues and observations. *International journal for quality in health care*. 21 **(5)**. P341-347.

Kendall, D. (2010). *Sociology in our times. The essentials*. 7th Ed. Wadsworth Cengage Learning: California.

Kitson, A.L., Muntlin Athlin, Å., Conroy, T. (2014). Anything but basic: nursing's challenge in meeting patients' fundamental care needs. *Journal of nursing scholarship*. 46 **(5)**. P331-339.

Klein, R. (2006). *The new politics of the NHS. From creation to reinvention*. 5th Ed. Radcliffe Publishing: Oxford.

Kollberg, B., Dahlgaard, J.J., Brehmer, P-O. (2007). Measuring Lean initiatives in health care services: issues and findings. *International journal of productivity and performance management*. 56 **(1)**. P7-24.

Kornblith, H. (1999). *In defense of a naturalized epistemology*. In: Greco, J., Sosa, E. (Eds). *The Blackwell guide to epistemology*. Blackwell Publishing Ltd: Oxford. P158-169.

Krauss, S.E. (2005). Research paradigms and meaning making: a primer. *The qualitative report*. 10 **(4)**. P758-770.

Kuokkanen, L., Leino-Kilpi, H. (2000). Power and empowerment in nursing: three theoretical approaches. *Journal of advanced nursing*. 31 **(1)**. P235-241.

Kuokkanen, L., Leino-Kilpi, H., Katajisto, J. (2003). Nurse empowerment, job-related satisfaction, and organizational commitment. *Journal of nursing care quality*. 18 **(3)**. P184-192.

Larson, M.S. (1977). *The rise of professionalism: a sociological analysis*. University of California Press: London.

Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. (2001). Impact of structural and psychological empowerment on job train in nursing work settings; expanding Kanter's model. *Journal of nursing administration*. 31 **(5)**. P260-272.

Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. (2003). Workplace empowerment as a predictor of nurse burnout in restructured healthcare settings. *Hospital Quarterly.* 6 **(4)**. P2-11.

Lawler, J. (1991). *Behind the screens: nursing, somology and the problem of the body*. Churchill-Livingstone: Australia.

Leavy, P. (2011). *Oral history. Understanding qualitative research.* Oxford University Press: Oxford.

Leininger, M. (1988). *Care: the essence of nursing and health*. In: Leininger, M. (Ed). *Care: the essence of nursing and health*. Wayne State University Press: Michigan. P3-16.

Leininger, M. (1994). *Evaluation criteria and critique of qualitative research studies*. In: Morse, J.M. (Ed). *Critical issues in qualitative research methods*. SAGE Publications Ltd: London. P95-115.

Lemke, T. (2002). Foucault, governmentality and critique. *Rethinking Marxism.* 14 **(3)**. P49-64.

Lemke, T. (2007). An indigestible meal? Foucault, governmentality and state theory. *Distinktion: Scandinavian journal of social theory.* 8 **(2)**. P43-64.

Lennard, C. (2012). How the Productive Ward scheme gives staff more time to care. *Mental health practice*. 15 **(5)**. P30-33.

Letherby, G. (2003). *Feminist Research in Theory and Practice.* Open University Press: Buckingham.

Lewis, J., Ritchie, J. (2003). *Generalising from qualitative research*. In: Ritchie, J., Lewis, J. (Eds). *Qualitative research practice: a guide for social science students and researchers.* SAGE Publications Ltd: London. P263-286.

Lewis, R. (2014). Thirty years on, the Griffiths report makes interesting reading. *Health service journal*. 21st July. Available at: http://www.hsj.co.uk/leadership/future-of-nhs-leadership/thirty-years-on-the-griffiths-report-makes-interesting-reading/5072885.article#.VM5Q2ctybIU. Accessed 01/02/15.

Liaschenko, J., Peter, E. (2004). Nursing ethics and conceptualizations of nursing: profession, practice and work. *Journal of advanced nursing*. 46 **(5)**. P488-495.

Light, D. (2010). *The final stage? Writing up ethnographic research.* In: Scott Jones, J., Watt, S. (Eds). *Ethnography in social science practice.* Routledge: Oxon. P173-186.

Liker, J.K., Morgan, J.M. (2006). The Toyota way in services; the case of Lean product development. *Academy of management perspectives*. 20 **(2).** P5-20.

Lipsky, M. (2010). *Street-level bureaucracy. Dilemmas of the individual in public services*. 30th anniversary expanded edition. Russell Sage Foundation: New York.

Lipson, J.G. (1994). *Ethical issues in ethnography*. In: Morse, J.M. (Ed). *Critical issues in qualitative research methods*. SAGE Publications Ltd: London. P333-355.

Lodico, M.G., Spaulding, D.T., Voegtle, K.H. (2006). *Methods in educational research: from theory to practice*. 2nd Ed. John Wiley and Sons: California.

Longino, H.E. (1999). *Feminist epistemology*. In: Greco, J., Sosa, E. (Eds). *The Blackwell guide to epistemology*. Blackwell Publishing Ltd: Oxford. P327-353.

Longino, H.E. (2002). *The fate of knowledge*. Princeton University Press: Princeton.

