The London School of Economics and Political Science

The 'Becoming' of Collective Action: A Social Movement Perspective on Large-Scale Organisational Change

THE NHS CHANGE DAY SOCIAL MOVEMENT

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DECLARATION

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

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ABSTRACT

The research presented in this PhD aims to understand how collective action can be mobilised through social movements to introduce improvements in large healthcare systems. This research uses the English National Health Service (NHS) and the NHS Change Day (NHSCD) social movement as a case study to investigate these processes. By examining the development of the NHSCD movement from the perspective of process and practice theory, this research proposes to understand collective action as a constantly evolving mobilisation practice, which is both driven and restricted by inherent tensions.

The research was designed as a longitudinal qualitative project conducted over a period of three years, which followed the movement's development and explored its engagement with organisational change, generating field participant observations, narratives from interviews, 'Stories of Change' and narratives of 'pledges', and a variety of documents, artefacts and digital collected data. The data corpus was approached using thematic, narrative and frame analysis.

The analysis of the emergence and development of the NHSCD movement highlights the strategising practices that mobilise grassroots activism. Four collective narratives of health guided the initiation and implementation of multiple small-scale changes in daily working practices, highlighting a multifaceted 'Logic of Care'. Enactment within a supportive group context is shown to be inextricable to participants' motivation to take part in collective action and to the mobilisation of change. The NHSCD movement managed to successfully mobilise collective knowledge through framing practices, suggesting 'framing' as a distributive, agentic and voluntary dynamic that supports organisational change processes.

This thesis expands our understanding of the mobilisation of collective action by conceptualising it as a process of 'becoming'. In situating the NHSCD social movement within both organisational and social movement studies, this research aims to bridge the historical divide between the academic fields, highlighting grassroots practices within organisations.

To

My parents who I wish were with me today

(Physician Performing Surgery: Dr. Yoram Ionel Harari by Hortensia Harari, 1966)[5]

5 Painting owned by Liora Moskovitz.

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INTRODUCTION

This PhD thesis focuses on the mobilisation of collective action within the context of healthcare systems through social movements, which have increasingly become a normative means of pushing for social change (De Bakker, Den Hond, King, & Weber, 2013; della Porta, Kriesi, & Rucht, 2009). In recent years, the world has witnessed how waves of collective action have burst into the socio-political and socio-economic arena (Baker, 2016; Gamson, 2011; Simsa & Totter, 2017). Yet, little empirical attention has been paid to the potential contribution of activism in grassroots, frontline, staff-led movements in addressing the challenges faced by large organisations such as healthcare systems (Bate, Bevan, & Robert, 2006; Bate, & Robert, 2010; Bate, Robert & Bevan, 2004; Carnall, 2007; Carson-Stevens, Patel, Nutt, Bhatt, & Panesar, 2013; Perla, Bradbury, & Gunther-Murphy, 2013). This thesis contributes to the literature on organisational and social movement studies through an in-depth longitudinal investigation of a grassroots movement, NHS Change Day, which emerged within the context of a large healthcare organisation, the English National Health Service (NHS).

The notion of 'collective action' is key to the elucidation of the dynamics through which societal or organisational change occurs (Hargrave & Van de Ven, 2006; Schneiberg & Lounsbury, 2008; Thornton, Ocasio, & Lounsbury, 2012; Wijen & Ansari, 2007). In particular, the mobilisation of collective action to effect change is a challenge faced by many large organisations and partnerships in today's changing economic and political environment (Courpasson & Vallas, 2016; Dubuisson-Quellier, 2013; Jerneck, 2014; Olsen, 2017). This is to say that the success of

organisational change programmes, both in their design and implementation, depends upon the successful mobilisation of collective action (Schneiberg & Lounsbury, 2017; see also Carnall, 2007; della Porta & Diani, 2006; Demers, 2007). Yet collective action, defined as 'action taken by a group (either directly or on its behalf through an organisation) in pursuit of members' perceived shared interests' (Scott & Marshall, 2009, p. 96), cannot be taken for granted, even in cases when such action seems to be, to the external observer, the rational way to behave. This contradiction has also been articulated by Olson (1971) as the 'free rider' paradox. Olson (1971) subsequently raises the question: How does the mobilisation and maintenance of collective action occur? (Mueller, 1992; Olson, 1971; Opp, 2009).

The problem of collective action mobilisation can be observed in the notable example of the English National Health Service (NHS), one of the largest healthcare organisations in the world. The NHS faces the challenge of achieving and maintaining appropriate standards of healthcare delivery and consistently meeting the requirements placed on it by the government and society (Crisp, 2011; Fotaki, 2010). This is manifested in the frequent design and implementation of organisation-wide, government-instigated change programmes (Edwards, 2013; Fotaki, 2014; Freeman & Peck, 2010; Hyde, 2010). The successful delivery of such change programmes, however, is especially challenged by the need to implement them in various regional contexts, epitomised by diverse local working practices; the specificity of these contexts needs to be considered and included in the overarching global wider policy (Anderson, 2012; Beer & Nohria, 2000a; Cumming & Worley, 2009; Huxham & Vangen, 2013; Reay et al., 2013). Consequently, tensions arise in the implementation of change policies, which include the need to align central and local design and

practices, stressing the necessity of engaging staff and patients in collective action (Bate et al., 2006).

Collective action has been widely researched in the social science literature, preoccupying scholars in various fields, such as sociology, political science, social psychology and economics (Campbell & Cornish, 2010; Campbell & Jovchelovitch, 2000; Snow, Soule, & Kreisi, 2004; van Zomeren & Iyer, 2009). In particular, the study of collective action has been core to both organisational and social movement scholarship (Campbell, 2005; McAdam & Scott, 2005). Although the understanding of the mobilisation of collective action as a socially-constructed phenomenon is shared by most scholars in both the fields of organisational and social movement studies, research on collective action and its role in change processes has been approached differently in both areas (Davis, McAdam, Scott, & Zald, 2005). Consequently, there has been a growing interest in social movements within contemporary organisational research, with a number of scholars calling for additional empirical studies with the aim of furthering the interdisciplinary dialogue between organisational and social movement studies (Schneiberg & Lounsbury, 2017; De Bakker, Den Hond, King & Weber, 2013). This focus of interest has emphasised the ways in which bottom-up initiatives can elucidate the challenges inherent to change processes within organisations (see for example: Bate & Robert, 2010; Bate et al., 2006; Bate et al., 2004; Boyd, Burnes, Clark, & Nelson, 2013; Briscoe & Gupta, 2016; Carnall, 2007; De Bakker et al., 2013; Dubuisson-Quellier, 2013; Haug, 2013; Munro, 2014; Soule, 2012). In particular, these calls highlight the need to re-conceptualise the implementation and adoption of new procedures in organisations as a process of collective action in which people are engaged into change, rather than

having change forced upon them (Reay, GermAnn, Golden-Biddle, Casebeer, & Hinings, 2016; Reay, Golden-Biddle, & Germann, 2006). Despite these calls, there remains a severe lack of empirical studies with the aim of furthering the exchange between these disciplines. Furthermore, the question of how to incorporate the insights generated from social movement research into an understanding of the mobilisation of collective action within organisational contexts remains insufficiently explored.

This thesis responds to these calls by offering a new understanding of collective action through a processual practice-based lens study. The research focuses on the emergence of collective action practices within the NHS Change Day – a social movement that developed within the confines of a large healthcare system, the English National Health Service, an organisational context that both enabled and constrained the movement.

The thesis creates novel theoretical connections between the fields of organisational and social movement studies in two distinct but interconnected ways. Firstly, by looking at the development of grassroots activism through the mobilisation of collective action in a large organisation, it links social movement literature to the theoretical field of emergent change in organisations. Furthermore, the use of a practice approach enables a strong focus on the social activities and practices inherent to the mobilisation of collective action (Chia, 2004; Chia & Holt, 2006; Nicolini, 2012; Thornton et al., 2012).

Empirically, the research looks at the mobilisation of collective action in the context of the grassroots activism of the NHS Change Day social movement, which

emerged as a response to the complex challenges faced by the English National Health Service – the NHS henceforth. The NHS has had, since its inception, a strong and formative social and political influence on the development of a modern national identity within the UK, and is viewed by many as inextricable from an understanding of what it is to be British (Ballatt & Campling, 2011; Shapiro, 2010). The founding ethos of the NHS aspired to make the best medical advice and treatment freely available to the entire British population, irrespective of means, age, sex or occupation (Delamothe, 2008b). Consequently, the institution of the NHS epitomises the idea of universal, equal access healthcare, and plays a significant role as a symbol of what is possible within overarching healthcare debates through the explicit belief that healthcare is a human right (Berwick, 2008; Wicks, 2007). As both the fifth largest organisation and the largest healthcare system in the world, the NHS plays a key role in shaping both health and social care in the UK (Bevan, Roland, Lynton, & Jones, 2013; NHS choices, 2015). There is, however, a growing perception that the scope of the NHS should not be strictly limited to basic healthcare: the general public sees the NHS as having a commitment or moral obligation to a holistic approach towards health, believing that 'care' should encompass a wide range of different services (Ballatt & Campling, 2011; Delamothe, 2008a, 2008b, 2008c, 2008d, & 2008e). A health system should encompass both diagnosis-based interventions as well the promotion and maintenance of health and well-being, as seen in initiatives of preventative medicine (Crisp, 2011; Horton et al., 2014; Sallis, 2011). Despite these widespread public beliefs, the NHS as we know it is under siege (Abbasi, 2017; Ham, 2016). Current pressures include restrictive budgets and shifting demographic structures, as well as concerns regarding the cost of treatment for an aging population (Boyd et al., 2013; Marshall & Øvretveit, 2011; Rimmer, 2017). These issues

challenge the dream of unlimited healthcare available for all (Crawford & Emmerson, 2012; Godlee, 2013; Majeed, 2017; Select Committee on Public Service and Demographic Change, 2013). In addition, the NHS has faced a series of investigations into performance failures that have severely affected morale, including the Francis Report (2013), which articulated both systemic and cultural failings regarding patient neglect on an organisational scale. To address these problems, many local and national organisational and development programmes, including the Health and Social Care Act (2012), have been implemented. Yet, the success of these initiatives has been the subject of debate within both public forums and academic circles, as well as subject to significant internal criticism (see for example: Clarke, Watt, Sheard, Wright, & Adamson, 2017; Davies & Mannion, 2013; Ham, 2017; Iacobucci, 2017a, 2017b).

NHS Change Day – NHSCD henceforth – a frontline-led grassroots movement of activists emerged within this context. The movement, active since 2013 and mainly constructed of NHS frontline staff engaging in and leading daily initiatives of change, calls for both staff and patients to engage dialogically in the practice of improvement. Although the NHSCD movement was initiated in the English NHS, it has now reached a global audience, with similar initiatives developing in Australia, Northern Ireland, Canada, the Netherlands, Finland, the USA, Scotland, Wales, New Zealand, Jordan and India (NHS Change Day, 2016):

> NHS Change Day is our opportunity to come together and harness our collective energy, creativity and ideas to make a change. Together each of our small actions will make a big difference in improving the care and wellbeing of those who use the NHS. What will your action be? (NHS Change Day, 2016)

NHSCD is understood in this thesis as a prefigurative social movement (Boggs, 1977; Cornish, Haaken, Moskovitz, & Jackson, 2016; Yates, 2015), a style of collective action that is defined as activists' efforts to establish and enact alternative structures of being within the present (Yates, 2015). Frequently twinned with the global justice movement and characterised by its rejection of traditional hierarchies and concern for collective, egalitarian modes of organization, prefigurative politics are experiencing a resurgence of interest in both activist and academic circles (Cooper, 2017; Simsa & Totter, 2017; Laamanen & Den Hond, 2015; Nolas, Varvantakis, & Aruldoss, 2016; Baker, 2016; Leach, 2013; Van de Sande, 2013; Young & Schwartz, 2012). The study of prefigurative politics, encompassing both the creation of prefigurative communities and the role of activists in the mobilisation of collective action, has emerged as a significant field within the study of social movements from the perspective of social and political psychology (Cornish et al., 2016). The NHSCD movement is an especially useful case study when developing a practice-based understanding of how and why collective action emerges within organisations, since the prefigurative settings facilitated by the movement were characterised by the creation of new spaces intended both for the practice of change and for cross level dialogue within the organisation (Western, 2014). This study follows and contributes to this emergent research focus in exploring, from a practice perspective, how social movements develop everyday practices. In doing so, this thesis expands our understanding of the mobilisation of collective action beyond the context of hitherto studied settings to encompass grassroots activism in a social movement that develops within the confines of an organisation, and, through this, shows that the forms of grassroots activism that emerge within organisational contexts are, nevertheless, social movements and as

such must benefit from the application of concepts drawn from social movement studies.

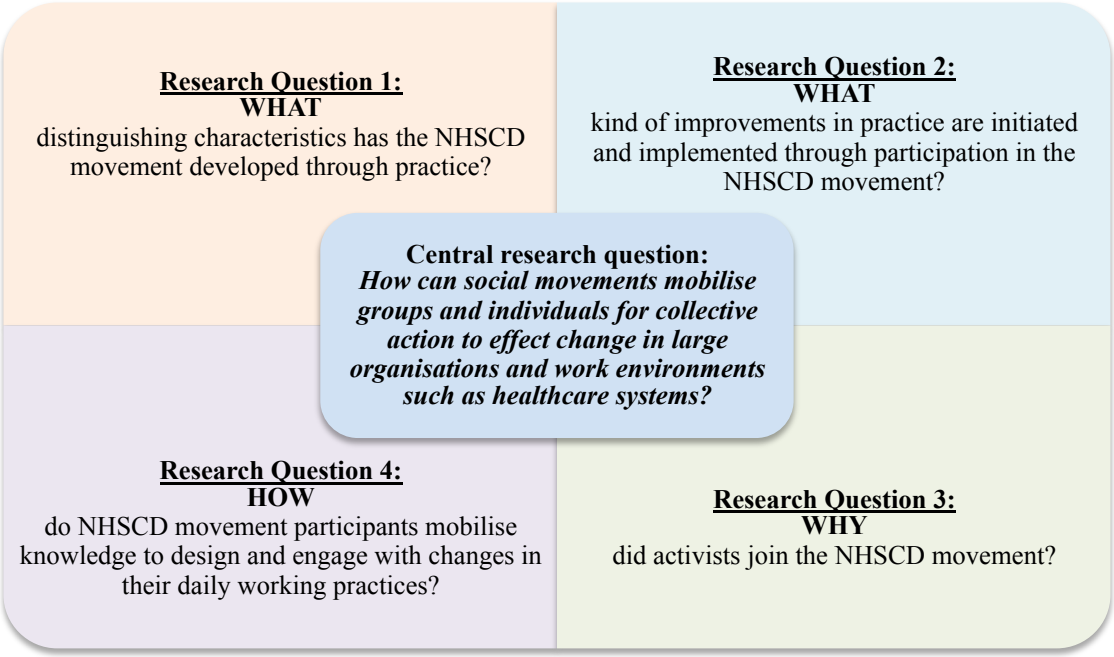
Seeking to thoroughly explore these processes, this research was designed to follow a three-year longitudinal qualitative approach and adopts a triangulation of qualitative methodologies. The data corpus consists of around 250 hours (during 7 meetings and events) of field participant observations, which were captured in more than 100 pages of field notes, 400 hours of digital observations, 800 emails from personal communication with movement's leaders, 389 media articles and around 50 original documents. Thematic and narrative analysis were applied to the data of 26 in-depth interviews, 100 'Stories of Change' and 9,479 narratives of 'pledges' made by the movement's participants.

This study has followed the development of the NHSCD movement almost from its inception, aiming to answer the following central research question: How can social movements mobilise groups and individuals for collective action to effect change in large organisations and work environments such as healthcare systems? This question was addressed through the consideration of four specific research questions. The first question investigates the emergence and development of the NHSCD movement and asks *what* distinguishing characteristics the NHSCD movement developed through practice. The second question concentrates on the implementation of change initiatives by the NHSCD movement participants, examining *what* kind of changes and improvements in practices are initiated and implemented through participation in the NHSCD movement. The third question is concerned with the motivation of activists in voluntarily involving themselves / participating in grassroots collective action and asks *why* activists joined the NHSCD

movement. The fourth question focuses on the issue of knowledge mobilisation practices, investigating *how* NHSCD movement participants mobilise knowledge to design and engage with changes in their daily working practices.

The data analysis is presented in four different but interrelated empirical chapters (4, 5, 6, and 7). The following diagram shows the way in which the research questions are addressed in this thesis:

Introduction Figure 1



In response to the first research question, the entire data corpus was reviewed (read or viewed/observed). Additionally, a thematic analysis of 26 in-depth interviews, 100 'Stories of Change' and 9,479 online 'pledges' was conducted. In addition to the main theoretical, processual practice-based framework outlined in this section and Chapter 1 of this thesis, the account of the emergence and development of the NHSCD movement presented in Chapter 4 specifically draws on the strategy as practice

literature as well as strategic perspectives within social movement scholarship. The results of this analysis reveal the development of the NHSCD movement and identify the prefigurative characteristics and settings created by the movement's activists. The findings are presented in a detailed account of the history and development of the NHSCD movement in Chapter 4, which contributes to the understanding of how prefigurative settings can be strategically facilitated within organisational systems. The topical notion of prefigurative settings for change is further considered and reflected upon in Chapter 2, written as a co-authored published introduction to a special issue that 'rethinks' the concept of prefigurative politics through the lens of social and political psychology.

In response to the second research question, Chapter 5 explores the narratives from 26 in-depth interviews, 100 'Stories of Change' and 9,479 online 'pledges', utilising two different levels of analysis. In addition to the main theoretical, processual practice-based framework of this thesis, the chapter draws on recent work on social movements and institutional change and in particular on recent advances in the understanding of the micro foundations of institutional logics. The chapter also reviews recent studies focusing on social movements in the field of health and healthcare. In doing so this chapter zooms in to analyse individual and group accounts of personal and collective enactments of change in their material practices and the meanings attributed by participants to such changes, and then zooms out to build four collective narratives of health via inductive methods, considering these in relation to other studies in the field of institutional logics, with a particular emphasis on those in health and healthcare. The chapter then contends that these four narratives can be understood as part of an overarching 'Logic of Care' that guides and informs

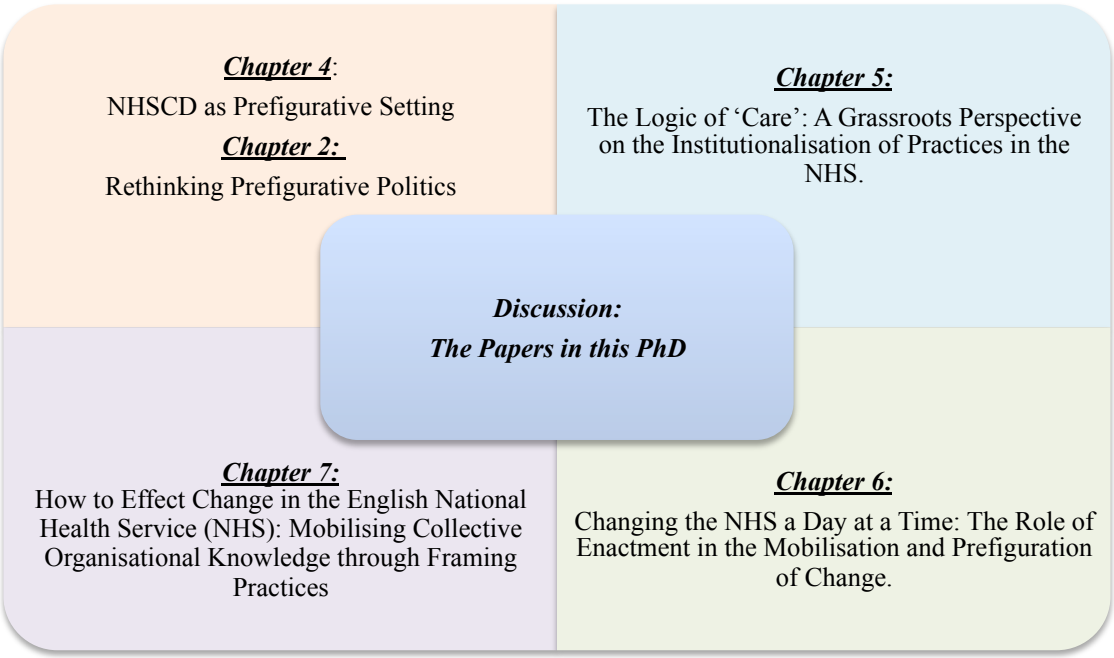
healthcare practices, examining the ways in which such a logic is both shaped by and shapes the simultaneous implementation of micro small scale changes in everyday working practices across social levels. Chapter 5 contributes to the literature by expanding on the empirically understudied process of the complex two-way dynamic between micro and macro levels of change to institutional logics. In demonstrating a bottom-up approach to the understanding of how institutional logics emerge in practice, this chapter highlights the process through which collective action both generates and is generated by the purposeful enactment of small-scale 'mundane' change in material practices by multiple embedded actors.

In response to the third research question, Chapter 6 explores the narratives from 23 interviews of activists. In addition to the main theoretical, processual practice-based framework of this thesis, the chapter draws on developments in the literature on prefigurative social movements and in the literature of the social psychology of collective action, especially recent understandings of how group identity processes affect the mobilisation of collective action. In doing so, the analysis highlights the role of enactment in these dynamics, and suggests that daily participation in and enactment of self-led small change initiatives play a more significant role than top-down managerial strategies in the construction of meaning for activists, directing and influencing their participation within the social movement. This meaning relies on the encapsulation of both personal agency and collective efficacy, a process which lends itself to the strengthening of a vocational identity, affirming the role and identity of the activist within the movement and the organisation as a whole. This paper presents an interrelated process of mutual construction and shows the interplay between the motivation to participate in

collective action and the experience of the daily enactment of small-scale, self-initiated changes within a supportive group context. This chapter is written as a second published co-authored paper.

In response to the fourth research question, Chapter 7 explores 26 in-depth interviews, 100 ‘Stories of Change' and 9,479 online ‘pledges’, utilising three different levels of analysis. In addition to the main theoretical, processual practice-based theoretical framework of this thesis, the chapter draws on the concept of frame analysis (Goffman, 1974, 1981), as developed in the social movement literature (Benford & Snow, 2000). The chapter illustrates the ways in which the NHSCD movement co-constructed three interconnected frames, which worked to shape collective action throughout the entirety of the institution by diagnosing the immediate problems faced by the movement, giving a prognosis of the necessary responses to such problems, and motivating movement participants to engage in collective action in their daily working practices. The findings in this chapter contribute to current understandings of how knowledge is mobilised within the context of large healthcare organisations, proposing ‘framing' as a distributive, agentic and voluntary process of knowledge mobilisation. Chapter 7 is written as third co-authored paper, which was recently peer reviewed (see peer review comments in Appendix 8).

Introduction Figure 2

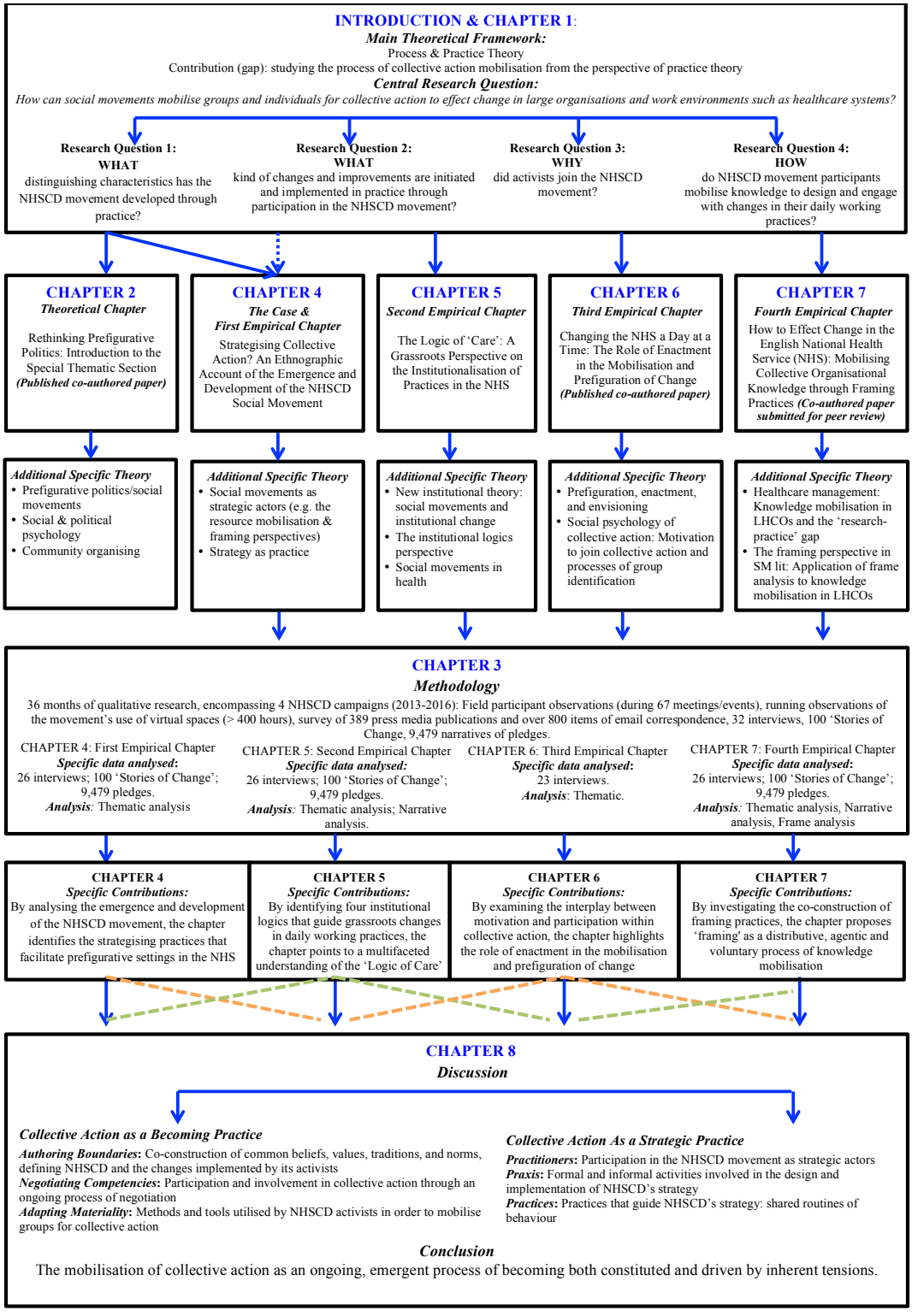


This PhD thesis is comprised of eight chapters. The first chapter establishes the theoretical framework that the thesis is grounded in: a processual, practice-based view of the mobilisation of collective action in organisations and social movements. The second chapter presents novel theoretical insights to the concept of prefigurative politics and is written as a published introduction to a special thematic issue on the topic. The third chapter describes the research methodology and fieldwork undertaken in this study. The fourth chapter is the first empirical chapter of this thesis and offers a detailed description of the case study and context, presenting an account of the development of the NHSCD movement and the troubled organisational context from which it emerged. Chapters 5, 6 and 7 are constituted of the three additional empirical chapters. Chapter 8 provides a discussion of the ideas presented throughout the thesis

and synthesises and solidifies the contributions of each chapter into a unified, overarching argument.

The following diagram presents an overview of the structure of this thesis and shows the ways in which the four papers are interrelated, delineating how they contribute to the argument of the thesis as a whole.

Introduction Figure 3



Chapter 1 Collective Action in Organisations and Social Movements: A Processual, Practice-Based Perspective

This chapter synthesises existing literatures from organisational and social movement studies, laying down the theoretical grounding of the thesis. The aim of this chapter is to review the interdisciplinary work that has been carried out by researchers in both fields, and in doing so to identify the gap that this thesis addresses, leading to the proposition that the application of a processual, practice-based perspective to the mobilisation of collective action can bridge these literatures. This approach offers a novel and original understanding of the phenomena of collective action.

1.1 A Processual Practice-Based Approach to the Study of Collective Action

1.1.1 Organisational Change: From a Linear Planned to an Emergent Approach

Historically, a central debate in the field of organisational studies is the tension between planned structured and emergent processes of change. The traditional approach in management studies maintains that managements or managers can strategically plan organisational change programmes in which they deliberately change and align internal structures to respond to environmental challenges and to ensure organisational survival (Burnes, 2009; Dawson, 2003; Demers, 2007; Hayes, 2010; Lawrence & Lorsch, 1967; Sine, Mitsuhashi, & Kirsch, 2006). Consequently, this academic discussion encourages and explores the development of intervention models and guides the implementation of organisational transformation programmes, which often advocate for the destruction of one configuration and its subsequent

replacement with another (Demers, 2007; Galbraith, 2000; Senior & Swailes, 2010). The underlying assumption of change informing these interventions involves a shift of the organisational structure from a 'present condition' to the more 'desirable future' envisioned by the organisation's management (Beer & Nohria, 2000a, 2000b; Burnes, 2013; Carnall, 2007). Additionally, this linear understanding has often been supported by an economic argument that states that structural-based interventions are an essential means of breaking organisational inertia and of reducing the costs that are involved in incremental change processes (Miller & Friesen, 1982). Although interventions, which focus primarily on planned change of organisational structure, remain prominent in contemporary scholarship and are pervasive in managerial practices, a growing body of research has turned its attention to the study of the emergent aspect of change in organisations (Carnall, 2007; Hirschhorn, 2000; Weick, 2000; Weick & Quinn, 1999). The initial seeds of the idea that organisational change cannot be narrowed down to linear thinking can be traced back to the work of scholars such as Chester Barnard and Philip Seiznick in the 1930s and 1940s, who turned their focus to the study of the social dynamics within organisational systems, aiming to account for the multifaceted nature of human relationships and group politics inside organisations (Schein, 2002; Scott & Marshall, 2009). This was the beginning of the idea that organisations necessarily contain unpredictable aspects which resist subjection to linear models. This theoretical approach opened the way for the study of the informal elements of organisational structure, which were seen as accompanying the formal elements, but which are equally as essential to the overarching dynamic (Demers, 2007; Schein, 1994). The formal organisation referred to structures, rules, procedures, hierarchical status and policies. Informal aspects of an organisation, however, included social networks, friendships, tacit values, perceptions and loyalties

(Cummings & Worley, 2009). Such work gradually evolved into an integrated view of people, process, structure and politics as interconnected elements of organisational life (Anderson, 2012).

The ongoing movement within the field of organisational studies towards a processual understanding of organisational change has been described in Weick and Quinn's seminal paper, which distinguishes between episodic and continuous change (Weick & Quinn, 1999). They emphasise that 'episodic change occurs during periods of divergence when organisations are moving away from their equilibrium conditions' (Weick & Quinn, 1999, p. 365). Shifting attention from change to changing, Weick and Quinn (1999) suggest replacing Lewin's traditional three-phase model (Lewin, 1947), of 'unfreeze – transition – refreeze', which suits inertia or equilibrium thinking, with the more processual framework of 'freeze – rebalance – unfreeze', which is suitable for the understanding of change as continuous (Weick & Quinn, 1999). Farjoun (2010) claims that 'stability and change are fundamentally interdependent – contradictory but also mutually enabling' (Farjoun, 2010, p. 202). Consequently, Weick and Quinn (1999) recommend a shift in vocabulary, from 'change' to 'changing', which comes with an attendant shift in focus, to change as an action and as a process. Furthermore, Tsoukas and Chia (2002) suggest that change be treated as the normative state within an organisation. Organisations, therefore, must be considered as a 'pattern that is constituted, shaped, and emerging from change' (Tsoukas & Chia, 2002, p. 567). This evolving understanding focuses on the emergent quality of change, stating that it is through the ongoing agency of human actors that change is accomplished (Tsoukas & Chia, 2002).

Tsoukas and Chia (2002) develop the understanding of the nature of things as 'becoming' in the context of organisational studies. In focusing on the emergent quality of change, they state that it is through the ongoing agency of human actors that change is accomplished. They coin the term for this process as 'Organisational Becoming' (Tsoukas & Chia, 2002). Robert Chia claims that the reverence that Western thought gives to concepts such as 'permanence', 'stability', and 'being', shapes common understandings of organisations in the post industrialised economies. He contrasts this with the Oriental understanding of the term 'becoming', rooted in 'change', 'emergence', and 'sequentiality', revealing that such thought is core to process thinking (Hernes & Maitlis, 2010). Tsoukas and Chia contend that in adopting a view of organisations as 'becoming', the researcher needs to adopt new language. Such a shift in linguistics is conceptually challenging, as it contradicts our largely formulaic educational training (Van de Ven & Poole, 2005).

1.1.2 The Ontology of 'Becoming': Organising as a Flow of Collective Action

Processual thinking is rooted in metaphysical philosophy and has a long historical lineage, developed across thousands of years, from Ancient Greece to modern philosophy (Rescher, 1996). Contemporary process theorists draw on Whitehead's understanding of existential reality, which states that individuals experience, in terms of their interaction with the universe, more than is possible for them to understand. The Whiteheadean approach to reality is essentially metaphysical: nature and human experience are inextricable (Hernes, 2008). Whitehead attempted to develop an epistemology that went beyond an understanding of the world that is limited to categorisations (Halewood, 2005). As such, Whitehead claimed that 'objects' are

necessarily abstractions from a dynamic universe, which is constantly in flux, and that the process of objectification is fundamental to human sense-making (Hernes, 2008): 'Objectification is an operation of mutually adjusted abstraction, or elimination, whereby the many occasions of the actual world become the complex datum' (Whitehead, 1929, p. 210). Whitehead's premises for this argument rely on a rejection of the idea that an object has a fixed location in time and space: an object cannot exist in a final state, and instead exists in a perpetual state of becoming (Hernes, 2008). In this context, Mullarkey states that whenever we observe a movement, we actually observe 'a complexity of other movements that only appear to us as a thing' (Mullarkey, 2010, p. 47). He claims that 'becoming' is not, by itself, a definition, but only implies 'what cannot be defined' (Mullarkey, 2010, p. 48). The influence of metaphysical philosophers such as Whitehead is evident in contemporary process scholarship in its inclusion of the idea that life exists in a permanent state of 'becoming'.

When applying process to an organisational context, theoreticians negotiated the semantic gulf between an understanding of 'organisation' as a noun, to a verb. This conceptualisation led to a shift in the understanding of stability and change in organisations:

> When we talk about organizing rather than organization, we acknowledge impermanence (we accept that coordination and interdependence are not stable but need to be reaccomplished). […] Organizing viewed as an emergent unpredictable order, replaces a distinctive, stable self as the actor with dynamic relationships as the actor. (Weick, 2009, p. 7)

Process thinking is an affirmation of the fact that moments of self-definition – of organising – are definitively unstable. This understanding is based upon an ontological assumption, which demands investigation as to how flow is deflected or

stabilised. Such an investigation is pertinent to structures such as organisations, which appear, at first glance, to be solid and architectonic, but are in reality complex groupings made up of shifting factors (Hernes, 2014). Examining the inextricable relationship between process and structure facilitates analysis of the temporal dimensions of organisational life: 'In this view, structure is not seen as separate from process; on the contrary, it belongs to process, much as process belongs to structure' (Hernes, 2014, p. 67). This understanding of the synergy between process and structure is vital if we are to reflect on our current realities (Hernes, 2014):

> As social scientists, we are probably less attentive than we should be to the wavering balance between structure and process in understanding human action. Structure is the invariant pattern of relationships among functional points in a system, while process is the continuous emergence of new elements from those already existing. Structure concerns itself with stability or quasi-stability; process, with change. Though seemingly in contrast, structure and process complement each other both as concepts, and in the real world: to paraphrase Whitehead (1929) structure can be snatched only out of process and the novelty that emerges from process can realize itself only by submitting to structure. (Cooper, 1976: 999)

Taking 'organisations' in their verbal mode, Hernes (2014, 2009) describes the act of organising as efforts to stabilise the relations between variant actors. Acts of social organisation can be understood as comparatively static (although far from fully stabilised) epiphenomena, defined in terms of concordant relationships and event grouping (Chia, 2010; Cooper, 1976). As such, it is necessary to conceptualise the spatial and temporal ways in which actors interact if we are to understand how networks, which comprise organisations, are formed (Hernes, 2014). Czarniawska (2004a) emphasises that the process of organising demands the rapid and frequent movement of actors involved, and occurs as dynamic movements happening simultaneously in variant contexts. In a more recent paper, she makes the following entreaty:

> My plea is to study organizing as the connection, re-connection, and disconnection of various collective actions to each other, either according to patterns dictated by a given institutional order or in an innovative way. Such collective actions need not be performed within the bounds of a formal organization; an action net can involve actions performed by several formal organizations or by assemblies of human and non-human actants. The actions can be connected loosely or temporarily. (Czarniawska, 2010, pp. 154-5)

The ontology of 'becoming' has similar implications for the study of both organisations and social movements, offering novel reflections on the divide between structure and emergence in both fields. As Czarniawska (2010) states above, the phenomena of organising itself should be seen as constituted by acts of collective action, and this should, therefore, be understood in the same terms as those applied to the phenomena of collective action within the prism of social movements. Hernes discusses how generic, social organisational processes enable the spatial and temporal extension and stabilisation of 'socio-material configurations' (Hernes, 2014, p. 13). From this perspective, therefore, he reveals how organisations could be seen as:

> […] connecting processes [which] would form part of phenomena as diverse as *social movements* [my emphasis], families, religions, corporations, think tanks and brands, and not be seen as a sociological phenomenon apart from them (Hernes, 2014, p. 13)

Emergent change theorists, consequently, understand life as 'flow' (Hernes & Weick, 2007). This understanding unites the range of scholarly studies that can be defined as the process approach to organisations (Hernes & Maitlis, 2010) and challenges traditional perceptions of organisations as wholly different to social movements, revealing the shared features that unite the two, most notably, through a consideration of the ways in which the phenomena of collective action underpins organisational processes. The ontology of becoming is at the core of the theoretical grounding of this thesis, which will also explore the shared nature of social movements and organisations as objects of study whose fabric is constituted by collective action. The

next section reviews the various ways in which the ontology of becoming has influenced the field of organisational studies.

1.1.3 The Applications of Processual Thinking to Organisational Studies

Processual thinking has exerted a profound and varied influence on the study of organisations. Approaches taken by emergent change theoreticians make a distinction between those oriented towards the 'phenomenological', and those oriented towards the 'biological'. Phenomenological approaches are concerned with the cognitive and experiential, whilst biological approaches are concerned with organic, natural rhythm (Rescher, 1996). With these distinctions between the phenomenological and the biological in mind, some process thinkers draw on the natural sciences and highlight the non-linear and self-organising nature of organisational dynamics (Cheng & Van de Ven, 1996; Stacey, 1995). They highlight the understanding of complex causality regarding change in organisations, which means that change intervention in one part of the organisation can produce unexpected and even counterproductive results in another area of the organisation (Anderson, 2012; Cheng & Van de Ven, 1996; Leonard, 2013; Sorge & van Witteloostuijn, 2004; Stacey, 1995). Morgan (2011) stresses the non-linear interdependence of the different parts of the organisation. Langley and Tsoukas (2010) emphasise the importance of context, in terms of place and time in the study of organisations. Camazine et al. (2001) propose a mechanism whereby adherence to a limited number of simple rules facilitates the emergence of self-organising processes and generates order. Taking this managerial approach, Burnes (2009) argues, safeguards organisations, which are required to function in the context of continuous transformation and changing contexts. As such, these studies suggest that traditional, organisational, hierarchical structures and bureaucratic

procedures fail to function effectively in turbulent environments, especially when the organisation relies on creativity and innovation (Morgan, 2011).

Conversely, Tsoukas and Hatch (2001) highlight the limitations of using the metaphor of nature in relation to human organisations. These limitations include the lack of sensitivity to specific organisational contexts; the reflexivity, which defines human nature; the complexity of the motives behind human action, and the fact that such logico-scientific complexity models do not allow the description of time as non-linear. They further contend that adopting a narrative approach could overcome the problems listed above (Tsoukas & Hatch, 2001). Chia (2011) emphasises the same point, arguing that the arts and humanities provide examples of the importance of appreciating that which is intangible, or can only be approached from an oblique angle. In this context, Hernes (2014, 2008) describes how the process of organising creates structures, systems, strategies, technologies, logistics and historic narratives, which appear to be fully determined, and thus provide the illusion of stability. Such organising processes, and such impressions of stability, therefore condition the ways in which actors understand the phenomena of organisational change (Hernes, 2014, 2008).

Thus, process theory is anchored by the understanding that ideas are objectified and endowed with a sense of stasis when they are turned into linguistic terms, such as labels and metaphors (Czarniawska & Sevón, 1996). This process of coining phrases or objectifying the conceptual at one fixed point in time, enables the translation of coherent ideas across time and space (Hermes, 2014). Such a process facilitates the structuring of events both in the present and in the future, as the linguistic codification of ideas enables the labelling of past and present action, as well

as the inception of future action (Czarniawska & Sevón, 1996), emphasises that organisational actors go to significant lengths to select particular memories, and to maintain a coherent past, creating archive systems and organisational narratives. Particular elements of the past are understood and revived in order to create and control a projected future. Constructive action can only exist when contextualised meaningfully, and the interpretation of meaning involves the fixing of meaning. This process of sense-making, in itself, implies a return to the worldview of substance. De Cock and Sharp (2007) contend that as long as process researchers attempt to use their methodologies for sense-making, they will be forced into a worldview that demands interpretation of the world based on entities and behaviours. De Cock and Sharp (2007) therefore suggest a dialectical view.

The processual concept of 'becoming' has advanced the field of organisational studies, opening a new perspective to the understanding of stability and change in organisations. These new horizons offer a theoretical grazing ground for the analysis of emerging change in organisations as well as in society. This thesis contributes to the developing body of literature produced by scholars in the process tradition through the investigation of the emergent change phenomenon as manifested in an emerging social movement taking a practice-based approach, which is reviewed in the next section.

1.1.4 A Processual, Practice-Based Approach to the Study of Collective Action

Over the last decade, a growing community of process theorists has focused on the micro-practices of organising, considering the ways in which organisational actors enact incremental, small-scale changes over time (Demers, 2007; Orlikowski, 1996).

The practice approach, or practice theory, views action as the matrix from which organisational life emerges (Feldman & Orlikowski, 2011).

The work of practice theoreticians, according to Reckwitz, who includes Bourdieu, Giddens, late Foucault, Garfinkel, Latour, Taylor and Schatzki in this category, belongs to the wider stream of cultural theory (Reckwitz, 2002). Reckwitz contends that cultural theories approach action as a mode, which can be elucidated through the reconstruction of symbolic knowledge structures. Such structures enable that which is abstract to be socially interpreted through the use of symbolic forms, and therefore to be made meaningful, and enacted upon. As such, the social order must be understood as 'embedded in collective cognitive and symbolic structures, through a "shared knowledge" which enables a socially shared way of ascribing meaning to the world' (Reckwitz, 2002, p. 246). In this context, a common thread in most literature on practice is the orientation of the distinction between the 'know-that' and the 'know-how', which are the interrelated parts of knowledge (Ryle, 1949); and tacit and explicit knowledge (Polanyi, 1966). Polanyi describes this as, 'we know how to do it in practice… but we know more than we can tell' (Polanyi, 1966). Therefore, an inexpressible tacit coefficient exists that allows every thought and action (Ray & Clegg, 2005). Hence, there has been increasing investment in understanding working practices, the know-how (Ryle, 1949), and non-canonical practices (Brown & Duguid, 1991). The concept of 'practice' suggests something that can be reified, transferred and trained (Turner, Oakes, Haslam, & McGarty, 1994); however, the influence of practice theorists in organizational literature is that of an epistemology for the exploration of working practices, and the 'hidden' knowledge that enables them (Corradi, Gherardi, & Verzelloni, 2010). It is working practices such as this that

this study explores. Organisations, therefore, can be approached as emergent knowledge-based systems and, simultaneously, as participatory activity systems (Blackler, Crump, & McDonald, 2000).

Process theorists emphasise the fact that practices within organisations are enacted and performed socially (Schatzki, 2002; Schatzki, Knorr-Cetina, & von Savigny, 2001). In many ways, the use of a practice lens embodies the social enactment of organising (Schatzki, 2005). This idea underpins pivotal work in organisational studies in the past decade across its various fields of research, including strategy-as-practice (Golsorkhi, Rouleau, Seidl, & Vaara, 2010; Johnson, Melin, & Whittington, 2003; Whittington, 2004, 2006), organizational learning and knowledge management (Blackler, 1993, 1995; Brown & Duguid, 1991, 2001; Gherardi, 2000, 2009; Nicolini, 2016) and literature on the development and application of technology (Orlikowski, 2002).

Brown and Duguid (1991) discuss the contradiction between the ways in which people work in practice and the ways in which organisational procedures expect them to work. They claim that work is performed through participation in informal communities of practice, which results in creative and dynamic performance of daily activity (Brown & Duguid, 1991). Agency is a consequence of the reiteration of enactments and routines (Feldman, 2000; Feldman & Pentland, 2003). Such a process of reiteration, or repetition, can refer to past, present or future potentials. This same process enables the organisation to re-live its past and delineate its boundaries. In doing so, it can project a vision or path towards its future (Hernes, 2014). Activities remind the organisation's members 'of what the organisation is capable of' (Hernes, 2014, p. 135).

Practice theories draw on ethnomethodological studies of organisations (Demers, 2007). Csordas contends that the process of embodiment is fundamentally phenomenological and, therefore, from the perspective of ethnography, a paradigm for the understanding of the relationship between culture and the self (Csordas, 1990). From an organisational perspective, practice theorists view practices as embodied experiences through which meaning is articulated (Schatzki, 2002). Orlikowski refers to Schatzki's definition of practices as 'embodied materially mediated arrays of human activity centrally organized around shared practical understandings' as particularly influential in the field (Orlikowski, 2010). Social momentum is elemental to the articulation of meaning through practices, which are performed publicly and construct the social fabric (Hernes, 2014). He states that 'social pattern may stretch back a long time, which means that it represents a total "timespace" of numerous actors at multiple events' (Hernes, 2014, p. 136).

Orlikowski (2010) differentiates between three types of research regarding organisational practice. The first investigates practice as a phenomenon. This approach studies organisations as they are performed in practice, as opposed to organisations in theory. The second approach articulates practice-centred theory. For the third approach, practice is ontology, and practice is regarded as the philosophical building block of social theory (Orlikowski, 2010). Feldman and Orlikowski (2011) claim that the first approach 'answers the "what" of a practice lens', the second approach 'answers the "how" of a practice lens', and the third approach 'answers the "why" of a practice lens' (Feldman & Orlikowski, 2011, pp. 2-3). They recognise three core principles to practice theory: '1) that situated actions are consequential in the production of social life; 2) that dualisms are rejected as a way of theorizing; and

3) that relationships of mutual constitution are important' (Feldman & Orlikowski, 2011, p. 4). These principles will be elaborated upon further in the following sections, through the in-depth exploration of how practice theorists address everyday activity.

Many practice-based studies are undertaken with the intent of delineating the interactive processes through which human agents constantly recreate and co-construct their organisations. Situated learning emphasises that such processes of social construction are activity or routine-based, defining the paths by which individuals become legitimised within their communities of practice (Pentland, Feldman, Becker, & Liu, 2012). Such studies reject the dogmatic approach to learning, and stress that acquiring knowledge is a collective, creative and innovative process, which is both context-based and task-oriented. They draw upon Giddens' argument that each act of repetition provides a situated opportunity for transformation (Demers, 2007).

1.2 Organisations and Social Movements: An Interdisciplinary Approach

1.2.1 Social Movements and Organisations: A Historical Perspective

In common with the notion of 'organisations', the notion of 'social movements' has been interrogated for more than a century within the social sciences (della Porta & Diani, 2006; Eyerman & Jamison, 1991, 1998; McAdam & Scott, 2005; McAdam, McCarthy, & Zald, 1996). Although both organisations and social movements deal with the mobilisation of collective action of large groups of people in pursuit of specific goals, the scholarship that surrounds these phenomena has historically been divided, with little cross-pollination between the fields (Schneiberg & Lounsbury, 2008). This is particularly evident in the paucity of case studies taking an

interdisciplinary approach to the process of collective action (Schneiberg & Lounsbury, 2017). Despite the nature of collective action as a diverse happening within many different contexts, the study of collective action has been marginalised by traditional organisational studies, which has mainly limited itself to the study of formal systems and their structures (Campbell, 2005). Instead, collective action has been associated with the field of social movement studies, particularly in connection to political protest (Davis, McAdam, Scott, & Zald, 2005; McAdam & Scott, 2005).

The marginalisation of collective action in organisation studies can be linked to historically different ways of seeing social movements and organisations (De Bakker, Den Hond, King, & Weber, 2013; Zald, 2017). Scholars became interested in the phenomenon of organisations and social movements as early as the eighteenth and nineteenth centuries (Scott & Marshall, 2009). The study of organisations was initially characterised by a firm structural focus: organisations were perceived as systems, involving the 'planned coordination of the activities of a number of people for the achievement of some common, explicit purpose or goal, through division of labor and function, and through a hierarchy of authority and responsibility' (Schein, 1994, p. 15). This essential definition stressed the planned functional aspects of the actions taken which construct an organisation, and the metaphor of organisations as solid stable entities arose out of this focus on hierarchy and structure (Morgan, 2011). On the other hand, social movements have traditionally been seen as an anarchic form of change, associated with metaphors of fluidity, movement and dynamism (Smelser, 1998). As such, the first appearance of the term 'social movements' comes from Henri de Saint-Simon, who applied the term to describe the protests opposing the status quo in eighteenth-century France (Calhoun, 2012; Scott & Marshall, 2009). The

idea of ‘social movements’ became popular and was subsequently applied to the social conflicts of the nineteenth century, which similarly concentrated on issues of labour and nations. These social movements are commonly classified in academia as ‘old social movements’, focused on the working class struggle for power and representation (Eyerman & Jamison, 1991; Hunt & Benford, 2004; Tilly & Wood, 2015).

These early definitions continued to shape popular and academic understandings of both social movements and organisations in the following centuries. In the first half of the twentieth century, scholars regarded social movements in a negative light, a view that was influenced and compounded by the activities of the fascist and communist movements of the 1930s. Sociologists such as Rudolf Heberle, in one of the first textbooks devoted entirely to the subject, concluded that social movements, their ideologies and followers even represented a threat to democratic political systems (Eyerman & Jamison, 1991). Thus, the perception of social movements as dangerous forms of collective political behaviour impelled sociologists to seek rational assessments of the phenomena that could address the potential threat to established society (della Porta, 2008; della Porta & Diani, 2006; Eyerman & Jamison, 1991). This initial suspicion of social movements, the understanding of them as impulsive and made up of irrational actors, made the perception of them wholly distinct from that of organisations. This early division was reinforced by both pervasive Weberian descriptions of the ‘ideal’ hierarchical organisational structure and Taylor’s principles of scientific management, which continue to influence our perception of organisations today (Hosking & Morley, 1991; Morgan, 2006).

The use of the terms ‘organisation’ and ‘social movement’ has evolved significantly in the last decade in the literature. The current view of organisations and of organisational change has expanded dramatically from the original narrow economic and management view of organisations as ‘rational’ and ‘flexible tools’ – entities which are solely driven by the aspiration to create economic value (Beer & Nohria, 2000a; Jensen, 2000). As such, the field of organisational studies has become increasingly interested in not-for-profit organisational forms such as public service systems, NGOs, social businesses and forms of community organising, which, in their form and intent, share more obvious similarities with contemporary social movements. Furthermore, ideas such as corporate social responsibility and social entrepreneurship entered the field (Den Hond & De Bakker, 2007). In a similar way, the contemporary use of the term ‘social movement’ has broadened to encompass a wide range of political actors who operate outside mainstream party politics, and who are concerned with wide-ranging socio-political and socio-cultural issues (Eyerman & Jamison, 1991; Haralambos & Holborn, 2008; Scott & Marshall, 2009). Contemporary examples of social movements include the movements for civil rights, gay rights, trade unionism, environmentalism and feminism, and are fundamental to modern democratic life; a manifestation of freedom of speech and expression (Eyerman & Jamison, 1991; Scott & Marshall, 2009). The magnitude of change sought by a social movement depends on the aspect of society involved, and the degree of required change also varies, ranging from a narrow scope, such as the acceptance of nudism or legalisation of marijuana, to a complete social restructuring, as in millenarianism (Scott & Marshall, 2009; Snow, Soule, & Kriesi, 2004). An important distinction can be drawn between the social movements preceding World War II and the social movements that have emerged since the student movements of

the 1960s and 1970s (McAdam et al., 1996; Tilly & Wood, 2015). 'New' social movements are distinguished from the 'old' both by their specificity and their classlessness (Eyerman & Jamison, 1991, p. 78). Moreover, new social movements may have more issue-based goals, struggle for autonomy and seek cultural or socio-cultural change (Haralambos & Holborn, 2008). Regardless of the change demanded, all social movements can be characterised as groups of citizens united by their common concern, engaged in common actions and sharing a common drive to change some aspect of society (Oberschall, 2017; Tarrow, 2011). Social movements are, therefore, viewed as prominent elements of democracy, their activities manifesting democratic freedom of speech and expression (Markoff, 2015). As understandings of both social movements and organisations have broadened, the traits and features shared between them have begun to receive scholarly attention, stressing the importance of an interdisciplinary exchange. This will be discussed in the next section.

1.2.2 Organisations and Social Movements: Beyond the Historical Divide

McAdam and Scott (2005) suggest that the fields of organisational and social movement studies are complementary rather than competing, and they construct a conceptual framework to unify them. They make the claim, for example, that both fields developed by recognising the environmental effect on organisations and social movements, and draw similarities between the reception of the notion of environment in both fields. In organisation studies, this is reflected through the inclusion of a consideration of open system elements, such as material resources, technical features, and political and cultural forces. In the case of social movement scholarship, the resource mobilisation and political opportunity approaches specifically address the

relationship between the social movement and its environment. McAdam and Scott (2005) conclude their analysis by arguing that a broader inter-disciplinary frame of analysis could illuminate both research fields and yield a better understanding of social change.

Campbell (2005) claims that 'Both organisations and social movements are forms of coordinated collective action and, therefore, ought to be conducive to similar forms of analysis' (Campbell, 2005, p. 41). Campbell contends that theories of institutional change can be advanced through the identification of the environmental, cognitive and relational mechanisms of social change common to organisations and social movements. He goes on to argue that environmental mechanisms are the contextual influences that determine the ability of actors to engage in change, cognitive mechanisms affect perception of change, and relational mechanisms affect networks and connections between actors, and therefore their ability to change. Campbell (2005) notes that change mechanisms that should be common to organisations and social movements have been studied mainly in one field and neglected by the other, as in the case of the role of strategic leadership, which has been explored in depth in organisational studies, but demands further attention in the social movement literature (Campbell, 2005). Marshall & Scott (2009) claim that:

> Social movements are not themselves formal organisations or political parties but are looser networks of individuals and groups that may embrace a number of such organisations (Scott & Marshall, 2009, p. 704).

Thus, both organisation and social movements can be viewed as constituted of and shaped by both formal and informal networks (Campbell, 2005; DiMaggio & Powell, 1983; Strang & Soul, 1998). McAdam (2003) for example, points to a significant number of studies, which illustrate the contribution of established groups and

networks to the emergence of social movements, giving the examples of the civil rights movement, the anti-war movement, and the two wings of the U.S. women's movement. Furthermore, Davis & McAdam (2000) note that in the age of 'globalism' the distinction between economic activities, which were traditionally associated with corporations and formal corporations organisations, and the political activities of social movements become increasingly intertwined. The development of technology and the global shift towards an information economy further blur the boundaries between traditional organisations and social movements (Davis & Anderson, 2008).

In further support of the connection between social movements and organisations is the observation that they interact on various levels. Historically, corporations are often the context in which social movements develop, such as in the case of trade unions or other forms of collective action aimed at improving employment conditions and gaining equal rights in the labour markets (Briscoe & Safford, 2008; Edelman, 1992; Kelly & Dobbin 1999). Social movements also influence organisations and can bring about organisational change through the activities of employees who belong to their networks or identify with their political or social agenda, such as in the case of feminism or human right activism (Scully & Creed, 2005). Moreover, organisations and corporations are often the target of social movements' activities, specifically in connection with the issue of corporate social responsibility (Den Hond & De Bakker, 2007; King & Soule, 2007). Furthermore, social movements contribute to the creation and change of institutional fields, such as in the field of French cuisine (Rao, Monin, & Durand, 2003) and organisational practices, such as in recycling (Lounsbury, Ventresca, & Hirsch, 2003).

The field of health and healthcare is a fertile ground for the growth of social movements and other types of grassroots activism (Brown & Fee, 2014; Brown & Zavestoski, 2004; Brown et al., 2004; Campbell & Burgess, 2012; Jackson & Moskovitz, 2015; Klawiter, 2008; Morgen, 2002; Morrison, 2013) and as such offers a uniquely appropriate context for the study of collective action within large organisations. Health social movement are preoccupied with the mutual obligations between governments, healthcare institutions and individual members of society (Brown, 2007; Crossley, 2006; Hoffman, 2003; Quadagno, 2005; Skocpol, 1997). An issue of particular prominence is that of equal access and provision of healthcare services (Banaszak-Holl, Levitsky, & Zald, 2010), and problems in this area range from patient experiences of illness, disease, disability, and disputed or unrecognised illnesses, the inequalities found around the areas of gender, race, ethnicity, class and sexuality to the relationship between human health and a changing environment (e.g. pollution, climate change, etc.).

Health social movements are often affected by problems of definition, as well as with the ongoing struggle of negotiating the real-world implementation of proposed initiatives and reforms (Brown & Zavestoki, 2005; Campbell, 2014). The activities of such movements and activists often bring the issue of healthcare into the public eye: as such, the question of just what healthcare is meant to do is continually being posed, with public perceptions of the role played by healthcare in social and political life often in flux (Mendel & Scott, 2010). As such, health social movements often strive to change government policy in the field of health and healthcare (medical, public health and political). Yet even when suggested proposals are accepted and transformed into legislation, health social movements often carry on their struggle,

continuing to attend to problems encountered with the attempt to meet these ideals in practice through the maintenance of appropriate standards (Rathert, Vogus, & McCelland, 2016; Welsh, 2007). Although the activities of these social movements and the influence that they exert on prevalent belief systems have enormous implications in healthcare, both in terms of legislation and the delivery of care in practice, they remain comparatively understudied from the perspective of organisation studies.

The following section sets out the process, practice-based approach adopted in this thesis with the aim of furthering our understanding of the mobilisation of collective action in large organisations such as healthcare systems through social movements and grassroots activism.

1.2.3 Understanding Social Movements in Healthcare Through a Processual Practice Approach

While there has been, as discussed in the previous sections, a growing interest in social movements and their relation to collective action in organisations (De Bakker et al., 2013), little scholarly attention has been paid to the empirical study of how social movements' participants engage with changes in their daily working practices. This section outlines the manner in which a processual practice approach will be applied in this study, offering a new perspective on the study of social movements, and bridging the divide between social movement and organisational studies.

This thesis draws upon the contemporary trend in social movement literature which shifts the focus from the social movement as a collective actor to the study of 'the internal lives of social movements' (Haug, 2013, p. 706). This evolving literature

studies the construction of meaning and identity within social movements, viewing movements as spaces enabling social change and cultural formation (Cornish et al., 2016; della-Porta, 2013; della Porta & Diani, 2006; Johnston, 2009; Melucci, 1996). This study explores the ways in which the mobilisation of collective action in organisations is interlinked with practice and involves a range of embodied activities configured around a shared set of understandings and daily practices, including information, meaning, power structures and belief systems, alongside routines, rituals and organisational constructs (Nicolini, 2012). As such, this study investigates the 'everyday' and 'life-world' of the organisation, where the 'social' resides (Reckwitz, 2002, p. 244). Practice theory views action as the matrix from which organisational life emerges. Consequently, this study focuses on the ongoing social accomplishment through which collective action develops, exploring the process through which it is constituted and reconstituted as actors engage the world in practice (Nicolini & Monteiro, 2017). In addressing this issue, this thesis draws on Nicolini's (2012) suggested framework of 'zooming in' and 'zooming out', which provides a visual metaphor for the movement that constitutes practice. Employing this understanding, collective action practices are re-presented in this study through the alteration of theoretical lenses and are re-positioned in the field, thereby emphasising certain features above others by bringing them forward (Nicolini, 2009). Hence, we first zoom out of the field, as activities never happen in isolation, taking into account all stakeholders, the shared narratives in the public sphere, and moving between practices as they are interconnected (Langley, 2007; Rantakari & Vaara, 2017). Next, we zoom in on sayings and doings through narratives and understandings, objects and artefacts used in the practices and observable practical concerns that organise practising, the aim being to zoom in on the accomplishments of practice and zoom out of their

relations in space and time to be able to comprehend and re-present practices (Nicolini, 2012, p. 223).

Nicolini (2012) suggests that the phenomenon of practice is complex and must be studied by applying a 'toolkit-logic' or a type of 'programmatic eclecticism'. Moreover, Nicolini (2009) recommends re-presenting practice by highlighting the active role of materials and tools, by focusing on the heterogeneous nature of practice (Engeström, 2000; Lahlou, 2015, 2017; Latour, 2005). The non-human, such as technological tools, artefacts and human and financial resources in organizations, and human actants must be equally zoomed in on in order to understand and re-present practice. As the findings will illustrate, we incorporate many non-human actants that are present in the research, such as documents, technology and platforms, amongst others. Zooming out allows for the trailing of connections and following the associations between practices by following them in space and time and exploring how their connections are maintained via organisation between human and non-human mediators (Nicolini, 2009).

The introduction to this thesis highlighted the need to re-conceptualise the implementation and adoption of new procedures in healthcare organisations as a process in which people are engaged with change rather than change being forced upon them (Reay, GermAnn, Golden-Biddle, Casebeer, & Hinings, 2016; Reay, Golden-Biddle, & Germann, 2006). This chapter argues that adopting an interdisciplinary approach that explores grassroots activism within social movements can contribute to our understanding of the mobilisation of collective action in organisations (Hensmans, 2003; Schneiberg & Lounsbury, 2008; Strang & Jung, 2005). This chapter also contends that, despite the advocacy of many scholars of the

need to construct a unifying conceptual framework, interdisciplinary approaches remain uncommon in both organisation and social movement studies, and highlights a specific lack of empirical studies that adopt a processual, practice-based approach in this area (Campbell, 2005; Davis et al., 2005; Davis & Thompson, 1994; De Bakker et al., 2013; Hambrick & Chen, 2008; Huag, 2013; McAdam & Scott, 2005; Munro, 2014; Quinn & Worline, 2008; Rao, Morrill, & Zald, 2000; Sutherland, Land, & Böhm, 2013; Willmott, 2014).

1.3 The Research Journey: Exploring the Space Between Social Movements and Organisations

The impetus behind this research emerged from my personal journey and became concrete over the time in which I met and engaged with the NHS Improving Quality team and the founders of the NHS Change Day social movement (NHSCD). Since the beginning of my career, I have held a fascination for human behaviour in a social context, and in particular for the social dynamics that drive individuals to act collectively and how the wider implications of this interplay between agency and collectivity have much to add to our understanding of both the personal and the political.

I first began to explore the social sciences through the lens of economics and accounting as I was captivated by the attempts of these disciplines to capture reality, rational decision-making and strategic thinking in mathematically quantifiable terms. Above all, it was the power of game theory to articulate and simplify real-world problems to yield new insights, which I found most compelling. I was particularly interested in the application of these theoretical concepts to the real life challenges faced in the field of healthcare, and this was reflected throughout the

research that I undertook in the early stages of my career, in which I further developed my understanding of the inter-relationship between individual and collective levels of analysis (Harari [Moskovitz], 1990, Shechter, Harari [Moskovitz], & Shavit, 1991) [6].

My training and professional experience as a Certified Chartered (Public) Accountant taught me a different language through which to conceptualise complex organisational reality, minimising variance and enabling meaningful economic comparison. The multi-faceted nature of my career introduced me to diverse organisational cultures, and it was through this role that I first observed the importance of dynamics between employees and organisations. My working life began to reveal the limitations of mathrmatical thinking to capture and account for the complexity of human dynamics in their entirety, and I became increasingly aware of how the purely rational model of strategic thinking neglected the backgrounds, experiences and internal worlds of organisational personnel.

I wanted to continue to explore these insights and expand my knowledge and understanding of behavioural, cognitive and emotional processes in societal and organisational contexts. Following a career break, during which I devoted time to raising my two children and moved with my family from Tel-Aviv to London, the opportunity presented itself. I decided to pursue further higher education and was exposed to a variety of lenses through which to examine the phenomenon of change in all its complexity. Simultaneous with my study of the organisational change literature was the outbreak of global social unrest, exemplified by the Arab Spring of early 2011. Although my original intention was to study innovation in the context of

[6] See also Shechter & Shavit, 1991, 1992.

rapid organisational change in the high tech sector, I decided to shift my focus to study this emerging phenomenon. I was intrigued by the question of how such large-scale collective action could arise from an apparent lack of organisation, planning and rational decision-making. The largest social movement in Israel's history emerged in July 2011, expressing public dissatisfaction with socio-economic policy through multiple sustained demonstrations and the establishment of over forty 'tent city' encampments across the nation. These processes mobilised the majority of the population and presented an exciting research opportunity through which to enhance my understanding of complex societal phenomena.

This rare occasion enabled me to undertake field research within the earliest stages of development of an emerging social movement. I triangulated qualitative methodology, including ethnography, semi-structured interviews, and document and discourse analysis in protest movement locations strategically chosen using purposive sampling. I observed the negotiation of meaning by participants and analysed the resultant frame of action. Furthermore, I examined social psychological aspects of the dynamics within the tent encampments in constructing a new collective identity and recruiting activists and supporters (Moskovitz, 2012, 2014a). I analysed my findings using a psychodynamic approach to change: a perspective which had not been explored before within the social movement literature (Amato & Moskovitz, 2015; Moskovitz 2014b). After a professional career focused upon quantitative approaches, I thoroughly enjoyed the opportunity to use qualitative research methods.

Studying the dynamics of an emerging social movement initiated my interest in the relevance of a social movement perspective to organisational change, showing me the fundamental influence of psychological processes upon societal action and

crystallising my ambition to become a scholar in this field. My journey with NHSCD started in July 2012, when I was invited to present my research on the Israeli social justice movement in a one-hour lecture, which was part of a full-day lecture series delivered by Helen Bevan OBE, Chief Transformation Officer of NHS Improving Quality at the University of Oxford, Saïd Business School. Dr Bevan's outlining of the application of the social movement perspective to leadership by the NHS Institute for Innovation and Improvement made a deep impression on me and was the beginning of my research relationship with the English National Health Service (NHS) and the NHS Change Day (NHSCD) social movement. This study situates the NHSCD social movement within both organisational and social movement studies, highlighting grassroots practices within organisations. My personal journey and interdisciplinary background are reflected in this study, located, as it is, in the space between social movements and organisations - the space in which the 'becoming' of collective action can be observed.

Chapter 2 establishes further theoretical grounding for this thesis by providing a comprehensive account of prefigurative politics as seen through the lens of social and political psychology. The chapter is a co-authored published paper. The two theoretical chapters (Chapter 1 & Chapter 2), when viewed together, provide a strong basis for the empirical chapters of this thesis. Chapter 2 is followed by an overview of the methodology applied to the case study explored in this thesis.

Chapter 2 Rethinking Prefigurative Politics: Introduction to the Special Thematic Section

Abstract[7]

This special thematic section responds to the 21st century proliferation of social movements characterised by the slogans 'another world is possible' and 'be the change you want to see'. It explores prefigurative politics as a means of instantiating radical social change in a context of widening global inequalities, climate change, and the crises and recoveries of neoliberal global capitalism. 'Prefigurative politics' refers to a range of social experiments that both critique the status quo and offer alternatives by implementing radically democratic practices in pursuit of social justice. This collection of articles makes the case for psychologists to engage with prefigurative politics as sites of psychological and social change, in the dual interests of understanding the world and changing it. The articles bridge psychology and politics in three different ways. One group of articles brings a psychological lens to political phenomena, arguing that attention to the emotional, relational and intergroup dynamics of prefigurative politics is required to understand their trajectories, challenges, and impacts. A second group focuses a political lens on social settings traditionally framed as psychological sites of well-being, enabling an understanding of their political nature. The third group addresses the 'border tensions' of the psychological and the political, contextualising and historicising the instantiation of

[7] This Chapter is a co-authored published paper: Cornish, F., Haaken, J., Moskovitz, L., & Jackson, S. (2016). Rethinking Prefigurative Politics: Introduction to the Special Thematic Section. *Journal of Social and Political Psychology*, *4*(1), 114-127.

prefigurative ideals and addressing tensions that arise between utopian ideals and various internal and external constraints. This introduction to the special section explores the concept and contemporary debates concerning prefigurative politics, outlines the rationale for a psychological engagement with this phenomenon, and presents the articles in the special thematic section. The general, prefigurative, aim is to advance psychology's contribution to rethinking and remaking the world as it could be, not only documenting the world as it is.

Keywords: prefigurative politics, activism, political psychology, democracy, horizontalism, radicalism, social movements, resistance, political responsibility, global capitalism, crisis

Since the emergence of the field of critical theory in the 1930s, politically committed scholars have struggled with the question of how to carry out empirical research while refusing collusion in the existing social order. In response to the rise of fascism in Europe, and drawing from anarchist traditions in the 1930s, pacifism in the 1940s, decolonisation, anti-colonialism and social revolutions in the 1960s and 1970s, through to the alter-globalisation movements of the 1980s and 1990s and the multi-faceted movements of today, activist researchers have engaged with social change in the spirit of their times while questioning oppressive orthodoxies. The problem of the 'tyranny of the empirical' — where researchers document existing phenomena and look for lawful patterns to explain them — continues to be taken up by critical theorists. Scholars drawing on post-modernist theories and discourse analytic approaches often address this problem by rejecting the procedural rules of the dominant paradigm. Psychology is now awash with studies that produce findings based on local narratives and habitats of meaning, rejecting the positivist scientific

aim of identifying laws of human behaviour. But this turn to the local and to marginalized voices is not necessarily progressive in the sense of challenging the status quo. Indeed, as the papers in this special thematic section show, the relationship between local knowledge and broader systems or structures of domination is not at all straightforward.

As co-editors of this special thematic section, we came together in 2014 with the aim of working through questions at the borders of psychology, politics, and knowledge production. We brought our individual studies and perspectives to a series of conversations on field research. But we found common ground in struggling with how to carry out social change or participatory action projects in the context of the major crises associated with neoliberal economic policies overtaking whole communities throughout the globe. The dominance of market-driven models and the dismantling of the regulatory and social welfare functions of the state are central features of neoliberalism (Connell & Dados, 2014; Giroux, 2008). Resistances to the regime of neoliberalism have flourished across the globe as well. But the expansion of social change projects under a widening NGO framework, under the banners of anti-trafficking or women's rights, for example, has been viewed by some as part of this same system of domination (Kurtiş & Adams, 2015). Many of these projects have been criticized as forms of rescue work where Western re-searchers bring their own agendas to 'save the child' or 'save the women', obscuring the complexity of these issues or how global economic forces contribute to the misery documented in these campaigns (Haaken, 2010). Activist NGOs confronting marginalisation and oppression in the global South and global North struggle to have their agendas recognised within global political systems characterised by individualisation,

marketization, and the attendant fatalism and failures of political actors to take responsibility for suffering (Chachage & Mbilinyi, 2003; Cohen, 2000). Others grappling with this complexity have found it difficult to practice solidarity between global South and North amidst the extreme inequalities produced by the current economic order, or have struggled to realise political change within bureaucratised frameworks of action that expertly co-opt the issues and language of activism, anti-oppression and liberation (Cornish, Campbell, Shukla, & Banerji, 2012). How do we confront the capacity of advanced capitalism to incorporate critiques — resisting what Louis Althusser (1972) describes as the ideological process of introducing critique as 'inoculation' against fundamental challenges to the system — while still carrying out community-based research?

We seized on the concept of prefigurative politics as a conceptual touchstone — a way of taking up questions about radical social change — that also provided a big enough tent to hold debate and differences. The term emerged in the New Left of the 1960s and 1970s and represented a break from 'Old Left' practices of focusing on structural and economic determinants while failing to address how people in movements for social justice often relate to each other in oppressive ways. The term was embraced by feminism, anarchism and the New Left to bring into focus modes of practice that make it possible to envision a transformed society based on actual human capacities rather than abstract principles (Boggs, 1977). These movements were guided by the idea that radical social change requires creating and experimenting with the kinds of egalitarian practices, democratic spaces, and alternative modes of relating that anticipate a future society that cannot yet be fully realized (Breines, 1980, 1982). In putting together this special section, we envisioned prefigurative politics as

encompassing many social experiments that have the aim of fostering alternative and radically democratic practices. These groups are defined by their attempts to reconfigure social relationships based on critiques of the dominant structures associated with capitalism, patriarchy, and neo-colonialism, often by creating networks of non-commodified relations outside of monetary exchange. Many of these groups experiment with reshaping social relations on a deep level, interrogating the construction of gender, race, ethnicity, sexuality, age, class, nationality, family, ability, health and well-being. In doing so, they work to develop new forms of social engagement, prefiguring the democratic and egalitarian relations desired of a future, more just society, without waiting for large-scale structural change (Breines, 1982; Maeckelbergh, 2012). Such movements include intentional communities, workers' cooperatives, direct democracy initiatives, the alter-globalisation movement, Transition Towns, timebanks, eco-villages, citizens' municipal budgeting, the Occupy movement, community gardening, reclamation of urban spaces for social use, health co-operatives, participatory economics, permaculture, restorative justice, food sovereignty, and the open-source movement (Calhoun, 2013; Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014; Gibson-Graham, 2006; Graeber, 2013a; Nettle, 2014; Springer, Ince, Pickerill, Brown, & Barker, 2012; Wright, 2010).

We take up a range of organizations, campaigns, and initiatives that have become part of a larger global justice movement based on inclusiveness and democratic principles. This definition separates these small-scale communities from conservative or reactionary groups that provide refuge to their followers. There are certainly many historical and contemporary cases of utopian communities where members share a vision of the world oriented toward preparing for a future

apocalypse or return of a messiah. Interesting questions arise in evaluating the progressiveness of religious alternative communities or futuristic societies. Swatuk and Vale (2016, this issue) take up some of these questions in the context of transformational politics in Southern Africa. But we focus for the most part here on progressive communities that find affiliation in global justice movements seeking alternatives to the dominant economic, political and social system.

John Holloway (2010) uses the metaphor of 'cracks' in the system to represent both openings for resistance in contemporary capitalism and the vulnerabilities of the system itself. The metaphor serves as signifier of small spaces and everyday acts of resistance as well — the small cracks that cumulatively produce the crumbling of seemingly impenetrable edifices of power. The threat of these cracks in the system — the revolutionary potential of small-scale resistances — may be easily over-stated. But our interest is in moving between these micro-level local sites and the larger macro picture to see what we can learn about the configuration of practices and possibilities.

Psychology and Prefigurative Politics

Where are the links between psychology and prefigurative politics? Why might scholars of social and political psychology be interested in prefigurative politics? For any political or social psychology concerned with emancip- atory social change, prefigurative politics offers a vital and interesting case, and as such, aspects of prefigurative politics have been considered within a range of psychological literatures, although with varying terminology. For traditions of social and political psychology concerned with social change, the study of prefigurative politics offers opportunities

to examine the psychological dynamics behind small scale and large scale social change, and particularly the relation between the psychological and the societal, the micro and the macro, the global and the local (Campbell, 2014; Howarth et al., 2013). There is a strong tradition of psychological research on collective action and protest (e.g. Campbell, Cornish, Gibbs, & Scott, 2010; Dixon, Levine, Reicher, & Durrheim, 2012; Haaken, Wallin-Ruschman, & Patange, 2012), which contributes to, and may benefit from, greater engagement with the protest dimension of prefigurative politics.

The study of prefigurative politics can also be appropriately situated within traditionally activist forms of social and political psychology, such as critical community psychology, liberation psychology or feminist psychology. These forms of psychology often strive to embody prefigurative ideals, that is, they strive to do psychology in ways that advance the critical, liberatory and feminist perspectives that they explore, often in a 'scholar-activist' role (Murray, 2012). For instance, within critical community psychology, Carolyn Kagan, Mark Burton, and colleagues have advanced a practice of *prefigurative action research* — where the conduct of research itself strives to instantiate the ideals of emancipatory social relations (Burton, 1983; Kagan & Burton, 2000; Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011). In a recent special thematic section, Adams, Dobles, Gómez, Kurtiş, and Molina (2015) bring together a set of papers focused on 'decolonizing psychological science' which critique the domination of the discipline of psychology by Euro-American authors and concepts, and which offer routes to decolonization.

In sum, prefigurative politics is not a topic to be addressed in a specialist branch of psychology, but one which is of relevance to a number of traditions, from quantitative studies of social and political change to more qualitative and participatory

action models. For this special thematic section we welcomed manuscripts from a broad range of psychological and related perspectives that interrogate and illustrate in innovative ways the contributions and interactions between prefigurative politics and psychology.

Impetus for This Special Thematic Section

The recent proliferation of small-scale social movements in the Global North and South provides the context and impetus for this special thematic section. These local initiatives developed in part as a direct response to the failed neoliberal economic politics and growing economic inequities of the last several decades. Many share affinities with earlier periods of resistance in anti-colonial struggles and the social movements of the 1960s onwards, from feminism, civil rights, environmentalism, indigenous people's rights, black/brown/red power to queer politics. While critical thinking has been central to traditions of prefigurative politics, the relationship between the emotional life of groups and their capacity to develop an analysis of their situation — one that is also responsive to changing circumstances — remains one of the more underdeveloped areas of critical social theory (Haaken, 2010; Haaken et al., 2012).

There are many lessons to be drawn from the revolutionary period of the 1960s and 1970s. The political projects of that era, from nationalist independence movements and guerrilla warfare to non-violent peace protests and myriad forms of class struggle, include heroic forms of resistance but also include bloody repression and marginalizing of dissent. Large-scale forms of struggle often meant silencing (sometimes jailing or imprisoning) some allies in the process of seizing state power.

The question of how to move forward in a way that advances democratic ideals of participation remains as daunting as ever. This ethos of a prefigurative politics is in response to the tendency for many liberation movements to reproduce many of the oppressive practices of their enemies, often rationalizing violent suppression of dissent as a pragmatic response to the requirements of the period. At the same time, social movements that take seriously the aim of building an alternative to hierarchical and exploitive systems must find means of coordinating their actions and resolving inter- and intra-group conflicts — some based on differences in power and privileges within their ranks.

Projects guided by the aim of social transformation provide important case examples for studying these dilemmas and how to work at the boundaries between small and large-scale group processes of change (Campbell, 2014; Cornish et al., 2014; Haaken, 2010; Holland & Correal, 2013). The papers in this special section attend specifically to the role of psychological dynamics in understanding the emergence, development, and sustaining of prefigurative projects. The authors also address the tension between psychological and political phenomena, recognizing that psychology, including critical social psychology, must go beyond the narrow boundaries of the academic or professional discipline (Campbell & Cornish, 2014). At the same time, activists must be able to carry some working model of psychological processes into their practices in order to change hearts and minds (Haaken, 2010, 2015).

In this set of papers, we bring a psychological lens to the study of prefigurative politics with the aim of generating greater interest among psychologist scholars in strategies and mechanisms of radical social change. As editors, some of us

identify as socialists, anarchists, socialist feminists, or anti-colonialists, to greater or lesser degrees. But whatever our political affiliations or differences, we share a passion for research that contributes to social justice and reflective modes of practice. We resonate with the anthem of the global justice movement that 'Another world is possible' (see Cornish et al., 2014). As Naomi Klein (2014) argues in *This Changes Everything*, the world is changing, whether we want it to change or not. A question for us centres on how progressive scholars participate in bringing about a world that is habitable for most rather than for an elite few.

Our approach to prefigurative politics, psychology, and the issues raised in these papers developed through dialogue with the authors and with students and colleagues participating in various workshops during the course of the conception of the special section. As part of the process, authors submitted long abstracts in response to a call for papers and those that were accepted were invited to present a draft of their papers at a two-day conference at the London School of Economics and Political Science (where three of the editors are based) in March 2015. The conference was a place to work through lines of argument, offer critiques, and confer on manuscripts-in- progress. Full papers were then submitted and peer-reviewed before the editorial team selected the fourteen papers that appear in the special section. We hope that the result is something more than the sum of its parts in providing a collective perspective on the theme of prefigurative politics and psychology.

The contributions benefit from the perspectives of a range of sub-specialties in psychology and other fields, including sociology, social work, community studies, anthropology, education, communications and development. We are delighted to have

a diversity of researchers working in a range of geographical contexts, including contributions from the UK, Australia, Turkey, Italy, South Africa, Greece, the US and Egypt. We also have authors at varying stages in their careers, from established professors to early career researchers and PhD students.

Our goal here is not to settle differences on what constitutes prefigurative politics. Indeed, the lively conference discussions revealed the widely divergent meanings of the term itself. Instead, we wanted to create space for open-ended inquiry, engaging with the complexity of the notion of prefigurative politics. Our aim is to promote a context-based, historically situated approach to scientific inquiry on projects guided by the idea that a better world is possible. The papers we have gathered here, which include empirical studies of projects around the globe and critical reflections on their processes, are guided by this ethos. Although there are many overlapping themes, we have organized the papers into three overarching aims. *A first set of papers brings a psychological lens to political phenomena.* The authors start with the premise that radical social change requires a transformation in the desires and relational capacities of groups and individuals. There is often a gap between the egalitarian ideals of groups and their actual practices. In attending more carefully to psychological dynamics and the contradictions that arise between ideals and attempts to realize those ideals, we are better equipped to engage in prefigurative politics. *A second group of papers brings a political lens to settings that have been largely framed as psychological sites of well-being.* A robust literature has emerged on the mental health benefits of cooperatives, community gardens, and other local initiatives. But these projects and the literature arguing for the benefits of small-scale participatory programs often overlook critical questions that emerge on the political

level. As conservative campaigns applaud 'localism' and calls for local control take on a nationalist tone, what distinguishes more progressive from conservative forms of local projects? Further, to what extent does the dominant system depend on small-scale 'alternatives' to maintain its legitimacy? This set of papers attempts to address these questions through studies of community-based projects that are widely regarded as helpful to people but may or may not be 'prefigurative' in their challenge to the status quo. *A third group of papers takes up 'border tensions' in working between the psychological and political dynamics of social movements.* Some authors work with the idea that the history of bringing psychology into politics has been a complex one, sometimes leading to the depoliticizing of social movements. For other authors, the border tensions centre on how boundaries are drawn between the personal and political, the private and the public. And for still others, the very definition of the prefigurative evokes psychological fantasies that produce inevitable collisions with reality.

Bringing the Psychological Into the Political

Although all of the papers in this special thematic section bring a psychological lens to political projects, a number of the papers focus specifically on a set of dilemmas that arise in bringing analyses of psychological processes into movement work. The authors in this group of papers describe projects where the political intervention serves as the basis of group identity, analysing dilemmas that arise in addressing emotional and relational aspects of group life.

Awad (2016, this section) considers the storytelling acts of individual participants in the Egyptian revolution, presenting a detailed account of personal

psychological growth, which is demonstrated through a growing sense of personal agency. While the emancipatory promise of the revolution has not been fulfilled on a political level, Awad argues that there is a sustainable social impact through the psychological empowerment and personal growth experienced by participants. In the spirit of prefigurative politics, the author asks us to recognise the everyday transformations of individual, psychological change, and not only to focus on the spectacular failures of national and global power structures.

In their study of participation in an ecological social movement, the Transition Town Movement in Italy, Biddau, Armenti, and Cottone (2016, this section) investigate the psychosocial conditions for engagement in prefigurative politics, explaining how the meaning participants attribute to their affiliation with local groups encourages collective identification with a global ideological network. Participants' understandings or social representations of sustain- ability and how to achieve it both motivate and make sense of their own engagement in the movement, but also create a boundary discouraging engagement with formal politics. The authors identify a challenge for the participants as they seek to implement ecologically sustainable towns and national infrastructures. Members are motivated to reach out and spread their message, but a deep distrust of formal politics, opposition to which is part of the very definition of members' identities, limits the potential for their wider, collective impact.

Acar and Uluğ (2016, this section) examine intergroup dynamics during the fifteen days in which protesters occupied Gezi Park in Istanbul, Turkey. The protests brought together very diverse groups of activists working together under conditions of extreme repression. They elaborate that the experiences at Gezi Park support the

argument of Dixon and colleagues (2012) that collective action is a productive way not only of reducing intergroup prejudice but also of producing social change, both in terms of achieving the immediate demand that the Park should be protected and in building inter-group collaborations and coalitions after the protests. The authors focus on the process of prejudice reduction between subordinate groups representing diverse religious and ethnic minorities, feminists, LGBTI activists, the political Left, and nationalistic interest groups. In doing so, they demonstrate the positive impact of collaborative participation in collective action, on reducing prejudice, reaffirming the prejudice reduction model of collective action.