Love, K.I. (2012). Using Theater of the Oppressed in nursing education: rehearsing to be change agents. *Journal for learning through the arts*. 8 **(1)**. P1-10.

Lukes, S. (1974). *Power. A radical view*. Macmillan Press Ltd: London.

Maben, J., Griffiths, P. (2008). *Nurses in society: starting the debate*. National Nursing Research Unit. King's College London.

Maben, J., Latter, S., Macleod Clark, J. (2006). The theory-practice gap: impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of advanced nursing*. 55 **(4)**. P465-477.

Maben, J., Latter, S., Macleod Clark, J. (2007). The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal study. *Nursing inquiry*. 14 **(2)**. P99-113.

Mann, M. (1986). *The sources of social power. Vol 1: a history of power from the beginning to A.D. 1760*. Cambridge University Press: Cambridge.

Manojlovich, M. (2007). Power and empowerment in nursing: looking back to inform the future. *Online journal of issues in nursing*. 12 **(1)**. Manuscript 1. Available at: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/LookingBackwardtoInformtheFuture.asp. Accessed 26/04/15.

Martin, B. (1982). Feminism, criticism, and Foucault. *New german critique.* 27 **(11)**. P3-30.

Maslow. A.H. (1943). A theory of human motivation. *Psychology review*. 50 **(4)**. P370-396.

May, C. (1992). Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of health and illness*. 14 **(4)**. P472–487.

Maynard, M. (1994). *Methods, practice and epistemology: the debate about feminism and research.* In: Maynard, M., Purvis, J. (Eds). *Researching women's lives from a feminist perspective.* Taylor and Francis: London.

Maynard. M. (2001). *'Race', gender, and the concept of 'difference' in feminist thought.* In: Juschka, D.M. (Ed). *Feminism in the study of religion: a reader.* Continuum: London. P434-451.

Mays, N., Dixon, A., Jones, L. (2011). *Return to the market: objectives and evolution of new labour's market reforms.* In: Mays, N., Dixon, A., Jones, L. (Eds). *Understanding new labour's market reforms of the English NHS.* The King's Fund: London. P1-15.

Mazzocato, P., Holden, R.J., Brommels, M., Aronsson,H., Backman, U., Elg, M., Thor, J. (2012). How does Lean work in emergency care? A case study of a Lean-inspired intervention at the Astrid Lindgren Children's Hospital, Stockholm, Sweden. *BMC Health services research*. 12 **(28)**. P1-13.

Mazzocato, P., Savage, C., Brommels, M., Aronsson, H., Thor, J. (2010). Lean Thinking in healthcare: a realist review of the literature. *Quality and safety in healthcare*. 19 **(5)**. P376-382.

Mazzocato, P., Thor, J., Bäckman, U., Brommels, M, Carlsson, J., Jonsson, F., Hagmar, M., Savage, C. (2014). Complexity complicated Lean: lessons from seven emergency services. *Journal of health organization and management*. 28 **(2)**. P266-288.

McNay, L. (1992). Foucault and feminism: power, gender and the self. Polity Press: Cambridge.

Meerabeau, L. (1998). *Project 2000 and the nature of nursing knowledge*. In: Abbot, P., Meerabeau, L. (Eds). *The sociology of the caring professions*. 2nd Ed. UCL Press Limited: London. P82-105.

Melia, K.M. (1984). Student nurses' construction of occupational socialisation. *Sociology of health and illness*. 6 **(2)**. P132-151.

Menzies, I.E.P. (1960). A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human relations*. 13 **(2)**. P95-121.

Miller, P., Rose, N. (1990). Governing economic life. *Economy and society*. 19 **(1)**. P1-31.

Mills, I. (1987). Resource management initiative. *Journal of management in medicine.* 2 **(1)**. P38-43.

Moffatt, F. (2013). *Working the production line: productivity and professional identity in the Emergency Department*. Unpublished doctoral thesis. University of Nottingham.

Mohapatra, S. (2013). *Business process reengineering. Automation decision points in process reengineering.* Springer: London.

Molloy, L., Walker, K., Lakeman, R., Skinner, I. (2015). Ethnonursing and the ethnographic approach in nursing. *Nurse researcher*. 23 **(2)**. P17-21.

Mooney, M. (2007). Professional socialization: the key to survival as a newly qualified nurse. *International journal of nursing practice*. 13 **(2)**. P75-80.

Morrison, K., Cowley, S. (1999). *Idealised caring: the heart of nursing*. In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age*. Blackwell Science Ltd: London. P21-35.

Morrow, E., Robert, G., Maben, J., Griffiths, P. (2012). Implementing large-scale quality improvement: Lessons from the Productive Ward: Releasing Time to Care. *International journal of health care quality assurance*. 25 **(4)**. P237-253.

Muecke, M.A. (1994). *On the evaluation of ethnographies*. In: Morse, J.M. (Ed). *Critical issues in qualitative research methods.* SAGE Publications Ltd: London. P187-209.

NHS Improvement. (2015). Bringing Lean to life; making processes flow in healthcare. Available at: http://www.nhsiq.nhs.uk/resource-search/publications/nhs-imp-lean.aspx. Accessed 12/03/15.

NHS Information Centre. (2011). *NHS workforce: summary of staff in the NHS: results from September 2010 Census*. Available at: http://www.ic.nhs.uk/webfiles/publications/010_Workforce/nhsstaff0010/Census_Bulletin_March_2011_Final.pdf. Accessed 14/02/12.

NHS Institute for Innovation and Improvement. (2007). Going Lean in the NHS. Available at: http://www.northamptongeneral.nhs.uk/Downloads/OurServices/ServiceImprovement/Toolsforimprovement/GoingleanintheNHS.pdf. Accessed 12/03/15.

NHS Institute for Innovation and Improvement. (2008). *Lean - seven wastes*. Available at: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/lean_-_7_wastes.html. Accessed 17/05/12.

NHS Institute for Innovation and Improvment. (2009). *The Productive Ward: Releasing Time to Care learning and impact review. Final report.* Available at: http://www.institute.nhs.uk/images//documents/Quality_and_value/Productive_Ward/PW%20review%20full%20report.pdf. Accessed 21/02/12.

NHS Institute for Innovation and Improvement. (2010). *Improving healthcare quality at scale and pace. Lessons from the Productive Ward: Releasing Time to Care programme. Full report.* Available at: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html. Accessed 31/01/12.

NHS Institute for Innovation and Improvement. (2012a). *The Productive Ward module structure.* Available at: http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_ward_module_structure.html. Accessed 23/05/12.

NHS Institute for Innovation and Improvement. (2012b). Putting patients first - the Productive Series. Available at: http://www.institute.nhs.uk/images/documents/Productives/Putting%20patients%20first%20-%20The%20Productive%20Series%20FINAL.pdf. Accessed 07/05/15.

NHS Institute for Innovation and Improvement. (2015a). The Productive Ward House. Available at:

http://www.institute.nhs.uk/quality_and_value/productive_ward/the_productive_ward_house.html. Accessed 23/03/15.

NHS Institute for Innovation and Improvement. (2015b). Homepage. Available at: http://www.institute.nhs.uk/. Accessed 17/04/15.

Nicholson, J.H. (2006). *'Them's fightin' words': naming in everyday talk between siblings*. In: Wood, J.T., Duck, S. (Eds). *Composing relationships. Communication in everyday life*. Wadsworth, Cengage Learning: United Kingdom. P55-64.

Nicolini, D. (2009). *Zooming in and zooming out: a package of method and theory to study work practices.* In: Ybeme, S., Yanow, D., Wels, H., Kamsteeg, F. (Eds). *Organizational ethnography. Studying the complexities of everyday life.* SAGE Publications Ltd: London. P120-138.

Nursing and Midwifery Council. (2015). *The code: professional standards of practice and behaviour for nurses and midwives.* Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf. Accessed 17/07/17.

Noordegraaf, M. (2011). Risky business: how professionals and professional fields (must) deal with organizational issues. *Organization studies*. 32 **(10)**. P1349-1371.

Norman, I., Cowley, S. (1999a). *Commentary: a profession based on caring*. In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age*. Blackwell Science ltd: London. P20.

Norman, I., Cowley, S. (1999b). *Commentary: present realities and future directions*. In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age*. Blackwell Science Ltd: London. P152-153.

Owens, T.J. (2006). *Self and identity*. In: Delamater, J. (Ed). *Handbook of social psychology.* Springer: New York. P205-232.

Papadopoulos, T., Merali, Y. (2008). Stakeholder network dynamics and emergent trajectories of Lean implementation projects: a study in the UK National Health Service. *Public money and management.* 28 **(1)**. P41-48.

Parkin, P.A.C. (1995). Nursing the future: a re-examination of the professionalization thesis in the light of some recent developments. *Journal of advanced nursing*. 21 **(3)**. P561-567.

Paterson, J., Zderad, L. (1976). *Humanistic nursing*. National League for Nursing: New York.

Peoples, J., Bailey, G. (2012). *Humanity. An introduction to cultural anthropology*. 9th Ed. Wadsworth Cengage Learning: California.

Peplau, H. (1952). *Interpersonal relations in nursing*. Pitmans: New York.

Perry, A. (1993). *A sociologist's view: the handmaiden's theory*. In: Jolley, M., Brykczynska, G. (Eds). *Nursing: its hidden agendas*. Edward Arnold: London. P43-79.

Petterson, J. (2009). Defining Lean production: some conceptual and practical issues. *The Total Quality Managment Journal.* 21 **(2)**. P127-142.

Phillips, R., Amos, A., Ritchie, D., Cunningham-Burley, S., Martin, C. (2007). Smoking in the home after the smoke-free legislation in Scotland: qualitative study. *British medical journal*. 335 **(7619)**. P553-557.

Pineau Stam, L.M., Laschinger, H.K.S., Regan, S., Wong, C.A. (2015). The influence of personal and workplace resources on new graduate nurses' job satisfaction. *Journal of nursing management*. 23 **(2)**. P190-199.