Permut (2016, this section) interviewed participants in the Occupy movement in the USA in her study of how participants developed identifications with the movement. She draws on the concept of 'psychological sense of community' to explore how occupiers generate a positive sense of community at a micro level within the Occupy movement. As Cooper (2014) argues, prefigurative political engagements, by instantiating an alternative order (e.g., inclusive participation in decision-making and care of fellow citizens), at the same time critique the existing order. Participants in Permut's study simultaneously praise and identify with the democratically inclusive and caring values that they associate with the Occupy movement, and criticise the electoral political system in the USA for being distant from the electorate and failing to care for its vulnerable citizens. The author highlights the value of such positive meaningful experience, potentially itself a valuable outcome of the protest.

Moskovitz and Garcia-Lorenzo (2016, this section) investigate a new social movement that has emerged within the organisational context of the UK National Health Service (NHS). Frontline healthcare providers, dissatisfied with the ways that

the organisation of the health service limits their ability to offer good quality care, have generated a campaign that enables them to enact high-quality care, in spite of the challenging institutional environment. This movement has many of the features of prefigurative action, including horizontalism, acting according to deeply held values, distributed leadership, and developing a democratic ethos through its evolving process. Most importantly, the movement advances a vision of how participants would like healthcare to function on a broader scale. The initiatives show that prefigurative principles of 'being the change you want to see' may be taken up in diverse social settings, including within large-scale bureaucracies. Based on a series of interviews with staff members involved in the movement, the authors explain how NHS activists reinvigorate deeply held beliefs about the value and role of socialised medicine and of health workers through a process that increases collective efficacy and resistance to top-down, managerial mandates.

Bringing the Political Into the Psychological

The second approach authors have taken to rethinking prefigurative politics draws our attention to social spaces with which psychologists might be familiar but may not have conceptualised as political in the sense of carrying potential for broader forms of social change. These authors illuminate the transformative possibilities of such spaces and highlight how the ethos of 'creating the future in the present' can be enacted in settings not ordinarily understood to be transformative.

Guerlain and Campbell (2016, this section) examine the activities and experiences of community gardeners in East London. While the gardeners conceptualise their activity as a positive means of connecting with others from a

position of marginalisation, Guerlain and Campbell argue that this activity may be viewed as prefigurative. The gardeners do more than simply grow vegetables in their neighbourhoods; they create an alternative to the dominant economic and social order that marginalises them. Through gardening, community members address their personal challenges and scarcities in ways that help combat the multiple forms of deprivation that define their daily lives and, in the process, discover wider existential possibilities.

Beckwith, Bliuc, and Best (2016, this section) review the development of the Recovery Movement which is a loose network of groups organized by people managing mental health conditions or addiction who chart their own pathways to recovery, against the traditional pathologisation, medicalisation, and professional dominance of the addiction and mental health fields. The authors introduce examples from Wales, Scotland, Australia and the UK to rethink dominant medical models of healthcare around mental illness and addiction. Taking the Recovery Movement as an instance of prefigurative politics brings to this study a further set of questions concerning the relationship between practices of the Recovery Movement and the medical system and how to confront the absorption of 'alternatives' into the dominant system. The movement prefigures social change, the authors argue, as it enacts in the present a vision of a more democratic conception of health and well-being. In creating new forms of community through recovery groups, the movement challenges the dominant orthodox institutionalised healthcare service structure, provoking a rethinking of alternatives to the bio-medical model of addiction and mental illness.

Nolas, Varvantakis, and Aruldoss (2016, this section) investigate the notion of prefigurative politics in the context of childhood, showing how everyday spaces

commonly considered outside the public sphere are marginalized in the social movement literature. In studying autobiographical narratives of children growing up in communist families in the USA, the authors draw out the meaningful political experiences of children both as political participants by default as well as strategic political activists. They also explore the narratives of children as students occupying schools in Greece in 1990/1991 to protest against proposed educational reforms, bringing into their analytical lens intergenerational issues in political identities.

Working With Border Tensions

A number of the papers look critically at some of the history of prefigurative politics and analyse border tensions that arise in working toward ideals for building a better society within the limits of the present. These papers address the tension between utopian tendencies in prefigurative politics and the barriers that emerge — some of which are produced by external factors beyond the group's control and some by internal factors.

In her review article, Trott (2016, this section) observes that prefigurative political activities have generated little interest in the literature on the psychology of social movements, which tends to focus on high-profile protests that engage explicitly with public policy or state power. To the extent that psychology concerns itself with theorising collective action, group processes and social change, there is much to be learnt in investigating groups oriented toward radical forms of social transformation. These groups include large-scale social and political movements as well as smaller scale, less spectacular participatory democratic experiments. Trott argues that the literature on the psychology of social movements has a great deal to contribute to

understandings of prefigurative politics, and that studying and engaging in prefigurative politics correspondingly has much to offer social psychology.

Polletta and Hoban (2016, this section) enlist a historical lens to analyze the concept of prefigurative politics. They focus on consensus-based decision making, taking up the varied purposes that activists have pursued in response to the wider social and political conditions of their eras. The authors contrast the understandings of radical pacifists in the 1940s, New Left activists in the 1960s, and contemporary Left activists. They argue that the enactment of radical democratic practices served to sustain stalwarts through repression in the 1940s and 1950s — times when radical pacifists were marginalised. Activists within the prefigurative movements of the 1960s, the authors argue, hoped to model new social values based on the principle that such practices of radical equality would be adopted as alternatives to capitalism. Contemporary activists, they suggest, focus particularly on unacknowledged privilege within progressive social movements. The authors draw out some of the key lessons of these three eras of radical experiments in alternatives.

Lin, Pykett, Flanagan, and Chávez (2016, this section) enlist a women-of-colour feminist theory and a reproductive justice framework in their paper on survival politics, illustrated by a case study of the We Are BRAVE programme in Oregon, USA. The programme encourages people of colourled organisations and social justice activists to integrate reproductive justice into their work, including and far beyond a focus on abortion access. They describe and analyse three strategies: creation of radical 'homeplaces' as sites of connection and places to recognise and resist domination; 'theory in the flesh' which grounds politics in bodies, spaces, and shared experiences of both; and coalitions as subjectivities — ways of living and deepening

intersectionality. Each strategy situates reproductive justice in and with other struggles, and emphasises the social and relational dimensions of prefigurative politics, drawing attention to the operation of stratifying forces of race, class and gender within movements that strive to be prefigurative.

Wallin-Ruschman and Patka (2016, this section) draw parallels between prefigurative politics and the ideology and practice of 'safe spaces' in a US college course on feminist consciousness and in a faith community's 'inclusive' liturgy. They note similarities in the value placed on building community and enacting alternative futures with a trusted group of like-minded others. They draw out the tensions that arise in making the classroom 'safe' for persons experiencing diverse forms of marginalisation and in adapting worship services to include people with intellectual disabilities, and the tendency to over-emphasize community in the construction and practices of such literal and figurative spaces. They propose 'critical collective spaces' as alternatives that provide valuable community-building opportunities, accommodation to diversity and resistance to oppression in a prefigurative fashion.

Focussing on Southern Africa, Swatuk, and Vale (2016, this section) examine prefigurative politics as an alternative to a strategic politics which engages with the state, addressing the classic critical debate of whether prefigurative experiments are powerful enough to mount a real challenge to the existing political order (e.g., Campbell, 2014; Farber, 2014). While they are critical of the ways that the modernist state form has failed to bring the majority of Africans the most basic physical or economic security, they do not consider prefigurative politics to be a sufficiently powerful alternative. They argue that in the Southern African context, state power is continually reasserted, both by liberation movements which strive to achieve a better

life by achieving a better state, and by mainstream politics which co-opts alternatives in the service of state power. The recent student movements in South Africa, they suggest, may hold greater potential for change, as they combine their radical critiques with engagement in strategic politics.

On the other side of the psychology/politics divide, Power (2016, this section) argues that within the Transition movement to create climate-resilient futures for communities, insufficient attention has been given to 'Inner Transition', that is, the processes of egalitarian decision-making, interpersonal dynamics and leadership internal to a prefigurative political group. She highlights how a 'doing/thinking' binary was evident in the Transition initiatives she studied, so that participants de-valued critical reflection on their own processes, feeling that 'action' was more important. While Swatuk and Vale argue that the small-scale and localist nature of prefigurative experiments are not enough to change southern African politics, Power's article reminds us of Paulo Freire's (1970) insistence on the simultaneous necessity of both reflection and action for emancipatory social movements. As Power argues (and Swatuk and Vale also detail), without attention to the modes of organisation and leadership employed, movements too easily repeat the failures of the dominant systems they intended to critique.

Conclusions: Psychology for a Prefigurative Politics

Collectively, this set of articles makes the case for psychology to explore prefigurative political engagements as sites of psychological and social change. They show both how established psychological theories can offer useful perspectives on what is happening at the levels of self, identity, relationships, community and modes

of solidarity, and how empirical engagement with prefigurative movements may produce new insights. Further, many of the papers extend psychological theories concerned with group processes, such as consensus, collaborative leadership, inclusion of diversity, and relations between individual, group and societal change (Acar & Uluğ, 2016, this section; Awad, 2016, this section; Biddau et al., 2016, this section; Polletta & Hoban, 2016, this section; Power, 2016, this section; Trott, 2016, this section). Other contributors question the social psychological dynamics of prefigurative spaces, exploring what constitutes a 'health-enabling space' (Guerlain & Campbell, 2016, this section), a 'critical collective space' (Wallin-Ruschman & Patka, 2016, this section), a space of alternative modes of relating and caring (Permut, 2016, this section), and the political nature of everyday spaces (Nolas et al., 2016, this section). And several papers foreground the political psychology of bodily health, through investigating the health-enabling potentials of the Recovery Movement (Beckwith et al., 2016, this section), the urgent politics of survival in a struggle for reproductive justice (Lin et al., 2016, this section), and the politicisation of healthcare providers around the ambition of offering care in the best sense of the term (Moskovitz & Garcia-Lorenzo, 2016, this section). In each of these ways, the articles offer to extend psychology in new directions.

But the articles do more than expand psychology into these critical areas of inquiry. They are provocative. They identify cracks that have been opened, in a National Health Service, a Recovery group, a community garden, a classroom, an urban park, and a variety of social movements. They encourage us to see emancipatory politics where we might not previously have seen them — in small personal changes, in the everyday, in childhood — and ask us to question how big a

change has to be to be significant (Awad, 2016, this section; Guerlain & Campbell, 2016, this section; Nolas et al., 2016, this section). At the same time, they assert the necessity of critical analysis of the macropolitical movements of our time and contexts where states repeatedly fail to provide citizens with basic forms of human security (Swatuk & Vale, 2016, this section). In various ways, the papers problematize the assumption that utopian ideals and pragmatic realities are at odds, inviting us to observe their simultaneity.

Much like other either/or dichotomies, it is important to resist forced-choice alternatives that leave out the irreducible complexities and uncertainties attached to any broad-scale movement for social change.

We hope that as a whole, this special thematic section invites curiosity and engagement in the various alternatives to individualising, divisive, environmentally unsustainable and inequality-producing forms of social organization that characterize so much of neoliberal global capitalism. Psychology has been all too easily incorporated into oppressive systems, from individualising the determinants of mental health and social problems, to investigating how to maximise individuals' and groups' capacity to produce profit. We hope the collection of papers reminds readers to keep asking the existential question posed by David Graeber (2013b), paraphrasing Marx: "assuming that we do collectively make our world, that we collectively remake it daily, then why is it that we somehow end up creating a world that few of us particularly like, most find unjust, and over which no one feels they have any ultimate control?" (p. 222). This special section does not answer this question. But we do hope that the papers contribute to the search.

Ideals are vital to social movements even as they produce potential for repression in the name of carrying them out, and terrible disappointments when leaders or movements betray those ideals. The productive interplay of psychology and prefigurative politics adds valuable analytical dimensions to understanding the attractions, manifestations, achievements and disappointments of efforts to instantiate those ideals. We hope that this special section will stimulate further research, intensify lively debate, and encourage greater research participation in projects throughout the globe that challenge neoliberal capitalism and further global justice by embodying the ethos of democratic radical alternatives.

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Chapter 3 Research Methods

This chapter outlines the methodological paradigm applied in this thesis, including the research design, data collection, analysis and related ethics. The first section begins with a description of the overarching methodology: the application of a longitudinal, in-depth case study approach to NHSCD in which a qualitative and interactive research paradigm is used, enabling theory and data collection to develop in synthesis. The various data sources that informed the case study approach, such as participant observations, in-depth interviews, digital collected data, document collection, NHSCD Pledge data, and NHSCD '100 Stories of Change', are then outlined. The chapter concludes by delineating the ways in which this collected data was analysed in reference to each of the sub-research questions informing the three papers, which constitute the core of this thesis.

3.1 Research Design

As the context of this study is the emergence and development of a grassroots movement within the NHS, one of the main goals and challenges in the design of this research was to reflect upon and capture the processes of organising as dynamic, continuous and constantly evolving (Feldman, 2000; Tsoukas & Chia, 2002; Weick, 2001; Weick & Quinn, 1999). Gergen (2010) emphasises the challenge when he says:

> Organisational studies is largely a benefactor of the tradition of substance. If process is in the forefront, how might we envision our subject matter, the process of inquiry, and the possible implications for world practices? An organisational science without organization? How is it possible to embrace a process orientation and sustain any form of science as we know it? In my view a fully developed process orientation would indeed require alterations in our traditional view of behavioural science. (Gergen, 2010, pp. 56-7)

This study addresses these challenges through the consideration of an in-depth, longitudinal case study of the NHSCD movement, utilising data collected from four consecutive NHSCDs, spanning from 2013 to 2016. Snow and Trom (2002) argue that the investigation of a single in-depth case study in the field of social movements enables the generation of rich and rounded elaborations and understandings of different aspects of confined social phenomena. In particular, the applicability of a triangulation of methodologies is said to facilitate an in-depth and multifaceted investigation into this complex social phenomena (Gerring, 2001; Snow & Trom, 2002). Organisational scholars have suggested that longitudinal studies are ideally suited to the purpose of capturing continuous, emergent change in organisations (Weick & Quinn, 1999), contending that this approach is pertinent to exploratory inquiry and emphasising a context-based understanding of processes (Langley, Smallman, Tsoukas, & Van de Ven, 2013; see also Gerring, 2001; Hartley, 2004). Such an approach is, however, vulnerable to criticism regarding wider generalisation (Bryman, 1989).

I chose to perform a longitudinal qualitative study as the most appropriate means of approaching the process-oriented nature of this study (Czarniawska, 2004a; Schwartzman, 1993). Qualitative data collection places a greater emphasis on interpretation, placing data in context, flexible methodologies, extraction of data from multiple sources, organisational reality as socially constructed, and on the proximity between the researcher and organisational phenomena (Charreire-Petit & Huault, 2008; Cummings & Worley, 2009; Schwartzman, 1993). The intention of this study was to gain insights into the emergence of collective action in day-to-day practices and into the associated co-creation of meanings and realities by organisational actors.

I aimed to maximise the richness of narrative content and the contextual understanding of these narratives: it was therefore imperative to allow people to express their views in their own terminology and to observe their behaviour in their day-to-day surroundings (Czarniawska, 2004a). Qualitative research strategies are, therefore, suitable for the collection of rich data, generating insights into how new meanings and realities can be co-created by organisational actors throughout the process of their activism (Maxwell, 1996).

This study adopted an interactive research paradigm between theory and observations, using an iterative or recursive approach. This resulted in the processes of data collection and analysis informing each other and developing in synthesis (Bryman, 2008; Turner, 1988). From this standpoint, the study takes an interpretive epistemological stance towards the meaning of organisational change processes (Bryman, 2008). According to Bryman (2008), taking an interpretive stance entails three layers of interpretation: how members of the group interpret the world around them; how the social scientist interprets their interpretations, and how the researcher's interpretations are further interpreted through a discipline's concepts, theories and literature. All three layers are present in this research. Firstly, the worldview, and the subjective meaning of both the NHS and NHSCD, is captured with primary data. Secondly, the researcher's interpretation of this data is considered. Finally, the interpretation of the data is further examined within the context of the theoretical frameworks by means of a constructivist perspective. Realities are therefore viewed as multiple, and exist as co-constructed paradigms: it is through a dialogic or reflexive process that social actors define and are defined by their worlds (Burr, 2003; Jabri, 2012; Lahlou, 1996; Moscovici, 2000).

3.2 Data Collection

Data was collected through an in-depth, longitudinal qualitative study as it was particularly suited to the exploration of emerging change processes (Charreire-Petit & Huault, 2008; Cummings & Worley, 2009; Schwartzman, 1993). Data access negotiations commenced in July 2012 and paved the way for the collection of in-depth qualitative research in a multilateral capacity (see Table 3.1). Access negotiation included meetings with NHSCD initiators and key activists. Data collection began with the conducting of meetings and participant observations (Bryman, 2008; Lichterman, 2002; Waddington, 2004), with the purpose of gaining a deep understanding of the phenomena of NHSCD. I conducted a variety of informal and formal interviews from this involved position (Boje, Blee, & Taylor, 2002), and my deep involvement as a participant observer gave me access to a variety of field documentation and tools. Given that, as a phenomenon, a substantial part of NHSCD is conducted online via official websites, digital data, collected in real time, was fundamental in shaping my research (Horst & Miller, 2012; Kozinets, 2010). These strategies allowed for in-depth insights into NHSCD as a dynamic and evolving phenomenon.

Interviews and participant observations complemented each other as research methods. Due to the diversified nature of NHSCD's activity spectrum, the use of interviews alone would have omitted too much information. Even during the initial stages of field research, it was clear that both important messages and framing efforts were delivered not only through text and verbal discourse, but also through multimedia communication such as short films, music, figurative artistic designs as well as visual symbols and ambiance. Consequently, I decided to include these

multimedia platforms of communication in my data collection, given the importance attributed to these and their role in change and mobilising processes in both the organisational change and social movement literature. Furthermore, participant observations provided an opportunity to gain a better understanding of the negotiation of meaning as it happened in situ, during the change process itself. Large events and meetings involving dozens of participants were centred upon unresolved debates, rendering interviews of participants necessary in order to clarify contentious issues. Additionally, interviews enabled an in-depth exploration of the personal interpretations, experiences, motivations and identity perceptions of participants, thus allowing for the investigation of different perspectives from those discovered solely through observation.

As NHSCD is a grassroots phenomenon, activists developed the associated events organically; subsequently, these were often scheduled at short notice. In order to successfully apply process theory, it was necessary for me to attend such events wherever and whenever possible. During the first 18 months of the field research, I therefore spent considerable time travelling the length and breadth of England, capturing the phenomenon of NHSCD in as detailed a way as possible, as it happened, in real time. This process was fundamental to my gaining an overview of NHSCD as a nationwide phenomenon. Whilst conducting this overview, I purposively sampled two geographically distinct sub-case studies: one NHS Trust and one Clinical Commissioning Group (CCG).

The longitudinal nature of this case study is designed to encompass four consecutive NHS Change Days: 2013, 2014, 2015 and 2016. Access to the case study was obtained during the summer of 2013, after the actual occurrence of the first

NHSCD in March. Consequently, data regarding NHSCD 2013 was collected through media research, the official website, and the collection of various printed documents and reports. Significant anecdotal data and retrospective reflection regarding the first NHSCD event was obtained throughout my time in the field, and also through participant observation attendance at 'NHSCD 2013 Lessons Learnt' core leadership meetings.

Table 3.1

NHS Change Day structures	Interviews	Participant observations	Digital Data Collection	Original Data and documents
NHSCD Pledges data				NHS 2014: 8,806 Pledge narratives NHS 2013: 673 Pledge narratives
Media review				389publications/articles
Key Public Events	Walk in ethnographic short interviews NHSCD other leaders and participants (2 in-depth interviews)	64 hours	NHSCD Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
Key Planning Events	Walk in ethnographic short interviews	32 hours	NHSCD Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
Core Leadership Team	NHSCD members of Core Leadership Team (11 in-depth interviews	39 hours	NHSCD Websites and Social Media	NHS IQ (NHSCD) email correspondence and internal circulated documents
Hub Leaders' meetings	NHSCD Hub local leaders (8 in-depth interviews)	13 hours	NHSCD Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
NHSCD events in local Trusts	NHSCD local Trust leaders and participants (6 in-depth interviews)	24 hours	NHSCD local Trusts' website	On site document collection (documents, leaflets, hand-outs, etc.)
1-1 & small group meetings with NHSCD leaders	NHSCD Founders (3 in-depth interviews)	17 hours		
CD Global movement meetings		11 hours	Review of international CD websites	Email correspondence and internal circulated documents
Local CCGs **Group discussion**	NHS Change Day local CCG leaders and participants (2 in-depth interviews)	10 hours		
Total	32 in-depth interviews	210 hours of participant observations	NHS Change Day Websites and Social Media ethnography 400 hours	9,479 pledges 389 media publications/articles 50 On site original document collection (documents, leaflets, hand-outs, etc.); 800 emails

3.2.1 Participant Observations

Field research focused on participant observations from July 2013 to June 2015, and concentrated on the following key spheres of activist engagement (See Appendix 1.1 for further details):

- Key public events, including keynote launch events of Change Day as well as wider NHS innovation, promotion and leadership events in which NHSCD featured. 64 hours (including 4 conferences) on site.
- Key NHSCD planning/strategic events. These events were exclusive to the key activist group within NHSCD and included 32 hours during 6 full 'strategy days' on site.
- Core leadership team meetings, limited to key leaders and activists of NHSCD, including 32 meetings on site and in conference calls.
- Hub leaders' meetings: grassroots leaders and activists' events, including 5 full 'Hubbie Away Days' on site.
- One-to-one and small group meetings with NHSCD leaders across various sites, including 7 meetings.
- NHSCD events and group discussions within a local, purposively-sampled Trust and CCG, including 30 hours, on site.
- Change Day Global Movement: participation in 9 international conference calls.

I kept a research diary whilst conducting participant observations, which represented the most pragmatic tool for recording information and impressions. Additionally, I registered the content of participants' comments alongside notes about the setting and communication interaction in a detailed workbook, documenting, for example, select observations regarding non-verbal gestures, tone of voice and crowd reactions. Information written in the diary was anonymised as it was taken.

In regard to the ethical considerations of participation, I was personally invited

via email to closed, official meetings and events, as well as to the core leadership meetings, in my capacity as a research student. The list of participants in each meeting was distributed in writing to all participants and my name and role as an LSE research student was included in all correspondence. In the majority of events, participants' roles were described either in text (for example, during Webex Telecom conference meetings) or on name tags, for example, in large, public events. In strategy meetings and other events, participants were introduced at the beginning of the meeting: in each case, I presented myself as an LSE PhD candidate, conducting research about NHSCD. Film and audio recordings were not used to collect data in these settings (Appendix 1.2).

3.2.2 In-Depth Interviews

Face-to-face interviews were conducted in order to gain an in-depth understanding of the movement's strategising process. Interview guides (Appendix 2.2) were developed on the basis of an initial literature review, as well as on preliminary insights obtained from participant field data collected in the first six months of fieldwork. The interviews were designed to collect rich narrative data, elucidating the emerging change dynamics encouraged by NHSCD and emphasising the development of narratives and frames of change from the perspective of activists and participants. Special attention was therefore given to experiences and interpretations of reality in the eyes of activists. The interview guide was interpreted flexibly, influenced by interactions during the interview. Questions were asked in an open-ended manner and significant care was taken to ensure that no leading questions were asked.

I conducted 32 in-depth interviews, which collect both retrospective narratives

regarding NHSCH 2013 and live narratives regarding NHSCD 2014 (Appendix 2.1). I interviewed a purposely-sampled range of interviewees in order to represent a large range of stakeholders within the movement and within the NHS. Table 3.2 details the number and type of interviews conducted.

Table 3.2

Interviewee Role in NHS Change Day	Number of Interviews	Number of Interviews Transcribed
Founder and CLT member	3	3
Core Leadership Team member	11	5
Hub Leader	8	8
Activist in a local trust	6	6
Activist in a local CCG	2	2
Other participants	2	2
Total	32	26

During my time in the field, and via correspondence with the members of NHSCD's Core Leadership Team, I learnt that Change Day activists were gravitating towards a range of voluntary work streams. I aimed to represent members from each of the work streams throughout the interviewing process:

- The Communications, Marketing & Stakeholder Engagement work stream.
- The Social Media & Website work stream.
- The Hubs work stream (national coordination).
- Members of the Learning Resources work stream.
- Members of the evaluation work stream.

This data collection design enabled the collection of both horizontal information that conveyed a broad sense of the Change Day movement and deep, vertical data within a local Trust and a local CCG. The collection of both horizontal and vertical data allows for the discussion of both the localised influence of NHSCD on particular groups

within the NHS, as well as a discussion of the wider influence NHSCD has beyond regional groups. Horizontal data collected in interviews was complemented by short, walk-in interviews, which were conducted in different occasions during participant observations.

All interviews were audio recorded; 26 interviews were transcribed. Participants were informed via a detailed information sheet and open discussion prior to each interview of the ways in which interview data would be used for the purposes of this research. They were advised to refrain from answering any questions which were not convenient. Written consent to use interview content in this research was obtained (Appendix 2.3).

3.2.3 NHS Change Day Pledges

In order to comprehend both the breadth of the movement and the unique qualities of Change Day as a platform for participants to express their narrative perspective on their involvement in the movement, pledge narrative data was collected. Every participant in the movement was encouraged to make a pledge, writing their intentions on the 'pledge wall' of the NHSCD official website. Official, separate websites were built for NHSCD 2013, 2014, 2015 and 2016. During the course of Change Day 2013, 189,000 pledges were made; 802,000 pledges were made for Change Day 2014. A pledges count was not available from 2015 onwards. These pledges were collected alongside supplementary data in which some of the participants explained their motivation in pledging. Some pledges represent an individual narrative, and others represent group accounts (see Table 3.3). As such, there is a discrepancy between the number of pledge narratives that were posted

online and the number of pledges made, or people pledging, as certain change initiatives became popular, and thus were joined by large numbers of activists (e.g., 802,000 pledges were made, which corresponded to 8,806 distinct narratives; see Table 3.3). The data concerning how many participants joined each pledge was also collected. For example (see also Appendices 3.2 & 3.4):

> I will do my utmost to address health inequalities in the NHS, particularly in breast cancer care (Pledge made on the 13 March, 2013; 50 people joined this pledge).
>
> My pledge is that I will do the education and training associated with becoming a Dementia Friend (Sir David Nicholson, 13 March, 2013; 15 people joined that pledged).
>
> At NHS Blood and Transplant we have listened to our donors and have devised a customer care training programme reflecting their needs (Pledge made on 11 March, 2013; 16 people joined that pledge)
>
> It's simple really, we are asking you, the wonderful staff of the NHS, to thank someone at work for something they have done. It can be in any way you want: kind words, a song, a cake, even a cup of tea during a busy night shift. The creativity is up to you. Then, share your act of gratitude with us: send us your words of thanks and why, a photo of the cake you made, a film of people spelling out 'ThankU4' in the car park. We will post them on our website, facebook and twitter pages: http://www.thankU4.co.uk Twitter: @ThankU4_ Facebook: ThankU4 (This Pledge Campaign was joined by 786 people in 2014)
>
> During my training as a student nurse and post qualification, I pledge to never dismiss the signs of pressure damage and to always develop my knowledge and educate others wherever possible (Individual pledge made in 2014).
>
> I pledge to make the most of e-learning. I am going to develop useful and accessible e-learning tools for staff who want to learn how to innovate and improve services. (pledge made in 2016)
>
> I pledge to promote and encourage rational antibiotic prescribing. Submitted by (pledge made in 2016).

NHSCD pledges are short narratives, mostly ranging between 1-10 lines. These emerging, short ante-narratives (Boje, 2008) describe what needs to be changed in the NHS and how to go about it from the perspective of the participants and their daily routines (Pentland & Feldman, 2005; Pentland, Feldman, Becker, & Liu, 2012). NHSCD pledges constitute the initial stage of the '100 Stories of Change' narratives described in the following section. Overall, 9,479 distinct narratives of pledge data

were collected for the purpose of analysis, consisting of 8,806 pledge narratives and supporting data submitted for NHSCD 2014, and an additional 673 pledge narratives accompanied by supporting data from NHSCD 2016 (see, for example, Appendices 3.2 & 3.4). These pledge narratives were initially organised in a large Word document. The collection of this online pledge data allowed the capture both the scope of the grassroots practices of the movement and the ways in which Change Day provided a unique platform for the expression of the narrative perspective of participants, providing significant insight into how participants viewed their involvement in the movement. This research constitutes a unique body of data in the sense that it gives voice to a vast number of people, with every participant's narrative heard and recorded, and offers an extension to the normative mode of enquiry in both social movement and organisational research.

Table 3.3

	Number of Pledge narratives	Number of people pledging
Individual Pledges	6,752	6,752
Group Pledges	2,393	49,152
Organisational Pledges	169	310,780
Campaign Pledges	123	424,332
Kickstarter Pledges	42	11,211
Global Pledges	4	446
Total	9,479	802,673

3.2.4 NHS Change Day "100 Stories of Change"

The 2015 NHS Change Day took a different approach to those of 2013 and 2014, building on and developing the strategies introduced in these previous events. Activists were invited to share stories of actions (e.g., complete and implemented pledges or change initiatives from previous NHSCD campaigns) that they had already performed, in addition to pledging. This activity showcased successful examples of change implementation and emphasised both the progress and growth of the movement and the accumulated experience and achievements of NHSCD's activists[8]. The build-up to NHSCD 2015 was marked by the online publication and dissemination of a 'change story', every day for the 100 days preceding the 11th March 2015, the day of NHSCD itself. Stories were collected in real time, coupled with digital observations, and the result of this was summarised in a diary used as background notes. In the case of many stories, the data also corresponded with data observed during participant observations and with interviewees' accounts. Examples of the action and implementation narratives as shared by participants in the '100 stories of change' are included in Appendix 4.2.

3.2.5 Digital Collected Data

NHSCD has a live web presence, creating and unifying virtual communities online through the use of social media and other online platforms, using Facebook, Twitter, and the official website to create momentum (Appendix 5.2).

From my participant observations in the core leadership team, all key members of the core leadership group utilised Twitter accounts with the intention of

[8] http://changeday.nhs.uk/latest-stories/

keeping NHSCD alive as a phenomenon in 'real time'. Twitter feeds were also used to encourage interaction, mobilisation and pledging amongst potential stakeholders, and to gain support for NHSCD as an endeavour. This was further supported through the consistent posting of podcasts to a specific NHSCD channel on YouTube (some vivid examples include the NHSCD 2014 Christmas song (NHS Change Day Christmas Song, 2013) as well as 'the Power of a Smile' video (McCrea & Lynton, 2013; see also Appendix 5.3). In recent years, social media has played an increasingly important role in contemporary protest, allowing social movements to spread their messages across the world (Juris, 2012). Data posted on social media played an important role in engaging participants in the NHSCD's call to action. Taking this into account, I conducted over 400 hours of digital observations over the course of my engagement in this study (Horst & Miller, 2012; Kozinets, 2010).

Web observations included, amongst other approaches:

- Textual and pictorial reviews of relevant NHSCD and affiliated public webpages and forums.
- Watching relevant film clips online, for example on YouTube.
- Following public social media discussions on platforms such as Twitter and on open Facebook groups.

I kept records of my observations, including the time, date, web platforms, and relevant links, with the purpose of conducting future analysis of this data. In terms of ethical considerations, I followed the Terms and Conditions outlined by each website visited in the process of my research (see example in Appendix 5.1).

3.2.6 Document Collection

The following documents are supplementary to the data collected above and were collected with the intention of elucidating NHSCD as a phenomenon:

- The NHS is dominant in public discourse throughout the UK: I therefore collected relevant data from popular media with the intention of analysing this research. 389 media articles, featuring the phenomenon of NHSCD, were collected (Appendices 6.1, 6.2 & 6.3).
- Additionally, more than 50 reports, documents, fliers and other artefacts produced by NHS Improving Quality were collected for further contextual background.
- I have also, through the process of participant observation, collected more than 800 items of direct email correspondence. This email correspondence was an essential part of my negotiation of access to NHSCD as a case study. However, given the confidential status of NHS emails, such information was only used as background information and was not used for coding.

3.3 Data Analysis

During the first part of the analysis, I carefully read (or viewed, in the case of images and videos) all the data corpus, including interviewees' 'pledges', the '100 Stories of Change', all press media articles, email correspondence, notes from participant observations, and all collected artefacts. Subsequently, data organisation was discussed with the supervisor of this this thesis with the aim of uncovering patterns in the material. See the following table for our data analysis strategy:

Table 3.4

	Interviews	100 Stories of Change	Pledges	Live Participant Observations	Digital Data Collection	Press Media	Movement Artefacts
Data Collected	26	100	9,479	200+ hours	400 hours, including email correspondence (800+)	389 publications	50+ hard copy and electronic leaflets, flyers, posters, logos, etc.
Collected during NHSCDs	2013-2014	2013-2015	2014, 2016	67 meetings and NHSCD events	2013-2016 (ongoing)	2014	2013-2016 (ongoing)
Method of Analysis	Thematic, narrative & frame analysis	Thematic, narrative & frame analysis	Thematic, narrative & frame analysis	Used to enrich contextual understanding	Used to enrich contextual understanding	Read as background for contextual understanding	Read as background for contextual understanding

A decision was taken to upload the data from the interviews, the pledge narratives, and the '100 Stories of Change' to NVivo for further analysis. The data was then organised and uploaded for analysis using NVivo software in the following manner:

- Each interview was uploaded to NVivo as a separate word file, 26 files in total (see detailed tables in Appendix 2.4).
- Each 'Story of Change' was uploaded to NVivo as a separate word file, 100 files in total (see detailed tables in Appendix 4.1).
- The original 525-page, single Word document in which the pledge data was collected was then divided into 43 smaller documents: 36 word documents (each containing 250 pledges) made for NHSCD 2014 and 7 word documents (each containing 100 pledges) made for NHSCD 2016 (see detailed tables in Appendices 3.1 & 3.3)

The following table presents a summary of data organising for uploading to NVivo.

Table 3.5

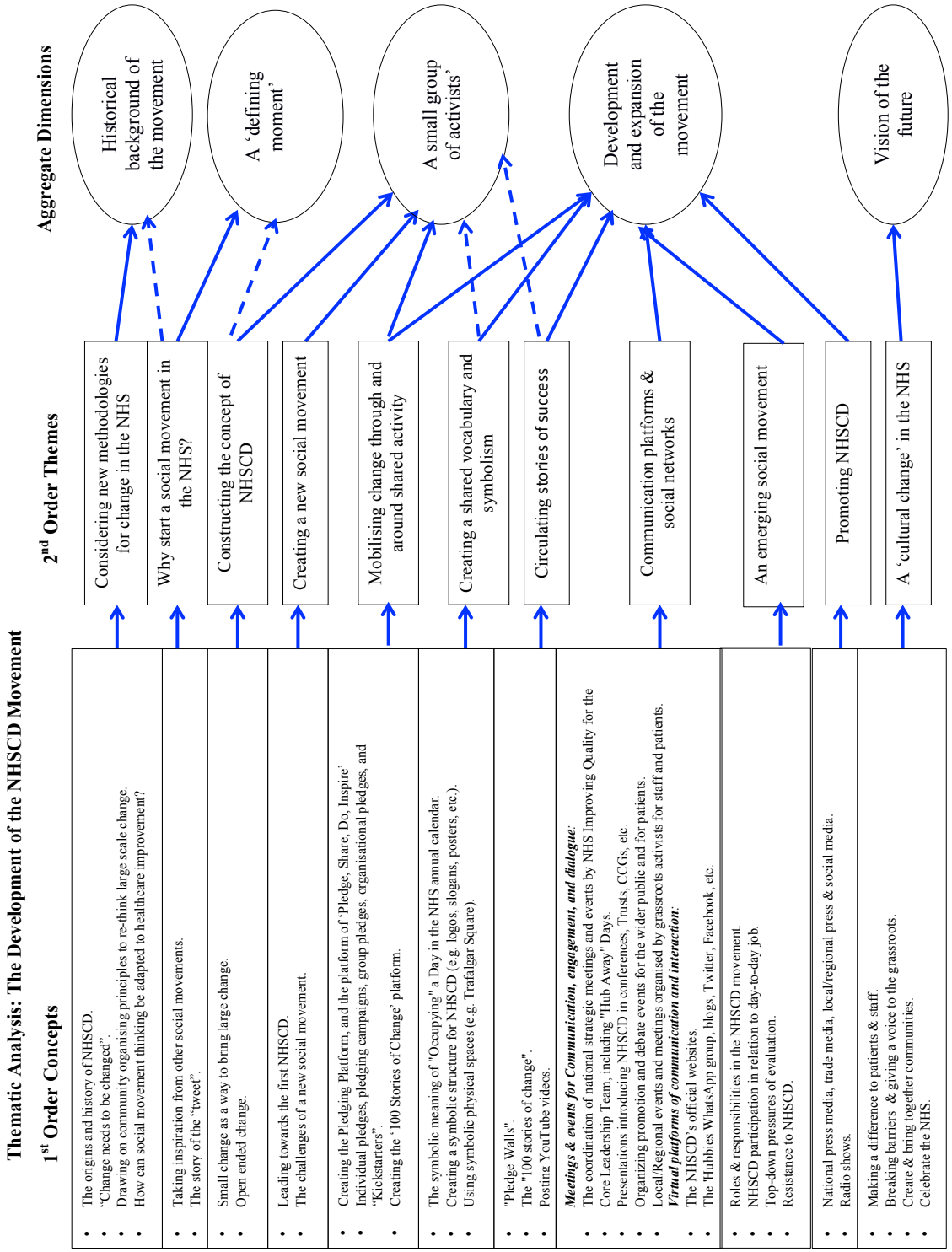
File number	File content		Number of pages	Lines of text	Additional data included
1-36	Pledges 2014	8,806 Pledge narratives	614	28,592	
37-43	Pledges 2016	673 Pledge narratives	120	5,358	
44-69	Interviews	26 1nterviews	406	19,184	
70-169	Stories of Change	100 'Stories of Change'	195	4,362	18 Videos
Total Data			1,335	57,496	18 Videos

3.3.1 Data Analysis – Chapter 4

The entire data (including the 26 interviews, 100 'Stories of Change' and 9,479 'pledges') was qualitatively analysed in order to answer the research questions. The first stage of the analysis involved the deconstruction of the texts into quotations,

which were then clustered into first order concepts according to the content of the practices that they described (Riessman, 2008; Gioia, Corley, & Hamilton, 2012). Following this, these basic codes were reviewed in isolation from their original placement in the data and examined for commonalities. I looked for the different phases that the social movement went through, exploring its development process as well as the experiences participants had of the NHSCD and the practices they engaged in. This process illuminated the specific patterns that characterised the evolution of the NHSCD movement according to its participants and formed a basis for the construction of second-order themes. I subsequently organised a linear representation of this growth, identifying five key periods and events in the evolution of the movement that participants found significant. The first set of participants' accounts describe a decade-long period during which the idea of creating a social movement for healthcare improvement was considered by a handful of change leaders within the NHS. I called this the 'historical background of the movement'. In the second group of narratives, participants referred to a widely circulated story of the movement's origin; the narratives describing these events were clustered as the 'defining moment'. The third group of accounts concentrated on the initial stages of the movement's development, particularly during the build-up to the first NHSCD; this period was labelled 'a small group of activists'. The fourth body of narratives describes the 'development and expansion of the movement', whilst the fifth group of participants' accounts depicts activists' 'vision of the future', both for the NHSCD movement and the NHS itself (see Appendix 7.1.1 for the extracts from the full coding book). The findings of this initial thematic analysis were used to construct an account of the emergence and development of the NHSCD movement, presented in section 3.3 of the third chapter in this thesis.

Figure 3.1: Thematic Analysis: The Development of the NHSCD Movement:



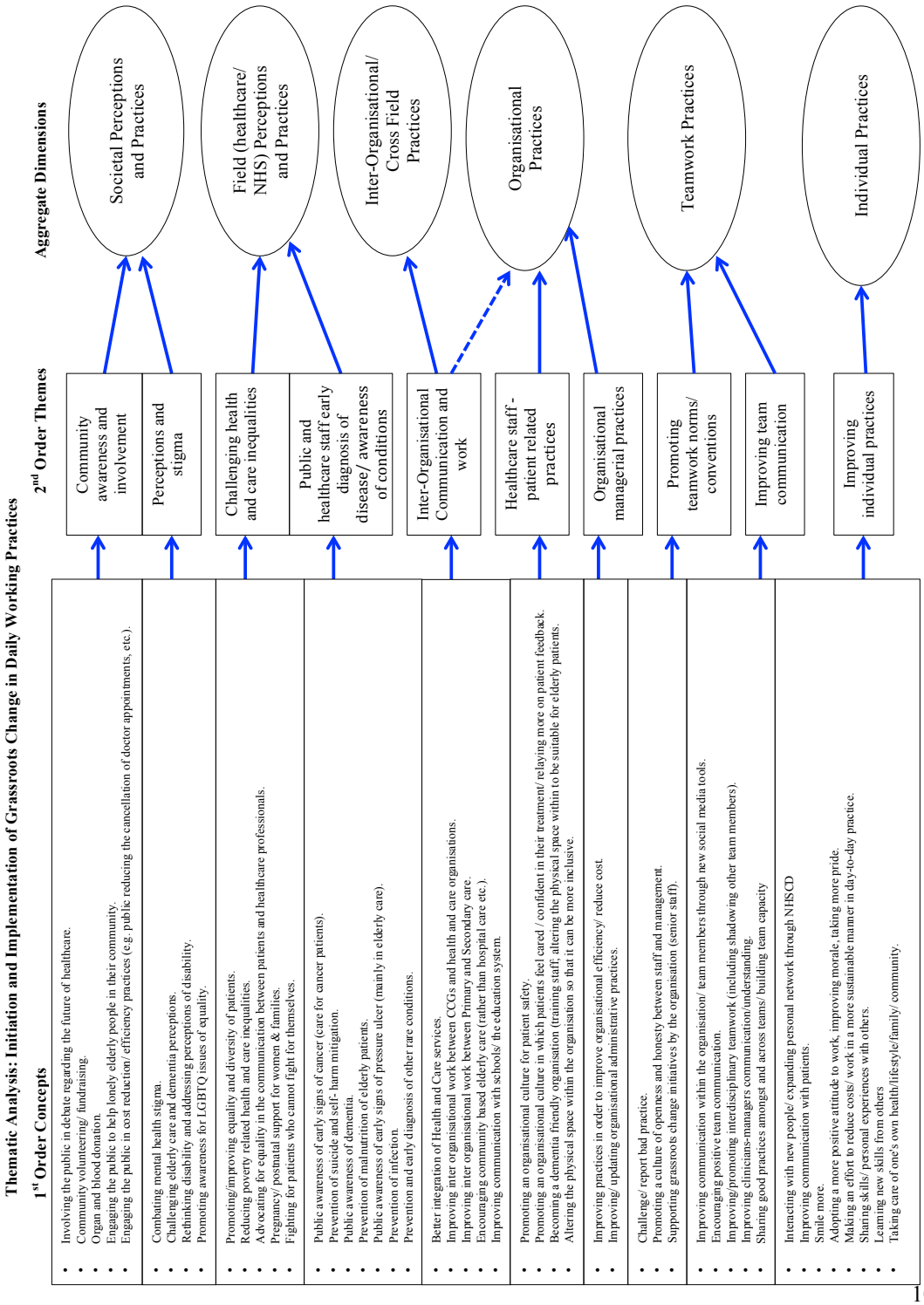
This initial analysis allowed for considerable insight into the evolution of the movement and directed attention to particular patterns within participants' accounts in which they described how they engaged with the required changes within the NHS. This analysis was, however, insufficient to address each one of the additional three specific research questions. Several further levels of analysis were, therefore, performed in order to tackle these questions.

3.3.2 Data Analysis – Chapter 5

The second specific research question concentrates on the implementation of change initiatives by the NHSCD movement participants, examining *what* kind of changes and improvements in practices are initiated and implemented in practice through the participation in the NHSCD movement and what meanings are assigned to them by participants. Over the first part of the analysis the data corpus was closely read: this included the reading of all press media articles, notes from participant observations, email correspondence and collected artefacts. Following this, the potential ways in which the data could be organised were considered. In the process of this patterns were sought amongst the gathered material. Next, the data was organised and uploaded using NVivo software. The entire data corpus (26 interviews, 100 'Stories of Change', and 9,479 'Pledges') was qualitatively analysed in order to answer the research question. In the first stage of analysis, the data was searched for common patterns and themes that would provide a structure for the subsequent grouping of the changes and improvements initiated by NHSCD participants. Interview, '100 Stories of Change' and 'Pledges' text was first deconstructed into quotations, which were then grouped into first order concepts depending on the practices they described. Removing these quotations from their original placement in the data allowed for the

reviewing of them in isolation: these basic codes were then inspected for commonalities and searched for second order themes. The final organisation of second order themes showed 10 categories. These spanned across various social levels and included a broad range of change initiatives: community awareness and involvement, perceptions and stigma, challenging health and care inequalities, public and healthcare staff early diagnosis of disease/awareness of conditions, inter-organisational communication and work, healthcare staff - patient related practices, organisational managerial practices, promoting teamwork norms/conventions, improving teamwork and communication, and improving individual practices. The ten categories were then clustered into aggregated dimensions, which made visible six cross social levels on which change initiatives simultaneously took place: societal perception and practices, field (NHS/ healthcare) perceptions and practices, inter-organisational/cross field practices, organisational practices, teamwork practices, and individual practices (see Appendix 7.2.1 for the extracts from the full coding book).

Figure 3.2: Thematic Analysis: Initiation and Implementation of Grassroots Change in Daily working practices.



The value of the initial thematic analysis lay in the insight that it provided to the first part of the research question (e.g. what kind of changes and improvements are initiated and implemented in practice through participation in the NHSCD movement?). The second part of the research question (e.g. what meaning is assigned to these changes?), however, required additional investigation. This led to the conducting of a narrative analysis (Boje, 2008). The decision to use a bottom-up analysis enabled the identification of the ways in which members of the NHSCD movement assigned meaning to change initiatives, which became apparent inductively, through both the explicit descriptions provided by participants and the specific vocabulary and language that they used. Basic codes were organised on the basis of how participants described themselves and others (e.g. agent), the reasoning and motivations that lay behind their change initiatives (e.g. purpose), problems combatted (e.g. scene), proposed resolutions (e.g. agency), and actual changes enacted under the guidance of these aims (e.g. plot). Four distinct narratives of health emerged from the data set: a narrative of compassion and communication, a narrative of fairness and human rights, a narrative of efficiency, and a narrative of scientific knowledge (see table 3.6; see also see Appendix 7.2.2 for the extracts from the full coding book).

Table 3.6

Narratives of Health	**Narrative of Compassion and Communication**	**Narrative of Fairness and Human Rights**	**Narrative of Efficiency**	**Narrative of Scientific Knowledge**
Agent (who) *Protagonist*	Healers/Mentors.	Social Justice Activists.	Service provider.	Healthcare professionals
	Members of the Community (Patients, Families, Carers).	Marginalised groups and individuals).	Service users.	Public
Purpose (why) - Driving values *Endorsed practices*	Health and wellbeing of all members of the community.	Equality and fairness across all social diversity.	Efficient provision of healthcare services.	Older practices need to be updated to more informed ways of doing things.
Scene (when/where) *practices that need to be changed*	Emotional disconnect in the communication of treatment, resulting in poor patient experience.	Social inequalities in access to health and care services.	Lack of resources, ageing population, budget crisis.	Insufficient implementation of evidence based research.
Agency (how)	Improving communication, prioritising patients, focusing on compassionate care.	Fighting stigma and standing up for the marginalised.	Efficiency measures and improvements.	The dissemination of knowledge and encouraging of its implementation.
Plot/Act (what)	From insufficient experience of communication to relationships which adequately and compassionatly involve all members of the community.	From exclusion to inclusivity.	From inefficiency to optimal use of resources according to needs of the community.	Progress based on scientific knowledge.

These co-existed in our data and are not representative of any particular group. They do not correspond perfectly to all change initiatives, but rather illustrate the key themes and ideas that participants brought together. However, in many cases (and especially when it comes to the shorter narratives of the pledges), a direct pathway between a pledge and a particular health narrative can be observed. In this scenario, a

pledge explicitly articulates the logic of a given narrative. In other cases there is no one-to-one correlation between a pledge and a single narrative: instead, the pledge involves multiple change initiatives or articulates several rationales for the proposed change. As the narrative analysis was coded thematically, large and complex change initiatives were broken down into smaller quotations and coded accordingly. Finally, data was organised with the aim of showcasing the insights from both levels of analysis. This allowed for the revisiting of the original first order concepts, which were grouped into a two-dimensional table according to both the relevant institutional level and their underpinning narrative (see table 3.7 for examples).

Table 3.7

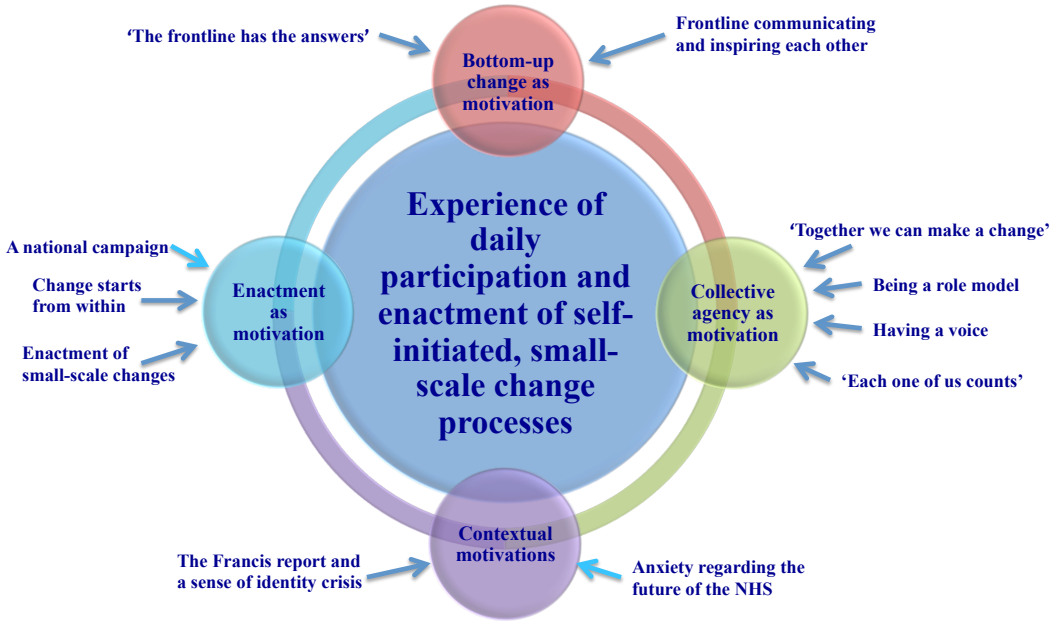
Social Levels	Narratives of Health			
	Narrative of Care, Interaction and Compassion	**Narrative of Fairness and Human Rights**	**Narrative of Efficiency**	**Narrative of Scientific Knowledge**
	Example Themes			
Societal Perceptions and Practices	Community volunteering. Helping lonely elderly people in their community.	Combattion mental health stigma in society. Prevention of suicide and self- harm mitigation	Community fundraising	Organ and blood donation
Field (healthcare/NHS) Perceptions and Practices	Public participation in debate surrounding the future of healthcare and the NHS. Pregnancy/ postnatal support for women & families	Promoting awareness for LGBTQ issues of equality in access to healthcare. Challenging dementia perceptions	Engaging the public in cost reduction/ efficiency practices, for example public reducing the cancellation of doctor appointments, etc.	Public awareness of early signs of illness, for example early diagnosis of cancer/ signs of presure ulcer/ preventio of infection
Inter-Organisational Practices	Better integration of Health and Care services/ to inprove patient experience of care. Impring communication with schools.	Improving interorganisation work in relation to vonurable groups in society: Encouraging community based elderly care for example (rather than hospital care etc.)	Improving inter organisational work between CCGs (Clinical Commitioning Groups) and health and care organisations	Improving inter organisational work between Primary and Secondary care (e.g. improving knowledge transfer between healthcare proffessionals).
Organisational Practices	Promoting an organisational culture in which patients feel cared for and are confident in their treatment (relaying more on patient feedback)	Altering the physical space within the organisation so that it is more suitable for elderly patients/becoming a dementia friendly organisation.	Improving practices in order to improve organisational efficiency/ reduce cost. Improving/ updating organisational administrative practices	Promoting an organisational culture for patient safety
Teamwork Practices	Promoting a culture of openness and honesty between staff and management. Encouraging positive team communication. Shadowing other team members.	Challenge/ report bad practice. Supporting grassroots change initiatives by the organisation (senior staff). Expressing gratitude to other staff members	Improving the efficiency of communication within the organisation/ team members through new social media tools.	Sharing good practices amongst and across teams/ building team capacity. Improving clinicians-managers communication and understanding.
Individual	Interacting with new people through NHSCD.(e.g. belonging to a large 'family like' work place). Improving communication with patients/ lshowing a carring attitude. Taking care of one's own health/lifestyle/family/ community. Smile more to show you care.	Having a more positive attitude to work, improving morale, taking more pride. Fighting for patients who can not fight for themselves.	Making an effort to reduce costs in day to day practice. Making an effort to work in a more sustainable manner.	Sharing skills with others. Learning new skills from others. Sharing personal experiences with others.

3.3.2 Data Analysis – Chapter 6

The first specific research question was concerned with the motivation of activists to become voluntarily involved and participate in grassroots collective action in the NHSCD movement, asking *why* activists joined the NHSCD movement. In order to address this question, an additional level of thematic analysis of 23 of the interviews was conducted. In this analysis, basic themes were organised into 11 second order themes, which were used to develop four aggregated dimensions: contextual motivations to participate in NHSCD; collective agency as motivation – 'do something better together'; the power of bottom-up change as motivation; and enactment as motivation. The findings of this analysis are outlined in the first paper included in this thesis (Moskovitz & Garcia-Lorenzo, 2016), which is presented in Chapter 4 of this thesis (see Appendix 7.3.1 for the extracts from the full coding book).

Figure 3.3

Enactment and motivation as mutually constructed processes



3.3.2 Data Analysis – Chapter 7

The second specific research question focuses on the issue of knowledge mobilisation practices, investigating *how* NHSCD movement participants mobilise knowledge to design and engage with changes in their daily working practices. This analysis investigated the co-construction of the collective action frames through which the question of how to engage with the required change within the NHS was negotiated amongst movement activists (Snow, 2013). This reading of the data set revealed certain topics and grievances that were repeatedly raised in and around the NHSCD's activities. It became clear during the reading of the data that these issues evolved into the focal points around which collective action was mobilised. Consequently, the data set was organised around these emerging patterns of knowledge mobilisation,

identifying three main frames: 'Local Leadership' Frame, 'Power/Status Quo 'Disruptive Activism' Frame, and 'Personal Learning Journey' Frame (see Appendix 7.4.1 for the extracts from the full coding book).

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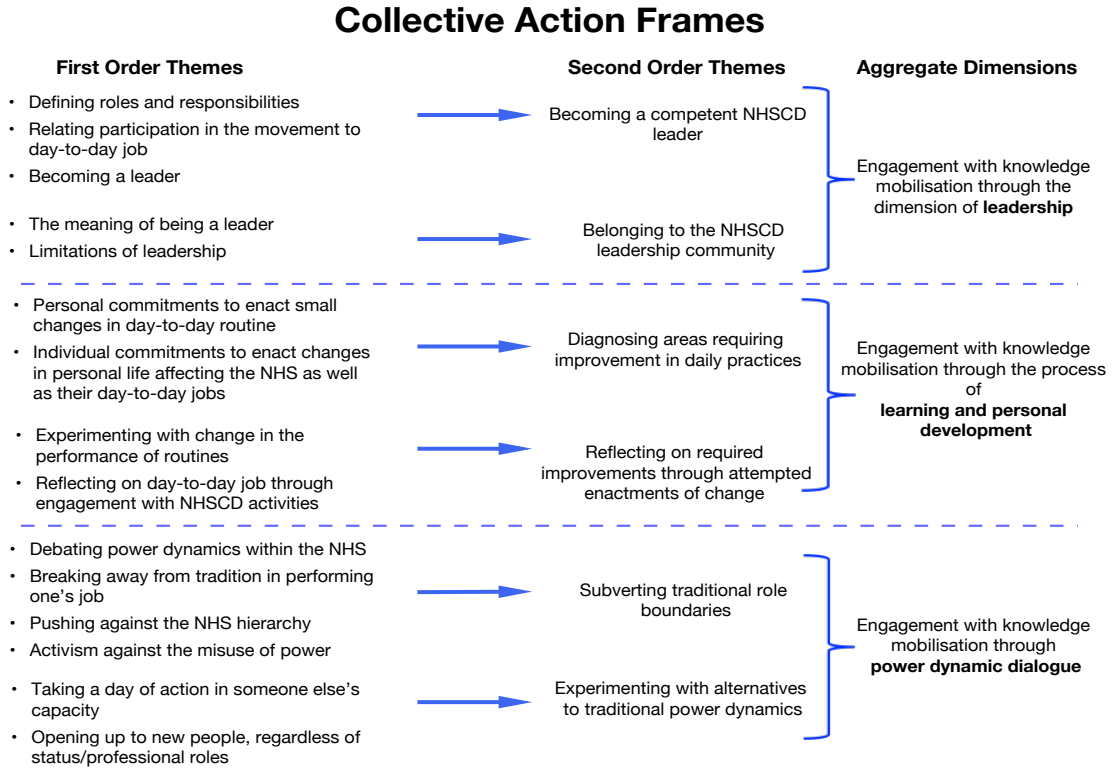
Figure 3.4



Following this, a narrative analysis of the data was applied to each frame, which looked at the individual elements that constituted each frame, exploring them through the categories of scene, agent, purpose, plot and agency (Boje, 2008) (see Tables 3.8.1, 3.8.2 & 3.8.3; see also Appendix 7.4.2 for the extracts from the full coding book). This decision was informed by the previous thematic analysis, which focused on activists' motivations for participation in the NHSCD movement (e.g. the analysis

performed in Chapter 6), and the insights from this investigation, which highlighted the significance of the meanings assigned by participants to their ability to express their voice and become the protagonists of their own self-initiated change activities (Moskovitz & Garcia-Lorenzo, 2016). This investigation of the narrative features of each frame aimed to combine these different critical approaches in a way that could overcome contemporary criticism made by social movement scholars of the framing perspective: specifically, its tendency to 'overemphasise cognitive factors' (Davis, 2002, p. 9). This analysis also drew upon studies in the field of social movements which suggest that the analysis of narratives can further the understanding of framing processes, such as the dynamic through which social movements' frames and participants' personal experiences are aligned (Davis, 2002; Ganz, 2008, 2010; Polletta, 1998). By doing so, I aimed to portray in our analysis the framing negotiating process, both from the perspective of the individual as well as from that of the movement.

Table 3.8.1

The 'Local Leadership' Frame				
Narrative Analysis				
CHARACTER – AGENT	**THEME-PURPOSE**	**PLOT-ACT**	**SPECTACLE-SCENE**	**DIALOGUE-RHYTHM-AGENCY**
The NHSCD Leader	**Taking the Lead**	**An Emerging Network of Leaders**	**A Crisis in the NHS**	**Enacting Distributive and Inclusive Leadership**
NHS IQ and the Core Leadership Team	Doing beyond one's day-to-day role in the NHS by joining NHSCD (expanding the way one approaches their day-to-day work)	Leadership in NHSCD as an evolving learning experience	NHSCD as a flexible platform for the expression of leadership and participation	Limitations of the NHSCD leadership model
Who are the Hubbies?	Leadership in NHSCD as a vehicle to perform one's vision	Leadership in NHSCD as an evolving network	Lack of support for NHSCD leaders by senior managers	Is there a need for people who are full time NHSCD employees?
Becoming a Hubbie	Having a sense of contribution/ achievement/ pride through leadership	Being empowered by empowering others		Is there a need to use external professionals and sources, sub-contractors for NHSCD?
Leading with likeminded people	Comparing small-scale impact to one's contribution through leadership in NHSCD	Lack of clear role definition for NHSCD leadership.		The need to engage the support of senior NHS leaders in order to help the grassroots leaders.
The need to match between roles in NHSCD and one's skills		Doing beyond one's role by helping others		A need to improve networks and communication amongst leaders/ better interaction between Hubbies
Linking activism in NHSCD to wider career goals				The need to incorporate feedback from the Hubbies (give more power to the grassroots)
Conflicting understandings over what it means to have a leadership role in NHSCD				What is the skillset to become a Hubbie?
Conflicting roles between NHSCD activism and daily work				Is there a competition amongst Hubbies?
				Popping in and out of leadership roles in NHSCD

Table 3.8.2

The 'Power Disruptive Activism' Frame				
Narrative Analysis				
CHARACTER – AGENT	**THEME-PURPOSE**	**PLOT-ACT**	**SPECTACLE-SCENE**	**DIALOGUE-RHYTHM-AGENCY**
The Activist	**Creating A Direct Democratic Dialogue**	**Subverting Traditional Role Boundaries**	**A Stagnant Hierarchy**	**Enacting 'Radical' Change**
Participation in NHSCD as a political statement against the established hierarchy	Using NHSCD as permission to work outside traditional hierarchy	Changing perceptions of others in the NHS by being exposed to them through NHSCD	Debating the agency of frontline staff, the possibility of empowering them, being empowered	Collecting, listening and implementing patients' feedback
Acknowledging the contribution of others as a political statement	Pushing against the traditional hierarchical order through actions taken as a part of participation in NHSCD	Reflecting on patients' experience through involvement in NHSCD	Debating the agency of the public/patients and the possibility of involving the public more in the NHS	Reflecting on one's role in relation with the roles of others by taking a day to shadow their activity/ be shadowed by them
Bringing to light abilities/ skills/experiences in NHSCD - that cannot be expressed otherwise - in day-to-day job		Going beyond traditional role boundaries in the NHS by working/ collaborating with other professionals through NHSCD (that one would not otherwise)	Rethinking power dynamics between NHS staff and patients (can patients be treated differently?)	Reflecting on one's role in relation with the roles of others by taking a day to work in their capacity
Challenging traditional role boundaries in the NHS by taking part in a non-hierarchical network of volunteers		Challenging traditional role boundaries in the NHS by expanding interest in patient care to non clinicians		Reflecting on the condition of others (particularly patients) by making an effort to experience it for a day
		Feeling that NHSCD should assign more		Reflecting on one's practice by trying to better the understanding and perception of others by participating in various NHSCD activities
				Using the NHSCD platform to

Table 3.8.3

Personal Learning Journey' Frame				
Narrative Analysis				
CHARACTER – AGENT	**THEME-PURPOSE**	**PLOT-ACT**	**SPECTACLE-SCENE**	**DIALOGUE-RHYTHM-AGENCY**
Frontline Participants	**Personal Development**	**Changing the Everyday**	**Change at the Grassroots Level**	**Enacting Change in Daily Practices**
Anyone can participate in the movement	Expanding one's personal network through NHSCD	Pledging as an evolving experience that reflects on day-to-day practice	Pledging to do a change that one meant to do anyway but needed a 'push'	Making an effort to reduce costs in day-to-day practice
Conflicting messages in defining NHSCD involvement	Sharing personal experiences with others	Changing one's attitude to routine practices by experiencing them from a different perspective in NHSCD	Interacting with new people through NHSCD	Making an effort to work in a more sustainable manner
	Sharing skills with others	Reflecting on one's job through the attendance of NHSCD sessions		Fundraising
	Learning new skills from others	Reflecting on one's job through the attendance of 'School for Health and Care Radicals'		Having a more positive attitude to work, improving morale, and taking more pridein one's work
				Expressing gratitude to other staff members
				Improving attitude towards teamwork
				Being a role model to others
				Having a sense of contribution in 'small wins'
				Improving communication with patients
				Smiling more
				Overcoming the fear of change
				Engaging in personal volunteering
				Taking care of one's own health/lifestyle/family/ community

Three core-framing tasks are stressed in literature as essential to the successful mobilisation of collective knowledge through framing practices (Benford & Snow, 2000). As a result of the narrative analysis, it also became apparent that each of the three frames performed these three core-framing tasks differently. As a consequence, the data was subjected to further scrutiny. This investigation capitalised on the previous readings of the data corpus and redistributed the codes between the three frames, grouping them according to the way in which each core framing task (i.e.,

prognostic, diagnostic and motivational) was performed (see Tables 3.9.1, 3.9.2 & 3.9.3; see also Appendix 7.4.3 for the extracts from the full coding book). Following this further level of analysis, I became aware of the various ways in which these three frames interacted with one another in a dynamic framing process in which ideas and experiences were exchanged, contested and adapted by actors within the social movement. Furthermore, particular tensions emerged from the data concerning how the movement pushed up against the formal rules and norms of the organisation and the attempts of the organisation to reappropriate the movement back into the formal and traditional institutionalised system – information which was coded under framing 'contested practices'.

Table 3.9.1

The 'Local Leadership' Frame			
Frame Analysis			
DIAGNOSTIC FRAMING	**PROGNOSTIC FRAMING**	**MOTIVATIONAL FRAMING**	**CONTESTED PRACTICES**
Failure of senior management to address organisation-wide crisis	**Creating platforms for the sharing and adaptation of knowledge**	**Empowerment**	**Conflicting understandings over the meaning/ limitations of distributed leadership**
Change is lectured to staff.	Knowledge is debated and discussed with staff.	Flexibility in goal setting.	Coping with top-down pressures of evaluation.
Senior management design change.	Top-down planning is adapted to fit local conditions.	Collective identity/ Belonging.	Difficulties in communication amongst leaders and activists' networks.

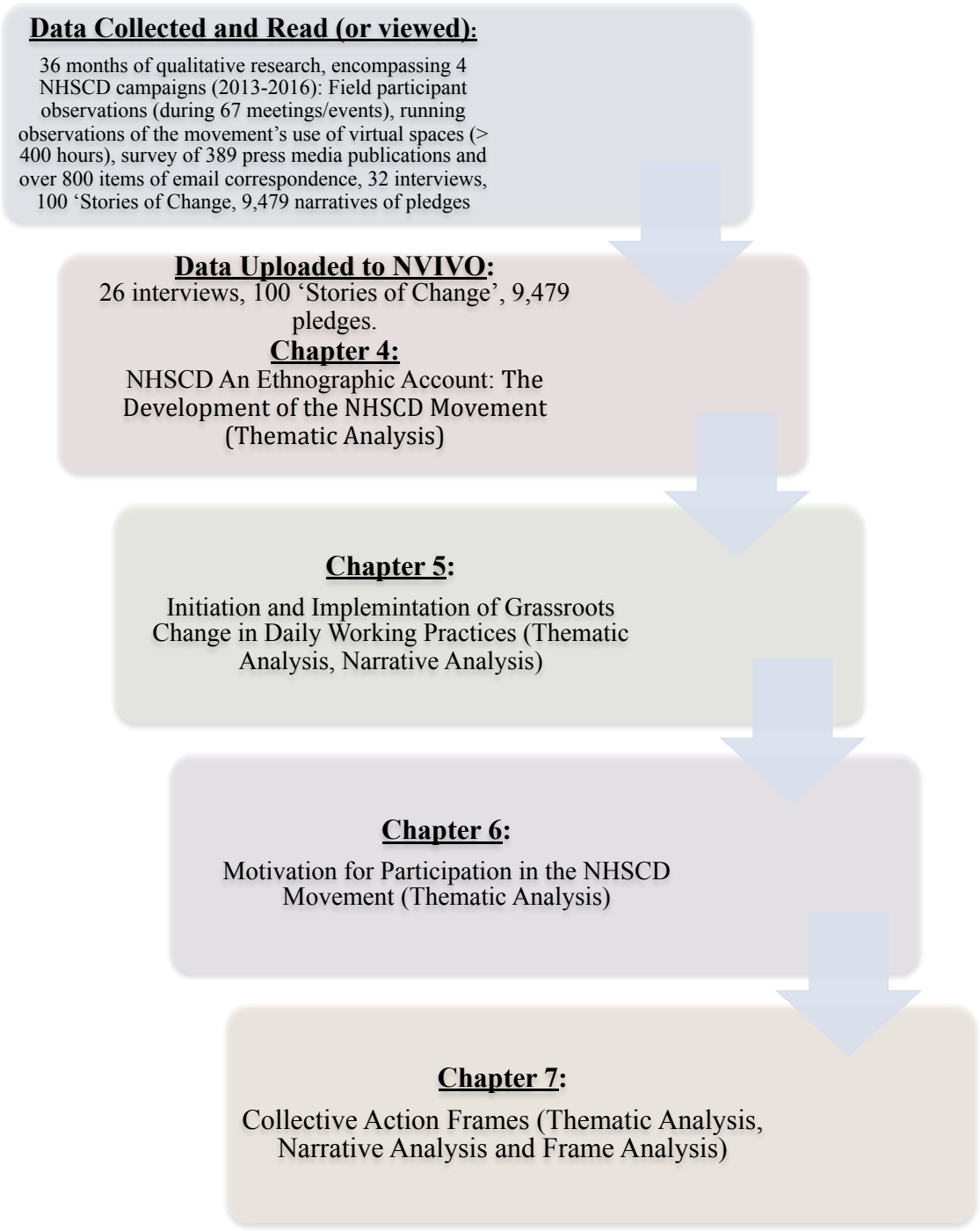
Table 3.9.2

The 'Power Disruptive Activism' frame			
Frame Analysis			
DIAGNOSTIC FRAMING	**PROGNOSTIC FRAMING**	**MOTIVATIONAL FRAMING**	**CONTESTED PRACTICES**
A fragmented institution: exclusion and a non-communicative power structure	**Legitimising grassroots change initiatives through inter-level dialogue**	**Inclusion**	**The need to keep NHSCD grassroots (not 'taken over' by management**
Grassroots ideas are blocked	Grassroots ideas are being legitimised and implemented	Experimentation with new ideas	Lack of support for NHSCD activists by their managers
Unequal knowledge distribution: various professions/ hierarchical levels	Transparency is encouraged, grassroots can speak truth to power'	Communication	Resistance to NHSCD by individuals and/or professional groups

Table 3.9.3

The 'Personal Learning Journey' frame			
Frame Analysis			
DIAGNOSTIC FRAMING	**PROGNOSTIC FRAMING**	**MOTIVATIONAL FRAMING**	**CONTESTED PRACTICES**
Failure of change initiatives to reflect and adapt to changing circumstances	**Personalising change to reflect a wide range of experiences and contexts**	**Innovation**	**Limitations to continuous learning processes**
One size fits all	Personalising change programs and sharing ideas	Tolerance towards mistakes	Balancing commitment to NHSCD with commitment to work
Disconnect between formal knowledge and reality on the ground	The point of view of the 'other' is incorporated	Personal and group development	The fact that NHSCD only 'happens once a year' challenges its sustainability

3.3.3 Summary of Data Analysis Process



The next chapter presents an overview of the case study explored in this PhD.

Chapter 4 The Case

This chapter introduces the subject of this thesis and is structured in two sections. The first part of the chapter consists of a literature review of the development of the English National Health Service (NHS), which provides the wider context for this study. The second section presents an account introducing the emergence and development of the NHSCD movement which is organised and presented in narrative form. The purpose of this chapter is to present a contextual overview of the rich and unique case study that forms the empirical basis for this PhD thesis.

4.1 The English National Health Service (NHS): The Wider Context

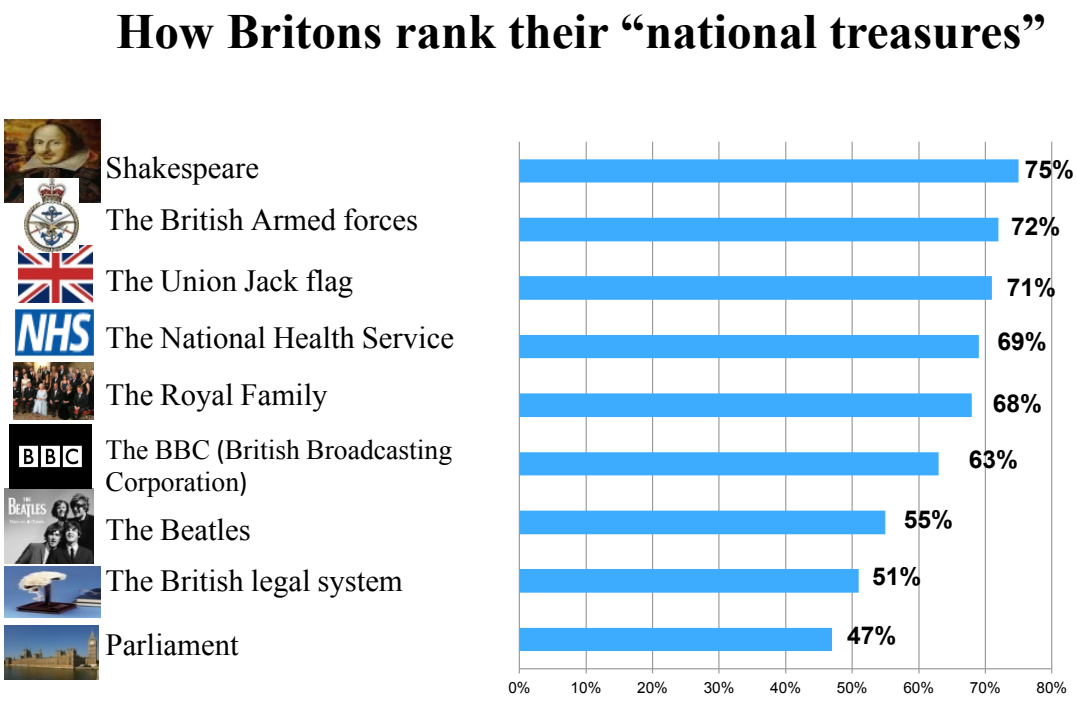
The aim of this literature review is not to present a complete chronological account of the history of the NHS, but rather to outline the important historical trends relevant to the emergence of the NHS Change Day movement. It focuses on the current economic and organisational challenges faced by the organisation in the context of a global recession – for example, the escalating costs of elderly care and new technology – alongside the turbulent process of recent attempts at organisational change. This section highlights the conflicting demands placed on the NHS, most notably the requirement to constantly improve the quality of patient healthcare whilst reducing the costs of its services. Pressures such as these resulted in the emergence of NHSCD.

4.1.1 A Vision of Free Healthcare

The founders of the NHS aspired to make the best medical advice and treatment freely available to the entire British population irrespective of means, age, sex or occupation (Delamothe, 2008b). Established on 5th July, 1948, the NHS was the first

comprehensive health system in the Western world to be based on principles of the national provision of services rather than the necessity of healthcare insurance (Delamothe, 2008a). In the current era, the NHS provides healthcare services to a population of 54 million people, of whom 1 million patients are estimated to be treated every 36 hours (NHS choices, 2015; see also Bevan, 2012; Bevan, Roland, Lynton, & Jones, 2013).

Figure 4.1



- Source: *Demos*/*Sunday Times*, 27th November 2011. Cited from Helen Bevan, *Leading Change: A social movement perspective* 14th July, 2012

The NHS plays a central part in the lives of British citizens: 'From the cradle to the grave, citizens are promised healthcare, delivered according to need, free at the point of delivery' (Ballatt & Campling, 2011, p. 1). For this reason, the NHS has the capacity to evoke strong responses, and permeates both public discourse and popular

media (Ballatt & Campling, 2011). The centrality of the NHS in British culture is exemplified by its frequent appearance in the news, on British television, and even in the 2012 Olympic opening ceremony (Abbasi, 2012).

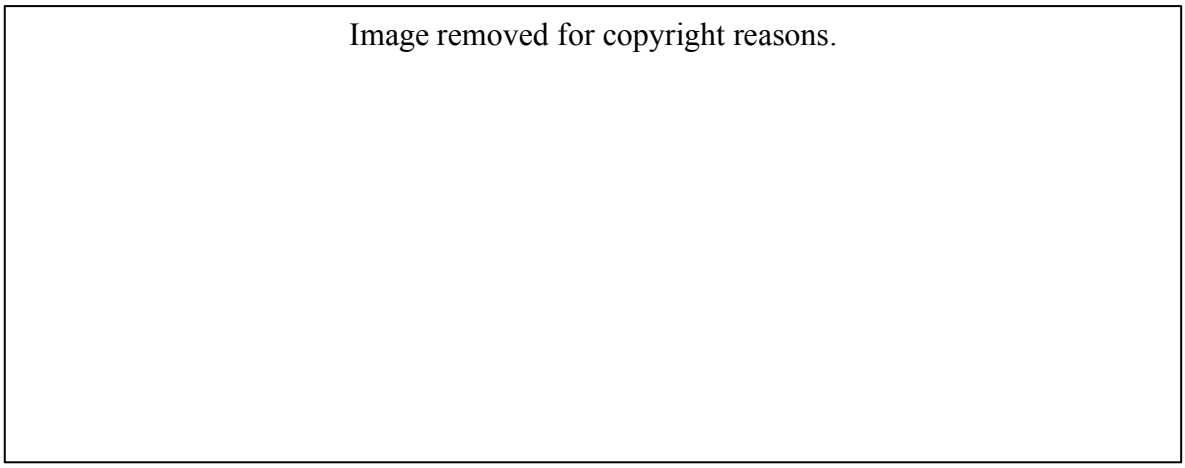
Figure 4.2

(Image taken from NHS Improving Quality resources)

Budget considerations have always clouded this founding vision, challenging the extent to which the NHS has been able to deliver on its promises. Shortly after the inception of the NHS, the concept of priority spending was introduced by the government: optometry and dentistry services were the first to undergo explicit cuts (Delamothe, 2008c). It has been argued that these budgetary pressures were aggravated by the gradual transition from the 'post-war working class' British population with modest expectations of what the NHS should provide to 'a customer society' (Delamothe, 2008c, p. 1344).

Given these budgetary concerns, the NHS has been the subject of recurrent political debates by successive governments. As well as questioning what proportion of gross domestic product (GDP) should be spent on healthcare, the issue of how these costs should be levied, whether through taxation, fee charges to patients or insurance policies, has also been frequently debated. These financial concerns have, over the years, become inextricably associated with patient autonomy, and the extent to which patients rather than experts should have the right to determine their own treatment (Delamothe, 2008d).

Figure 4.3



4.1.2 Healthcare Quality Regulation

In addition to funding dilemmas, several healthcare scandals triggered public concern about the ability of staff to deliver consistent, high-quality, efficient services (Delamothe, 2008e). High-profile scandals, from the murders carried out by Dr. Harold Shipman, to the recent cases of abuse at Winterbourne View care home, sent shock waves through the NHS (Mohammed et al., 2001; O'Dowd, 2012). Negligent

surgical practices at Bristol Royal Infirmary, leading to excessive paediatric mortality, constitute another pertinent example (Kennedy, 2001; Stevens, 2004). In the latter case, a 'club culture' was described: groups of influential clinicians reinforced poor-quality care. This led to criticism over the absence of managerial structures, which resonated throughout the whole of the NHS and triggered policy change (Mannion, Davies, & Marshall, 2005; Mannion et al., 2010).

Revelations about malpractice at Stafford Hospital affected the atmosphere within and without the NHS and led to the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013). It highlighted poor-quality care on an organisational scale and stated that the Trust:

> […] failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. (Francis, 2013, p. 3)

A major feature of the inquiry was to highlight the tension between focusing on patient care and the delivery of government targets:

> This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care. (Francis, 2013, p. 3)

A recent systematic review of patient neglect in healthcare settings distinguished 'procedur[al] neglect' from 'caring neglect' (Reader & Gillespie, 2013):

> Caring neglect can be damaging to the emotional well-being of patients (e.g. dignity) even if subjective beliefs about staff attitudes are not accurate… [it] is largely invisible to healthcare institutes because it refers to behaviours which have not been (and possibly cannot be) fully proceduralised. (Reader & Gillespie, 2013, pp. 12-15)

4.1.3 The NHS Constitution and its Values

The NHS Values are enshrined within the NHS Constitution, published by the Department of Health in 2011. The publication of the NHS Constitution is of

significance, as it is the first document within the history of the NHS to establish explicitly what NHS stakeholders can expect from the NHS, and what the NHS expects from its stakeholders. Furthermore, the Constitution safeguards the NHS from political change, as it cannot be modified without the full involvement of NHS stakeholders. The NHS Values encode the aspirations of NHS service provision, in enabling co-operative working at every level within the NHS. The values result from extensive consultation with NHS stakeholders, from staff, to patients, to the public, and act as a touchstone for action within the NHS. The NHS Values can be categorised into the following six areas:

Figure 4.4

(NHS England, 2014)

4.1.4 The NHS Outcome Framework

Quality is pivotal to the delivery of care within the NHS. Quality is defined as an inextricable combination of high standards of patient safety, clinical effectiveness and patient experience. To measure performance, and to drive quality improvement, the NHS has developed an Outcomes Framework, which delineates five principles of quality of care (NHS Group, Department of Health, 2014). The Outcomes Framework states that effective healthcare provision must:

1. *Prevent people from dying prematurely*
2. *Improve the quality of life for people living with long-term health conditions*
3. *Aid recovery for those with ill health or following injury*
4. *All care should be delivered in a safe environment*
5. *All care should be delivered in a way that is positive for the patient.*

4.1.5 Organisational Changes in the Largest Health System in the World

The NHS is the largest health system in the world, and the fifth largest employer in the world today, with an estimated 1.7 million employees (Alexander, 2012; Bevan, 2012; Bevan et al., 2013).

Since its inception, the NHS has undergone episodes of significant organisational change. Momentous structural changes include those resulting from the 'Griffiths Report' (1983), which introduced the role of General Manager (Clinical Research Editor, 1983; NHS Management Inquiry, 1983) and endeavoured to include doctors in cost-based decision-making (Mannion et al., 2010).

With the new millennium, several notable changes in policy were implemented, specifically focused on the NHS's financing and structure. In response to concerns about care quality, significantly increased funding was announced

between 2002 and 2007, aiming to elevate spending to levels consistent with the European average (Ballatt & Campling, 2011). Competition for contracts within NHS services was encouraged by the development of a quasi-market system and 'Payment by Results'. This was followed by structural changes, including transition to NHS Foundation Trusts, service redesign and increased commissioning from the private sector (Freeman & Peck, 2010; Hyde, 2010).

In April 2013, the NHS embarked upon its most recent structural change with the introduction of the Health and Social Care Act (2012) and its associated reconfiguration of service provision. This has been described in the *British Medical Journal* as 'the largest set of changes the NHS in England has seen since its formation' (Edwards, 2013, p. 2090). These structural changes were summarised in NHS England's guide to 'Understanding the New NHS' as concentrating on the following five key changes (NHS England, 2014):

- Shifting the commissioning structure, taking the responsibility from Primary Care Trusts (PCTs) and giving it to clinician-led Clinical Commissioning Groups (CCGs).
- An effort to increase patient involvement by establishing 'independent consumer champion organisations' at both a local and national level within the NHS.
- An emphasis on the importance of public health through the creation of an executive agency of the Department of Health: Public Health England. This agency was responsible for improving public health and for addressing health inequalities.
- An effort to streamline 'arms-length' bodies, through endowing the National Institute for Health and Care Excellence (NICE) with the responsibility of developing social care guidelines and quality standards, and through tasking the Health and Social Care Information Centre (HSCIC) with the responsibility for managing health and social care data.

- The introduction of healthcare market competition to provide patients with greater choice and control in their care. To safeguard the interest of patients, a sector regulator was established: Monitor.

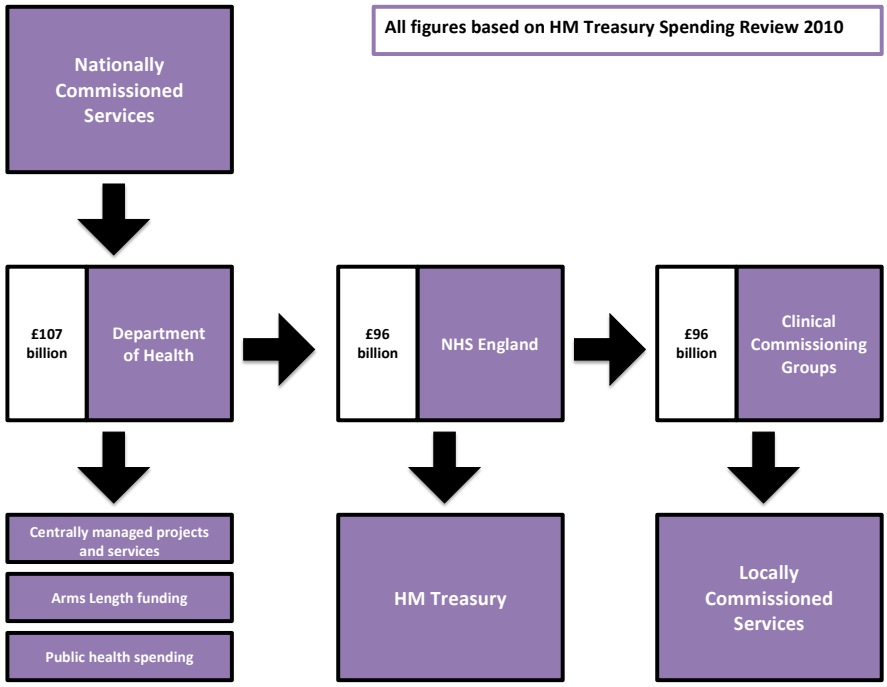
Elements of the Health and Social Care Act continue to be debated in the public domain, including the risk of fragmentation in patient care. These concerns focus around the abolition of Primary Care Trusts, the introduction of Clinical Commissioning Groups, and the auctioning of a broader portfolio of contracts to the private sector (Holmes, 2013).

Public concerns over the immediate future of the NHS include ensuring sustainable funding whilst improving service responsiveness to patient demand and investing in health promotion and prevention (Crisp, 2011; see also Bevan, 2012; Lynton, 2013). These challenges are amplified by the growing healthcare needs of an expanding elderly population with long-term conditions and dementia (Boyd, Burnes, Clark, & Nelson, 2013). There is widespread debate about the system's preparedness for continued universal healthcare in the context of these challenges (Godlee, 2013; Select Committee on Public Service and Demographic Change, 2013).

Thus, the NHS is in constant need of change and improvement. In the words of David Nicholson, the former CEO of the NHS:

> Change is a constant for health care. […] Technology changes, the expectation of our patients, the demography, all of those things make change a constant in the NHS. […] Our job, people who are both working in the NHS and leading it, is to make sure the NHS changes along with it. (Nicholson, 2013)

Figure 4.5



(NHS England, 2014)

4.1.6 The NHS Change Day Movement

The organisational, political and economic challenges the NHS faces as an organization as outlined above provide the backdrop to the development of the NHSCD movement; a movement mainly consisting of NHS frontline staff engaging in and leading daily initiatives of change. The following section focuses on the historical moment in which the research took place, with special focus on the economic and political events of the time and the implications of major health care policies for the NHS. The section describes the public's firm belief in the necessity of the NHS and its founding principles. These reactions focused on the role of the government and of other organisational bodies in addressing the crisis faced by the NHS.

4.1.7 A Closer Look at the Historical Moment in which the Research Took Place

The NHS is the largest healthcare system in the world, and the sections above outline the scale of the challenges faced in managing change in such an organisation (Bevan, 2012; Bevan et al., 2013; Bevan & Fairman, 2014; Crisp, 2011; Plsek, 2003). The multiple top-down organisational changes the NHS has been subject to throughout its existence need to account for the difficulties of introducing proposed changes into a bureaucratic, hierarchical system in which professionalised roles take central stage in the day to day delivery of services (Bucher, Chreim, Langley, & Reay, 2016; Ferlie, Fitzgerald, McGivern, Dopson, & Bennett, 2013; Reay, Goodrick, & Hinings, 2016). The high-risk nature of the profession and the unique stresses that this creates both for staff and patients are necessarily reflected in the wider working context and its attendant risk-averse procedural culture (Cole-King & Leppina, 2010; Mannion et al., 2010; Nicolini, Delmestri et al., 2016).

This research took place against the backdrop of the introduction of the Health and Social Care Act (2012). The reforms instigated by this legislation were so substantial that they were famously described by NHS chief executive Sir David Nicholson ‘as so big that they could be seen "from space"’ (Triggle, 2012). The effectiveness of this massive restructuring was widely debated in the public sphere, with criticism not only surrounding the issue of potential privatisation of services but also focusing on the direction of scarce resources towards the implementation of the legislation (Holmes, 2013; Krachler & Greer, 2015; Speed & Gabe, 2013). The strong emphasis placed upon patient safety within the NHS was also central to public discourse during the time of this research (Newdick & Danbury, 2013; Traynor, 2014;

Triggle, 2017). As described in the sections above, public inquiries into care, most recently by the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), linked poor-quality care on an organisational scale to the pressure to meet both financial and national access targets.

The issues surrounding the NHS's ability to provide universal health and care services became an increasing public worry during the time of this research (Black, 2013; Wright, 2014). The global economic crisis and the following austerity policy established by the coalition government in 2010 placed unprecedented financial pressures on the NHS, which demanded that the healthcare system produced 'additional value' from already strained resources in order to continue to meet growing demand, even as public spending remained static in real terms (Vize, 2011). Despite such efficiency efforts there was a widespread agreement that the NHS would not be able to manage without additional funding (Appleby, Galea, & Murray, 2014; Taunt, Lockwood, & Berry, 2014).

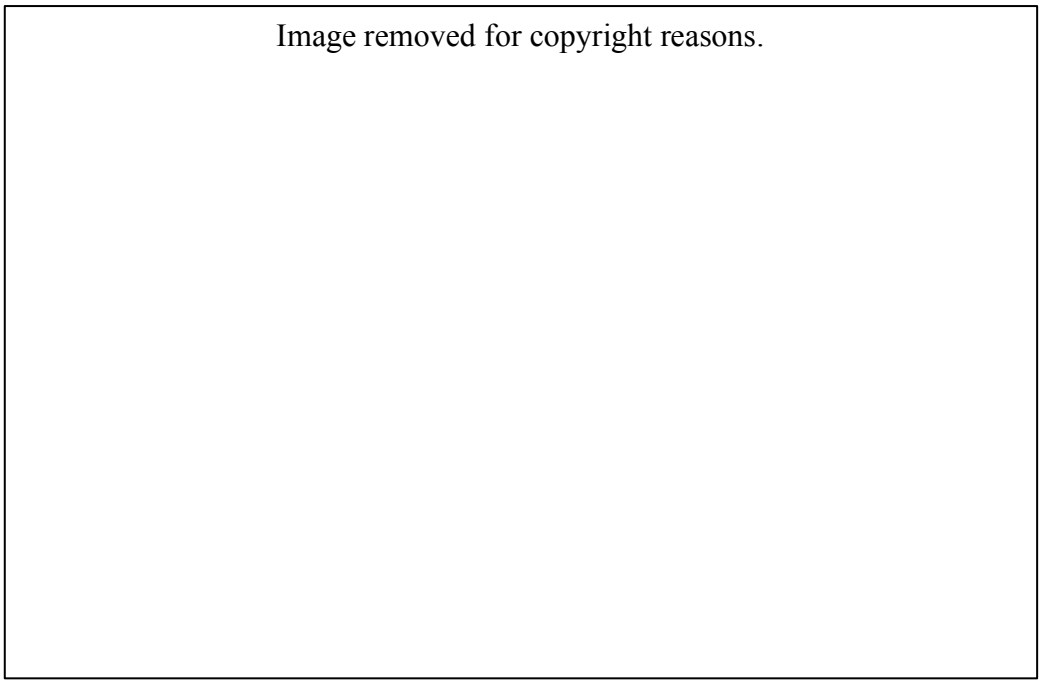
A shortfall of 30 billion pounds by 2020 was forecasted by the NHS in the Five Year Forward View published by the NHS in October 2014 (NHS England, 2014a). Although the plan emphasised the progress made by the NHS over the previous 15 years and the definite improvements instantiated by staff even in a time of austerity, it pointed out that future success was predicated on significant governmental support over the coming years in order to sustain existing services as well as develop the level of preventative care necessary to address wider societal issues, combating avoidable sickness and disease (Iacobucci, 2014a). The Five Year Forward View also laid out the goal of the NHS to give patients greater autonomy over their own care and to reforming the delivery of care, highlighting the necessity of

providing community-orientated care initiatives (Iacobucci, 2014b). The plan also stressed the need for better integration of various services such as primary and secondary care, physical and mental health, and health and social care (Maruthappu, Sood, & Keogh, 2014). The plan made a convincing argument for the necessity of additional funding in order to avert future crisis, but put forward a brutal estimate that a significant portion (22 billion) of the projected funding gap of 30 billion could be met by increases in productivity within the NHS. However, even under this idealised scenario, an additional 8 billion would have to be provided by the government (Ham, Baird, Gregory, Jabbal, & Alderwick, 2015; Pym, 2015a). The need to recoup 22 billion through increased efficiency measures placed an enormous amount of pressure on NHS staff, who for several years had already struggled under the pressures of austerity and staff shortages (Gainsbury, 2016; Webster, 2015).

This predicted deficit in NHS funding presented a challenge to which both the coalition government and the opposition parties put forward very different policies in the build up to the election of 2015 (McGuire, 2017; Vize, 2015). Despite the fact that all parties pledged to support the Five Year Forward View by giving an additional 8 billion of funding by 2020, the Labour party promised to allocate 2.5 billion over this amount in order to recruit 8,000 more GPs, 20,000 more nurses and 3,000 more midwives (Wilkinson, 2015). A key difference in the approaches presented in the election debate was made evident through the arguments surrounding the Health and Social Care Act (2012). As mentioned in section 4.1.5 the intensely debated Health and Social Care Bill was passed into law in March 2012. The reforms focused on creating a purchaser-provider split in the NHS England, which led to widespread debate regarding the privatisation of the system dominating election campaigns (Ham

et al., 2015; McGuire, 2017). In the coalition government, both parties agreed to carry on with the implementation of proposed reforms, whereas the Labour party suggested capping the amount of profit that private firms were able to make from the NHS and expressed their opposition to wider privatisation of the healthcare system (Pym, 2015b; Watson, 2015). They also suggested January 2015 in the Labour's 10-Year plan for health and care that if they were to win the next election, the party would repeal the 2012 Health and Social Care Act in its first Queen's speech (Vize, 2015).

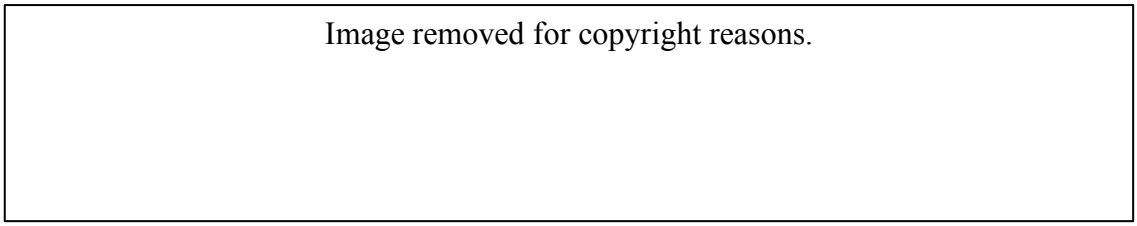
Figure 4.6



This climate of uncertainty came to the forefront in the tensions regarding working conditions within the NHS following the intervention of the Health Secretary, Jeremy Hunt, into the junior doctors' contract negotiations during 2015-6 (Goddard, 2016;

Spooner et al., 2017). The election pledge made by the Conservative party to implement a 7-day NHS was argued to be unsustainable and impractical given the existing constraints placed on the system, which was seen as being overworked and on the verge of crisis. Junior doctors protested against the proposed measures, arguing that the promise was unrealistic given the chronic understaffing of nurses and doctors, crowding of services, and the fact that many junior doctors already worked 7-day weeks (McKay & Majeed, 2016; Rimmer, 2016).

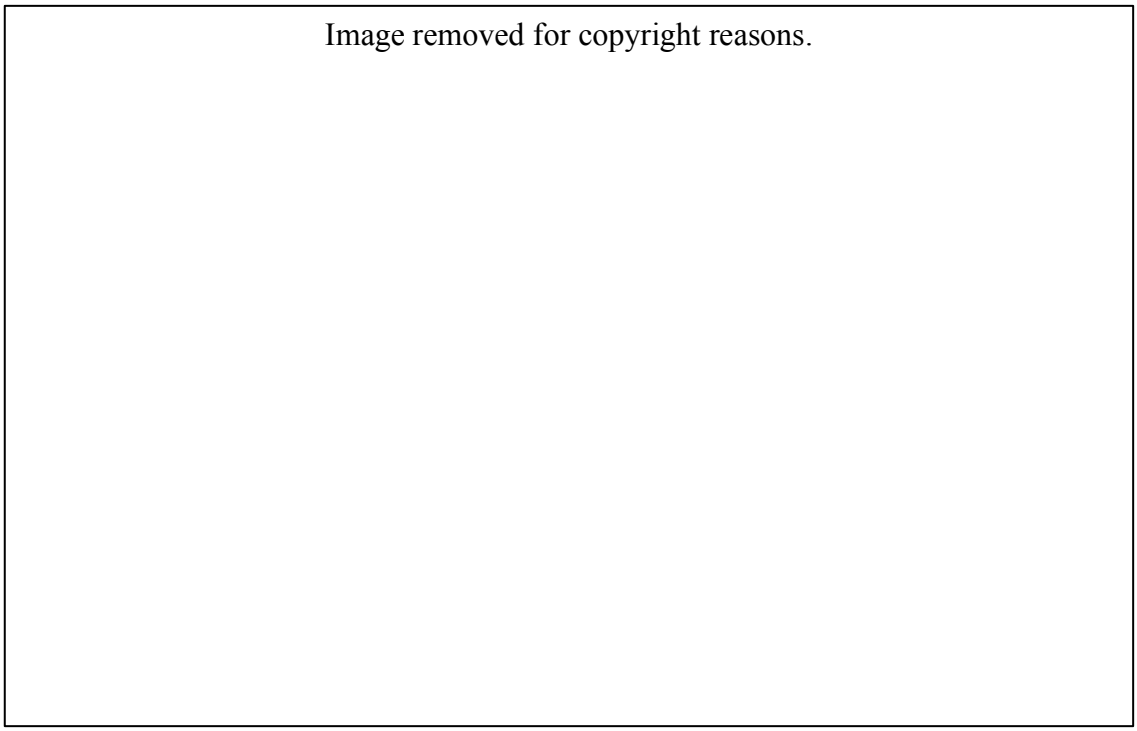
Figure 4.7



The emotions surrounding the increasing funding crisis experienced by the NHS were mobilised by the Leave campaign in the 2016 referendum on Britain's continued membership in the European Union (EU) (Godlee, Abbasi, Gulland, & Coombes, 2016; Williams, 2016). The Leave campaign heavily implied that exit from the EU (commonly referred as 'Brexit) would mean that an additional £350 million of available funding per week could be transferred from Britain's EU membership contributions to the NHS (Arie, 2016). This claim, however, was consistently refuted by the government. The results of the referendum added to the difficulties faced by the NHS by making uncertain the fates of the approximately 50,000 citizens from the European Economic Area employed within it (including over 9,000 doctors and

18,000 nurses), thus intensifying an already existing staffing crisis (McGuire, 2017).

Figure 4.8



The restriction of budgets discussed above intensified public and academic debate regarding the future of the NHS (Maynard, 2017). A report by the The King's Fund, in collaboration with Ipsos MORI, examined public beliefs regarding future funding of the NHS and found continuous strong support for the principles on which the NHS was founded, with public belief that need, rather than ability to pay, should determine access to healthcare, with 'Both younger and older groups support[ing] the collective funding of health care, appreciating that health care costs can be high' (Galea, Dixon, Knox, & Wellings, 2013, p.1). As such, conservative ideas such as paying for preferential care and means testing were seen very negatively and a potential decrease in the quality of care was completely rejected. The report found, however, that there

was some public agreement with suggestions such as user charges for '"not clinically necessary" procedures and for needs resulting from inappropriate lifestyle choices or misuse of the system'. The research also found some agreement with the notion of payments by the very rich for particular services, especially in the case of voluntary insurance (Galea, Dixon, Knox, & Wellings, 2013). Overall, public opinion as expressed in both this report and wider media overwhelmingly showed firm support for the NHS, resisting financial pressure as a cause or justification for eroding its founding values.

The following sections present an account of the emergence and development of the NHS Change Day (NHSCD) movement. They draw on and expand the understandings developed in the strategy-as-practice literature by investigating the strategizing practices of the NHSCD movement. In addition, they draw on a long tradition within the social movement literature that regards social movements as strategic actors (e.g., the resource mobilisation approach) and, in doing, so bridge scholarly traditions within organisational and social movement studies.

4.2 Strategizing Collective Action?

The concept of strategy is central to both contemporary management studies and practice (Golsorkhi et al., 2010), and is pivotal to the manner in which managerial roles are represented in the teaching of management studies, as well as in the world of practitioners and the media (Knights & Morgan, 1991). Evolving from practice theory, and therefore paying 'close attention to the work done by people inside organizational processes' (Whittington, 2003, p. 118), the strategy-as-practice (hence forth SAP) approach aims to both elaborate upon and challenge traditional strategy

management literature by studying strategy as an activity undertaken by individuals, and not just as an attribute of the company (Rouleau, 2013).

Vaara and Whittington (2012, p. 133), in their recent and comprehensive review of the field, claim that: 'To date, SAP research has concentrated on formal planning and strategizing activities […] However, emergent strategies are important too (Mintzberg & Waters, 1985) and these have received less attention in SAP research so far (Tsoukas, 2010)'. Applying a strategy-as-practice lens to a study of the strategy of social movements is therefore particularly relevant, due to the emergent nature of social movements' strategizing processes.

Furthermore, the understandings developed within the strategy-as-practice literature are broader and more encompassing than the orthodox notion of strategy, which limits its relevance to the executive world of senior management, and its associated profit margins (Carter, Clegg, & Kornberger, 2008; Whittington, 2006). In fact, drawing on Giddens' structuration theory and 'its emphasis on agency', Whittington (2010) stresses potentiality, key to an understanding of distributed agency, in terms of revealing the 'capacity of nearly everybody to make a difference' (Whittington, 2010, p. 120). Strategy-as-practice studies have therefore expanded the scope of strategizing beyond senior management, highlighting the role of middle management and consultants (Balogun & Johnson, 2005; Howard-Grenville, 2007; Jarzabkowski, 2004; Jarzabkowski & Spee, 2009; Kaplan, 2008; Mantere, 2008; Paroutis & Pettigrew, 2007; Regnér, 2003; Rouleau, 2005; Whittington, 2010, 2006).

Referring to strategy in the context of social movements may seem counterintuitive at times, as we often tend to associate the activities of social

movements, particularly when referring to political protests, with spontaneity and unexpected social dynamics (della Porta & Diani, 2006; Smelser, 1998). Yet, the application of a strategic lens has been central to social movement literature since the 1970s, when the view of social movements as political, collective entities which act deliberately, using tactical methods and unconventional means in order to obtain specific goals was introduced (McCarthy & Zald, 1977). Scholars have examined the variety of resources, including moral, cultural, social-organisational, human and material (Edwards & McCarthy, 2004), which may be used efficiently by social movements, stating that such resources are not distributed equally among social groups (Opp, 2009). Generally, resources studied are defined as 'those collective vehicles, informal as well as formal, through which people mobilise and engage in collective action' (McAdam, McCarthy, & Zald, 1996, p. 3). Yet, this economically centred, resource based approach, addresses the strategy of social movements centring its analysis on either the movement, or on the social movements' organisation (SMOs) as the unit of study (Opp, 2009; McAdam et al., 1996), an approach, which has been subject to criticism in literature (Cohen, 1985). Subsequently, the framing approach, which focuses on the manner in which social movements mobilise ideas has been central to contemporary social movement literature (Benfort & Snow, 2000). Social movements' framing efforts have also been defined in strategic terms as 'conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action' (McAdam, et al., 1996, p. 3). The framing perspective is discussed in length in Chapter 7 of this thesis.

As highlighted in the introduction to this thesis, there have been recent calls

for further empirical studies to advance the cross-fertilisation between organisational studies and social movement scholarship, highlighting the potential contribution of grassroots activism in addressing challenges faced by large organisations (see, for example, Bate, Bevan, & Robert, 2006; Bate, & Robert, 2010; Bate, Robert & Bevan, 2004; Carnall, 2007; De Bakker, Den Hond, King, & Weber, 2013; Dubuisson-Quellier, 2013; Haug, 2013; Munro, 2014; Soule, 2012). The intention of this account is to contribute to this evolving contemporary corpus of work through the particular lens of the strategy-as-practice tradition (Johnson, 2007; Whittington & Cailluet, 2008; Whittington, Molloy, Mayer, & Smith, 2006). Specifically, the goal is to expand the understanding of strategizing in organisations beyond the context of formal planning within managerial settings to encompass the performance of strategic practices within a social movement framework (Dobusch & Kapeller, 2013; Stieger, Matzler, Chatterjee & Ladstaetter-Fussenegger, 2012).

4.3 The NHS Change Day Movement

In constructing this section, I drew on more than 200 hours of field participant observations (during 67 meetings and events) and 400 hours of social media observations. This section also draws on a long and extensive engagement with the movement's leaders and activists via personal and group email correspondence (including more than 800 emails). The aforementioned data was mostly collected over 18 months (June 2013 to November 2014), during which in-depth field research was conducted. However, the collection of data from these sources carried on until after NHSCD 2016. The presentation put forward in this section also draws on the review of 32 media articles (Appendix 6.2), which were purposively sampled from a survey of 389 media articles featuring NHSCD (Appendix 6.1), as well as the review of more

than 50 movement artefacts (including hard copy and electronic leaflets, flyers, posters, logos, etc.).

My presentation of the emergence and development of the NHSCD movement is organised in narrative form. This linear, 'timeline' representation is based on the first level of analysis, which was conducted using the data corpus of 32 in-depth interviews, 100 'Stories of Change' and 9,479 pledge narratives. In this analysis, I identify five key periods and events in the evolution of the NHSCD movement that are used to structure this section (see diagram 3.1; see also Appendix7.1.1).

Relevant quotes from the various data resources described above, together with quotes from short walk-in interviews conducted during time in the field, are interwoven in the text. Where such quotes draw on publicly available data, such as a media article, reference to the source is provided. Participant observations, interviews, and non-publicly available field data is anonymised. When, however, NHSCD data was specifically made accessible to the general public, as in a published media article or open access website, words and opinions are attributed to their authors.

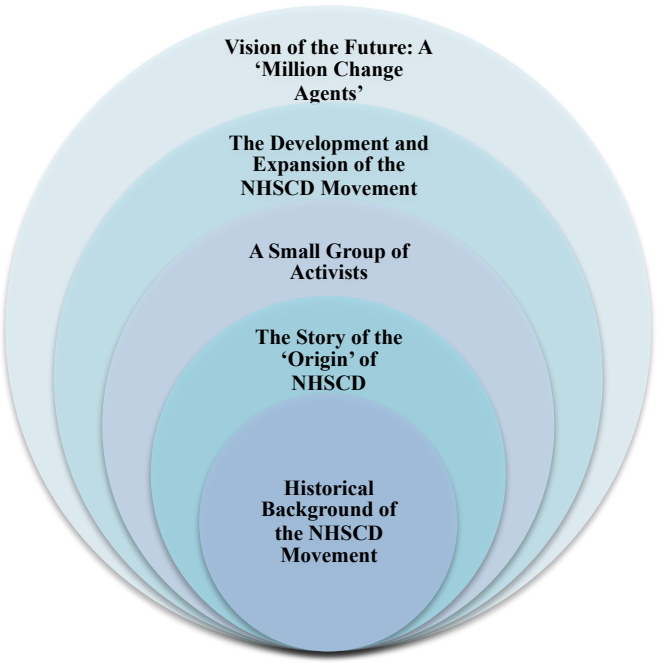
The participatory nature of in-depth field observations is core to the synthesis of the data collected and as such it implies a personal account of events. This chapter does not, therefore, presume to present an 'objective' truth regarding the development of the NHSDC movement: a different researcher might have focused upon an alternative perspective on the field, and would have synthesised the data in a different manner.

The account presented in this section introduces five key periods or stages in the emergence and development of the NHSCD movement:

- ‘The historical background of the Movement’: a decade-long period which preceded the emergence of the NHSCD movement, during which the idea of strategizing a social movement for healthcare improvement was deliberated by a small number of leaders within the NHS.
- A ‘defining moment’: A widely circulated story of the movement’s origin.
- ‘A small group of activists’: The initial stages of the movement’s development, particularly during the build-up towards the first NHSCD.
- ‘The development and expansion of the movement’.
- A vision of the future’: A ‘Million Change Agents’.

The accounts describing the emergence and development of the NHSCD movement are organised in the form of a linear narrative presentation. The account describing the emergence and development of the NHSCD movement is, however, better read and understood as a non-linear story as shown in Figure 4.9:

Figure 4.9



4.3.1 Historical Background of the NHSCD Movement

Participants described how a movement for healthcare improvement existed as an idea long before the emergence of the NHSCD. The search for a paradigm through which to facilitate agency for change on a large scale within the NHS was first expressed by leaders from the NHS Modernisation Agency over a decade ago. This Modernisation Agency was a national change body within the NHS and was established in 2001. A member of the core leadership team described in an interview how a particular focus on 'radical thinking about change' led to the inspiration for the idea of building a movement of a 'million change agents' (Bate et al., 2006):

> At the time I talked to my boss, who was X, and we talked about how do we build a movement of a million change agents, how can we create a situation where everybody in the NHS is a change agent? (NHSCD founder)

I was told by a member of the Core Leadership Team that in order to translate this thought further into practice, a project involving a senior practitioner and academic scholars began to investigate social movement thought, and the practicalities of putting it into action within the context of the NHS. This process was described as a synergy of academic and practical perspectives. Interviewees described how these thought processes developed organically as they resonated and were subsequently shared and shaped within the world of the NHS. This stage of the process was described as generating a lot of interest and enthusiasm.

> [...] So we started to work with these ideas and whoever we talked to in the NHS – people loved these ideas and could see the relevance of them. [...]we held an international meeting where we just got a whole load of social movement thinkers to come over from the States – like Zald and really, really key thinkers – they all just came for free because they were interested in what we were doing and wanted to have a conversation with our practitioner community. (NHSCD founder)

It was within this climate, and specifically within the NHS Institute for Innovation and Improvement, that attention started to be given to the issue of building a more

practical toolkit. In 2009, the NHS team responsible for examining the relevance of social movement thinking to mobilisation within the NHS began to introduce ideas from the field of community organising. This work was done in collaboration with a team from Harvard's Kennedy School, led by Marshall Ganz (Ganz, 2010; Ganz, 2008; Taylor, 2009). This process was described to me by several interviewees as formative in terms of translating hitherto abstract concepts into practice. This phase was, however, also described as creating critical tension, as the methodologies and concepts of community organising were initially delivered 'in a very purist community organising way'. An interviewee described how these methodologies required adaptation: 'what we were doing is that we were working in a hierarchy, so in a sense how do you make these ideas relevant in a hierarchical context?'

Figure 4.10

(Image taken from NHS Improving Quality resources)

There were several initiatives which prefigured the launch of NHSCD, and which applied the shared methodologies that came under the NHS title of 'Mobilising and Organising'. These included a headlining project, which examined the prescription of

antipsychotic drugs for dementia patients (Boyd et al., 2013). Significantly, these projects drew on learning developed in collaboration with Ganz's team and were designed to implement 'those tools and techniques to mobilise and change behaviours within existing groups in the NHS'. This experience of learning and implementation was described as an interactive process: 'What they taught us was so invaluable, and there would never have been a Change Day without it, but what we were able to do was to blend it, which was really important'.

4.3.2 A 'Defining Moment': The Story of the 'Origin' of the NHSCD Movement

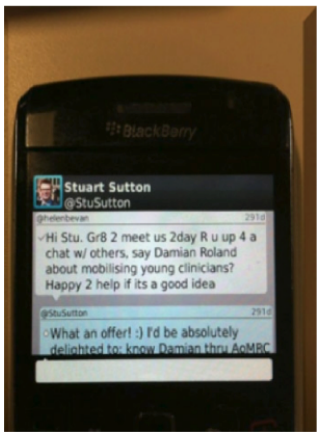
It is common for social movements to celebrate a story that describes a moment of genesis, or a narrative inversion imperative to their existence, emergence or success. These stories capture and articulate elements of the movement's wider narrative construction and can be understood as an integral part of the framing process, often encapsulating the essence of the movement's collective action frame. In doing so, they act as catalysts: important narrative moments that are capable of motivating participants to action (Benford & Snow, 2000; Ganz, 2008). Within the NHSCD movement, activists circulated a story that described how a Twitter exchange between a young doctor, Damian Roland, GP Dr Stuart Sutton and the Chief Transformation Officer with NHS Improving Quality's Horizons Team, Helen Bevan, was formative for the movement (Steen, 2014). This interaction developed into an exchange of discourse and ideas regarding the potential impact of small-scale changes, if enacted collectively, on the future of the NHS (Bevan, 2013; Bevan et al., 2013). In their interviews, movement founders described how this exchange took place against a general sense of disorder and chaos within the NHS and included discussions about

the possibility of overcoming their 'learnt helplessness' and introducing positive change through collective action:

> Yes. So NHS Change Day 13, I guess, started as a result of a conversation I had with X, who's a paediatrician and the other co-founder, and Y [...]. And that must have been around September/October time, 2012. And I think probably I had got involved as someone who was quite cynical initially, [...] I think we have this thing of learnt helplessness sometimes... that we feel like we can't make change, we can't alter the situation we find ourselves in, particularly as junior doctors, but more widely perhaps in the NHS [...] Y then sent me a tweet message a couple of nights later. It said, why don't we get together and talk with X and see if there's anything we can do about mobilising and getting this energy that's out there converted into action. (An NHS GP)

This story of the NHSCD's moment of origin was of critical narrative importance and occupied a symbolic performative space within the collective psyche of the movement. The moment of creation, or self-determination, will be cited again in a variety of different contexts, continually employed as a relevant animus within the overarching project.

Figure 4.11



(Image taken from Bevan et al., 2013)

4.3.3 A Small Group of Activists

Participants further describe how the initial ideas of this founding conversation were taken up with enthusiasm by a small group of activists who launched NHSCD shortly

afterwards in winter 2012 through NHS Improving Quality, a body that has been involved in coordinating many of NHSCD's activities (NHS England, 2014). This allowed the further development of the initial ideas of the founding conversation into a wider exchange of discourse and ideas regarding the potential impact of collective small-scale changes on the future of the NHS. One of the founding members of NHSCD described this process as inspired by watching videos from another social movement called Earth Hour, which mobilised participants to collective environmental action, along with other influences such as initiatives from Children in Need and Comic Relief's Red Nose Day:

> [...] we'd watched the Earth Hour video and were mulling over how we could use that type of approach and develop that into something that would be suitable for the healthcare and someone was talking about well, in Comic Relief and in Children in Need you often pledge to do something at a particular time and I think that's where the concept of pledging came from. (An NHS Doctor)

These activities occupied a singular calendar day or time, and part of their appeal consisted of their yearly repetition: participants were able to concentrate their energies and express their ideas within a specific temporal context. This made the concept of sustained change more accessible and less intimidating by rendering it into smaller, more achievable events. The idea of NHSCD drew on a critical consideration of annual change events such as these, and sought to address the crisis within the NHS through a series of small individual and grassroots-led actions and initiatives:

> And from that we had a telephone conference call and pushed around a few ideas. We thought about a quality group a week, we thought about QI day – quality improvement day – and then we said why... together, we said look, why don't we have a day where we get people from all over the NHS to make one small change to improve what we're doing and the quality of care we give to patients? (An NHS GP)

In an article published on the 10th of January, 2014 in the *Guardian*, Pollyanna Jones, a member of the NHSCD founding team, described how these initial ideas were

further solidified through discussions led by a small group of activists:

> It started when a small group of us got behind an idea to "make a pledge, a commitment, to do something better, to improve patient care". We asked others around us to join our mission. To take the opportunity to come together and empower each other to make the difference we wanted to see for our patients and show everyone what a brilliant thing our NHS is. (Jones, 2014)

The group of activists who initiated NHSCD were mainly volunteers who devoted their time to leading the movement and building the first NHSCD campaign. In an article published in the *Guardian* on the 31st of January 2014, the leadership of this emerging process and the philosophy of the movement is described:

> The first NHS Change Day took place in March 2013 as a concept that sprang from frontline staff. It has been described as the largest ever health and care social movement, and one of the unusual aspects of this grassroots movement is that it has no single figurehead but aims to make healthcare staff themselves leaders of change. (Rutter, 2014)

This was, however, not without difficulties. The challenges of setting up a volunteer-led, large-scale event within the context of an already crowded organisational life were complex. The following quote describes some of the initial struggles of the NHSCD movement:

> […] we had a running start. So we started from 0 to 60. So around October/November time, if I remember rightly, that people were getting set up with Change Day. We had no team, we had no support. We didn't really have anything. (An NHS Doctor)

Figure 4.12

(Image taken from NHS Improving Quality resources)

4.3.4 The Development and Expansion of the NHSCD Movement

NHSCD core activists engaged a vast quantity of people through participation both in the creation of the movement's basic infrastructure and through outreach events that encouraged potential participants to connect and invest in the movement's spirit. The story of the NHSCD was widely circulated throughout the organisation using a wide range of mobilisation platforms (see Figure 4.14). The movement used both physical and virtual platforms to engage participants in its practices, enabling the mobilisation of a large spectrum of stakeholders by transforming these spaces into inclusive and interactive events, as seen in the inflected construction of the Change Day movement's dialogue, which typically revolved around ideas of community and positive change. The NHSCD movement utilised physical platforms for the mobilisation process, both in the public sphere as well as within the NHS domain, such as meetings and events aimed at a range of people, purposes and goals, which

enabled face-to-face interaction and communication between participants. Additionally, the movement relied on numerous virtual platforms of communication and interaction to facilitate communication between participants, including the creation of an official website for the movement, as well as accounts and pages on an array of social media:

> […] We have a WhatsApp group, and that's where most of our conversations happen […] there're about 30 of us on the group and we just all converse […] We share resources, share what we see. A lot of us are inspired on Twitter. Twitter is the main way we use to communicate, apart from that. We have a weekly phone call on Tuesday evenings. It's completely optional because it's volunteering, and people can just drop in […]. We've had a Hubs Away Day where people all presented what Change Day meant to them and what they were doing in their region. It wasn't like a normal away day when you put loads on the agenda; we had one thing on the agenda, which was to come up with a plan for Change Day and for each individual person and what it meant to them. (An NHS Manager)

> On Wednesday 11 February, with exactly one month to go, NHS Improving Quality, which includes the team who supports NHS Change Day, will be hosting a daylong event at Skipton House, where many of the organisations that support the service are based. The day is both intended to promote the concept of NHS Change Day to these staff and bring frontline NHS staff into the building to explain the value of Change Day. Our 'takeover' event will feature a number of doctors, nurses and other NHS staff from a range of disciplines given the opportunity to talk about their experiences directly to staff based at Skipton House. (Story 28/ 100, '100 Stories of Change)

Events that allowed participants to contribute to the central aims and imperatives of the original call for action revolved around the creation of a platform for dialogue and the free exchange of ideas, whilst events that encouraged participants to engage on an emotional and imaginative level employed physical theatre and fantasy as a means of communication. Symbolism played an important role in the development of the NHSCD movement and was created and used to promote the central cause. This can be seen in the slogan 'Do something better together', the symbolic meaning of the event 'occupying' a day in the NHS annual calendar, as well as the symbolic use of physical spaces in its events. For example, on 25th February, 2014, Trafalgar Square in London was used as a platform with beds, patients, volunteers and frontline NHS staff to perform a 'mock hospital', stating that their goal was 'to encourage Londoners

to make an NHS Change Day pledge to "give up at least an hour of time volunteering to help their local health and care services"'. (Royal Voluntary Service, RVS website, 25th February, 2014)[9].

> I was involved in a photo shoot in Trafalgar Square with X, where we sat in a patient bed, and had pictures taken of us; that was to try and drum up PR interest. [...] it was really interesting, because although I sat in the bed for 30 minutes, there were some times when people were sitting next to me, again, for the camera, but they were talking amongst themselves, and being in there, the patient experience, I was, like, that's not really nice when you've got doctors or physicians talking over you (A member of the Core Leadership Team – an NHS Quality Improvement Leader)

The movement's official website changed and developed in each consecutive NHSCD campaign year, a process through which lessons learned and feedback collected resulted in improvements and redesign of the website. Similarly, as the movement developed and participation experience accumulated, these insights were incorporated into the ongoing development of the movement's activities.

> I went a different way round with things. I believe the public should have more ownership. I've got a local music band that did a pledge […] I'll send you photos because they went mad on Twitter, and they pledged to discourage crowd surfing to save A&E the trouble. I had the local councilman, pledge for me, got the photos, and they pledged to help keep the roads clear for the ambulances. (An NHS Sister)

The NHSCD movement employed the press media as a means of self-publication, and the activists used these platforms to spread the idea of participation beyond an internal audience of healthcare staff, encouraging widespread participation through the idea that the general public should be active in the movement. The press and social media strategy employed by the NHSCD activists was an effective means for the sharing of knowledge, paving the way for the implementation of changes in the real world. In an article published in BBC News Health, for example, an interactive call for

[9] See video https://youtu.be/p8iCfts-mfE

participation is explicitly stated[10]:

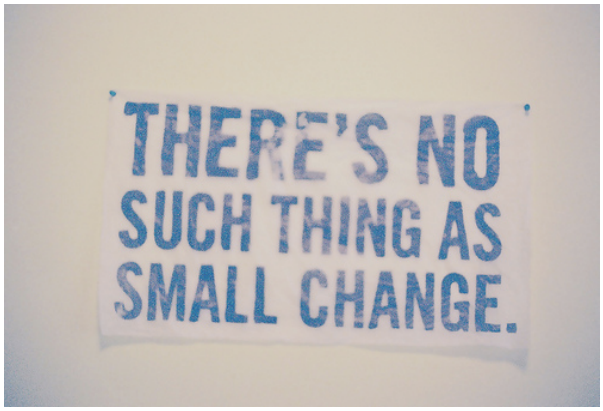
> If you work in the NHS and are planning to make a pledge, the BBC would like to hear from you. […] tell us about your pledges before Monday 3 March. If you would like to be interviewed by a BBC journalist, please include your daytime telephone number in your message.

The main characteristic of the movement's appeal and expansion was, however, its establishment and utilisation of activity platforms for the mobilisation of groups and individuals. The main formal activity of the NHSCD movement was to invite NHS staff, as well as the public, to pledge and fulfil personal and group change initiatives, with the aim of bettering practice. The movement's 'pledge engagement tool' was further developed as an activity platform of 'storytelling', a unique feature that came to characterise participation in the movement. The activity of pledging was the key means by which initiatives of change and knowledge were shared and translated into potential action, with the practice of storytelling adding an additional dimension to the process, and completed pledges providing concrete examples of change implementation.

> It's about getting ideas out there, a cross pollination of the ideas as well and I thought the Pledge Wall was an absolutely brilliant idea and you can scroll through it, look for people that you recognise or people who look interesting or organisations that you feel some affiliation with and look at what they're doing. You can also search for it on a town by town basis and again, there's stuff there that you may or may not agree with, but there's stuff that you want to get involved with. (An NHS A&E Doctor)

[10] http://www.bbc.co.uk/news/health-26379303 (See also BBC News Health (2014a, March 3) and BBC News Health (2014b, March 3)

Figure 4.13



(Image taken from NHS Improving Quality resources - Story 91/ '100 Stories of Change')

Furthermore, as part of their participation in the movement, NHSCD's participants and activists generated a wide range of artefacts that articulated the meaning that they attributed to participation. These artefacts, in turn, encouraged further performances from those who would later view them. The processes through which artefacts were produced were, themselves, a collaborative endeavour:

> Most of the hub leads start with their own organisation, and the way I found it most effective to do this is to make my own pledge and to put that up on my desk at work and then people see it and ask questions about it. (An NHS Manager)

The production of these artefacts was a gradually emerging process, generated both by the grassroots and from the overarching aims of the NHS Improving Quality leaders. These artefacts were not just static records but, due to the types of technologies involved, continued to exert the power and meaning of the original social performance. Videos uploaded to YouTube could be replayed many times, to different audiences, and the pledges and quotes uploaded to the official website provided continuing inspiration. These methods ensured the enduring relevance of the artefacts and the technological extension of a single speech act. The NHSCD movement constantly posted podcasts to a specific NHSCD channel on YouTube,

where they could be seen by members of the public, and they continue to engage people through the virtual platforms of the internet.

In other cases, the artefacts produced by the movement, whether locally or nationally, contained messages that were only relevant to a single situation. In order for their messages and the performativity to continue to resonate with both larger and local organisational cultures, a further process of updating, generalising or specifying their content was required.

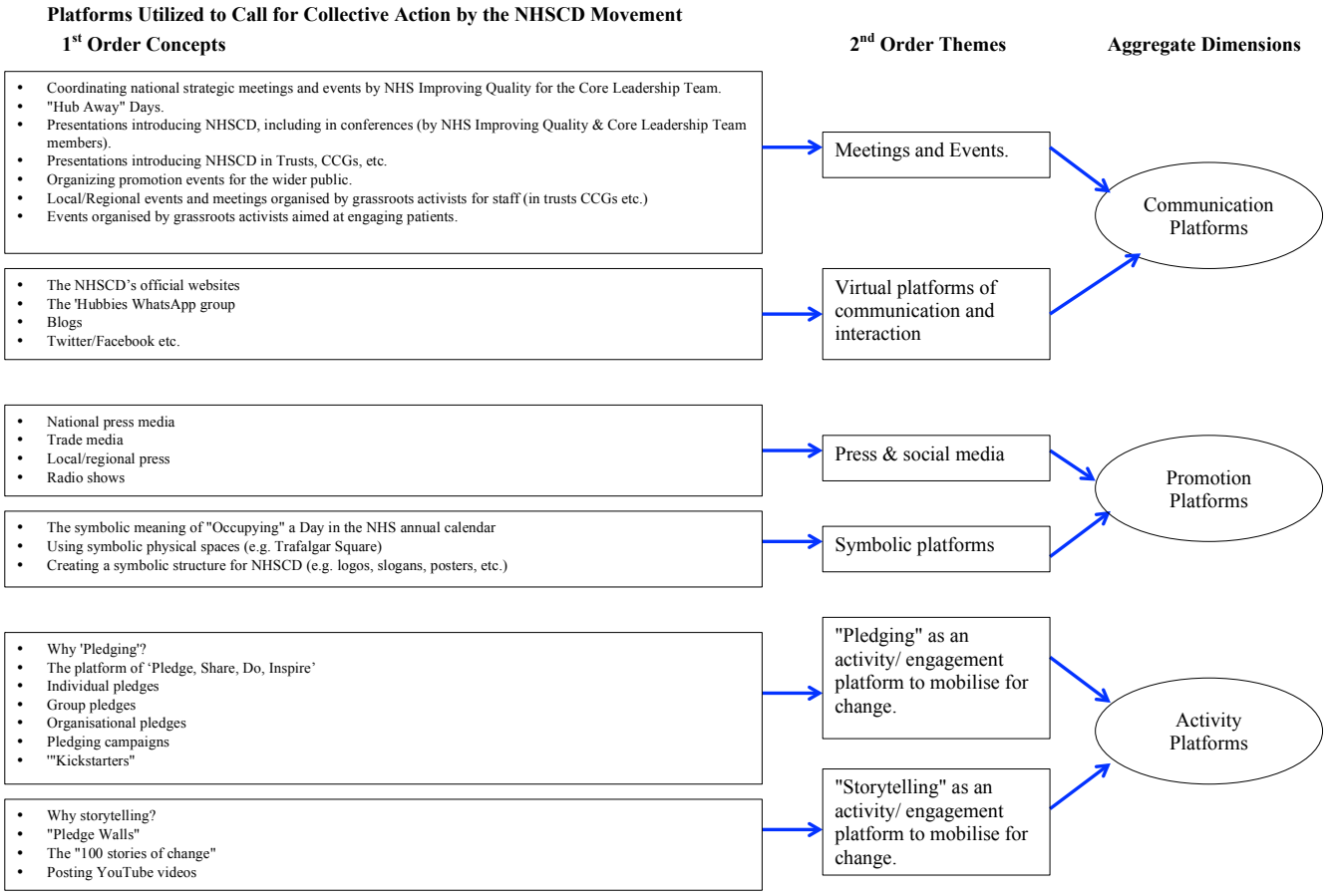
> […] we send them posters that they can print out and put in and around the hospital, but again what we found was that they didn't like pictures of generic nurses or generic doctors – they would cut out the pictures of the patients or whatever we put there, and they would paste their own staff – because that's what the staff wanted to see. If they saw a nurse that wasn't from their hospital, then they didn't like Change Day and they didn't get the message. So that's what we had to start doing, to kind of tailor the message. (A Hubbie)

> Yes, one of the challenges was, when producing something, you would always understand it in your small group, the person that was at the event or filming the piece; we understood what was happening. But then it was hard to illustrate that to our viewers. Would they understand what we were trying to make? (An NHSCD Activist)

The lasting effect of the various records and artefacts produced during the NHSCD's campaigns was essential to the ongoing mobilisation of the movement. The collation of pledges, testimonies and visual artefacts on the official website was, for example, an organising impulse that gave these fragmented individual efforts the authority of a sanctioned ideology or vision, which will be described in the next section.

Figure 4.14

4.3.5 Vision of the Future: A 'Million Change Agents'



The overarching vision unifying participants' accounts is one of making a difference to the quality, safety and experience of care in the NHS, and it is within the context of this that participants define their individual visions in opposition to the problems that they are hoping to resolve. Such issues included, for example, problems with waiting times, underfunding, overwork, endemic bullying, transplant shortages, patient safety, communication between staff, communication with patients and their families, barriers between different professions, a hierarchical and rigid system, prejudice, and unequal access to services by all patients:

> Lincolnshire is a huge county and in the past certain areas have received more speech and language therapy sessions than others making for an inequitable service delivery. This has caused stress for both staff and patients and their families. (Story 5/100, '100 Stories of Change')

> More than 10,000 people in the UK currently need a transplant. Of these three a day will die waiting as there are not enough organs available. (Story 33/100, '100 Stories of Change')

> I identified that there was a need to address endemic bullying in the NHS... (Story 8/ 100, '100 Stories of Change')

NHSCD's participants envisioned a reality in which their actions would count and be able to make a difference, influencing the areas that they were passionate about:

> I suppose it's often the people, the passion, of making the difference to the NHS. When a group of people come together who have got this great idea of making significant change in the NHS, that's quite interesting to me, and so I'm naturally interested in engaging with people who are interested in making large-scale change and involved in change per se. (An NHS Project Manager)

An image of future growth was key to the conceptual landscape of the NHSCD movement, as participants envisioned organisational change as a cumulative process in which the individual-led work of small changes would eventually come together to form a lasting change in the organisational culture. In many ways, the NHSCD movement can be seen as future-oriented, with the importance of change as a lasting motif continually highlighted by participants:

> If Change Day continues to develop and grow over the next couple of years, I think really by 2016-18 we may be delivering things that are having a real impact on patient care because so many people are getting involved in doing small things simultaneously. (An NHS Doctor)

The following image exemplifies the future-oriented drive of the NHSCD movement:

Figure 4.15

(Image taken from NHS Improving Quality resources)

This emphasis on the value and importance of the individual and their ability to have an impact and make a contribution was also the impetus driving the vision to create and bring together like-minded communities, which embody the central ideas of the movement. As such, the focus is on the freedom of the individuals within the organisation to exchange ideas and methodologies. In the example given below, a complex and specialist medical procedure is explained to children through the use of an interactive performance, expanding the notion of participation in the NHSCD community to the wider public, including children:

> The children 'radiographers' wore a special lead apron, they then placed their teddy bears on the X-Ray table and took mock images of their soft toys' hearts. The young patients were rewarded with certificates after completing their duties. Helpful staff were on hand to talk about the specialist areas in radiography and qualifications needed, and they gave visitors a tour of the X-ray rooms and demonstrated an ultrasound examination. […] The teddy bear chest X-rays gave our young patients a good understanding of what a radiographer does and it made radiography appear less frightening because they were able to get their hands on the equipment and take mock images of their teddy bears. (Story 75/100, '100 Stories of change')

The idea here is of radical inclusionary politics: a push towards grassroots, community-oriented engagement is displayed through an effort to educate and include the youngest members of the population, reducing their anxiety about these medical procedures and thus improving the experience of patient care for the children over the

course of their lives as NHS users, and simultaneously improving the situation for staff. The notion of a community of like-minded change agents aspiring for a better future was also linked to the idea of change as a creative process of improvisation. One of NHSCD's core leaders used the metaphor of an improvised performance in which the actors do not adhere to a pre-written script, but rather create as they go along to capture this idea:

> […] you're not quite sure, but you have an infrastructure or you have a framework, it's almost like a stage. It's like you don't know what's going to happen, you're not quite sure. Are the audience going to respond to it or not, are they going to throw tomatoes […] You make a few hard places, but the things that you really need to pay attention to are the soft things that are in between the hard places […] these are your hard places, so this one is a website, let's say, this one is some event that you're going to put on. But actually what happens, that flows through all of this is, is all this wonderful stuff […] it's almost like a theatre piece, so you have a script, but actually you say to people, you can adlib, and the best plays and the best actors are... because as change agents, we are actors, and the best people who do it is that they have a script and you know what the script is, and you know that actually the hero comes to the rescue at the end, but actually how you get there, you need to leave people to say how you get there. (An NHS Senior Improvement Leader).

The movement's vision for the future of the NHS was also expressed through the production of various artefacts, as described in the section above. Many of these artefacts resulted from the implementation of pledges that sought to rectify gaps in the system of teamwork, as well as of patient care, and embodied participants' vision of how such problems should be addressed, as in the example below:

> And the second one is also to do with the Child Development Centre, which is to create a storyboard which explains to autistic children what their care pathway is. At the moment our autism waiting list is about two years, before you can get a diagnosis. It's just horrendous and a lot of people feel like they're dropping out of the system. They don't hear back, they don't get an acknowledgement letter about when their appointment is. So the storyboard is to show who you might meet, where you might meet them, what you can expect, who you can contact, but all in child friendly writing, with pictures and things. (An NHS Graduate Management Trainee)

4.4 NHSCD: Facilitating Prefigurative Settings within Organisations

The features of NHSCD as described in this section are discussed in current literature as paradigmatic of prefigurative social movements. This section demonstrates how the NHSCD movement embodies these key characteristics (see figure 4.16). Prefigurative social movements are defined through their challenging of previously established structures and value systems through the activist-led enactment of alternative realities: the emphasis placed by prefigurative politics on the idea of 'enactment' highlights the necessity of aligning ideology to action (Leach, 2013). In doing so, prefigurative movements bring their goals for the future forward into the present (Yates, 2015). The NHSCD's call to action stresses the importance of the enactment of self-initiated small-scale changes. Moreover, the key slogan of the movement, 'Do Something Better Together', shows how the core message of the movement calls for collaborative rather than structured thinking. Prefigurative movements enact this performance of alternative political realities and this is seen as presenting a strategy for the transformation of the distribution of power (Maeckelbergh, 2011). As Cornish and colleagues (2014) describe in the case of the Occupy movement:

> [...] the movement not only offered a critique of the global political–economic system, it also instantiated an evolving alternative: a means of doing participatory politics through consensus-based decision-making in 'general assemblies'. (Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014, p.63)

The NHSCD movement's emphasis on the agency of frontline staff resonates with the direct democratic approach of prefigurative movements (Western, 2014). The NHSCD activists placed a similar importance on the idea of public participation, and also emphasised the importance of small-scale, bottom-up changes associated with prefiguration, contrasting these with the large top-down change programmes typically

linked with organisational reform (Cornish, Haaken, Moskovitz, & Jackson, 2016). Activists performing within prefigurative settings create new spaces for change, practice, dialogue and distributed or horizontal leadership (Maeckelbergh, 2012; Western, 2014). Similarly, the NHSCD movement opened up new dialogic spaces through the developing of a distributive leadership model (most notably seen in the case of the 'Hubbies') drawn from all layers of the institutional hierarchy. Volunteers took on particular roles suited to their individual skill sets, but there was no correlation between seniority within the NHS and the influence that individuals held within the social movement.

The ephemerality and space of digital communication has played an important role in both the development and maintaining of prefigurative social movements, and this type of communication, via social media platforms and instant messaging apps, is often seen as an alternative or challenge to established, hierarchical means of organisational communication. Following this model, much of the NHSCD movement's communication took place via digital interfaces (Juris, 2012). Moreover, a key characteristic of contemporary movements is their use of space and/ or time as a platform, which is 'occupied' and used to exemplify and enact their message. The physical and metaphoric use of space by prefigurative movements resonates with the symbolic 'occupation' of time in the NHS working calendar by the NHSCD. This celebration of the movement's cause through an annual national campaign which is subsequently transformed into a continuous or repetitive temporal platform, a designated space in time in which the performance of the original emotional imperative or desire can be re-performed by a host of new actors, echos the activities

of other social movements such as the Red Nose Day campaign by Comic Relief[11].

Figure 4.16

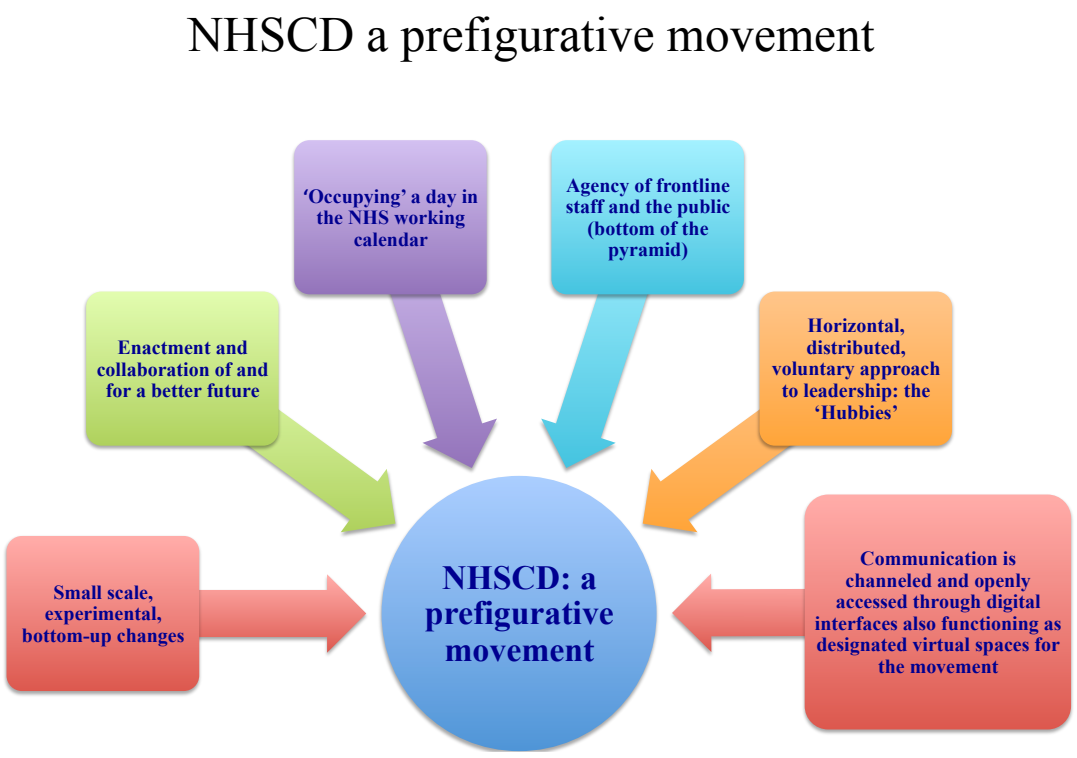


Figure 4.17 captures the NHSCD movement's most notable prefigurative feature through the image of a child with one of the central messages of the movement drawn across their feet. This image clearly conveys the future-oriented drive of the movement and the hope of participants that the changes introduced by NHSCD will last. The pairing of the image with the caption of the NHSCD Global Campaign shows the aspiration of the movement to impact healthcare beyond the borders of the United Kingdom: the child is made to symbolise the hope of free and accessible healthcare for all. For participants within the NHSCD movement, the idea that the

[11] See website https://www.comicrelief.com/rednoseday

changes introduced and enacted in the present would continue into the future was imperative; so, too, was the idea of a radical inclusionary politics that would open up the institution as a whole to all social groups. Furthermore, the image of a child – commonly associated with both vulnerability and futurity – ties in to the greater purpose of the movement, which was seen as protecting the existing NHS against a tangible threat, thus preserving the organisation for future UK citizens.

Figure 4.17

(Image taken from NHS Improving Quality resources)

The notion of NHSCD as a prefigurative setting for change is further explored in the four papers included in this thesis (Chapters 2,5,6, & 7) and is particularly prominent in Chapter 2 and Chapter 6.

Chapter 5 Logic of Care: A Grassroots Perspective on the Microfoundations of Change in Institutionalised Practices in the NHS.

Abstract[12]

The growing interest in social movements and how they explain the emergence of institutional change is opening up new research opportunities for contemporary organisational studies. Following this evolving trend, this paper examines the micro dynamics by which the bottom-up enactment and narration of change in day-to-day practices introduce alternatives to established practices and disrupt taken for granted institutional beliefs. In particular, the paper investigates the ongoing construction of meaning by activists in the English National Health Service (NHS) Change Day (NHSCD), a social movement engaging stakeholders to improve working practices within the NHS. The paper is based on the thick description of a qualitative research project conducted over a period of three years. The data corpus includes narrative data from 26 interviews, 100 activists' online published 'Change Stories' and 9,479 'Pledges'. The findings illustrate a bottom-up approach to the investigation of the emergence of institutional logics in practice, as multiple embedded actors purposefully enact the simultaneous implementation of micro small-scale changes in everyday working practices across social levels. This paper contributes to the literature by illuminating an empirically understudied process: the complex and two-

[12] Preliminary findings of the analysis conducted in this chapter were presented and discussed on the 21st of June 2017 in the Pre-Symposium Professional Development Workshop of the Ninth International Symposium on Process Organization Studies.

way dynamic between micro and macro levels of change to institutional logics, which both generates and is generated by the process of collective action.

Key words: social movements, collective action, institutional logics, working practices, English National Health Service

Introduction

The growing interest in social movements and how they explain the emergence of institutional change is opening up new research opportunities for contemporary organizational studies (Bauer, 2015; Davis, McAdam, Scott, & Zald, 2005; Davis & Thompson, 1994; Hambrock & Chen, 2008; Huag, 2013; Quinn & Worline, 2008; Rao, Morrill, & Zald, 2000; Sutherland, Land, & Böhm, 2013; Willmott, 2014). Recent calls have asked for further empirical studies to advance the cross-fertilisation between organisational studies and social movement scholarship, highlighting the potential contribution of grassroots activism in addressing challenges faced by large organisations (see for example: Bate, Bevan, & Robert, 2006; Bate & Robert, 2010; Bate, Robert & Bevan, 2004; Carnall, 2007; De Bakker, Den Hond, King, & Weber, 2013; Dubuisson-Quellier, 2013; Haug, 2013; Munro, 2014; Soule, 2012). Advocating for the need to construct a unifying conceptual framework, scholars have claimed that institutional change can be brought about both by external social movements and movements internal to the institution itself (Schneiberg & Lounsbury, 2017, see also Campbell, 2005; Davis et al., 2005; McAdam & Scott, 2005; De Bakker et al., 2013). External movements push for change by challenging institutions through their opposition to particular measures and frames, questioning the legitimacy of the institution, whilst movements which emerge internally ‘promote path creation

and change incrementally by engaging in institutional processes (or becoming institutional forces)' (Schneiberg & Lounsbury, 2008, p. 656). Health social movements, which are internal to healthcare organisations, are a particularly prominent, yet under-researched example of this process (Levitsky & Banaszak-Holl, 2010).

This paper explores the role that individuals and small groups (e.g. actors) that participate in grassroots activism play in the initiation, enactment and disseminating of change in institutionalised practices (Briscoe & Gupta, 2016; Hensmans, 2003; Schneiberg & Lounsbury, 2017; Strang & Jung, 2005). In doing so, this paper aims to expand our understanding of the multilevel interactive process through which new practices emerge and develop (Lounsbury & Crumley, 2007). In particular, this paper draws on recent work that examines the micro foundations of institutional logics (Ocasio, Thornton, & Lounsbury, 2017; Thornton, Ocasio, & Lounsbury, 2012; Zilber, 2016) and responds to calls for further practice-driven institutionalism (Smets, Aristiou & Whittington, 2017) by empirically both 'zooming in' to focus on particular micro grassroots change initiatives and 'zooming out' to investigate the ways in which these change initiatives become meaningful in practice and are governed by broader societal-level logics (Friedland & Alford, 1991; Nicolini, 2012; Smets et al., 2017).

In particular, this paper investigates micro change initiatives in the context of grassroots activism in the NHS Change Day (NHSCD) movement (NHS Change Day, 2016), a pre-figurative social movement that called for NHS staff and the public to initiate and enact meaningful change improvements both on a personal and group level (Moskovitz & Garcia-Lorenzo, 2016). In focusing on specific bottom-up

institutional practices that became key areas of concern for the social movement members when implementing practical changes in their working practices, we address the following research question: what kind of changes and improvements are initiated and implemented in practice through participation in the NHSCD movement, and what meaning is assigned to these changes? This paper is based on the thick description of a longitudinal qualitative research project conducted over a period of three years following the movement's development. The data corpus includes narrative data from 26 in-depth interviews, 100 activists' online published 'Change Stories' and 9,479 narratives of 'Pledges'.

Our analysis identifies four narratives of health, revealing four institutional logics as the underlying animus of institutional change within healthcare, which co-construct a 'Logic of Care' governing the initiation and implementation of grassroots change in daily working practices: a narrative of care, interaction and compassion (a 'community logic'); a narrative of fairness (a 'human rights' logic); a narrative of efficiency (an 'economic/ managerialism' logic); and a narrative of professionalism (a 'scientific' logic). These findings further highlight the meaning assigned by grassroots activists to 'mundane' change initiatives which they enact in their daily working practices: the social movement setting enables activists to describe and express the importance of these changes in light of their broader societal context; a dynamic which reinforces and shapes their meaning. As such, the findings illustrate a bottom-up approach to the investigation of the emergence of institutional logics in practice, as multiple embedded actors purposefully enact the simultaneous implementation of micro small-scale changes in everyday working practices across social levels. In doing so, this paper further illuminates an empirically understudied process: the

complex and two-way dynamic between micro and macro levels of change to institutional logics, which both generates and is generated by the process of collective action. Thus, the findings illustrate how a 'logic of care' both shapes and is shaped by the simultaneous implementation of micro small-scale changes in everyday working practices across social levels.

This paper is structured as follows: following this introduction, the second part of this paper reviews the literature surrounding institutions, social movements, and grassroots activism in health. The third section outlines the fieldwork and methods applied in researching the case study. The fourth section presents the findings of the study and the fifth section discusses these findings in light of the relevant theory.

Institutions, Social Movements and Grassroots Activism in Health

The interest in social movements and collective action both as phenomena and as theoretical subjects arose in the field of neoinstitutionalism in response to the need for a more nuanced understanding of the role of agency in institutional change (Schneiberg & Lounsbury, 2017). Understandings of collective action, particularly in relation to social movements' activities, tend to focus on the challenges posed by the collective mobilisation of agentic actors (both individuals and groups) to the status quo (Benford & Snow, 2000; Scott & Marshall, 2009). This contestation of established institutions by social movements has been understood in literature in two different ways: the first views movements as 'forces *against* institutions, forces operating outside established channels to assert new visions and disrupt and or directly contest existing arrangements', whereas the second understanding focuses on the 'rise and impact of movements *within* fields' (Scheinberg & Lounsbury, 2017).

Internal social movements' efforts aimed at mobilising change can be argued as utilising a dialectical process in which formal or informal groups/sub-systems in the organisation (which may hold different interests) participate, and compete amongst themselves (see for example: Crozier, 1964; Hensmans, 2003; Lawrence, 2008; Mintzberg, 1983, 1984; Schneiberg & Lounsbury, 2008; Quinn, 1978; Zald & Berger, 1978). This means that purposive actors 'working to preserve, alter, or replace an institution' (Hirsch & Bermiss, 2009, p. 262) need to engage in an incremental process of 'meaning co-construction' which aims at both changing and sustaining institutional practices (Hirsch & Bermiss, 2009; Mintzberg, Ahlstrand & Lampel, 1998; Quinn, 1980; Zilber, 2008). However, collective action activists embedded within organisations face the challenge of co-constructing their change narrative, imagined alternatives and frame of action, whilst being 'constrained and enabled by the broader availability of institutional logics within a particular context' (Thornton et al., 2012, p. 97; see also Giddens, 1984; Sewell, 1992).

The study of internal social movements creates a space for a deeper understanding of change within institutions and enables an emphasis on institutional micro processes, in which change to institutional logics can be investigated as a bottom-up incremental process (Powell & Colyvas, 2008; Zilber, 2008). This focus highlights an understudied process: the complex and two-way dynamic between micro and macro levels of change to institutional logics, which both generates and is generated by the process of collective action (Thornton & Ocasio, 2008; Lok, 2010). Thornton and colleagues (2012) observe the potential of such an approach, claiming that 'Institutional logics research can be advanced by attention to social movement processes, particularly with respect to how multiple logics within organisations and

institutional fields facilitate practice variation as a result of collective mobilisation' (Thornton et al., 2012, p. 176).

In this context, recent studies in the field of healthcare management looked at the meaning co-construction of healthcare institutionalised practices through the prism of how change in healthcare delivery is implemented on the ground as an array of micro changes in working practices (Nicolini, 2006; Reay et al., 2013; Reay, Golden-Biddle, & Germann, 2006). This growing body of literature highlights the importance of embedded activity and moves the focus from the measurement of such activity to the social interactions and micro-level processes that constitute the fabric of daily working practices and the way in which they are experienced (Gherardi, 2012; Nicolini, 2011). This paper adds to this body of work by drawing on recent work that examines the micro foundations of institutional logics (Reay, Goodrick, Waldorff, & Casebeer, 2017; Reay & Hinings, 2009; Smets, Morris, & Greenwood, 2012). This line of study laid the ground for recent calls that explicitly stated the need for further empirical investigation of 'the ways institutional logics are worked out on the ground, in day-to-day behaviours and experiences of actors' (Zilber, 2013, p. 82; see also Zilber, 2016). Smets et al. (2017) lay out the importance of such a focus when they argue that a practice-driven investigation of the micro dynamics of institutional logics advances the research agenda of both practice theorists and institutional scholars. Focusing on both the meaning offered by institutional logics and the actual practices through which they are instigated prevents reductive understandings of these phenomena, and Smets et al. (2017) argue that paying attention to 'societal-level logics [...] strengthens the explanatory power of both logics and praxis, closes the gap between institutions and actions, and attends more closely

to the structuration of societal orders in *action*' (Smets et al., 2017, p. 374).

The field of health and healthcare offers a rich context for the study of institutional logics through a social movement prism, as it provides a particularly fertile ground for grassroots activism and for the activity of social movements across the globe (Brown & Fee, 2014; Brown & Zavestoski, 2004; Brown et al., 2004; Campbell & Burgess, 2012). As such, the field of health and healthcare is constantly subject to public interest, and perceptions of health and healthcare are continually being modified (Mendel & Scott, 2010). The question of just what healthcare is and what obligations, mutual or no, exist between governments, healthcare institutions and individual members of society occupies the attention of many social movements, some of which specifically aim at changing laws and government policy (medical, public health and political), such as in the case of issues surrounding the access to and provision of healthcare services (Banaszak-Holl, Levitsky, & Zald, 2010). Activists in this area concentrate on issues ranging from patient experiences of illness, disease, disability and disputed or unrecognised illnesses, the relationship between human health and a changing environment (e.g., pollution, climate change, etc.) to the inequalities found around the areas of gender, race, ethnicity, class and sexuality. These movements struggle both with issues of definition as well as with negotiating the implementation of suggested initiatives or reforms (Brown & Zavestoki, 2005; Campbell, 2014). Moreover, even when concepts introduced by social movements have become mostly accepted within a particular society, and have passed into legislation, there remain problems associated with the actual implementing and maintaining of standards which meet these values in practice (Rathert, Vogus, & McCelland, 2016; Welsh, 2007). Despite the fact that the activity of social

movements in healthcare is orientated around changing belief systems regarding health and thus influences not only legislation but also the delivery of healthcare in practice, they remain an understudied phenomenon from the institutional logics perspective.

Increasing attention has been given to the manner in which institutional logics can be used to elucidate change processes within healthcare in recent studies. Although these have predominantly taken a field-level empirical approach, there has been a surge of interest in micro processes and practice. Little attention has been paid to institutional logics, however, in the context of grassroots activism within health social movements. This paper aims to address this gap through the investigation of grassroots activism within prefigurative settings facilitated by the NHSCD social movement. The research on prefigurative settings is particularly useful in understanding grassroots processes of meaning co-construction from a process perspective as it emphasises the importance of context, in terms of place and time (Langley & Tsoukas, 2010). This research tradition focuses on bottom-up activism and is characterised by an emphasis on the symbolic enactment of desired change rather than on predesigned or imposed goals (Cornish, Haaken, Moskovitz, & Jackson, 2016; Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014; Polletta & Hoban, 2016; Yates, 2015). In focusing on specific bottom-up institutional practices that became key areas of concern for the social movement members when implementing practical changes in their working practices, we address the following research question: what kind of changes and improvements are initiated and implemented in practice through participation in the NHSCD movement and what meaning is assigned to these changes?

Fieldwork and Methods

The NHSCD Movement

The NHS is the fifth largest organisation and the largest health system in the world today, employing an estimated 1.6 million employees, providing health and social care services to a population of 54 million people, with 1 million of this number accessing the NHS's services every 36 hours (Alexander, 2012; Bevan, Roland, Lynton, Jones, & McCrea, 2013). Since its inception, the NHS has undergone episodes of significant organisational change. Recent momentous structural changes, contextualising this study, include the much publicly-debated Health and Social Care Act (2012) (Holmes, 2013).

The broad-based understanding of the role of the NHS in the UK encompasses a deep cultural belief that healthcare should provide the best medical advice and treatment, catering equally for the entire British population, irrespective of means, age, sex or occupation (NHS England, 2016). The constant political, economic and organisational challenges to this vision gave rise to the development of the NHS Change Day movement (Moskovitz & Garcia-Lorenzo, 2016).

As a call for action amongst NHS employees under the slogan 'Do something better together', the movement invited participation from NHS staff and the public in the form of initiating and carrying forward personal and group actions with the purpose of bettering practice. This call for action was issued through NHS Improving Quality, a body which has been involved in coordinating many of NHSCD's activities (NHS England, 2014; NHS Improving Quality, 2013).

The research was designed as a longitudinal qualitative study; this approach is pertinent to exploratory study, emphasising a context-based understanding of processes (Huber, 1995; Langley, Smallman, Tsoukas, & Van de Ven, 2013). The research was conducted during turbulent times in the NHS. The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) had published its findings in 2013, only a few months before the first NHSCD, bringing to light a systemic problem of patient neglect (Francis, 2013). Additionally, the programme to restructure the NHS, the Health and Social Care Act (2012), had been implemented during the second NHSCD. These events had significant implications for NHS employees, impacting their experience of participation in NHSCD (Moskovitz & Garcia-Lorenzo, 2016).

Data Collection

The overall fieldwork and data collection were designed to encompass four successive NHSCD annual events (2013, 2014, 2015 and 2016 NHSCDs). Field observations were conducted with the purpose of providing the necessary background for writing thick descriptions of the phenomena of NHSCD. Much of the initial data collection, therefore, involved participant observations and, from this involved position, a variety of formal and informal interviews were conducted; access to various field documents and materials was also obtained. In addition to these onsite participant observations during 67 meetings and events, the work developed is also informed by 450 hours of real time social media digital observations; a survey of 389 press media publications; as well as the collection of various documents and materials, including 50 artefacts (reports, documents, advertisements, flyers, posters, tools, etc.), and more than 800 emails from an ongoing correspondence with the movement's leadership and activists.

Fieldwork commenced after the actual occurrence of the first NHSCD, during the summer of 2013. Hence, data regarding NHSCD 2013 was collected through press media research, the NHSCD 2013 website research, and the collection of various printed documents and reports. Significant anecdotal data, and retrospective reflection regarding NHSCD 2013, was obtained throughout the period in the field, as well as through participant observation and attendance at three 'NHSCD 2013 Lessons Learnt' core leadership meetings. The majority of participant observations, a total of 62, were conducted during the 18 months from June 2013 to December 2014, focusing on the following key spheres of activist engagement:

- Key public events, including keynote launch events of Change Day as well as wider NHS innovation, promotion and leadership events in which NHSCD featured. 64 hours (including 4 conferences), on site.
- Key NHSCD strategic/ planning events. These events were exclusive to the key activist group within NHSCD. 6 full 'strategy days', on site.
- Hub leaders' strategy meetings: grassroots leaders and activists events. 5 full 'Hubbie Away Days', on site.
- Core Leadership Team meetings, limited to key leaders and activists of NHSCD. 32 meetings, on site and in conference calls.
- One-to-one and small group meetings with NHSCD leaders, across various sites. 7 meetings.
- NHSCD events and group discussions within a local, purposively sampled Trust and CCG. 30 hours, on site.
- Change Day Global Movement: participation in 9 international conference calls.

The findings outlined in this paper specifically triangulate data analysis drawing on participants' change narratives from three data sources: 26 in-depth interviews, 100 'Stories of Change', and 9,479 'Pledges'.

Interviews

In order to gain an in-depth understanding of the movement's development, face-to-

face interviews were conducted. Interview guides were developed on the basis of preliminary insights obtained from participant field data collected in the first six months of fieldwork. The interviews were designed emphasising the development of narratives and frames of change from participants' perspectives. Therefore, special attention was given to experiences and interpretations of reality in the eyes of NHSCD activists.

Face-to-face in-depth interviews were conducted with 26 participants, collecting retrospective narratives regarding NHSCD 2013, and live narratives regarding NHSCD 2014. Interviewees were purposely sampled to represent a large range of stakeholders within the movement and within the NHS - including the 3 movement founding activists, 5 members of the national core leadership team, 8 'Hubbies' (regional leaders), 6 activists in a local Trust, 2 activists in a local CCG, and 2 other participants. Interviewees also represented a spectrum of professions, levels of seniority and geographic locations. This research design enabled the collection of both horizontal information – to get a sense of the Change Day movement – as well as deep, vertical data within a local Trust and a local CCG.

Participants were informed through a detailed information sheet and an open discussion prior to each interview of the ways in which interview data would be used for the purposes of this research. Written consent to use interview content in this research was obtained.

'100 stories of change'

In order to gain perspective of the implementation process of actual changes, over time, the narratives of the '100 Stories of Change' were collected. These stories

represent retrospective narratives (Boje, 2008) shared by activists in the form of a publication on the movement's official website. They celebrate the implementation of changes from NHSCD 2013 and 2014 that had been completed, rather than pledged (NHSCD, 2016)[13]. The stories were distributed in the countdown marking a 100-day build-up to NHSCD 2015; each day was marked by an online publication and dissemination of a 'Change Story', showcasing a successful example of change implementation. Stories were collected in real time, coupled with digital observations, which was summarised in a diary used as background notes. In the case of many stories, the data also corresponded with data collected during participant observations.

Pledges

In order to be able to comprehend the breadth of the movement's grassroots practices, and the unique qualities of Change Day as a platform for participants to express their perspective on their involvement in the movement through narratives, data on online pledges was collected.

Every participant in the movement was encouraged to make a pledge, writing their intentions on the 'Pledge Wall' of the NHSCD official website (Change Day, 2016)[14]. In fact, participants viewed the act of 'pledging' as the definitive act of participation in or belonging to the NHSCD movement. NHSCD pledges are short antenarratives (Boje, 2008) mostly ranging between 1-5 lines.

Official, separate websites were built for NHSCD 2013, 2014, 2015 and 2016. During the course of Change Day 2013, 189,000 pledges were made; 802,000 pledges

[13] http://changeday.nhs.uk/latest-stories/
[14] For pledges made on the NHSCD 2016 'pledge wall' see: http://changeday.nhs.uk/actions/

were made for Change Day 2014; the pledges count was not available in 2015 and 2016. These pledges were collected, alongside supplementary data in which some of the participants explained their motivation for pledging. Some pledges represent an individual narrative, and others represent group accounts[15]. The data concerning how many participants joined each pledge was also collected. For the purpose of this paper, 8,806 distinct pledge narratives, made for NHSCD 2014, have been analysed; 673 additional pledges from 2016 are in the process of being analysed.

The pledge data of 2014 constitute a 525-page Word document, including 8,806 distinct pledge narratives, containing 27,576 lines of text. These narratives represent 802,000 pledges, as change initiatives often became popular, and thus were joined by many activists. A prominent example of an inspirational pledge campaign is the 'Hello my name is…', launched by the late Dr. Kate Granger, joined by over 24,000 participants – 'endorsed by an increasing number of well-known figures including David Cameron, Jeremy Hunt, Nicola Sturgeon, the Countess of Wessex, Kylie Minogue, Bob Geldof and Drew Barrymore' (100 Stories of Change, Story 37[16]).

Data Analysis

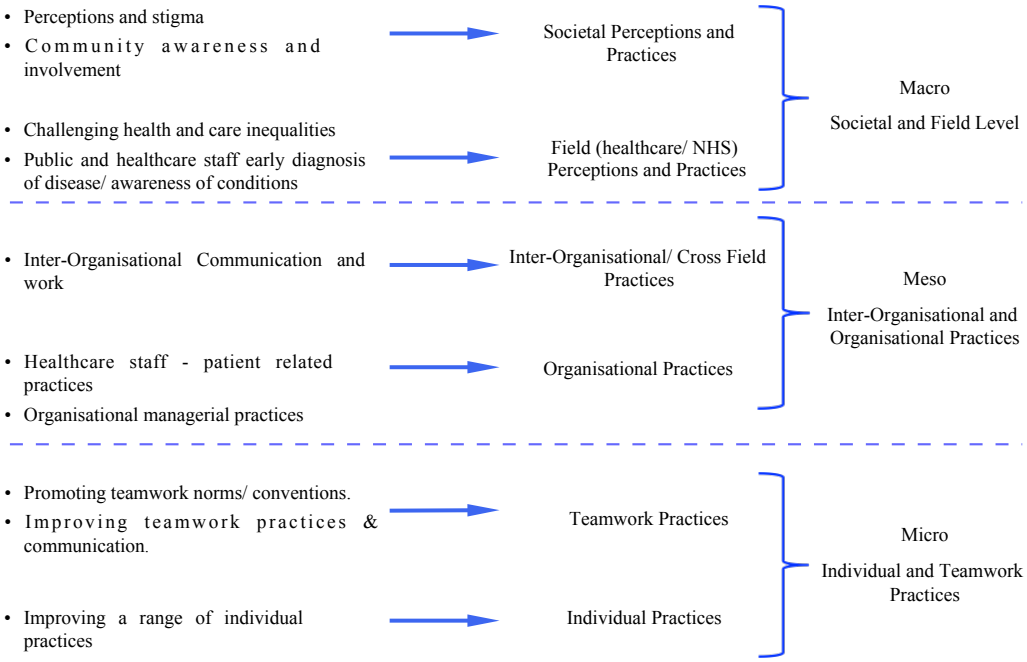
During the first part of our analysis, all data corpus was carefully read, including all press media articles, email correspondence, notes from participant observations, and all collected artefacts. Subsequently, we turned our attention to data, looking for patterns among the material. The data was then organised and uploaded for analysis

[15] See for instance: http://changeday.nhs.uk/change-starts/
[16] http://changeday.nhs.uk/story37/

using NVivo software. The entire data corpus (26 interviews, 100 ‘Stories of Change’, and 9,479 ‘Pledges’) was qualitatively analysed to answer the research question. The first stage of the analysis involved searching for common themes and patterns in the data, according to which the changes and improvements initiated by NHSCD participants could be grouped. Text was initially deconstructed into quotations, which were clustered into first order concepts according to the content of the practices that they described. Following this, these basic codes were reviewed in isolation from their original placement in the data, examined for commonalities, and searched for second order themes (Gioia et al., 2012; Riessman, 2008). The final clustering of second order themes revealed 10 categories that spanned across social levels and encompassed a wide range of change initiatives: community awareness and involvement, perceptions and stigma, challenging health and care inequalities, public and healthcare staff early diagnosis of disease/awareness of conditions, inter-organisational communication and work, healthcare staff–patient related practices, organisational managerial practices, promoting teamwork norms/conventions, improving teamwork and communication, and improving individual practices. These were grouped into aggregated dimensions, which revealed six cross-social levels at which change initiatives were initiated simultaneously: societal perception and practices, field (NHS/ healthcare) perceptions and practices, inter-organisational/cross-field practices, organisational practices, teamwork practices, and individual practices. These six cross-social levels are further grouped in the diagram shown below into macro, meso, and micro social levels (see also Figure 3.2 for the expanded diagram).

Figure 5.1

Thematic Analysis: Initiation and Implementation of Grassroots Change in Daily Working Practices



The initial thematic analysis provided insight into the first part of the research question (What kind of changes and improvements are initiated and implemented in practice through participation in the NHSCD movement?), however, the second part of the research question (What meaning is assigned to these changes?) required further investigation, which led to the conduction of a narrative analysis (Boje, 2008). The use of a bottom-up analysis allowed for the identification of the ways in which meaning was assigned to the change initiatives, which emerged inductively both through the often explicit descriptions provided by participants as well as through the vocabulary and language they used (Reay & Jones, 2016). The basic codes were organised according to the way participants described themselves and others (e.g. 'agent'), the reasoning/motivations that drove their change initiatives (e.g. purpose),

the problems that they combatted (e.g. scene), how they aimed to resolve such problems (e.g. agency) and the actual changes enacted according to these aims (e.g. plot). Four distinct narratives of health emerged from our data: narrative of compassion and communication, narrative of fairness and human rights, narrative of efficiency, and narrative of scientific knowledge. These four distinct narratives of health co-exist in our data. They are not representative of any particular group nor do they correlate perfectly to all change initiatives, but rather illustrate the key themes participants brought together. In many of the cases (especially when it comes to the short narratives of pledges), there is a direct pathway between a pledge and one of the health narratives (e.g. the pledge explicitly articulates the logic of a particular narrative). In other cases, however, there is not a one-to-one correlation between a pledge and a single narrative, rather the pledge involves more than one change initiative or articulates more than one rationale for change. Since the narrative analysis was coded thematically, complex change initiatives were deconstructed into smaller quotations and coded accordingly. Lastly, data was organised to showcase the insights from both levels of analysis. This organisation of the data revisited the original first order concepts and grouped them into a two-dimensional table both according to their underpinning narrative and the institutional level to which they were relevant.

Findings: Narratives of Health as Driving Change

The compassion, fairness/ human rights, efficiency and scientific narratives presented below capture and articulate elements of the NHSCD movement's wider narrative construction. This section presents the four different narratives and the ways they

were revealed through participants' enactment of change initiatives (see Table 5.1).

Table 5.1

Narratives of Health	**Narrative of Compassion and Communication**	**Narrative of Fairness and Human Rights**	**Narrative of Efficiency**	**Narrative of Scientific Knowledge**
Agent (who) *Protagonist*	Healers/Mentors.	Social Justice Activists.	Service provider.	Healthcare professionals
	Members of the Community (Patients, Families, Carers).	Marginalised groups and individuals).	Service users.	Public
Purpose (why) - Driving values *Endorsed practices*	Health and wellbeing of all members of the community.	Equality and fairness across all social diversity.	Efficient provision of healthcare services.	Older practices need to be updated to more informed ways of doing things.
Scene (when/where) *practices that need to be changed*	Emotional disconnect in the communication of treatment, resulting in poor patient experience.	Social inequalities in access to health and care services.	Lack of resources, ageing population, budget crisis.	Insufficient implementation of evidence based research.
Agency (how)	Improving communication, prioritising patients, focusing on compassionate care.	Fighting stigma and standing up for the marginalised.	Efficiency measures and improvements.	The dissemination of knowledge and encouraging of its implementation.
Plot/Act (what)	From insufficient experience of communication to relationships which adequately and compassionatly involve all members of the community.	From exclusion to inclusivity.	From inefficiency to optimal use of resources according to needs of the community.	Progress based on scientific knowledge.

Narrative of Compassion and Communication

The archetype of the Healer or Mentor animates these accounts and participants describe being motivated by the desire to do good within their communities, aiming

towards an ideal of compassionate care and hoping to overcome what they perceived as key problems within the institutional structure of care-giving. These included what was understood as the emotional disconnect between professionals and patients in the communicating of treatment, which led to negative patient experiences. A prominent example of this narrative is the #hellomynameis campaign (Story 48/ '100 Stories of Change'), which was initiated by the late Dr. Kate Granger, who, as a terminally ill cancer patient, described her experience of the lack of empathetic communication between doctors and herself, particularly in the incident in which she was told that her cancer was incurable. In her pledging campaign for NHSCD 2014, Dr. Granger wrote:

> As a healthcare professional you know so much about your patient. You know their name, their personal details, their health conditions, who they live with and much more. What do we as patients know about our healthcare professionals? The answer is often absolutely nothing, sometimes it seems not even their names. The balance of power is very one-sided in favour of the healthcare professional. (Pledge 1,148/9,479 joined by 20,241 people in 2014)

This story resonated with the experiences of patients and staff and what was seen as a problematic communicative style in the institution at large also received significant media attention. The number of people who joined this has increased exponentially since 2014, and the #hellomynameis hashtag became a prevalent way in which healthcare staff present themselves in the NHS. The change initiatives within this category were specifically designed to bridge this gap, improving communication and creating an institutional space in which the emotional needs of patients were also catered for, with professionals compassionately engaged in their practice. The narrative was present throughout the data in change initiatives at various social levels.