Pinnick, C.L., Koertge, N., Almeder, R.F. (2003). *Introduction*. In: Pinnick, C.L., Koertge, N., Almeder, R.F. (Eds). *Scrutinizing feminist epistemology: an examination of gender in science*. Rutgers University Press: New Jersey. P1-4.

Pitschas, R. (2004). New Public Management as a loss of value? The change of administrative culture and ethics in the German public sector. In: Jain, R.B.

(Ed). *Corruption-free sustainable development. Challenges and strategies for good governance*. Mittal Publications: India. P19-36.

Poksinska, B. (2010). The current state of Lean implementation in health care: literature review. *Quality management in health care*. 19 **(4)**. P319-329.

Porter, S. (1992). The poverty of professionalization: a critical analysis of strategies for the occupational advancement of nursing. *Journal of advanced nursing*. 17 **(6)**. P720-726.

Porter, S., Ryan, S. (1996). Breaking the boundaries between nursing and sociology: a critical realist ethnography of the theory-practice gap. *Journal of advanced nursing*. 24 **(2)**. P413-420.

Pratt, M.G., Rockmann, K.W., Kaufmann, J.B. (2006). Constructing professional identity: the role of work and identity learning cycles in the customization of identity among medical residents. *Academy of management journal*. 49 **(2)**. P235-262.

Putnam, R.D. (2000). *Bowling alone. The collapse and revival of American community.* Simon and Schuster: New York.

Radnor, Z. (2000). Changing to a Lean organisation: the case of chemicals company. *International journal of manufacturing and technology management*. 1 (4/5). P444-453.

Radnor, Z. (2010). *Review of business process improvement methodologies in public services.* Advanced Institute of Management Research: London.

Radnor, Z., Holweg, M., Waring, J. (2012). Lean in healthcare: the unfilled promise? *Social science and medicine*. 74 **(3)**. P364-71.

Radnor, Z., Osborne, S.P. (2013). Lean: a failed theory for public services? *Public management review*. 15 **(2)**. P 265-287.

Radnor, Z., Walley, P. (2006). Lean on me... *Public finance*. 28th July. Available at: http://www.publicfinance.co.uk/2006/07/lean-me-zoe-radnor-and-paul-walley. Accessed 21/04/16.

Radnor, Z., Walley, P. (2008). Learning to walk before we try to run: adapting Lean for the public sector. *Public money and management*. 28 **(1)**. P13-20.

Radnor, Z., Walley, P., Stephens, A., Bucci, G. (2006). *Evaluation of the Lean approach to business management and its use in the public sector*. Scottish Executive Social Research: Edinburgh.

Ramazanoğlu, C., Holland, J. (2002). *Feminist methodology. Challenges and choices*. Sage Publications Ltd: London.

Rankin, J.M., Campbell, M.L. (2006). *Managing to nurse. Inside Canada's health care reform*. University of Toronto Press Incorporated: London.

Robert, G., Morrow, E., Maben, J., Griffiths, P., Callard, S. (2011). The adoption, local implementation and assimilation into routine nursing practice of a national quality improvement programme: the Productive Ward. *Journal of clinical nursing*. 20 **(7-8)**. P1196-1207.

Robson, M., Ullah, P. (1996). *A practical guide to business process re-engineering.* Gower: Hampshire.

Roper, N., Logan, W., Tierney, A. (1985). *The elements of nursing*. Churchill Livingstone: Edinburgh.

Rose, N. (1999). *Governing the soul: the shaping of the private self.* 2nd Ed. Free Association Books: London.

Rosen, R. (2000). *Turning words, spinning worlds. Chapters in organizational ethnography.* Routledge: London.

Roszell, S.S. (2013). *Measuring Lean management penetration on the hospital nursing frontline: instrument development*. Unpublished dissertation. University of North Carolina.

Salvage, J. (1985). *The politics of nursing*. Heinemann: London.

Salvage, J. (1988). Professionalization - or struggle for survival? A consideration of current proposals for the reform of nursing in the United Kingdom. *Journal of advanced nursing*. 13 **(4)**. P515-519.

Salvage, J. (1990). The theory and practice of the 'New Nursing'. *Nursing times*. 86 **(1)**. P42-45.

Salvage, J. (2003). *Nursing tomorrow and today*. In: Hinchliff, S., Norman, S., Schober, J. (Eds). *Nursing practice and healthcare*. 4th Ed. Arnold: London. P1-26.

Sandberg, J. (2005). How do we justify knowledge produced within interpretive approaches? *Organizational research methods*. 8 **(1)**. P41-68.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in nursing and health*. 23 **(4)**. P334-340.

Sandoval, C. (2000). *Methodology of the oppressed (Vol. 18)*. University of Minnesota Press: Minneapolis.

Sayer, N.J., Williams, B. (2007). *Lean for dummies*. Wiley Publishing Inc. Indiana.

Schatz, E. (2009). *Ethnographic immersion and the study of politics*. In: Schatz, E. (Ed). *Political ethnography: what immersion contributes to the study of power*. University of Chicago Press: London. P1-22.