Within this grouping, the emphasis placed on compassionate care can be traced back to the founding idea of the NHS as a whole, echoing the sentiments

conveyed in the NHS statement of values: 'We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need' (NHS England, 2014). The findings explored the manifestation of the narrative of 'compassion and communication' at a societal level, describing the shared belief of participants in a collective responsibility with regards to vulnerable members of society. These accounts ranged from emotional narratives and personal resolutions, but each demonstrates the way in which a compassionate narrative was not limited to the space of the institutional, but seen to extend to society at large:

> [...] If you are compassionate about the desperate and lonely and about those who sleep in the open, please use the NHS Change Day 2015 initiative and commit to making a positive change, whether through raising awareness or helping in specific ways, and inspire others by showing compassion and kindness to those who most need it! (Story 11/ 100 Stories of Change)

On a field level, the 'compassion and communication' narrative was expressed through initiatives designed to engage the public in change, signifying that the NHS and the community were one and the same thing and highlighting the unique role played by the NHS in British society:

> I pledge to use my free time (if possible one weekend a month) to volunteer where possible to work with and help elderly patients who may have to be in hospital especially over the Christmas period. (Pledge 422/ 9,479)

> 1611: Host community conversations to explore what our community can do to better enable Compassion to be a driving force of healthcare in our Compassionate City. (Pledge 1,611/ 9,479)

The NHS was seen as 'belonging' to everybody and this implied a reciprocal relationship - it was necessary that everybody be involved within overarching institutional change, both healthcare professionals and the public at large:

> I pledge to help make Bristol a city where the conversations about health are debated and discussed in a public environment. (Pledge 932/9,479)

Similarly, at an inter-organisational level, the 'compassion and communication' narrative was manifested through the idea of responsibility towards the larger community: the ideal of improved inter-organisational communication was promoted through the idea that no individual should be left behind, or slip through the institutional cracks. This was observed, for example, in the drive to connect the NHS and schools regarding the treatment plans of children:

> Diabetes Care Plan for Schools (DCAPS) [pledge]: every child with type1 diabetes in the UK should have a personalised care plan for management of their condition in school. (Pledge 4,872/ 9,479)

On the organisational level, this push towards communication improvement was visible in initiatives such as the #CuppaCare hashtag on social media that aimed to combat the isolating and stressful nature of work within the NHS, encouraging staff to take their breaks with patients: to 'make it acceptable for everyone - including nurses, consultants and patients - to take the time to have a refreshing drink [together]' (Story 31/ '100 Stories of Change'). Additionally, the 'compassion and communication' narrative was supported by an increased emphasis both on the importance of teamwork and the role of the individual in personally committing to change in organisational practices, promoting a sense of 'togetherness' within the NHS as a whole. Participants often express their belief that compassionate work relations relate to compassionate care to patients:

> FNP Cornwall team pledge to show compassion to each other. (Pledge 1,824/ 9,479)
>
> To show the same compassion to all staff as we expect our staff to show to patients. (Pledge 2,551/ 9,479)
>
> To provide support and education to staff on work life balance and on what compassion looks like. (Pledge 5,242/ 9,479)

The findings showed how narratives of 'compassion and communication' acted as driving forces within the NHS, promoting and pushing for change, with participants

describing the idea of a united community as a motivation to pledge and make individual and group efforts to improve organisational practices. Improving communication within the NHS was seen as a means of expressing the ideal of compassionate care and this generated thousands of small individual and group initiatives that aimed to humanise the relationship between patients and staff members:

> My first pledge was that I wanted to spend extra time with my patients and try to listen to them more. And then I was asking them questions I wouldn't normally ask, like how can I... how are you feeling, rather than how's your pain? (An NHS Nurse)

> To help my elderly neighbours to get to Doctor/hospital appointments. Keep a close eye on them and keep giving them freshly baked cakes. (Pledge 4,994/ 9,479)

Narrative of Fairness and Human Rights

The findings describe the 'fairness and human rights' narrative, which groups together the various participant accounts detailing the desire of participants to stand up for the interests of marginalised individuals and groups within the NHS, protecting the values of equality and fairness within the institution:

> We value every person - whether patient, their families or carers, or staff - as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. […] We speak up when things go wrong. (NHS Values in NHS England, 2014)

These accounts describe activists as being motivated by existing problems within the system, such as a widespread sense of exclusion, with access to quick and efficient healthcare seen as contingent on social class. Change initiatives within this narrative grouping are specifically geared towards the promotion of inclusivity and the overcoming of these barriers. Participants emphasised the intrinsic value of the individual, valuing both patients and staff-members.

The findings described the efforts of participants to stand up for marginalised

groups and encourage greater efforts within the NHS with regards to human rights issues. Participants hoped to make a difference through raising awareness across a range of different platforms, both social media and through physical fieldwork. The NHSCD activists conceptualised their role as healthcare professionals as encompassing more than the official duties prescribed by their working roles: they hoped to combat wider social problems and prejudices:

> I pledge to continue raising the profile of mental health and wellbeing, lesbian, gay, bisexual and transgender within the NHS and wider communities. One life lost to hate crime is one too many. (Pledge 554/ 9,479)
>
> I pledge to make a difference to individuals with mental health problems by raising awareness of mental health issues and tackling the stigma associated with it by tweeting. I also pledge to fundraise for local mental health charities that work closely with the NHS to help and support individuals with mental health problems by doing a sponsored dog walk in my onesie. (Pledge 452/ 9,479)

Within the field of healthcare, the narrative of fairness was expressed through pledges that aimed to make practices more inclusive, suggesting training processes that would prepare staff members to meet a wider range of individual requirements - the example given below concentrated on improving inclusivity specifically around visual and hearing impairments and dyslexia:

> My action for NHS Change Day is I'm going to challenge and actively support training within the NHS to become more inclusive, specifically around visual, and hearing impairment and dyslexia. I want to widen access to our training, and ensure that it is adapted so that it meets the needs of everyone...(Story 10/ '100 Stories of Change')

This idea was continued in inter-organisational efforts to improve patient care for vulnerable individuals, such as people suffering from dementia. Participants pledged to create 'dementia-friendly' practices and increase community awareness of dementia through the efforts of the NHS within the wider public sphere. On the organisational level, a narrative of fairness can be seen in initiatives designed to connect patients with their care, explaining processes that might have initially seemed

complicated or distant and catering to specific individual needs. A push towards greater inclusivity can be seen in the example of a storyboard designed to explain care pathways to autistic children:

> And the second one is also to do with the Child Development Centre, which is to create a storyboard which explains to autistic children what their care pathway is. At the moment our autism waiting list is about two years, before you can get a diagnosis. It's just horrendous and a lot of people feel like they're dropping out of the system. They don't hear back, they don't get an acknowledgement letter about when their appointment is. So the storyboard is to show who you might meet, where you might meet them, what you can expect, who you can contact, but all in child friendly writing, with pictures and things. (A Graduate Management Trainee)

The idea of fairness was also expressed in pledges that concentrated on improving teamwork practices and encouraging greater efforts from individuals themselves:

> I intended to encourage and support the staff in pathology to achieve their NHS Change Day pledges. I'm keen to see staff realise their potential, enjoy their roles, build effective networks across the organisation and feel proud to work at MK. (Pledge 518/9,479)

> I pledge to say thank you and well done to all members of my team on a daily basis, encouraging them to be proud of what they do. (Pledge 653/9,479)

Our findings showed how a narrative of fairness sought to overcoming existing inequalities of care, promoting inclusivity and standing up for the interests of marginalised individuals and groups. A key way in which this was done was through reaching out to such groups, improving communication and including them within their own care. The strongest example of such an initiative is the #UcanCope pledging campaign targeted at both raising awareness of mental health issues and combatting the stigma associated with them. This pledge was made by 234,138 people in 2014 alone, and represented a wide-scale mobilisation against the manner in which mental health issues were perceived and treated in both the organisation and society. The language used in the pledge specifically focuses on the right of people to achieve a state of positive wellbeing (as defined by the World Health Organisation) and realise their potential:

> I pledge to develop my wellbeing and emotional resilience & encourage those around me to do the same. Positive wellbeing is about being able to live life to the full, to develop and maintain relationships and to be able to deal with the stresses and difficulties of everyday living. Based on the World Health Organisation wellbeing is achieved when someone feels good and can reach their full potential and is able to: Cope with the normal stresses of daily life, be productive and able to join in with their family, friends, work and community. Please download the #UcanCope pledge certificate by copying this link into your browsers URL: http://changeday.nhs.uk/files/Certificate.pdf. (Pledge 388/9,479 joined by 234,138 people in 2014)

Narrative of Efficiency

Our findings also explored how narratives of efficiency were expressed in participants' accounts that focused on the role of the NHS as a service provider obliged to provide users with the best possible service, subjugating ideas of care to an economic or managerial view. Participants within this narrative focused on the efficient provision of services and initiatives concentrated on overcoming existing problems such as the lack of resources, a budget crisis, and the threat of an aging population through a push towards greater efficiency and improving of existing structures. The animating slogan for this logic can be found in the NHS statement of values: 'We maximise our resources for the benefit of the whole community' (NHS Values, NHS England, 2014). The findings show how the narrative of efficiency was expressed through pledges that concentrated on raising awareness of existing inefficiencies. On a societal level, participants hoped to address these problems through innovative solutions: this was manifested through resolutions to accomplish more both through participants' efforts and involvement in fundraising for various social issues and through broader efforts to raise awareness in the community:

> I have been volunteering at SIFA Fireside for over two years and only recently there weren't enough funds available to serve breakfast to the Birmingham homeless. I intend to raise awareness regarding this issue and collect as much financial and other support in order for SIFA Fireside to continue with providing meals for the hungry and homeless. (Pledge 978/ 9,479)

Participants expressed their ideas of efficiency in the field through their belief that

each individual could make a contribution to the overall economic wellbeing of the NHS and how these small contributions can accumulate to have a significant impact:

> Although I haven't ever DNA'd (did not attend) an NHS appointment I pledge a promise NEVER to do so. And I pledge to share the messages with my family, friends and those I meet. The impact of someone NOT attending an appointment without cancelling is immense. Overnight we could save precious resource if we stopped any DNAs. Please join me in sharing the message and NOT DNA-ing (Pledge 548/ 9,479).

A push towards greater efficiency can also be observed in initiatives designed to improve inter-organisational practices and improve working practices or perceived inefficiencies, such as lack of equipment or ineffective use of existing resources:

> We pledge to develop integrated primary and secondary care medication record for West Cheshire. (Pledge 6,564/9,479)

Organisational inefficiencies are also described and measures proposed to tackle them are raised: these focused on both the improving of existing practice through greater attention and the introduction of new practices designed to save time and conserve resources, such as through recycling:

> To use resources effectively, recycling sharing 'pre-loved' items including furniture to save the Trust money and to generate income where appropriate. A furniture 'bank' has been set up so items can be allocated according to need [...] Recycling of other items is also increasing in the Trust (Pledge 1,360/9,479)

Poor organisation was perceived as leading to problems with working practices in one sample pledge, and an initiative involving the transition from paper to digital organisation systems was suggested as a means of overcoming the problem:

> [...] We had a lot of problems with seeing patients and everything, and there was an email coming around saying NHS Change Day is coming, would you like to do a pledge, and I met with my colleagues [...] and I said, well, why don't we do a pledge to try to improve and work more efficiently and make sure that we sort these problems that we have, with communication with the patients and with each other. [...] I went home and after thinking about it, I put the idea forward to put all the patients on the computer. The computers, they were not used, they were always just put on paper, and I decided to put an informatics programme on, to put all the patients on and to allocate the patients through a spread sheet, and that's how the Directory Roll started. (An NHS Nurse)

On an individual level, participants resolved to make personal changes to their

practice, increasing their productivity and minimising waste:

> Ian Siara - NUH HR Manager: I will approach any decisions on spending NHS money as carefully as I would if its my own. (Pledge 1,866/9,479)
>
> I pledge to print less, saving paper and money! (Pledge 2390/9,479)

The findings describe how a narrative of efficiency is present in participants' perception of the NHS as a service provider with specific obligations towards service users. Within the narrative of efficiency, the improving of practice is a moral imperative shaped by what is seen as the NHS's duty to society.

Narrative of Scientific Knowledge

The findings also describe a narrative of 'scientific knowledge', in which the drive to extend the boundaries of medical knowledge is closely linked to the imperative to improve quality of care.

> We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care - safety, effectiveness and patient experience - right every time. (NHS Values, NHS England, 2014)

A concern with scientific knowledge is present on the level of social perceptions and practices. Participants describe specific shortcomings or areas of weakness that they hope to see overcome through wider organisational or their own efforts as exemplars. In the example of the text below, a participant describes how people from ethnic minorities are less likely to give blood and stocks are low: this prompted the participant to volunteer to give blood again. NHSCD was seen as an opportunity to encourage a narrative of increased professionalism; the impulse towards social justice through inclusion and equal access is present but is secondary to the professional necessity of having a developed blood inventory.

> […] ethnic minorities blood count level is low, and I've always given blood but it had been a long time before I'd given blood last, so that just spurred me to actually do that. And so I just thought yes, I'll do it for change day. (An Improvement Leader)

A narrative of scientific knowledge is also evident in participants' pledges to do more within the field by raising awareness concerning specific issues with the hope of preventing their reoccurrence, engaging the public by encouraging them to participate in their own care. Examples include raising awareness of breast cancer within male groups, and preventing pressure ulcers through greater education regarding their signs and symptoms.

> On NHS Change Day I pledge to do my best to raise awareness for Breast Cancer in MEN!!! (Pledge 319/ 9,479)

> I pledge to make a difference and raise awareness of pressure ulcers. To prevent pressure ulcers by talking to patients, carers and health care professionals. To make people aware of signs and symptoms to aid prevention. (Pledge 28/9,479)

This focus on improving scientific knowledge can also be seen in participants' desire to work together to strengthen inter-organisational practices, improving, for example, the ties between everyday procedures and academic research within the NHS. Participants describe their intentions to promote the use of the hospital library in furthering the practice of evidence-based healthcare and innovation and their aim to develop interdisciplinary initiatives that support healthcare professionals in their daily working practice.

> I pledge to promote the role of the hospital library in supporting evidence-based healthcare. (Pledge 2,028/9,479)

> To include evidence of how to support health care professionals in their work when I am doing projects to improve practice in social care. (Pledge 4,636/9,479)

Resolutions to implement new research within everyday organisational practice also

express a narrative of scientific knowledge:

> We pledge to consistently use a new screening tool for patients with lower back pain to target effective treatment through evidence-based practice. (Pledge 4,987/9,479)

This concern is also reflected at the level of teamwork practices through efforts to increase the use of such knowledge within groups of staff, with participants describing initiatives to keep staff engaged with contemporary research and share knowledge, encouraging them to study outside of the demands of their everyday work.

> Journal club once a month in the practice-based setting. Encourage staff to research a journal article which is evidence-based to improve and broaden knowledge. (Pledge 3,142/9,479)

A renewed focus on the use of scientific knowledge at the level of group practices and teamwork was mirrored at the level of individual practice. Participants described their personal resolutions to improve their knowledge through increased engagement with contemporary research and evidence.

> I pledge to base every aspect of the care I give on the most up to date, critically appraised evidence. (Pledge 7,994/9,749)

Our research shows how a narrative of scientific knowledge is key to the overarching project of NHSCD. Participants are keen to improve their professional knowledge and implement innovative, cutting-edge research within their daily practice. The difficulty of juggling intensive frontline work with the need to keep up with contemporary research is acknowledged, but participants resolve to improve their practice through the pursuit of knowledge on several different levels. A narrative of scientific knowledge is seen as key to patient satisfaction and general progress within the NHS and its practices.

Discussion: From Narratives of Health to The Logic of Care

This paper has explored the kind of changes and improvements initiated and implemented in practice through participation in the NHSCD movement and the meaning assigned by participants to these changes (Zilber, 2008; Nicolini, 2012). The initial thematic analysis showed that participants initiated change across a range of social levels simultaneously and the subsequent narrative analysis revealed four narratives of health. These emerged from data that grouped participants' accounts according to common themes and metaphors which described both the way participants related to themselves and others, their motivations to initiate change, the practices they believed needed to be modified, how they suggested changing these practices and the described implementation of such initiatives. The findings from both stages of analysis were combined to illustrate how the four narratives of health emerged across social levels and were expressed through and reflected in particular change initiatives made by participants.

This paper relied on various data sources when investigating change initiatives and the meaning assigned to them (Czarniawska, 2004b; Weber & Glynn, 2006). A critical source proved to be that of pledge data, which was significant in both its scope and content: pledge data was generated in vivo and with no researcher influence and also presented the accounts of a large population, capturing simultaneously a vast number of voices from multiple sites that could not be achieved using other methods, such as interviews (Zilber, 2014). The size of this undertaking allowed for a bottom-up exploration of how narratives emerge in the data (Garud, Gehman & Giuliani,

2014). These findings illuminated the process by which narratives function as the building blocks of institutional logics (Thornton et al., 2012). By showing how some ante narratives (e.g. pledges) (Boje, 2008) took precedence or became dominant over other narratives, this paper provides a detailed insight into the bottom-up nature of collective narrative co-construction (Zilber, 2007). Moreover, by zooming in to examine a large number of in ante narratives, the findings in this paper show the way in which bottom-up vocabularies of practice emerge through many of the popular pledging campaigns from the beginning of their circulation (e.g. #hellomynameis, #UcanCope, #StopthePressure, etc.) (Zilber, 2016). Furthermore, the findings show the way in which some narratives become institutionalised practices through a viral process of dissemination, as seen in the popularity of particular pledges or ideas (e.g. #hellomynameis) (Cunliffe, Luhman, & Boje, 2004; Zilber, 2009).

This paper responded to recent calls that advocated for additional empirical investigation of the manifestation of institutional logics in day-to-day practice (Zilber, 2013). This was achieved by paying close attention to the formation of collective narratives through grassroots activism. Thornton et al. (2012) state that '*Narratives,* by linking theories and frames with specific practices, generate specific linkages between the symbolic and material elements of institutional logics.' (Thornton et al., 2012, p. 152). By focusing on individual and group narratives, the findings illustrate the importance of 'zooming in' to investigate the role and agency of individuals and small groups in the emergence of institutional change (Nicolini, 2009). The investigation of these participant narratives (e.g. pledges, stories of change) stressed the intertwined nature of symbolism and materiality: each one of these narratives encapsulates a symbolic interpretation of change in the actual material configuration

of specific actions and particular change initiatives (Thornton & Ocasio, 1999). As such, this paper further demonstrates that the symbolic and material elements of institutional logics are inextricably linked and should necessarily be investigated as a whole.

The findings further highlight the meaning assigned by grassroots activists to mundane change initiatives (Fernández, Martí & Farchi, 2017). The focus on the setting of grassroots activism reveals the strength and importance of actors' agency in instigating institutional change as well as stressing the constraints placed on them by virtue of being embedded in their institutional context (Battilana & D'aunno, 2009; Friedland & Alford, 1991). Participation in grassroots activism highlights the voluntary agency of actors who were able to decide whether to opt in and take part in collective action or to bystand (Briscoe & Gupta, 2016; Olson, 1971; Powell & Colyvas, 2008). The accounts in each narrative reveal that participants were able to enact their agency when it came to small-scale 'mundane' change initiatives as opposed to initiating large-scale transformational change initiatives (Smets et al., 2017; Powell & Colyvas, 2008). The focus on small-scale 'mundane' change is almost absolute and, as described in Moskovitz & Garcia-Lorenzo (2016), is a core reason for participants' motivation to join in the social movement's activities (Moskovitz & Garcia-Lorenzo, 2016). Hence, the social movement setting enables activists to describe and express the importance of these changes in light of their broader societal context; a dynamic which reinforces and shapes their meaning (Jones, 2014b).

The collective narratives of health that emerged from the data articulate links made by participants between shortcomings in their day-to-day working practices and

their agency to enact change in those practices (Nicolini, 2006; Reay et al., 2006). Each one of the narratives is centred around a metaphor that captures participants' aspirations for a better NHS (e.g. more compassionate, fairer, more efficient and more thoroughly grounded in contemporary scientific knowledge) (Zilber, 2009). Each one of the narratives of health exhibits a direct line between specific change initiatives and individual, group and collective processes of both sensemaking and sensegiving, in which day-to-day challenges are confronted (Cloutier & Langley, 2013). The popular pledge to smile more, for example, was simultaneously linked by participants in different ways to all four narratives of health. In the narrative of compassion and communication, smiling is prompted by such emotions, and is an act of kindness and empathy towards patients, whereas in the second narrative this act is treated with a slightly different focus, seen instead in terms of the patient's right to be treated with a smile. In the narrative of efficiency, smiling is described as a small action that requires no financial resources (e.g. smiling is 'for free') and yet has a significant, positive impact. In the narrative of science, however, participants mention research and evidence regarding the impact that individual care accompanied with a smile has on recovery. As such, each one of the four health narratives emerges from the construction of meaning around specific practices and change initiatives and 'become[s] a process by which individual cognition is translated into group and collective sense-making and action' (Thornton et al., 2012, p. 155).

The findings also show how small-scale change in practice was initiated across different social levels simultaneously (Thornton, 2004; Thornton & Ocasio, 2008, 1999). This finding elucidates the role of minor modifications in vocabularies of practice and small-scale changes in material practices observed at a micro level in

the co-construction of meso or macro social levels of change (Davis, Morrill, Rao, & Soule, 2008; Ocasio, Loewenstein, & Nigam, 2015). Although these findings are not sufficient to demonstrate meso or macro level change, which would require both additional analysis and a different set of methodological tools, they provide insight into the complexity of meso and macro change as processes that emerge from the accumulated effect of a massive amount of such changes in practice (Reay & Jones, 2016; Zilber, 2016). The social movement provides a unique setting for observation of this phenomenon as it records accounts of such actions as they happen in real time and also allows for the consideration of the narratives and perspectives of a very large number of actors rather than concentrating on a small number of institutional 'entrepreneurs' (Lounsbury & Glynn 2001; Rao, Monin, & Durand, 2003; Schneiberg & Lounsbury, 2008). As such, these findings give a better understanding of how small-scale change in practice is initiated and enacted in vivo by multiple actors.

The shift from a micro lens to a meso or macro one requires the conceptual shift from narratives to logics. The findings in this paper concentrated on the co-construction of narratives at a micro level rather than on the identification of institutional logics at the societal level. It is possible, however, to zoom out from the more immediate implications of these findings and reflect on them in light of pivotal work that investigates institutional logics in the field of healthcare.

The narrative of compassion and communication resonates best with the secondary logic of a 'voluntary ethos' identified by Scott, Ruef, Mendel, & Caronna, (2000) in their study of the American healthcare sector between the years 1945 and

1965. This logic, which the authors describe as ‘a complex of beliefs linking hospitals and other healthcare organisations to charitable work and to community services’ (Scott et al., 2000, p. 183), relates to Thornton et al.’s (2012) conceptualisation of a community logic. The emotional orientation of the narrative of compassion and communication links to the sources of identity in the community logics described by Thornton et al. (2012), as well to the emphasis on the value of volunteering and taking an active membership role within the community. The narrative of compassion corresponds also with what Dunn and Jones (2010) term a ‘logic of care’, which focuses on quality of care – ‘quality of life rather than innovative new treatments’ – and which ‘provide compassionate, preventative care to patient[s] and treat them as whole people rather than simply diseases’ which ‘highlights physicians’ clinical skills used to treat patients and improve the health of the community’ (Dunn & Jones, 2010, p. 116). The notion of community and volunteering in the micro level analysis conducted in this paper is punctuated by a family metaphor, which further stresses the intimacy of the community logic, as staff often describe their aspirations to treat patients as if they were members of their own family. This narrative of compassion and communication is the most prevalent in the data, although this is not to say that it is necessarily the dominant logic, as these findings may have been influenced by the preceding release of the Francis Report (2013), which concentrated on issues such as patient neglect, which instigated a debate around the issue of compassion in the NHS.

The narrative of ‘fairness and human rights’ bring to mind the state logic identified by Scott et al. (2000) as dominant in the American healthcare system

between the years of 1966 and 1982, which is based on the 'great society vision of enhanced equity of access to healthcare services, increasingly viewed as a right of all citizens' (p. 205). The narrative of fairness and human rights gives further insight into this logic by highlighting difficulties in the implementation of equal access to healthcare in practice. The accounts in this narrative go beyond the generic idea of universal healthcare and its funding to stress the particular challenges faced by marginalised groups and individuals in society. These challenges are described as more than simply issues of funding, as participants want to combat widespread prejudices and correct certain assumptions. The narratives of 'efficiency' and of 'scientific knowledge' relates to recent studies, which identify and describe the market or managerial and the professional logics in healthcare (Goodrick & Reay, 2011; Nigam & Ocasio, 2010; Reay, Goodrick, & Hinings, 2016; Reay & Hinings, 2009; Ruef, 1999). The narrative of 'scientific knowledge' appears in the data frequently, whereas the narrative of 'efficiency' is the least explicitly evoked by participants. The narrative of efficiency is present in the data in a salient manner in the way in which participants overwhelmingly initiate changes which require little or no funding at all. As such, the narrative of efficiency is more prevalent in the data as a constraint to agency rather than as a value that motivates change.

The four narratives of health described in this paper emerged from the data as a result of the examination of the voluntary change initiatives enacted by participants in the NHSCD movement. In initiating change, participants expressed their beliefs regarding the care the NHS should provide: care which is compassionate, fair, driven

by up-to-date research and that uses funding efficiently. This narrative tessellates with the four institutional logics of community, state, professionalism and managerialism. Overall, these four collective narratives of health stress the dynamic co-construction of four institutional logics and how they can be used to understand the delivery of healthcare on the ground (i.e., community, state, professionalism and managerialism) (Lawrence, Suddaby, & Leca, 2009). The findings in this paper suggest that these four institutional logics need to be seen as working together simultaneously underneath the overarching category of the 'logic of care', as they are bound together by the motivation of staff to take voluntary action in order to improve patient care. This paper proposes the logic of care as a way of understanding the practice of healthcare, as the institutional logics at play in participants' accounts can all be understood as belonging to the same overarching category or imperative: care for the wellbeing of patients, staff and society at large are continually prioritised and are also expressed through all accounts regardless of their organising logic. As such, the logic of care is a way of understanding what binds these singular logics together in the overarching 'work' of healthcare. By zooming in to investigate participants' narratives at a micro level and by then reflecting on these narratives through the institutional logics perspective from a macro lens, this paper highlights the multifaceted complexity of the logic of care.

Conclusion

This paper focused on changes and improvements initiated and implemented in practice through participation in a grassroots and frontline-led movement within the

English National Health Service. The social movement context of this paper presented an opportunity to consider the original perspectives of a vast number of participants through the investigation of a unique data set, which included 9,479 short narrative accounts that expressed in vivo the voices of more than 800,000 people. The findings in this paper both zoom in to investigate individual and group accounts of their personal and collective enactment of change in material practices and the meaning attributed to them, and zoom out to inductively construct four collective narratives of health, interpreting these in light of other studies on institutional logics, particularly in the field of health and healthcare. This paper argues that these four narratives of health can be understood as making up an overarching 'logic of care' that informs healthcare practices. Thus, this paper illustrates how this logic of care both shapes and is shaped by the simultaneous implementation of micro small-scale changes in everyday working practices across social levels. In doing so, this paper further illuminates the empirically understudied process: the complex and two-way dynamic between micro and macro levels of change and institutional logics, which both generates and is generated by the process of collective action. As such, the findings illustrate a bottom-up approach to the investigation of the emergence of institutional logics in practice, as multiple embedded actors purposefully enact 'mundane' small-scale changes in their material practices within the constraints of their setting.

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Chapter 6 Changing the NHS a Day at a Time: The Role of Enactment in the Mobilisation and Prefiguration of Change

Abstract[17]

This paper aims to contribute to our understanding of the unique role of enactment in the dynamics of motivation and participation in prefigurative social movements, with the intention of providing a deeper understanding of the mechanisms, inherent to prefiguration, driving change through collective action. We achieve this through examining what motivates people to participate as activists in a social movement trying to enact changes within the National Health Service (NHS) in the United Kingdom. To do so, we explore the narratives of 23 activists working to develop the NHS Change Day movement. The narratives describe how NHS frontline staff engage in daily grassroots change activities while having to navigate top-down, planned, organisational change interventions. We analyse our findings in light of recent developments in the understanding of group identity processes in the mobilisation of collective action, and highlight the role of enactment in these dynamics. The findings indicate that it is not the overall top-down managerial strategies, but rather the daily participation and enactment of self-initiated small-scale change actions that gives meaning and direction to the activists' participation in the social movement – a meaning which is constructed through the encapsulation of a sense of personal agency and collective efficacy, contributing to a sense of the affirmation of vocational and organisational identity. We contend that the relationship between the experience of

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the daily enactment of self-initiated activities within a supportive group setting and the motivation to participate in collective action is mutually constructed, and as such, inextricable.

Keywords: motivation, enactment, participation, identity, prefiguration, mobilisation, social movements, NHS Change Day

Introduction

Prefigurative social movements are characterised by the insurrectional challenge to established values and structures that activists bring when they enact alternative realities. Activists performing within this paradigm create new spaces for change, practice, dialogue and distributed leadership (Maeckelbergh, 2012). This paper aims to investigate the potential to mobilise communities of healthcare providers within the National Health System (NHS) in the United Kingdom, looking at what drives them to participate and engage in change activities. We use this case study as a lens through which to elucidate the relationship between the drive to mobilise, and the process of enactment within prefigurative movements.

Drawing on a broader research study, this paper explores the emergence of the NHS Change Day (NHSCD) movement. It focuses concretely on the efforts of its activists to create a frontline mass movement aimed at mobilising collective action for the improvement of the NHS. NHSCD is a frontline led grassroots' movement of activists, which has been emerging since 2013 (Hilton & Lawrence-Pietroni, 2013). The movement calls for both staff and patients to engage dialogically in the practice of improvements, aiming to show that small, individual actions can have a large impact:

> NHS Change Day is a grassroots movement that's about harnessing the collective energy, creativity and ideas of thousands of people to improve the care and wellbeing of people who use health and care services, their families and staff. Over the past two years thousands of people made pledges to change things. This year we want to inspire people to take action. Anyone can get involved, whether they work in or alongside the NHS or are a patient or member of the public. (NHS Improving Quality, 2016)

The NHS has had, since its inception, a strong and formative social and political influence on the development of a modern national identity in the UK, and is viewed by many as inextricable from an understanding of what it is to be British. As the fifth largest organisation, and the largest healthcare system in the world, the NHS plays a key role in shaping both health and social care in the UK. The NHS is viewed by the British public as a social movement with a pioneering philosophy – one which makes a global contribution, conceptualizing the moral right to access free healthcare.

Yet, the NHS as we know it is under siege, facing political, economic, and cultural pressures, which challenge the founding vision of unlimited healthcare available for all. These pressures include restrictive budgets and shifting demographic structures, as well as encompassing concerns regarding the cost of treatment for an aging population. These issues challenge the dream of unlimited healthcare available for all. In addition, the NHS has faced a series of morale-reducing investigations into performance failures, including the Francis Report (Francis, 2013), which articulated both systemic and cultural failings regarding patient neglect on an organisational scale.

Policy makers have addressed these problems in the most part through the implementation of top-down local and national organisational and development change programmes, including The Health and Social Care Act (2012). Yet, the success of these initiatives has been the subject of public and critical debate.

In this context, NHS Change Day has been emerging since 2013. While this

social movement was initiated in the English NHS, it has recently started to reach a global audience, with similar initiatives emerging in Australia, Northern Ireland, Canada, the Netherlands, Finland, the USA, Scotland, Wales, New Zealand, Jordan, and India.

As a prefigurative social movement, NHSCD spans the length and breadth of England. The movement's call to action emphasises enactment and collaborative thinking under the slogan 'Do Something Better Together'. The movement's activism is rooted in, and emphasises the agency of frontline staff, as well as being open to public participation (Hilton & Lawrence-Pietroni, 2013; NHS Change Day, 2016; NHS England, 2014; NHS Improving Quality, 2013; Steen, 2014). Critical to our research on prefigurative social movements linked to large formal organizations, NHSCD emphasises the importance of nourishing small-scale, experimental, bottom-up changes, rather than large, planned, top-down change programmes; the movement encourages NHS stakeholders to make voluntary public commitments on an official website, to "make a difference": an achievable change in their practice. It is through these individual actions of the NHS staff and public that the movement aims to reveal that grassroots actions can lead to large-scale improvements (Bevan, Roland, Lynton, Jones, & McCrea, 2013; Hilton & Lawrence-Pietroni, 2013). As such, NHSCD has developed a distributive network of leaders, most notably the 'Hubbies', from all levels of the hierarchy within the NHS. The movement's volunteers fulfil particular roles, and there is no correlation between their influence within the movement and their seniority within the NHS. The movement's activists volunteer their time to the movement through organising events, sharing communication, and collaborating on a national scale (Jones, 2014; Rutter, 2014).

In common with other contemporary prefigurative movements which challenge the established, hierarchical means of communication by utilising social media platforms, much of the Change Day movement's communication is mediated and channelled through digital interfaces, including an official website of the movement. Moreover, just as Change Day 'occupies' specific places – online platforms through which participants voice opinions, record actions, and co-construct the movement's dialogue – it also 'occupies' a day within the NHS calendar. The movement celebrates its cause and activities through an annual national campaign, enabling participants to have the opportunity to focus upon, and experiment with change initiatives that they might not otherwise have attempted.

In an article published in BBC News Health, the small-scale changes performed by movement participants were described:

> This year, there have been pledges from everyone from NHS managers and chief executives, to nurses, doctors and healthcare assistants around the country. Pledges range from the simple, such as making sure a child's teddy bear is right next to them when they wake up in recovery, to the innovative, such as helping terminally ill children understand and relate to the cycle of life by growing and nurturing seeds on the ward. (BBC News Health on March 3rd, 2014)

Drawing upon an overall, ongoing, longitudinal and in-depth qualitative study of the movement almost from its origins, this paper is based on the analysis of 23 in-depth interviews of the movement's activists and participants.

In this paper, we examine the motivations for becoming involved in collective action as participants in the NHSCD movement. It is through this investigation that we aim to illuminate the complexity of the dynamics between the motivating factors driving people to activism, and the actual meaning they assign to their experience of participation in a prefigurative movement. In particular, we focus on the meaning assigned to the experience of the enactment of change in a prefigurative movement.

We analyse our findings in light of recent developments in the understanding of group identity processes in the mobilisation of collective action, and highlight the role of enactment in these dynamics. This exploration of the role of enactment in the dynamics of motivation and participation aims to provide a deeper understanding of the mechanisms of collective action inherent in prefigurative movements, and thus, to contribute towards the understanding of the processes driving change through prefigurative movements.

The paper is structured as follows: the following section outlines our theoretical framework regarding prefigurative social movements as challenging and presenting an alternative to top-down planned change. We proceed with a section delineating the fieldwork process and methodology applied in approaching the case study, and the analysis of collected data performed for the purposes of this paper. This is followed by a section that outlines the wider research context: the NHS, its core ethos, and significance to the UK's national identity, as well as its wider organisational and political environment and challenges. A further section lays out findings regarding activists' narratives, describing their processes of becoming NHSCD participants. We then analyse our findings in discussing the interplay between enactment, identity and motivation. We conclude this paper by arguing that motivation and enactment are mutually constituted processes.

Prefiguration: Challenging Planned Top-Down Change

The term 'prefigurative culture', coined by Margaret Mead (1970), refers to cultures of collective, multigenerational learning – cultures in which adults learn simultaneously from ancestors, peers and children (Mead, 1970, p. 51). Karl Boggs

(1977) was the first to situate the term 'prefigurative' in a political context: "By 'prefigurative' I mean the embodiment, within the ongoing political practice, of a movement, of those forms of social relations, decision- making, culture and human experience that are the ultimate goal" (Boggs, 1977, p. 100). This concept has since developed to encompass various politically oriented, day-to-day activities (Yates, 2015). Prefigurative social movements are characterised by the insurrectional challenge to established values and structures through the activist-led enactment of alternative realities. This approach, therefore, emphasises the need for movements to align their ideology with their actions (Leach, 2013). By doing so, it is argued that prefigurative movements bring forward to the present their goals for the future (Yates, 2015). This performance of alternative political realities through enactment is argued to present a strategy for the transformation of the distribution of power (Maeckelbergh, 2011). Activists performing within this paradigm create new spaces for change, practice, dialogue, and distributed or horizontal leadership (Maeckelbergh, 2012).

Prefigurative movements challenge the way in which change is traditionally conceptualised as a linear, structured process, which can be strategically pre-planned and designed. According to such views, change interventions can set predetermined goals (Morgan, 2006). Change is often understood to be a dramatic process, involving the destruction of one configuration and its replacement with another (Demers, 2007; Galbraith, 2000). This understanding of change encourages the development of intervention models to guide, monitor and evaluate the implementation of change programmes (Senior & Swailes, 2010). Drawing on mainstream economic and management literature, such interventions aim to generate a shift from a 'present

condition' to a more 'desirable future', often envisioned by small groups of external or senior people within the system (Beer & Nohria, 2000a; Burnes, 2013; Carnall, 2007). This top-down view of change undermines the importance of social interaction and human agency, regularly failing to address the complexity and diversity of societal and environmental contexts in which change processes are implemented, and often, therefore, confronting resistance (Garcia-Lorenzo, 2008; Howarth et al., 2013).

In the context of the NHS, the effectiveness and resistance to top-down, large-scale restructuring programmes of change are constantly debated in healthcare management and improvement literature. Dominant change modules are attacked for being influenced by management theories. Such theories are critiqued for making oversimplified assumptions regarding the correlation between elements within the healthcare system, and consequently advocating for change programmes which ignore fundamental aspects of the organisational life (Plsek & Wilson, 2001). Moreover, healthcare environments such as hospitals, are delineated as extremely dynamic, interactive settings, which are difficult to evaluate according to performance models (Shiell, Hawe, & Gold, 2008). Other authors discuss the shifting standards and values by which the British public expects the NHS to adhere. They argue that a current health service must alter its focus from implementing change and improvements, to developing the ability to adapt so that it is constantly responsive to changing demands (Fraser & Greenhalgh, 2001). Top-down approaches of programmes focusing, for example, on "inspection and performance management" resulted in a lack of engagement of clinical staff with what many felt to be "yet another misconceived attempt by politicians to extend their control over frontline care" (Degeling, Maxwell, Iedema, & Hunter, 2004, p. 2).

Conversely, prefigurative initiatives invite us to trust the process of change, emphasising improvisation, and the importance of the journey involved in the change processes, and in collective action. Viewing improvisation as emerging from the tension between innovation and continuity enables goal setting to be flexible, and develop organically, rather than being stated from the outset (Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014; Nolas, 2014). Viewing change as a continuous process rather than a periodic event, which happens incrementally rather than radically, gives a clearer vision of how it is through the agency of human actors that change is accomplished (Garcia-Lorenzo, 2010, 2007; Miller & Friesen, 1982; Tsoukas & Chia, 2002; Weick & Quinn, 1999).

Yet, the need to clarify how engagement and participation happens is key to understanding collective action. Indeed, social movement theory has, over the past few decades, been investigating various approaches to the study of the dynamics of mobilisation (Benford & Snow, 2000; della Porta & Diani, 2006; Snow & Benford, 1988).

Early studies in the field, popular in the 1950's and 1960's, attributed the emergence of protests to spontaneous and unexpected crowd responses to strain upon the social structure (Smelser, 1998). These studies tended to associate participation in collective action with negative connotations, often viewing social movements as posing a threat to democratic political systems (Eyerman & Jamison, 1991). The motivation to participate in collective action by joining social movements has been further attacked, most dominantly in the 1970s, by the proponents of 'instrumental rationality', arguing that it would not be rational for people to join in collective action when they could by-stand (or 'free ride') and still enjoy the results of others' efforts.

Olson's (1971) 'free rider' paradox thus further stresses the question of how the mobilisation and maintenance of collective action occur (Opp, 2009; Mueller, 1992).

The perception of social movements has, however, altered significantly with the emergence of the counterculture movements of the 1960's and 1970's, the civil rights movement, and the 'new social movements'. These movements were perceived as driving positive social change, and as fundamental to the democratic freedom of speech and expression (Scott & Marshall, 2009). These new types of movements also presented new theoretical questions and new opportunities for research, highlighting the importance of group identity, as well as the need to move beyond the logic of strategic or instrumental rationality in conceptualising the mobilisation of collective action (Cohen, 1985). Gamson (1992), for example, criticised Olson's theory as "an individual utilitarian model", which fails to address issues of group identity, claiming that "when people bind their fate to the fate of a group, they feel personally threatened when the group is threatened. Solidarity and collective identity operate to blur the distinction between individual and group interest, undermining the premises on which such utilitarian models operate" (p. 57). Klandermans (2004) further claims that even though participation in collective action requires, on the one hand, the investment of both time and effort, as well as often putting participants in risk, it answers, on the other hand, participants' psychological need "to change their circumstances [...] to act as members of their group, or [...] to give meaning to their world and express their views and feelings" (p. 361).

In reviewing early and recent conceptualisations of collective identity, Hunt and Benford (2004), trace the interest in the concept to the works of Marx and Weber, discussing the dominant contribution to the understanding of collective identity made

by social psychologists such as Mead, Berger, Luchmann, Giddens, Moscovici and others, and elaborating upon the development of the concept in the study of social movements, highlighting the dynamic, multi-layered and multifaceted nature of collective identity:

> Collective identity is conceptualized as individuals' identifications of, identifications with, and attachments to some collectivity in cognitive, emotional, and moral terms. Rooted in and shaped by particular sociocultural contexts, collective identities are produced and reproduced in ongoing interactions between allies, oppositional forces, and audiences who can be real or imagined. (Hunt & Benford, 2004, p. 450)

The study of identity processes within social movements thus aims to elucidate the manner in which a 'collectivity' is formed, and sustained. It further explores the process of identification through which group members become associated with a collective, and make sense of their participation in it (Melucci, 1996, p. 69).

Van Zomeren, Postmes, & Spears (2008) state that the three key subjective drivers shown to predict collective action in quantitative research are the collective sense of injustice, identity, and efficacy – three socio-psychological factors, which they argue should be considered in one integrated model rather than separately. The authors suggest the Integrative Social Identity Model of Collective Action (SIMCA), which argues for the centrality of identity in mobilisation, both as a direct and indirect prediction of collective action. The SIMCA model contends that social identity "underlies injustice because it provides the basis for the group-based experience of injustice" and also "underlines efficacy because a stronger sense of identity empowers relatively powerless individuals" (van Zomeren et al., 2008, p. 511). Another key recent contribution to the field is the Encapsulation Model of Social Identity in Collective Action (EMSICA) developed by Thomas, McGarty, and Mavor (2009a). The model further nuances the dynamic relationship of group membership, claiming

that “perceptions of injustice and group efficacy provide the basis for the emergence of social identity and become captured in social identity” (Thomas, Mavor, & McGarty, 2012, p. 3). Thomas et al. (2009a) contend that “understanding the ways that people give meaning to their identities, in context, is what truly underpins the study of social change” (p. 205). The interest taken by contemporary scholarship in social movements, therefore, considers the underlying processes shaping actors’ perceptions of their interests and identities, and possibilities for change (Campbell, 2005).

Fieldwork and Methods

This paper stems from a wider, ongoing PhD research project. Field research adopted a triangulation of three distinct qualitative methods of data collection. In-depth longitudinal qualitative research, beginning in July 2012, and encompassing three consecutive NHS Change Days, in 2013, 2014 and 2015, involved field research, in which first-hand data were collected through travelling the length and breadth of England, capturing the nationwide phenomenon of NHSCD in acute detail. Field research included more than 200 hours of participant observations, discussions, and the collection of field documentation, such as pamphlets, leaflets, and email correspondence. As a phenomenon, a substantial part of NHSCD is conducted online, via official websites; thus, more than 400 hours of digital observations were conducted in real time. Furthermore, a media review of 389 articles surveyed local, national and trade print publications. This variety of data collected has been vital to the understanding of the dynamics of the movement, and has informed the development of this paper.

Specifically, the findings presented in this paper are based upon data from 23 in-depth interviews, conducted with a range of purposely-sampled stakeholders, including the movement's founders, leaders, and participants. The corpus of interviews encapsulates perspectives from a range of stakeholders within the NHS, representing a spectrum of professions, levels of seniority, and geographical locations, designed to portray both horizontal and vertical processes. The interview process used a semi-structured guide, designed to collect rich narrative data from the perspective of activists, which was developed on the basis of preliminary insights obtained from participant field data. Throughout the process of interviewing, the guide was interpreted flexibly, based on the interaction during the interview. Care was taken to ensure that no leading questions were asked; questions were asked in an open-ended manner.

A thematic analysis was utilised in order to code the data, organising basic themes into 11 categories, which were used to develop 4 global themes: contextual motivations to participate in NHSCD; collective agency as motivation – "do something better together"; the power of bottom-up change as motivation; and enactment as motivation.

The Wider Research Context: The NHS

The NHS was founded in 1948 with the aspiration of making the best medical advice and treatment freely available to the entire British population. The NHS was the first comprehensive health system in the Western world based on national provision of services rather than on insurance principles (Delamothe, 2008a, 2008b). The NHS plays a central part in the life-course of British citizens: "From the cradle to the grave,

citizens are promised healthcare, delivered according to need, free at the point of delivery" (Ballatt & Campling, 2011, p. 1). In this sense, the NHS has the capacity to galvanise nationalist sentiment, as is exemplified by its frequent treatment in political discourse, in the news, in British television, and in iconic symbolic events such as the 2012 Olympic Opening Ceremony (Abbasi, 2012; Ballatt & Campling, 2011).

The NHS is the largest healthcare system in the world, as well as one of the five largest workforces today, including the US Department of Defence, McDonalds, Walmart, and the Chinese People's Liberation Army. The NHS employs an estimated 1.6 million people, with 1.3 million of whom work for NHS England. Today, NHS England provides health and social care services to a population of 54 million people, of whom 1 million patients are estimated to access the NHS's health and social care services every 36 hours (Alexander, 2012; NHS choices, 2015).

The NHS, however, has had to face the increasing challenges, imposed by budget constraints, of delivering its vision of free adequate healthcare for all (Delamothe, 2008c). The recent years of global recession (Appleby, 2012; Stuckler, Basu, & McKee, 2010) have aggravated political questions about what proportion of gross domestic product (GDP) should be spent on healthcare, as well as the issue of how these costs should be levied, whether through taxation, fee charges to patients, or insurance policies (Delamothe, 2008d). This has made the NHS a constant and critical topic in current political debates (Mason & Morris, 2014).

Funding concerns have become inseparably associated with patient autonomy, and the extent to which patients rather than experts should have the right to determine their own treatment (Delamothe, 2008d). Moreover, the NHS is challenged with improving service responsiveness to patient demand, whilst investing in health

promotion and prevention (Crisp, 2011; Bevan, 2012). These challenges are amplified by the growing healthcare needs of an expanding elderly population, including treatments for long-term conditions and dementia (Boyd, Burnes, Clark, & Nelson, 2013). There is debate about the system's preparedness for continued universal healthcare in the context of these challenges (Godlee, 2013; Select Committee on Public Service and Demographic Change, 2013). The conflicting demands in which the NHS is required to constantly improve the quality of patient healthcare whilst reducing its costs is aggravated by the need to maintain currency with increasing technological innovations (Bevan et al., 2013).

In addition to funding problems, healthcare scandals, from the murders of Harold Shipman(i), to the recent abuse at Winterbourne(ii) View, have sent shockwaves throughout the NHS, undermining public faith in the ability of staff to deliver consistent, high quality services (Delamothe, 2008e; Mohammed, Cheng, Rouse, & Marshall, 2001; O'Dowd, 2012). The media furore triggered by high-profile scandals undermines public opinion of the NHS, dents the morale of frontline staff, and forces NHS employees through retroactive programmes of change, designed to tackle systemic problems (Hilton & Lawrence-Pietroni, 2013).

Negligent surgical practices at Bristol Royal Infirmary, leading to excess paediatric mortality, for example, were attributed to groups of influential clinicians reinforcing poor-quality care. Subsequently, the critique of the absence of managerial structures resonated NHS-wide, triggering policy change (Kennedy, 2001; Mannion, Davies, & Marshall, 2005; Mannion et al., 2010; Stevens, 2004). The high-profile nature of the Mid-Staffordshire NHS Foundation Trust Public Inquiry into revelations of malpractice at Stafford Hospital highlighted poor quality care, patient neglect and

cultural failings on an organisational scale (Francis, 2013a). The report highlighted the tension between the staff needing to focus on patient care and pressure in terms of delivering government targets (Francis, 2013).

In order to address the onslaught of issues faced by the NHS, organisational development programmes have been introduced locally and nationally. A quasi-market system has been developed where different subcontractors compete for contracts, in which 'payment' is determined 'by results'. NHS Foundation Trusts have been established, resulting in service redesign throughout NHS organizations, and increased private sector commissioning (Freeman & Peck, 2010; Hyde, 2010). In 2013, the NHS embarked upon its most recent structural change: The Health and Social Care Act (2012). This restructuring involves a move to clinically led commissioning, increased patient involvement through independent consumer champion organisations, and a complete reconfiguration of health service provision. These changes have been described in the British Medical Journal as "the largest set of changes the NHS in England has seen since its formation" (Edwards, 2013, p. 2090).

Findings: Enacting Activism, Becoming a Participant in the NHSCD Movement

Contextual Motivations to Participate in NHSCD

Anxiety Regarding the Future of the NHS

Anxiety about the future of the NHS, and a sense of disempowerment resulting from contextual pressures, were described by NHSCD participants as motivators

compelling them to take on personal responsibility for improvements. Participants articulated the emotional importance of finding ways to respond effectively to challenges with positivity and meaningfulness.

Anxieties expressed focused upon the gradual disestablishment and privatisation of services. The fears voiced orientated around implications of budget constraints undermining the core NHS values, and the ability to provide integrated care:

> I hope that the NHS doesn't get broken up, it feels like we're heading towards piecemeal privatisation of the NHS where industry takes over the easy parts of the NHS – easy services, easy operations, things like that. (An NHS doctor)

NHSCD participants worried about whether the NHS could survive the dramatic slashes predicted. Furthermore, there was a sense of anticipation, resulting from the understanding that pressure exerted on the current system would alter what the healthcare system represented in the UK, not just what it was able to deliver.

> [...] we're not going to survive in the NHS [...] we have to make savings every year and they've done all the salami slicing, they've done all the quick wins, but now they need a whole new change to deliver savings and to deliver care effectively and that's what NHS Change Day can help deliver. (An NHS Graduate Management Trainee)

NHSCD participants emphasised the day-to-day insecurity created by the constant restructuring programmes including the recent Health and Social Care Act. They described external political pressures which they felt were shaping the NHS, and how the uncertainty associated with having to navigate unseen obstacles was becoming a daily reality on the frontline of healthcare provision in the UK.

> [...] the Health and Social Care Act is a massive change: having to battle with reducing finances and in- creasing demand [...] I think we're talking a bit more crystal ball here and I think it depends a bit on what the politicians do over the next few years. We've seen a major reorganisation of the NHS, to a scale that we've never seen before and it's going to take a good ten years before we understand what that reorgan- isation is going to look like in terms of the NHS. (An NHS Graduate Management Trainee)

Participants described how this sense of anxiety and the ensuing anger provoked by

what they described as the constant onslaught of top-down organisational changes, was a key motivator, inspiring them to participate in the Change Day movement.

> My personal motivation was really because I think I was so negative about the Health and Social Care Bill that came out around the time we set up the first Change Day... and this real frustration that all this top-down change and reorganisation was being done to us [...] We didn't want a lot of this change to be forced on us. I think it was almost a reaction to that... that actually we've got to take charge, and we've got to take an ownership of what is within our gift to control – so, the things we can change. (An NHS General Practitioner)

In addition to top-down pressure to cope with repeated structural changes and budget cuts, NHSCD participants described the demoralising impact of media critiques of frontline professionalism, and, in particular, of the Francis report.

The Francis Report, and a Sense of Identity Crisis

NHSCD participants described how the movement's positive ethos, celebrating the everyday efforts of the NHS staff, felt like a necessary antidote to frequent media criticism, highlighting poor performance within the NHS. Constant criticism was described as hurtful to highly motivated, conscientious staff:

> I think NHS Change Day is important because you have a lot of negativity in the NHS, in the media at least. A lot of the media stories are about negative elements – long hospital waiting times, long accident and emergency waiting times, the scandals that happen with patient care, the budget. You never hear the positive things that the nurses do, that the frontline staff do, that people do to try and make the NHS what it is. (An NHSIQ Improvement Leader)

NHS frontline staff prided themselves, especially under the pressure of budget cuts, on working at full capacity: the public criticisms levied against the NHS were felt undermine their sense of vocation as NHS staff.

> I also think that because of our loss of confidence, because of the constant attacks and the pressure – as we've seen with the Francis report – people buckle and I think Change Day just helps them inject some enthusiasm and inject some positivity in amongst that pressure and helps people refocus on what are the important things rather than just seeing the NHS as a job. (An NHS doctor)

Participants described how they viewed the relationship between Change Day, and the NHS staff reaction to the Francis report. They explained how they felt that the

opportunity to participate within, as well as identify with the Change Day movement was crucial to their capacity to assert, through changes in their practice, the fact that they were vocationally driven and collectively unified.

> People say Francis is one sign of a lot of poison in the NHS. I don't know if I believe that, I haven't experienced it in my organisations, but Francis shows why people need to have the confidence in their colleagues to remain inspiring [...] without Change Day, Francis is just individuals trying to respond in all these haphazard ways, and Change Day gives people something to hold onto. [...] and there are 100,000 people doing that, that shows more respect and care for the people – those families that made the effort to campaign in Francis, I think, than anything else that we can do. (An NHS manager)

Participants described how the feeling of being attacked motivated participation in Change Day: frontline staff were keen to reassert a sense of positive collective identity.

Collective Agency as Motivation – "Do Something Better Together"

Collective Belief: "Together We Can Make a Change"

NHSCD participants described how the ethos of NHSCD reinforced the self-belief of its members, challenging the traditionally hierarchical working culture of the NHS, which tended towards passivity.

> I think that there has been a history of top-down, authoritarian management in the NHS and now we have realised that we need networks, we need influences, and we need to believe in ourselves, and that's what NHSCD does, it helps us to believe that we can make that change, and we don't have to wait for that directive. (An NHS Graduate Management Trainee)

Participants described how their actions and initiatives were validated through the collective passion and power within the NHSCD movement, composed of like-minded, dynamic individuals who had responded with positivity and vision to the movement's call for action.

> I suppose it's often the people, the passion, of making the difference to the NHS. When a group of people come together who have got this great idea of making significant change in the NHS that's quite interesting to me, and so I'm naturally interested in engaging with people

> who are interested in making large-scale change and involved in change per se. (An NHS Researcher)

Participants described how the opportunity to engage in, and to act collectively within the Change Day movement was key to the ways in which they connected with their peers and other activists.

> The more reassuring thing, I found, is that I was not on my own. My problems were the other people's problems, and the fact that we shared the problems and we found a solution together, that's what I found very powerful about Change Day. (An NHS Nurse)

This sense of togetherness liberated those who felt pigeonholed by the system; participants described how their capacity to enact change grew as their network expanded.

Having a Voice: "Each One of Us Counts"

Change Day participants described the sense of revelation that the incremental impact of multiple small changes could produce a cultural shift, impacting the ability of the NHS to deliver its vision.

> [...] a very small change and repeated by a lot of people, can make a big impact. That made me think that instead of complaining that I was unhappy to work and everything, [...] maybe, if I change something, I can make something better [...] And if all my colleagues do the same and repeat it several times, I think, we can achieve something in the end. Because what can I lose? It cannot get any worse. The only thing is it can get better. And it got a lot better. (An NHS Nurse)

Individuals explained that this paradigm shift was fundamental to their sense of being valued, and key to their sense of purpose within the movement: NHSCD enabled participants to celebrate and share their expertise, testing their individual capacity to enact positive change:

> I'd done lots of different roles and now what I wanted to do was to bring all of that experience to bear onto something, that I could really make a difference. (An NHS IQ Improvement Leader)

Participants described how NHSCD enabled individuals to both have a voice, and be

heard. They revealed how staff often felt constricted within the NHS, to the point that they had to ask permission to make a change: NHSCD gave them the impetus to take action.

> I think the biggest thing that it's had – and you can recognise this nationally – is, like I say, the breaking down of the barriers for people to say, actually, if I've got an idea I can raise it... I do feel empowered to do that, I do feel okay to speak up about things. (An NHS HR Manager)

Participants particularly stressed that they felt that belonging to the movement provided them with the opportunity to break down the rigid hierarchies within the NHS and to assert the importance and power of individual voices in collectively shaping the future of the NHS.

> What I like about Change Day is that anyone from any background can have an input [...] You can have your say and people will listen to you. And it's that combination of there's no hierarchy or anything. It's just say what you need to say and you will make a difference. (An NHS Graduate Management Trainee)

Being a Role Model

The Change Day movement grew rapidly and organically: participants, inspired by the actions of others, lent their voices to the cause. Those in positions of responsibility acknowledged their potential to act as role models, and as catalysts for the movement's expansion. They affirmed however, that involvement in NHSCD was driven by deep, personal beliefs in the movement's power and ideology, rather than from a sense of obligation.

> Equally, as part of my role as head of department, I think within that role itself, it's important to set a standard, to try and get other people involved, and the only way of getting other people involved is to do it yourself. But that's not the main reason I did it. The main reason is because I believe in it, but as a leader, you can't expect other people to do it if you're not interested yourself. (An NHS Frontline Manager)

The Power of Frontline and Bottom-Up Change as Motivation

"The Frontline Has the Answers"

NHSCD was believed to engage disconnected realms of the NHS in vital dialogue, ensuring that the expertise of frontline workers was used to shape relevant policy decisions:

> I think we need to find a different way of finding the balance between what we can do and the resources we have. I don't think that the senior managers always have the answer, sometimes they do but not always, and I think that there are a lot of people at the frontline who do know the answer and could help. (An NHS Doctor)

NHSCD was understood as an important opportunity, not just for the frontline to have a voice, but also for strategic decision makers to join and support the movement, and to affirm that they were listening.

> Some specialties we're just starting to work with for the first time to actually try and engage with people and say, okay, no, we're serious here, we genuinely mean we want your views, we genuinely mean we will try things that you're suggesting, because every organisation has a history and some areas of this organisation have been quite top-down dictatorial and the staff don't believe you when you say that they can contribute. (An NHS Improvement Leader)

Frontline Communicating and Inspiring Each Other

Much of the impetus behind NHSCD came from the frontline: participants described how they felt empowered by enacting and envisioning change. The sense of empowerment generated through prefiguring change was associated with the feeling that celebrating positive stories within the workforce was a considerable cultural shift.

> So for me, this is really positive, to hear some of the good stories that were happening on the wards, and the good-news stories about what we'd done, how we'd do [...] how the teams were pledging to make that happen. (An NHS HR Manager)

Participants discussed the positive momentum of NHSCD: each progressive change inspired a vision of future potential.

Enactment as Motivation

Change Starts From Within

Participants described how NHSCD's profound and philosophical notion of change stimulated action, which resonated at a deep personal level, motivating their commitment to the movement. Through enacting changes focusing on patient care and wellbeing, individuals reconnected with a fundamental sense of their vocational identity:

> I quite like the idea of pledging because it's really a promise to yourself, that's really what it is, and when you think about the motivation for change, that if you're able to use your own motivation for change, then it's much more likely that it's going to happen, and I think that that's what this notion is all about: what's important to you? (NHS IQ Improvement Leader)

Participants described the sense of freedom generated from making their own, independent, elective decisions to join NHSCD.

> It was something different. It didn't tell me that I needed to do it. It wasn't saying that you must do it. [...] It didn't tell me what I had to do. Basically, I can do anything I wanted. (An NHS Nurse)

Participants, exercising their agency to align with the movement's philosophy and momentum, described the change enacted through joining the movement as ceremonial, marking a step taken to match their working style with their values as healthcare practitioners.

The Enactment of Small-Scale Changes

Participants noted how the movement's celebration of incremental changes motivated their personal engagement with NHSCD. From an organisational perspective, the meaning assigned to small-scale, individual, self-determined improvements resonates with Karl Weick's notion of the 'enactment' of shared reality, which emphasises the

unconscious, proactive role played in creating perceptions of the world we live in (Weick, 2001). Furthermore, the emphasis that the movement puts upon feasible change initiatives resonates with Weick's concept of 'small wins', which he defines as resulting from the breakdown of larger problems, making the steps needed to address them seem more manageable (Weick, 1984). The efforts which participants made, however small, were figured as part of a wider, cultural shift:

> I think on an individual level people are making small changes, I think when lots of people make the same change then that becomes a big change. I also think that there's something else – I think there's something bigger than that that's changing, and I think this is changing culture. (An NHS Doctor)

For some participants, the value which NHSCD placed on their individual capacity to enact change, effected an emotional transformation:

> What Change Day did for me is it made me realise that I have the power and I have control of what I do and what I want to do in my life. And Change Day gave me my passion for my work back that I lost before, because I thought that I could not influence anything, I could not change anything. (An NHS Nurse)

The notion that the ability to pledge individual action was a 'gift' was repeated by interviewees, suggesting that the system of pledging was key to participants feeling that the Change Day movement enabled them to reclaim their power, sense of initiative, and autonomy within the NHS.

> [...] the majority of changes happen to you. They're enforced changes, they happen to you, not with you [...] yes, you get a certain amount of involvement, but ultimately, depending on your role within that, it's taken away from you, whereas the pledge is personal and it's within your gift to take it as far as you possibly can. (An NHS Porter)

NHSCD, a National Campaign

Participants in NHSCD described how their involvement in the movement determined their ability to envision a brighter future for the NHS. The mind shift, which participation in Change Day necessitated, was in itself felt to be the tangible change, which could influence the future direction of the NHS:

> We need to create an environment for professionals to develop [...] We need to create the environment for them to realise that throughout their training [...] what they put in can be amplified in terms of what they get out. And if we can start from an early stage then perhaps, just perhaps, when they get into a position where they have a bigger influence over the bigger picture they're not that cynical person, they are an enabler. (An NHS Doctor)

Participants described the utopian potential of this shift, exploring the importance of endowing individuals with personal responsibility.

> Every day should be Change Day in the way that every day is a school day. We should be coming in to try and make things better every single day. I don't think that anyone in the NHS comes to work because they want to do a bad job. You should be coming to work with the idea that there is no point getting annoyed with things, you should be thinking about how you can make things better. (An NHS IQ Improvement Leader)

For some, the power of NHSCD lay in the number of participants mobilised by the movement. The potential for large-scale change, in the light of this, was described as unprecedented. NHSCD was felt to mark a sea-change from fragmentation to unity.

> To think about being part of something that's being delivered on a national level, that's quite exciting for me; large-scale change, seeing 350,000 to 400,000 people make a pledge [...] In terms of numbers, it's quite significant. (An NHS Researcher)

One of the movement's key activists described how he felt that the Change Day movement illuminated the national significance of the NHS as a social movement facilitating and inspiring a culture of socialised medicine.

> It's the love of the NHS. It's the love of the job. It's the love of caring for people. It's the love of socialised medicine. For me, it's slightly political as well, with a small 'p', because it's saying the NHS is a social movement, and NHS Change Day is a social movement within the NHS. (An NHS Doctor)

There was the sense that Change Day was creating a different NHS where, when it came to engaging with government decision-making and drives which would impact healthcare policy, frontline workers would have power and influence.

Discussion: Prefiguration as the Interplay Between Enactment, Identity, and Mobilisation

This paper has considered what motivates people to participate as activists in the NHSCD social movement. The narratives of participants suggest a cyclical relationship between the processes of motivation and participation. Narratives illustrate that the experience of participation in NHSCD, and the motivation to participate, are co-constructed. The exploration of the tension between individual motivation and collective action, illuminates the difficulty in creating a chronological explanation to address the relationship between motivation and collective action. From an organisational perspective, this finding resonates with the dynamic of the action-structure paradox described by Poole and Van de Ven (1989), shedding light on the difficulties associated with the implementation of top-down organisational change.

NHSCD activists articulated how participation in the movement enabled them to address the sense of disempowerment triggered by the contextual financial and organisational challenges that they faced. The strong "sense of ownership of the NHS among both public and NHS workers" (Shapiro & Smith, 2003), as described in the context section above, is key to the reading of our findings. The understanding that the existence of the NHS, built upon the principal of access to, and support of, its services, is inextricable from the modern concept of British citizenship, contextualises the interpretation of this study. The role, and expectations, of NHS frontline employees as compassionate care providers is key to the positive identification of NHS staff, both as individuals and as a workforce (Dutton, Dukerich, & Harquail, 1994; Tajfel & Turner, 1979). This wider contextual role of the NHS and its staff

sheds light on the anxiety described by participants regarding the NHS's future, as well as on the sense of identity crisis caused by external criticism of frontline staff, associated in particular with the commissioning, findings of, and political reaction to the Francis report. In this respect, the described daily pressures to perform, combined with the constraints from budgetary restrictions to time pressure experienced by frontline staff, amount to a perceived restricted agency which is emphasised by the perceived onslaught of frequent top-down organisational changes. The relevance of these findings can be elucidated with the aid of both the Integrative Social Identity Model of Collective Action (SIMCA; van Zomeren et al., 2008) and the Encapsulation Model of Social Identity in Action (EMSICA; Thomas et al., 2009a).

The SIMCA model suggests that "social identity is central to collective action because it directly motivates collective action and simultaneously bridges the injustice and efficacy explanations of collective action" (van Zomeren et al., 2008, p. 505). Our findings resonate with SIMCA's understanding of the pivotal role of "social identification" in collective action (e.g., participants' identification with NHS and with their vocation) as galvanising the effects of participants' motivation to join positive collective action, contributing to "improve the care and well-being of those who use the NHS" (NHS Improving Quality, 2016). The emotions of anxiety and frustration, however, are also described by participants to "precede and precipitate" the group formation of the NHSCD movement (Thomas et al., 2012, p. 3).

Jasper (1997) argues that the development of motivations is complex, determined through the individuals' experience of the world, as well as through their moral code. The ethos of Change Day, celebrating the core ideologies of the NHS, was key to motivating participation in the movement. Actions taken in the name of

the movement resonated with core shared beliefs regarding the NHS, its staff, and its role in society. "The content" of the NHSCD's movement identity was shaped "through an inductive process of norm-generation, debate and consensualisation about what that group membership means" (Thomas & McGarty, 2009, p. 129); for example, the belief that the frontline, holding the expertise, and values at the heart of the NHS, both could and should be in a position to direct change. NHSCD provided frontline workers with the opportunity to reprioritise their values over and above a sense of being driven by targets.

Our findings further suggest that the experience of involvement in the NHSCD movement enabled participants to regain a strong sense of their vocation and to celebrate their collective identity. Particularly, our findings reveal that the experience of activating personal agency within the constraints of the wider NHS system was meaningful in motivating people to action. These findings tessellate with the EMSICA model, which claims that "it is social identification that mediates the effects of affective reaction to injustice and efficacy on commitment to action" (Thomas et al., 2009a, p. 205). In the case of our findings, it is the experience of enactment within a supportive group setting that participants describe to be fundamental to the containment of their anxiety and to the sense that they lack agency, stressing the mediating function of enactment in enabling the translation of anxiety into pro-change beliefs (Thomas & McGarty, 2009, p. 129), enabling meaningful positive collective action; e.g., "Doing Something Better Together" (Hilton & Lawrence-Pietroni, 2013). Our findings further suggest that it is through the process of enactment that the identification of participants with the NHSCD movement occurs. It is through this process of identification as activists in the movement that the positive group identity

of NHS staff is strengthened. In particular, this process encapsulates the belief that "change is possible" (Thomas & McGarty, 2009, p. 129) – a belief that is fundamental to participants' claims of regaining their sense of individual agency and group efficacy.

Our findings further tessellate with Thomas et al.'s (2009a) normative alignment model in which they consider "action, emotion, and efficacy elements as content of the identity". These content elements, they claim, are "complementary aspects of identity meaning", and thus, they argue that "change in one part of the normative framework of the identity would also produce shift in the whole identity meaning" (p. 207). Our findings reveal the key role of enactment in the construction and shaping of shared group beliefs in respect of participants' individual agency and collective efficacy. In particular, participants articulated their beliefs regarding group efficacy as a motivating factor, giving meaning to their individual agency, and inspiring their collective action. In this context, participants found especially meaningful the belief that as participants in a large group, they could have an increased individual as well as collective impact. Significantly, the sense of both feeling empowered to voice personal opinions and being listened to, as well as acting as role models within the group, was expressed.

Activists described how their sense of personal agency was strengthened through an increasing belief in their group efficacy. A sense of empowerment was formed through their collective non-hierarchical enactment of small- scale, individual improvements. The fact that such practices involved individuals from a wide spectrum of the NHS hierarchy and from a range of professional backgrounds, all enacting personal improvements in an atmosphere of equality, was often described as

a motivating factor. This experience of collaborative enactment tessellates with other ethnographic descriptions of prefigurative movements (Cornish et al., 2014; Maeckelbergh, 2011, 2012; Moskovitz, 2012). Western's (2014) analysis regarding the enactment of leadership in prefigurative movements for example, states: "Leaders or followers are interchangeable and both participate autonomously to co-create the enactment of leadership" (p. 7). The movement's own, non-hierarchical structure led activists to experience the mobilising potential in devolution, with the contingent feeling of togetherness, liberating individuals from the sense that their actions were constrained by the system. This resulted in the dialogical construction of the 'Hubbies' network, which relied both on the expansion and coordination of the existing network, and on the generation of new networks. Consequently, frontline staff felt impelled to initiate change rather than wait for managerial inter- vention. Similarly, participants were motivated by a sense of collective passion and potential, as they experienced how their actions and voices were validated through their membership of an ever-expanding, dynamic, and like- minded network.

Our findings further reveal the process of enactment to be value based. Participants describe how this resonated with their experience at an existential level, associating a sense of emotional transformation with their involvement in the movement, describing feelings of liberation and empowerment. Ganz (2010) discusses how emotions are crucial in motivating people to join social movements. He splits emotions into two categories: those that motivate participation in collective action, such as urgency, anger, hope, and solidarity, and those that prevent participation in collective action, such as inertia, apathy, fear, isolation, and self-doubt (p. 535). Participation within the NHSCD movement had wide-scale implications:

through affirming their potential to enact small-scale change, participants acknowledged their capacity to match their working style with their values as health-care practitioners. In particular, feelings of compassion and empathy for patients' needs were repeatedly expressed as motivating emotions for collective action (Thomas, McGarty, & Mavor, 2009b).

In describing how their individual agency was galvanised through their participation in a collective and national initiative, Thomas et al. (2012) state that "EMSICA proposes that emotions and efficacy can themselves initiate a shared emergent understanding of "who we are" as group members, where the resultant group membership is premised in a shared understanding of emotional reactions" (p. 3). Participants shared their understanding of the interplay between the individual and collective experience, stressing the profound impact on their sense of efficacy, in taking part in a national campaign.

Ultimately, in this paper, we show how individuals are driven to voluntarily participate in prefiguring change in the NHS through the daily enactment of self-initiated activities. These findings tessellate with the developing notion in the literature that identification with a social movement is a performed phenomenon. Johnston (2009) states, for example, that movement activists "make their unique contribution to the collective definition of identity through their actions, and also contribute their own unique perspective on strategy, goals, and behaviors. These different perspectives on courses of action are important sources of innovation, experimentation, and opposition" (p. 10). Eyerman and Jamison (1998) further refer to the role of enactment in social movements on a collective level, discussing how social movements reconstitute both politics and culture. They emphasise the lasting

impact which social movements can have on cultural memory, long after the movements themselves no longer play an active role in directly affecting political change.

Conclusion

The findings in this paper illustrate how the NHSCD movement embodies the key characteristics of a prefigurative movement. Enactment and collaborative thinking drive the movement; its activism is rooted in the grassroots agency of frontline staff, emphasising the importance of nourishing small-scale, experimental, bottom-up changes rather than large, planned, top-down change programmes.

There are as many different reasons why NHSCD exists, as there are individuals who have participated in it. As presented in the results above, participants in the movement emphasise different aspects of the experience of participation as meaningful to them, and as their driving force in activism. Our findings show that motivation, although inspired by strong emotions preceding group formation, is not purely an individual, intrinsic endeavour, which exists prior to the enactment and engagement associated with the NHSCD movement. Even when exploring the contextual factors motivating their activism, participants constantly emphasised their belief that enactment within the setting of NHSCD presented them with an emotionally satisfying solution for their sense of disempowerment.

The Change Day movement aims to bring about change and improve day-to-day practices and experiences for NHS staff and patients; however, the manner in which change is delivered holds a greater significance for participants than just as a means to an end. We illustrate the dynamic and circular interplay between motivation

and participation in collective action, and the key role played by enactment in the process through which the participants identify themselves with the movement, and the movement's collective identity is crystallised. We argue that it is through enactment that the process of participation, as well as the movement's ideology and vision, is shaped. We argue that the notion of change as promoted by the movement was perceived as philosophical, inspiring participants with a deep sense of hope. Participation in the movement, we argue, resonated with contextual, preexisting senses of anxiety and strong emotions related to a positive and value based sense of vocational identity. It is through the enactment, we contend, that the encapsulation and translation of these emotions into a sense of efficacy and pro-change beliefs was facilitated. The sense of collective energy generated through the movement was vital, especially as, in celebrating the power of small-scale, incremental changes, participants were able to envision the grander impact of enactment, and a brighter future for the NHS.

The participants described experiences of the process through which change was delivered; their associated sense of their ownership of change through enactment was viewed by participants as empowering, and thus viewed as a goal in its own right. In this sense, it becomes impossible to separate the improvement goals that change is aiming to achieve from the manner in which change is being delivered. It is, therefore, impossible to separate motivation from enactment and vice versa, to separate enactment from motivation: they are completely interwoven processes, which inform each other over time.

Notes

i) During a major investigation initiated in 1999, British General Practitioner, Harold Shipman, was found to have killed at least 250 of his patients, mostly elderly ladies, over a period of 23 years in service, and was given fifteen life sentences (Batty, 2005). Shipman's disturbing legacy had a profound effect on the NHS. John Mayberry, Editor of the British Medical Journal (BMJ), summarized the reaction within the healthcare services: "We need to recognize that deviant and criminal behavior can occur in any sector of society and that medicine and nursing are no exceptions" (Baker, 2004).

ii) An undercover BBC Panorama investigation into serious abuses at Winterbourne View, a residential hospital for adults with autism and learning difficulties, was broadcast nationally in May 2011, and led to six hospital staff being jailed, and five being given suspended sentences. The Judge investigating the case stated that "A culture of ill-treatment developed and as is often the case, cruelty bred cruelty" (Hill, 2012). South Gloucestershire's Safeguarding Adults Board commissioned a serious case review, in which it asserted that the NHS hospital closure program and a failure to commission local services recommended by the Department of Health had led to business opportunism, creating the culture of cruelty at Winterbourne View. The Department of Health further acknowledged the failure of commissioning, and the necessity to plan for vulnerable adults in need of long-term care to be supported in domestic, rather than hospital settings (Flynn & Hollins, 2013).

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Chapter 7 How to Effect Change in the English National Health Service (NHS): Mobilising Collective Organisational Knowledge through Framing Practices

Abstract[18]

Designing and implementing successful organisational change programmes requires the effective mobilisation of collective knowledge. We propose 'framing' as a distributive, agentic and voluntary process of knowledge mobilisation to expand the traditional, centralised understanding of the phenomenon. We look in particular at the process of knowledge mobilisation in the context of purposeful collective action, as orchestrated by the English National Health Service (NHS) Change Day (NHSCD), a social movement that calls upon healthcare practitioners and members of the public to create 'better' working practices within the NHS. Through a longitudinal qualitative study which uses 26 in-depth interviews, 100 'Stories of Change', 9,479 online 'pledges' plus documents and field notes, we show how participants in the NHSCD movement have mobilised collective knowledge to effect change. The analysis shows how, through ongoing online and face-to-face engagements, the movement has co-constructed three interconnected frames to shape collective action by diagnosing NHS problems, prognosticating the actions needed to solve those problems and motivating participants to take action, both in their daily working practices and across the overall NHS. Our research expands current understandings of organisational knowledge mobilisation in large healthcare organisations.

[18] This paper was co-authored with Dr Garcia-Lorenzo. The paper was recently peer reviewed and rejected for publication in Organisation Studies (see Appendix 8 for peer review feedback).

Key words: knowledge mobilisation, framing process, large healthcare organisations, collective action, organisational change, working practices.

Introduction

Large healthcare organisations (LHCOs) dominate the health and care arena such that changes in their governance have ramifications for the healthcare sector in general. A key challenge in the constant reorganisations LHCOs undergo is in the engagement and mobilisation of staff (Ferlie, Fitzgerald, McGivern, Dopson, & Bennett, 2013; Waring & Bishop, 2010). In addressing this challenge, research in the field of healthcare management has traditionally focused on providing policy-makers with an array of evidence-based intervention tools, focusing on issues such as the mobilisation of resources, decision-making and leadership (Davies, Powell, & Nutley, 2016). Only recently have researchers looked at how knowledge and working practices are mobilised and developed on the ground within healthcare working environments (Nicolini, 2006; Reay et al., 2013; Reay, Golden-Biddle, & Germann, 2006). This evolving body of literature stresses the centrality of knowledge mobilisation and shifts the focus from the production or utilisation of evidence to social activities and practices 'in which knowing is not separated from doing' (Gherardi, 2000, p. 215). As such, this research tradition is mostly concerned with micro-level processes, considering the study of organisational knowledge as a mutually constructed and negotiated process that is accomplished through the performance of diverse routines and practices (Gherardi, 2012; Nicolini, 2011).

The mobilisation of collective knowledge cannot be taken for granted, however, as disparities such as the 'translation gap', 'knowledge-doing gap' and

'research-practice divide' are common in healthcare (Gkeredakis et al., 2011; Grol, Wensing, Eccles, & Davis, 2013; Nutley, Walter, & Davies, 2003). Our study suggests a novel approach to investigating the practice of knowledge mobilisation in LHCOs by drawing on Goffman's (1974) concept of 'frame analysis' as developed by social movement researchers (Snow, 2013; see also Cornelissen & Werner, 2014; van der Haar & Verloo, 2016). This perspective focuses on the emergence of activism and looks at the methods by which social movements mobilise support for their causes and engage participants in collective action (Dewulf et al., 2009; Werner & Cornelissen, 2014). A frame-analysis perspective allows us to focus on the mobilisation of distributed knowledge by all agents in healthcare organisations, including members of staff and patients (Bate & Robert, 2010; Snow & Lessor, 2010). Specifically, our study addresses the question of how the process of framing can be used to further the understanding of the emergence of grassroots initiatives through knowledge mobilisation in healthcare organisations. We propose framing as a distributive, agentic and voluntary process of knowledge mobilisation that not only expands but sometimes also runs counter to the traditional centralised notion of the phenomenon.

In particular, we investigate the mobilisation of knowledge within the context of grassroots activism (Briscoe & Gupta, 2016) in the English National Health Service (NHS), which provides a particularly prominent example of the organisational challenges outlined above (Ballatt & Campling, 2011; Crisp, 2011). We address the following research question: How do movement participants in NHS Change Day (NHSCD) mobilise knowledge to engage with organisational changes in their daily working practices? The paper is based on a larger research project which follows the

development of the NHSCD, a movement constructed by frontline staff who engage with and lead daily initiatives of change in response to the current organisational, political and economic challenges faced by the NHS (Bevan, Roland, Lynton, & Jones, 2013; 'NHS Change Day', 2016).

Our analysis shows that the movement's framing negotiation process is organised around three interconnected and collectively developed frames – 'Local Leadership', 'Power Disruptive Activism', and 'Personal Learning Journey'. These frames were constructed via the mobilisation of collective knowledge, which consists of and is confined to a network of practices and is generated by an ongoing dialogue between grassroots and movement leadership. The framing process created a resonance between participants' grievances and the movement's frames, thereby enabling the resulting collective action frames to guide concrete actions. The process of framing also generated a flexible response strategy in the NHSCD, and therefore allowed the social movement to respond quickly to contextual challenges. Our findings illustrate how knowledge mobilisation in healthcare organisations can be further understood through framing practices and how the process of framing can improve organisational change programmes implemented in LHCOs.

The paper is structured as follows: The first section brings together a review of the existing research carried out on the mobilisation of knowledge in healthcare organisations and the contribution of framing practice from the social movement literature. The second section delineates the research design and methodology applied in researching the case study. The final section presents and discusses our findings from the qualitative data analysis in light of the relevant theory.

Knowledge Mobilisation in Healthcare Organisations

The healthcare sector constitutes a key segment of the GDP in developed countries, often accounting for a large portion of government spending (NHS England, 2014). Therefore, healthcare attracts a great deal of policymakers' attention and is subjected to constant interventions and top-down policy changes (Pollitt, 2013). Many LHCOs and partnerships are thus forced to design and implement wide-scale improvement programmes (Holms, 2013). These organisation-wide programmes frequently involve the dissemination of new working practices at the individual, small-group and macro-organisational level which need to be implemented in various regional contexts with diverse local working practices (Reay, GermAnn, Golden-Biddle, Casebeer, & Hinings, 2016). The problems and tensions arising from such implementation attempts, including the need to align central and local design and practices, are particularly prominent in large and complex organisations, and they are amplified in today's uncertain economic and political landscape (Kimberly, de Pouvouville, & d'Aunno, 2009).

As a response to these challenges, two main bodies of policy-driven work have been developed and dominate the literature in this field with significant impact on practice: The first focuses heavily on evaluative empiricism, mimicking clinical research, whilst the second imports general ideas and change models from business literature into health management (Ferlie, Montgomery, & Pederson, 2016). In contrast to these approaches, a third, smaller group of scholars have approached these challenges by drawing on a variety of social science theoretical perspectives (Crilly, Jashapara, & Ferlie, 2010). These theoretically-informed studies have advanced the understanding of many of the above policy-related issues, exploring processes such as

performance measurement and cost reduction (Lewis, 2003), organisational culture and the quality and safety of services (Ballatt & Campling, 2011), professional-organisational dynamics (Fitzgerald, 2016; Reay et al., 2006), and leadership (Fitzgerald et al., 2013; Sergi, Comeau-Vallée, Lusiani, Denis, & Langley, 2016).

While previous research has advanced our understanding of the process of organisational change in LHCOs, only recently have researchers started to look at the ways in which the mobilisation of knowledge develops and takes place in the context of working practices in healthcare settings (Nicolini, 2006; Reay et al., 2006; Reay et al., 2013). This emergent research tradition has started to focus in particular on the mobilisation of collective knowledge to effect change in LHCOs (Davies et al., 2016**;** Swan, Newell, & Nicolini, 2016; Nicolini, Scarbrough & Gracheva, 2016), and it stresses the centrality of knowledge mobilisation to both contemporary healthcare organisational studies and to the world of healthcare improvement practitioners (Ferlie, Crilly, Jashapara, & Peckham, 2012). Grounded in the ontology of 'becoming', this evolving literature focuses on how knowledge sharing and learning are accomplished in healthcare organisations through social activities and practices, thus viewing knowledge as inseparable from practice (Nicolini, 2012; Orlikowski, 2002; Tsoukas & Chia, 2002).

The mobilisation of collective knowledge in organisations is interlinked with practice, and involves a range of embodied activities configured around a shared set of understandings and daily practices, including information, meaning, power structures, and belief systems, alongside routines, rituals, and organisational constructs (Gherardi, 2000). Current research into LHCOs investigates the 'everyday' and 'life-world' of the organisation where the 'social' resides (Reckwitz, 2002, p.

244). Practice theory views action as the matrix from which organisational life emerges; the 'site' of knowledge is, therefore, seen as an ongoing social accomplishment, constituted and reconstituted as actors engage the world in practice (Gherardi & Nicolini, 2002).

This study is interested in 'how' the NHSCD mobilises collective knowledge that unfolds across time and space. Knowledge must be mobilised on multiple levels within the organisation to successfully implement new policies (Reay et al., 2013). It is therefore important to further the understanding of how different organisational actors from different contexts may contribute to the mobilisation of knowledge for change or, conversely, to resist top-down programmes and their implications (Kislov, Waterman, Harvey, & Boaden, 2014). However, the mobilisation of collective knowledge in healthcare is often fraught with difficulties, and research has shown that it cannot be taken for granted, highlighting the frequent occurrence of disparities known as the 'translation gap', 'knowledge-doing gap' or 'research-practice divide' (Gkeredakis et al., 2011; Grol et al., 2013; Nutley et al., 2003). These disparities contradict the idea that knowledge mobilisation is a straightforward linear 'transfer' of knowledge (from researchers to healthcare practitioners or from healthcare professionals to patients) and point to the need to see it instead as an emergent, socially negotiated and dialogical practice, in which new understandings are shared and co-constructed (Swan et al., 2016). In this paper we address this gap from a new perspective by looking at framing practices, which have been shown to be essential players within the process of the mobilisation of collective organisational knowledge:

> as they are often the shoals upon which medical and health care initiatives and interventions become stuck together. Consider, for example, the Surgeon General's ongoing efforts to curtail smoking by highlighting how it 'increases the risk of lung cancer' in contrast to the cigarette industry's framing smoking as 'pleasurable'. (Snow & Lessor, 2010, p. 284)

The concept of 'frame analysis' (Goffman, 1974) used by social movement scholars (Snow, 2013; see also Cornelissen & Werner, 2014; Dewulf et al., 2009; van der Haar & Verloo, 2016; Werner & Cornelissen, 2014) is useful in understanding how NHSCD social movement participants mobilise collective knowledge to identify problems in the NHS, propose solutions to those problems and attempt to effect lasting change in their daily working practices and in the overall NHS. Framing has been defined in social movement literature as the 'conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action' (McAdam, McCarthy, & Zald, 1996, p. 6). Frame analysis focuses on understanding the relationship between grievances (or perceived injustices) and their link to mobilisation (Gamson, 1988, 1992). We therefore propose to use a framing practice perspective to better explore the interplay between top-down strategic efforts to communicate new perspectives by the NHSCD movement and the involvement of potential grassroots participants in the process of realising these ideas to change the NHS. We develop these ideas in the next section.

Knowledge Mobilisation Through Framing Practices: A Social Movement Perspective

Social movement theory has been applied to the study of change processes within organisations, which scholars have argued can be influenced both by external social movements and movements internal to the institution itself (Briscoe & Gupta 2016; De Bakker et al., 2013; Haug, 2013). External movements push for change by challenging institutions through their opposition to particular measures and frames, questioning the legitimacy of the institution, whilst movements which emerge

internally ‘promote path creation and change incrementally by engaging in institutional processes (or becoming institutional forces)’ (Schneiberg & Lounsbury, 2008, p. 656). Thus, organisation studies have started to look at the mobilisation of collective action from a social movement perspective to account for emergence and agency in large collectives (Fernández, Martí, & Farchi, 2017). Within the context of this literature, scholars have recently highlighted the potential contribution of the framing perspective to the understanding of bottom-up practices within organisations (Cornelissen & Werner, 2014; Dewulf et al., 2009; Gray, Purdy, & Ansari, 2015; Kaplan, 2008; Lounsbury, Ventresca, & Hirsch, 2003; Purdy, Ansari, & Gray, 2017; van der Haar & Verloo, 2016; Werner & Cornelissen, 2014). We contribute to these efforts by looking at knowledge mobilisation through framing processes. According to Goffman (1974), ‘frames’ are ‘definitions of the situation (that) are built up in accordance with the principles of organisation which govern events – at least social ones – and our subjective involvement in them’ (Scott & Marshall, 2009, p. 263). Thus, Goffman’s (1974, 1981) notion of ‘frame analysis’ focuses on the organisation of experiences and the manner in which collectives such as social movements mobilise ideas (Oliver & Johnston, 2000).

In their seminal application of Goffman’s work on framing to the study of social movements, Snow, Rochford, Worden and Benford, (1986) contrasted their use of the term *frame* with *schema* as utilised in cognitive psychology. Unlike cognitive frames (Minsky, 1975) or schemas of memory (Bartlett, 1932), which refer to ‘mental structures that facilitate organizing and interpreting incoming perceptual information by fitting it into already learned schemas or frames about reality’ (Dewulf et al., 2009, p. 158), the framing perspective emphasises the interactive elements of the

negotiation of shared meaning between social movement participants (Gray et al., 2015). Two important assumptions of the framing perspective are stressed in the literature: first, that the framing process is viewed, at least partly, as a purposive action (Werner & Cornelissen, 2014). This does not mean it is fully controlled by one person or one group but that the role of movements' entrepreneurs in constructing a collective action frame is vital (Lounsbury et al., 2003). Second, that 'frames are constructed from a cultural fabric and that they have a specific content' (Johnston & Noakes, 2005, p. 7). The framing perspective compensates for the limitations of previous approaches by taking a constructivist approach to social movements. This allows for a greater understanding of the internal dynamics and the ways in which knowledge is mobilised and meaning is constructed in and around social movements, and it is particularly relevant to the understanding of knowledge mobilisation in LHCOs, as it focuses on the willingness of people to engage with change (Bate & Robert, 2010; Cornelissen & Werner, 2014; Snow & Lessor, 2010).

Furthermore, the notion of collective action frames focuses on agency and purposeful mobilisation, describing 'action-oriented sets of beliefs and meanings that inspire and legitimate the activities and campaigns of a social movement organisation (SMO)' (Benford & Snow, 2000, p. 614). Thus, this approach views *framing* as a verb and treats framing as an ongoing process. As such, 'interactional framing can explain the emergence of an idea from its early instantiation through periods of contest to the eventual formation of new organisations, industries, and cultural practices' (Purdy et al., 2017). Framing involves active efforts to construct reality as a dynamic evolving process through which new generations of interpretive frames challenge existing ones and thus cause social movements to evolve, thereby defining 'master frames' that

'perform the same function as movement-specific collective action frames, but they do so on a larger scale' (Snow & Benford, 1992, p. 138). That is, constructed master frames affect historical cycles of protest and provide a theoretical explanation for the process through which frames of social movements inspire each other and through which collective action gains legitimacy (Gamson, 1988). In this context, an important distinction is drawn between the framing processes of emerging social movements and those of mature movements. The former relies on the shared understandings of followers and develops mostly as a spontaneous, unconscious process. In contrast, the framing of mature movements seems more predictable and frequently appears 'owned' by a movement's official leadership (McAdam et al., 1996).

Three basic elements must be identified in the framing process: a social or political problem, the parties responsible for generating the problem, and a solution (Johnston & Noakes, 2005):

> [A]t a minimum people need to feel both aggrieved about some aspect of their lives and optimistic that, acting collectively, they can redress the problem. Lacking either one or both of these perceptions, it is highly unlikely that people will mobilise even when afforded the opportunity to do so (McAdam et al., 1996, p. 5).

Research suggests that there are a number of steps involved in developing a successful frame (Benford & Snow, 2000; van der Haar & Verloo, 2016). First, a renewed definition must present and interpret existing problems, events and grievances to potential activists and participants. This is understood as a process of 'diagnostic framing' and often entails the utilisation of the 'cultural toolkits' available in the society in which the social movement emerges (Johnston, 2009). Additionally, the process of diagnostic framing identifies 'the actors who are entitled to have opinions on it' and often employs the altered features of successful frames of other

social movements in a new historical context (della Porta & Diani, 2006, p. 75). The second requirement is that the frame negotiation process must successfully present ways of solving these problems, in what is understood as 'prognostic framing'. Lastly, these framing processes must convince people to act in ways prescribed by the prognosis, in what is known as 'motivational framing' (Snow & Benford, 1988). Thus, the framing perspective in the study of social movements tessellates with the concepts developed within the practice tradition, which draws attention to the lived experiences of organisational actors in LHCOs (Gherardi, 2000).

This paper investigates the framing negotiation process of the NHSCD movement, which developed within the confines of the overarching organisation of the NHS. In doing so, we address the following research question: How do NHSCD movement participants mobilise knowledge to design and engage with changes in their daily working practices?

Methodology

The NHSCD Movement

Our study follows knowledge mobilisation practices within the NHSCD movement (Bevan et al., 2013; NHS Change Day, 2016), a social movement developed within the NHS in response to acute organisational problems (Crisp, 2011). The English NHS was established on the principle of universal healthcare offered free of charge at the point of delivery, and this principle has become integral to British identity. In fact, as the largest healthcare provider in the world and the first to offer universal healthcare in the West, the NHS is seen by many to represent social justice and equality (Ballatt & Campling, 2011).

The NHSCD movement developed as an emergent response to some of the major organisational challenges currently faced by the NHS. The NHSCD had a long inception: Participants describe a decade-long period in which the idea of creating a social movement for healthcare improvement was considered by improvement leaders within the NHS (Bate & Robert, 2010). The defining moment, however, was marked by a widely-circulated story regarding the movement's moment of origin, which involved a Twitter exchange between the three founders of the movement. The narrative of how the movement developed further describes the initial stages of its emergence, in which a small group of activists developed the idea of initiating a social movement within the NHS (Bevan et al., 2013). The focus and scope of the movement continued to expand and develop, as did activists' 'vision of the future', both for the NHSCD movement and the NHS itself.

A few months prior to the first NHSCD, the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) published its investigation of the NHS in what was widely known as the 'Francis Report', revealing problems such as widespread patient neglect (Francis, 2013). Although the NHS was no stranger to structural upheaval, the Health and Social Care Act (2012), introduced around the time of the second NHSCD, is a particularly strong example of top-down organisation-wide change (Holmes, 2013), as it explicitly focused on restructuring NHS organisational practices. These above events provided the context for our research as they held deep significance for NHS employees: participants in NHSCD were extremely aware of the need for organisational change.

Both NHS employees and members of the public were encouraged to join the NHSCD movement following its call for action to 'Do something better together',

which resulted in a variety of initiatives and personal and group actions intended to improve general practice. The call for action was disseminated by NHS Improving Quality, an organisation that helped to coordinate many of NHSCD's events and activities (NHS England, 2014).

Data Collection

We designed a longitudinal qualitative study to explore how collective knowledge was mobilised in the NHSCD social movement to effect change. This approach allowed us to focus on the process of change and the practices and narratives that support it within a context-based approach (Langley, Smallman, Tsoukas, & Van de Ven, 2013). Our data collection and overall fieldwork was carried out over an extended period, encompassing four of NHSCD's annual events (2013, 2014, 2015, and 2016) (NHS Change Day, 2016).

The first author attended meetings and discussions with NHS leaders from July of 2012 in preparation for data collection and to establish background knowledge of the movement and its participants. Fieldwork was carried out intermittently from July of 2013. The first author participated in and recorded 67 meetings and events onsite and 450 hours of live digital data collection (e.g., a review of the movement's Twitter and Facebook accounts and viewing participants' YouTube videos) and reviewed the movement's annual official websites (NHS Change Day, 2016). The first author also collected and read 389 publications which were published in 2014 in various press media outlets (e.g., national, local and trade media), 80 relevant artefacts (e.g., documents, reports, fliers, advertisements, tools, posters, etc.) and over 800 emails from her personal correspondence with the leaders and activists of the

movement. This level of intense engagement with the NHSCD provided us with a rich understanding of the movement and its practices of knowledge mobilisation. This knowledge was expanded through a range of formal and informal interviews with leaders and movement participants. See Table 1 for the full data corpus.

Table 1: Data collection Statistics

	Interviews	100 Stories of Change'	Pledges	Live Participant Observations	Digital Ethnography	Press Media	Movement Artefacts
Data Collected	**26**	**100**	**9,479**	**200+ hours**	**400 hours (including over 800 email correspondence)**	**389 publications**	**50+ hard copy and electronic leaflets, flyers, posters, logos, etc.**
Collected during NHSCDs	**2013-2014**	**2013-2015**	**2014, 2016**	**67 meetings and NHSCD events**	**2013-2016 (ongoing)**	**2014**	**2013-2016 (ongoing)**

Interviews

Drawing on preliminary insights taken from participant field data, we carried out a purposeful sampling of interviewees to obtain a representation of different stakeholders within the NHSCD and the NHS and to better understand the movement's development. This sampling included the three activists who founded the movement, eleven members of the national core leadership team, eight regional leaders ('Hubbies'), six activists in a local trust, two activists in a local clinical commissioning group (CCG), and two other participants. Interviewees were also selected from a variety of professions, institutional levels and geographic locations. Through this purposeful sampling, we aimed to gain both a generic impression of the NHSCD movement across the UK and specific information regarding a local CCG. The interviewees were asked about their personal background, the process through

which they became involved in NHSCD, their experience of participation in the movement, their perspectives on the movement and their vision for the future.

NHSCD Pledges

The NHSCD movement encouraged every single participant to make a pledge, an act that was considered a definitive moment of participation. Pledges were recorded on a 'pledge wall' found on the official website of the NHSCD movement[19] (NHS Change Day, 2016). They reflected participants' concerns and beliefs regarding the improvement of everyday practices at both local and institutional levels. The movement built official and separate websites for each NHSCD, from 2013 to 2016.

189,000 people pledged over the course of NHSCD 2013. This number rose to 802,000 for NHSCD 2014. No pledge count was available for 2015 and 2016. The pledges differ: Some are individual narratives; others are group accounts. The movement's website provided participants with a platform on which they could either compose their own individual pledge narrative or join an existing pledge. As such, the 9,479 distinct pledge narratives made in 2014 represent a total of 802,000 pledges. As change initiatives became popular, increasing numbers of activists joined them. A particularly significant example of a popular pledge can be seen in the 'Hello, my name is…' pledging campaign that was created by the late Dr. Kate Granger with the purpose of 'remind[ing] health care professionals and all staff of the importance of introducing themselves to patients'. This campaign was ultimately joined by over 24,000 participants in 2014, and was 'endorsed by an increasing number of well-known figures including David Cameron, Jeremy Hunt, Nicola Sturgeon, the

[19] For an example of online pledges, see http://fabnhsstuff.net/fabchangeweek/add-pledges/.

Countess of Wessex, Kylie Minogue, Bob Geldof and Drew Barrymore' (100 Stories of Change, Story 37[20]).

This paper is the result of the analysis of 8,806 and 673 distinct pledge narratives made for NHSCD 2014 and 2016, respectively. We also acquired data that described the number of participants that joined each pledge in 2014. We refer to the 673 pledges that were posted online in 2016 as individual pledges, as no supplementary data was available (See Table 2). The majority of pledges range from between 1-5 lines. The pledge data was downloaded from the 2014 and 2016 pledge walls and organised in Microsoft Word documents. All of the pledge data is contained within 525 pages and 27,576 lines of text.

Table 2: NHSCD Pledge Data:

	Number of Pledge narratives	**Number of people pledging**
Individual Pledges	6,752	6,752
Group Pledges	2,393	49,152
Organisational Pledges	169	310,780
Campaign Pledges	123	424,332
Kickstarter Pledges	42	11,211
Global Pledges	4	446
Total	9,479	802,673

The collection of this online pledge data allowed us to capture both the scope of the grassroots practices of the movement and the ways in which the NHSCD creates a

[20] https://fabnhsstuff.net/2015/02/02/story37/

unique platform for the expression of the narrative perspective of participants, thereby providing significant insight into how participants viewed their involvement in the movement. These emerging, short, ante-narratives (Boje & Henderson, 2014) describe what needs to be changed in the NHS and how to go about it from the perspective of the participants, hence constituting the initial stage of the '100 Stories of Change'.

100 Stories of Change

To gain insight into the implementation of activist-led change, we also collected what the NHSCD movement calls the '100 Stories of Change'. These are retrospective narratives (Boje, 2001, 2008; Czarniawska, 1999) shared between activists through a publication on the official website of the movement[21] which celebrate which celebrate the successful implementation and completion of the changes pledged during the 2013 and 2014 NHSCD. Activists distributed the stories as part of a 100-day countdown to NHSCD 2015, with every day marked by the showcasing and dissemination of a successful change story on the website. In many cases, the narratives described in the stories corresponded with interview accounts, and in some cases the first author directly observed and experienced the described events as they unfolded during participant observation sessions.

Data Analysis

The data corpus was interrogated three times. The first part of the analysis sought to understand the development of the NHSCD movement and what made activists join the NHSCD. The entire data corpus was carefully read: interviews, 'pledges', the '100

[21] For examples, see https://fabnhsstuff.net/fabchangeday/stories/.

Stories of Change', press media articles, notes from participant observations, email correspondence and collected artefacts.

The 26 selected interviews, 100 Stories of Change and 9,479 pledges were qualitatively analysed in NVIVO. The first stage of the analysis involved the deconstruction of the texts into quotations, which were then clustered into first-order concepts according to the content of the practices that they described (Gioia, Corley, & Hamilton, 2012; Riessman, 2008). The analysis sought to clarify the different phases that the social movement went through as well as the participants' understanding of how NHSCD could be an instrument for changing the NHS.

While the first analysis uncovered participants' understandings of the NHSCD movement as a potential instrument for change within the NHS, it was yet unclear what exactly participants thought needed changing and how they would effect that change both at local and institutional levels. We therefore interrogated the data a second time, looking both for general understandings and personal narratives of what needs to be changed in the NHS according to participants. We performed a thematic-narrative analysis (Gioia et al., 2012) that reorganised our data according to the categories of scene, agent, purpose, plot and agency (Boje, 2008) (see Table 3), and through this identified three main narratives that frame the movement's understanding of what needs to change in the NHS and why: the 'Local Leadership' frame, 'Power Disruptive Activism' frame, and 'Personal Learning Journey' frame. By combining narratives and frames in our second analysis, we aimed to overcome the tendency of framing analysis to 'overemphasise cognitive factors' (Davis, 2002, p. 9) and to show how a social movements' general frames and participants' narratives describing personal experiences can be aligned (Ganz, 2010; Polletta, 2006). The resulting

frames – described as narratives – encompass both individual participants' experiences and the overall movement's understanding of the directions required to improve the NHS.

The third level of analysis sought to understand the functions of these three frames in the process of mobilising and implementing change through daily working practices. Capitalising on previous readings of the data corpus and following the literature on framing (Benford & Snow, 2000), we identified three main core framing functions of those narratives: diagnostic, prognostic, and motivational. This was done following a thematic analysis (Gioia et al., 2012) in which we reorganised codes and categories, grouping them according to how each core framing task was performed (see Table 3).

NHSCD: Framing Collective Action from the Grassroots

The leadership, power and journey narratives we present below capture and articulate elements of the NHSCD movement's wider narrative construction. These collective action frames act as catalysts, highlighting important narrative moments that aim to motivate participants to action (della Porta & Diani, 2006; Ganz, 2010; Snow & Benford, 1988). In this section, we present the three different but interconnected narratives and also illustrate their function as collective action frames, in which NHSCD participants relate the particular ways in which the NHS could be improved and which actions need to be taken to do so. They are not representative of any particular group but rather show the experiential dimensions of participants' engagement with the movement through the implementation of change initiatives.

Table 3: Thematic-Narrative Analysis

	The 'Local Leadership' Frame	**The 'Power Disruptive Activism' Frame**	**The 'Personal Learning Journey' Frame**
Scene	A Crisis in the NHS	A Stagnant Hierarchy	Change at the Grassroots Level
Agent	The NHSCD Leader	The Activist	Frontline Participants
Purpose	Taking the Lead	Creating A Direct Democratic Dialogue	Personal Development
Plot	An Emerging Network of Leaders	Subverting Traditional Role Boundaries	Changing the Everyday
Agency	Enacting Distributive and Inclusive Leadership	Enacting ‘Radical’ Change	Enacting Change in Daily Practices

Our analysis also outlines the dynamics underlying the framing process. Drawing on the notion of core framing tasks (Snow, 2013), we show at the end of each narrative how knowledge is mobilised within the NHSCD, describing how these framing functions serve the operation of the movement on the ground. In each frame, we illustrate the problematic areas identified by movement participants through the ‘diagnostic framing’ practice. Diagnostic framing is defined as ‘involv[ing] identification of a problem and the attribution of blame and causality’ (Snow & Benford, 1988, p. 200). We show how participants within the NHSCD movement defined the NHS as structurally flawed. Through ‘prognostic framing, participants collectively identified potential solutions, envisioning an organisation in which top-down planning, although an essential reality, could be flexible, adapted to fit both local conditions and the particular requirements of different trusts, departments and teams on the ground. The third framing function was that of motivating participants, which used a variety of means to emotionally engage them as activists, outlining a ‘rationale for activism’ and creating ‘a sense of agency to affect change and urgency

to do so' (Davis, 2002, p. 7). Motivational framing creates 'appropriate vocabularies of motive', compelling participants towards collective action and sustaining their engagement with the social movement (Benford & Snow, 2000, p. 617). We present each frame in Table 4 below.

Table 4: Analysis of Framing Practices

Collective Action Frames									Framing Practices
The 'Local Leadership' frame			*The 'Power Disruptive Activism' frame*			*The 'Personal Learning Journey' frame*			
Change is lectured to staff Senior management design change	Failure of senior management to address organisation-wide crisis		Grassroots ideas are blocked Unequal knowledge distribution: various professions/ hierarchical levels	A fragmented institution: exclusion and a non-communicative power structure		One size fits all Disconnect between formal knowledge and reality on the ground	Failure of change initiatives to reflect and adapt to changing circumstances		*Diagnostic Framing*
Knowledge is debated and discussed with staff Top-down planning is adapted to fit local conditions	Creating platforms for the sharing and adaptation of knowledge		Grassroots ideas are being legitimised and implemented Transparency is encouraged, grassroots can speak truth to power'	Legitimising grassroots change initiatives through inter-level dialogue		Personalising change programs and sharing ideas The point of view of the 'other' is incorporated	Personalising change to reflect a wide range of experiences and contexts		*Prognostic Framing*
Flexibility in goal setting Collective identity/ Belonging	Empowerment		Experimentation with new ideas Communication	Inclusion		Tolerance towards mistakes Personal and group development	Innovation		*Motivational Framing*
Coping with top-down pressures of evaluation Difficulties in communication amongst leaders and activists' networks	Conflicting understandings over the meaning/ limitations of distributed leadership		Lack of support for NHSCD activists by their managers Resistance to NHSCD by individuals and/or professional groups	The need to keep NHSCD grassroots (not 'taken over' by management		Balancing commitment to NHSCD with commitment to work The fact that NHSCD only 'happens once a year' challenges its sustainability	Limitations to continuous learning processes		*Contested practices*

The 'Local Leadership' Frame

The 'Local Leadership' narrative revolves around *the scene* of *crisis in the NHS.* Issues such as underfunding, staff shortages and patient neglect are prominent in this frame:

> I think all of us as employees of the NHS have a responsibility to try and improve it because we see what goes wrong and we see the snags the patients, the colleagues come across on a daily basis. (An NHS Doctor)

> I was part of the Francis Enquiry and I sat through a lot of the evidence of that on my first placement, and that's really what inspired me to do Change Day. […] When I came into the NHS, I was really concerned that a nurse works a shift and goes home, whereas people don't work over the hours. (A Hubbie - an NHS Manager)

NHSCD enabled participants not only to voice their concerns, but also to become leaders and solve problems locally. The NHSCD's open-ended structure encouraged participants to design change initiatives that meet what they thought were the specific needs and requirements in their local departments or areas, therefore allowing for the emergence and development of 'social movement leaders'. The *agent* in this narrative, the *NHSCD leader,* is ambiguously defined, as the movement kept leadership roles open to anyone, encompassing a wide array of tasks. These tasks range from the leadership of the NHS Improving Quality Horizon team to the key voluntary role of the 'Hubbies' (who acted as intermediaries between the grassroots and the core leadership team) and the improvised leadership roles performed by volunteers on the frontline. Participants describe how taking on leadership roles provided by NHSCD gave them a sense of *collective purpose*, as they had the ability to envision and drive positive change in the NHS. An example is the voluntary role played by the Hubbies, who took responsibility for encouraging wider participation in NHSCD and helped to develop a*n emerging network of leaders:*

> But for me the greatest thing about the Hubbies was bringing together managers, doctors, nurses – and I don't think anyone has ever really managed to do that in a way that has been so productive. (A Core Leadership Team Member - an NHS Doctor)

Local leadership roles are described as crucial to bringing the movement forward, providing unique opportunities for junior members to develop and communicate their skills and to lead innovative personalised change initiatives. Furthermore, participants described how being in a local leadership role meant interacting with a vast range of different people from across the NHS, thereby broadening their understanding of the organisation. The leadership narrative is driven by a sense of *agency* that enables

greater freedom for innovation and change initiatives, circumvents traditional paths to leadership and generates a space in which a distributive and inclusive approach towards leadership can be enacted:

> For me NHS Change Day represents what I truly believe: that we can all make a change, no matter how small. When joined together with all the other small changes others make it can lead to better care for patients and better working for staff. I personally cannot facilitate large-scale change but I can make small changes that have an impact on those that matter most, those that I care for. (Story 35/ 100 'Stories of Change')

The 'Local Leadership' frame incorporates the idea of collective responsibility, reproducing the movement's idea that the large-scale enactment of small, individual-led changes could lead to overarching systemic change within the NHS. The 'Local Leadership' frame indicates how to 'do' leadership for change in the NHS through a personally-engaged, multiple-voiced interpretation rather than through the grand, top-down, single-voice interpretation of traditional leadership visions (Boje, 2001, 2008; Czarniawska, 1999).

The 'Local Leadership' frame supports the process of collective knowledge mobilisation in a number of ways. First, the frame helps to *diagnose* NHS leadership problems as participants see them. In their interviews, participants frequently saw the organisational structure as inefficient and distant. The risks faced by the institution were associated with badly planned change programs and the way that these were delivered. Second, the frame also offered a *prognostic* framing function through an inclusive leadership model. NHSCD's emerging leaders adapted the NHSCD message to the specific regional needs represented by each 'Hubbie', aiming to demonstrate that this method of change implementation was feasible. The process was facilitated by the construction of a variety of physical and virtual *platforms* to enable communication, including face-to-face and group meetings, larger organised events

and social-media platforms such as Twitter and Facebook:

> I pledge to think about and work on how our web resources could best reach and support patient leaders (Pledge 4,754/9,476)
>
> On Change Day I will be a dementia advocate influencing change through local leadership and networks. This will be done through archived word, picture and film (Pledge 5,064/9,476).

The emphasis on the personalisation of change encouraged individuals to *debate*, *discuss*, and share their own particular issues and visions, to consider how *top-down planning could be adapted*, and express the movement's call for action in whatever way they saw fit. Finally the 'Local Leadership' frame outlines participating in the NHSCD movement as a personal and individual journey towards self-improvement. Helping others was framed as the catalyst towards helping oneself and becoming a better person. Thus, the 'Local Leadership' frame shifted the stress from external rewards to intrinsic motivation through an emphasis on flexibility in goal setting, a sense of *collective identity* and the idea of *belonging*. The frame was challenged, however, on a number of levels. The looseness and ambiguity of both its structure and the device of pledging led to a feeling of vagueness that was seen as being detrimental to the implementation of real change. Critics argued that balancing distributive leadership with traditional leadership models was necessary for organisational effectiveness. Critics also described the problems they faced when coping with the top-down pressures of evaluation and described problems of communication. Some of these issues were further discussed in the 'Power Disruptive Activism' frame that we explore next.

The 'Power Disruptive Activism' Frame

The second frame focuses on addressing power dynamics, status quo and power

structures within the NHS. The participants describe a *scene* characterised by a s*tagnant and formal hierarchy* in which the traditional boundaries between roles were rarely questioned and healthcare workers felt disempowered and alienated from their peers. A person's ranked position in the hierarchy was a method commonly used to identify NHS personnel, emphasising the disconnect between people and departments:

> Everyone's referred to by their Band in the NHS and I just think it's quite demeaning in a way, that you're basically reducing someone down to their salary in fact is what it is. […] (A Hubbie – a Finance Management Trainee)

In this frame, the character of the '*Disruptive Activist'* is the *agent*, pushing against existing power structures so that people lower down on the organisational ladder are able to speak out and contribute to the movement:

> I always think of an example with one healthcare assistant, or a porter in a hospital, he wanted to make the pledge that if he saw a doctor speaking into the Dictaphone in a public setting, he would tell that doctor off. Now, the reason he can do that more comfortably on Change Day is because he feels like, oh, there's hundreds of people around the world who are doing this thing as well. (A Hubbie - an NHS Quality Improvement Leader)

The *purpose* of this narrative was to disrupt the existing power dynamic by exemplifying an alternative, an environment in which direct democratic dialogue could be fostered (Polletta & Hoban, 2016). The annual NHSCD was seen as an opportunity for wider participation within the overarching progress narrative of the NHS itself.

Participants emphasised the centrality of grassroots activism to the movement, resisting institutional efforts to control or limit the change impulses of the NHSCD. The movement encouraged diversity and brought together professionals from different backgrounds, thereby overcoming the boundaries between departments and enabling participants to see how their work was directly connected with the general

meaning of the NHS. For many participants, patient care was seen as having become secondary to financial imperatives and social problems, and healthcare staff were hard-pressed to maintain standards of care. The radical inclusivity of the NHSCD movement aimed to bring power back to the patients and those who could not fight for their own interests. Anyone could join the movement and make their voice heard in a non-traditional way within the wider call for organisational change: This led to an increased understanding of the ways in which patient care could be improved and to the accommodation of the wishes and desires of marginalised groups within the organisational structure.

The 'Power Disruptive Activism' frame supports the process of collective knowledge mobilisation in various ways. First, it *diagnoses* power structures within the NHS as a problem. The NHS is seen as fragmented and divided, with limited communication between departments. Participants described the way in which ideas from the grassroots were either disregarded or blocked by senior levels of management:

> So I'm on a centrally run programme […] we don't set the agenda, we don't decide what we want to study. They decide everything (A Hubbie – an NHS Management Trainee).

Second, the 'Power Disruptive Activism' frame suggests *inter-level dialogue* and increased *transparency* in the organisation as a *prognosis* of what to do to solve power problems. The frame encourages members of staff to speak out and report bad practice, connecting this with the idea that the grassroots can *speak 'truth to power'*:

> I pledge to speak out if I see bad practice and to strive to improve patient care wherever possible (Pledge 7217/9,476).

The activity of 'pledging' is the act through which opinions were expressed, experiences related, knowledge shared and information transformed into potential

action, forming a space of enactment (Boje & Henderson, 2014) that *legitimised the perspective of the grassroots*. Finally, the 'Power Disruptive Activism' frame helped to *motivate* towards collective action by challenging the pre-existing hierarchy of the NHS, thereby facilitating *inclusion* and *experimentation with new ideas*.

However, elements of this frame were *contested* both internally and externally. Participants described the *need to keep NHSCD grassroots* and expressed their anxiety about the increasing professionalisation and formalisation of the event:

> [W]e have to keep the grassroots nature of [NHSCD] but we have to find ways of connecting – there's inherent tension between doing things in a very organised, professional way and being grassroots and front-line. (NHSCD founder)

The organisational environment presented another challenge to the optimism of the social movement, as participants often felt misunderstood. Individual initiatives were met with a *lack of support from managers* and efforts made by junior members to take on leadership roles were not always welcomed, as they added to the pressure of balancing individual-led initiatives for change with full-time work. Furthermore, participants described meeting *resistance to the NHSCD movement* when promoting the movement to others. The open-ended nature of pledging was seen by critics as ineffectual, and participants connected this scepticism with the unclear nature of the movement's aims and goals.

The 'Personal Learning Journey' Frame

The third frame groups together accounts that explore ideas of progress and self-discovery. Thus, a recurring theme in the narrative is how participation in NHSCD is a vehicle for personal development. The *scene* of this frame is that of *change from a grassroots position*:

> I pledge to spend time with people I haven't work[ed] with before, in new and different areas that I haven't experienced and to listen and learn from their day to day experiences to help improve my ability to do my Job and benefit the NHS and the people it serves. (Pledge 365/ 9,479)

Frontline participants are the main *agents* in this narrative, whose ability to learn from their day-to-day experience is seen as overlooked and neglected. Thus, in this frame, the key *objective* of participation in the NHSCD is that of reconciling activism with career development. Pledges made were often interpreted as ways to fill 'gaps' within the daily work practices:

> I think the pledges we made were quite simple, but they were focused on patient experience, and I think as a result of doing that, I think we were able to change the way we looked at what we did, and actually think, why haven't we got a patient participation group, which some surgeries have? And so as a result of doing the comments form and doing the meet-and-greet, we thought actually we should be engaging more widely with our patients. (An NHS GP)

The sense of personal learning through the *enactment* of tangible and achievable *changes in daily practice* animated many of the accounts. The experience of 'small wins' (Reay et al., 2006; Weick, 1984) was described as meaningful, a way of slowly implementing new solutions: as '…a very small change repeated by a lot of people, can make a big impact'. (A Hubbie - an NHS Nurse). Knowledge mobilisation emerges in these narratives through the focus placed on the sharing of personal experiences and knowledge:

> I pledge to always take time to listen to my patients. To treat them in the way that they wish to be treated. I pledge to role model this and inspire others to be as passionate about the care they deliver as I am. (Pledge 410/9,479)

The dialogism of the movement enabled participants to draw on the same sources of inspiration, fostering the experimentation of new forms of social interaction of lived action (Lefebvre, 1991). Action became central to the process of personal learning and development.

The 'Personal Learning Journey' frame supported the mobilisation of collective

knowledge through three different functions. On the one hand, the frame was a means of *diagnosing* the problems that faced the NHS. Participants argued that the *one-size-fits-all* nature of top-down change programs ignored the reality of their lived experience and the improvisation demanded by working practices across different contexts. According to participants, change initiatives that ignored the particularity of grassroots experience were destined to fail:

> Certainly I've seen a lot of initiatives that have been sent down from the hierarchy without proper engagement with people on the shop floor, and they fail – they just don't work because people can't relate to the reasons why it's needed to be done. (A Hubbie-an NHS doctor)

Furthermore, the NHSCD movement utilised the notion of personal learning to create a *prognosis* for future action. Imaginative exercises were key to the projective element of the movement as they envisioned a reality in which *the point of view of the 'other' could be incorporated* into the structure of change:

> I got a cast put on for a day to understand going through the process of how we currently work with [the Clinical Fracture Team] […] I think you forget about what the impact of healthcare means from a personal level […] Are we designing it almost for somebody who is fit? For someone who is healthy? For somebody who is fully mobile? It's very easy to design this with yourself in mind as opposed to with the user in mind. (An NHS Senior Manager)

Initiatives were designed that adapted and personalised policy to *reflect different contexts and the experiences* of individuals and groups, of staff and patients, with a particular focus on marginalised groups. Finally, participants were *motivated* towards change through the encouragement of *innovation* through the inclusion of new voices and perspectives. Furthermore, *tolerance towards mistakes* was viewed as being essential to the learning process, and this attitude encouraged participants to experiment with their ideas:

> Our painter and decorator came to a Dementia Friends session. Afterwards, he told me that it costs no more to paint in dementia friendly colours than what he was using before. This went right the way to the Chief Nurse, Alison Kelly, and the hospital has now decided to do its redecoration like that. It's a change that costs nothing, but brings huge benefits. That's what NHS Change Day is about – low cost or no cost change that makes a real difference. (Story

69/ 100 ‘Stories of Change’)

However, the central ideas of this frame were *contested* due to what participants described as problems of sustainability. The lack of centralised authority meant that the responsibility for seeing the pledged change through depended on the individual alone, which generated uncertainty, introducing *limitations to the continuous learning process* promised by the movement. Additionally, the difficulty of measuring the impact of pledges led critics to question the ability of the movement to translate enthusiasm into tangible change. The NHSCD movement was also seen as being constrained by *the fact that it only happened once a year:* critics argued that participants should aim to make continuous changes. Participants also described the problems associated with balancing a commitment to NHSCD with a *commitment to their full-time work*. The attempt to engage with the social movement and encourage others to do the same was seen as adding to their already busy work schedules.

The three frames reported here illustrate the ways in which NHSCD participants understood problems in the NHS from a bottom-up perspective. They point toward the existing leadership, toward hierarchical and power structures and toward the blocking of personal learning opportunities as central issues and suggest practical actions to address them. Beyond their descriptive power, the above frames also facilitated the mobilisation of collective knowledge in the NHS by collectively diagnosing specific problems, offering solutions and motivating NHSCD participants into concrete actions to enact change in their working practice.

Discussion

This paper has explored the practices of knowledge mobilisation within the NHSCD social movement to effect change in the NHS through collectively developed frames

that enable them to also improve their daily working practices (Nicolini, 2012). The process of framing enables particular events such as the NHSCD campaigns to acquire meaning over time through the use of a variety of materials, the combination of collective co-constructed frames and the use of individual lived experiences (Davis, 2002; Dewulf et al., 2009).

In our study, we have seen how NHSCD carved out a variety of physical and virtual platforms to mobilise collective knowledge and disseminate an awareness of its 'call for action'. These include communication platforms such as face-to-face and group meetings, as well as larger organised events (Haug, 2013). The movement also utilised virtual platforms to facilitate communication between its members, thereby facilitating continuous dialogue and engagement with and around initiatives of change within day-to-day practices (Nicolini et al., 2016). Pledging, for instance, a critical part of the movement, was mainly (and continues to be) done online. These spaces were used for the sharing of knowledge and the definition of problems and to encourage people to join the movement (Juris, 2012). The movement also used promotion platforms to further its message: The movement's web page publicises the '100 stories of change' and various publications have appeared in both the printed press and social media. These platforms allowed for greater freedom of expression than conventional NHS environments, constituting autonomous creative spaces with their own momentum and impetus (Reay et al., 2016). Indeed, it was the creative act of pledging online that defined competent participation in NHSCD (Bjørkeng, Clegg, & Pitsis, 2009). The vast quantity of pledges were produced and recorded across the three NHSCD events, and they transformed speech acts into narrative textual artefacts able to inspire future audiences (Gabriel, 2004). Similarly, the sharing of

implemented pledges – e.g., the 100 Stories of Change – became a practice of knowledge mobilisation that still influences current NHSCD activities (Polletta, & Hoban, 2016).

A central impetus behind the NHSCD knowledge mobilisation process was the enabling of all participants to express themselves (Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014). Social movement scholars consider knowledge mobilisation to be an essentially complex collective phenomenon. The notion of 'collective action' defined as 'action taken by a group (either directly or on its behalf through an organisation) in pursuit of members' perceived shared interests' (Scott & Marshall, 2009, p. 96) emphasises the notion of collectivity rather than of single agentic actors in knowledge mobilisation (Weick & Roberts, 1993). Our findings illustrate how, through the NHSCD movement, everyone from NHS receptionists, to doctors and patients, were able to engage with the movement and contribute. It is traditional in social movements to use a perceived injustice as the rallying point around which the movement is founded (Gamson, 1992). NHSCD participants strove to understand the causality of the present-day NHS crisis in order to combat it, attributing blame to certain elements of the existing organisational structure and arguing for the necessary change (De Bakker, Den Hond, King, & Weber, 2013). The challenges facing the NHS were identified and presented in an effort to encourage participation within the movement (Briscoe & Gupta 2016). The three central frames that emerged from the movement as a whole manifested the practice of *diagnostic framing* differently. For instance, in the 'Local Leadership' frame NHSCD participants described the need to move away from the archetype of the individualistic manager towards an organisation in which nurses, cleaners, low-ranking healthcare

professionals and patients could perform a leadership role (Fitzgerald et al., 2013) whereas in the 'Power Disruptive Activism' frame participants described the power struggles inherent to the hierarchical structure of the NHS and the way inequality was emphasised through a ranking system that privileged certain agencies over others (Reay et al., 2016). Our analysis shows that framing requires interplay between single agents and the collective: The three frames we encountered - the 'Local Leadership', 'Power Disruptive Activism' and the 'Personal Learning Journey' frames - were collectively co-constructed and represent a coming-together of individual viewpoints, yet they also enabled the expression of individual narratives and experiences (Cornish, Haaken, Moskovitz, & Jackson, 2016).

Furthermore, as Swan et al. (2016) indicate, in being collective, 'knowledge mobilisation is a political act' (p. 225). In Goffman's (1974) view, the framing activity is itself an exercise of power because it challenges a dominant interpretation of events. In the context of our research, the engagement of participants in framing practices represents political agency: Actors with less power combined their efforts to try and change the overarching narrative of the NHS (Politt, 2013). The distributive model of leadership presented by the 'Local Leadership' frame was a potential solution to an organisation-wide crisis, reinterpreting leadership roles as group enterprises, a coming-together of multiple aims and agencies aimed at changing specific practices (Nicolini & Monteiro, 2017). Participants conceptualised change in this frame around the formal and informal leaders needed for the general improvement of the NHS and patient care (Sergi et al., 2016). The 'Power Disruptive Activism' frame concentrates on initiatives taken to instigate debate, challenge traditional hierarchies, blur the boundaries between professional roles, and disrupt the

balance of power in the interests of a general institution-wide improvement (Fitzgerald, 2016). The device of pledging was essential to this purpose, as it encouraged inter-level dialogue and gave the grassroots an important tool with which to speak 'truth' to power, therefore bridging structural inequality within the NHS (Kitchener & Thomas, 2016). Participation in this frame was organised around the metaphor of activism: Challenges were posed to the existing hierarchy via role-play and other types of empathetic imagining in which participants attempted to experience the organisation from the perspective of the 'other' (Hardy & Thomas, 2016). Participants also explored how hierarchy was embodied within the physical spaces of the NHS (Foucalt, 1995) and introduced alternative ways of exchanging ideas and opinions within these spaces in the hope of enacting more egalitarian and democratic practices (Yates, 2015). The creation of non-hierarchical and subversive forms of engagement with change stood in sharp contrast to a restrictive experience of time and space within the NHS (Giddens, 1984). Thus, our findings further show how prognostic framing has enabled NHSCD participants to use framing as a political act to address areas of concern (Gray et al., 2015).

Snow et al. (1986) also indicate that the ability of social movements to connect with individual experiences is crucial to their process of knowledge mobilisation. Snow (2013) calls this process 'resonance': the extent to which a frame resonates with the lived experience and real grievances of participants and transforms individual motivations into a collective sense of purpose (Gamson, 1992). The process of 'frame resonance' is strongly connected to 'cultural narration', which describes the extent to which the target audience are able to see themselves in the suggested frame (Johnston, 2009). The NHSCD activists deployed different

metaphors in each frame to motivate and connect with members, allowing them to project themselves into the overarching narrative of the movement (Polletta, 2006). For example, the 'Local Leadership' frame stressed participation in the NHSCD movement through the metaphor of the volunteer: The drive towards organisational change was closely linked with the idea of helping and empowering others. Through pledging and storytelling, participants could see themselves as protagonists in their own individual quests for improvement whilst at the same time maintaining an awareness of an overarching group purpose and identity (Moskovitz & Garcia-Lorenzo, 2016). The motivating metaphor in the 'Power Disruptive Activism' frame was the activist, confronting institutional inequality (Kitchener & Thomas, 2016). For the 'Personal Learning Journey' frame, on the other hand, the motivational element was the idea of a gradual process of self-improvement (Reay et al., 2006).

Framing is, however, a dialogical process (Gray et al., 2015). As such, the development of the three frames presented was further encouraged through contested processes, as the frames put forward by the NHSCD activists were not unambiguously accepted (Kaplan, 2008). For instance, in the 'Local Leadership' frame, the distributive model of leadership was criticised as vague: Potential 'local leaders' struggled to understand what was expected of them (Cornish et al., 2014; Yates, 2015). The flexibility of the leadership model created difficulties for participants when trying to balance flexibility with the top-down pressures of evaluation, especially the difficulty of measuring the overall impact of pledging (Lewis, 2003). In the 'Power Disruptive Activism' frame, participants were afraid that the NHSCD movement would be absorbed into the NHS, and they articulated their desire to resist the formalisation and professionalisation of the event (Bate, 2010). However, when

trying to enact further inter-level dialogue and increased transparency in the organisation, participants encountered a lack of support from managers and a general resistance to the aspirational ideals of the movement, resulting in a pervasive cynicism that made it difficult to promote the movement amongst others (Kitchener & Thomas, 2016; Schneiberg & Lounsbury, 2008). Finally, the 'Personal Learning Journey' frame, while welcomed as encouraging the exploration of ideas of career progress and self-discovery, was also criticised for being unsustainable as it allocated too much responsibility to individuals (Fernández et al., 2017; Yates, 2015). Contest and conflict are part of the process of framing and reflect its dialogical and open-ended nature (Purdy et al., 2017). Overall, we have shown how the flexibility of the three collective action frames allowed for the narrative investment of participants: They were able to make their voices heard and see themselves within the overarching, open narrative of the social movement.

Conclusion

Our study expands our understanding of the process of knowledge mobilisation in LHCOs (Swan et al., 2016) in three different ways. First, while most research in LHCOs regards knowledge mobilisation as the transfer of knowledge from key stakeholders (Crilly et al., 2010; Ferlie et al., 2012; Gkeredakis et al., 2011), our research has shown that the efficient mobilisation of collective knowledge in LHCOs requires a process like framing to enable all actors within the organisation to diagnose, offer solutions and become motivated to act. A framing perspective stresses the collective nature of knowledge mobilisation, which is then presented as a negotiated and enacted process between involved actors rather than a direct 'transfer' from individuals or groups to a wider audience. Furthermore, enabling all participants

to bring subjective daily experiences in addition to technical knowledge in relation to their jobs motivates further participation and the desire to engage and effect change.

Second, we further show that mobilising collective knowledge in organisations is not a neutral, technical process. Our social movement framing perspective enables us to see the mobilisation of collective knowledge as a political process that entails the challenging of existing frames and demands the articulation and proposing of alternative ways to design and implement change. The mobilisation of organisational knowledge is therefore a contested, emerging, distributive and voluntary process. Looking at knowledge mobilisation through framing enables us to align individual experiences within the larger collectivity of the social movement.

Lastly, our research indicates that, to implement and foster the emergence of knowledge mobilisation initiatives in LHCOs from the grassroots, practitioners need to encourage the following: organisation-wide interactions through face-to-face and mixed-media platforms to debate change plans that can then be adapted to fit local conditions; safe communication channels within the grassroots; and the creation of a safe space where members of the movement or organisation can learn through the sharing of experience in an environment that both encourages experimentation and tolerates mistakes.

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Chapter 8 Discussion

This discussion chapter draws together the findings, analysis and discussions presented in this thesis, outlining and further developing the conceptualisation of collective action delineated throughout. The chapter commences with a summary of the theoretical and empirical contributions presented in this thesis, highlighting the contributions of the separate yet interrelated papers of this thesis. In revisiting the contributions of each chapter, the second section of this chapter emphasises the ways in which each chapter contributes to bridging the historical divide between organisational and social movement studies. Following this, the third and fourth sections of this chapter draw on two theoretical models from practice theory (i.e. Whittington, 2006 and Bjørkeng et al., 2009) with the aim of further developing these theoretical understandings. These two sections, when read together, construct a wider argument about the practice of collective action. Finally, a fifth and concluding section is presented that draws on the previous sections. In this closing section, the mobilisation of collective action is conceptualised as a process of 'becoming'– an emergent phenomenon that is both constituted of and driven by inherent tensions. The chapter concludes with suggestions of areas for further research.

8.1. The Contributions of the Papers in this Thesis

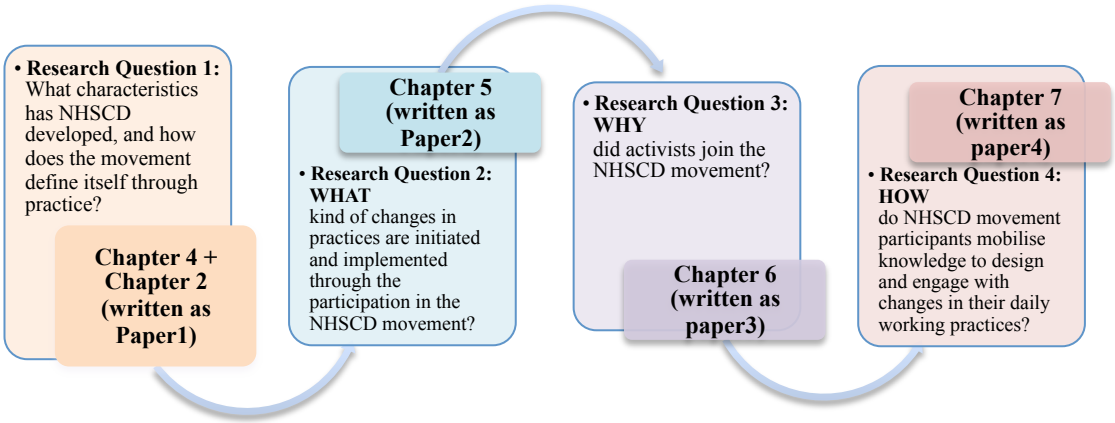
Decision-makers need to mobilise large groups of employees when designing organisational change programmes capable of adapting to contextual demands. As was elaborated throughout this thesis, this problem is especially acute within large healthcare organisations (LHCOs) (Ferlie, Montgomery, & Pederson, 2016; Swan, Newell, & Nicolini, 2016). LHCOs dominate the health and care arena and are constantly subjected to change and reorganisations. Due to their size and complexity,

changes in their governance have ramifications for the healthcare sector in general (Greener & Powell, 2008). A key element in the success of change programmes within LHCOs is the engagement and mobilisation of staff (Ferlie, Fitzgerald, McGivern, Dopson, & Bennett, 2013; Reay, GermAnn, Golden-Biddle, Casebeer, & Hinings, 2016; Reay, Golden-Biddle, & Germann, 2006; Waring & Bishop, 2010), and the challenge posed by these requirements has been the focus of this research.

The enthusiasm and indignation generated by social movements amongst their members stands in contrast to the lukewarm reception given to change initiatives within LHCOs (Bate, Bevan, & Robert, 2006; Bate, & Robert, 2010; Bate, Robert & Bevan, 2004; Bevan, Roland, Lynton, & Jones, 2013; Boyd, Burnes, Clark, & Nelson, 2013; Carnall, 2007; Hilton & Lawrence-Pietroni, 2013). Yet, it has been demonstrated in the social movement literature that 'Mobilising grievances are seen neither as naturally occurring sentiments nor as arising automatically from specifiable material conditions' (Snow, 2013). As such, it has been shown that social movements depend on their ability to successfully mobilise participation in collective action in and around their activities – a problem that mirrors the challenges faced by policymakers when introducing change within the context of LHCOs (Zald, 2017; see also Banaszak-Holl, Levitsky, & Zald, 2010; Polletta & Jasper, 2001). This thesis integrates a social movement perspective with organisation studies literature to offer a considerable contribution to the study of large-scale change in organisations, especially in LHCOs. This includes the incorporation of certain characteristics associated with social movements such as the successful voluntary mobilisation of participants in the creation of bottom-up change initiatives (Schneiberg & Lounsbury, 2008; Thornton, Ocasio, & Lounsbury, 2012).

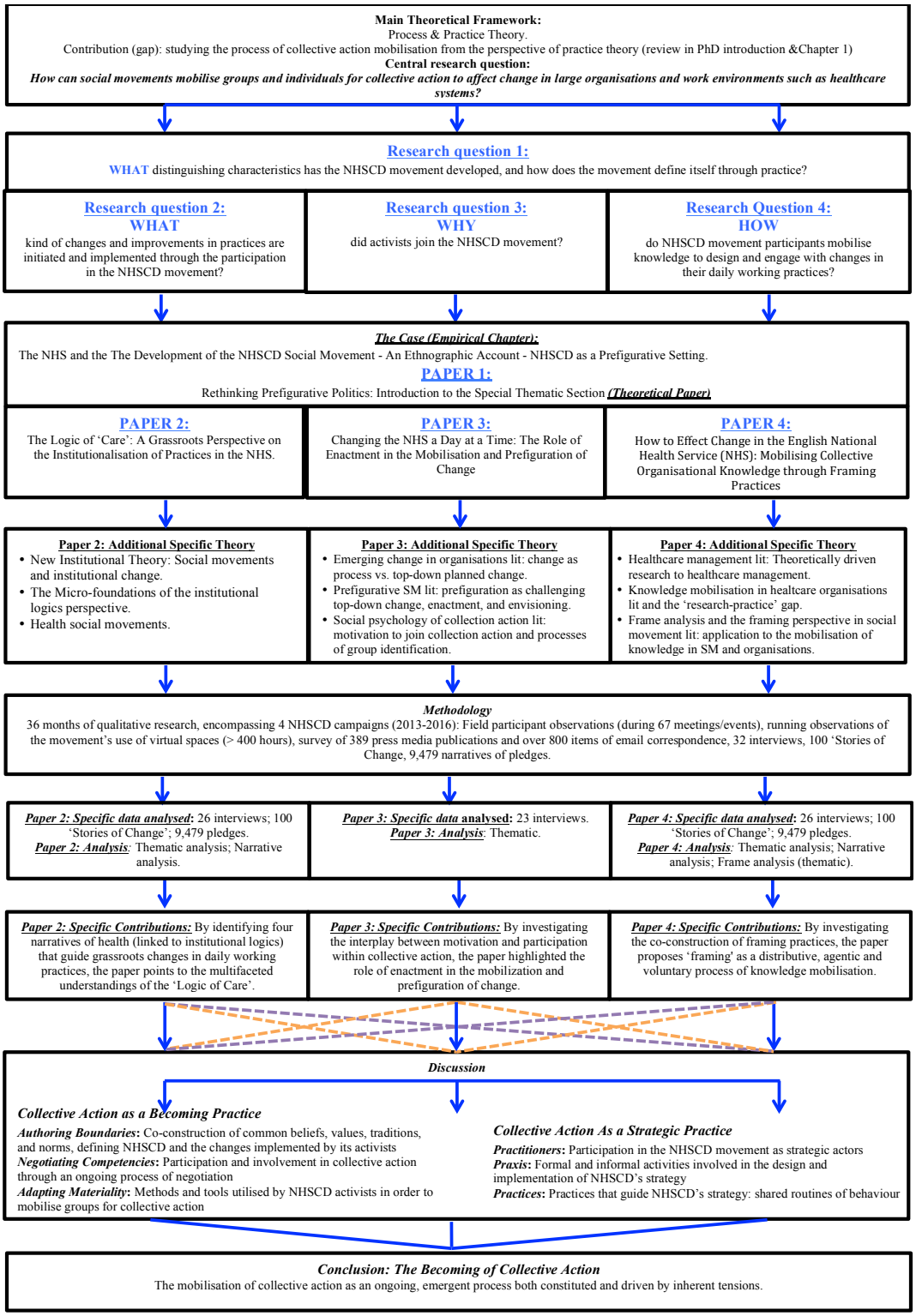
In particular, this thesis concentrates on the role and potential contribution of activism and grassroots practices in addressing the challenges faced by large organisations in the specific context of change processes (see, for example, Bate & Robert, 2010; Bate et al., 2006; Bate et al., 2004; Carnall, 2007; De Bakker, Den Hond, King, & Weber, 2013; Dubuisson-Quellier, 2013; Haug, 2013; Munro, 2014; Soule, 2012). This was achieved through the investigation of the ways in which the NHS Change Day social movement mobilised collective action with the purpose of bettering practice within the NHS. In doing so, this thesis addressed the central research question: How can social movements mobilise groups and individuals for collective action to affect change in large organisations and work environments such as healthcare systems? This question was addressed through the consideration of four specific research questions explored in the account describing emergence and development of the NHSCD movement and in the four separate yet interconnected papers, which are presented in the above chapters (see Figure 8.1).

Figure 8.1



The following diagram summarises the structure and provides a conceptual map of this thesis, focusing on the contribution of the three empirical papers that constitute the core of this work (see Figure 8.2).

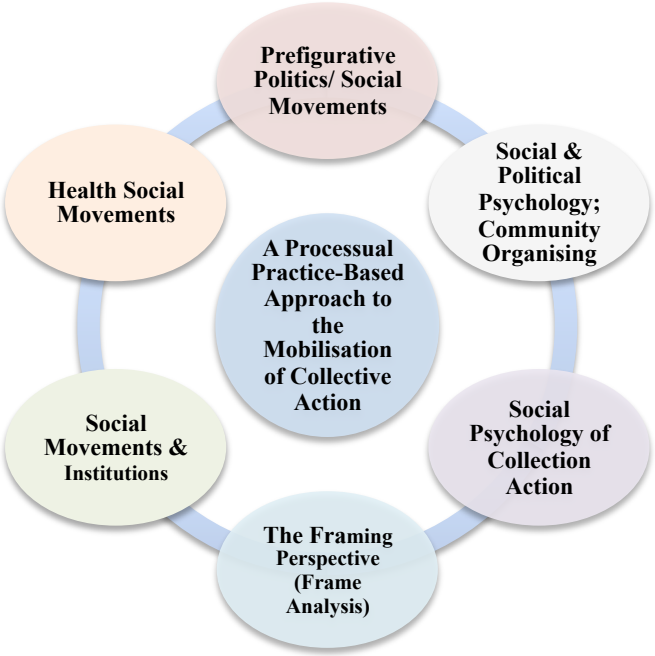
Figure 8.2


Main Theoretical Framework:
Process & Practice Theory.
Contribution (gap): studying the process of collective action mobilisation from the perspective of practice theory (review in PhD introduction &Chapter 1)
Central research question:
How can social movements mobilise groups and individuals for collective action to affect change in large organisations and work environments such as healthcare systems?
Research question 1:
WHAT distinguishing characteristics has the NHSCD movement developed, and how does the movement define itself through practice?
Research question 2:
WHAT
kind of changes and improvements in practices are initiated and implemented through the participation in the NHSCD movement?
Research question 3:
WHY
did activists join the NHSCD movement?
Research Question 4:
HOW
do NHSCD movement participants mobilise knowledge to design and engage with changes in their daily working practices?
The Case (Empirical Chapter):
The NHS and the The Development of the NHSCD Social Movement - An Ethnographic Account - NHSCD as a Prefigurative Setting.
PAPER 1:
Rethinking Prefigurative Politics: Introduction to the Special Thematic Section (Theoretical Paper)
PAPER 2:
The Logic of 'Care': A Grassroots Perspective on the Institutionalisation of Practices in the NHS.
PAPER 3:
Changing the NHS a Day at a Time: The Role of Enactment in the Mobilisation and Prefiguration of Change
PAPER 4:
How to Effect Change in the English National Health Service (NHS): Mobilising Collective Organisational Knowledge through Framing Practices
Paper 2: Additional Specific Theory
• New Institutional Theory: Social movements and institutional change.
• The Micro-foundations of the institutional logics perspective.
• Health social movements.
Paper 3: Additional Specific Theory
• Emerging change in organisations lit: change as process vs. top-down planned change.
• Prefigurative SM lit: prefiguration as challenging top-down change, enactment, and envisioning.
• Social psychology of collection action lit: motivation to join collection action and processes of group identification.
Paper 4: Additional Specific Theory
• Healthcare management lit: Theoretically driven research to healthcare management.
• Knowledge mobilisation in healtcare organisations lit and the 'research-practice' gap.
• Frame analysis and the framing perspective in social movement lit: application to the mobilisation of knowledge in SM and organisations.
Methodology
36 months of qualitative research, encompassing 4 NHSCD campaigns (2013-2016): Field participant observations (during 67 meetings/events), running observations of the movement's use of virtual spaces (> 400 hours), survey of 389 press media publications and over 800 items of email correspondence, 32 interviews, 100 'Stories of Change, 9,479 narratives of pledges.
Paper 2: Specific data analysed: 26 interviews; 100 'Stories of Change'; 9,479 pledges.
Paper 2: Analysis: Thematic analysis; Narrative analysis.
Paper 3: Specific data analysed: 23 interviews.
Paper 3: Analysis: Thematic.
Paper 4: Specific data analysed: 26 interviews; 100 'Stories of Change'; 9,479 pledges.
Paper 4: Analysis: Thematic analysis; Narrative analysis; Frame analysis (thematic).
Paper 2: Specific Contributions: By identifying four narratives of health (linked to institutional logics) that guide grassroots changes in daily working practices, the paper points to the multifaceted understandings of the 'Logic of Care'.
Paper 3: Specific Contributions: By investigating the interplay between motivation and participation within collective action, the paper highlighted the role of enactment in the mobilization and prefiguration of change.
Paper 4: Specific Contributions: By investigating the co-construction of framing practices, the paper proposes 'framing' as a distributive, agentic and voluntary process of knowledge mobilisation.
Discussion
Collective Action as a Becoming Practice
Authoring Boundaries: Co-construction of common beliefs, values, traditions, and norms, defining NHSCD and the changes implemented by its activists
Negotiating Competencies: Participation and involvement in collective action through an ongoing process of negotiation
Adapting Materiality: Methods and tools utilised by NHSCD activists in order to mobilise groups for collective action
Collective Action As a Strategic Practice
Practitioners: Participation in the NHSCD movement as strategic actors
Praxis: Formal and informal activities involved in the design and implementation of NHSCD's strategy
Practices: Practices that guide NHSCD's strategy: shared routines of behaviour
Conclusion: The Becoming of Collective Action
The mobilisation of collective action as an ongoing, emergent process both constituted and driven by inherent tensions.

8.2 Bridging the Historical Divide Between Organisational and Social Movement Studies

The research in this thesis answered recent calls for further empirical studies, investigating case studies which bridge the historical divide between the academic fields of organisational and social movement studies, which have traditionally been considered distinct (Moskovitz & Garcia-Lorenzo, 2016, 2016a, 2016b, 2017a, 2017b). This goal was achieved through the grounding of this study in a processual, practice-based theoretical approach as outlined in the first chapter of this thesis and through the introduction and integration of various bodies of work from social movement literature, including prefigurative politics and prefigurative social movement literature, social and political psychology and community organising literature, the framing perspective in social movement literature, the literature on social movements and institutions, and studies investigating health social movements (see Figure 8.3).

Figure 8.3



I now examine the dialogue created between organisational studies and social movement literature throughout this thesis, exploring how each chapter contributes to this process.

The account presented in Chapter 4 describes the growth of the NHSCD movement, identifying five key periods and events in the evolution of the movement. The chapter comes to the conclusion that the NHSCD movement created prefigurative settings within the NHS, and describes in detail the manner in which this was achieved by identifying six prefigurative characteristics of the NHSCD movement. In doing this, Chapter 4 contributes to the bridging of organisational and social movement studies through a strategic lens. The chapter brings together insights from the strategy-as-practice literature and the social movement literature that considers social movements as strategic actors (i.e. the resource mobilisation and framing perspectives). By analysing the emergence and development of the NHSCD movement, the chapter contributes to the literature by identifying the strategising practices which facilitated the prefigurative setting within the NHS. The account of the emergence and development of the NHSCD movement is supplemented by a theoretical paper (presented in Chapter 2), which diverts from the empirical focus of this thesis to give a detailed account of prefigurative politics through the lens of social and political psychology. This paper contributes to the overarching argument of the thesis by providing additional theoretical insight into the phenomenon of prefigurative politics. In doing so, it provides further background to the three papers that follow (presented in Chapters 5-8), establishing the foundation for the arguments that constitute the main contribution of this thesis. In particular, Chapters 2 and 4 when

viewed together, provide a strong basis for the ideas explored in the papers that make up the rest of this thesis.

Building on the account of the emergence and development of the NHSCD movement presented in Chapter 4, the next chapter concentrates on the changes and improvements initiated by NHSCD participants and the meaning attributed to them. Chapter 5, written as the second paper presented in this thesis, outlines the initiation and enactment of changes in practices by participants in the NHSCD movement through the inductive derivation of four narratives of health, which are positioned and considered in relation to other studies in the field of institutional logics, with a particular focus placed on those in health and healthcare. These four narratives are seen as pointing to the multifaceted nature of the 'Logic of Care' and the influence it holds over daily working practices within healthcare. Chapter 5 further bridges organisational and social movement literature by presenting relevant literature on health social movements and bringing together insights regarding social movements and institutions with work on the microfoundations of the institutional logics perspective. By taking a bottom-up approach to the investigation of the emergence of institutional logics in practice, this paper contributes to the literature by illuminating the empirically understudied process of the complex and two-way dynamic between micro and macro levels of change to institutional logics, concluding that this process both generates and is generated by the process of collective action. By highlighting how multiple embedded actors purposefully enact the simultaneous implementation of micro small-scale changes in everyday working practices across social levels, this chapter provides a grounding on which to base the exploration of the dynamics of

motivation and participation in prefigurative change, which is the focus of the next chapter.

Further developing the ideas expressed in previous chapters, Chapter 6 focuses on participants' motivations for joining the NHSCD social movement. Chapter 6 is the third paper presented in this thesis and outlines how the NHSCD movement embodied key aspects of a prefigurative setting: participants were motivated by the two values of enactment and collaborative thinking, and these twinned drives ensured that the movement's activism remained grounded in the grassroots agency of frontline healthcare staff. Different participants emphasised different aspects of the movement as being important to them, highlighting the complex nature of motivation. The NHSCD movement sought to effect change and improve the daily working practices and experiences of both staff and patients, but the process of change embodied by the movement was more important to participants than a means to an end. Chapter 6 further bridges organisation and social movement literature by bringing together insights from the literature on emerging change in organisations with contemporary developments in the literature on the social psychology of collective action, especially understandings regarding group identity processes in the mobilisation of collective action. The paper argues that motivation, although encouraged by strong individual emotions and reason, is not a purely individualistic endeavour, and neither does it exist in all completeness prior to the individual's enactment and engagement within the social movement. The paper contributes to the literature by highlighting the key role that enactment played within both the identification of participants with the NHSCD movement and the crystallisation of the movement's collective identity, and by arguing that it is impossible to separate the improvements that such changes aim

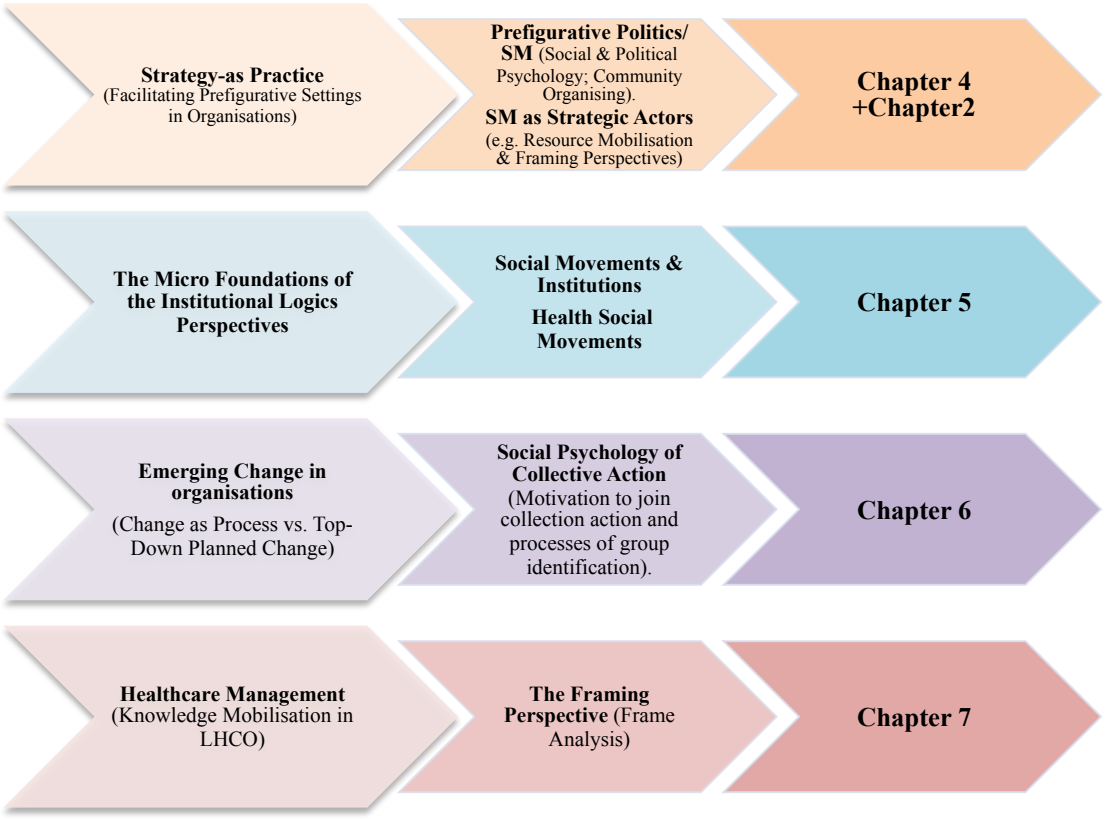
for from the manner in which such change is delivered: motivation cannot be separated from enactment and vice versa as they are completely interwoven processes. The three empirical chapters (i.e., Chapters 4-6) as a whole create the foundation for the following chapter's investigations concerning framing as a knowledge mobilisation practice in and around the activities of the NHSCD movement.

Chapter 7 builds upon the efforts of previous chapters and explores the manner in which NHSCD movement participants mobilise knowledge to design and engage with changes in their daily working practices. Chapter 7 is the fourth paper presented in this thesis and extends the understanding of how knowledge mobilisation takes place in LHCOs by arguing that aligned framing practices are necessary for such mobilisation to be effective. The paper identifies three collective action frames and analyses the core framing tasks performed in practice through each frame, enabling all organisational actors to diagnose problems and subsequently offer solutions, motivating them to act. By investigating framing dynamics through the practice lens adopted by knowledge mobilisation studies within the field of healthcare management, the chapter connects these research traditions (i.e., the framing perspective and practice theory) in a novel empirical way, and in doing so further connects organisation and social movement research. By drawing on the framing perspective as developed in social movement literature, the paper expands on the understanding of knowledge mobilisation as a political process that necessarily challenges existing frames and requires the creation of alternative ways of designing and implementing change. Subsequently, knowledge mobilisation is seen as a contested, emergent and voluntary process, in which individual experiences are

aligned with the larger collective arc of the social movement. The paper draws attention to the importance of building a strong foundation on which knowledge mobilisation can take place: in order to encourage or implement knowledge mobilisation initiatives from the grassroots within the context of LHCOs, activists/practitioners must encourage organisation-wide interactions through both personal and mixed-media platforms in which change plans can be debated and adapted to meet changing local conditions; secure and established communication pathways within the organisation's grassroots; and, lastly, the establishing of a safe space in which organisation or movement members can learn through the mutual sharing of experiences in a tolerant and encouraging environment.

The following diagram illustrates the conceptual links made throughout the various chapters between organisation and social movement literature. The left column outlines the specific processual, practice-based literature on which each chapter draws whereas the middle column delineates the specific areas of theory from social movement scholarship which were integrated into each chapter (see Figure 8.4).

Figure 8.4



The chapters in this thesis have specific conclusions and contributions, but each can be seen as part of a unified whole. The next two sections integrate the ideas and conclusions of the individual chapters and further develop them to form a wider argument about the practice of collective action. The following section draws on the framework developed by Bjørkeng et al. (2009) to further consider and unify the findings in this thesis.

8.3 Collective Action as a Becoming Practice

In this section, I draw on the framework suggested by Bjørkeng et al. (2009) to discuss the 'becoming' of the practice of collective action as explored throughout this thesis. Bjørkeng et al. (2009) identify three 'arrays of activities: authoring boundaries,

negotiating competencies and adapting materiality' which, they claim, 'are essential mechanisms in becoming a practice' (Bjørkeng et al., p. 145). This classification will be employed in the following section as a means of bringing the conclusions drawn by the findings together and crafting them into an overarching argument about collective action as a phenomenon of becoming.

8.3.1 Co-construction of common beliefs, values, traditions and norms defining NHSCD and the changes implemented by its activists.

Social movements depend on their ability to mobilise supporters to their cause, yet their leaders and activists are confronted with a similar problem to that faced by healthcare organisations, which is the absence of a linear correlation between cause and effect (Lewis, 2016; Pickerill & Krinsky, 2012; Tufekci, 2014; Yates, 2015). In the case of social movements, this presents itself as the lack of a simple and predictable relationship between grievances (or injustices) and mobilisation (Johnston & Noakes, 2005; Snow, 2013a). In the case of the NHSCD movement, the limitations of linear causality underpinned the movement's call for action and were expressed in several ways. On the one hand, participants voiced their discontent with using a system that gradually became more dependent on evaluative linear models, prioritising measurable outcomes over the unquantifiable elements of care (e.g., how many patients were seen during a shift vs. quality of communication and patients' experience of care) (Baggott, 2004; Rather, Vogus, & McClelland, 2016; Smith & Malcolm, 2010; Vogus & McClelland, 2016). The NHSCD, however, allowed for a space in which the top-down evaluative approach to individual work could be replaced by an emphasis on the importance of the process of change itself (McNulty & Ferlie, 2004; Pentland & Feldman, 2008; Tsoukas & Chia, 2002). For participants,

as discussed in Chapter 5, NHSCD stood for qualitative change, experimentation and communication (Bouckaert & Peters, 2002). Despite this focus on the unquantifiable aspects of work in healthcare, participant attitudes were inevitably influenced by the traditional evaluative approach of the NHS as an organisation at large: they were keen to showcase the impact of their actions and frequently found themselves (and often subjected themselves) to the top-down pressures of evaluation, aiming to understand and explain the pledges that they made within the framework of the NHSCD movement through the evaluative lens of the wider organisation (Lewis, 2016). This tension between the quantification of healthcare and the unquantifiable characteristics of healthcare work was also expressed in the desire to enable open-ended processes of change and underlined both the re-authoring of the boundaries of existing practices and the 'authoring' of new activities by NHSCD's participants' practices (Bjørkeng et al., 2009).

As such, the tension between the quantifiable and the unquantifiable underpins the dynamic of both the practice of calling for collective action by the NHSCD movement and the implementation of change in daily working practices that NHSCD participants were trying to enact. Furthermore, our findings emphasise that for participants the implications of the present crisis were not seen as only impacting the quantifiable aspects of the quality of care, but also what the NHS represented within the cultural and social landscape of the United Kingdom (an idea that is central to the argument made in Chapter 6). Participants described the pressure created by a target-orientated organisational culture combined with the negative depictions of frontline services in the media as acutely demoralising, creating the sense that the NHS was failing and losing its identity (Davies & Mannion, 2013). This focus on quantification

and the demoralisation that it led to was countered by the emphasis placed by the NHSCD movement on multiple changes, which participants believed could be impactful, producing tangible organisational change (Reay et al., 2006; Weick, 1984).

Bjørkeng et al. (2009) contend that when an activity is performed within or outside the boundaries of established practices, it is clear to the observer whether or not that practitioner is practising the practice, giving the example of eating meat as falling outside of the practice of vegetarianism and the playing of football with one's hands as falling outside the boundaries of football. This distinction becomes less obvious when observing emerging practices, as 'the fluid constant construction of norms becomes vivid because the rules of the game have not been stabilized' (Bjørkeng et al., 2009, p. 150). This understanding ties into the phenomena of collective action as an emergent and co-constructed process, in which the boundaries of practice are continually being authored that, consequently, privileges the unquantifiable and experimental aspects of change (Dorado, 2013; Lawrence, Leca, & Zilber, 2013). In the case of the NHSCD participants, this understanding of a game in which the 'rules have not been stabilized' can be seen both as relating to the notion of prefigurative change (Cornish, Montenegro, van Reisen, Zaka, & Sevitt, 2014) and as connected to Karl Weick's concept of the 'enactment' of reality (Weick, 1979; Weick, Sutcliffe, & Obstfeld, 2005).

8.3.2 Participation and involvement in collective action through an ongoing process of negotiation.

The results highlight the embeddedness of activists and participants in the contextual environment of both the NHSCD movement and the wider NHS (Giddens, 1984;

Klandermans, 2004). In this context, the findings reveal the ongoing negotiation of roles and responsibilities within the NHSCD movement. This evolving practice, which Bjørkeng et al. (2009) term 'negotiating competencies', is pivotal to the mobilisation of collective action. This thesis contributes to the understanding of this process by showing the ways in which it is underpinned by the tension between agency and collectivity.

A tension between agency and collectivity is particularly evident in the complex notion of leadership generated by movement's activists. NHSCD's aspiration was to expand the notion of competent leadership within the NHS by opening up leadership roles to anyone. In doing so, the movement aimed to empower the individual's experience of their own agency (Llewellyn, 2007), and the broad and varied definition of leadership roles within the movement were especially suited to this task (Denis, Cazale, & Langley, 1996). These roles encompassed a wide range of tasks, ranging from the voluntary position of the 'Hubbies', who functioned as intermediaries between the core leadership team and the frontline staff members of the grassroots, to the central leadership roles performed by members of the NHS Improving Quality Horizon team, and stressed the unique value of each individual for the organisation (Smith & Malcolm, 2010). As such, local leadership roles played a crucial role in the development of the movement and provided opportunities for junior members of staff, who were able to take on responsibilities typically reserved for senior managers, developing and honing their skills through the leadership of personalised change initiatives (Hurley & Linsley, 2007). This intentional broadening and opening up of leadership roles emphasises the value placed by the NHSCD movement on the idea of the individual and their agency, and the inherent value of all

organisational actors within the NHS (Kociatkiewicz & Kostera, 2012). The central role of individual agency is highlighted in Chapter 5 through the attention given to individual and group narratives as constituting the building blocks of the four identified collective narratives of health.

This privileging of individual agency, however, only gained its profound meaning to participants when accompanied by what could be seen as the opposite ideological impulse: the movement's drive towards collectivity (Nilakant & Rao, 1994; Poole & Van de Ven, 1989; Tuominen & Lehtonen, 2017). The findings show how the negotiation of competencies was driven by the sense of efficacy created through participants' experience of enactment of change processes within the context of a supporting group; a process that contributed to an enhanced sense of vocational identity and group belonging (van Zomeren, Postmes, & Spears, 2008). The findings in Chapter 6 show that the sense of collectivity promised by the movement was a significant motivating factor for participants (Thomas, Mavor, & McGGarty, 2012; Thomas & McGGarty, 2009). Individual participants felt an increasing sense of efficacy that empowered them to make positive changes in a way that challenged the passivity inherent to the traditional hierarchical structure of the NHS (Battilana & D'aunno, 2009; Garud, Hardy, & Maguire, 2007). The sense of a collective push towards change within the institution was validating, and the connection that individuals felt to other participants and activists was seen as creating a sense of togetherness (Goodwin, Jasper, & Polletta, 2004; Thomas, McGarthy, & Mavor, 2009a). The findings presented in Chapter 6 were further developed into an understanding of the ways in which the idea of collective responsibility was incorporated into the fabric of the social movement in Chapter 7, through the analysis

of the 'Local Leadership' frame. Accounts in this frame reflected the wider ethos of the movement, which stressed that many small-scale individual changes could lead to wide-scale institutional change and counteract top-down models of change (Degeling et al., 2004; McNulty & Ferlie, 2004). These accounts consistently stressed the potential and strength of the NHSCD movement as a collective, envisioning what could be achieved when many like-minded individuals were joined together beneath a single organising impulse (Cornish, Haaken, Moskovitz, & Jackson, 2016; Cornish et al., 2014). The emphasis that the NHSCD movement placed on collectivity was supported by the open nature of participation and the availability of leadership roles. Participants were given the opportunity to think about their work and agency in a new light, as belonging to part of a greater effort, and this created a sense of collective purpose (Ganz, 2009; van Zomeren et al., 2008). The crucial role of the encapsulation of a sense of collectivity is further stressed throughout Chapter 6, in participants' descriptions of how the NHSCD movement acted as an antidote to the proliferation of critical articles in the media attacking poor performance within the institution (Thomas et al., 2012). The sense of constantly being criticised upset conscientious staff members, who were already working at full capacity in the face of extreme budget cuts, and contributed to a growing collective sense of injustice (Gamson, 1992). NHSCD was seen as giving participants a chance to prove that they were committed to their vocations as healthcare staff and to show that they were unified in the goal of improving patient care, reasserting a group identity (NHS England, 2014).

The experience of the enactment of small-scale change initiatives, which allowed for individual expression within a validating group context, generated an interplay between an individual sense of agency and a collective sense of efficacy

(Thomas & McGarthy, 2009). This sense of efficacy, or the belief that activists as a group could contribute to wider change, gave meaning to each individual change initiative (Thomas, McGarthy, & Mavor, 2009b). The role of small-scale 'mundane' changes in the emergence of institutional logics in practice was stressed in Chapter 5, which illustrated the manner in which multiple embedded actors purposefully enacted such changes in their material practices within the constraints of their setting (Currie & Spyridonidis, 2016; Ocasio, Thornton, & Lounsbury, 2017; Smets, Aristidou, & Whittington, 2017; Zilber, 2016). As further argued in Chapter 6, this process, through which a larger sense of identity was encapsulated, was crucial to the mobilisation of collective action (Thomas et al., 2012). For participants, the movement embodied freedom and innovation, a chance to bypass traditional routes to the enactment of change initiatives and leadership by means of an inclusive and distributive model that was capable of encapsulating a collective sense of identity (Nolas, 2015).

8.3.3 Methods and tools utilised by NHSCD activists in order to mobilise groups for collective action.

The findings in this thesis reveal how the activists in the NHSCD movement engaged in the practices of adapting materiality (Bjørkeng et al., 2009). The adaptation of materiality in the context of prefigurative social movements involves the utilisation of various platforms through which social movements engage participants in collective action through a dimension of temporality (Maeckelbergh, 2016; Yates, 2015). Social movements' engagement platforms include various activities termed by social movement scholars as 'performances', designed for a variety of audiences: the public, authorities, the media, and counter-movements (della Porta, 2013; Kavada, 2015). In

these episodes of collective action, participants engage with an alternative experience of time and space in which past and future are brought together into the present (Swain, 2017). The adapting of materiality in the becoming of collective action highlights the tension between permanence and impermanence. The NHSCD movement relied on temporary performances that symbolically occupied specific times with the NHS working calendar (as seen in the temporality of the event itself), providing a symbolic platform that encouraged experimentation, spontaneity and freedom (Goodwin, Jasper, & Polletta, 2009; Polletta, 2009). However, the aspiration of enduring or sustainable change necessarily summons a vocabulary of durable physicality (Hernes, 2014; Hernes & Schultz, 2017; Melse & Dibben, 2017). The tension between impermanence and permanence is expressed in the process of adapting materiality via the dynamics through which temporary performances are converted into tangible practice (Leonardi, 2017). Through the process of adapting ideas into events that can be experienced and into articulated speech acts (such as pledges and stories), material artefacts were created that invested the movement's efforts with permanence, capable of communicating such performances to future audiences (Maeckelbergh, 2012; Minuchin, 2016).

Performances included demonstrations, marches, protests, press conferences, presentations and violent confrontations, and internal discussions and debates, planning sessions, narrative performances and conflicts among members (Johnston, 2009). In the context of the NHSCD movement, various platforms were created and developed to facilitate the expansion of the movement: each campaign was seen as a means to take NHSCD a step further, and each was characterised by the creation of prefigurative settings (Reinecke, 2018; Roth, Saunders, & Olcese, 2014). Within these

settings, movement activists challenged the manner in which the hierarchical structure was represented within the NHS's day-to-day physical working spaces (Foucault, 1995) by introducing alternative ways of exchanging ideas and opinions, enacting more egalitarian and democratic practices (della Porta, 2013). Similarly to other prefigurative platforms, such as community gardening, the platforms themselves embodied a symbolic strategic role, generating the individual and collective performances that constituted the ideological content of the movement: by creating these zones, organised and operated according to certain rules but, at the same time, free, the NHSCD members managed to instantiate an autonomous creative space with its own momentum and impetus (Guerlain & Campbell, 2016).

> Stylistic Strategy Story is defined as orchestration of image, or more a dialogism, among oral, print and video media, websites, gesture-theatrics, décor and architecture modes of image expression. Stylistic strategy story orchestration is defined as juxtaposition of varied styles for image management. Stylistic strategy story dialogism is defined as the interactivity of various modes of expressing organization image in interplay with forces of narrative control. The contribution is to illustrate three stylistic strategies: hailing, dramaturgic, and triple-narrative control of emergent story. (Boje, 2008, p. 123)

An example of this dialogic interaction between physical platforms and their transformation into psychological spaces was vividly seen through the way in which the physical platforms were divided into subregions, symbolising the emotional and active imperatives of the movement's campaigns (Friedland, 2018; Ganz, 2010). The words used in its logo, 'Pledge', 'Share', 'Do', and 'Inspire', are an example of this (NHS Change Day Team, 2013). The dialogism of the humoristic, festival like design of the physical space enabled participants to draw on the same sources of inspiration and thus fostered the experimentation of new forms of social interaction of lived action (Cartel, Boxenbaum, & Aggeri, 2018; Lefebvre, 1991).

The encouragement of visitors at NHSCD events to participate in activities while moving freely between activity zones through dynamic and flexible event

schedules stood in sharp contrast to the day-to-day restrictive experience of time and space within the NHS (Giddens, 1984; Toraldo & Islam, 2017). In addition to this, participation in the movement's performances involved the production of cultural artefacts capable of communicating the movement's ideology, such as placards, signs, videos, posters, etc. (Johnston, 2009; Jasper, 1997). The creation of such artefacts is also understood as a performative process: 'artefacts are not only materially constructed but also socially constructed (Lahlou, 2017). Even though they may be individually produced, their creation too is, in a sense, a social performance because the audience is always in the artist's mind' (Kilmova, 2009, p.7). Such artefacts were produced as a continual process of artefact creation through NHSCD's performances and then distributed and re-created through subsequent performances and future NHSCD campaigns (Comi & Whyte, 2017). For example, the artefacts left over from past performances or earlier stages of the movement become material that was used, recycled and reformed in future campaigns and future engagement of participants (Klimova, 2009). The messages contained within these artefacts were often re-designed to influence or demand the continuing engagement of participants (Johnston, 2009). The most dominant example of such artefacts were the 'pledge' narratives and the 'change stories', which continued to be circulated and disseminated through the organisational networks, expanding, therefore, beyond their original performativity as speech commitment for action (Austin, 1962) by continuing to inspire future change initiatives (Polletta, 2014 & 2006).