Schein, E.H. (1978). *Career dynamics: matching individual and organisational needs*. Addison-Wesley Publishing Company: Massachusetts.

Schwandt, T.A. (2000). *Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics, and social constructionism*. In: Denzin, N.K., Lincoln, Y.S. (Eds). *The SAGE handbook of qualitative research*. 2nd Ed. SAGE Publications Ltd: London. P189-214.

Scott, H. (2004). Are nurses 'too clever to care' and 'too posh to wash'? *British journal of nursing*. 13 **(10)**. P581.

Seddon, J., O'Donovan, B. (2009). Rethinking Lean service. Available at: http://www2.warwick.ac.uk/fac/sci/wimrc/projects/major/agility/sdd/introduction/timetable/03_challenging_paradigms_js.pdf. Accessed 05/10/11.

Shah, R., Ward, P.T. (2007). Defining and developing measures of Lean production. *Journal of operations management*. 25 **(4)**. P785-805.

Shaw, M. (1993). The discipline of nursing: historical roots, current perspectives, future directions. Journal of advanced nursing. 18 (10). P1651-1656.

Shields, R. (1996). Meeting or mis-meeting? The dialogical challenge to verstehen. *British journal of sociology*. 47 **(2)**. P275-294.

Shuford, A.L. (2010). *Feminist epistemology and American pragmatism: Dewey and Quine.* Continuum International Publishing Group: London.

Smith, J., Rudd, C. (2010). Implementing the Productive Ward management programme. *Nursing standard*. 24 **(31).** P45-48.

Smith, P. (1992). *The emotional labour of nursing: how nurses care*. The Macmillan Press: London.

Sparrow, S., Robinson, J. (1994). Action research: an appropriate design for research in nursing? *Educational action research*. 2 **(3)**. P347-356.

Spear, S. (2005). Fixing health care from the inside, today. *Harvard Business Review*. Available at: https://hbr.org/2005/09/fixing-health-care-from-the-inside-today. Accessed 02/07/15.

Stanley, L., Wise, S. (1993). *Breaking out again: feminist ontology and epistemology*. 2nd Ed. Routledge: London.

Stein, L.I. (1967). The Doctor-Nurse Game. *Archives of general psychiatry*. 16 **(6)**. P699-703.

Stevens, S. (2004). Reform strategies for the English NHS. *Health Affairs*. 23 (3). P37-44.

Storch, J., Stinson, S. (1988). *Concepts of deprofessionalization with application to nursing.* In: White, R. (Ed). *Political issues in nursing: past, present and future*. Vol 3. Wiley and Sons: Chichester. P33-44.

Street, A.F. (1992). *Inside nursing. A critical ethnography of clinical nursing practice.* State University of New York Press: Albany.

Taylor, M.J., McNicholas, C., Nicolay, C., Darzi, A., Bell, D., Reed, J.E. (2014). Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. *BMJ quality and safety.* 23 **(4)**. P290-298.

Tedlock, B. (2003). *Ethnography and ethnographic representation*. In: Denzin, N.K., Lincoln, Y.S. (Eds). *Strategies of qualitative inquiry*. 2nd Ed. SAGE Publications Ltd: London. P165-213.

Thomas, R., Davies, A. (2005). Theorizing the micro-politics of resistance: new public management and managerial identities in the UK public services. *Organization studies*. 26 **(5)**. P683-706.

Thomas, R., Snelling, P. (2017). *Law*. In: Sellman, D., Snelling, P. (Eds). *Becoming a nurse. Fundamentals of professional practice for nursing.* 2nd Ed. Routledge: London. P79 – 111.

Timmermans, S., Tavory, I. (2012). Theory construction in qualitative research: from grounded theory to abductive analysis. *Sociological theory.* 30 **(3)**. P 167-186.

Timmons, S., Coffey, F., Vezyridis, P. (2014). Implementing Lean methods in the Emergency Department: the role of professions and professional status. *Journal of health organisation and management.* 28 **(2)**. P214-228.

Timmons, S., East, L. (2011). Uniforms, status and professional boundaries in hospital. *Sociology of health and illness*. 33 **(7)**. P1035-1049.

Tischler, H. (2011). *Introduction to sociology*. 10th Ed. Wadsworth Cengage Learning: California.

Tragardh, B., Lindberg, K. (2004). Curing a meagre health care system by Lean methods - translating 'chains of care' in the Swedish health care sector. *International journal of health planning and management.* 19 **(4)**. P383-398.

Traynor, M. (2007). A historical description of the tensions in the development of modern nursing in nineteenth-century Britain and their influence on contemporary debates about evidence and practice. *Nursing inquiry*. 14 **(4)**. P299-305.

Traynor, M. (1999). *Managerialism and nursing: beyond oppression and profession*. Routledge: London.

Traynor, M. (2013). *Nursing in context: policy, politics, profession*. Palgrave Macmillan: Hampshire.

Traynor, M. (2014). Caring after Francis: moral failure in nursing reconsidered. *Journal of research in nursing.* 19 **(7-8)**. P546-556.

Traynor, M., Evans, A. (2014). Slavery and jouissance: analysing complaints of suffering in UK and Australian nurses' talk about their work. *Nursing philosophy*. 15 **(3)**. P192-200.