Building on the framework developed by Bjørkeng et al. (2009), this section proposed collective action as a becoming practice, constituted of and driven by three inherent tensions as summarised in the table below (see Table 8.1).

Table 8.1

Collective Action as a Becoming Practice		
Authoring Boundaries	***Quantifiable*** ↔ ***Unquantifiable***	Co-construction of common beliefs, values, traditions, and norms, defining NHSCD and the changes implemented by its activists.
Negotiating Competencies	***Agency*** ↔ ***Collectivity***	Participation and involvement in collective action through an ongoing process of negotiation.
Adapting Materiality	***Permanence*** ↔ ***Temporal*** (Future, present and past brought to the present through prefigurative settings)	Methods and tools utilised by NHSCD activists in order to mobilise groups for collective action.

8.4 Collective Action as Strategic Practice

This section adopts a strategic lens to argue that collective action should be seen as an emerging strategic practice. In doing so, I employ the framework developed by Whittington (2006), which highlights the three concepts of praxis, practices and practitioners, which provide a 'consistent vocabulary' that allows for coherent scholarly conversation around the topic of strategy from a practice perspective (Whittington, 2006, p. 619).

8.4.1 Participants in the NHSCD Movement as Strategic Actors.

The issue of participation in collective action has occupied theorists for several decades. The idea of collective action as a strategic phenomenon has been a particular challenge in light of the work of 'rational choice theory' scholars (Jasper, 1998, 2004; Melucci, 1996). According to this paradigm, which has dominated much of the theoretical work in micro-economics, 'rationality' implies that individuals act to maximise personal advantage: utility at minimised personal cost (Cook & Levi,

2008). The underlying assumption is that individuals always prefer to possess more goods rather than less. Analysing market interaction, rational behaviour theory hypothesises striving for equilibrium: when each agent chooses the action which, given other agents' options, he perceives as optimal (Varian, 1984: 1). The application of this thinking to the study of collective action formed three propositions. The first proposition, the 'preference proposition', defines utility as preferences, goals, interests or motivations. The individual's behaviour is considered driven by his own preferences. Second, the 'constraints proposition', defines the concept of cost or profit, reality factors affecting actors. Cost is understood as constraints, obstacles or limitations that impede the actor from obtaining his goal. Respectively, profit is understood as behavioural opportunities assisting achievement of his goal. Third, the 'utility maximisation proposition', is that individuals choose between the behavioural alternatives available by maximising their utility (Opp, 2009, p. 2-3).

This logic was used by Olson (1971) to define the concept of a 'public good', constructing an argument that led to a controversial conclusion regarding the irrationality of collective action. A public good was described as a product which, if it exists, can be consumed by every member of a group regardless of their contribution to the effort producing that good. For example, voting rights for women obtained by collaborative feminist social movements were not limited to activists, but enjoyed by all women. Those who consume the public good without contributing to its provision were defined as 'free riders'. Consequently, Olson (1971) argued that it would not be at all rational for individual actors to invest resources in the collaborative effort to produce a public good: to bear the cost of failure if they can enjoy the fruits of success for free. Olson's conclusion that the rational actor is a free rider raised the 'free rider

paradox': if everybody rides, free how does mobilisation for collective action occur (Mueller, 1992)? Despite the obvious controversy of the micro-economic origins of the 'free rider paradox', which refers to short-term decision making as opposed to the nature of social movements and protests as long-term activities, the concept has underpinned the question of what motivates bystanders to actively involve themselves in collective action (della Porta & Diani, 2006). This thesis approached this question from a processual practice-based perspective, highlighting the ways in which participants described their motivation to play an active role in the NHSCD movement. In doing so, the transition from a position of bystanding to active participation is revealed to be a socially constructed process in which 'the relationship between the experience of the daily enactment of self-initiated activities within a supportive group setting and the motivation to participate in collective action is mutually constructed, and as such, inextricable' (Moskovitz & Garcia-Lorenzo, 2016, p. 197). As such the question of motivation for participation is understood as an embodied and negotiated practice rather than that of linear rational decision-making.

An interplay between spontaneity and intentionality in the emergence of collective action is uncovered throughout this thesis. The findings show how participation in collective action is described as a spontaneous reaction to contextual grievances (Goodwin, Jasper, & Polletta, 2004; Jasper, 1997; Snow, 2013a). The findings throughout the various empirical chapters highlight a widespread sense of anxiety throughout the NHS: participants felt both disempowered by and disenchanted with what they perceived as the gradual undermining of key services within the NHS, and the increasing privatisation of the institution (Pollock, 2004). They were explicitly concerned with what budget constraints would mean for the

future of the NHS and its capacity to provide integrated care for the population; this anxiety was strengthened by the prospect of further cuts (Crisp, 2011). In the context of the NHSCD movement, this anxiety was a key motivating factor towards spontaneous participation: healthcare staff wanted to do their part to help the NHS in a time of crisis and they saw participation and a commitment to positive improvements as an issue of personal responsibility (Jones, 2014a; Rutter, 2014).

Counter to this, however, the intentionality of participation in collective action is also revealed. In the account presented in Chapter 4 of this thesis, the development of the NHSCD movement was outlined, and a decade-long consideration of the potential benefits of the grassroots activism of 'A Million Change Agents' for the future of the NHS was described (Bate et al., 2006). The founders related how they thought that the encouraging of active involvement from all tiers of staff in the organisation at large was key to the survival of the NHS, especially in the context of the massive change processes that the NHS was and is undergoing (Bate et al., 2004). The chapter further delineates the intentional efforts of the members of the Core Leadership Team and key activists to facilitate the conditions that would encourage wider participation in the movement (Bevan et al., 2013), and these accounts reveal the strategic efforts that underpin the origins of the NHSCD social movement (Bate & Robert, 2010). These findings are intriguing, since referring to strategy in the context of social movements may seem counterintuitive, as we often tend to associate collective action within social movements, particularly in the context of political protests, with spontaneity and unexpected social dynamics (della Porta & Diani, 2006; Smelser, 1998). However, when drawing on practice theory, especially when paying 'close attention to the work done by people inside organizational processes'

(Whittington, 2003, p. 118), the strategic efforts of the NHSCD movement activists can be seen in a light that challenges the top-down view of strategy in traditional management literature. In taking a processual, practice-based view we understand these practices as activities undertaken by individuals, and not just an attribute of the company (Rouleau, 2013). Moreover, viewing NHSCD's activists in this light links to Whittington's (2006) identification of strategic 'practitioners', a notion which he uses to define individuals who take part in the activities that constitute strategic practices: 'strategy actors, the strategists who both perform this activity and carry its practices' (Whittington, 2006, p. 619).

Our findings in all three papers support this expanded understanding of grassroots activists as strategic actors (Briscoe & Gupta, 2016; Whittington, Cailluet, & Yakis-Douglas, 2011). This can be seen in the participant accounts in Chapter 5, which describe how participation within the movement was emotionally important; a way to find meaning and counteract the feelings of insecurity associated with the present situation (Hilton & Lawrence-Pietroni, 2013). Participants' narratives revealed both the strategic agency of grassroots participants as well as the limitations to this agency (Battilana & D'aunno, 2009; Friedland & Alford, 1991). The concentration of the NHSCD movement on small-scale 'mundane' change initiatives allowed participants to enact their agency in this area, but also revealed the structural constraints of grassroots agency when it came to their ability to initiate larger changes (Briscoe & Gupta, 2016; Feldman & Pentland, 2003; Fernández, Martí, & Farchi, 2017; Olson, 1971; Powell & Colyvas, 2008).

Furthermore, the findings in Chapter 7 show how the NHSCD movement offered participants the opportunity to become a local leader, encouraging them to

make a personal effort to solve the problems that they witnessed in their daily working environments, thus playing an active strategic role within the movement (Carroll, Levy, & Richmond, 2008; Maeckelbergh, 2011; Morris & Staggenborg, 2004). In this sense, NHSCD was not only seen as an opportunity for frontline members to make their voices heard, but also as a chance for policy makers to demonstrate their willingness to listen (Nicol, 2012). Indeed, the central impetus of the NHSCD movement came from frontline members who yearned to see a cultural shift within the institution in terms of their value and the inclusion of their lived experiences within future policy (Ganz, 2000; Maeckelbergh, 2012).

Vaara and Whittington (2012, p. 133) claim that until recently strategy-as-practice research 'has concentrated on formal planning and strategizing activities' but that this ignores the way in which emergent practices play an important role in the planning and implementation of change. Thus, the findings in this thesis support the strategy-as-practice scholars who have revolutionised the notion of intentionality assumed in traditional strategy literature, revising understandings of agency, action and practice, and the ways in which such concepts inform each other, arguing that strategising neither demands nor assumes predesigned goals, and should therefore be viewed as a reactive process in the light of day-to-day challenges (Chia & MacKay, 2007; Chia & Holt, 2006). The findings in this thesis support this statement, illustrating the need to expand the view of who the strategic actors in organisations are – beyond the limited field of senior and middle levels of management – to encompass the strategic activities and narratives of organisations' grassroots members (Balogun & Johnson, 2005; Howard-Grenville, 2007; Jarzabkowski, 2004; Jarzabkowski & Spee, 2009; Kaplan, 2008; Mantere, 2008; Paroutis & Pettigrew,

2007; Regnér, 2003; Rouleau, 2005; Whittington, 2010, 2006). As described in this section as well as in section 8.3.2 above, the notion of who is a competent strategic practitioner was negotiated on the ground as the NHSCD movement developed (Bjørkeng et al., 2009; Fenton & Langley, 2011). This thesis suggests, therefore, that it is necessary to expand Whittington's (2006) notion of 'practitioners' to the more inclusive concept of 'participants' or, even more pertinently, to 'participating' as to stress the processual ongoing elements of participation. Thus, this thesis argues that the 'free rider paradox' and the subsequent question of participation in strategic collective action is an ongoing process of negotiation in which actors 'become' engaged in the strategising dynamic (see Figure 8.5).

8.4.2 Formal and informal activities involved in the design and implementation of NHSCD's strategy.

Whittington claims that the notion of practice as used by practice theorists embodies a 'dual sense of practice in social theory, both as something that guides activity and as activity itself' (Whittington, 2006, p. 619). As such, he utilises the concept of 'praxis' to distinguish between the descriptive observation of what people actually do in practice and deeper analysis of the shared underlying understandings that guide this praxis (i.e. 'practice'). A processual, practice-based approach necessarily focuses on the actual activities performed by people as seen in their daily working practices (Gherardi, 2012). Following this, the decision to adopt this method of research in this thesis directed attention to the specific actions of movement participants in the mobilisation of collective action and in the initiation and implementation of specific changes in their working routines – a focus of inquiry that relates to Whittington's (2006) notion of 'praxis'.

A tension between formal and informal practices is seen throughout the praxis of NHSCD activists and participants. In particular, this tension can be seen in the way that NHSCD activists carved out a variety of physical and virtual platforms, as described in detail throughout the thesis and in section 8.3.3 above. It is through these platforms that participants' strategic narratives could be co-negotiated through the wide-scale inclusion of other participants (Haug, 2013; Reay, GermAnn, Golden-Biddle, Casebeer, & Hinings, 2016). These platforms existed in a liminal zone between formality and informality and this was especially evident in the device of pledging, in which the nature of the personal or group obligation to initiate and enact change was essentially informal (i.e., not part of participants' job descriptions or any other kind of formal requirement), but was perceived as formal once transformed into a public speech act (Austin, 1962; Klimova, 2009). The praxis of calling for collective action involved the process of adapting materiality as described in the paragraphs above (Bjørkeng et al., 2009). This process also embodied a tension between, for example, the informality and temporality of many of the spaces created by activists and the formality of the NHSCD's official campaign date, which was supported by NHS England (NHS Improving Quality, 2016). The tension between formality and informality within the movement's praxis paralleled the nature of the movement as a whole, as occupying a space between social movement and organisation by dint of its unique role as a social movement inside an organisation (Schneiberg & Lounsbury, 2008). The interplay between formal and informal allowed for a creative psychological freedom that drove collective action forward (Denis, Lamothe, & Langley, 2001; Mesle & Dibben, 2017). Attention to the role that the tension between formal and informal practices played in opening up the psychological spaces necessary for individual and collective identity work was crucial to understanding

how and why participants engaged with the NHSCD movement (see detailed discussion in Chapter 6). This tension is symbolically captured through one of the dominant messages endorsed by NHSCD, with the central message of the school of 'Healthcare Agents of Change' containing an explicit promotion of the call for action: 'you can rock the boat and stay in it!

It was within those settings that the praxis of collective knowledge mobilisation was explored in-depth, with particular attention paid to the manner in which the three key framing functions were expressed by grassroots activists (Benford & Snow, 2000). This focus further highlighted the tension between formal and informal organisational narratives. The 'Local Leadership' frame discussed in Chapter 7, for example, enabled participants to diagnose existing problems within the current formal leadership structure of the NHS: they described how they saw the existing leadership as distant and inefficient and the suggested change programmes as poorly planned and implemented (Fitzgerald, Ferlie, McGivern, & Buchanan, 2013; James & Routledge, 2011; Plsek & Wilson, 2001). The frame also provided a prognostic framing function by means of an alternative, inclusive informal leadership model, allowing the emerging leaders of the NHSCD movement to adapt the central message of the movement according to the specific needs and requirements of their local areas in a manner that countered the perceived clumsiness of top-down change initiatives (Ferlie & Pettigrew, 1996; Fraser & Greenhalgh, 2001). The findings also revealed that the personalisation of change encouraged individuals to share their own individual visions, debating and discussing innovative ideas in a wide public quasi-formal forum, which contained both formal and informal elements - the forum was coordinated by NHSIQ as a voluntary experimental setting. The 'Local Leadership'

frame also contained motivational praxis, presenting participation in the NHSCD movement as path to self-improvement through the informal image of the volunteer (Sergi, Comeau-Vallée, Lusiani, Denis, & Langley, 2016). This representation of leadership as a voluntary act expresses the tension between the formal perception of leadership and the informal interpretation of the concept by the NHSCD movement, shifting the focus of the change story the individual and their intrinsic motivation, emphasising flexibility, the idea of belonging, and a sense of collective identity (Friedman & McAdam, 1992; Gamson, 1992; Jasper, 1997; Tajfel & Turner, 1979).

The tension between formality and informality can be further seen in the manner in which stories regarding participants' beliefs about required changes and how to enact them were circulated as a central strategic praxis that both constituted the enactment of collective action as well as aimed at the mobilisation of collective action (Brown & Thompson, 2013; Mayer, 2014). This study examined the various verbal and written narrative forms articulated by the NHSCD movement leadership and participants (Barry & Elmes, 1997; Doheny-Farina, 1986; Robichaud, Giroux, & Taylor, 2004). Such stories ranged from the short ante-narratives captured in the form of NHSCD pledges to the widely-circulated, plot-driven '100 Stories of Change' (Boje, 2008). By describing the manner in which some ante-narratives became dominant over others, this PhD contributes to our understanding of collective strategic narrative co-construction (Boje, 2011; Cunliffe, Luhman, & Boje, 2004; Yolles, 2007; Zilber, 2007). By closely examining such narratives, the findings show how bottom-up strategic vocabularies of practice come into use within collective action (Rouleau, 2010). In the case of the NHSCD movement, this can be seen in the particular popularity of certain pledging campaigns (De La Ville & Mounoud, 2010). The viral

nature of these campaigns and the popularity of certain pledges over others illustrates the process through which some strategic narratives become institutionalised practices (Zilber, 2016).

This process of grassroots collective narration of the meaning of change linked various levels of experience through co-negotiation, forming the ideology of the NHSCD movement (Seidl & Whittington, 2014). The collective co-construction of strategic narratives in which the future is presented and experienced in the present enabled each member of the group to express their vision for the future direction of the NHS (Schatzki, 2006). This process also created a narrative space in which each participant was able to not only describe but also to experience the visualised future (Comi & Whyte, 2018). As described in Chapter 2, having the opportunity to express one's beliefs regarding the projected organisational or political path of an as-yet unrealised strategic narrative is characteristic of prefigurative social change (Cornish et al., 2016). This embodied experience allows participants to describe the details of their journey through the fictional space of a possible strategic narrative (Savage, Cornelissen, & Franck, 2018), while the march of the individual through the corridors of the envisioned future accompanied by the other participants in collective action allows them to transition from a single individual to a member of a collective body (Harquail & Wilcox King, 2010). As such, the praxis of strategic narrative co-construction enables a simultaneous experiencing of the change process from both an individual and group perspective, and opens the way for events to emerge that are unscripted and unforeseen (Vaara & Whittington, 2012). This space is conducive to the building of emotional group and individual experiences: the sense of 'marching together' creates positive emotional resonances, memories, and enables the sharing of

aspirations, allowing participants to feel as though they belong to a group story and strengthening the identity of the social movement (Ruebottom & Auster, 2018). Both past events and the projected events of the idealised future provide the narrative milestones of the journey, and both are continually enacted in the present tense of change initiatives as part of the prefigurative leaning of the movement (Farias, 2017). In this context, the findings in Chapter 7 can be interpreted as exploring the 'praxis' of framing as a strategic, co-negotiated and continually evolving narrative that drives the mobilisation of collective action (Snow, Rochford, Worden, & Benford, 1986). This process was encouraged by the open-ended structure of the primary change mechanism – the enacted ante-narratives created by the act of pledging – which allowed participants to envision and enact change initiatives as they saw fit (Reedy, King, & Coupland, 2016).

Strategic narrative praxis was not limited to written or spoken text, however, but also included images, recordings, videos, and other physical and digital artefacts (NHS Change Day, 2016). As such, this thesis suggests that in the case of collective action the notion of 'strategic narrative praxis' should refer to all forms of strategic performance in order to emphasise the physical embodiment of narratives in the 'becoming' of collective action (Butler, 2010; Tsoukas & Chia, 2002). This understanding contributes to both organisational literature and social movement literature as the notion of strategic performances in social movement literature, which focuses on praxis such as internal events including discussions, debates, and planning sessions by SMO (social movement organisation) members, events aimed at engaging the wider public such as press conferences, demonstrations, protests, and marches (Johnston, 2009), pays little attention to the strategising praxis on the ground.

Through the above focus on the interplay between intentionality and spontaneity and between formality and informality, both tensions inherent to the mobilisation of collective action in the NHSCD movement, this PhD highlights the generation and infiltration of meaning involved in grassroots strategic change (Rouleau, 2005). The notion of performances explored in this section not only expands the understanding of strategising praxis in organisations beyond the context of formal planning within managerial settings to encompass the performative praxis developed within physical and digital emerging settings (Alexander, Giesen, & Mast, 2006; Cooren, 2004), but also highlights strategic collective action as a embodied purposeful performance narrated and enacted by an emerging group driving (or resisting) change (see Figure 8.5).

8.4.3 Practices that guide NHSCD's strategy: shared routines of behaviour.

This thesis illustrated how the NHSCD movement challenged and reconstructed principles, such as the role of traditional hierarchical structures, regarding the implementation of change within the NHS (Whittington, 2010). This thesis uncovers how the the strategic narrative of the NHSCD movement was constructed around the tension between the traditional hierarchical ways of doing things (or the existing status quo) and the aspiration for inclusion, a more compassionate practice, and the application of new understandings and methodologies for change (Bevan & Fairman, 2014; Crawford, Brown, Kvangarsnes, & Gilbert, 2014; Labatut, Aggeri, & Girard, 2012). The results unpacked these tensions, revealing in detail the unfolding of the philosophy of change that both developed and guided activism (Thornton et al., 2012). Whittington (2006) uses the term 'practice' to describe 'the strategy practices

that practitioners typically draw on […] the shared routines of behaviour, including traditions, norms and procedures for thinking, acting and using "things"' (Whittington, 2006, p. 619).

Drawing on this definition, Fenton and Langley (2011) emphasise the role of strategic narratives around practices that have become institutionalised as well as provide examples in which the act of constructing strategic narratives becomes an institutionalised practice in itself, such as in the case of scenario planning. The pledge data used throughout this PhD presented particularly relevant empirical way investigate this dynamic. The pledge data allows us to see the in-vivo co-negotiation of strategic narrative of a huge population across multiple sites, and the quantity of information gained through this method enabled a detailed, bottom-up exploration of how narratives emerged in strategic praxis, illustrating the ways in which such narratives function as the building blocks of institutional logics (Thornton et al., 2012). The findings presented throughout this thesis showed that some narratives were more successful than others, suggesting that with time these narratives might become dominant and potentially institutionalised (Zilber, 2013, 2016). The findings also highlighted how over time institutionalised narratives became less relevant, or even stale, and as such conflicted with individual's personal narratives (Zilber, 2008, 2009). In light of this understanding, the activity of social movements aiming at challenging the norms of the status quo can be seen as belonging to this category of 'practice' (Fenton & Langley, 2011).

All four empirical chapters discuss, for example, how the 'practice' of inclusivity developed and guided action within the NHSCD movement (Reinecke, 2018). This became apparent especially in the way in which the NHSCD movement

was seen as connecting previously separate areas of the NHS in a necessary dialogue concerning improvements, including the perspectives of frontline staff members in the shaping of future policy decisions (Oborn, Barrett, & Dawson, 2013; Waring & Currie, 2009). Such inclusivity is characteristic of prefigurative social movements, which are 'guided by the idea that radical social change requires creating and experimenting with the kinds of egalitarian practices, democratic spaces, and alternative modes of relating that anticipate a future society that cannot yet be fully realized' (Cornish et al., 2016).

As such, the strategic narratives that developed around the notion of inclusivity challenged various traditional practices of hierarchy and dominance (Balogun, Jacobs, Jarzabkowski, Mantere, & Vaara, 2014). In particular, the findings in Chapter 7 explored the ways in which the 'Power Disruptive Activism' frame addressed the status quo, power dynamics and power structures within the NHS (Ashburner, Ferlie, & Fitzgerald, 1996). The analysis highlighted how the existing power structures within the NHS were presented as problematic: the institution as a whole was seen as fragmented and divided, with communication between different departments described as limited (Kitchener & Thomas, 2016). Senior levels of management were perceived as either disregarding or blocking ideas from the grassroots elements of the organisation (Bailey & Horvitz, 2010; Bridwell-Mitchell, 2016; Parker et al., 2009; Seyfang & Smith, 2007). The NHSCD movement co-narrated a viable alternative to the existing institutional structure by promoting inclusivity and experimentation through its commitment to inter-level dialogue and transparency, encouraging staff members to take a stand and report bad practice, speaking 'truth to power' (Bevan et al., 2013; Lynton, 2013; Hilton & Lawrence-

Pietroni, 2013, Kitchener & Thomas, 2016). By suggesting informal alternatives to institutionalised practices and thus pushing against the traditional hierarchy of the NHS, the NHSCD strategic narrative expresses the ongoing tension between informal and formal ways of instantiating change within the organisation (Preston & Loan-Clarke, 2000).

Social movement scholars highlight the pivotal role of shared purpose in the co-negotiation of a collective strategic practice (Ganz, 2000, 2009). Chapter 5 particularly focuses on the dynamic between personalised micro strategic enacted narratives and the emergence of a co-constructed, shared perspective, discussing how practices in healthcare are guided by a combination of narratives from which an overarching 'Logic of Care' can be deduced or extracted (Zilber, 2016, 2013). A sense of purpose emerged from participant accounts: the crafting of specific change initiatives involves the evocation of fundamental shared emotional principles such as compassion, fairness and vocational purpose (Friedland, 2018; see Chapter 5 for a detailed account). A striking observation is that the findings presented through this PhD, when seen together, highlight the role of compassion as the underlying animus of work in healthcare (Ballatt & Campling, 2011; Benziman, Kannai, & Ahmad, 2012; Conti-O'Hare, 2002; Holmes, 1991; Rather, Vogus, & McClelland, 2016). Karakas (2010) defines organisational spirituality as 'the journey to find a sustainable, authentic, meaningful, holistic and profound understanding of the existential self and its relationship/interconnectedness with the sacred and the transcendent' (Karakas, 2010, p. 8). Graber and Johnson (2001) contextualise the significance of spirituality in relation to health and healthcare organisations, highlighting the key role of compassion in the relationship between healthcare professionals and patients, stating

that ‘caring and compassion for the sick may comprise one of the few nearly universal human values’ (Graber & Johnson, 2001, p. 3). This motivation is seen throughout this PhD in the efforts of NHSCD participants to enact positive and meaningful change in their working environments, driven by the aspiration of overcoming the emotional disconnect between patients and professionals, the image of a united community, the aim of improving communication between patients and staff in everyday working practices and the desire to protect the interests of marginalised individuals and groups, standing up for equality and fairness within the context of the institution (Lucas, Manikas, Mattingly, & Crider, 2017).

The practice of compassion was also expressed in the form of role-play praxis, either directly enacted through the taking of a commitment to experience the challenges in the lives of the patients or colleagues, or in the form of the ‘shadowing’ of fellow team members, most often the effort to experience the roles of those whose responsibilities or seniorities were significantly different (Chu, 2016; Mendes, 2014). This was particularly evident throughout the findings: practitioners attempted to share the experience of patients, replicating patients’ experience as closely as possible, including deliberately confining their own personal movements to better understand the challenges faced by patients (Rathert, Vogus, & McClelland, 2016). This was an empathetic effort to experience the pain of the other person (West & Markiewicz, 2016). As discussed in sections 8.3.3 above, the NHSCD movement provided participants with both the time and physical platforms to enable the development of such empathetic practices. The temporary settings opened up the imaginative psychological spaces necessary for these types of exploration: a transitional space (Amado & Ambrose, 2001; Amado & Amato, 2001; Amado & Vansina, 2005; Amato

& Moskovitz, 2015; Moskovitz, 2012; Winnicott, 1971) where roles can be temporarily exchanged,understanding fostered between traditional divisions, and the boundaries between the formal and informal can be made permeable (see also section 8.4.2).

The idea of the NHS as a service provider with a specific moral obligation to the welfare of the wider community was the central value behind participants' desire to provide a service capable of meeting the demands of the general public (Mueller, Sillince, Harvey, & Howorth, 2004; O'Reilly & Reed, 2011). Participants' accounts highlight time and time again the need to regard the individual holistically, emphasising that curing the body should be inseparable from healing the mind and the soul, and viewing their role as compassionate healthcare professionals as relating not only to physiological symptoms but also to the social, psychological, symbolic, and spiritual aspects of the human (Kirmayer, 2004). As such, many of the stories told by the participants in the NHSCD movement emphasise the importance of the relationship and need for trust between the individual and the healthcare professionals (Fotaki, 2014; Reader & Gillespie, 2013; Graber & Johnson, 2001). As discussed in section 8.3.1, the emotive, compassionate drive expressed by the NHSCD movement participants often conflicted with the norms of quantifiable managerialism (Reay & Hinings, 2005).

The emphasis placed by NHSCD movement on compassion can be seen as part of the overarching challenge that the movement presented to established institutionalised practices (Fotaki, 2015, 2013; Zulueta, 2013). The notion of a one-size-fits-all model of top-down change that ignored the lived experience of frontline staff members and the necessary improvisation that their work entailed, for example,

was a key institutionalised practice that was challenged by the NHSCD movement (Nicolini, 2011, 2012). In particular, narratives identified the existing leadership structure and its excessive hierarchy as key problems and described the blocking of grassroots ideas as an obstacle to their personal learning and the implementation of real and effective change (Adler, Kwon, Heckscher, 2008). Participants argued that change initiatives that failed to take the particularity of grassroots experience into account not only showed no compassion for the hard-earned wisdom of staff members but had no chance of succeeding (Nicolini, Powell, Conville, & Martinez-Solano, 2008). Participants therefore described the necessity of adapting policy to reflect multiple contexts and experiences (Ansari, Reinecke, & Spaan, 2014; Currie & Spyridonidis, 2016). Participants' accounts grouped under the 'Personal Learning Journey' frame in Chapter 7, for example, highlighted the tension between formal knowledge and the formality of knowledge utilisation programmes and the informality of tacit knowledge gained through personal experience and mobilised through informal practices of knowledge sharing (Reay et al., 2006; Swan et al., 2016).

The NHSCD movement expressed the idea of personal learning as part of their strategic narrative: a plan for future action that, through the inclusion of imaginative exercises and a projective drive, worked towards an organisational reality in which the point of view of the other would be included in the basic make-up of change (Nembhard & Edmondson, 2006; Tasselli, 2018). Activists aimed to co-author a welcoming strategic narrative in which individual growth could flourish (Fotaki, Long, & Schwartz, 2012). The movement's leadership aspired to create a contrast with the institutionalised perception of change through a dual emphasis on innovation

and tolerance, with mistakes being seen as essential to the learning processes that change entails (Garcia-Lorenzo, Donnelly, Sell-Trujillo, & Imas, 2017). Indeed, the central impetus of innovation within the NHSCD movement came from frontline members who yearned to see a cultural shift within the institution in terms of their value and the inclusion of their lived experiences in future policy decisions (Balogun, Best, & Lê, 2015; Dent, 1995). In this sense, the strategic narrative of the NHSCD movement told a story in which participation in the movement was not only seen as an opportunity for frontline members to make their voices heard, but also as a chance for policy makers to demonstrate their willingness to listen (Chreim, Langley, Comeau-Vallée, Huq, Reay, 2013). The notion of inclusivity and the opening up of strategising practices to incorporate frontline participants were the guiding principles through which the tension between the hierarchical and traditional NHS structure and the movement's central innovative idea of a 'million change agents' was explored (Bate et al., 2006).

As such, the NHSCD movement participants both introduced and explored various new strategic 'practices' in 'praxis', each embodying the tension between the traditions of the NHS and the aspiration for innovation, compassion and inclusion (Huq, Reay, & Chreim, 2017; Johns, Green, & Powell, 2012; Shute et al., 2012; West, Dawson, & Kaur, 2015). These principles, which drove participation in the NHSCD movement, were then developed from one NHSCD campaign to another in a dynamic process which both enabled grassroots participants to introduce new praxis as well as to negotiate in vivo the possibility of re-authoring the boundaries of existing practices (Bjørkeng et al., 2009; see also section 8.3.1 above).

Building on the framework developed by Whittington (2006), this section proposed collective action as a strategic practice, constituted of and driven by three inherent tensions as summarised in the table below (see Table 8.2).

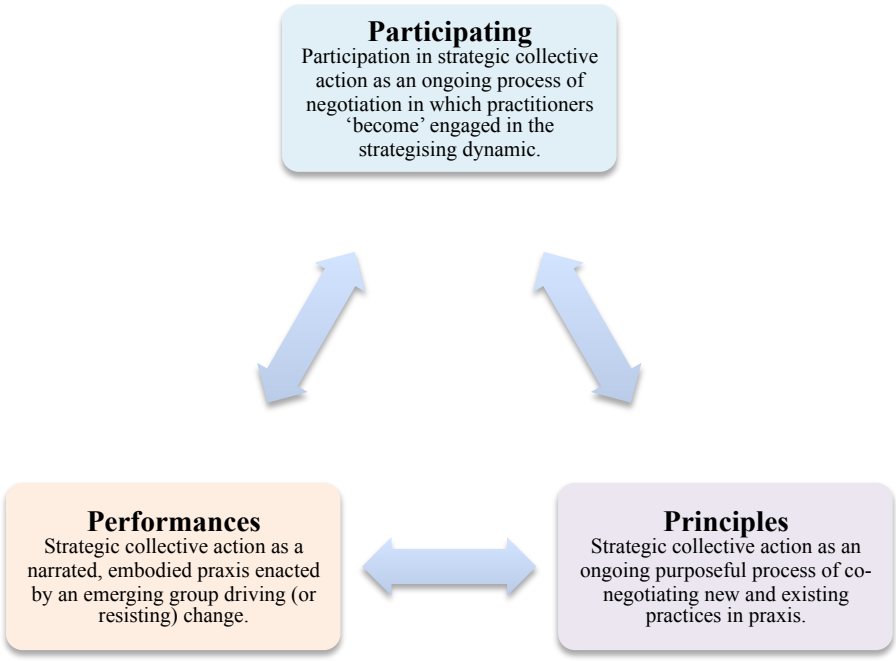
Table 8.2

Collective Action as Practice			
Practitioners	***Intentionality***	***Spontaneity***	Participants in the NHSCD movement as strategic actors.
Praxis	***Formal***	***Informal***	Formal and informal activities involved in the design and implementation of NHSCD's strategy.
Practices	***Hierarchy & Tradition***	***Innovation, Compassion & Inclusion***	Practices that guide NHSCD's strategy: Shared routines of behaviour.

By further drawing on the understandings developed by Fenton and Langley (2011) about Whittington's (2006) framework, this section further suggests the following view of collective action as a 'becoming' strategic practice (see Figure 8.5).

Figure 8.5

Collective Action as a 'Becoming' Strategic Practice



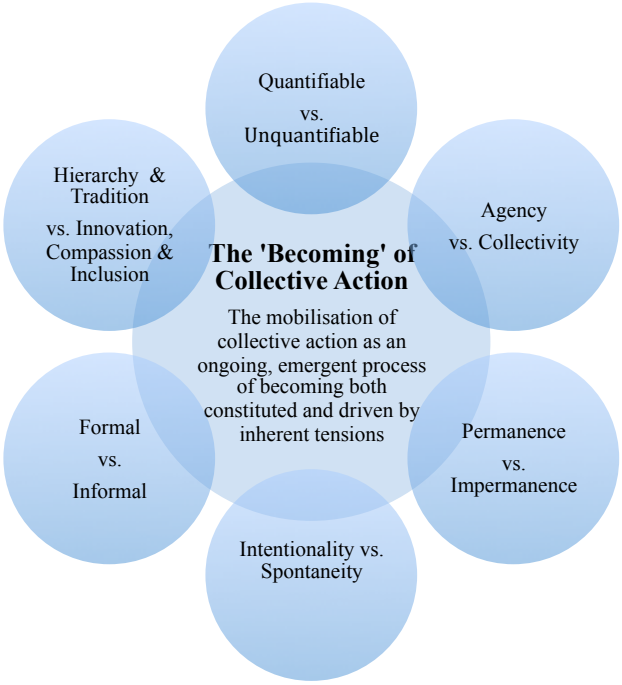
The following section concludes this discussion by presenting the mobilisation of collective action as a process of 'becoming' – an emergent process that is both constituted of and driven by inherent tensions – and by suggesting areas for further research.

8.5 Conclusion and Suggestions for Further Research

The discussion in this chapter brought together the empirical and theoretical contributions from the various chapters of this thesis. The first section of the discussion provides a conceptual map to the thesis, highlighting the contributions of the three empirical papers that constitute the core of this work. The second section draws attention to the different ways in which each chapter works to bridge the historical gap between social movement and organisation studies by revisiting the specific contributions of each individual chapter. Next, the third and fourth sections of

this discussion further develop these understandings, considering their implications for wider theories about the practice of collective action. In doing so, I focused on two theoretical models from practice theory (i.e., Bjørkeng et al., 2009 and Whittington, 2006) and utilised the insights gained from these frameworks to structure an integrated view of the findings in this thesis. Throughout the discussion, six tensions that guided collective action within the NHSCD movement were identified (see Figure 8.6).

Figure 8.6



Each of the above tensions between conflicting values created a friction that in turn generated a drive towards the resolution of these contradictions. The mobilisation of collective action was born out of the push to resolve the conflict between these naturally contradictory priorities. This thesis shows that the setting facilitated by the NHS Change Day movement was a fertile ground on which the change initiatives of employees could flourish, allowing them to imbue their individual and small group

change practices with a sense of overarching purpose. As such, this thesis reveals an interplay between these inherent tensions and the enactment of actual small-scale change initiatives in day-to-day practices through an embodied experience of collective action. The dynamic of collective action enabled participants to experience alternative realities via enactment within the social movement setting, allowing them to challenge, as well as come to terms with, the limitations of their reality. Collective action emerged from this interplay of opposites, igniting social change through both individual and collective processes. This thesis shows that such inner contradictions are central to the emergence of collective action and have a pivotal role in the social construction of organisational change. Furthermore, this discussion highlighted that despite the fact that such tensions drive the process of collective action, they cannot be fully contained. The reality of day-to-day healthcare, as expressed by NHSCD participants – the need for further change and improvement – can never be seen as completed: there is always more to do and new obstacles to overcome. The reconciliation of opposites is never truly resolved. There is a disjunction between the aims of participants in collective action and what can be achieved in reality that can never be completely overcome: the cycle of collective action has to begin once more. In this sense, the NHSCD movement's call for action embodies a deeper process: participants are called to take part in a change journey, not aiming at a particular goal, rather aspiring to walk a path of 'becoming' (Tsoukas & Chia, 2002). Encompassing this is the understanding that the tensions that guide the mobilisation of collective action need to be seen as inherent to the dynamic itself. As such, this thesis argues that the mobilisation of collective action needs to be viewed as an ongoing, emergent process both constituted and driven by inherent tensions.

The research undertaken for this thesis was constrained by the several limitations. Regrettably, these limitations could not be overcome within the scope of this thesis. Several suggestions for future research arise from this work.

The research focused on examining the development of the unique case study of the NHSCD, which limited the possibility for comparison with other similar cases. Further research might profitably relate the conclusions drawn from the case of the NHSCD movement to other social movements within healthcare, considering the implications for collective action with reference to an even broader data set. Furthermore, this research commenced with the collection of data from the NHSCD global movement, however due to the limitations of time and length set by the framework of the PhD this research requires further work to be concluded. Moreover, some of the findings in this thesis highlight issues that are especially relevant to the field of healthcare due to the nature of the NHSCD case study. However, these could be taken further by future research and be examined in the context of other fields.

The empirical focus of this study was on the emergence of collective action and the processes that take place during the initial stages of large-scale change in organisations. The theoretical contribution of this thesis is therefore largely relevant to the understanding of such processes, particularly the early engagement in large change initiatives. Further research needs to be carried out in order to reflect upon the sustainability of such change. The long term implications of the bottom-up change initiatives explored in this study also require further empirical and theoretical attention that was beyond the scope of this study.

This research adopted a longitudinal qualitative approach to investigating the case study. The research was limited in length, however, due to the nature of a PhD

project. A longer study would have allowed for additional understandings. In particular, a longer period of study would have enabled for the collection and analysis of quantitative data, and could have generated further macro insight. The approach adopted in this study was further constrained by the fact that the researcher was not an internal member of the NHS. Conducting further research from the perspective of an internally embedded researcher would produce additional insight. The perspective of an action researcher could be particularly useful.

Overall, this thesis made a contribution to the debate regarding collective action and grassroots activism, especially within the context of large organisations such as healthcare systems. The phenomenon of collective action is, however, multifaceted and complex, and therefore provides a fertile ground for an ongoing scholarly conversation. As highlighted throughout this thesis, studies that focus on grassroots activism within the confinement of organisations and corporations are scarce. Further studies in this area may help to overcome the limitations of this work and thereby enrich the understandings developed throughout this thesis, moving towards the development of a rich and informed theory of collective action as a phenomenon of 'becoming'.

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APPENDICES

APPENDIX 1: Research Design

Appendix 1.1: Research Design with Detailed Participant Observations

	Methodology			
NHS Change Day structures	**Interviews**	**Participant observations**	**Digital Data Collection**	**Original Data and documents**
NHS Change Day Pledges data				NHS 2014: 8,806 Pledge narratives NHS 2016: Pledges
Media review				389 publications/articles
Key Public Events	Walk in short interviews NHS Change Day other leaders and participants (2 in-depth interviews)	NHS Change Day 2014 Launch Event in London, November 6th, 2013 [9h] NHS Change Day main event at EXPO in Manchester from March 2nd to March 4th, 2014 [30h] Agents for Change conference, BMA House in London from June 26th to June 27th [15h] NHS Change Day Celebration Day, online interactive participation, July 4th, [10h]	NHS Change Day Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
Key Planning Events	Walk in short interviews	NHS Improving Quality Onsite Strategy Meeting in London June 24th, 2013 [4h] NHS Improving Quality Onsite Strategy Meeting in Coventry December 2nd, 2013 [4h] NHS Change Day Onsite Strategy Day in London January 9th, 2014 [4h] NHSCD debrief day: on site half day workshop 'The story of us' in Coventry March 28th, 2014 [5h] NHSCD evaluation planning & debrief day in Coventry April 30th, 2014 [8h] NHS Change Day 2015 Habbies Away Day in Stone, Staffordshire, September 25th, 2014 [7h]	NHS Change Day Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
Core Leadership Team	NHS Change Day members of Core	Participation in 26 weekly Core Leadership Team Webex conference call meetings: on each Monday from	NHS Change Day Websites and Social	NHS Improving Quality NHSCD email

	Leadership Team (11 in-depth interviews)	July 15th, 2013 to February 24th, 2014 [26h] Research & Evaluation Work stream Telecom meeting October 2nd, 2013 [1h] Meeting with Core Leadership Team at AHCM Award event November 27th, 2013 [3h] Core Leadership Team debrief Webex Conference call meeting after EXPO March 11th, 2014 [1h] NHSCD Evaluation Team meeting in Coventry March 28th, 2014 [3h] Core Leadership Team - publications planning Webex Conference call meeting May 16th, 2014 [1h] Meeting with NHS IQ team in London – planning and preparations for 'NHS Change Day Celebration Day' June 19th 2014 [4h]	Media	correspondence and internal circulated documents
Hub Leaders' meetings	NHS Change Day Hub local leaders (8 in-depth interviews)	NHS Change Day Hubs' Away Day in London January 9th, 2014 [4h] Hubs' Away Day in London June 11th [7h] Hubbies "Public Narrative" Webinar November 3rd [2h]	NHS Change Day Websites and Social Media	On site document collection (documents, leaflets, hand-outs, etc.)
NHS Change Day related events in local Trusts	NHS Change Day local Trust leaders and participants (6 in-depth interviews)	Full day visit and observations at Nottingham University Trust April 1st, 2014 [8h] Full day visit and observations of NHS Change Day presentations Nottingham University Trust April 3rd, 2014 [8h] Full day visit and observations of NHS Change Day staff presentations, award ceremony, and NHS Improving Quality presentations at Nottingham University Trust May 29th, 2014 [8h]	NHS Change Day Websites and Social Media (including local Trusts' website	On site document collection (documents, leaflets, hand-outs, etc.)
One to one or small group meetings with NHS Change Day leaders	NHS Change Day Founders (3 in-depth interviews)	Lecture presentation and discussion with Helen Bevan July 14th, 2012 [6h] Conference call with Helen Bevan October 3rd, 2012 [1h] Conference call with Helen Bevan May 13th, 2013 [1h] Meeting with Jackie Lynton in Coventry June 18th, 2013 [2h] Meeting with Jackie Lynton & Joe McCrae in Coventry (NHSCD 2013 lessons learnt) June 27th, 2013 [3h] Meeting with Jackie Lynton in Coventry June 2nd, 2014 [2h] Meeting with Pollyanna Jones June 12th, 2014 [2h]		
Change Day Global		Change Day Global movement Webex conference calls:	Review of international	email correspondence

movement meetings		July 30th, 2013 [1h] October 1st, 2013 (two calls) [2h] January 28th, 2014 (two calls) [2h] July 8th, 2014 (two calls) [3h] October 23rd, 2014 [1.5h] January 26th, 2015 [1.5h]	websites related to Change Day	and internal circulated documents
Local CCGs	NHS Change Day local CCG leaders and participants (2 in-depth interviews)	Group discussion June 18th 2014 [10h]		
Total	32 in-depth interviews	210 hours of participant observations	NHS Change Day Websites and Social Media observations 400 hours	9,479 pledges 389 media publications/articles 50 On site original document collection (documents, leaflets, hand-outs, etc.) 800 emails

Appendix 1.2: Research Design Ethics Form

Ethics Application
Department of Social Psychology

Title of project: Mobilising Collective Action for Healthcare Improvement in the English national Health Service (NHS): A social Movement Perspective on Large Scale Organisational Change.

Name of Researcher(s): Liora Moskovitz

Email Address: l.moskovitz@lse.ac.uk

Name of Supervisor (for MSc/PhD projects): Dr. Lucia Garcia Lorenzo

Date: 13 January 2014

		Yes	No	N/A
1	Will the proposed research entail any risk to the researcher(s)? (eg., entail travel to unstable regions, exposure to environmental risks, collection of sensitive data, or lone working in an unfamiliar context)		X	

If you ticked **Yes** to Q1, you should complete a **risk assessment form**

		Yes	No	N/A
2	Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?	X		
3	Will you tell participants that their participation is voluntary?	X		
4	Will you obtain written consent for participation?	X		
5	If the research is observational, will you ask participants for their consent to being observed?	X		
6	Will you tell participants that they may withdraw at any time and for any reason?	X		
7	With questionnaires, will you give participants the option of omitting any questions they do not want to answer?	X		
8	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	X		
9	Will you debrief participants at the end of their participation (i.e. given them a brief explanation of the study)?	X		

If you ticked **No** to any of Q2-9, you should **tick box B** overleaf.

		Yes	No	N/A
10	Will your project involve deliberately misleading participants in any way?		X	
11	Is there any realistic risk of you or any participants experiencing either physical or psychological distress or discomfort? If **Yes,** give details on a separate sheet and state what you will tell them to do if		X	

	they should experience any problems (e.g., who they can contact for help).				
12	Does your project involve work with animals?		X		
13	Do participants fall into any of the following special groups? Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students).	Schoolchildren (under age 18)	X		
		People with learning or communication difficulties	X		
		Parents	X		
		People in custody	X		
		People engaged in illegal activities (e.g. drug taking)	X		

If you have ticked **Yes** to any of Q10-13 you should **tick box B** overleaf.

There is an obligation on the lead researcher or supervisor to bring to the attention of the Departmental Ethics Committee any issues with ethical implications not clearly covered by the above checklist.

PLEASE TICK **EITHER** BOX A OR BOX B BELOW AND **PROVIDE THE DETAILS REQUIRED** IN SUPPORT OF YOUR APPLICATION. THEN SIGN THE FORM.

	Tick box
A. I consider that this project has **no** significant ethical implications to be brought before the Departmental Ethics Committee	X
Give a brief description of participants and procedure (methods, tests used etc.) in up to 150 words. Participant observation in meetings via personal email invitation from NHS Improving Quality staff. Introduction as PhD researcher and purpose of research stated to all participants attending each meeting. Interviews (participant consent form and debrief sheets attached). Data collected from open access web sites. All data anonymised. *If you have ticked box A, then sign and submit this form (and any attachments) to the ISP Ethics Committee.*	

	Tick box
B. I consider that this project **may** have ethical implications that should be brought before the Departmental committee, and/or it will be carried out with children or other vulnerable populations	
Please provide all the further information listed below on a separate attachment. Title of project: Mobilising Collective Action for Healthcare Improvement in the English national Health Service (NHS): A social Movement Perspective on Large Scale Organisational Change.	

Purpose of project and its academic rationale: Studying collective action in the context of large-scale organisational change.
Brief description of methods and measurements: Interviews with NHS employees, Participant observations (personal email invitation from NHS Improving Quality staff). Digital ethnography on publically open websites. Collection of other publically available data such as media articles.
Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria. Around 30 interviews, adults, all genders, NHS employees, interviews scheduled in person during meetings or via email correspondence.
Consent, participant information, debriefing (***attach information, consent, & debrief sheets**)
A clear concise statement of ethical issues raised by the project and how you intend to deal with them.
Estimated start date and duration of the project. Attached

If any of the above information is missing, your application will be returned to you.
If you have ticked box B, then sign and submit this form along with a separate document providing the above information (and any attachments) to the ISP Ethics Committee.

I am familiar with the BPS Guidelines for ethical practices in psychological research and I have discussed them with other researchers involved in the research (e.g., supervisor or co-researcher).

Student signature LM Print Name Liora Moskovitz Date 13 January 2014

Supervisor signature

Print Name Lucia Garcia Date 15 Jan 2014

Statement of Ethical Approval: To be Completed by the Chair of the Ethics Committee
This project has been considered using agreed procedures and is now approved.

Signature Dr Ilka Gleibs

APPENDIX 2: Interviews

Appendix 2.1: List of Interviewees

	Interviewee Role in NHS Change Day	Profession/ Role in the NHS	Interview Location	Interview Date
1	National Hub Leader and Core Leadership Team (CLT) member	Manager	London	20 February 2014
2	CLT member and Hub leader	Improvement Leader	Manchester	3 March 2014
3	CLT member and Hub leader	Doctor	Manchester	3 March 2014
4	Hub Leader	Finance Management Trainee	Manchester	3 March 2014
5	Hub Leader	Management Trainee	Manchester	3 March 2014
6	Founder and CLT member	Doctor	Manchester	3 March 2014
7	Activist	Doctor	Manchester	3 March 2014
8	Activist	Doctor	Manchester	3 March 2014
9	CLT member	Improvement Leader	Manchester	4 March 2014
10	Hub Leader	Management Trainee	Manchester	4 March 2014
11	Hub Leader	Management Trainee	Manchester	4 March 2014
12	Hub Leader	Management Trainee	Manchester	4 March 2014
13	Member of the CLT evaluation work stream	Behavioural Scientist	Coventry	6 March 2014
14	Social Media Lead and member of CLT	Social media	Coventry (via Skype)	6 March 2014
15	Founder and CLT member	Chief Transformation Officer	London	10 March 2014
16	Founder and CLT member	Doctor	London (via Skype)	10 March 2014
17	NHS Change Day National Lead and member of CLT	Improvement Leader	Coventry	13 March 2014
18	CLT member	Improvement Manager	Coventry	13 March 2014
19	Hub Leader	Nurse	Chesterfield	14 March 2014
20	Hub Leader	Ward Sister	Chesterfield	15 March 2014
21	Hub Leader	Graduate Management Tranee	Swindon	24 March 2014
22	Hub leader and Local CCG Change Day Activist	Graduate Management Tranee	Bristol	24 March 2014
23	Activist	Program Director	Nottingham	1 April 2014
24	Activist	HR Manager	Nottingham	1 April 2014
25	Activist	Improvement Leader	Nottingham	1 April 2014
26	Activist	Student Nurse	Nottingham	1 April 2014
27	Activist	Radiographer	Nottingham	3 April 2014
28	Activist	Porter	Nottingham	3 April 2014
29	CLT member, social media and communication.	Film maker	London	7 April 2014
30	Local CCG Change Day Leader and Hub Leader	Improvement Leader	Bristol	23 April 2014
31	CLT member, social media and communication	Communication	London	16 June 2014
32	CLT Member	Improvement Leader	London	19 June 2014

Appendix 2.2: Interview Guides

Interview Guide: General

Name:	
Job title:	
Role in NHSCD:	
Interview date:	
Interview location:	
Interview duration:	

Personal/ your role in the NHS and in NHSCD

If interviewee answered Core Leaders interview guide move on to next section

1) How long have been working with or connected to the NHS?
2) In what capacity?
3) How does NHSCD relate to your work in the NHS?
4) How do you balance your commitments to NHS Change Day (NHSCD) with your work in the NHS?

NHSCD 2013 – Reflecting on the process

5) Were you involved in NHSCD 2013? If so, in what capacity?
   If not, move on to "NHS CD 2014".

Motivation for personal involvement in NHSCD 2013

6) How did you learn of NHSCD 2013 (through publicity and/or through other people around you)?
7) Why did you get involved?

Personal Participation/Pledging in NHSCD 2013

8) Did you make a pledge for NHSCD 2013? If so:
   a) Could you describe it?
   b) What were the reasons behind that pledge?
   c) How does this pledge link to your daily job/ the state of the NHS?
9) What do you think of the pledging campaign? Do you believe it is a good way of making necessary changes? If so, why? Would you go about change in a different way? If so, how?
10) Do you know other people who made pledges for NHSCD 2013? Was it an individual/personal decision or a group process? Did you discuss/ share your pledge with anyone?

11) If you made a pledge, did you carry it out? If so, what impact do you believe it had?

Experience and Impact of NHSCD 2013

12) What was your experience of NHSCD 2013 like?
13) Do you think NHSCD 2013 had any influence? If so what do you think it influenced? Did you see any results?
14) Did NHSCD 2013 affect your work or work-attitude on a daily basis? Have you noticed any changes around you because of NHSCD 2013?
15) What could have been improved in the process of the NHSCD 2013? Do you believe there could have been improvement in the impact made by it upon the NHS?

NHS Change Day (NHSCD) 2014 – (Narratives of the process as it happens)

Motivation for Personal Involvement NHSCD 2014

16) How did you first become involved with NHSCD 2014?
17) What made you want to be involved?

Personal Participation/Pledging NHSCD 2014

18) Did you make a pledge for NHSCD 2014? If so, what was it?
    a) Could you describe it?
    b) What were the reasons behind that pledge?
    c) How does this pledge link to your daily job/ the state of the NHS?
    d) Did you involve other people in your pledge or join others in their pledges? If so, how?
19) Are you participating in any of the following as part of NHSCD 2014? If so, please describe your experience:
        a) Campaign pledges
        b) Kick Start pledges ('I will do, if you will do')
        c) Global pledges
        d) Organisational pledges
20) Are you participating in the School for Healthcare Radicals? If so, please describe your experience.
21) If you made a pledge, did you carry it out? If you have not yet carried it out, how do you intend to?
22) What impact do you believe your pledge might have?

Evaluating the NHSCD 2014

23) Could you compare your experience of NHSCD 2014 and of NHSCD 2013? ***(This question should be only asked if the interviewee participated in both NHSCD 2013 and NHSCD 2014.)***
24) Can you give me an example? Do you have a story you would like to share?

25) What do you think of the pledge/ share/ do/ inspire campaign? Do you believe it is a good way of making necessary changes? If so, why? Would you go about change in a different way? If so, how?
26) Do you believe the initiatives, inspired by NHSCD, will contribute to a major organisational change? If so, how?
27) Do you believe this NHSCD 2014 will translate into continuous change? If so how?

Challenges and limitations of NHSCD 2014

28) In your mind, what are the challenges faced by NHSCD 2014?
29) What do you think are the limitations of NHSCD 2014?

NHSCD – your perspective

30) Could you describe what you think NHSCD is?
31) Why do you think NHSCD is important to the NHS?
32) In your mind, what are the goals of NHSCD 2014?
33) What do you think NHSCD 2014 can influence or change inside or outside the NHS?
34) How do you believe this change should be achieved?
35) How do you think NHSCD 2014 should be promoted?
36) What are the values or ethics, which you think underlie NHSCD 2014?
37) Do you believe NHSCD is an imperative campaign to the NHS, if so why?

NHSCD Looking Ahead to the Future

38) Would you like to share your vision/ thoughts about the future of NHSCD/ the NHS?
39) Are there any metaphors/ associations that come to your mind that you would like to share?
40) Is there anything that you would like to add?

Researcher notes and comments about interview:

Interview Guide: Social Media NHSCD 2014

Name:	
Job title:	
Role in NHSCD:	
Interview date:	
Interview location:	
Interview duration:	

Personal/ your role in the NHS

1) How long have been working with or have been connected to the NHS?
2) In what capacity?

NHSCD – Social Media

3) Could you describe what the Social Media work stream is?
4) Could you describe the development of the NHSCD website 2013?
5) Could you describe the development of the NHSCD website 2014?
6) What was the role of social media in NHSCD 2013?
7) How did this role develop over time (from NHSCD 2013 to NHSCD 2014)?
8) What were the new social media requirements for NHSCD 2014, how were they addressed?
9) Could you describe the social media channels used for NHSCD? Why were these channels chosen?
10) Which social media channels were more effective? In what way?
11) Could you describe the interaction between the communication through social media and other means of communication in NHSCD?

Personal/ your role as at the Social Media Work Stream

12) Could you describe your specific role/ roles in NHSCD?
13) How does NHSCD relate to your work in the NHS?
14) How do you balance your commitments to NHS Change Day with your work in the NHS?
15) How has your role in NHSCD developed over time (from NHSCD 2013 to NHSCD 2014)?
16) At what stage does the social media team report back to the Core Leadership Team? Could you describe this dynamic?

Challenges and Limitations

17) What is unique about NHSCD a social media perspective so far?
18) What are the main challenges facing social media for NHSCD 2014? How are you tackling these?

Interview Guide: Hub Leaders

Name:	
Job title:	
Role in NHSCD:	
Interview date:	
Interview location:	
Interview duration:	

Personal/ your role in the NHS

1) How long have been working with or have been connected to the NHS?
2) In what capacity?
3) Could you describe what the Hubs are?

Raising awareness for NHSCD

4) How has NHSCD been promoted within local organizations/ local trusts?
5) Could you give me a couple of specific example of how awareness of NHSCD has been raised in your region? Could you share some stories?
6) How has NHSCD been promoted within the royal colleges of medical staff? Could you give me some examples?
7) How has NHSCD been promoted within the nursing community? Could you give me some examples?
8) Could you give me example of how NHSCD has been promoted within other communities or groups of similar interest (such as the Darzi fellows)?
9) How is awareness for NHSCD being raised nationally? What role do the Hubs and Noads have in this promotion?

Coordinating NHSCD – the Role of Hubs and Hub Leaders

10) How are new ideas being raised/ discussed/ debated on the 'front line'?
11) How are front line ideas and initiatives collected and how do you and your team ensure that these ideas and initiative are implemented?
12) Can you give me some examples or stories of the grassroots dynamics of NHSCD?
13) Once information, ideas and initiatives have been collated at the grassroots level what does the team do next?
14) At what stage do the hubs report back and involve the Core Leadership Team?
15) What influence do the hubs have on the activity of the Core Leadership Team?
16) What influence does the Core Leadership Team have on the activities of the Hubs?
17) Could you describe the 'top-down' vs. 'bottom-up' dynamics of NHSCD?
18) Could you compare this dynamic to the day-to-day dynamics at the NHS?
19) How do different Hubs interact between them, influence one another and help one another?

20) Could you compare national initiative to local initiatives and the interplay between them? Could you give some examples?

Personal/ your role as a Hub leader

21) Could you describe your specific role/ roles in NHSCD?
22) How does NHSCD relate to your work in the NHS?
23) How do you balance your commitments to NHS Change Day with your work in the NHS?
24) What are the main challenges and difficulties Hub leaders and grassroots activist in NHSCD face?
25) How has your role and the role of Hubs in NHSCD developed over time (from NHSCD 2013 to NHSCD 2014)?

Interview Guide: Communications, Marketing & Stakeholder Engagement

NHSCD 2014

Name:	
Job title:	
Role in NHSCD:	
Interview date:	
Interview location:	
Interview duration:	

Personal/ your role in the NHS

1) How long have been working with or have been connected to the NHS?
2) In what capacity?

Communications, Marketing and Stakeholder Engagement

3) Could you describe what the Communications, Marketing & Stakeholder Engagement work stream is?

Framing of Key Messages

4) Could you describe how the key messages are being defined?
5) Could you describe how the NHSCD Scripts are being developed?
6) How are these scripts used internally and externally?
7) How do you ensure homogeneity between related work streams? What is the importance of this?
8) How do you shape the development of NHSCD 2014's outputs?
9) How do you assess the quality of the outputs?

Identifying Key Stakeholders, Marketing Channels and Campaign Plans

10) Could you describe the process of identifying the stakeholders?
11) How are marketing channels being researched?
12) How are the marketing strategies and campaign plans being developed?
13) Can you summarise NHSCD 2014's marketing strategy?
14) Can you summarise NHSCD 2014's campaign plan?
15)

Personal/ your role as at the Communication, Marketing and Stakeholder Engagement Work Stream

16) Could you describe your specific role/ roles in NHSCD?
17) How does NHSCD relate to your work in the NHS?
18) How do you balance your commitments to NHS Change Day with your work in the NHS?
19) How has your role in NHSCD developed over time (from NHSCD 2013 to NHSCD 2014)?

20) What does NHSCD 2014's communication, marketing and stakeholder engagement have in common with other projects or initiatives of which you have experience?
21) At what stage does the Communications team report back to the Core Leadership Team? Could you describe this dynamic?

Challenges and Limitations

22) What is unique about NHSCD from a communication, marketing and stakeholder engagement perspective so far?
23) What are the main challenges facing communication, marketing and stakeholder engagement for NHSCD 2014? How are you tackling these?
24) What are the challenges faced by media relations for NHSCD 2014? How are you tackling these?

Appendix 2.3: Participant Information Sheet & Consent Form

You are being invited to take part in a research study. Before deciding to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information. Feel free to discuss issues with anyone, and if there is anything which is not clear or any questions you have, feel free to ask. Take your time reading, and don't feel rushed.

What is this research about?

This research is being conducted within the Department of Organizational Social Psychology at the LSE, as a PhD project. It focuses on NHS Change Day as a grassroots mass movement and investigates the application of a social movement perspective to large scale organizational change.

Who is doing this research?

This research is conducted by Liora Moskovitz, BSc, MSc, Executive Specialized MSc and PhD Candidate at the Department of Social Psychology, LSE (L.Moskovitz@lse.ac.uk).

The research is supervised by Dr. Lucia Garcia-Lorenzo (L.Garcia@lse.ac.uk) and Dr. Tom Reader (T.Reader@lse.ac.uk) from the Department of Social Psychology at the LSE.

Why have you asked me to participate?

Key supporters, organizers and participants of NHS Change Day have been asked to give their perspectives on the phenomenon.

What will participation involve?

This research is attempting to capture the spirit of NHS Change Day as it happens and so in this interview, I use a flexible guideline: you will be invited to answer a series of questions and can, of course, decline to answer any of the questions.

How long will participation take?

You would be asked to share your individual experiences and stories of the event in an interview, lasting for approximately an hour. It would be ideal if you were willing to share your views in second, and potentially third follow-up interviews.

What about confidentiality?

All data will be anonymized. I do, however, request permission to associate your professional status (e.g. 'Nurse', 'Doctor' etc.) with your views. You can of course, decline.

If you are willing to participate, then please sign a Consent Form.

You can keep this Information Sheet for your records.

Informed Consent

Project: Mobilizing Collective Action for Healthcare Improvement in the NHS: A Social Movement Perspective on Large Scale Organizational Change

Researcher: Liora Moskovitz, BSc, MSc, Executive Specialized MSc and PhD Candidate at the Department of Social Psychology, LSE (L.Moskovitz@lse.ac.uk).

S**upervisors:** Dr. Lucia Garcia-Lorenzo (L.Garcia@lse.ac.uk) and
Dr. Tom Reader (T.Reader@lse.ac.uk) from the Department of Social Psychology at the LSE.

To be completed by the Research Participant

Do you feel you have been given sufficient information about the research to enable you to decide whether or not to participate in the research?	Yes	No
Have you had an opportunity to ask questions about the research?	Yes	No
Do you understand that your participation is voluntary, and that you are free to withdraw at any time, without giving a reason, and without penalty?	Yes	No
Are you willing to take part in the research?	Yes	No
Are you aware that the interview will be audio recorded?	Yes	No
Will you allow the research team to use anonymized quotes in presentations and publications?	Yes	No
Will you allow the anonymized data to be archived, to enable secondary analysis and training future researchers?	Yes	No

Please answer each of the following questions:

Participants Name: _____

Participant's Signature: _____ Date:_____

If you would like a copy of the research report, please provide your email or postal address.

Appendix 2.4: Interview Data Uploaded to Nvivo for analysis

File number	File content	Number of pages	Lines of text
44	Interview 1	23	1,018
45	Interview 2	12	566
46	Interview 3	20	895
47	Interview 4	19	878
48	Interview 5	11	524
49	Interview 6	12	507
50	Interview 7	19	1,060
51	Interview 8	9	270
52	Interview 9	10	479
53	Interview 10	19	941
54	Interview 11	18	850
55	Interview 12	18	855
56	Interview 13	10	467
57	Interview 14	13	597
58	Interview 15	10	465
59	Interview 16	14	669
60	Interview 17	19	909
61	Interview 18	10	465
62	Interview 19	26	1,286
63	Interview 20	15	729
64	Interview 21	14	654
65	Interview 22	15	698
66	Interview 23	12	592
67	Interview 24	25	1218
68	Interview 25	17	838
69	Interview 26	16	754
Total Interviews		**406**	**19,184**

APPENDIX 3: NHS Change Day 'Pledge' Data

Appendix 3.1: Pledge Data 2014 Uploaded to Nvivo for analysis

File number	File content	Number of pages	Lines of text
1	Pledge 1-250 (2014)	20	975
2	Pledge 251-500 (2014)	23	1,099
3	Pledge 501-750 (2014)	24	1,139
4	Pledge 751-1,000 (2014)	19	866
5	Pledge 1,001-1,250 (2014)	17	780
6	Pledge 1,251-1,500 (2014)	20	887
7	Pledge 1,501-1,750 (2014)	19	867
8	Pledge 1,751-2,000 (2014)	20	884
9	Pledge 2,001-2,250 (2014)	17	763
10	Pledge 2.251-2,500 (2014)	20	916
11	Pledge 2,501-2,750 (2014)	19	867
12	Pledge 2,751-3,000 (2014)	16	799
13	Pledge 3,001-3,250 (2014)	16	773
14	Pledge 3,251-3,500 (2014)	15	712
15	Pledge 3,501-3,750 (2014)	15	755
16	Pledge 3,751-4,000 (2014)	15	743
17	Pledge 4,001-4,250 (2014)	16	784
18	Pledge 4,251-4,500 (2014)	16	742
19	Pledge 4,501-4,750 (2014)	15	721
20	Pledge 4,751-5,000 (2014)	16	786
21	Pledge 5,001-5,250 (2014)	16	771
22	Pledge 5,251-5,500 (2014)	18	906
23	Pledge 5,501-5,750 (2014)	12	603
24	Pledge 5,751-6,000 (2014)	14	701
25	Pledge 6,001-6,250 (2014)	19	840
26	Pledge 6,251-6,500 (2014)	19	864
27	Pledge 6,501-6,750 (2014)	19	841
28	Pledge 6,751-7,000 (2014)	17	750
29	Pledge 7,001-7,250 (2014)	17	772
30	Pledge 7,251-7,500 (2014)	17	738
31	Pledge 7,501-7,770 (2014)	17	772
32	Pledge 7,771-8,000 (2014)	17	754
33	Pledge 8,001-8,250 (2014)	14	633
34	Pledge 8,251-8,500 (2014)	17	750
35	Pledge 8,501-8,750 (2014)	18	817
36	Pledge 8,751-8,806 (2014)	5	222
Total Pledges 2014		**614**	**28,592**

Appendix 3.2: Example of 'Pledge' Data 2014

The following presents a page of 2014 pledge data as collected, organised and uploaded for analysis:

6297 [***e.g. Pledge consecutive for data organisation. This pledge is pledge no. 6297 out of 8,806 pledges that were collected at 2014***] (76) [***e.g. number of people who made or joined this pledge. The total nubled of people who joined the 8,806 collected pledge narratives is 802,000***]: We will offer our patients an opportunity for them to tell their stories both to drive up standards and recognise good practice. We pledge to publish them all on our website.

6298 (9): My team and I pledge to support a Ward at one of our sites at least once a month with certain activities, like for example helping patients at meal times.

6299 (2): I pledge to ask my patients who smoke if they would like nicotine replacement therapy as an inpatient and a referral to a Stop Smoking service on discharge.

6300 (1): I will work up and sponsor 10 'just do it' initiatives in order to support staff and teams to deliver the fantastic care that they want to deliver every day.

6301 (1): I pledge to SMILE all day, every day I am working. I will not frown at any customers! :)

6302 (1): I pledge to improve my understanding of End of Life Care and to provide the best possible care.

6303 (3): To work hard alongside the service improvement team to support and ensure that all PAH pledges for change are embedded this year for the benefit of our patients

6304 (1): I pledge to help make health tech products more usable and more useful, for the benefit of patients and clinicians.

6305 (1): I promise to spend more time with services, so that I can better understand their IT needs. So together we can improve both our services.

6306 (1): I will promote patient's voice and make sure that their opinions are valued during MDT meetings.

6307 (12): That Strategic Clinical Networks will work in partnership with commissioners (including local government, supporting their decision making and strategic plans.

6308 (1): To never say "in my day..." Or "wait till you are a .... Then you will understand"

6309 (22): To work on embedding the 6C's in my organisation and with the providers I work with everyday

Appendix 3.3: Pledge Data 2016 Uploaded to Nvivo for analysis

File number	File content	Number of pages	Lines of text
37	Pledge 1-100- (2016)	15	657
38	Pledge 101-200 (2016)	15	695
39	Pledge 201-300 (2016)	19	805
40	Pledge 301-400 (2016)	21	939
41	Pledge 401-500 (2016)	21	952
42	Pledge 501-600 (2016)	18	811
43	Pledge 601-673 (2016)	11	499
Total Pledges 2016		**120**	**5,358**

Appendix 3.4: Example of 'Pledge' Data 2016

The following presents a page of 2016 pledge data as collected, organised and uploaded for analysis:

412 [***e.g. pledge narrative no. 412 out of 673 pledges collected for 2016***]: Autism assessment and diagnosis

Work with colleagues to secure a working, timely autism pathway of assessment, diagnosis and support. For both adults and children across Bradford district and Craven

Submitted by: Clare Smart

413: Making it easy to initiate change

We pledge to make it easier for staff to understand how they can initiate change by providing them with tools and support.

Submitted by: LIS NTH

414: I pledge to do all I can to enhance communication between staff, patients and the public

I will write stories, take photographs, create social media posts and make videos for Fab NHS Change Day and beyond to keep staff, patients, the public, the media and stakeholders well informed of our Trust's activities. I am to empower people with knowledge through excellent print and online communications.

Submitted by: Ingrid Kent

415: I pledge to support all of the Oxford Health Children and young peoples services to make pledges

I am Claire Garrison, a member of Oxford Health improvement and Innovation team and my role is to support teams to move forward with improvements that they identify as important to them.

Submitted by: Children's Directorate

416: I pledge to let the lovely clinical team I work with know how much I appreciate their support.

I help to deliver NIHR portfolio adopted mental health research in Cambridgeshire and Peterborough NHS Foundation Trust, and I couldn't do it without the support of our wonderful clinical teams. Tomorrow I pledge to bring some lovely snacks to work and tell the Cameo North team that their enthusiasm for research is really valued.

I bought the team some treats and emailed them all to let them know how much I value their help.

Everyone was very happy and I received some lovely messages back!

Submitted by: Clare Knight.

APPENDIX 4: NHS Change Day '100 Stories of Change' Data

Appendix 4.1: '100 Stories of Change' Uploaded to Nvivo for analysis:

File number	File content	Number of pages	Lines of text	Additional data included
70	Story 1	2	45	
71	Story 2	1	22	
72	Story 3	1	11	Video
73	Story 4	1	38	
74	Story 5	1	30	
75	Story 6	2	43	
76	Story 7	2	43	
77	Story 8	2	33	
78	Story 9	3	71	
79	Story 10	1	26	
80	Story 11	2	35	
81	Story 12	1	12	Video
82	Story 13	2	41	
83	Story 14	2	58	
84	Story 15	1	27	
85	Story 16	2	44	
86	Story 17	1	11	Video
87	Story 18	2	53	
88	Story 19	3	55	
89	Story 20	2	56	
89	Story 21	2	54	
90	Story 22	1	27	
91	Story 23	1	38	Video
92	Story 24	2	39	
93	Story 25	1	16	Video
94	Story 26	2	62	
95	Story 27	3	74	
96	Story 28	2	27	
97	Story 29	2	54	
98	Story 30	2	49	
99	Story 31	2	43	
100	Story 32	2	58	
101	Story 33	1	24	
102	Story 34	2	37	
103	Story 35	2	47	
104	Story 36	2	38	
105	Story 37	2	49	
106	Story 38	2	48	

107	Story 39	2	45	
109	Story 40	2	51	
110	Story 41	3	64	
111	Story 42	2	36	
112	Story 43	2	39	
113	Story 44	2	29	
114	Story 45	2	58	
115	Story 46	2	45	
116	Story 47	2	46	
117	Story 48	1	35	
118	Story 49	3	69	
119	Story 50	2	47	
120	Story 51	2	32	
121	Story 52	2	43	
122	Story 53	3	60	
123	Story 54	3	64	Video
124	Story 55	2	58	
125	Story 56	2	45	
126	Story 57	3	58	
127	Story 58	2	53	
128	Story 59	2	51	
129	Story 60	2	40	
130	Story 61	2	49	
131	Story 62	2	35	
132	Story 63	2	49	
133	Story 64	3	57	
134	Story 65	2	54	
135	Story 66	2	62	
136	Story 67	2	42	
137	Story 68	2	49	
138	Story 69	2	31	
139	Story 70	2	61	Video
140	Story 71	3	53	Video
141	Story 72	1	28	
142	Story 73	3	67	
143	Story 74	2	33	
144	Story 75	1	33	
145	Story 76	2	44	Video
146	Story 77	1	35	Video
147	Story 78	2	46	
148	Story 79	1	32	Video
149	Story 80	2	34	Video
150	Story 81	2	31	Video
151	Story 82	2	46	Video

152	Story 83	2	51	
153	Story 84	2	46	
154	Story 85	2	49	
155	Story 86	2	41	
156	Story 87	2	52	Video
157	Story 88	2	39	
158	Story 89	2	40	
159	Story 90	2	36	Video
160	Story 91	2	28	
161	Story 92	3	52	
162	Story 93	2	36	
163	Story 94	2	47	
164	Story 95	2	45	
165	Story 96	2	48	
166	Story 97	2	53	Video
167	Story 98	2	39	Video
168	Story 99	2	43	
169	Story 100	2	40	
Total 'Stories of Change'		**195**	**4,362**	

Appendix 4.2: Example of 'Stories of Change'

The following stories are examples of the data of the '100 Stories of Change'.

NHS CHANGE DAY – 100 DAYS OF CHANGE

STORY 22– 17th February 2015 – Helen Croft, Mental Health Student Nurse

Making Change as a Student Nurse

Whilst on placement as a student mental health nurse I made a small change to improve the recording of patient's vital observations. Vital observations include taking Blood pressure, pulse, respirations, and temperature and oxygen saturations.My placement works with people in a rehabilitation setting and as such, vital observations are taken on a monthly basis. I found that vital observations were always recorded in the patient's nursing notes, they were sometimes missed from the vital observations recording sheets.I made a suggestion to my mentor that perhaps vital observations recording sheets could be taken out of the patients nursing notes and put in a file in the clinic instead (where observations are taken), so that they could be recorded at time of writing. My mentor agreed that this may improve the recording of vital observations and suggested that I speak to my manager.

(Image taken from NHS Improving Quality resources)

As a student nurse, I felt uneasy about suggesting this change, but my support from my mentor encouraged me to do so. My manager also agreed with the change I suggested. I then collected all vital observations recording sheets and placed them in the clinic. I also completed two information sheets, one for the nursing office and one for the clinic to communicate this to all staff. As well as this, my manager communicated this change to all staff and recognized my input.

Although I consider this a small change I am very proud that my suggestion has been implemented in the clinical setting that I am learning in. It has been very important for me to

be supported in this by both my Mentor and Manager who have allowed me to action this and shown support and encouragement but have also recognized my efforts.

(Above picture shows Helen's uniform at first day of placement)

NHS CHANGE DAY – 100 DAYS OF CHANGE

STORY 69 – 1 January 2015 – Andy Tsoe and Rob McWhinnie

Dementia friendly painting

(Image taken from NHS Improving Quality resources)

In 2014, Countess of Chester Hospital, in Chester, decided to make a very simple change in its paint work to become Dementia friendly, after advice from their painter and decorator Rob McWhinnie.

Dementia Nurse Andy Tysoe said today: "Dementia is not just about memory loss. It can also affect the way a person with dementia thinks, reasons and understands their environment. "
"When things have got low contrast, they're harder to make out. For people with dementia, they can be impossible. If you're looking for a white toilet, with a white seat, in a white tiled room in a hospital, and you've got dementia, it can make something which is

obvious to most people really difficult and a complete blur. But if you use a dark coloured toilet seat, it makes it stand out more."

"It's the same principal with using contrasting colours when painting. A simple change that can make people's lives much easier, and it costs no more."

"Our painter and decorator came to a Dementia Friends session. Afterwards, he told me that it costs no more to paint in dementia friendly colours than what he was using before. This went right the way to the Chief Nurse, Alison Kelly, and the hospital has now decided to do its redecoration like that. It's a change that costs nothing, but brings huge benefits. That's what NHS Change Day is about — low cost or no cost change that makes a real difference."

Alison Kelly, Director of Nursing and Quality at Countess of Chester Hospital said "Our dementia-friendly decision is to make sure we use dementia-friendly colours every time we decorate."

Rob McWhinnie, painter, said "At the end of the day, it doesn't matter what colour I use to paint with, the price is still the same."

The changes began as part of the hospital's rolling maintenance programme in summer 2014.

APPENDIX 5: Digital Data Collection

Appendix 5.1: NHS Change Day website

NHS Change Day 2014 official website's term and conditions (These terms and conditions were published by the movement at the time the 2014 pledge data and the '100 Stories of Change' data was collected). Retrieved on March 31st, 2015 from: http://changeday.nhs.uk/policies?select=tandc

"When you post comments or questions, these can be read by anyone visiting the page. Your user name will appear next to your comments. We do not allow anonymous contributions. We reserve the right to remove or edit material posted on the site." (NHS Change Day 2014 Official Website, 2013)

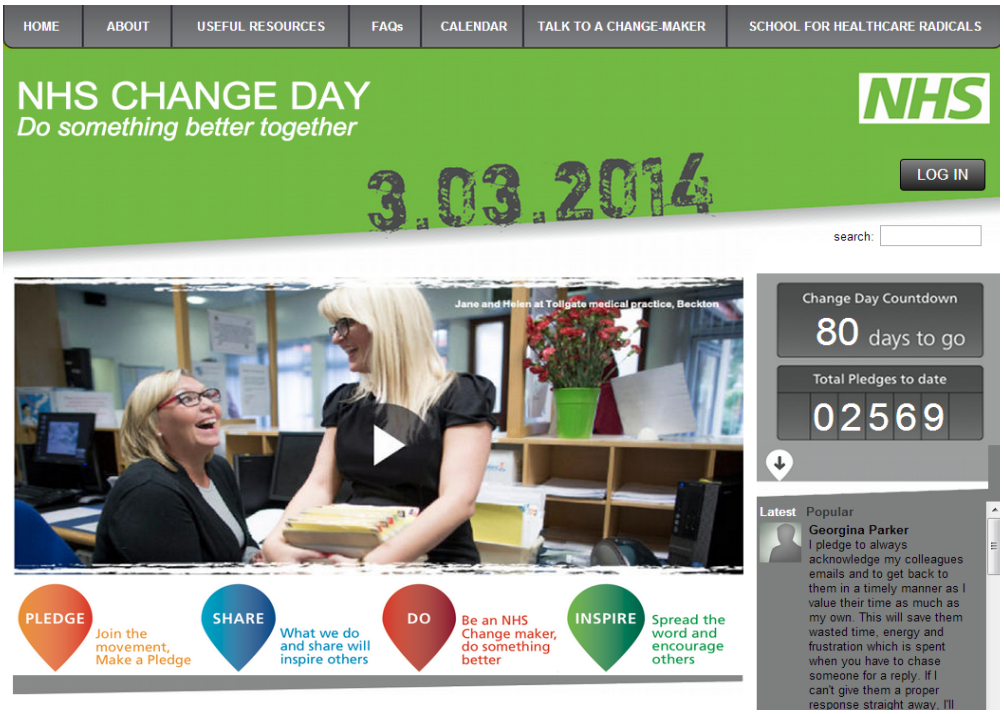
"Any User submitting their own details to be posted on the Website, agrees to their details being shared with any other Users including any Users accessing the Website, and/or only such Users entitled to post content on the User Content Pages, as appropriate. Users from organisations other than an NHS organisation who post details about their services confirm their agreement to comments being posted about their services on the Website by other Users." (NHS Change Day 2014 Official Website, 2013)

NHS Change Day 2014 official website's privacy protection terms: http://changeday.nhs.uk/policies?select=privay

"NHS IQ Materials may be reproduced for the purposes of research for non-commercial purposes, private study, criticism, review and news reporting, provided that this is only to the extent strictly necessary for such purposes and any publication is accompanied by a clear acknowledgement that NHS IQ is the source of such materials. This does not, however, imply a right to use any brand names, trade marks or logos appearing on the Website, which are owned by or licensed to the NHS IQ and the use of which is prohibited".

Appendix 5.2: NHS Social Media Presence

(Image taken from McCrea, 2014)



(Image taken from NHS Improving Quality resources)

(Image taken from NHS Improving Quality resources)

Appendix 5.3: Images from Digital Data Collection

(Images taken from NHS Improving Quality resources)

(Images taken from NHS Improving Quality resources)

(Images taken from NHS Improving Quality resources)

(Images taken from NHS Improving Quality resources)

(Images taken from NHS Improving Quality resources)

(Images taken from NHS Improving Quality resources)

APPENDIX 6: Document Collection

Appendix 6.1 Media Articles Featuring NHS Change Day

Region or Media Domain	Number of Articles Collected
National	22
East Midlands	29
East of England	14
London	8
North East	15
North West	32
South and Central	22
South East	5
South West	29
West Midlands	35
Yorkshire and Hull	45
Scotland	1
Northern Ireland	1
Wales	8
Trade media	108
Other stakeholders	15
Total	389

Appendix 6.2: Media Articles Reviewed

	Article title	Published in	Region or Media Domain
1	Voices: Pledged to NHS Change Day	BBC News, Health	National
2	Why social care professionals should pledge for NHS Change Day	The Guardian, Social Care Network	National
3	Aintree University Hospital Chief Executive takes part in NHS Change Day	Bay TV, Liverpoool	North West
4	Thousands pledge to 'do something different' for NHS	BBC News, Health	National
5	NHS Change Day: even the smallest pledge makes a difference	Health Service Journal	National
6	Bath's RUH staff sing together for Change Day	NOW Website	South West
7	Make a pledge for NHS Change Day	Sheffield Telegraph	Yorkshire and Hull
8	NHS Change Day in Derbyshire	Mansfield Chad	East Midlands
9	Health staff in pledges to improve NHS services	Leicester Mercury	East Midlands
10	Health chief pledges to tackle coronary heart disease	Cambridge News	South Central
11	Nursing chief will be serving meals	Dorset Echo	South West
12	Hospital staff pledge change	Basingstoke Gazette	South Central
13	People power can change the National Health Service from within	The Guardian	National
14	How NHS Change Day became the biggest movement in the health service's history	The Guardian	National
15	Trafalgar Square transformed into mock hospital ward for NHS Change Day 2014	Royal Voluntary Service	National
16	The Mourinho Way is Not the Healthcare Way	The Huffington Post	National
17	NHS Change Day is about a different approach to leadership	The Guardian	National
18	Doctors shadow patients' experiences in the name of 'NHS Change Day'	British Medial Journal GP Edition	Trade
19	Pledging to help make the NHS better	Buxton Advertiser	East Midlands
20	Health staff make pledge to improve NHS	Eastern Daily Press	East of England
21	From bedside storytelling for young patients to ditching the jargon…staff vow to do their bit for the NHS.	Colchester Gazette	London
22	Showing we really care for patients	Hartepool Mail	North East
23	Health chief to visit patients	The Sentinel (Stoke on Trent)	North East
24	Chief rolls up sleeves for day at sharp end	The Leader (Chester)	North West
25	NHS staff in Change Day challenge	The Visitor	North West
26	Manager's mission is to make a change	Royal Borough Observer (Windsor)	South Central
27	NHS staff in Change Day challenge	Haverhill Echo	South East Coast
28	Hospital workers make changes	The Bath Chronicle	South West
29	Pledge to help staff make NHS better	Derbyshire Times	West Midlands
30	NHS Staff in Change Day Challenge	Sheffield Telegraph	Yorkshire and Hull
31	Care Scheme's First Birthday	Pontypridd & Llantrisant Observer	Scotland, Wales and Northern Ireland
32	Getting set for NHS Change Day pledges	Quality Healthcare Environments, News, NHS Property Services	Scotland, Wales and Northern Ireland

Appendix 6.3: Images from Media Articles

APPENDIX 7: Codebooks

Note: The following are excerpts from my codebook because the full codebook is too large to be included in this document.

Appendix 7.1 Codebook Chapter 4

Appendix 7.1.1 Codebook 1: The Development of the NHSCD Movement

Thematic Analysis					
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Code**	**Description**	**Example**
Historical background of the movement	Considering new methodology -es for change in the NHS	The origins and history of NHSCD	Why start a social movement in the NHS?	This code describes the different perspectives the initiators of NHSCD on why they decided to start a social movement within the NHS.	I think we are part of a hierarchical NHS system where we think that change has to happen top-down, and we're living in a new age now where change happens more through community and network and hierarchy is diminishing, and to me Change Day is the spirit of the new way (Interviews, p. 119)
		"Change needs to be changed"	Re-thinking the notion of change.	This code describes the foundation story of NHSCD as circulated by NHS Improving Quality participants, who describe a long process of searching for a new way of thinking about change and improvements.	At the time I talked to my boss, who was X, and we talked about how do we build a movement of a million change agents, how can we create a situation where everybody in the NHS is a change agent? (Interviews, p. 120) The first School for Organisational Radicals was run in 2004. Based on the assumption that change starts with activists and the recognition that there was a lack of practical tools and techniques to support this, the school aimed to ignite activists to take part in healthcare improvements. This was a one-day face-to-face school that presented theory on social movements in organisational change. (Story 83/100 'Stories of Change')
			Drawing on community organising principles to re-think large scale change.	This code describes the principles of community organising, that NHSCD initiators identified as influences on them.	I was asked to join that very small core team to say, okay we need to do something with this, how can we do something? So, I was involved very early in on in the whole set-up of Change Day, how it was going to work, using the organising and mobilising theories that Marshall Ganz advocated. (Interviews, p. 131) This drew on the insights of Marshall Ganz's work on community organising, as well as Gary Hamel's work on organisational change and John Kotter's work on leadership. (Story 83/100 'Stories of Change')
			How can social movement thinking be adapted to healthcare improvement?	This code describes the process through which NHSCD participants engaged in the learning and adapting of social movement principles to the purpose of creating a social movement within the NHS.	[...] So we started to work with these ideas and whoever we talked to in the NHS – people loved these ideas and could see the relevance of them. [...]we held an international meeting where we just got a whole load of social movement thinkers to come over from the States – like Zald and really, really key thinkers – they all just came for free because they were interested in what we were doing and wanted to have a conversation with our practitioner community. (Interviews, p. 120)
A "defining moment"	Why start a social movement in the NHS?	Taking inspiration from other social movements	Searching for inspiration.	This code includes participants' descriptions of other social movements who inspired them for NHSCD, such as Earth Hour, Comic Relief, and the first	[...] we'd watched the Earth Hour video and were mulling over how we could use that type of approach and develop that into something that would be suitable for the healthcare and someone was talking about well, in Comic Relief and in Children in Need you often pledge to do something at a particular time and I think that's where the

				presidential campaign of President Obama	concept of pledging came from. (Interviews, p. 229)
		The story of the "tweet"	How it all started?	This code describes the particular significance placed by participants on the story of the tweet, which was seen as the catalyst of the movement; the "moment" that started NHSCD. In particular, this code focuses on the perspectives of the three individuals seen as the movement entrepreneurs.	Yes. So NHS Change Day 13, I guess, started as a result of a conversation I had with X, who's a paediatrician and the other co-founder, and Y [...]. And that must have been around September/October time, 2012. And I think probably I had got involved as someone who was quite cynical initially, [...] I think we have this thing of learnt helplessness sometimes... that we feel like we can't make change, we can't alter the situation we find ourselves in, particularly as junior doctors, but more widely perhaps in the NHS.[...] Y then sent me a tweet message a couple of nights later. It said, why don't we get together and talk with X and see if there's anything we can do about mobilising and getting this energy that's out there converted into action. (Interviews, p. 35)
			Brainstorming of ideas	This code describes participants' stories of how the concept of NHSCD formalised.	And from that we had a telephone conference call and pushed around a few ideas. We thought about a quality group a week, we thought about QI day – quality improvement day – and then we said why... together, we said look, why don't we have a day where we get people from all over the NHS to make one small change to improve what we're doing and the quality of care we give to patients? (Interviews, p. 35)
	Constructing the concept of NHSCD	Small change as a way to bring large scale change	Why small scale change matters?	This code describes a key characteristic of NHSCD's philosophy of change as articulated by participants - their belief that major change is constructed of small changes.	If 189,000 people are willing to either make a pledge or join a pledge, and make a commitment to do something different, then I think okay it's not everybody that works in the NHS but every little bit counts. So I think yes, I think, change can be achieved in small steps, and we shouldn't think that if even if a small group of people have made that change that change still exists, that change still happened. (Interviews, p. 86)
			Social movement principles as a way to encourage knowledge mobilisation.	This code describes the way in which participants envisioned and used NHSCD as a methodology to encourage the mobilisation of knowledge within the NHS.	[...] although we're very able to make swift changes and improvements we often don't, because we don't actually often go to our neighbours and say what are you doing that works in your practice? How does your appointment system work, how does your telephone system work, what's your website like? Just really simple things that we don't actually go and ask our colleagues. (Interviews, p. 34)
		Open ended change	Lack of prescription as of what change initiatives should consider.	This code describes another key characteristic of NHSCD's philosophy of change as articulated by participants - their belief that change initiatives should not be restricted to preconceived ideas.	[…] you're not quite sure, but you have an infrastructure or you have a framework, it's almost like a stage. It's like you don't know what's going to happen, you're not quite sure. Are the audience going to respond to it or not, are they going to throw tomatoes […] You make a few hard places, but the things that you really need to pay attention to are the soft things that are in between the hard places […] these are your hard places, so this one is a website, let's say, this one is some event that you're going to put on. But actually what happens, that flows through all of this is, is all this wonderful stuff […] it's almost like a theatre piece, so you have a script, but actually you say to people, you can adlib, and the best plays and the best actors are... because as change agents, we are actors, and the best people who do it is that they have a script and you know what the script is, and you know that actually the hero comes to the rescue at the end, but actually how you get there, you need to leave people to say how you get there. (Interviews, p. 276)
			Social movement principles as a way to encourage	This code describes the way in which participants envisioned and used NHSCD as a methodology to encourage innovation within the NHS.	There's no shame or no problem with that. That's how innovation happens. You try things out – if it doesn't work, you don't carry on with it. Or if it does work but you want to tweak it, you tweak it. (Interviews, p. 37)

			innovation.		
A small Group of Activists	Creating A new social movement	Leading towards the first NHSCD	Starting from scratch	This code describes participants' experiences of the challenges involved in establishing a social movement that did not exist before.	[…] we had a running start. So we started from 0 to 60. So around October/November time, if I remember rightly, that people were getting set up with Change Day. We had no team, we had no support. We didn't really have anything. (Interviews, p. 39).
			Pressures for mobilising the first NHSCD.	This code describes how participants' experiences of the pressure in the build-up towards the first NHSCD.	We had to set all this up in five, six months. We had to get it all up and running to the day. So I think there's no question time was a problem, and we could have done with more time.[...] And I'd say Change Day 2013 was a bit rough and really – sort of quick and dirty, I guess, is the way you'd describe it. (Interviews, p. 39)
		The challenges of a new social movement	Difficulties in setting up the NHSCD basic structures, including its official website.	This code describes the challenges and the thought process behind the creation of the NHSCD basic structures including the movement's official website both from the perspective of the website designers as well as from that of the users.	Well there were certainly things we could have done better, whether we could have actually predicted that…it would have been nicer to have a better website last year – I think we lost a lot of traction because of the difficulties we had with the website – that would be my biggest thing. (Interviews, p. 234)
			Difficulty to mobilise media coverage	This code describes the difficulties experienced by the social movement core leadership team in the process of mobilising the media in order to gain coverage for NHSCD.	But it would have been great to have more GP involvement, from a personal perspective, but I think more widely we would have liked more media coverage. (Interviews, p. 39)
	Mobilising change through and around shared activity	"Pledging" as an activity/ engagement platform to mobilise for change.	Why 'Pledging'?	This code describes the creation of the pledging concept as a mobilisation platform and how people experienced the implementation of this.	I think our approach - by asking people to do whatever they want, and do what's important to them, and do as little or as much as they liked was really important; whether that's termed a pledge or an initiative or a change – I'm not sure. I don't think there are many other large-scale things that have been as open as we are, [...] And I think that's the innovation of Change Day, and there's probably not another way of doing it. There might have been another way to describe what a pledge was, but it would still have been a pledge you're making. (Interviews, p. 230)
			Individual pledges	This code describes how individual pledges were used as mobilisation platforms.	I thought it was good because I completely get it, I get that it's having an action and when lots of other people are doing it, it feels easy to be part of something that a lot of people are doing, because there are some things that you can make an argument for that you should be doing anyway. (Interviews, p. 2)
			Group pledges	This code describes how group pledges were used as mobilisation platforms.	I think it's both; I think a lot of people pledged individually, but I think because we're all working from a brief it was easier for us to provoke people to do group pledges, and I think actually a lot of pledges, when we did them on a group level, encouraged people to do more than as individuals. If you have a ward doing pledges, a ward to do something, and then individual staff members might engage in doing something specific about their pledge. (Interviews, p. 169)
			Organisational pledges	This code describes how organisational pledges were used as mobilisation platforms.	The campaign structure was really interesting because I thought it was something that was going to be extremely well-utilised and people would get excited about but what became apparent to me is actually people liked the concept of campaigning as a way of doing their pledge, as opposed to what we envisaged the campaign pledge was about would be organisations really getting people behind one aim. (Interviews, p. 234)
Development	Mobilising	Expanding	The platform	This code describes the process of creating the	The Pledge – Share to Inspire enabled us to really catalogue what people have pledged, when they've

and expansion of the NHSCD movement	change through and around shared activity	the platform of pledging	of 'Pledge, Share, Do, Inspire'	'Pledge, Share, Do, Inspire' platform of NHSCD and the subsequent utilisation of this platform.	definitely done it, and actually how they've used that to inspire others, or inspire themselves, and I was hoping that that sequence of events would really mean that when we came to evaluate Change Day we'd have a really structured way of saying look, this many people pledged, this is what the outcome was, and this is what came from it in a way that we just didn't have last year. (Interviews, p. 239-240)
			Kickstarters	This code describes how kickstarter campaigns were used as mobilisation platforms.	[…] my Chief Executive did a kick-starter, and I saw all the kick-starter videos on YouTube. Where people make a pledge to do something if other people get on board, so it's almost like an I will if you will. My Chief Exec pledged to be HCA for the day – which she's done, and it was brilliant. There was the Birmingham Children's Hospital reading stories to children. (Interviews, p. 114)
			Pledging campaigns	This code describes how pledging campaigns were used as mobilisation platforms.	And then it's talking to people, so myself and a lot of the hub leaders, we capture people at meetings and when we see them in the corridors. Once you've got ten people to pledge with you and then they're getting a bit more committed, you can then get ten… and then you can go to your trust comms people and say we've got this campaign and we've got enough people running it, and getting some trust bulletins and to put some posters up around the hall. When that starts happening, whether it's your trust comms person or it's a comms person just for a small department, then that department is doing it, and then it kind of becomes a knock on effect in a hospital. (Interviews, p. 356) Several ideas supported by NHS Change Day have turned into campaigns in their own right, including My Wheelchair, Future Focus Finance and Stop the Pressure. As part of NHS Change Day 2015, we want to support and develop a selection of small to medium sized campaigns in order to raise awareness of issues that affect the NHS. Could that be the issue you are passionate about and is it time to give a louder voice to your campaign? (Story 91/100 'Stories of Change')
		"Storytelling " as an activity/ engagement platform to mobilise for change.	Why storytelling?	This code describes the uses of storytelling as a mobilisation platform and how people experienced the implementation of this process.	I pledge to gather stories of compassion from staff, patients, service users and carers. These stories will recognise and celebrate compassionate care and remind us of our shared humanity, while also celebrating the power of story to bring about positive change and transformation. Where appropriate, some of these stories may go forward to become digital stories and join the growing body of Patient Voices digital stories at www.patientvoices.org.uk. (Pledge 622/ 2014)
	Circulating stories of success	Initiating the story telling initiative	Creating the '100 stories of change' platform	This code describes the creation and usage of the "100 Stories of Change" - popular stories which were circulated in various forms in order to celebrate the achievements of NHSCD particpants as well as to mobilise others.	I pledge to gather 50 change day stories about great care in the NHS and aim to get them published, with at least 1 in a national newspaper for 3.3.2014. Calling everyone who wishes to express an interest in sharing their story. jackie.lynton@nhsiq.nhs.uk (Pledge 393/ 2014) Every day, for the 100 days prior to NHS Change Day, we are sharing stories of change as part of the #100DaysofChange campaign. These stories are designed to highlight great actions and to inspire others to make a change for the better. From patients to nurses, carers to doctors, people who have made a change for the better are sharing their story so that they can encourage other people to also embrace the change that they made, and to inspire new changes and great ideas. (Story 66/100 'Stories of Change')
			"Pledge Walls"	This code describes the creation and usage of the "100 Stories of Change" - popular stories which were circulated in	It's about getting ideas out there, a cross pollination of the ideas as well and I thought the Pledge Wall was an absolutely brilliant idea and you can scroll through it, look for people that you recognise or people who look interesting or organisations that

				various forms in order to celebrate the achievements of NHSCD participants as well as to mobilise others.	you feel some affiliation with and look at what they're doing. You can also search for it on a town by town basis and again, there's stuff there that you may or may not agree with, but there's stuff that you want to get involved with. (Interviews, p. 53)
			Posting YouTube videos	This code describes the creation and usage of YouTube videos, which were posted in various social media platforms in order to celebrate the achievements of NHSCD particpants as well as to mobilise others.	Yes, one of the challenges was, when producing something, you would always understand it in your small group, the person that was at the event or filming the piece; we understood what was happening. But then it was hard to illustrate that to our viewers. Would they understand what we were trying to make? (Interviews, p. 214)
	Creating shared vocabulary and symbolism	"Occupying "Symbolic time and space	The symbolic meaning of "Occupying" a Day in the NHS annual calendar (e.g. symbolic time)	This code describes the meaning associated with the main characteristic of the NHSCD movement: the 'occupation' of a symbolic space represented in a single day of the NHS calendar.	[…] the original phone discussion was about what can we do to engage junior doctors in delivering quality improvement, and how can we do a joint effort that would mobilise as many junior doctors as possible, and the idea was that they would all – on the same day – do one quality improvement endeavour or initiative because we thought that would be a really good day of combined action which would be a bit promotional but would get a lot of people involved. But from the original idea we were wondering, well actually, does it really matter that it's just junior doctors, and does it really matter what you're doing? So we came up with the idea that actually, let's get anyone to get pledge whatever they want on one single day, and that was Change Day basically. (Interviews, p. 229)
			Using symbolic physical spaces (e.g. Trafalgar Square)	This code describes how the movement utilised various physical spaces as symbols for their activism.	I was involved in a photo shoot in Trafalgar Square with X, where we sat in a patient bed, and had pictures taken of us; that was to try and drum up PR interest.[...] it was really interesting, because although I sat in the bed for 30 minutes, there were some times when people were sitting next to me, again, for the camera, but they were talking amongst themselves, and being in there, the patient experience, I was, like, that's not really nice when you've got doctors or physicians talking over you. (Interviews, p. 7)
		Creating a symbolic structure for NHSCD	Creating logos, slogans, posters etc.	This group of codes describes how the movement created a whole array of symbols for the puprose of mobilising people for change and for the creation of an NHSCD identity.	[…] we send them posters that they can print out and put in and around the hospital, but again what we found was that they didn't like pictures of generic nurses or generic doctors – they would cut out the pictures of the patients or whatever we put there, and they would paste their own staff – because that's what the staff wanted to see. If they saw a nurse that wasn't from their hospital, then they didn't like Change Day and they didn't get the message. So that's what we had to start doing, to kind of tailor the message. (Interviews, p. 12)
	Communicat -ion platforms & social media	Meetings & events for communicati on engagement, and dialogue.	Coordinating national strategic meetings and events by NHS Improving Quality for the Core Leadership Team.	This code describes NHS Improving Quality participants' descriptions of how they coordinated national strategic meetings and events in order to encourage volunteers to engage with NHSCD, creating a platform for the leadership of NHSCD to emerge and engage with the movement's strategizing process.	So the first time I heard about Change Day it was peripheral knowledge and it wasn't until I was invited to join a team that I started paying more attention to it and see what it was about and what the team were doing. But after a couple of meetings I realised what the intent was, I understood what it was about and it was something I believed in so I embraced it and moved forward with it. (Interviews, p. 71)
			"Hub Away" Days.	This code describes participants descriptions of a particular set of strategic meetings named 'Hub Away Days' which were national	We've had a Hubs Away Day where people all presented what Change Day meant to them and what they were doing in their region. It wasn't like a normal away day when you put loads on the agenda; we had one thing on the agenda, which was to come up with a plan for Change Day and for

				meetings coordinated to enable the networking of Hubbies from different regions.	each individual person and what it meant to them. (Interviews, p. 361)
			Presentations introducing NHSCD, including in conferences (by NHS Improving Quality & Core Leadership Team members).	This code describes participants' descriptions of how they introduced the topic of NHSCD in various conferences; this way done mainly by NHS Improving Quality members and Core Leaders.	On Wednesday 11 February, with exactly one month to go, NHS Improving Quality, which includes the team who supports NHS Change Day, will be hosting a day long event at Skipton House, where many of the organisations the support the service are based. The day is both intended to promote the concept of NHS Change Day to these staff, and bring frontline NHS staff into the building to explain the value of Change Day. Our 'takeover' event will feature a number of doctors, nurses and other NHS staff from a range of disciplines given the opportunity to talk about their experiences directly to staff based at Skipton House. (Story 28/100 'Stories of Change')
			Presentations introducing NHSCD in Trusts, CCGs, etc.	This code describes participants' descriptions of how they introduced the topic of NHSCD in Trusts and CCGs.	[…] we engaged with the senior members of the organisation. Now, we had junior staff presenting to the Directors group. How often does that happen? We took senior staff around different parts of the organisation. I think what staff learnt was that our senior team want to hear about the great work that they're doing and they felt very empowered by that. (Interviews, p. 322)
			Organizing promotion events for the wider public.	This code describes how participants organised public events in order to introduce the topic of NHSCD to a wider audience.	I went a different way round with things. I believe the public should have more ownership. I've got a local music band that did a pledge […] I'll send you photos because they went mad on Twitter, and they pledged to discourage crowd surfing to save A&E the trouble. I had the local councilman, pledge for me, got the photos, and they pledged to help keep the roads clear for the ambulances. (Interviews, p. 342)
			Local/Regional events and meetings organised by grassroots activists for staff (in trusts CCGs etc.)	This code describes how Hubbies organised meetings and events in their local areas, Trusts and CCGs, in order to encourage people to join NHSCD.	One of the other things we did, we did lunchtime seminars. So we said to staff that we would facilitate 30-minute seminars, and were there particular subjects they would like to have the seminars in? And one of the project managers who's working on the mental health re-procurement said that she thought it would be really valuable to do something around mental health, to raise awareness about the work that was happening in Bristol around re-commissioning of services for mental health. So we ended up with, I think, we had seven seminars during that week across the five days... (Interviews, p. 217)
			Events organised by grassroots activists aimed at engaging patients.	This code describes how Hubbies and other grassroots activists organised events aimed at introducing the topic of NHSCD and encouraging them to join in.	The children 'radiographers' wore a special lead apron, they then placed their teddy bears on the X-Ray table and took mock images of their soft toys' hearts. The young patients were rewarded with certificates after completing their duties. Helpful staff were on hand to talk about the specialist areas in radiography and qualifications needed, and they gave visitors a tour of the X-ray rooms and demonstrated an ultrasound examination. […] The teddy bear chest X-rays gave our young patients a good understanding of what a radiographer does and it made radiography appear less frightening because they were able to get their hands on the equipment and take mock images of their teddy bears. (Story 75/100 'Stories of Change')
		Virtual platforms of communication and interaction	The NHSCD's official websites	This code describes the process of the creation of the NHSCD official website and user experiences.	I think it's good that people put their pledges on the website because then other people can see them and so, for example, if I do something like Prepared Learning, this Doctor/Manager programme, someone in, like, Nottingham could read it and be, oh, that's interesting, and I can contact this person. So I think it's really valuable to have the website and also to put it on the website it's more of a commitment because you've put it on the website. (Interviews, p. 341)

			The 'Hubbies WhatsApp group	This code describes the way in which Hubbies moblised themselves through WhatsApp.	I think that the Hubbies had a brilliant way of discussing actually how things could be put to the grass-roots and delivered to the grass-roots in a much better way than we did as a core leadership team.[...]It was more shared, [...] sharing of information that the WhatsApp group provided a great platform for allowing people to have a discussion within their own peers... (Interviews, p. 238)
			Blogs	This code describes the various ways in which Hubbies and other participants used blogs to propagate the topic of NHSCD and to share their experiences of it.	I pledge to blog and tweet about my experiences and work at NHS England, as well as my thoughts as a patient using this fabulous service, as much as I can in 2014! (Pledge 732/ 2014)
			Twitter/Facebook etc.	This code describes the various ways in which Hubbies and other participants used Twitter and Facebook to propagate the topic of NHSCD and to share their experiences of it. In particular, Twitter was a key platform in the mobilisation of NHSCD.	We actually spoke over social media; we started tweeting about Change Day and what was going to happen at the Trust […] and then we thought, well, actually if we want to make that happen, it has to be one of us who does it. So we re-tweeted about it more, and then we decided to meet […] and then we bounced ideas off each other and then decided on a plan of action to take forward on what we wanted to do for Change Day. (Interviews, p. 167)
	Promoting NHSCD	Press & social media	National press media	This code describes the use of National Press media as a mobilising platform for NHSCD.	If you work in the NHS and are planning to make a pledge, the BBC would like to hear from you. […] tell us about your pledges before Monday 3 March. If you would like to be interviewed by a BBC journalist, please include your daytime telephone number in your message. (http://www.bbc.co.uk/news/health-26379303)
			Trade media	This code describes the use of trade media as a mobilising platform for NHSCD.	They photographed our nurses, me, our pharmacists... as a sort of... for publicity. And then also we had the interview with Neil from GP Magazine to talk about NHS Change Day. (Interviews, p. 40)
			Local/regional press	This code describes the use of local and regional media as a mobilising platform for NHSCD.	But this year, you could not hide anywhere. Everywhere you were going, the Change Day was happening. It was on social media, in papers and everywhere. Whoever did not know about Change Day this year, it's because they live on another planet. (Interviews, p. 302)
			Radio shows	This code describes the use of radio shows, particularly local radio stations, on the actual day of NHSCD, as a mobilising platform for NHSCD.	[...] they're all on local radio stations, so we did... it was amazing. We sat in a booth and we did 12(shows) in a row. We did Kent and Surrey and Sussex and Middlesbrough and Lincoln. So it was trying to say the same things over again, but in a slightly different way [...] they were all different listeners, but... it was all local radio, but it was fantastic. It was really good, and it was nice to connect with the people who had phoned. They had a phone-in, and they had lots of patients who called in and talked about what they felt about Change Day, some of it very positive, some of it slightly cynical. (Interviews, p. 40)
	An emerging social movement	Roles and responsibilities in the NHSCD movement		This category of codes includes the negotiation of roles and responsibilities and the ways/methods by which to assess/evaluate actors' fulfilments of these responsibilities. Under heading, the actors that become involved in the movement's collective action are identified, and their motivations for involvement are described.	I've been very lucky – because I've been a management trainee they've reduced my capacity at work so that I can take it on because I've done it as a lead for Change Day, so I've been able to take it on in that sense. I've been doing the local and national stuff together – well the very local and regional stuff together – but then they're going to be filling it up with another job after Change Day now. But it's been quite hard. (Interviews, p. 113)

		NHSCD participation in relation to day-to-day job		This group of codes describes the different experiences of participants in relation to the way in which their participation within the movement interacted with their everyday jobs.	For NHS Change Days many people have pledged to smile, to greet patients with a smile, and to try to work positively and supportively. […] For example, Petra Howard's action this year is to create a positive atmosphere in the team she supports. Besides supporting the team where she can, she is sending an email at the beginning of the day with a positive quote. She says it's "perhaps not 100% relevant to the work we do, but always positive." (Story 51/100 'Stories of Change') Many tears were shed in our office when we read the difference we had made to many moms and babies! Have we made a change? Yes for those moms and babies we have supported. (Story 55/100 'Stories of Change')
		Top-down pressures of evaluation.		This group of codes describes the experiences of participants with regard to top-down pressures of evaluation.	I think each year it should be looking to try and enthuse even more people to make a pledge to do something different. I think the risk is if it starts to almost answer some of the questions I've posed of it, it loses what it becomes. If it tries to become too outcome focused, too metric focused, too linked to the targets, it becomes the same as most other things. The power of this is because it genuinely is what it is. It's the invitation and the opportunity for people to do something and be proud of it, and I think that's the power of it. (Interviews, p. 409)
		Resistance to NHSCD		This group of codes describes participants' experiences of resistance to the NHSCD movement.	They're managing the tension between top-down information and dealing with frontline issues, and so for middle managers it's often quite complex to implement change because they're dealing with the political arenas within a director and a chief exec level, but dealing with the operational aspects from frontline staff. So my gut feeling would be that middle managers, and certain levels within director level are where I think there's going to be the most resistance for change, but again, I can't generalise. (Interviews, p. 391)
Vision of the future	A 'cultural change' in the NHS	Making a difference to patients and staff.		This group of codes describes the vision of NHSCD activists to make a difference to patients and staff through their engagement with NHSCD activities.	If Change Day continues to develop and grow over the next couple of years, I think really by 2016-18 we may be delivering things that are having a real impact on patient care because so many people are getting involved in doing small things simultaneously. (Interviews, p. 240) We wouldn't have an NHS without someone thinking we need to change the way we care for people. Way back then they changed your world. Maybe now it's time for you to change the world. I'm not saying go create a whole new amazing care system, I'm saying just think about the stuff that niggles away at you and then think "Do I really just have to put up with it?" Who knows maybe you could inspire others to change their worlds too! (Story 63/100 'Stories of Change')
		Breaking barriers & giving a voice to the grassroots.		This group of codes describes the vision of NHSCD activists to bring about cultural change in the NHS by breaking barriers between people, patients and staff and by giving a voice to the grassroots.	Personally, I've found that whenever I had interaction with people that have pledged themselves, one to one interactions, it's been really rewarding to see what people have pledged and how they feel pledging, because it's really empowering for them, it's really nice to see that happening. (Interviews, p. 24)
		Create & bring together communities		This group of codes describes the vision of NHSCD activists to create new communities of practice and bring together staff and patients through their engagement with NHSCD's activities.	Our friends across the globe say it has led to a massive community of people coming together, to thinking differently about how we go about change. When you put leading change into the hands of those who deliver improvement everyday, it makes a greater difference. (Story 90/100 'Stories of Change')

		Celebrate the NHS		This group of codes describes how each progressive change inspired a vision of future potential, and was an opportunity to celebrate the values of the NHS.	That's why a lot of the people in this movement are the same, they love the NHS, they're proud of the NHS. To answer your question about what value and ethics they prescribe, I don't think they have a set value and ethics. I think they have the value and ethics of the people that they have, which are generally the ethics about celebrating the NHS, loving the NHS, that anyone can make a difference. (Interviews, p. 20)
		Having a global impact (e.g. NHSCD Global)		This group of codes describes the development of the NHSCD Global Movement and activists' vision of a global social movement for healthcare improvement.	Change Day British Columbia (BC) is building on the successful global movement ignited by the National Health Service (NHS) in England. Countries from all over the world have launched their own change days, spreading the energy and excitement to improve care globally. […] Even seemingly small pledges can have a positive effect. When combined with all of the other pledges, we can create a tremendous wave of improvement that ripples throughout our system. So for everyone in British Columbia, the question now is … what will you pledge? […] Early pledges for Change Day BC have started coming in and we are feeling so inspired by the wonderful ideas and energy! (Story 19/100 'Stories of Change') "We describe Change Day Australia as a people led, accessible and energetic social movement for better health outcomes" […] In our first year we gathered more than 15,000 pledges from all over Australia and this year we are hoping for many more. But it's not the number of pledges that keeps our commitment and enthusiasm so high. We have seen first hand the incredible results that arise when just one person is willing to take an action to improve outcomes. The ripple effect of small change can be powerful. (Story 44/100 'Stories of Change') The first Saskatchewan Change Day was held on Nov. 6, 2014. The campaign, which was launched by the Health Quality Council, was the first of its kind in Canada. Saskatchewan Change Day organisers hoped to receive 1,000 pledges on the Change Day website however, they surpassed that goal and received nearly 1,400 pledges from health care providers, patients and others in the province of about 1.1 million people. (Story 54/100 'Stories of Change') We are the Global Community of the School for Health and Care Radicals. We are passionate people who are willing to take responsibility for change. We support the goals of our health and care systems, but also want to change existing thinking and practice and improve care for patients and people who use services. The School provides tools, ideas and connections with a community of radicals to help us thrive and survive as agents of positive change. Register today on this website. (Pledge 1536/ 2014)

Appendix 7.2 Codebooks Chapter 5

Appendix 7.2.1 Codebook 2: Initiation and Implementation of Grassroots Change in Daily Working Practices (Thematic Analysis)

Thematic Analysis				
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Description**	**Example**
Societal perceptions and practices	Promote community awareness and involvement	Promote public participation in debate regarding the future of healthcare	This code describes how NHSCD activities promoted public participation in debates surrounding the future of the NHS, and challenged the status quo.	[...]I started working with a couple of colleagues in my old trust at UH Bristol, and a GP colleague here, [...] Bristol has a festival of ideas where they set up talks, and last year we did, they did a festival of economics, and they had a lot of stuff about, you know, is the public sector reform viable and all those kind of things. So we're talking to them, and we're setting up a programme of health related talks from things like, meet the chief execs with a completely open forum, and, you know, what does… what's, kind of, a green health… a green city look like and those kinds of things. To then divide care into emergency services and things like that. (Interviews, p. 151)
		Community volunteering/ fundraising	This code describes how NHSCD activities involved staff, patients and the wider community in various forms of volunteering within the community, reshaping and enhancing community involvement practices	I have been volunteering at SIFA Fireside for over two years and only recently there weren't enough funds available to serve breakfast to the Birmingham homeless. I intend to raise awareness regarding this issue and collect as much financial and other support in order for SIFA Fireside to continue with providing meals for the hungry and homeless. Pledge 978/ 2014
		Promote organ and blood donation	This code describes how NHSCD involved participants in the activity of promoting organ and blood donation.	[…] ethnic minorities blood count level is low, and I've always given blood but it had been a long time before I'd given blood last, so that just spurred me to actually do that. And so I just thought yes, I'll do it for change day. (Interviews, p. 2) I had been a regular blood donor for many years but it wasn't till I shadowed one of my colleagues on the Paediatric Intensive Care Unit that I found out about the urgent need for more platelet donors and the vital importance of platelets to some of the hospital's sickest children. (Story 56/100 'Stories of Change')
		Engaging the public to help lonely elderly people in their community (often through personal	This code describes how NHSCD engaged participants, staff and the wider public in initiatives to help lonely elderly people in their community.	To help my elderly neighbours to get to Doctor/hospital appointments. Keep a close eye on them and keep giving them freshly baked cakes. Pledge 4994/ 2014

		volunteering)		
		Engaging the public in cost reduction/ efficiency practices (e.g. public reducing the cancellation of doctor appointments, etc.)	This code describes initiatives made by NHSCD participants to involve the public in cost reduction and efficiency practices of the NHS, in order to improve the use of the NHS's budget.	I pledge to do my best to ensure that I and my family never cancel or are late for an NHS appointment. Pledge 7494/ 2014
	Challenging perception and stigma	Combating mental health stigma	This code describes the various commitments and activities made by participants regarding the need to combat mental health stigma.	I pledge to make a difference to individuals with mental health problems by raising awareness of mental health issues and tackling the stigma associated with it by tweeting. I also pledge to fundraise for local mental health charities that work closely with the NHS to help and support individuals with mental health problems by doing a sponsored dog walk in my onesie. Pledge 452/ 2014
		Challenging elderly care and dementia perceptions	This code describes the various commitments and activities made by participants regarding the need to combat elderly care and dementia stigma.	There are currently 800,000 people with dementia in the UK. For NHS Change Day, we are asking NHS staff and the public to become a Dementia Friend and give up a small amount of time to improve their understanding of dementia and take action to make their community more dementia friendly by giving a helping hand. For the 55,000 Dementia Friends and Champions already out there, we want you to use Change Day to spread the word by telling those around you or running your own information session. Pledge 2433/ 2014
		Rethinking disability and addressing perceptions of disability	This code describes the various commitments and activities made by participants regarding the need to combat perceptions of disability.	My action for NHS Change Day is I'm going to challenge and actively support training within the NHS to become more inclusive, specifically around visual, and hearing impairment and dyslexia. I want to widen access to our training, and ensure that it is adapted so that it meets the needs of everyone... (Story 10/100 'Stories of Change')
		Promoting awareness for LGBTQ issues of equality	This code describes the various commitments and activities made by participants regarding the need to raise awareness for LGBTQ issues of equality.	I pledge to continue raising the profile of mental health and wellbeing, lesbian, gay, bisexual and transgender within the NHS and wider communities. One life lost to hate crime is one too many. People learn to hate so they can also learn to understand, show compassion, and accept that some of us are individual people who happen to be gay, lesbian, bisexual or transgender or have mental health problems/conditions. Pledge 554/ 2014
Field (healthcare/ NHS) perceptions and practices	Challenging health and care inequalities	Promoting/improving equality and diversity of patients	This code describes the various activities and commitments made to improve the equality of care given to patients, encompassing a range of different needs and catering for diversity	And the second one is also to do with the Child Development Centre, which is to create a storyboard, which explains to autistic children what their care pathway is. At the moment our autism waiting list is about two years, before you can get a diagnosis. It's just horrendous and

				a lot of people feel like they're dropping out of the system. They don't hear back, they don't get an acknowledgement letter about when their appointment is. So the storyboard is to show who you might meet, where you might meet them, what you can expect, who you can contact, but all in child friendly writing, with pictures and things. [...]I've done a blog, I've made a video, I've put some information on our Trust Internet. I've got the Leadership Development Nurse and the Learning Disability Nurse actively promoting the concept of autism to other staff. And hopefully it's going to become part of the mandatory Trust induction now, just a quick understanding of autistic patients and what they could face. (Interviews, p. 107)
		Reducing poverty related health and care inequalities	This code describes efforts made by participants to reduce inequalities in care between social classes.	[...] I started feeling truly compassionate about those lonely men and women who spent their nights in the open cold. Each morning they would gather and patiently wait for the doors to open. There they would receive tea and coffee, a bowl of cereal or butter on toast. Later on a light lunch would be provided. Those few hours they spent at the charity were the best hours of their day.[...] If you are compassionate about the desperate and lonely and about those who sleep in the open, please use the NHS Change Day 2015 initiative and commit to making a positive change, whether through raising awareness or helping in specific ways, and inspire others by showing compassion and kindness to those who most need it! (Story 11/100 'Stories of Change')
		Advocating for equality in the communication between patients and healthcare professionals	This code describes participants' efforts to enact changes that considered the need to improve equality and communication between patients and health care professionals.	[...] my first pledge was to make Bristol a city where conversations about health are being held in public. So, I mean, I've lived in Bristol an awfully long time, and I know from experience that, you know, we've got two major acute trusts. We've got a brand new CCG, we have all of these GPs but, actually, unless you're in that system and know who to go to for information, there isn't an awful lot of dialogue between professionals and the public. So what I wanted to, kind of, use it as was for a catalyst to, kind of, start doing something to have those conversations. (Interviews, p. 151)
		Pregnancy/ postnatal support for women & families	This code describes participants efforts to enact changes to improve the care of pregnant women and postnatal support of families.	My name is Jenny Clarke and I am a clinical midwife at Blackpool Teaching Hospitals NHS Foundation Trust. I have a true passion that babies are not separated from their mothers and I will do anything to encourage staff to promote this vital part of birth. (Story 76/100 'Stories of Change') We pledge to improve the information we give to women

				being booked for an elective caesarean section to improve their day. The maternity/ theatres/ recovery team (Pledge 2627/2014) I pledge to continue with my quest that all women who have a Caesarean section get immediate skin-to-skin contact with their new born. (Pledge 2692 /2014)
		Fighting for patients who can not fight for themselves	This code describes the various commitments and efforts made by participants in order to further the cause of speaking up for patients who were unable to fight for themselves.	I pledge to make more awareness amongst the people I will be working with in my future placements. I will be there to fight for patients who have no one there to fight for them when they cannot fight for themselves. Pledge 59/2014
	Public and healthcare staff early diagnosis of disease/ awareness of conditions	Public awareness of early signs of cancer (care for cancer patients)	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the early signs of cancer (as well as to improve the care for cancer patients).	On NHSchangeDay I pledge to do my best to raise awareness for Breast Cancer in MEN!!! Pledge 319/ 2014
		Prevention of suicide and self-harm mitigation	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the prevention of suicide and self-harm mitigation.	Its time to incorporate a new mind-set into the whole population and the entire workforce of Health, Social and Third Sector that together we can prevent the terrible tragedy of suicide. Cambridgeshire and Peterborough CCG are embarking on a new Suicide Prevention plan which will be developing a Pledge that individuals and organisations alike can sign up to. However the principles are the same for all the UK. We hope to get over 1000 pledges by April 2015. Pledge 4345/ 2014
		Public awareness of dementia	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the early signs of dementia.	Gill Philips and Ken Howard launched a campaign to help people living with dementia have a voice. Ken lives with younger onset dementia, having been diagnosed with Alzheimer's about eight years ago. Together, Gill and Ken have been sharing his story and the message of treating people with dementia as human beings with real lives and aspirations, and that people can live well with dementia and speak out in their own right. A lot of their work is just talking to people, helping them to see things differently. (Story 41/100 'Stories of Change')
		Prevention of malnutrition of elderly patients	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the prevention of malnutrition of elderly patients.	I will recognise the signs, early on, of a patient who is malnutritioned or dehydrated. Pledge 173/ 2014
		Public awareness of early signs of pressure ulcer (mainly in elderly care)	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the early of signs of pressure ulcer.	I pledge to make a difference and raise awareness of pressure ulcers. To prevent pressure ulcers by talking to patients, carers and health care professionals. To make people aware of signs and symptoms to aid prevention. Pledge 28/ 2014
		Prevention of	This code describes the	Life-threatening group B Strep

		infection	efforts of participants to promote awareness within the public and other professionals concerning the prevention of infection.	infections in newborn babies can usually be prevented. A simple and inexpensive test in the later stages of pregnancy can detect the bacteria, allowing treatment to be offered to Mum during labour so minimising the risk of infection in the newborn baby. Group B Strep Support wants health professionals to have access to the 'gold standard' ECM (Enriched Culture Medium) tests for group B Strep carriage in NHS laboratories to help improve prevention of these severe infections. This test is routinely available in many countries in Europe and the USA. Pledge 1163/ 2014
		Prevention and early diagnosis of other rare conditions	This code describes the efforts of participants to promote awareness within the public and other professionals concerning the prevention and early diagnosis of other rare, chronic, terminal and life-long conditions.	So my pledge was to improve early recognition and management of sepsis in children, which was the sepsis project I was doing and as it was taking shape it became clear that that was what it boiled down to and what I wanted to do was the sepsis project, and that became distilled down to the pledge that I made. (Interviews, p. 72)
Inter organisational practices	Improving inter organisational work	Better integration of Health and Care services	This code describes the commitments made and actions taken by participants to address the issue of the integration between Health and Care services.	The ambition in Leeds is to become one of the best-integrated cities in the UK. That demands great relationships across the whole city, not just in health but in all the sectors; that is health, social care, the voluntary sector and also in the businesses that create the vibrancy of the city. With Connected Coffee, you commit to meeting someone you have always wanted to know more about for coffee (or any other beverage of your choice) to learn more about what they actually do. Why wouldn't you? It's a great idea that will change the network of connections across Leeds - go on, be brave - invite someone for coffee! You never know what will happen. Pledge 2109/ 2014
		Improving inter organisational work between CCGs and health and care organisations	This code describes the commitments made and actions taken by participants to improve the interorganisational work between CCGs and health and care organisations.	The 'West Cheshire Way' describes how our local health and care system will work together in Chester, Ellesmere Port and the surrounding rural areas. It is a partnership between the West Cheshire Clinical Commissioning Group, Countess of Chester Hospital NHS Trust, Cheshire and Wirral Partnership NHS Trust and Cheshire West and Chester Council to respond to a number of challenges. Pledge 1212/ 2014
		Improving inter organisational work between Primary and Secondary care	This code describes the commitments made and actions taken by participants to improve inter organisational work between Primary and Secondary care	We pledge to develop integrated primary and secondary care medication record for West Cheshire. Pledge 6564/ 2014
		Encouraging community based elderly care (rather than hospital care	This code describes the commitments made and actions taken by participants to encourage community based elderly care (rather than hospital care etc.)	[...] One in three people over the age of 65, in the UK, will die with dementia, and the average age of a patient in a hospital bed in the NHS is 75. All staff, whatever they do for a living, are going to get old, they

		etc.)		are going to have older people in their families, and live in a community. So what is the point of a dementia friendly hospital, when the community it sits in isn't? Therefore, I was also keen to offer training to all organisations, members of the public and carers of people with dementia. Carers need education and training, as well as ongoing support. (Story 65/100 'Stories of Change')
		Improving communication with schools/ the education system	This code describes the commitments made and actions taken by participants to improve communication with schools/ the education system	Diabetes Care Plan for Schools (DCAPS) [pledge]: every child with type1 diabetes in the UK should have a personalised care plan for management of their condition in school. Pledge 4872/ 2014
Organisational practices	Healthcare staff - patient related practices	Promoting an organisational culture for patient safety	This code describes the efforts of participants to engage with changes concerned with patient safety, encouraging a culture that prioritised patient care.	I will put Change Day onto the agendas of the patient safety forum and the hospital management team, and encourage WIHB to embrace the concept of the pledge for positive personal change within the organisation. Pledge 480/ 2014
		Promoting an organisational culture in which patients feel cared for and are confident in their treatment (relaying more on patient feedback).	This code describes the efforts of participants to engage with changes that promoted a culture in which patients could feel cared for and could be more confident in their treatment.	Why spend five minutes having a quick drink behind a door out of sight, whilst learning nothing of your patient, when that exact same time could be taken by sharing a drink with your patient, allowing for a more person-centred, individualised approach? […] #CuppaCare will aim to tackle the traditional idea for staff to 'go and grab a drink, whilst it's quiet and nobody is watching', and make it acceptable for everyone – including nurses, consultants and patients – to take the time to have a refreshing drink [together]. (Story 31/100 'Stories of Change')
		Becoming a dementia friendly organisation (training all staff etc.).	This code describes participants' efforts surrounding the issue of dementia care, which aimed to create a more dementia friendly environment in the work place.	Hi. I'm Andy Tysoe. I primarily work […] as a memory nurse. I [also] […] inspire people to think differently about dementia […] In 2014, I pledged to create 2000 dementia friends by the end of dementia week […] I had delivered my 100th dementia training session. These dementia workshops have now been delivered to over 3,000 people […] [which] has been widespread, with the desire to create a dementia friendly town and borough. People from all walks of life have attended. My other NHS Change Day pledge was to roll out this model of dementia awareness to other NHS trusts. (Story 65/100 'Stories of Change')
		Altering the physical space within the organisation so that it is more suitable for elderly patients.	This code describes participants' efforts to alter the physical space of the organisation in order to make it more suitable for elderly patients.	[…] Dementia is not just about memory loss. It can also affect the way a person with dementia thinks, reasons and understands their environment. […] When things have got low contrast add a sentence, they're harder to make out. […] If you're looking for a white toilet, with a white seat, in a white tiled room in a hospital, […] which is obvious to most people [but] really difficult and a complete blur [to

				people with dementia]. […] Our painter and decorator came to a Dementia Friends session. Afterwards, he told me that it costs no more to paint in dementia friendly colours than what he was using before. This went right the way to the Chief Nurse, Alison Kelly, and the hospital has now decided to do its redecoration like that. It's a change that costs nothing, but brings huge benefits. (Story 69/100 'Stories of Change')
		Altering the physical space within the organisation so that it can be more inclusive	This code describes participants' efforts to alter the physical space of the organisation in order to make it more inclusive (e.g. for people with disabilities, etc.)	And the second one is also to do with the Child Development Centre, which is to create a storyboard, which explains to autistic children what their care pathway is. At the moment our autism waiting list is about two years, before you can get a diagnosis. It's just horrendous and a lot of people feel like they're dropping out of the system. They don't hear back, they don't get an acknowledgement letter about when their appointment is. So the storyboard is to show who you might meet, where you might meet them, what you can expect, who you can contact, but all in child friendly writing, with pictures and things. (Interviews, p. 95)
	Organisation-al managerial practices	Improving practices in order to improve organisational efficiency/ reduce cost	This code describes the efforts made by participants to improve working practices with the aim of becoming more efficient and reducing costs.	[...] I met a porter who… he had a personal ambition to save money for the hospital, [...] he noticed small things like wheelchairs weren't in the right place. So, you've got somebody that needs to go from A&E to radiology, they need a wheelchair, and the wheelchair is not where is should be, which then means that patient is waiting to be moved from one place to another because of a wheelchair. It then means the appointments late; another person coming in can't get in, so the impact for something like a wheelchair was massive. So, he came up with an idea of have, like, wheelchair banks, like trolley banks when you go to Tesco's. So, it puts the wheelchairs with a little chain, and the token, and so they get put back to where they need to be [...] So, he set this system up, [...] So, the systems and the processes within the hospital have flowed better because he recognised that that was an issue. (Interviews, p. 137)
		Improving/ updating organisational administrative practices	This code describes the efforts made by participants to improve and update administrative practices	[...] We had a lot of problems with seeing patients and everything, and there was an email coming around saying NHS Change Day is coming, would you like to do a pledge, and I met with my colleagues.[...] and I said, well, why don't we do a pledge to try to improve and work more efficiently and make sure that we sort these problems that we have, with communication with the patients and with each other. [...] I went home and after thinking about it, I put the idea forward to put all the patients on the computer. The

				computers, they were not used, they were always just put on paper, and I decided to put an informatics programme on, to put all the patients on and to allocate the patients through a spread sheet, and that's how the Directory Roll started. (Interviews, p. 299)
Teamwork practices	Promoting teamwork norms/ conventions	Challenge/ report bad practice	This code describes participants' commitments to challenging and reporting the bad practices of other team members.	Nikki Evans Senior cancer research nurse Challenge any bad practices regarding nursing care and support of patients in outpatient and in patient areas. Pledge 8703/ 2014
		Promoting a culture of openness and honesty between staff and management	This code describes participants' commitments to promote and enforce a culture of honesty within the organisation.	[…] I made a pledge last year as part of NHS Change Day to constructively criticise and report any drug errors that I came across in my practice. […] I realised that I couldn't criticise others unless I was prepared to be open to criticism myself. […] It's not easy to hold the mirror up to yourself and be honest. But it's been really powerful for both my professional and personal growth. It's made me realise is that this is what I want to do in my life: to help other people to learn and to grow. (Story 87/100 'Stories of Change')
		Supporting grassroots change initiatives by the organisation (senior staff)	This code describes the efforts made by participants to support grassroots change initiatives, through the engagement of senior staff with NHSCD.	I intended to encourage and support the staff in pathology to achieve their NHS Change Day pledges. I'm keen to see staff realise their potential, enjoy their roles, build effective networks across the organisation and feel proud to work at MK. (Pledge 518/ 2014)
	Improving team communication	Improving communication within the organisation/ team members through new social media tools.	This code describes participants' efforts to improve the communication within the organisation and with their team members through the promotion and better usage of various social media tools.	We Pledge to continue to create and share the value of using social media to connect nurses that are passionate about their role, passionate about delivering great care, passionate about supporting the NHS through tough times for the good of continuing great care here in the UK. (Pledge 757/ 2014)
		Encouraging positive team communication	This code describes participants' commitment to encouraging positive patterns and habits of team communication, fostering a more productive environment.	Registered nurse Sue-Ellen White wants to promote team spirit in the workplace[...] Her pledge was "to promote team work and to encourage everyone to treat each other equally and with respect." [...] With her friend Marie Orr-Gosselin, a licensed practical nurse at Parkridge Centre in Saskatoon, she is working on a grassroots initiative to foster a sense of team spirit among health care employees. Sue-Ellen and Marie are selling brightly coloured T-shirts that are emblazoned with the words "We work as a TEAM." The logo on the T-shirt lists various health care jobs, and each job is depicted as an equal piece of the pie. (Story 74/100 'Stories of Change')
		Improving/promoting interdisciplinary teamwork (including	This code describes participants' efforts to improve and increase interdisciplinary teamwork, including the practice of shadowing other professionals and other team	I pledge to spend time shadowing members of my team/department to make sure that I understand as best I can the area in which I work & the people I work with. (Pledge 6406/ 2014)

		shadowing other team members)	members.	
		Improving clinicians-managers communication/ understanding	This code describes participants' efforts to work towards the creation of a better understanding and collaboration between clinicians and managers.	We've all heard the stereotypes – the pen pushing managers and the consultants having hissy fits when things don't go their way […] I chose this as my NHS Change Day pledge as increasing the understanding between doctors and managers is something that I feel passionate about […] I pledge to set up a paired learning programme for doctors and managers to work together and learn from each other. (A Change Day Pledge 2014 Stories, p.17)
		Sharing good practices amongst and across teams/ building team capacity	This code describes participants' commitments to sharing good practices amongst and across teams in the NHS, with the aim of building better team capacity.	We pledge that we will offer our patients an opportunity for them to tell their stories both to drive up standards and recognise good practice. We pledge to publish them all on our website. (Pledge 6297/ 2014)
Individual practices			This category of codes describes an array of commitments to enact personal changes in individual practices.	The idea of Health Pledge came to Ingrid Brindle on the train home from presenting at a conference in London. She had just seen an inspirational talk by Pollyanna Jones about "NHS Change Day". Ingrid thought: 'Why don't we set up something similar at our GP practice so that patients can pledge to do something differently to improve their health?' Then of course she realised that it wasn't just about patients at the practice but the whole community. (Story 78/100 'Stories of Change')

Appendix 7.2.2 Codebook 3: Initiation and Implementation of Grassroots Change in Daily Working Practices (Narrative Analysis)

Narrative Analysis				
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Description**	**Example**
Agent (who) Protagonist	Community (narrative of care, interaction and compassion)	Healers	This group of codes describes how participants saw themselves as healers with the ambition of providing care and compassion (sometimes referring to religious or spiritual metaphors)	I pledge to provide high quality care to patients, making sure to keep a close eye out for pressure ulcers, making sure patients are moved regularly to prevent them occurring and when one has been found to make sure something is done to make it better and heal it. (Pledge 18/ 2014) I pledge to show empathy and compassion to my patients at all times. To smile at them and show them love as Jesus loved everyone through simple kindness and care. (Pledge 2085/ 2014)
		Carers (As care givers)	This group of codes describes how participants saw themselves in the role of carers, caring for vulnerable patients.	To care for my Mum (Pledge 7630/ 2014) Leah - to care for patients so that they feel less vulnerable; and reassure them that they deserve care and attention and are not a burden. (Pledge 7589/ 2014)
		Mentors	This group of codes describes how participants saw themselves as mentors, obliged to support both other members of staff and patients.	We will give our time to mentoring emerging clinical leaders and to supporting them generally (Pledge 3626/ 2014) I pledge to become a nursing student mentor by the end of the year. Sarah (staff nurse). (Pledge 4819/ 2014)
		Patients (as family)	This group of codes describes how participants viewed the people they cared for through an emotional lens, making pledges that promised to treat them like members of family.	I PLEDGE TO TREAT ALL PATIENTS AS I WOULD A MEMBER OF MY FAMILY. (Pledge 4932/ 2014) I pledge to 'think family' in my day to day approach to health and social care. (Pledge 5032/ 2014)
		Family	This group of codes describes how participants hoped to take the compassionate ethos of NHSCD and apply it to their own family members. As such, their role as caregivers extended beyond their formal roles in the NHS, emphasising that the role of caregivers is both personal and relates to the larger community.	To continue to support my mother-in-law who is in a residential home suffering from Dementia and to support other family members who find it hard to understand (Pledge 5241/ 2014)
		Family of patients	This group of codes describes how participants aimed to make a greater effort to support the needs of patients' families.	#DAACCZA: The Carers: call to action!! To support the needs and rights of family carers of people with dementia to bring about a real and lasting change. (Pledge 7295/ 2014)
		Community	This group of codes describes how participants	Anna Gangham: Life story network To continue to ensure that people

			resolved to put the community at the centre of their thinking.	remain connected with their local community and have the support they need. (Pledge 7328/ 2014) I pledge to be the first Healthcare Chaplain and Rev in the World to have a one page profile, and to pass this onto my friends as a way of encouraging us to find out about each other and to add to community cohersion. To find out more look at Helen Sanderson's Pledge to get 1000 #onepp participants in the Health Sector. (Pledge 640/ 2014) Nutritional Care Team "Continue to support and promote safe discharge of all patients requiring artificial nutrition into the community". (Pledge 833/ 2014)
	Human rights (narrative of fairness)	Social justice activists	This group of codes describes the human rights perspective of participants, who conceptualised themselves as activists standing up for both patient and staff rights.	To make my voice heard and to help others find theirs. To stand up for injustice and what I believe is right. (Pledge 3993/ 2014) Paul H pledged to: Stand up for the junior doctors who are having unfair and unsafe working conditions imposed upon them. Submitted by: Northumbria Healthcare NHS Foundation Trust. (Pledge 127/ 2016)
		Marginalised groups	This group of codes describes how participants were determined to push for the greater visibility of marginalised groups within the NHS, giving examples such as patients suffering from mental health issues, dementia, disability. In addition to increasing the visibility of groups suffering from stigmatised health issues, participants also stressed their commitment to work towards the greater inclusion of socially marginalised groups.	The injustice and lack of respect for people with schizophrenia. Its time to raise the profile of severe mental illness. (Pledge 7309/ 2014). I pledge to continue raising the profile of mental health and wellbeing, lesbian, gay, bisexual and transgender within the NHS and wider communities. One life lost to hate crime is one too many. People learn to hate so they can also learn to understand, show compassion, and accept that some of us are individual people who happen to be gay, lesbian, bisexual or transgender or have mental health problems/conditions. (Pledge 554/ 2014).
		Marginalised individuals	This group of codes describes how participants aimed to help marginalised individuals within the NHS, concentrating on resolving issues experienced by both staff and patients.	To ensure our staff and managers are treated equally and fairly. (Pledge 891/ 2014)
	Economic/ Managerial (narrative of Efficiency)	Service providers	This group of codes describes the managerial perspective of participants, concentrating on improving the NHS via improving the efficiency of established practice. Participants saw themselves as service providers with the obligation of providing the best possible service for patients.	Our NHS Change Day marks a new era of blended learning at East London Foundation Trust. It is the day our new learning management system, OLM, will go live prior its launch across the Trust on 10th March, offering a great variety of learning and development opportunities which we want our staff to take the most advantage of. Liberating our learning can only help us transform our healthcare system and provide services of the highest quality. (Pledge 2718/ 2014) Amaramark - Epsom To serve and provide the best possible customer and patient service in all departments and wards. To provide service with a smile! (Pledge 8716/ 2014)

		Service users	This group of codes describes how participants resolved to learn from patients in their role as service users, using their feedback to improve existing practice.	To take time to understand why service users act in the way they do and learn from them how to help. (Pledge 423/ 2014)
	Scientific (narrative of professionalism)	Healthcare professionals	This group of codes describes how participants drew on a narrative of professionalism that revolved around their role as healthcare professionals, using this as an impetus to improve practice.	I pledge to use my skills to prevent pressure ulcers and use my knowledge to educate both other professionals and patients to be more aware of the risks and early signs for prevention. (Pledge 193/ 2014) Write more professional, well-spelt notes in surgery. (Pledge 5787/ 2014)
		Scientists	This group of codes describes how participants understood themselves as scientists, resolving both to improve the use of and to produce scientific knowledge.	I will teach the biomedical scientists in my department about prostate biopsies so they understand the importance of embedding them correctly. (Pledge 5047/ 2014) Azilleo - I pledge to contribute to cancer research to that we can one day find a cure. (Pledge 7558/2014)
		Public	This group of codes describes how participants aimed to create their practice with the general public in mind, adopting inclusive language	We will help patients and the public engage with the work we do by using plain English and not jargon. (Pledge 5236/ 2014)
Purpose (why) – Driving Values	Community (narrative of care, interaction and compassion)	Health and well-being of all members of the community	This group of codes concentrates on the purpose and underlying values of the NHSCD movement and participants' accounts reveal underlying narratives of community, compassion and care.	To try and improve the emotional well being of all young people I see in my schools to show them I care and will do my upmost to support them and give them hope. (Pledge 5292/ 2014)
	Human rights (narrative of fairness)	Equality and fairness across all social diversity.	This group of codes describes how participants saw the purpose of NHSCD as advancing the cause of fairness within the NHS, concentrating on the ways in which the system could be improved and made more inclusive.	To work towards a fairer, more equal society where systems, pathways and processes are truely integrated and not just words on paper. (Pledge 6105/ 2014) National Ugly Mugs: To continue to advocate for sex workers to have access to health and criminal justice. (Pledge 7655/ 2014)
	Economic/ Managerial (narrative of Efficiency)	Efficient provision of healthcare services.	This group of codes describes how participants saw the purpose of NHSCD as improving managerial practices and subsequently the efficiency of practices across the organisation. The efficient provision of healthcare services was strongly linked with the duties participants saw as existing between staff members and patients.	Gill pledged to: Be a cost cutting champion. Reduce waste, be mindful of cost of equipment. i.e. reduce use of disposable finger probe monitoring. Submitted by: Northumbria Healthcare NHS Foundation Trust. (Pledge 142/ 2014) To reduce postage and printing costs by better use of email as a means of communication for our hospital's charity. (Pledge 2449/ 2014) Nottingham City CCG is raising awareness of the cost of missed NHS appointments and encouraging people to phone and cancel so others can be seen. (Pledge 3556/ 2014) I pledge to improve the efficiacy in my everyday working life and strive to keep costs down in all areas of my work. (Pledge 3648/ 2014)

	Scientific (narrative of professionalism)	Older practices need to be updated to more informed ways of doing things.	This group of codes describes how participants saw the purpose of NHSCD as advancing professionalism across the institution and encouraging scientific progress. Participants described their desire to see old practices updates to reflect current medical research and hoped that the space provided by the NHSCD movement for innovation and experimentation would allow this aim to flourish.	[I pledge to] 1) to ensure all health professionals from HCSW, AHPs GPs and RNs work together to reduce pressure ulcers by implementing SSKIN. 2) to ensure that an equipment pathway is developed so Staff can upgrade/ downgrade equipment safely and cost efficiently. (Pledge 30/ 2014) Technology Enabled Care (TECS) for Dementia and MCI Following a successful evaluation of using Simple Tele-health with patients who have dementia and MCI we have a proof of concept for an App developed with a local technology company and service users as co-producers. Despite many setbacks I pledge to try my best to push through bloackages and identify funding sources to get this to market ready demonstrator stage and galvanize support. The BeAble App concept could help so many individuals improve wellbeing and with potential NHS cost savings. Submitted by: Lisa Sharrock. (Pledge 267 / 2016)
Scene (when/ where)	Community (narrative of care, interaction and compassion)	Emotional disconnect in the communication of treatment, resulting in poor patient experience.	This group of codes describes the scene in which the NHSCD movement was creating as that of an emotional disconnect between staff and patients. Participants relate their desire to improve the quality of patient experience.	I pledge to listen to patient stories, hear what they say and make changes to our service to improve the patient experience and outcomes. (Pledge 1899/ 2016) To listen to patients more, understand their needs and work towards improving their experience. (Pledge 6549/ 2016) To stop people making poor non-patient centric decisions. (Pledge 8160/ 2016)
	Human rights (narrative of fairness)	Social inequalities in access to health and care services.	This group of codes describes how the NHSCD movement emerged into a scene of inequality, with different groups receiving different access to health and care services. Participants described their desire to make the NHS a fairer place.	Sue Beatson - I pledge to support staff and patients in ensuring our service delivery is inclusive and fair for all. (Pledge 1956/ 2014) I pledge to make NHS fair to all, free from racist bullying and a pleasant place to work. (Pledge 2855/ 2014) Continue to raise awareness of the impact of gender, sexuality, identity & diversity & other health inequalities on health & well-being. (Pledge 5525/ 2014)
	Economic/ Managerial (narrative of Efficiency)	Lack of resources, ageing population, budget crisis.	This group of codes describes how participants hoped to address a scene of crisis, which included issues such as a lack of resources, an ageing population and budget restrictions, through a managerial approach that concentrated on improving efficiency and continuing to provide services despite existing pressures.	Our pledge is to continue to provide our excellent diabetic foot service despite crazy governmental cost pressures. (Pledge 3688/ 2014) I will support my fabulous team to work smarter not harder. We face unprecedented change and reductions in budget. My already hard working team have to lead the change management while keeping performance high. I pledge to support them, enabling them to be creative and think outside the box. We have earned the right to be radicals and we will be to improve services with and fro CYPF in Worcestershire. (Pledge 461/ 2016)
	Scientific (narrative of professionali	Insufficient implementation of evidence	This group of codes describes how participants believed that the NHSCD movement could help	I pledge to counter irrationality; fuzzy thinking and non- evidence based practices wherever I find them within the NHS and her

	sm)	based research	improve a context in which the implementation of evidence based research was seen as being insufficient. Participants hoped to encourage the greater use of research and theory within the institution.	partners. (Pledge 1160 / 2014) I pledge to promote the role of the hospital library in supporting evidence-based healthcare. (Pledge 2028/ 2014) Support students in understanding evidence base and bridge the gap between theory and practice. (Pledge 4321/ 2014)
Agency (how)	Community (narrative of care, interaction and compassion)	Improving communication, prioritising patients, focusing on compassionate care.	This group of codes focuses on agency and the way that it is expressed in the different narratives that arose around participation in NHSCD. Participants described their desire to prioritise the idea of the community in their work, putting patients at the centre of their practice. Pledges in this grouping concentrate on improving communication and encouraging compassionate care.	I will treat people with dignity, respect and compassion, never turning my back on others but extending a hand to help. (Pledge 2398/2014) DCHS - Committed to implementing the NHS 6 Cs Care Compassion Commitment Communication Courage & Competency for the benefit of patients carers and staff. (Pledge 2581/2014) I pledge to treat all patients with care and compassion and to approach every need of an individual with empathy. (Pledge 3429: /2014) To always be compassionate, actively listen & provide the best holistic care to both my patients & colleagues & peers. (Pledge 3783/2014) A champion for compassion in healthcare. To build on the legacy of Dr Kate Granger by being a champion for compassion in health care, always promoting the little things that make a big difference to our patients, families and carers. (Pledge 266/2016)
	Human rights (narrative of fairness)	Fighting stigma and standing up for the marginalised.	This group of codes focuses on participants' pledges to fight stigma and stand up for marginalised groups and individuals. Participants pledge to do this through increasing the visibility of such groups within the organisation as a whole.	I pledge to challenge the stigma associated with learning disability by talking, listening & sharing. (Pledge 5941/2014) Help end mental health stigma! When it comes to mental health we have nothing to be ashamed of! It is the stigma and bias that over shadows it, that shames us all. Living with Mental Health issues does not describe who someone is, they are not the illness! It's hard to believe that such an outspoken world that we live in today, can remain largely silent when it comes to mental health. That is why we as a society need to continue to become more open, transparent and understanding. Make your pledge for #FabChangeDay. (Pledge 223/2016)
	Economic/ Managerial (narrative of Efficiency)	Efficiency measures and improvements.	This group of codes focuses on participants' pledges to improve efficiency throughout the organisation, giving the examples of improved communication and customer care.	I pledge to lead on improving communication within my service line, both between staff and for our service users. I aim to start this by redeveloping a webpage. (Pledge 4884/2014) I pledge to work with my colleagues in providing excellent customer care to our service users, through creativity, challenge & to inspire colleagues. (Pledge 5086/2014)
	Scientific	The	This group of codes focuses on participants' pledges to	I pledge to ask myself and my colleagues if we know 'why we do

	(narrative of professionalism)	dissemination of knowledge and encouraging of its implementation.	encourage both the dissemination of new research and its implementation. Participants hoped to improve daily working practice through the adoption of scientific knowledge.	what we do, in the way that we do it'. To look for an evidence base for the advice that I give and support I provide. To apply research to everyday practice and share that with others. (Pledge 504/2014) Improve pain knowledge and understanding. There is little pain management undergraduate education & what there is focuses on medication & detecting underlying pathology. In chronic pain, medication is less useful & often there is either no underlying pathology or there may be a condition, which is not curable. For chronic pain, a rehabilitation approach is often more helpful. This requires an ability to understand & explain the bio psychosocial nature of chronic pain. (Pledge 393/2016)
Plot/Act (what)	Community (narrative of care, interaction and compassion)	From insufficient experience of communication to relationships which adequately and compassionately involve all members of the community.	This group of codes describes what participants hoped to achieve via their pledges. Participants described how they hoped to move away from a place in which patient experience was insufficiently considered and establish strong relationships between patients and healthcare staff that adequately and compassionately involved all members of the wider community.	I pledge to listen to patients views on NHS services and make a difference in how local services are commissioned and delivered. (Pledge 4024/2014). Care about the friends/families of patients we are treating along with the patients. By asking how they are and let them know where we are if they need to talk. (Pledge 7820/2014). I'll strive to prevent the important being trumped by the urgent & model compassionate leadership Working in an arm's length body I will challenge colleagues to focus on the patient and sustainable improvement & role model compassionate, inclusive leadership of those in my team & those who look to me as a leader. (Pledge 218/2016) The Compassion Project This creative project will see a national conversation and art making between health professionals on the theme of compassion, compassion fatigue, burn out and resilience. It will result in a short animated film on the theme providing health professional's perspective on what compassionate practice is and how is impacts on their health. It will also look at resilience and support. (Pledge 343/2016)
	Human rights (narrative of fairness)	From exclusion to inclusivity.	This group of codes describes how participants hoped to move from a position of exclusion to one of inclusivity, reaching out to marginalised groups and raising awareness surrounding issues of access.	I pledge to break down the barriers that people living with dementia face on a regular basis by increasing the awareness within the workplace and too the wider community whilst learning from these individuals and their loved ones what changes can be made that will ease their journeys. Inclusion not seclusion - challenging and changing our routines not the patients. (Pledge 434/2014). Continue to raise awareness of the impact of gender, sexuality, identity & diversity & other health inequalities on health & well-being. (Pledge 5525/2014).

				To recruit at least 10 Personal Fair Diverse Champions to develop our culture of person-centeredness. This links to our Diversity and Inclusion Strategy and our ambition to provide Safe Personalised Accessible and Recovery Focused care to all our service users, through behaviours that support our Trust Values of Proud to CARE (compassionate, approachable, responsible, excellent). Information on Personal Fair Diverse (PFD) Champions shared with Diversity and Inclusion Champions and key contacts. (Pledge 532/2016)
	Economic/ Managerial (narrative of Efficiency)	From inefficiency to optimal use of resources according to needs of the community.	This group of codes describes how participants hoped to improve what they understood as an inefficient use of resources, envisioning a future in which resource use was optimised, meeting the needs of the community.	I pledge to ensure personal health budgets are offered and taken up by people who are less likely to access health services. (Pledge 3381/2014) The TLC campaign is about improving the hospital environment to enhance patient wellbeing through the simple means of Turning off equipment, switching off Lights and Closing doors. The benefits can be measured in terms of protected sleep for patients and effective management of room temperature for both staff and patients. It also positively effects the carbon footprint of the hospital which shows our commitment to the prevention the negative health impacts of a changing climate. (Pledge 5623/2014)
	Scientific (narrative of professionalism)	Progress based on scientific knowledge.	This group of codes describes how participants hoped to include cutting-edge medical research in their practice, encouraging a broader and experimental attitude to innovation across the institution.	To develop and implement technology solutions to help support efficient and safe use of medications. (Pledge 5973/2014) To extend the use of mobile IT to become more efficient in data collection, sharing & analysis and improve access to clinical information at the point of care. (Pledge 6582 /2014) Virtual coeliac clinic For stable patients, annual face-to-face review could be replaced using new technologies – i.e. a virtual clinic whereby email/telephone contact can be greater utilised, saving both patient and clinician time whilst ensuring adequate monitoring (bloods, bone scans, nutritional status and dietary treatment). We could have a Virtual clinic – based on the Bournemouth model which has been shown to be highly effective at reducing costs and improving patient satisfaction. (Pledge 399/2016)

Appendix 7.3 Codebook Chapter 6

Appendix 7.3.1 Codebook 4: Motivation for Participation in the NHSCD Movement

Thematic Analysis				
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Description**	**Example**
Contextual motivations to participate in NHSCD	Anxiety regarding the future of the NHS	Large scale structural changes	This code describes how NHSCD participants were influenced by external political pressures which they felt were shaping the NHS and the uncertainty that they experienced as a consequence of this	[…] the Health and Social Care Act is a massive change: having to battle with reducing finances and increasing demand […] I think we're talking a bit more crystal ball here and I think it depends a bit on what the politicians do over the next few years. (Interviews, p. 80)
		The Health and Social Care Act	This code describes the ways in which NHSCD participants emphasised the day-to-day insecurity created by the constant restructuring programs, including the recent Health and Social Care Act.	We've seen a major reorganisation of the NHS, to a scale that we've never seen before, and it's going to take a good ten years before we understand what that reorganisation is going to look like in terms of the NHS. (Interviews, p. 81)
		Budget struggles	This code describes participants' fears, which were orientated around the implications of budget constraints as a lack of money might necessitate decreased quality of care.	[…] we're not going to survive in the NHS […] we have to make savings every year and they've done all the salami slicing, they've done all the quick wins, but now they need a whole new change to deliver savings and to deliver care effectively and that's what NHS Change Day can help deliver. (Interviews, p. 117-118)
		Fear of privatisation of the NHS	In this code the anxieties expressed about the gradual disestablishment and privatisation of services are described.	I hope that the NHS doesn't get broken up; it feels like we're heading towards piecemeal privatisation of the NHS where industry takes over the easy parts of the NHS – easy services, easy operations, things like that. (Interviews, p. 81)
	A sense of identity crisis	The Francis Report, compassion	This code describes participants' understanding of the relationship between Change Day and the NHS staff reaction to the Francis report. They explained how the Change Day movement allowed them to assert, through changes in their practice, the fact that they were compassionate practitioners.	I also think that because of our loss of confidence, because of the constant attacks and the pressure – as we've seen with the Francis report – people buckle, and I think Change Day just helps them inject some enthusiasm and inject some positivity in amongst that pressure and help people refocus on what are the important things rather than just seeing the NHS as a job. (Interviews, p. 78)
		Excess focus on targets	This code describes how NHS frontline staff were pressured by the excessive focus placed on targets in the NHS system, and how joining Change Day allowed them to move away from that focus.	Across the whole of the NHS there are lots of big changes happening and it's hard for staff because everything's so much about finance and time, and it's all about savings – making cost savings - or improving a target. It's really hard for staff. I think Change Day has given us an opportunity to engage with our staff without thinking about the money, without thinking about the target.

				(Interviews, p. 314)
		Negative media	This code describes the ways in which NHSCD participants felt that the movement's positive ethos felt like a necessary antidote to frequent media criticism highlighting poor performance within the NHS.	I think NHS Change Day is important because you have a lot of negativity in the NHS, in the media at least. A lot of the media stories are about negative elements – long hospital waiting times, long accident and emergency waiting times, the scandals that happen with patient care, the budget. You never hear the positive things that the nurses do, that the frontline staff do, that people do to try and make the NHS what it is. (Interviews, p. 15)
Collective agency as motivation – 'Do something better together'	Collective belief 'together we can make a change'	Together we can make change	The code describes how participants were inspired by the collective force of like-minded, dynamic individuals who responded with positivity and vision to the movement's call for action.	I suppose it's often the people, the passion, of making the difference to the NHS. When a group of people come together who have got this great idea of making significant change in the NHS, that's quite interesting to me, and so I'm naturally interested in engaging with people who are interested in making large-scale change and involved in change per se. (Interviews, p. 381)
		Sense of togetherness	This code describes how a sense of togetherness liberated those participants who felt pigeonholed by the system.	I think that there has been a history of top-down, authoritarian management in the NHS, and now we have realised that we need networks, we need influences, and we need to believe in ourselves, and that's what NHSCD does - it helps us to believe that we can make that change, and we don't have to wait for that directive. (Interviews, p. 117)
	Collective belief 'Each one of us counts'	Frontline has the answers	This code describes how NHSCD enabled frontline participants to share their experiences, testing their individual capacity to enact positive change.	I'd done lots of different roles and now what I wanted to do was to bring all of that experience to bear onto something, that I could really make a difference. (Interviews, p. 274)
		Frontline communicating and inspiring each other	This code describes participants' belief that the opportunity to engage and to act collectively within the Change Day movement was key to the ways in which they connected with their peers and other activists. They described how their capacity to enact change grew as their network expanded.	[…] there is also the simple factor of making a tiny little switch in your practice or in your attitude and then if you cascade that to another ten people who then cascade that to another ten people you can make a huge amount of difference with a very simple change. (Interviews, p. 53)
	Having a voice	Having the permission to speak up.	This code describes how participants revealed that they often felt constricted within the NHS, to the point that they had to ask permission to make a change. NHSCD gave them the impetus to express themselves.	I think it's a way to share new knowledge, or established knowledge that hadn't previously been shared. And it's a way to support those who don't always have a voice, and give them authority. Give them a backing and a campaign that then gives them the voice to be able to change or challenge. And when others then criticise them, they can say, I'm doing it for Change Day. So that's what I like about it. (Interviews, p. 98)
		Feeling empowered to raise ideas	This code describes how participants felt that belonging to the movement provided them with the opportunity to break down	I think the biggest thing that it's had – and you can recognise this nationally – is, like I say, the breaking down of the barriers for people to say, actually, if I've got an

			the rigid hierarchies that existed within the NHS and to assert the importance and power of their individual voices.	idea I can raise it... I do feel empowered to do that; I do feel okay to speak up about things. (Interviews, p. 266)
		Being heard	This code describes how NHSCD enabled individuals to both have a voice and be heard: their ideas would not be ignored and would be able to impact the NHS on a wider scale.	[…] it provides a platform for those that didn't feel like they were heard before. And it's just a way of doing that on a huge scale. There must be lots and lots of little initiatives that try to give people that didn't previously have authority... to give them a voice. But this is just a huge initiative that addresses it for people on a much larger scale. (Interviews, p. 98)
	Being a role model	Taking action and being a role model as a leader	This code describes how those in positions of responsibility acknowledged their potential to act as role models and catalysts for the movement's expansion.	Equally, as part of my role as head of department, I think within that role itself, it's important to set a standard, to try and get other people involved, and the only way of getting other people involved is to do it yourself. But that's not the main reason I did it. The main reason is because I believe in it, but as a leader, you can't expect other people to do it if you're not interested yourself. (Interviews, p. 185)
		Being inspired by the beliefs of others	This code describes how participants, inspired by the actions of others, lent their voices to the cause of movement.	[…] the power of Change Day is not strangers inspiring strangers, it's your friend encouraging your friend. (Interviews, p. 356)
		Establishing personal standards as your own role model	This code describes how involvement in NHSCD was driven by deep, personal beliefs in the movement's power and ideology, rather than from a sense of obligation, and how individuals established their own personal standards.	From a personal perspective, I always think that we can always do more and on a personal basis, we all think we give 100% and whatever, but there's always something we can change, even if it's just something in how we do things. (Interviews, p. 185)
The power of bottom-up change as motivation	'The frontline has the answers'	Respecting the expertise of frontline practitioners	This code describes how NHSCD was believed to engage disconnected realms of the NHS in vital dialogue, ensuring that the expertise of frontline workers was used to shape relevant policy decisions.	However, as managers we can sit there and we can look at what we're doing with them... say, okay, we think we should do that. But actually it's people on the shop floor that understand the services more than we do, and we value their experience and what they've got to say. And again, I think NHS Change Day has helped us just listen to those staff a little bit more than we may normally have taken the time to do. (Interviews, p. 270)
		Strategic decisions made with reference to the reality of frontline working practice	This code describes how NHSCD was understood as an important opportunity, not just for the frontline to have a voice, but also for strategic decision makers to join and support the movement, and to affirm that they were listening.	Some specialties we're just starting to work with for the first time to actually try and engage with people and say, okay, no, we're serious here, we genuinely mean we want your views, we genuinely mean we will try things that you're suggesting, because every organisation has a history and some areas of this organisation have been quite top-down dictatorial and the staff don't believe you when you say that they can contribute. (Interviews, p. 398)
		The expertise or experience of frontline	This code describes how NHSCD was believed to engage disconnected realms of the NHS in vital dialogue,	I think we need to find a different way of finding the balance between what we can do and the resources we have. I don't think that the

		workers is invaluable	ensuring that the expertise of frontline workers was used to shape relevant policy decisions.	senior managers always have the answer; sometimes they do but not always, and I think that there are a lot of people at the frontline who do know the answer and could help. (Interviews, p. 78)
	Frontline communica-ting and inspiring each other	Frontline workers feeling reconnected with their vocation	This code describes how frontline workers were able to gain a sense of renewed vocation through the sharing of stories in NHSCD.	So for me, this is really positive, to hear some of the good stories that were happening on the wards, and the good-news stories about what we'd done, how we'd do […] how the teams were pledging to make that happen. (Interviews, p. 265)
		The positive momentum of NHSCD for the frontline	This code describes participants' discussions of the positive momentum of NHSCD.	I guess, coming newer into the NHS as well, and having all these, I want to do things differently concepts, seeing that people were trying to actively promote that. I was like, oh, this is perfect. I want to actively do things differently anyway, people are supporting that and pioneering it, so I'll get involved with that. (Interviews, p. 102)
		The empowering sense of leading from the frontline	This code describes how the sense of empowerment generated through the prefiguring of change was associated with the feeling that celebrating positive stories within the workforce was a considerable cultural shift.	I think Change Day is bringing about a new confidence that we didn't have before and that confidence is coming from front-line people rather than being the senior people telling everyone it's all going to be all right. (Interviews, p. 77)
		Celebrating the values and working ethos of those on the frontline	This code describes how each progressive change inspired a vision of future potential, and was an opportunity to celebrate the values of the frontline.	I just think it's an opportunity to show the fun and energy and positivity that is within the NHS for a large number of staff that often gets overlooked because a lot of the press is often quite negative, and so I think it's an opportunity to show some of the really positive things that are happening and continue to happen. (Interviews, p. 227)
Enactment as motivation	Change starts from within	Motivation for change comes from your own values	This code describes how through the enactment of changes focusing on patient care and wellbeing, individuals reconnected with a fundamental sense of the values that made them become NHS practitioners, emphasising the role of their own personal values.	[…] change can start from within, from yourself, as an individual, it actually starts from you. So you can either go off and do a training course and then learn about how you can change, or it could be something you just do anyway regardless of having any training to tell you how to do it. It's got to come from within your own values I think. If you have those values anyway – and I would hope to think that people who work in the NHS do have those values, that's why they joined in the first place, that it's about actually tapping back in your mind those values as well. (Interviews, p. 85)
		Matching working style with personal values on an every day basis	This code describes participants' exercising of their agency to align with the movement's philosophy and momentum, matching their working style with their values as healthcare practitioners.	I quite like the idea of pledging because it's really a promise to yourself, that's really what it is, and when you think about the motivation for change, that if you're able to use your own motivation for change, then it's much more likely that it's going to happen, and I think that that's what this notion is all about: what's important to you? (Interviews, p. 277)
	The enactment of	The large scale cultural impact	This code describes how participants believed that their efforts, however small,	I think on an individual level people are making small changes. I think when lots of people make the same

	small-scale changes	resulting from incremental change	figured as part of a wider, cultural shift.	change, then that becomes a big change. I also think that there's something else – I think there's something bigger than that that's changing, and I think this is changing culture. (Interviews, p. 77)
		Making every individual aware of the tangible impact they can have	This code describes how for some participants, the value which NHSCD placed on their individual capacity to enact change effected an emotional transformation, making them aware of the tangible impact that they could make upon their working environment.	What Change Day did for me is it made me realise that I have the power and I have control of what I do and what I want to do in my life. And Change Day gave me my passion for my work back that I lost before, because I thought that I could not influence anything, I could not change anything. (Interviews, p. 299)
		The collective energy and enthusiasm generated through enacting change	This code describes how pledging was key to participants feeling that the Change Day movement enabled them to reclaim their power, sense of initiative, and autonomy within the NHS, and generated energy and enthusiasm through the enactment of change.	It's great, because, you know, you're using all of your energy to motivate others, and then when they, kind of, pick up on it and they become involved, and they get really excited, that energy and enthusiasm really motivates you. It's a bit like a cycle, it's fantastic. So the more people that we're getting engaged, and getting involved, the more excited I was being, and, kind of, the more I was throwing everything at Change Day, so. (Interviews, p. 151)
	NHSCD, a national campaign	The collective capacity to change the future of the NHS	This code describes the sense that Change Day was creating a different NHS where, when it came to engaging with government decision-making, through the importance of collective action.	To think about being part of something that's being delivered on a national level, that's quite exciting for me; large-scale change, seeing 350,000 to 400,000 people make a pledge [...] In terms of numbers, it's quite significant. (Interviews, p. 388)
		Having a national focus on individual capacity	This code describes how the national focus introduced by NHSCD could impact healthcare policy, allowing individual frontline workers to have power and influence on a much larger scale.	We need to create an environment for professionals to develop […] We need to create the environment for them to realise that throughout their training […] what they put in can be amplified in terms of what they get out. And if we can start from an early stage then perhaps, just perhaps, when they get into a position where they have a bigger influence over the bigger picture, they're not that cynical person, they are an enabler. (Interviews, p. 79)
		Doing this for NHSCD so having the permission to experiment	This code describes how participants believed that NHSCD gave them permission to experiment through changes made to their practice, which they could not do otherwise.	It's an ideal platform. It's like anything, if there is a government drive or an incentive throughout the NHS to make a change, it makes sense for us to think about what we want to change and push it into that because it will have greater momentum. (Interviews, p. 196)
		The collective energy and empowerment of a national celebration	This code describes how the mood created by participation in Change Day was in itself felt to be the tangible change which could influence the future direction of the NHS	It's the love of the NHS. It's the love of the job. It's the love of caring for people. It's the love of socialised medicine. For me, it's slightly political as well, with a small 'p', because it's saying the NHS is a social movement, and NHS Change Day is a social movement within the NHS. (Interviews, p. 48)
		Carrying the ethos of NHSCD	This code describes how participants believed that the ethos created by NHSCD should be implemented	Every day should be Change Day in the way that every day is a school day. We should be coming in to try and make things better every single

		throughout the year	throughout the year, with this enthusiasm continuing to influence their practice.	day. I don't think that anyone in the NHS comes to work because they want to do a bad job. You should be coming to work with the idea that there is no point getting annoyed with things, you should be thinking about how you can make things better. (Interviews, p. 57)

Appendix 7.4 Codebooks Chapter 7

Appendix 7.4.1 Codebook 5: Collective Action Frames (Thematic Analysis)

Thematic Analysis				
Aggregate Dimensions	**Second Order Themes**	**First Order Themes**	**Description**	**Example**
Engagement with knowledge mobilisation through the dimension of ***leadership***	Becoming a competent NHSCD leader		This group of codes identifies the actors that become involved in the NHSCD movement and describes the process through which they negotiated their roles and responsibilities in the NHSCD movement.	So again in the first seven months it was just sort of dipping in and out because I had some ideas about how they could get pledges or do certain things. I would just dial in on the leadership course from time to time. (Interviews, p. 1) I think it must have been about a year learning curve and I felt that I could actually do something, and I was in the right position at work to make a change and I felt like I had the right networks now to be able to feed into and get people on board…(Interviews, p. 114) I was, one day a week, allocated to the Change Day team this time. So, from January to March I've been given a day a week from my day job to support the Change Day Core Team…(Interviews, p. 130)
		Who is competent to join NHSCD?	This group of codes describes the idea of competency within the NHSCD movement and identifies the various roles that participants were assigned and took upon themselves.	So the fact that I've done it […] with no experience shows that anyone can do it if they really wanted to. So I'm not really keen on people telling me excuses. If they really believe in it and they really want to transform the NHS and make it better for patients in the future and make it caring and compassionate, they have the power to do it. And anyone can do it. …(Interviews, p. 359)
		Defining roles and responsibilities	This group of codes describes the formation and negotiation of roles and responsibilities within the NHSCD movement.	So in my language what a Hubbie is encouraging people to get involved, reassuring them that there's no rules, almost being the person to give permission if people are saying, what can I do, what can't I do, and making connections between people in your path, in your area. So some people didn't know where to start, so give them ideas, thoughts. If they want to know what other trusts are doing to get some ideas, example pledges, so spread that kind of information. …(Interviews, p. 328) So to answer your question, I've been helping out with campaigns, and actually making sure they're in a good, interesting, attractive format, to be on the website. Helping out, sort of, more informally, I Tweet out campaigns, or I re-tweet campaigns. …(Interviews, p. 5)