Trede, F., McEwen, C. (2012). *Developing a critical professional identity: engaging self in practice*. In: Higgs, J., Barnett, R., Billett, S., Hutchings, M., Trede, F. (Eds). *Practice-based education: perspectives and strategies*. Sense Publishers: Rotterdam. P27-40.

Tsui, M., Cheung, F.C.H. (2004). Gone with the wind: the impacts of managerialism on human services. *British journal of social work*. 34 **(3)**. P437-442.

Tuana, N. (2001). *Introduction*. In: Tuana, N., Morgen, S. (Eds). *Engendering rationalities*. State University of New York Press: Albany. P 1-20.

Turner, B.S. (1995). *Medical power and social knowledge*. 2nd Ed. SAGE Publications Company: London.

Tylor, E.B. (1871). *Primitive culture: researches into the development of mythology, philosophy, religion, art, and custom. Volume 1.* John Murray: London.

Ulhassan, W., Westerlund, H., Thor, J., Sandahl, C., von Thiele Schwarz, U. (2014). Does Lean implementation interact with group functioning? *Journal of health organization and management*. Organization. 28 **(2)**. P196-213.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: a new preparation for practice*. UKCC: London.

Usher, P. (1997a). *Challenging the power of rationality*. In: McKenzie, G., Powell, J., Usher, R. (Eds). *Understanding social research: perspectives on methodology.* Falmer Press: London. P42-55.

Usher, R. (1997b). *Telling a story about research and research as story-telling: postmodern approaches to social research.* In: McKenzie, G., Powell, J., Usher, R. (Eds). *Understanding social research: perspectives on methodology.* Falmer Press: London. P27-41.

Valentine, P.E.B. (1995). Management of conflict: do nurses/women handle it differently? *Journal of advanced nursing*. 22 **(1)**. P142-149.

van den Broek, J., Boselie, P., Paauwe, J. (2014). Multiple institutional logics in health care. *Public management review*. 16 **(1)**. P1-20.

Visweswaran, K. (1994). *Fictions of feminist ethnography.* University of Minnesota Press: Minneapolis.

Visweswaran, K. (1997). Histories of feminist ethnography. *Annual review of anthropology.* 26 **(1)**. P591 – 621.

Walker, K. (1997). Cutting edges: deconstructive inquiry and the mission of the border ethnographer. *Nursing inquiry*. 4 **(1)**. P3-13.

Walsh, M., Ford, P. (1989). *Nursing rituals; research and rational actions*. Butterworth-Heinemann Ltd: Oxford.

Waring, J.J., Bishop, S. (2010). Lean healthcare: rhetoric, ritual and resistance. *Social science and medicine*. 71 **(7)**. P1332-1340

Watson, T, J. (2008). Managing identity: identity work, personal predicaments and structural circumstances. *Organization*. 15 **(1)**. P121-143.

Wells, J.S.G. (1999). *The growth of managerialism and its impact on nursing and the NHS.* In: Norman, I., Cowley, S. (Eds). *The changing nature of nursing in a managerial age.* Blackwell Science Ltd: London. P57-81.

White, M., Waldron, M. (2014). Effects and impact of Productive Ward from a nursing perspective. *British Journal of nursing*. 23 **(8)**. P419-426.

White, M., Wells, J., Butterworth, T. (2013). Leadership, a key element of quality improvement in healthcare. Results from a literature review of 'Lean Healthcare' and the Productive Ward: Releasing Time to Care initiative. *The international journal of leadership in public services*. 9 **(3/4)**. P90-108.

White, M., Wells, J., Butterworth, T. (2014). The transition of a large-scale quality improvement initiative: a bibliometric analysis of the Productive Ward: Releasing Time to Care programme. *Journal of clinical nursing*. 23 **(17-18)**. P2414-2423.

Whitfield, L., Pritchard, M.J., Latchmore, L. (2005:11). An independent audit of the NHS under Labour (1997-2005). Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/independent-audit-nhs-under-labour-1997%E2%80%932005-sunday-times-march-2005.pdf. Accessed 27/06/2017.

Wilkinson, G., Miers, M. (1999). *Power and professions*. In: Wilkinson, G., Miers, M. (Eds). *Power and nursing practice*. Macmillan Press: London. P24-36.

Willetts, G., Clarke, D. (2014). Constructing nurses' professional identity through social identity theory. *International journal of nursing practice*. 20 **(2)**. P164-169.

Wilson, J.R. (2014). Fundamentals of systems ergonomics/human factors. *Applied ergonomics*. 45 **(1)**. P5-13.

Witt, C. (2004). *Feminist history of philosophy*. In: Alanen, L., Witt, C. (Eds). *Feminist reflections on the history of philosophy.* Kluwer Academic Publishers: The Netherlands. P1-16.

Woodward, K. (2008). Hanging out and hanging about: insider/outsider research in the sport of boxing. *Ethnography.* 9 **(4)**. P536–560. Available at: http://oro.open.ac.uk/12795/2/12795.pdf. Accessed 10/03/17. P1-33.

Woodward, K. (2012). *Planet sport.* Routledge: London.

Wolcott, H.G. (2005). *The art of fieldwork*. 2nd Ed. Altamira Press: California.

Womack, J.P., Jones, D.T. (2003). *Lean Thinking: banish waste and create wealth in your corporation.* 2nd Ed. Simon and Schuster UK Ltd: London.

Womack, J.P., Jones, D.T., Roos, D. (1990). *The machine that changed the world.* Simon and Schuster Inc: New York.

Wright, S., McSherry, W. (2013). A systematic literature review of ReleasingTime to Care: the Productive Ward. *Journal of clinical nursing*. 22 **(9-10)**. P1361-1371.

Wright, S., McSherry, W. (2014). Evaluating the Productive Ward at an acute NHS trust: experiences and implications of Releasing Time to Care. *Journal of clinical nursing*. 23 **(13-14)**. P1866-1876.

Young, T., McClean, S. (2009). Some challenges facing Lean in healthcare. *International journal for quality in healthcare.* 21 **(5)**. P309-310.

Appendix 1. Details and results of the literature search

A literature search was performed in order to scope existing literature relevant to Lean implementation in the context of nursing. More specifically, the search aimed to identify and review any conceptual or theoretical literature concerning the relationship or interaction between Lean and nursing. It also aimed to identify and review any empirical studies which qualitatively considered Lean implementation from the perspective of front-line, clinically focused nurses, as the primary and substantive focus. For example, qualitative studies considering experiences, understandings, interpretations, consequences or implications of Lean implementation, from a front-line nursing perspective. From the literature search, it was envisaged that insight could be gleaned into the state of knowledge concerning Lean applied to the context of nursing, and gaps in understanding identified, in order to inform the direction of the thesis, in terms of the formulation of research aims, objectives and research questions. Through this process, the way in which the thesis contributed to knowledge, could also be identified. It was not intended that the search would represent a systematic and exhaustive search of literature however. Given the broad nature of the topic of interest, and its 'fuzzy boundaries' with respect to it spanning several disciplines and bodies of knowledge, together with the abstract nature of, and variously defined, concepts of interest, a search of this kind was not considered to be appropriate or feasible.

Figure A1 provides details of the searches conducted. It identifies the search terms used, the databases searched, the number of results retrieved and reviewed following each search (per database and total across all databases), and the number of relevant results for each search (total across all databases). It also identifies the total number of results across all searches per database, the total number of results across all searches and databases, and the total number of relevant results across all searches and databases.

Search terms	Databases			Total number of results per search across all databases	Total number of relevant results per search across all databases
	PubMed (All fields)	ProQuest (Abstract)	EBSCO Host (Cinahl Plus with Full Text) (Abstract)		
Search 1. Lean AND nurse	206 results	231 results	24 results	461 results	0 results
Search 2. Lean AND nurses	104 results	222 results	43 results	369 results	0 results
Search 3. Lean AND nursing	323 results	176 results	48 results	547 results	0 results
Search 4. Productive ward	130 results	226 results	28 results	384 results	0 results
Total number of results per database across all searches	763 results	855 results	143 results		
Total number of results across all searches and databases: 1761					***Total number of relevant results across all searches and databases: 0***

Figure A1. Details and results of the literature search.

The searches were initially performed in May 2012 and were then updated periodically throughout the period of doctoral study, with the final searches performed in July 2015. The number of results identified for each search (per

database, and total across all databases) represents the sum of the number of results retrieved from the original search, and the number of further results retrieved from update searches. The databases were chosen on the basis of their relevance to the topic of the literature search, in terms of their coverage and incorporation of journals and databases relevant to the topic area. The searches were confined to the abstract only in ProQuest and EBSCO Host (Cinahl Plus with Full Text) databases, owing to preliminary searches in 'all fields' returning an unmanageable number of results (over 35,000 in ProQuest for Search 1, for example). It was thought that confining the search to the abstract would be unlikely to exclude any articles of relevance, given that the search attempted to locate papers where Lean and nursing formed the central focus, and would therefore be expected to be mentioned in the abstract. No further restrictions were applied to the searches.

A total of 1761 results were returned from the searches. The title and abstract of each result was read in order to ascertain relevance to the topic of interest. Full papers were read where the titles and abstracts indicated potential relevance. Following this process, results which considered the conceptual or theoretical relationship between Lean and nursing, or reported an empirical study which qualitatively considered Lean implementation from the perspective of front-line, clinically focused nurses, as the primary and substantive focus (as per the aims of the literature review), were not found. Examples of the focus of search results included anecdotal reports of Lean or Productive Ward implementation, studies focusing on other quality improvement methodologies, papers focusing on Lean implementation from a Lean leader or manager perspective, quantitatively oriented Lean outcome papers (e.g. time and financial impact), quantitative or qualitative studies of experiences of mixed groups of staff, workers, employees or non-front-line nurses, and biomedical papers relating to breastfeeding, weight management, obesity and related animal trials.

Appendix 2. The 'Continuous Process Improvement Cousins' of Lean Thinking (Sayer and Williams, 2007:22)

Total Quality Management (TQM): TQM focuses on a quality-driven organisation. Quality therefore acts as the driver behind, and is managed at, every operational stage - planning, design, self-inspection, continuous process monitoring and improvement, and organisational leadership (Sayer and Williams, 2007, Radnor, 2000 in Radnor, 2010). As such, TQM focuses on organisation and culture incorporating a quality perspective, together with emphasising management commitment, customer orientation, fact-based decision-making, continuous improvement and employee participation (Sayer and Williams, 2007). It promotes a culture of improvement, team-working, ownership and commitment, premised on customer and process orientation, and continuous improvement principles (Radnor, 2010). Lean Thinking incorporates the practices and principles of TQM (Sayer and Williams, 2007).

Business Processes Reengineering (BPR): – BPR focuses on change, driven primarily by business strategy, and aims to make improvements through increasing the effectiveness and efficiency of business processes across and within organisations (Mohapatra, 2013). It considers a business process as 'a series of steps which if implemented lead to a product or service. Through these business processes, organizations endeavour to add value for the customers, both internal and external' (Mohapatra, 2013:1). BPR can be defined as 'the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical and contemporary measures of performance, such as cost, quality, service, and speed' (Mohapatra, 2013:214), or 'the creation of entirely new and more effective business processes, without regard for what has gone before' (Robson and Ullah, 1996:3).

Robson and Ullah (1996) suggest that BPR can assist in circumstances where large-scale improvements are required but which cannot be made within the existing format of processes currently used (Robson and Ullah, 1996). BPR starts from a 'blank page' and approaching business processes with a 'blank mind' or 'clean slate' perspective is considered key, in order for organisations to think beyond the constraints of existing

systems, assumptions and ways of thinking, and determine how to best construct processes to improve business processes and operations, through replacing current processes with those that are more effective for both the organisation and customer (Robson and Ullan, 1996:3, Mohapatra, 2013.:214). It is also considered to provide a means of achieving the large-scale gains which an organisation may have long realised were available, but did not have the courage or technology to exploit (Robson and Ullah, 1996). Information technology generally plays a role in enabling new forms of collaborating and organising within BPR, rather than in supporting existing organisational business functions (Mohapatra, 2013).

Plan-Do-Study-Act (PDSA): PDSA cycles offer a method for 'structuring iterative development of change', and can be used as part of broader quality improvement approaches, or as in a standalone way (Taylor, McNicholas, Nicolay et al, 2014:291). PDSA prescribes a 'cyclic learning approach' composed of four stages, with adapt changes made, with the aim of improvement (*ibid.*:291). Drawing on Taylor et al (2014) and Sayer and Williams (2007:341), the 'plan' stage involves the identification of a change which is aimed at improvement, and defining issues, objectives and a potential solution. During the 'do' stage, the planned change is tested in 'trial mode'. The results of the trial (the change's success) are examined and verified during the 'study' stage, and in the 'act' stage, the change is fully implemented as a standardised solution, or adaptations and subsequent steps are identified, which inform the next PDSA cycle. PDSA cycles allow for an iterative approach to intervention testing, as they allow rapid assessment and the flexibility and freedom to learn from, and adapt changes in accordance with, feedback, ensuring the development of solutions which are fit for purpose (Taylor et al, 2014). This is considered to minimise the risk presented to the organisation, resources and patients, and provides the opportunity to accumulate evidence for and confidence in the intervention (*ibid.*). Documentation at each cycle stage supports scientific quality, reflection and learning, and also allows for the assessment of the impact of the change on the outcomes or processes of interest, over time (*ibid.*). PDSA occupies a central place in the Lean Kaizen process - 'the incremental continuous improvement that increases the effectiveness of an activity to produce more value with less waste' (Sayer and Williams, 2007:339).

Six Sigma: Six Sigma was developed at Motorola and was subsequently adopted by General Electric in 1996 (Sayer and Williams, 2007). The well-defined management, training and implementation framework of Six Sigma gave focus and form to the application of many quality techniques and tools (*ibid.*). Drawing on Dedhia, (2005) and Antony (2006), Radnor (2010:19) suggests that Six Sigma aims to lower organisational costs and enhance the satisfaction of customers, through reducing defects and service failure. It focuses on measuring service and product quality, process improvement and reducing variation and cost, through the use of management and statistical tools to make improvements. The basic goal of Six Sigma is to 'reduce variation within the tolerance or specification limits of a service performance characteristic'. The measurement or quantification of variation, and the development of potential strategies to reduce it, are imperative for improving the quality of services. Similarly, Sayer and Williams (2007:23) explain that Six Sigma involves identifying and controlling variation in processes that affect profits and performance most. 'Black Belts', who are trained practitioners, follow a prescribed methodology, perform root cause analyses and implement appropriate corrective action. These 'Black Belt projects' typically last between four and six months.

Six Sigma shares many of the tools of Lean and the 'Define-Measure-Analyze-Improve-Control (DMAIC) problem-solving methodology' can be applied within Lean as a set of tools to eliminate waste resulting from defects and reduce process variation (Sayer and Williams, 2007:23).