		Relating participation in the movement to day-to-day job	This group of codes describes the different experiences of participants in relation to the way in which their participation within the movement interacted with their everyday jobs.	It wasn't necessarily linked to my job role in Cambridge although they were happy to support me working on it and it was obviously good for the organisation to have a regional lead at their hospital but I suppose it was more for the greater good, almost, of the NHS. I knew that it was something that was having a positive impact, something that I wanted to do in my own time rather than at work. …(Interviews, p. 244) Relates to my work massively because it gave me a tool to use and the backing, really, of the whole movement to get what I was trying to get done, done anyway, because before Change Day, it didn't have a name. Me trying to get the staff to be engaged and to take on ownership of things, and to change things, and to look for the benefits in potential shifts in practice was just basically management saying they wanted something else, whereas as soon as I got Change Day as a tool, it gave me a chance to say, because of Change Day, what do you think you could do? …(Interviews, p. 342)
		Becoming a leader	This group of codes describes the process of becoming a leader in the NHSCD movement.	But then when I became a Hubbie I just worked longer hours. You can't just say I'll do it on the weekend because some times you have to have a meeting in the week. It just means that I work later. So if I have a meeting about Change Day, like for argument's sake at ten o'clock on a Wednesday, I then normally… Over the last few weeks I've ended up working later in the evenings and working at home, working on Sundays. …(Interviews, p. 328)
	Belonging to the NHSCD leadership community		This group of codes focuses on the formation and negotiation of leadership roles within the NHSCD movement.	There's something about the value of giving the leadership to the frontline and actually leaders, the grassroots, top-down thing, that actually it's a teach or learn or... that the leaders are not always the people who've got leadership on their badge. …(Interviews, p. 296)
		The meaning of being a leader	This group of codes describes the experience of leadership within the NHSCD movement.	My vision is to lead a revolution to improve patient care at Northern Health. This change is driven by my passion to ensure patients are at the centre of decisions and processes that affect their health and wellbeing. (Story 6/100 'Stories of Change') I never thought in my wildest dreams that an opportunity to become a volunteer would lead to this. […] Every day I meet women who have such amazing courage and determination, who want to carry on with their everyday life and look and feel like the person they really are. I am privileged to be able to play a part. (Story 53/100 'Stories of Change') It is amazing thinking back to the difference a year can make. I am so proud to be a platelet donor and I

				love that the excitement and momentum surrounding NHS Change Day can help me spread the word for such a fantastic cause. (Story 56/100 'Stories of Change')
		Limitations of leadership	This group of codes describes the struggles faced by leaders in the NHSCD movement.	Some specialties we're just starting to work with for the first time to actually try and engage with people and say, okay, no, we're serious here, we genuinely mean we want your views, we genuinely mean we will try things that you're suggesting, because as an organisation every organisation has a history and some areas of this organisation have been quite top-down dictatorial and the staff don't believe you when you say that they can contribute. …(Interviews, p. 398)
Engagement with knowledge mobilisation through the process of ***learning and personal development***	Diagnosing areas requiring improvemen -t in daily practices		This group so codes describes the various ways in which participants reflected on and engaged in a learning process regarding their day-to-day jobs in the NHS.	[…] And again, that was something that, I think, we wanted to do, but actually making a pledge to do it for Change Day gives you more of an, kind of, an impetus not just to fall back and have it come to nothing. It, kind of, almost formalises an intention, and, kind of, makes you need to, kind of, show an outcome. …(Interviews, p. 151) Gill pledged to: Be a cost cutting champion. Reduce waste, be mindful of cost of equipment. i.e. reduce use of disposable finger probe monitoring. (Pledge 142/ 2016) Automation of reports with appropriate testing and documentation will save money and improve quality The result will be faster production, at reduced cost and fewer errors. It will offer standard presentation through templates and styles. User will require less time to assimilate information presented and will see exceptional activity which warrants action much more quickly. Band 4 Development programme initiated which includes a technical skills development component. Advanced Excel functions and Visual Basic for Applications. Contract reports are now standardised, documented and automated. Once testing is complete, the time taken to produce reports has been reduced by a massive margin. (Pledge 390/ 2016)
		Personal commitments to enact small changes in day-today routine.	This group of codes describes the various personal commitments taking on by participants in order to fulfil their own individual 'change' in their daily routine.	Hello. My name is Carolyn Nelson and I work at Leeds Community Healthcare NHS Trust. For Change Day 2014, I pledged to do at least one thing every week of the year that is "not in my job description". (Story 85/100 'Stories of Change')
		Individual commitments to enact changes in personal life affecting the NHS as well as their day-to-	This group of codes describes the various personal commitments taken on by participants in order to enact changes in their personal lives, which may have broader affect on their work within the NHS, such as volunteering and leading	I pledge to always remain positive and continue to focus on service improvements that benefit all - staff & patients - despite the challenges that I encounter. (Pledge 2772/ 2014) I pledge to volunteer as often as I can, do arts and crafts with the patients to brighten their day.

		day jobs.	healthier lives.	As a patient, I pledge to keep doing my exercises before and after my surgery to help my recovery. (Pledge 2684/ 2014) Submitted by: Northumbria Healthcare NHS Foundation Trust. (Pledge 149/ 2016)
	Reflecting on required improvements through attempted enactments of change		This group of codes describes how participation in NHSCD triggered the learning and reflection process for participants by challenging the boundaries of their roles.	That's where I got involved with the case. We were looking at different ways of doing things, improving communication with the wards and internally, trying to resolve issues that we get with portering and patient delays […] and then with the Change Day this year, it was basically a continuation of that. We've got a goal to do something, and then Change Day was more on a personal level, what personally we wanted to do. …(Interviews, p. 186)
		Experimenting with change in the performance of routines.	This group of codes describes participants' learning and reflection process resulting from their challenging the way in which they interact within their daily working routines.	"I've noticed that I'm now spending more time sitting with families at their patient's bedside to go through and try to better explain what is happening to their loved one. I thought I was doing a pretty good job of this before my Change Day pledge, but now I think I can do better based on what I noticed and felt." (Story 54/100 'Stories of Change')
		Reflecting on day-to-day job through the engagement with NHSCD activities	This group of codes describes the various ways through which participants' reflection on their day-to-day jobs through their participation in NHSCD.	The change I have pledged to make relates to my practice as a nurse and not as a lecturer. When I am with a patient, their families or their significant others, I pledge to really see the person, and not the task I have to perform with them. On a shift recently I sat with a wife and her daughter by the bedside of her sick husband. Only after a few minutes I realised that I had put the cot side of the bed up and she couldn't get close enough to hold his hand. If my change in view has led to an improvement in that one family's experience, it shows that a very small change can mean the world to our patients. (Story 59/100 'Stories of Change')
Engagement with knowledge mobilisation through ***power dynamic dialogue***	Subverting traditional role boundaries		This group of codes describes the way in which participants attempted to renegotiate their traditional role boundaries in relation with power dynamics.	I am proposing a Rebel Alliance: a social network of people that are involved in leading change in health and social care. I'm not talking system leaders (although they are very welcome too). This is a group for everyone who wants to do something to make a change for the better. The alliance is not about the tools and methods underpinning change and quality improvement […] The alliance is all about peer support for individuals through the inevitable emotional and motivational ups and downs of leading change. (Story 18/100 'Stories of Change')
		Debating power dynamics within the NHS.	This group of codes describes the way in which the NHSCD movement facilitated an environment in which the issue of power dynamics within the NHS was confronted through	Together we discuss the common challenges in health and care today and how we can use simple rules and social movement thinking to make practical change in health and care. We all recognise that having a bottom up approach whilst being

			debate.	supported from the top is essential. (Story 90/100 'Stories of Change')
		Breaking away from tradition in performing one's job.	This group of codes describes how participants use NHSCD platform in order to expand the way they perform their roles going beyond their regular role boundaries.	I feel that a lot of things are done on historical backgrounds and it's trying to break people's perceptions that because you always do it this way doesn't necessarily mean it has to be done this way and I think through my 20 years' experience here, I learned that a lot of things that we do here are historical. We keep them very much in-house, we don't communicate to the outside world in terms of to other hospitals in the area to ask what do you do sort of thing. …(Interviews, p. 196)
		Pushing against the NHS hierarchy.	This group of codes describes the way in which NHSCD participants experiment with subverted traditional role boundaries, particularly taking a stance against the NHS hierarchical nature.	[…] I think its main limitations are, you are still battling the NHS hierarchy. We're still in a system where we, as much as we love movements to come from the bottom, there's still that system to get through, and I think that's probably one of its limitations, is that you are... as much as you want to make change, unless you're really determined, I think you've got to have a really strong sense of character and be really passionate about that change you want to implement to get it to go […] But there are still always going to be hospitals where the hierarchy is not good, and you get to a point where you get stuck. So I think you've got to have a real sense of determination to get through that, but I think that's the main limitation. …(Interviews, p. 176) The Clinical Human Factors Group report that hierarchies influence good communication between clinicians. In the interests of improving communication, patient safety, and basic respect for my colleagues, I pledge to encourage those who are junior to me use my first name. (Pledge 1170/ 2014)
		Activism against the misuse of power.	This group of codes describes the way in which participants explicitly utilized the NHSCD platform in order to take a stand against the misuse of power within their working environment.	I pledge to speak the truth, even if my voice shakes. (Pledge 468/ 2014) To ensure the best possible support and person centred care for vulnerable people who are unable to speak up for themselves. (Pledge 1475/ 2014) I pledge to promote a supportive culture where NHS staff treats each other with courtesy respect and compassion and work to eradicate the bullying culture. (Pledge 2154/ 2014)
	Experimenti-ng with alternatives to traditional power dynamics		This group of codes describes the way in which participants attempted to renegotiate their traditional role boundaries by subverting the traditional ways by which they are regularly performed.	For NHS Change Day 2014 I decided to pledge to find out for myself what it is like working as a receptionist. As a GP I obviously interact with our reception staff all of the time, sometimes giving them work to do, sometimes receiving work from them. I hear from them how difficult a job it can be, and how challenging the patients can sometimes be with them. I wanted to try things out for myself. (Story

				49/100 ‘Stories of Change’)
		Taking a day of action in someone else’s capacity	This group of codes describes how NHSCD participants utilised the NHSCD 'occupying a day' platform in order to take a day in which they could connect with other NHS employees and patients by experiencing the world in someone else's capacity.	For NHS Change Day 2014, St George’s University Hospitals NHS Foundation Trust pledged to shadow – and be shadowed by – a member of staff from a different department. They called this, ‘the staff swap shop.’ Over 200 people from across the organisation joined this action. […] Sarah and Carolyn reflected on what they had learned about their experience last year. Sarah tends to work with patients who have been in the hospital for over 28 days and Carolyn spends most of her time with patients who are not conscious. The swap shop allowed both Carolyn and Sarah to see more of the patient journey and recognise the holistic care that is provided in the Trust. (Story 15/100 ‘Stories of Change’)
		Opening up to new people, regardless of status/ professional roles.	This group of codes describes how participants opened up to new people and reflected on the boundaries of their roles in relation to other members of the NHS, as well as patients.	I pledge to spend time with people I haven't work with before, in new and different areas that I haven't experienced and to listen and learn from their day to day experiences to help improve my ability to do my Job and benefit the NHS and the people it serves. (Pledge 365/ 2014) To open up access to supervision for all not just clinical colleagues (Pledge 734/ 2014) To celebrate International Nurses Day 2017 Liverpool CCGs General Practice Nursing Leadership Team pledge to organise an RCT for all nurses working across the city’s 93 GP practices. There is so much good work going on in general practice and innovative ideas just waiting to be shared. Our plan is to connect, get general practice nurses talking, discover, understand, and learn from each other! (Pledge 382/ 2016)

Appendix 7.4.2 Codebook 6: Collective Action Frames (Narrative Analysis)

Narrative Analysis					
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Code**	**Description**	**Example**
The 'Local Leadership' Frame	Character-Agent	The NHSCD Leader	NHS IQ and the Core Leadership Team	This code identifies the team, which initiated Change Day and was responsible for the coordination of the social movement.	It started when a small group of us got behind an idea to "make a pledge, a commitment, to do something better, to improve patient care". We asked others around us to join our mission. To take the opportunity to come together and empower each other to make the difference we wanted to see for our patients and show everyone what a brilliant thing our NHS is. (Jones, 2014)
			Who are the Hubbies?	This code describes the identity and role of the Hubbies within the movement: these are volunteers who were designated to be regional champions of the movement, encouraging other practitioners to participate, and raising awareness on a regional scale.	About five, seven years ago the NHS was split into certain regions – I think 13 – and the Hubbies, or the Hub Regional Leads, have been split up according to that old NHS structure – so you've got the north-west, central and all the other demarcations of Great Britain. And so Hubbies are Change Day regional champions of each of these regions who will then lead the actual getting people to pledge, lead talking to the hospitals and organisations, and they're all generally young people or emerging leaders in their fields. (Interviews, p. 11)
			Becoming a Hubbie.	This code describes the experiences of becoming a Hubbie from the point of view of participants.	I knew about Change Day last year because I saw it but I didn't really know what I wanted to pledge and I didn't actually know as much as I do now about Change Day, so I didn't realise that it was a pledge that I could change and in the job that I was in I felt like I couldn't make a change, but I've learned more about it this year through one of the other Hub leads who invited me to help and get on board. So I agreed and that's how I'm here today. (Interviews, p. 114)
			Leading with likeminded people	This code describes the importance assigned to the community created between leaders.	I guess, I read about what the concept behind it was, why it was important, what people were doing about it and thought, this is... I guess, coming newer into the NHS as well, and having all these, I want to do things differently concepts, seeing that people were trying to actively promote that. I was like, oh, this is perfect. I want to actively do things differently anyway, people are supporting that and pioneering it, so I'll get involved with that. (Interviews, p. 102)
			The need to match between roles in NHSCD and one's skills?	This code describes the different opinions concerning the need to have a particular skill-set and background (or job) in order to have roles within Change Day.	It's related in the fact that I am in contact with clinicians – it can be related in any way, can't it because Change Day is what you make it so I think every job is related to Change Day because it's about how you are able to enable change. So you can't tell me that you're in a job that you can't ever change. (Interviews, p. 113)
			Linking activism in NHSCD to wider career goals	This code describes how NHSCD participants viewed the connection between their activism in Change Day and their wider career goals.	[...] at the time I was also thinking about where my career was going to go – and when I say that I don't mean my personal career, I meant there was something I felt I needed to do and my own project – which was on sepsis, which is severe infections in children – I was trying to think about how I could make that project work – which I guess also involves a large-scale quality improvement and large-scale change in peoples' behaviour and habits, and I guess I saw parallels between Change Day and my project and I felt that Change Day would help me in my own development and to

					become more effective at doing my own project. (Interviews, p. 71)
			Conflicting understandings over what it means to have a leadership role in NHSCD	This code describes the debate over what it means to be a leader in NHSCD and the setbacks that some participants experienced.	Limitations again in maybe not understanding workloads – so with the Hubbies, they've got full time jobs [...] that it's very difficult, very difficult, to ask the Hubbies to do all they were doing, to ask them to get in touch with this, email that person, join the call – all these things - when they're doing full-time jobs. And all the Hubbies and everybody else are all at different stages as well – some are really responsive to emails, some people aren't, and so I think we're limited by not understanding everybody's capabilities and even giving some basic training as to say this is what we expect of you and this is what you should be like. (Interviews, p. 10)
			Conflicting roles between NHSCD activism and daily work	This code describes participant experiences regarding the difficulties faced when trying to balance their activism and daily work.	There is also a Hubby for universities, to tackle universities and charity organisations, but again that person is a full-time student, a medical student, so he doesn't have a great amount of time to contact every university around the country and say what are you doing for Change Day? (Interviews, p. 11)
	Theme-Purpose	Taking the Lead	Doing beyond one's day-to-day role in the NHS by joining NHSCD (expanding the way one approaches their day-to-day work)	This code describes the viewpoint expressed by participants that by joining NHSCD they were volunteering to do more than their day-to-day job allowed them or required of them.	[...] I do transformation project management within the Trust. So it's about project managing changes and new concepts and also bringing on new ideas into the organisation. So Change Day correlates with that quite closely. But I wouldn't say my role is to do Change Day within the organisation, it is an extra role that we do. But because I'm doing transformation, it kind of comes within the transformation concept. (Interviews, p. 101)
			Leadership in NHSCD as a vehicle to perform one's vision.	This code describes the experience of some participants who viewed Change Day as an avenue through which they could express their own particular visions.	I've come at it from the point of view that because I'm interested in medical education the way that I see changes is in terms of educating people. So as much as it was a decision I'd already taken to change something about my own practice I thought the most powerful way was not just to pledge that I was going to change my practice, but actually to pledge to make a resource that explains to people how and why they should change their practice... (Interviews, p. 64)
			Having a sense of contribution/ achievement/ pride through leadership	This code describes the meaning participants assigned to their leadership in NHSCD, through their gaining of a sense of contribution, achievement and pride.	But in terms of my actual pledge, like the volunteering, it might help someone in my local community, but I don't think it's a massive impact. So actually, I think I'm more proud of the original pledge, to pledge to get more involved in Change Day, which I have done by actually working for it (Interviews, p. 7)
			Comparing large-scale impact to one's contribution through leadership in NHSCD.	This code describes the participants' accounts of their leadership experience in NHSCD and how they evaluated the impact of these experiences.	I think all of us as employees of the NHS have a responsibility to try and improve it because we see what goes wrong and we see the snags the patients, the colleagues come across on a daily basis. I think if you can have the imagination to think about making it better and put a simple plan into place then that plan could have repercussions all over the country really. (Interviews, p. 52)
	Plot -Act	An Emerging Network of Leaders	Leadership in NHSCD as an evolving network.	This code describes the participants' experiences of their leadership roles within NHSCD as a way to engage with and develop their network.	If I was to do it again, because I've met so many more people, interacted with so many people, had more relationships, it would be easier to do that because I felt, rather than being able to have a lot of people which is helping out, I felt I was doing most of the running around... (Interviews, p. 29)

			Lack of clear role definition for NHSCD leadership.	This code describes the experiences of some participants regarding the ambiguity of the role definition of leadership in NHSCD.	But a lot of it has also been ad hoc, so although those are my defined roles, from time to time someone might need some help making sure an organisation gets a pledge in there, I might have to help with tweeter or with the school for health care radicals. (Interviews, p. 1)
			Being empowered by empowering others	This code describes the sense of empowerment leaders in NHSCD described as a consequence of their role in the empowerment of others.	Personally, I've found that whenever I had interaction with people that have pledged themselves, one to one interactions, it's been really rewarding to see what people have pledged and how they feel pledging, because it's really empowering for them, it's really nice to see that happening. (Interviews, p. 24-25)
			Leadership in NHSCD as an evolving learning experience.	This code describes the leadership process as an evolving learning experience described by participants both through the enactment of a pledge and through leading year after year.	[...] so it came down to a decision about do I do Change Day or do I do the leadership programme? And I felt that I would rather do something practical, something real, than do a virtual, theoretical, education programme on leadership. I felt the best way would be to get out there and do it and learn to be a leader by being a leader. (Interviews, p. 72)
			Doing beyond one's role by helping others.	This code describes the meaning participants assigned to their ability to take upon themselves a voluntary leadership role and the satisfaction that they gained from the feeling of helping others.	I pledge to provide approachable and responsive HR support to clinical services. I will ensure a positive attitude is personally maintained and I will strive to help others to see the benefits of change. I will work alongside clinical departments and managers to support staff to realise their pledges and by doing so help to ensure efficient and quality care is delivered. (Pledge 647/ 2014)
	Spectacle-Scene	A Crisis in the NHS	NHSCD as a flexible platform for the expression of leadership, and participation	This code describes participants' experiences regarding the their leadership roles within NHSCD and the comparison of those experiences with leadership roles within the NHS in general.	I think the other thing about Change Day is that, although it's a national campaign, when it trickles down at a local level it is carried out differently in every different Trust and in every different area. So although there's a concept of pledging to change […] it can be interpreted however you need to interpret it to drive change. It doesn't have to just be the literal. (Interviews, p. 93)
			Lack of support for NHSCD leaders by senior managers	This code describes the difficulties faced by some leaders within their organisations in their attempts to gain support and understanding from their managers for their activism.	He completely didn't understand it. I think if I had a manager who really understood it and valued it and read my blogs, or read what I was doing, and paid interest in it and was supportive, then I think I would have done a lot better. That was quite a big limitation. (Interviews, p. 29)
	Dialogue-Rhythm-Agency	Enacting Distributive and Inclusive Leadership	Limitations of the NHSCD leadership model.	This code describes the debate surrounding the merits and limitations of having a distributive leadership approach, such as the one embodied by the social movement.	And all the Hubbies and everybody else are all at different stages as well – some are really responsive to emails, some people aren't, and so I think we're limited by not understanding everybody's capabilities and even giving some basic training as to say this is what we expect of you and this is what you should be like. But the irony is it wants to be anyone can do it, you don't need permission, then you don't have these quality-control things in place that try and limit people and guide people …(Interviews, p. 11)
			The need for people who are full time NHSCD employees?	This code describes the debate and the conflict regarding the need to employ full-time or part-time people who would be able to devote their time to Change Day on a non-voluntary basis.	So, from January to March I've been given a day a week from my day job to support the Change Day core team. [...] It wasn't a defined day a week, it was scattered through everything that I did. It's been slightly harder to define a day a week working on Change Day because one, it interests me, two, it's the kind of thing that you can't say, well I'm going to work between eight and four just on Change Day, nothing else, and then on other days I'm not going to mention Change Day. (Interviews, p. 130)
			The need to use external professionals and sources,	This code describes the relationship between the movement and external professionals, and the debate surrounding the use of such sources.	We also have a social enterprise/private company Social Kinetics who helped with PR and I think they had PR executives or assistants who would help get in touch with Royal Colleges or organisations to get the message out as well. (Interviews, p. 12)

			sub-contractors for NHSCD?		
			The need to engage the support of senior NHS leaders in order to help the grassroots leaders	This code describes the efforts made by leaders to engage senior NHS managers to support the movement in order to assist their activism.	I didn't really like that, if an organisation really understands it, because I thought my chief exec really did, but then it would have been good if [she] actually sat down with me and said, what's important?, what do you need? (Interviews, p. 29)
			A need to improve networks and communicatio n amongst leaders/ better interaction between Hubbies	This code describes the criticism of some participants regarding the need to improve communication within the movement and foster interaction between leaders.	The other limitation is that we didn't have that many sessions together, and some of the regions are doing really good things, and it would have been good to share all that stuff earlier on. (Interviews, p. 29)
			The need to incorporate feedback from the Hubbies (give more power to the grassroots)	This code describes leaders' identification of a need to both give and incorporate feedback and their experience of the process of such an interaction.	[...] I think it's something I'm going to have to think about, and they said that we're going to have a learning session after this, and give our ideas and suggestions. Depending on how well it's taken and used, and whether or not it's implemented, is whether I'd continue to play as active a role... (Interviews, p. 28)
			Skillset to become a Hubbie?	This code describes the debate regarding who is competent to become a Hubbie.	But for me the greatest thing about the Hubbies was bringing together managers, doctors, nurses – and I don't think anyone has ever really managed to do that in a way that has been so productive. (Interviews, p. 236)
			Competition amongst Hubbies?	This code describes the emerging leadership challenges and discourse surrounding the issue of evaluation and underlining competition between Hubbies	[...] I didn't quite know what I was, kind of, getting myself into when I said that I'd help out and start doing stuff. But it became really, kind of, infections, you know, as soon as you get a response from one person who's really keen, and then another person, and then you start seeing all these little, kind of, hives of activity going on in your region, you just, you become slightly more competitive. (Interviews, p. 150)
			Popping in and out of leadership roles in NHSCD	This code describes participants' experiences of not being completely committed to leadership roles, and the amorphous nature of such voluntary roles.	So with Change Day, you can't say, I'm going to do half an hour here, and an hour here. You either do it or you don't do it. So, I was doing it all the time, so I'd be having a meeting with a midwife about reducing caesarean sections, and then I say, what do you do for Change Day? Or, I'm in a meeting my colleagues and I'd be talking about something completely different, and I'd say, how are we going to do our Change Wall? (Interviews, p. 130)
The 'Power Disruptive Activism' Frame	Character-Agent	The Activist	Participation in NHSCD as a political statement against the established hierarchy	This code describes the way in which participants felt that by joining NHSCD they would have an opportunity to affect change outside the bounds of traditional hierarchy, and how the process of joining was a political statement with various meanings - a way of protesting the	Because I was quite new to the NHS, and then you realise how hierarchical it is, and there are so many people who put so much hard work into what they do and it doesn't often get recognised. (Interviews, p. 23)

				strongly hierarchical order of the NHS.	
			Acknowledging the contribution of others as a political statement	This code describes how participants felt that it was important to acknowledge the contributions made by others (less senior staff / staff who are usually ignored), and the overarching effect that this recognition could have within the wider sphere of the NHS, amounting to an activist statement.	I will remember to say "Thank you" to the colleagues I work with for doing an exceptional job everyday (not just when they've done a superhuman one) (Pledge 375/NHSCD 2014)
			Bringing to light abilities/ skills/ experiences in NHSCD - that can't be expressed otherwise - in day-to-day job.	This code describes the way in which NHSCD allowed participants the freedom to use abilities and skills that they could not express in their day-to-day work.	[...] I work as a Project Support Manager in the Strategic Planning and Business Development Team [...] My pledge for Change Day 2014 was to start up a small singing group to visit the wards and spend time with patients. [...] I started to recruit singers from across the Trust in early September, and now have a choir of eight singers, all of whom are incredibly committed and talented individuals. The choir is currently made up of two healthcare assistants, a domestic, a librarian, a service manager, an office manager, an executive assistant and me...(Story 77/100 'Stories of Change')
			Challenging traditional role boundaries in the NHS by taking part in a non-hierarchical network of volunteers.	This code describes how the subversion of daily roles within the forum of NHSCD allowed participants to push against a hierarchical way of doing things.	[...] the 'Hubbies',[...] with roles ranging from cleaner to consultant, manager to student nurse. It is a role for which anyone can sign up. They coordinate NHS Change Day through setting up campaigns, speaking in their regions and organisations, and setting an example through taking action themselves. From actions which include the manager who spends weekends doing voluntary health care assistant shifts, to the patient who is working to improve partnership working with #HelloOURaimis, they do what they can to make a difference. [...]This work culminates in a day of change and celebration, where everyone takes an action and shares it far and wide across the country – connecting across traditional boundaries: NHS Change Day. (Story 1/100 'Stories of Change')
	Theme-Purpose	Creating A Direct Democratic Dialogue	Using NHSCD as permission to work outside traditional hierarchy.	This code describes how participants explicitly used the platform of NHSCD as a means of working beyond the confines of traditional hierarchy, quoting NHSCD as giving them the permission to overcome these boundaries.	[...] a Hubbie is encouraging people to get involved, reassuring them that there's no rules, almost being the person to give permission if people are saying, what can I do, what can't I do, and making connections between people in your path, in your area. So some people didn't know where to start, so give them ideas, thoughts. If they want to know what other trusts are doing to get some ideas, example pledges, so spread that kind of information. (Interviews, p. 328)
			Pushing against the traditional hierarchical order through actions taken as a part of participation in NHSCD.	This code describes how actions (pledges) taken for NHSCD enabled a reversal of the normal order, which allowed employees in non-senior positions to step beyond their roles.	I also pledged to stop referring people by their Band. There's quite a lot of that in the NHS so people who are… You know, he's a Band Seven Ward Manager or that's my Band Six or I want to be a Band Six OT when I'm older when I've got the experience. Everyone's referred to by their Band in the NHS and I just think it's quite demeaning in a way, that you're basically reducing someone down to their salary in fact is what it is. (Interviews, p. 248)
	Plot -Act	Subverting Traditional Role	Changing perceptions of others in the	This code describes how participants felt that being exposed to new people/people that they	I've learned a lot about me and that I'm able to enable people, I've learned a lot about not making judgements of people – so there's a consultant at my work who is very negative, very sceptical about

		Boundaries	NHS by being exposed to them through NHSCD	would regularly not be exposed to in their day-to-day work changed their perception of these people, and encouraged them to make greater efforts to reach out to others.	everything, and he was the first consultant to make a pledge. (Interviews, p. 115)
			Reflecting on patients' experience through involvement in NHSCD	This code describes how participants felt that NHSCD gave them an imaginative platform on which they could engage with the experiences of patients and visualise improvements from perspectives other than their own.	I got a cast put on for a day to understand going through the process of how we currently work with [the Clinical Fracture Team] […] I think you forget about what the impact of healthcare means from a personal level […] Are we designing it almost for somebody who is fit? For someone who is healthy? For somebody who is fully mobile? It's very easy to design this with yourself in mind as opposed to with the user in mind. (Interviews, p. 402)
			Going beyond traditional role boundaries in the NHS by working/ collaborating with other professionals through NHSCD (that one wouldn't otherwise).	This code describes the ways in which NHSCD allowed participants to collaborate with other professionals in a way that they would otherwise not have done, going beyond the confines of their usual roles and the ways in which their roles are usually performed. This is described by participants as both as an activist statement and as a learning opportunity.	The Hubbies were brilliant, I think a new way of engaging with a diverse group of professionals – so for me what it demonstrated is that professionals of different backgrounds can get together if they have a shared purpose and can work in a constructive, meaningful way that creates good dialogues and good outcomes. (Interviews, p. 236)
			Challenging traditional role boundaries in the NHS by expanding the interest in patient care to non clinicians.	This code describes how participation in NHSCD allowed a dynamic in which non-clinicians could engage with the issue of patient care in ways that were previously not available for them, and how this was described by participants as an important activist statement – e.g. the overcoming of job limitations.	[…] it was really hard for me in Finance to make a link between my work and patient care, and Change Day really helped to address that and it helped me to see that there is a link to patient care, and everyone makes a difference regardless of what role that you're in. (Interviews, p. 22)
			Feeling that NHSCD should assign more power to the grassroots	This code describes how participants felt that, at times, NHSCD failed to give adequate power to the grassroots of the movement, favouring instead more senior staff.	This is about grassroots, it should really be about grassroots, and I think that's got a bit confused. [...] I don't think I'm the only hubbie that would say that, I think there's quite a few people that would agree with that. (Interviews, p. 28)
	Spectacle-Scene	A Stagnant Hierarchy	Debating the agency of frontline staff, the possibility to empower them, be empowered.	This code describes the discourse surrounding the idea of how NHSCD could empower frontline staff to initiate changes which they would not have had the confidence to initiate within their normal power dynamics.	[...] actually what I really like about it is the fact that it's been the catalyst for, you know, in kind of having those conversations with other people who don't necessarily see change as part of their responsibility. [...] the NHS goes in and out of change in just almost constant cycles, and, I feel, like, actually what we need to be doing is that more proactive element, which is where I think Change Day is really beneficial, it, kind of, it's making everyone stop and think and say, okay, what can we do to change? What can we do to be more proactive? What can we do to engage with other staff, other patients more, that we're not currently doing, and I think that's where the value of it is... (Interviews, p. 149)

			Debating the agency of the public/patients and the ability to involve the public more in the NHS.	This code describes the discourse surrounding the agency of patients and the questions that were raised regarding how to involve them more in the future of the NHS.	And then my other pledge came through Twitter, with a conversation with a group of us with a patient. And I was saying, if you don't know what to pledge, speak to patients and see what they want improving. So a patient then tweeted me to say that she was autistic and she felt that NHS staff didn't understand autism very well. And she'd be pleased if someone would understand it better and help spread that message […] I pledge to do that. I said, well you'll have to help me with this, give me some information to understand autism better and help me spread it and together we worked. She told me her stories, shared with me. (Interviews, p. 106)
			Rethinking power dynamics between NHS staff and patients (can patients be treated differently	This code describes the discourse surrounding questions regarding the possibility of involving patients more within their own care, and discussed measures that would improve the dynamic between staff and patients.	We also invited parents and families to make pledges, and we also invited parents and families to suggest pledges, and one of them was a parent wrote up on the wall my child has been in intensive care for three months, I really wish that we could go out for a walk – and so we arrange that for them. I think things like that that we take for granted, I mean yes, there are things we need to think about in terms of safety and equipment and staffing to arrange that, but you know what – it was valuable for the family and I think it was worth it. (Interviews, p. 75)
	Dialogue-Rhythm-Agency	Enacting 'Radical' Change	Collecting, listening and implementing patients' feedback	This code describes how NHSCD created a space where participants could, or chose to, exchange, discuss, and implement the feedback given to them by patients.	So our pledge ended up being, you know, that we were going to keep patients at the heart of everything we did, and the outcome, and how we can measure we did it, we were doing it, was we would achieve this pledge by having new representatives on the steering group, by making sure that they're involved in all the major projects, and by encouraging the major providers in the area to use patients and patient feedback in their work as well. (Interviews, p. 153)
			Reflecting on one's role in relation with the roles of others by taking a day to shadow their activity/ be shadowed.	This code describes the experiences of participants who used the NHSCD platform in order to shadow other professionals in their work and better understand the work that they carried out.	And today I have pledged with X that she and I are, she's a NHS manager and I'm a NHS doctor and we have, we've been in discussion about bodying up. So we're going to do some shadowing. I'm going to go and spend the day shadowing her and seeing what a manager actually does and she's going to come, she tells me she's got a nice chair and a coffee machine and she's going to come and shadow me as an emergency department doctor and see what I do and hopefully that will be useful for us as people who by necessity work together, but perhaps don't have the best understanding of each other's roles and improve our working and therefore, improve the care that our patients can get and function of our departments. (Interviews, p. 65)
			Reflecting on one's role in relation with the roles of others by taking a day to work in their capacity.	This code describes the experiences of participants who used the NHSCD platform in order to perform somebody else's job, giving them the chance to experience work from a different perspective.	I think we've had about 20 or 22 people that took up the opportunity to go out into practice and spend a morning or a day in general practice to see what it's like, so we felt we'd used that as an opportunity around Change Day to see how receptive surgeries would be to welcome staff in and share their roles. . (Interviews, p. 217) I will work as a Health Care Assistant with our teams at least once each quarter over the next year. (Pledge 2895/2014)
			Reflecting on the condition of others (particularly patients) by making an effort to experience it for a day.	This code describes how participants used NHSCD as a way to reflect on the condition of others, particularly patients, through their commitment to take a day to experience the world through their perspectives -- (e.g. spend a day in a wheelchair to better understand mobility and visibility issues).	For NHS Change Day 2013, I used the opportunity to promote International Wheelchair Day by spending a working day in a wheelchair. What struck me about the day was how the little things which we all take for granted became so much more difficult […] getting through doors, closing toilet doors behind us, crossing a room with a cup of tea, driving a car and climbing stairs […] There was one thing, however, which I really wasn't expecting; the social isolation. (Story 50/100 'Stories of Change')

			Reflecting on one's practice by trying to better the understanding and perception of others by participating in various NHSCD activities.	This code describes the efforts participants made to improve their understandings of the perspective of others through participation in NHSCD and associated activities, and how participants expressed that these perspectives related to their day-to-day work.	[...] Being part of the hubbie network, has broadened my understanding of the different functions of the NHS and given me a greater oversight of how things within the NHS fit together, which has helped me in my current role. More importantly, having this understanding and over sight has changed my mind-set. In the past I would become frustrated if I felt things were not working as well as they could. Through the confidence that I have gained from being part of the network, I now know I have the ability to do something about it... (Story 1/100 'Stories of Change')
			Using the NHSCD platform to promote transparency in practice/being more transparent	This code describes the commitments made by participants to take an active stance regarding organisational transparency, and their subsequent experiences.	I pledge to support a culture of financial transparency - to be open re how & why financial decisions are made, & to share info on the costs of our services. (Pledge 4777/2014)
			Using the NHSCD platform to speak truth to power	This code describes how participants believed that NHSCD gave them a unique chance to question authority, make their voices heard, and even openly criticise their superiors.	I always think of an example with one healthcare assistant, or a porter in a hospital, he wanted to make the pledge that if he saw a doctor speaking into the Dictaphone in a public setting, he would tell that doctor off. Now, the reason he can do that more comfortably on Change Day is because he feels like, oh, there's hundreds of people around the world who are doing this thing as well. (Interviews, p. 3)
The 'Personal Learning Journey' Frame	Character-Agent	Frontline Participants	Anyone can participate in the movement.	This code describes the different understandings regarding the inclusivity of NHSCD.	NHS Change Day last year was cited as being a very new, or young generation led initiative - my sense is though that the people doing the pledges are a very diverse group and they're not the next generation, but they may well be an older generation – it doesn't make their pledges any more or less important or valid but it's interesting that what was once billed as a new, or young generation, type initiative... (Interviews, p. 230)
			Conflicting messages in defining NHSCD involvement.	This code describes participants' viewpoints regarding the interaction between grass-roots activists and the core leadership team in NHSCD.	They'd have this thing where they'd have this emails, the chief executive pledged, the chief exec mentioned it on his emails and news, that kind of thing, but I don't think my organisation actually understood that it was about grassroots, and I think they did it to tick a box really. (Interviews, p. 29)
	Theme-Purpose	Personal Developmen-t	Expanding one's personal network through NHSCD	This code describes how participants expanded their personal network and reflected upon it as a consequence of NHSCD.	I'm quite new to the NHS and Change Day has helped me to meet a lot of people, and it's helped me for networking and I've met some lovely people. (Interviews, p. 24)
			Sharing personal experiences with others	This code describes the commitment participants took upon themselves to share personal experiences with others in NHSCD and their reflection upon that process.	[…] I took a leap of faith and made a personal pledge to share my story of mental health services to help improve care for others. I still have not finished my work around this and I'm not sure if it will ever be complete as I have so much to say […] I built my confidence though as NHS Change Day taught me that no matter who you are, you have the right to make a change […] find the courage to stand up, talk about my personal experiences and make changes to services. (Story 84/100 'Stories of Change')
			Sharing skills with others.	This code describes participants' commitment to and experiences of sharing a variety of skills with others through the platform of NHSCD.	I've made a pledge, which was to teach more. We're both in emergency medicine positions and as you might be aware there's a little bit of crisis in emergency medicine at the moment and quite often we revert to just get on with, just, instead of teaching, instead of explaining the problem

					properly and exploring somebody's ideas and getting a message across it's very much of do this, do that, do the other to increase patient turnover as quickly as possible. So one of my pledges was to, when somebody comes to me with a question to teach on that question and to do that for at least one staff member everyday if they ask... (Interviews, p. 54)
			Learning new skills from others	This code describes participants' experiences of learning a variety of new skills from others through the platform of NHSCD.	I pledge to spend 2 days before march with different healthcare professionals and patients to learn about how our whole service works and could be improved. I pledge to take my learning back to the organisation and share. (Pledge 602/ 2014)
	Plot -Act	Changing the Everyday	Pledging as an evolving experience that reflects on day-to-day practice.	This code describes participants' experiences of their participation in NHSCD by pledging and how this pledging process became an evolving learning experience for them.	I think the pledges we made were quite simple, but they were focused on patient experience, and I think as a result of doing that, I think we were able to change the way we looked at what we did, and actually think. why haven't we got a patient participation group, which some surgeries have? And so as a result of doing the comments form and doing the meet-and-greet, we thought actually we should be engaging more widely with our patients. And I think as a result we looked at, for example, actually things like, what's our website like? What does it look like when people come to our website? And we looked at it and thought, actually, it'd dreadful. It's really hard to navigate... people don't like it, people don't use it. So we decided, right, we're going to invest in a new website. (Interviews, p. 38)
			Changing attitude to routine practices by experiencing them from a different perspective in NHSCD.	This code describes how participants expressed that their attitudes towards routine practices have changed through the process of participation and reflection in NHSCD	I know that as a manager I'm very prone to taking on projects with massive enthusiasm, and then, you know, when they're done they're done. Not, kind of, going back and seeing what lessons have been learnt and things like that. So that was more of a personal one, something that I know is a weakness in the way that I do things, and actually enables me, by pledging to, kind of, just be aware of that gap in my own work, and try and do something to counter it. (Interviews, p. 152).
			Reflecting on one's job through the attendance of NHSCD sessions.	This code describes how the attendance in NHSCD sessions triggered participants to reflect, leading them to reconsider the ways in which they performed their everyday work.	I think I've seen the attitudes [change] so far. So, I've had feedback from people who are, kind of, teams where they don't really engage with others, and, kind of, that feedback has been, you know, I now know what other people do, I know all this fantastic stuff, and actually I can take that and use some of it in my day to day work. (Interviews, p. 155).
			Reflecting on one's job through the attendance of 'School for Health and Care Radicals'.	This code describes how the attendance in the sessions of the 'School for Health Care Radicals' triggered a thinking and reflection process within participants.	I pledge to complete the healthcare radical course and then spread the learning within my Trust. (Pledge 601/2014) I pledge to discuss tactics for rocking the boat and staying in it with other radicals. (Pledge 1547/2014)
	Spectacle-Scene	Change at the Grassroots Level	Pledging to do a change that one meant to do anyway but needed a 'push'.	This code describes participants' experiences of how NHSCD encouraged them to enact changes that they were thinking about for a period of time but needed an extra boost or platform through which to perform them.	I think that people get the opportunity to make a pledge and it sparks off that initiative that's inside people, that might have been lying dormant, and then you say do you want to make a pledge and they say I've been meaning to do that – I'll pledge to do it and that's what I can do, so it's kind of the rocket up the bottom that people sometimes need, really. (Interviews, p. 114).

			Interacting with new people through NHSCD.	This code describes how the interaction with new people outside of the day-to-day working routine initiated a process of change in the way participants continued to interact in their day-to-day jobs.	I pledge to spend time with people I haven't work with before, in new and different areas that I haven't experienced and to listen and learn from their day to day experiences to help improve my ability to do my Job and benefit the NHS and the people it serves. (Pledge 365/2014)
	Dialogue-Rhythm-Agency	Enacting Change in Daily Practices	Making an effort to reduce costs in day-to-day practice.	This code describes the efforts made by participants to enact changes, which would reduce expenses on a day-to-day basis.	In the current climate where money is short and time is squeezed these twelve members of staff work at the coal-face to deliver high quality service in a timely and efficient manner. (Story 5/100 'Stories of Change')
			Making an effort to work in a more sustainable manner.	This code describes the efforts made by participants to enact changes, which would result in a more sustainable working practice.	I pledge to work with the other teams in the department to improve working practices and reduce duplication of work. (Pledge 816/2014)
			Fundraising	This code describes participants' engagement with the process of fundraising for a variety of causes through the overarching platform of NHSCD.	I pledge to undertake a fundraising challenge later this year for the Alzheimer's Society. (Pledge 5185/2014)
			Having a more positive attitude to work, improving morale, taking more pride.	This code describes how participants expressed a commitment to making an effort to pay more attention to the maintaining of a positive attitude in their day-to-day work.	I pledge to always remain positive and continue to focus on service improvements that benefit all - staff & patients - despite the challenges that I encounter. (Pledge 2826/2014)
			Expressing gratitude to other staff members	This code describes participants' commitment to the appreciation of the efforts of others in their work.	I pledge to say thank you and well done to all members of my team on a daily basis, encouraging them to be proud of what they do. (Pledge 653/2014)
			Improving attitude towards teamwork	This code describes participants' commitment to improving attitudes towards teamwork.	I pledge to help NHS England Colleagues to be agile workers: so they are adept at team working and collaboration, and more effective when mobile. Listen to the needs of Colleagues, helping them to be increasingly comfortable with their ICT, assisting them in building confidence and competence in the use of the tools and services now at their disposal. Help identify and support workplace ICT expert users, assisting them to provide ongoing local support. (Pledge 570/2014)
			Be a role model to others.	This code describes participants' commitment to making an effort to work in an exemplary manner, in order to act as role models to others.	I pledge to always take time to listen to my patients. To treat them in the way that they wish to be treated. I pledge to role model this and inspire others to be as passionate about the care they deliver as I am. (Pledge 410/2014)
			Having a sense of contribution in 'small wins'	This code describes the commitment that participants took upon themselves to pay attention to the 'small wins' and to examine the ways in which these constituted progress within their goals, rather than ignore them.	For me NHS Change Day represents what I truly believe: that we can all make a change, no matter how small. When joined together with all the other small changes others make it can lead to better care for patients and better working for staff. I personally cannot facilitate large-scale change but I can make small changes that have an impact on those that matter most, those that I care for. (Story 35/100 'Stories of Change')
			Improving communicatio n with patients	This code describes the commitment that participants took upon themselves, and the	My first pledge was that I wanted to spend extra time with my patients and try to listen to them more. And then I was asking them questions I wouldn't normally ask, like how can I... how are

				associated experiences they had, to improve communication between staff, patients, patients' families, etc.	you feeling, rather than how's your pain? […] spending a bit more time asking patients different questions, and thinking more - and listening more - about what I was asking rather than asking a blanket list or a check-list of questions we go through every day - delving a bit deeper into our patients.[...] it is really important to me because sometimes I feel that when we're on placement we're really rushed and we stick to a regimen of things. So we'll, say, walk into a patient's room and ask eight questions, and each of those questions are pre-defined – so, are you in pain? Do you want a drink? Do you want food? that's not how I want to help my patients, that's not how I act as a normal person outside a hospital, so why should I change that when I've got a uniform on? So it's really important to me to think about how I could do that differently, because it's just that when people just do what's just normal everyday practice... (Interviews, p. 168).
			Smile more	This code describes a particular measure introduced by participants in order to improve communication and morale, through the pledge to 'smile more'.	My pledge was very simple last year, it was just to smile and say good morning to people when I go into work. Which I stuck to pretty much all year. […] I say good morning every day when I get into work. I say good morning to everybody in the office, everybody I pass on the stairs, and 90% of people say good morning as well, back. […] a lot more people smile and say good morning now, or at least to me. So you reciprocate the good morning and smile back. Sometimes, at first, people would just nod their head, or shake, or something, but now they expect it when I come towards them. They're like, morning 'X'. (Interviews, p. 102-103).
			Overcome the fear of change	This code describes participants' experiences of overcoming their fears of change through their participation in NHSCD.	It would be good to do that, but overall I think it's a great start to making change and I think change is something that a lot of people are scared of, and it's something that puts a lot of people off, but I think Change Day helps people to see that change is sometimes positive as well. (Interviews, p. 26)
			Engaging in personal volunteering	This code describes participants' commitment to engage in personal volunteering within both the context of their daily work and outside the context of their daily work, in order to help the wider goal of the NHS.	I pledge to use my free time (if possible one weekend a month) to volunteer where possible to work with and help elderly patients who may have to be in hospital especially over the Christmas period. (Pledge 422/2014)
			Taking care of one's own health/lifestyle /family/ community.	This code describes commitments that participants took upon themselves to lead a healthier lifestyle and to contribute to a healthier way of life within their community, expressing their belief that prevention is better than cure.	[…] my pledge was to lead a healthier lifestyle, and encourage others in the NHS to lead a healthier lifestyle, which is already in practice […] At my hospital we have a huge tower block. […] At the bottom of the lift […] I've got a sign that says, 'Think about your heart: take the steps, take the stairs!' And then, inside the life there's a sign that says, 'Did you know stair climbing is one of the best ways to burn calories?! You've decided to take the lift, why don't you get out a floor early?' […] A lot of people laugh. A lot of people, I think, have now started to think about it and take the lift to the floor below. (Interviews, p. 106)

Appendix 7.4.3 Codebook 7: Collective Action Frames (Frame Analysis)

Frame Analysis (Thematic)					
Aggregate Dimensions	**2nd Order Themes**	**1st Order Concepts**	**Code**	**Description**	**Example**
The 'Local Leadership' Frame	Diagnostic Framing	Failure of senior management to address organisation-wide crisis		This group of code describes how participants believed that senior management had failed to address an organisation wide crisis. Participants concentrated on the problems associated with the Francis report as symptomatic of greater issues within the NHS, and described their conviction that such problems could only be dealt with through a radically different approach to organisational change.	The reason Change Day is important to the NHS is because we need different methods of change – top-down, structural, hierarchical change will get us so far...(Interviews, p. 128) And also there's a lot of stuff coming out in the news about safety and patient care – customers can now choose their hospitals, they can feed back in real time to hospitals now, so if we're not understanding and improving the patient journey then we're failing ourselves and as a trust we're making a mistake really. It's almost like you're a private organisation, you don't want to ruin your brand. ...(Interviews, p. 118) For me, and I don't think everyone connects Francis to Change Day, what happened is because people were not compassionate, but the nurses and staff who join, they don't start by being a nurse or a doctor, not to be compassionate and not wanting to try. They do it because they are weighed down by targets, they are pushed around, they are bullied. […] People say Francis is one sign of a lot of poison in the NHS. I don't know if I believe that, I haven't experienced it in my organisations, but Francis shows why people need to have the confidence in their colleagues to remain inspiring and to bounce off people, and Change Day gives people the opportunity to do that together. […] I sometimes think with these enquiries, they make so many recommendations but things don't tangibly happen...(Interviews, p. 360)
			Change is lectured to staff	This code contains participant' descriptions of the way in which top-down change was seen as being lectured to staff-members, depriving them of agency. Participants wanted both to contribute to and to see their expertise and lived experience reflected in such change initiatives.	[…] I'm on a centrally run programme, the Leadership and Management programme run by the Leadership Academy and we get loads of lectures. We get taught lots of things and you have to do it. […] I do see the value in it but I was asked to do it and also we don't set the agenda, we don't decide what we want to study. They decide everything. […] We've had whole days where it's presentation after presentation and not a lot of discussion…(Interviews, p. 337) We're both in emergency medicine positions and as you might be aware there's a little bit of crisis in emergency medicine at the moment and quite often we revert to just get on with, just, instead of teaching, instead of explaining the problem properly and exploring somebody's ideas and getting a message across it's very much of do this, do that, do the other to increase patient turnover as quickly as possible…(Interviews, p. 54)
			Senior management design change	This code describes the way in which senior management designed top-down change programs that failed to adequately reflect the lived experience of staff members. Participants saw this as representative of an authoritarian style of governance within the institution.	I think I was quite sceptical about it, because it was a huge top-down reorganisation – a big change in the NHS, again. All about structures and all about changing the way organisations work together. And I think people just felt frustrated and unable to engage with it. …(Interviews, p. 34) I think there's been a history of top-down, authoritarian management in the NHS and now we've realised actually we need networks, we need influences, and we need to be able to believe in ourselves, and that's what NHS Change Day does…(Interviews, p. 117) I think from an NHS perspective where we're at

					athe moment is people are talking very much about, we need to do something transformational. In my book transformational is changing something on a scale to an extent that hasn't been done before, that hasn't been achieved before, that really breaks the mould of what it is. You can't do transformational change in a transactional framework …(Interviews, p. 398)
	Prognostic Framing	Creating platforms for the sharing and adaptation of knowledge		This group of codes describes the way in which NHSCD was seen as creating new platforms for the sharing and adaptation of knowledge, something that was seen as critical to the project of wider change.	#MatExp is a powerful grassroots campaign using the Whose Shoes? ® approach to identify and share best practice across the nation's maternity services. #MatExp is one of the camp It has been wonderful to see mixed groups gathered around a board game in a relaxed environment, with cake and babies. The board games are used to trigger discussions that share good practice and explore challenging and often sensitive issues to see how things can improve. aigns that NHS Change Day is supporting this year. (Story 21/100 'Stories of Change')
			Knowledge is debated and discussed with staff	This code describes how, in the alternative envisioned by the NHSCD movement, knowledge would be debated and discussed with staff, with change initiatives reflecting the expertise of the grassroots.	The success of the project in London was due to many factors. As project manager, I took the opportunity to visit the stroke units and explain the project face to face with staff working on the units […] This helped to build rapport, create relationships and gave teams the forum to have critical discussions about previous and current evidence for DVT prevention in stroke patients. As the project progressed I was able to build a knowledge base on the practicalities of using IPC sleeves in a clinical setting and shared this with the stroke units. Visiting the units, it was clear that there was a very clear desire to talk, share and network with stroke colleagues, so I am setting up a Stroke Nursing Forum with support of the SCN to discuss clinical outcomes and best practice, across the whole stroke pathway. (Story 9/100 'Stories of Change')
			Top-down planning is adapted to fit local conditions	This code describes how NHSCD allowed for the adaptation of top-down planning to reflect the needs of specific local contexts, encouraging a mood of experimentation that was seen as a key element of positive and lasting organisational change by participants.	I think the other thing about Change Day is that, although it's a national campaign, when it trickles down at a local level it is carried out differently in every different Trust and in every different area. So although there's a concept of pledging to change, some organisations use the trees to show... or some organisations use it to share learning, some people embed it in their hospital values. So it can be interpreted however you need to interpret it to drive change. It doesn't have to just be the literal. (Interviews, p. 93)
	Motivational Framing	Empowerme -nt		This group of codes describes the way in which the empowerment of staff and patients was seen as being central to the aims of the movement, and how this sense of empowerment was a motivating factor behind participant in the movement.	I think about Joanne and I think about how she felt empowered, and how felt for me to be empowering, to empower someone else. That's Change Day for me really, it's emotional and it's about making a difference to people, and valuing the difference that people are making because people do so much and it's important to recognise it. (Interviews, p. 30) I pledge to empower the team to have new ideas and to try them out. I will set up a pledge box and each month we will celebrate the exciting things achieved (Pledge 343/2014) 1577: We pledge to empower our staff, so they feel able to get on with making improvements for patients without needing to seek permission (Pledge 1577/2014) 5925: To continue to empower women to be confident in making birth choices suited to themselves and their family. Because she can do it. (Pledge 5925/2014) 6333: To empower others to take good care of themselves (and do the same myself). (Pledge 6333/2014)
			Flexibility in goal setting	This code describes how the flexibility in goal setting allowed by the movement's device of	Lego, the bricks. Because I think at the end of the day there's two ways that you can progress forwards and they kind of in some ways are polar opposites. One is mobilisation. The other is quite

				pledging was seen as motivating participants. Change was seen instead as a gradual, co-constructed process, capable of reacting and adapting itself to a changing organisational climate.	formal, discipline, programme structure and I think there is a healthy middle ground where you can try and put a framework around mobilisation to make sure that actions are done and pace can happen, but the more rigour you put into it, the more you squeeze the life out of the theory of mobilisation. Now, the picture I've got in my mind is Lego. […] you have to release that energy, release the passion, but associated with that is a risk of, the answer might not be the answer that we want to get, but it will be markedly different and I think that's the conundrum at the moment. So Lego is the answer to everything. (Interviews, p. 397) This is how I see it: you have a stage, you've got props on the stage, you've got an actor, the leading lady, the leading man, or whatever, but actually all the stuff, how the story unfolds, to me... and that's how I think about it, and I think about it in this way as well. I don't think about it in that you do this, then you do that, then you do that. […] We're doing a debrief at the moment, and it's like, are we... because of course you need to get organised, and I'm quite a controlling person naturally, but I think when I hear myself speaking... at work, people... maybe that's not relevant, but I like to be organised, but I don't mind the organisation being a little bit chaotic. I don't mind chaos. (Interviews, p. 276-7)
			Collective identity/ Belonging	This code describes how the NHSCD movement was seen as creating a sense of collective identity and belonging. Participants described the camaraderie created by group initiatives and the following that these attracted on social media.	It's not long until NHS Change Day on 11 March, and the Living Longer Lives team have set themselves a big challenge: to travel the equivalent of Berwick upon Tweed to Land's End under their own steam. […] For the team this is the start (or continuation) of an ongoing commitment to stay healthy, and they all plan to have fun along the way too. You can track their progress by following #LLL550 on Twitter. (Story 2/100 'Stories of Change')
	Contested practices	Conflicting understandings over the meaning/ limitations of distributed leadership		This group of codes describes the conflicting understandings that arose around the idea of distributed leadership. The ambiguity of Change Day, and the fact that it could mean different things to different people, when combined with the perceived looseness of this leadership model, was seen by participants as a possible weakness. They emphasised the necessity of both a clear message and of combining this experimental leadership model with elements derived from the traditional hierarchy, describing the inherent tensions between the two.	[...] we really need to think about what Change Day is aiming to do, what is our strategy for Change Day, so that we have a clear, coherent message that we can sell to others in Change Day. Because Change Day is proving to be lots of different things to different people and we may want it to continue like that, but that's a message in its own right... (Interviews, p. 242) I think personally distributed leadership is good in theory, but I still think you need a hybrid of the two, I think you need a focal point – someone to say yes or no, particularly with the NHS where you've got the rules about procurement and if you want to raise a purchase order to get stuff you need to get three different quotes, and all these other things about logistics – it's very difficult to have a distributed leadership model in a structure and an organisation that is just built for the hierarchical structures. (Interviews, p. 10) I think this year the tension between keeping it a grass-roots movement and doing big, broad communication around it – I think was much, much more inherent.[…]And we have to resolve it because in a sense we have to try and make it both, we have to keep the grass-roots nature of it but we have to find ways of connecting – there's inherent tension between doing things in a very organised, professional way and being grass-roots and front-line… (Interviews, p. 125)

			Coping with top- down pressures of evaluation	This code describes participants attempts to cope with the pressure of top-down evaluation, which was seen as being an inherent part of the organisational culture that participants replicated on an internal level, when confronted with the unquantifiable elements of NHSCD, tasked with recording a change that could not easily be measured with reference to traditional evaluative markers.	I don't like the numbers, the target numbers, I absolutely hate it because I don't think it should be about numbers. It's good, obviously, to have something to aim for, so, you know how well you could do with your region, but I feel it really does question the authenticity of it. (Interviews, p. 25) I think it's more of a mind-set shift. I think it's about... I think there is much more of an acceptance now about the fact that we need to be looking at what we're delivering in terms of patient experience... going back to basics like care and values and why people join the NHS. And I think it's been... I think it has made a bit of a shift in terms of those sort of things. Has it made productivity gains? Can we show any financial benefit of NHS Change Day? Hard to say. (Interviews, p. 39) I think one of the… You see one of the things that I think's a limitation and a strength is the fact that it's really quite, it's got its roots in a really, kind of, idealistic place. And I love that, I think that's a strength. But, to other people who are very pragmatic, and very logical, that's a limitation. So I think showing outcomes of Change Day, being able to say to those, kind of, you know, what has Change Day actually done? Actually being able to say, okay, it's done this, it's done this, it's done this I think that's definitely a challenge. (Interviews, p. 161) Often it's based on what people feel, and because we're not trying to change legislation or trying to do equal rights or equal pay or whatever... and what we're trying to do is improve patient care, I think it has its limitations in really showing that in a hard evidence way, because the pledges are too diverse. (Interviews, p. 295) […] it's understanding what impact, at a micro level, it's going to have, and how we try and capture that to demonstrate that there are limitations there of reaching people, but really, truly understanding what impact it's had, I don't… at a micro level. Because of the scale of it, and the limited results, we might have to try and evaluate its impact – that that's our limitation. (Interviews, p. 391)
			Difficulties in communicatio n amongst leaders and activists' networks	This code describes the communication difficulties that arose between movement leaders and activist networks. Due to both the informal nature of NHSCD and the limitation of the event to a single calendar day, communicating ideas across a wide geographical area was seen as being difficult.	I feel it would have been good to meet up a bit earlier, that way we could share ideas and actually implement them. Do you know that session that we had in London? I feel that could have been a bit different, to make it more engaging, because I think everyone worked in their little groups, and within your group you got ideas and things, and then they were shared with everybody, but you didn't really share it, we didn't really share it into as much detail. […] Another limitation for me is networks, because I didn't really have any networks when starting with Change Day because I was completely new to the NHS, because I joined in September. […] (Interviews, p. 29)
The 'Power Disruptive Activism' Frame	Diagnostic Framing	A fragmented institution: exclusion and a non-communicati ve power structure		This group of codes describes participants' beliefs that there were deep structural problems in the present structure of the NHS. They describe a fragmentary institution, with little communication between departments, endemic bullying, internal political manoeuvring and a rigid institutional hierarchy.	I identified that there was a need to address endemic bullying in the NHS, so I created a collection of research and information on how we could tackle bullying within the NHS. I researched best practice, sources of help and support and I collated case studies. […] My mentees, The NHS Leadership Academy Mary Seacole Programme and The Francis Inquiries influenced me to make this change. The mentees have survived intolerable pressures, and so I asked them whether I could share their stories anonymously. (Story 8/100 'Stories of Change') I think there are a lot of nurses who think we are a kind of a target. When I say target, I think wherever you want to look for something that has

					gone wrong, blame the people who are most involved, and the people who are most involved are nurses, so you'll say, oh, okay, well, this medical error happened... well, how could it happen? There were nurses there for 12 hours on shift. But then they forget about the others, like politics in nursing, and again, the nurse/doctor hierarchy and that kind of thing. But I think it's easiest to blame the people who are there constantly, nurses. (Interviews, p. 178) I pledge to reduce the notion of hierarchy in the NHS by not referring to colleagues by their job band. (Pledge 3200/2014)
			Grassroots ideas are blocked	This group code describes the way in which grassroots ideas were seen as being blocked or ignored by higher levels of management. NHSCD was seen as means of highlighting the possible contribution of such ideas.	I think one of the things I could pick up straight away is probably that junior members have ideas that are simple go ahead and dos but for some reason there not being done and I wonder whether there not being done because, like any organisation to get things done you have to have a certain amount of clearance, a certain amount of buy-in from other provisions and some things have to go through certain channels and it's wondering if that causes us the blockages. (Interviews, p. 200) […] NHS Change Day is seen by many as a powerful way of promoting the message that 'change starts with me' and of getting rid of the deeply entrenched sense that many staff share that they do not have permission to make change. (Story 83/100 'Stories of Change')
			Unequal knowledge distribution: various professions/ hierarchical levels	This group of code describes what participants perceived as an unequal distribution of knowledge throughout the organisation, giving examples of pledges made that focused on combatting this through the sharing of knowledge.	to make sure that the nurses and healthcare staff working along side me are aware of pressure ulcer awareness and prevention . I also will make sure staff have the knowledge to conduct risk assessments effectively whilst using clinical judgement also. (Pledge 54/2014) We are going to bring together the healthcare sector within Interservice. Interservice design and build healthcare facilities, provide facilities management to support NHS care & deliver long term complex care. We will bring these teams together for the benefit of healthcare. We held a healthcare café in 10 locations across England for Interserve health colleagues. Sharing knowledge across construction. Facilities management and healthcare in our organisation. (Pledge 650/2016)
	Prognostic Framing	Legitimising grassroots change initiatives through inter- level dialogue		This group of codes describes the aim of the NHSCD participants to legitimise grassroots change initiatives through inter-level dialogue, encouraging all levels of the institution to listen to each other.	At Barts Health NHS Trust we get really excited about NHS Change Day because we have another opportunity to encourage and support our staff to make changes for the better, to contribute to more of us having a good experience at work. For NHS Change Day 2014 we pledged that 'when our staff speak, we are going to do our very best to listen and we will respond to the benefit of colleagues, our community and, most of all, to enhance care for our patients…. (Story 43/100 'Stories of Change')
			Grassroots ideas are being legitimised and implemented	This code describes the legitimisation and implementation of grassroots ideas that was seen as taking place through the framework created by the NHSCD movement. This reflected the movement's core belief, that small changes from the grassroots could add up to a very big difference in organisational functioning, improving the NHS as a whole.	As a student nurse, I felt uneasy about suggesting this change, but my support from my mentor encouraged me to do so. My manager also agreed with the change I suggested. […] As well as this, my manager communicated this change to all staff and recognized my input. […] Although I consider this a small change I am very proud that my suggestion has been implemented in the clinical setting that I am learning in. It has been very important for me to be supported in this by both my Mentor and Manager who have allowed me to action this and shown support and encouragement but have also recognized my efforts. (Story 22/100 'Stories of Change') Small ideas can start out as seeming impossible, but if we dare to dream, believe in ourselves, work together as teams and put patients' needs first anything is possible. That is what NHS Change

					Day is all about. (Story 35/100 'Stories of Change')
			Transparency is encouraged, grassroots can speak truth to power'	This code describes how the NHSCD movement encouraged organisational transparency, promoting the belief that the grassroots could 'speak truth to power'. Initiatives such as the creation of a confidential and anonymous space in which staff members could share their issues, concerns and fears were seen as being integral to a more fair, transparent NHS.	My name is Ashley Brooks, NHS Patient Champion, and I am very proud of what I have created. The Guardian Service is a service, a place and a space where any and all NHS staff and volunteers can come to a completely safe, confidential and anonymous environment, to discuss their issues, concerns and fears. Patient safety, staff bullying and harassment, incivility and disrespect, human resource problems, anything and everything have been bought to the attention of The Guardian Service. […] Whistle blowing is historically harmful and staff of the NHS are mindful of this. Fear of reprisal, damage to career and loss of job are the most common reasons staff prefer to use The Guardian Service over more formal alternatives. Face to face is the best way to gain trust and delve deeper into situations. Staff can be fearful of email, digital copies, a trail. Old fashion talking, listening and paper are trusted. They own this, they are the courageous ones. Staff feel at ease and conversation sparks in all directions. (Story 13/100 'Stories of Change') I think it was interesting that it was talked about this week – one of the pledges from Queen's Hospital last year was around developing an anonymous safety reporting panel and they were able to demonstrate that the staff confidence in reporting safety issues had doubled afterwards, so I think we need to show more stories like that. But I think there are also dozens of other great stories from Change Day. (Interviews, p. 75)
	Motivational Framing	Inclusion		This code describes how the NHSCD movement promoted the value of inclusion, giving the example of a change initiative that aimed to reduce stigma surrounding mental illness.	https://www.youtube.com/watch?v=dPN4y8WJU9I People with mental health problems who use NHS services describe being treated with disrespect, or as a nuisance, both when presenting in an emergency and during more routine intervention and they describe how their symptoms can be down played or even ignored by NHS staff. […] Here, writer and mental health campaigner Lisa Rodrigues shares her own personal mental health story and tells us why it is Time to Change, to get NHS staff to consider their own attitudes to mental illness, and to ask NHS staff who have experienced mental illness and who are willing to do so, to speak about their experiences, thus reducing the sense of 'them' and 'us'. (Story 25/100 'Stories of Change')
			Experimentation with new ideas	This code describes the movement's commitment to experimenting with new ideas, encouraging a creative and organic approach to organisational change.	You don't need permission from your boss or colleagues to take action, you don't even have to work for the NHS. If you care, if you have an idea you think could help make the NHS or social care a little bit better – or a great deal better – for one day or every day, you can take action. (Story 66/100 'Stories of Change') But for them, they're just having a conversation, they're just sharing ideas and saying this could happen, that could happen, and I suppose it is like you say, that that's how things happen in organisations, that actually a hierarchy is created, and then somebody hears an idea, and then somebody says, I think we ought to make something of this. I think we ought to have this as a policy or whatever. So it happens in that way or they just get on and just do what they're doing at a local level, and that's what I prefer. I'd much prefer people just get on. (Interviews, p. 284)
			Communicatio-n	This code describes pledges in the NHSCD event that sought to improve communication throughout the organisation, helping to	Adam Bojelian is a 14 year old boy with cerebral palsy, who has been in and out of hospital for most of his life. Adam has experienced the best and the worst of the NHS and has been an active commentator on the healthcare service – often sharing his own experiences on Twitter. Adam first

				include marginalised groups and to create change initiatives that reflected their experience of the NHS.	heard about NHS Change Day via twitter, as he follows and interacts with a lot of NHS professionals who were engaging in conversations about pledging. [..] Adam was motivated to join in with this social movement and pledged: "to help ensure children with disabilities receive the best possible care," as he is passionate about encouraging NHS staff to understand his life and that of other disabled children; hoping that an increased awareness will result in improved care. (Story 82/100 'Stories of Change')
	Contested practices	The need to keep NHSCD grassroots (not 'taken over' by management		This group of codes describes pledges in the NHSCD event that sought to improve communication throughout the organisation, helping to include marginalised groups and to create change initiatives that reflected their experience of the NHS.	I think remaining a grass-roots social movement and not being taken over [...] I think is a big challenge. Being very, very well-organised so that we get the balance right between it being grass-roots and relational and getting all the transactional aspects of it right that are necessary. (Interviews, p. 127) Some have questioned the face value of some of the individual pledges made and questioned whether whole organisations signing pledges, as has happened in some cases, is in keeping with the fundamental message. (Story 83/100 'Stories of Change')
			Lack of support for NHSCD activists by their managers	This code describes what was perceived by participants as a lack of support for NHSCD and its goals from their managers. This was sometimes attributed to the movement's failure to give out a clear and coherent message.	Cynicism – because sometimes I don't think our messages are clear, I think even within the group it's becoming obvious that the value and the vision for Change Day are slightly different – not that that's a bad thing, but my personal beliefs in what Change Day can do are slightly different, maybe, from some of the other core leadership team. So I think we need to be really clear about where we want Change Day to go so that we can respond to some of the sceptics in a coherent fashion. (Interviews, p. 240) How to engage these middle management that they don't support change and they are a bit resistant and they block a bit of things. As I always say, I see that not as an obstacle but a challenge you try to jump, but this year I didn't have any more energy. (Interviews, p. 310)
			Resistance to NHSCD by individuals and/or professional groups	This code describes what was perceived as resistance to NHSCD from both individuals and professional groups. Participants describe the problems they experienced when attempting to communicate the central messages of the movement when promoting it in wider circles.	I work in headquarters, and with admin staff generally, it's quite difficult to promote it. Towards the end they finally got around to the idea and did start making a pledge or two. (Interviews, p. 24) The only limitations really are policy, communications teams, people who don't understand the concept. I suppose it's frontline having too much power… or the Comms teams and the gatekeepers of the organisation feeling that the people in the frontline have too much power and they don't really understand it themselves. […] people who act as blockers; the people who are always saying, well, that's how we've always done it, we need permission to do this, there isn't a policy written for that. So they're the people who are limiting things. (Interviews, p. 258)
The 'Personal Learning Journey' Frame	Diagnostic Framing	Failure of change initiatives to reflect and adapt to changing circumstance -s		This group of codes describes participants' belief that the top-down planned change initiatives from the upper levels of management failed to adequately reflect the real conditions of work on the ground and were incapable of adapting to changing circumstances.	Ripley Minor Injuries Unit pledge to be flexible & adaptable to develop and change our service to meet the needs of our local population in line with DCHS plans. (Pledge 4194/2014)

			One size fits all	This group code describes participants' belief that top-down change initiatives had a 'one size fits all' approach that did not reflect the organisational reality. Participants hoped to combat this through pledges that promised to respect the diversity of experience within the NHS.	To remember that everyone is different and 'one size does not fit all'. (Pledge 4952/ 2014)
			Disconnect between formal knowledge and reality on the ground	This code describes what participants perceived as a disconnect between formal knowledge and reality on the ground, expressed via top-down initiatives that failed to adequately engage with frontline experience and were subsequently unsuccessful.	Certainly I've seen a lot of initiatives that have been sent down from the hierarchy without proper engagement with people on the shop floor, and they fail – they just don't work because people can't relate to the reasons why it's needed to be done. ...(Interviews, p. 73)
	Prognostic Framing	Personalisin-g change to reflect a wide range of experiences and contexts		This group of codes describes the NHSCD movement's efforts to personalise change to reflect a wide range of individual experiences and organisational contexts, reflecting the diversity of experience within the NHS.	Cook, consultant, junior doctor, social worker, matron, patient or medical secretary, whether you work in the NHS or social care, volunteer, or simply want to see an improvement or say thanks, you can act now to do something better together. (Story 66/100 'Stories of Change')
			Personalising change programs and sharing ideas	This code describes how the personalising of change programs was complimented by the sharing of ideas. This was seen as strengthening change initiatives.	I like it because the more you share the more powerful it becomes. And the change, you can achieve a lot bigger change if you share it. One thing I love about Change Day is there are all these ideas, but before, they were not connected. They were individual and they were in a very small team, and suddenly, with the excuse of Change Day, you just put it somewhere where other people can see it. […] Suddenly, an idea or a problem that was very localised, suddenly it has a lot of people behind it. I always say the more the people are behind an idea, the better it will become, because you get feedback and you reach each other with different ideas that, if you put together, it's like a puzzle that at the end will lock and unlock a fabulous thing. (Interviews, p. 308)
			The point of view of the 'other' is incorporated	This code describes the importance placed by the NHSCD movement on the inclusion of the point of view of the 'other'. This was seen as a way of expanding understanding throughout the NHS and thus creating a better working environment.	The Paired Learning campaign would like people to pair up with someone who works in a different profession to them but who they want to learn more about, to enable better partnerships in the future. This could be between a doctor and a Physio, a hospital manager and a community services provider, a commissioner and a GP trainee, or just about any other combination one might think of. By getting to know each other through paired learning, you can learn so much more about each other's roles, values, challenges and barriers and therefore make a difference for the future. (Story 20/100 'Stories of Change')
	Motivational Framing	Innovation		This group of codes describes how innovation was seen as being a central value within the NHSCD movement.	My little change just impacted on a larger scale. It doesn't stop there though – without realising, I've not just changed our collective worlds. As a by-product I've actually inspired people! Yes people have seen the change in my world and think "It's a great idea". Then crikey: they're all at it now! There's fancy, colourful and creative artwork hanging everywhere! In my opinion our worlds are better just through making that one little change. (Story 63/100 'Stories of Change')

			Tolerance towards mistakes	This code describes how the NHSCD movement encouraged tolerance towards mistake, believing this to be essential to the promotion of change. This was seen by participants as a motivating factor behind participation.	If I was to advise somebody who had an idea and wanted to take it further. It would be to just do it. Let the negative comments drive you forward and your mistakes guide you to your success. (Story 64/100 'Stories of Change')
			Personal and group development	This code describes how participants saw the NHSCD movement as an opportunity for both personal and group development.	Most of the hub leaders are very junior members of staff in the NHS, and the local physicians, and this gives them an exposure to loads of trusts in their regions and loads of things that are going on. So I think it's good for their personal development as well. (Interviews, p. 355)
	Contested practices	Limitations to continuous learning processes		This group of codes describes how participants perceived limitations to the continuous learning process promoted by the NHSCD movement, questioning whether the act of pledging could really lead to sustained and tangible change.	Inspire, yes. But, I think, the real, kind of, key to sustainable change, through Change Day would be having that evidence of whether or not people have actually done those things, and they've used that and learnt from that. I think, what Change Day has managed to do very well is that enthusiasm, and that, kind of, excitement. But I think that the next couple of years will be, kind of, developing that into the more sustainable change. (Interviews, p. 154) I know that some people made a personal pledge to try and be more positive at work, not always be as negative. I suppose that's easier in the short term than it is in the long term, because you can make a conscious effort over a shorter term but there'll always be something that comes in to lower morale or kick you in the teeth or whatever. Over a period of time, something like that will be harder and harder to do…(Interviews, p. 189)
			Balancing commitment to NHSCD with commitment to work	This code describes the problems faced by participants when balancing their commitment to NHSCD with their already demanding full-time jobs.	I've got quite a lot of scheme commitments as well, I've got my full-time time job and my manager already thinks I've got a lot of time out of the job as it is, they weren't very supportive of me doing anything to do with Change Day. (Interviews, p. 22) It's been a challenge because I work full time as a nurse. I have a busy schedule at work, and then I do Change Day after work normally, after five o'clock, and I spend a lot of evenings working with Change Day. I've done, probably, in the last three months, 14 to 15 hours' work. (Interviews, p. 300)
			The fact that NHSCD only 'happens once a year' challenges its sustainability	This code describes the various challenges faced by participants and the movement due to the fact that the NHSCD was based on a single yearly event, and the question of how to maintain the momentum of the movement throughout the year.	I know some people believe that Change Day should be one day a year to highlight everything, I think a lot of cynical people think well it's just one day a year – we should be doing this every day of the year and they're right, we should be doing this all through the year but I think that having the Change Day becomes a rally point and helps motivate people. But for me Change Day isn't just about today, it's about making that change sustainable through the rest of the year and beyond. So I'm quite happy to go and do that pledge later in the week, or next week, and maybe continue to do that throughout the year. (Interviews, p. 74)

APPENDIX 8: Paper 3 Peer Review Feedback

12-Mar-2018

Dear Author(s),

We have now completed our review of your paper, OS-18-0029 entitled "How to Effect Change in the English National Health Service (NHS): Mobilising Collective Organisational Knowledge through Framing Practices" which you submitted to Organization Studies. I asked Mark Learmonth, Senior Editor to make the editorial decision.
As you will see from the letter below, Mark , based on the reading of your paper and the reviewers' comments, is of the opinion that the discussion of the issues dealt with in your paper does not make a significant contribution, and is not close enough to Organization Studies publications expectations to warrant requesting a revision.
Accordingly, Mark has decided not to accept your paper.
Mark 's comments and those of the reviewers are clear and there is little more for me to add, except to say that I hope their comments (see attachments) will be useful to you as you continue developing the core ideas of your paper.
I am sorry I have been unable to convey better news to you this time and would like to thank you for considering Organization Studies as a possible outlet for your work. I hope, however, that you will continue to think of Organization Studies as an outlet for your research work in the future.

Best wishes
Daniel Hjorth
Editor, Organization Studies
oseditorhjorth@gmail.com

Senior Editor Comments to Author:

Senior Editor: Learmonth, Mark
Comments to the Author:

Dear Author(s)

Thank you for submitting your work to Organization Studies, which has now been reviewed by three experts in the field. As you can see, their appraisals are somewhat mixed. R1 is the most positive, while R2 and R3 both recommended rejection. I have reread your work in the light of their reviews and have come to the view that your paper does not make enough of a theoretical contribution to be published in Organization Studies. I am afraid, therefore, that I will not be requesting further revisions. I know a rejection is disappointing; however, I have taken this opportunity to set out what I see as the key issues to work on as you revise your work for another journal.

Organization Studies require the papers it publishes to make a strong theoretical contribution. While you clearly have a large data set that is very rich – and that is a great foundation on which to build – as currently written your paper is too orientated towards its empirical (rather than its theoretical) contribution. This may well work well for some journals especially perhaps, those that focus particularly on health care issues. However, for Organization Studies you need to develop new contributions to theory that are likely to be of interest to scholars across the discipline – not just in health care. The point about theory development is what R2 is getting at when s/he makes the point that there needs to be "greater critical engagement with the data". R3 is explicit about the need to make contributions with a wide interest in organization studies as a discipline.

If you decide to target another theory development journal then I suggest you need to focus much more on the "generic literature about knowledge mobilisation and social movements" as R3 puts it, and show how your empirical findings help us to see this literature in new ways that are meaningful more or less independently of the empirical setting. I would also, therefore, be inclined to play down the health care setting somewhat. I don't necessarily mean play it down to the extent of making it irrelevant – but to the extent that someone with no knowledge of the context – though with an interest in knowledge mobilisation or social movements would be able more readily to draw lessons from it for other contexts. As currently written it comes across as a

specialist health care paper.

I suggest you also consider strengthening the discussion and conclusion section so that the theoretical implications of the study are more prominent. For example, you mention Goffman's ideas about framing, relating it to power. You might want to start the discussion with such ideas and show in much more detail than you currently do how your findings have cast new light on such ideas. Also, rather than use the conclusion as a kind of brief summary of your paper, I suggest you use it much more actively to suggest why your contributions to theory matter – and to whom they matter.

I am sorry not to be able to bring you better news. However, your empirical work is very promising and I hope that my overview and the more detailed views of the reviewers will help to further develop your work.

Reviewer(s)' Comments to Author:

Reviewer: 1

Comments to the Author
Overall this is a strong paper. It is very well written, and uses a diverse data set to make well founded and interesting points about how framing processes can be used to mobilise co-ordinated organisational change that engages and apparently empowers those at the front line of service delivery. The theory on which it draws seems sound, and it rehearses the existing literature clearly, as well as indicating where its contribution fits (particularly in relation to the more linear aspects of the knowledge mobilisation literature). I have a number of suggestions for how it might be improved, mostly relatively minor, though some I think are quite important.

- Page 4 paragraph 2: this is a minor point but the paper overview paragraph states there are three further sections, when actually there are many more (or the authors need to delineate more clearly which are sections and which are 'subsections').
- Page 5 paragraph 1: the authors indicate that there are three fields of literature

on change management / implementation, but devote but a single sentence to the first two. A little more information on these and a brief critique of their shortcomings would be helpful.

- Page 7 last paragraph: it's not clear here about whether the authors are talking about influences exogenous to an organisation or an institution (i.e. an entire field) here – perhaps they could clarify.
- Page 11 last paragraph: this reads slightly confusingly, in that it seems to suggest that the second Change Day happened in 2012 and the first in 2013. I think replacing the word 'introduced' with the word 'implemented' in relation to the Health and Social Care Act would clarify this.
- Page 12 last paragraph: it would be useful to have some reference to any ethical considerations, including appropriate approvals, somewhere around this paragraph, particularly in relation to the analysis of e-mails and personal correspondence, and in relation to the "informal interviews." Were participants and e-mail correspondents aware that their words were being used as a data source? Did they give consent to this?
- Page 13 paragraph 2: consider either rephrasing or explaining the meaning of the words trust and clinical commissioning group, as these won't be familiar to non-English / non-healthcare audiences.
- Pages 14 last paragraph: I would like more description of the sampling process in the methods section. First of all, why were 2014 and 2016 chosen as years for analysis? Second, why were so many more pledges sampled from 2014 than 2016? Third (and perhaps most important), what was the sampling approach? Given a population of around 802,000 pledges in 2014, and presumably a similar number in 2016, the sample is actually quite small – so how was it selected, and to what extent would the authors say it was representative?
- Page 17 last line: missing inverted comma after framing
- Page 20 line 4: programs should read programmes
- Last paragraphs of each of the subsections of results: the authors give interesting accounts of how each frame was challenged, but in contrast to other parts of the analysis, they do not give illustrative direct quotations for this. This makes it difficult to verify the accounts, and also means the reader cannot see what kind of individuals were making these challenges (and the style of the authors does not help

here – e.g. page 20 last para “The frame was challenged…” – use of the passive voice here makes it impossible to determine whether this was an external or internal challenge, and from what kind of stakeholder). The paper would be strengthened, and would read more evenly, if this was addressed.

- Page 22 line 7 et passim: capital letters after colons should be lower case
- Page 23 paragraph 2: this felt like a bit of a non sequitur from the previous paragraph: in what way does the “need to keep NHSCD grassroots” conflict with the description of the framing of Change Day given in the previous passage?

Reviewer: 2

Comments to the Author

Many thanks for the opportunity to read about this project. This is generally a well organised paper which reaches across several prominent themes of current organisational analysis. The researchers evidently had very good access to the study setting and a huge amount of work has been undertaken. The paper therefore draws on a large volume of potentially useful mixed methods data. A great deal of thought and effort has evidently gone into this project and I’m certain there are useful findings to be brought out. However, as currently presented, I think there are some quite significant problems with the paper.

- The literature review introduces a number of areas of theory, including that on organisational change in healthcare, knowledge mobilisation, practice theory and frame analysis. While key works associated with each perspective are cited, I am not convinced that the various strands of literature are stitched together tightly enough or that a clear enough theoretical gap is identified. Indeed the research question is addressed firmly at the empirical context, rather than preceding theory.

- In particular, some of the literature on ‘knowledge mobilisation’ appears something of a red herring. At the moment the issue of translating knowledge from research evidence to practice appears to be a rather peripheral to much of the data and analysis, which focuses on quality improvement. Similarly it is hard to see how the practice perspective has informed the data analysis and findings.

- For a paper titled ‘How to Effect Change…’ I feel there needs to be a much greater sense of what, if anything, has changed across the organisation(s) in response to the NHSCD. While this was evidently an important event for those involved I feel there needs to be some sense of what has resulted from this.
- Following the above, as it is currently presented, I feel there needs to be more reflection on describing the NHSCD as a social movement. There are some intriguing comments on the origin story of the NHSCD – could there be some deeper reflection here in the founders’ (and authors’) framing of the event as a social movement and indeed the participants as activists at the grassroots, with the associated claims of authenticity. While I think it can be useful to adopt the participants own terms, there needs to be some critical engagement before doing so. Being provocative, couldn’t the NHSCD potentially be more transparently seen as corporate marketing following a corporate scandal? How did different interest groups get involved over time?
- Leading on from the above, many of the pledges quoted could be described as platitudes, rather than substantive threats to the current institutional or social order. Although it is claimed the movement is ‘disruptive’ and even ‘subversive’, in my view the NHSCD sits quite neatly with dominant management discourses of quality improvement, individualised accountability and improved patient (as customer) focus. For example, pledges quoted P17 L34, p18 L40, p 21 L49 emphasise front-line responsibility and a broad endorsement of a caring ethos, pursued through individuals efforts, rather than (say) singling out individuals or policies to blame for public service failure or (more radically) proposing collective political action against organisational or policy elites.
- The concertive control embedded within NHSCD should be recognised. This is outlined on page 24 which (reading between the lines) states: NHSCD expects individuals to make enthusiastic and dramatic improvements in their work; on the basis of individual effort; without any additional resources; on top of their demanding full time jobs; without any commitment/risk by the organisation; while claiming to be a ‘grassroots’ movement. This contradiction needs to be taken more seriously.
- Some of the claims in the results are not well linked to the evidence presented. For example, following the same quote mentioned above, the text says the NHSCD enabled participants ‘not only to voice their concerns, but also to become leaders and solve problems locally’ also it enabled them to ‘envision and drive positive change in

the NHS' – but what did they lead and what did they change? Similarly p21 L13-22 – the suggestion that NHSCD led to 'an increased understanding of the ways in which patient care could be improved' and also to the accommodation of marginalised groups. This is a bold claim – understood by who? Which marginalised groups?

- There is a lack of agency in the narratives as currently written. Table 3 is potentially very useful in this regard, and identifies leaders, activist and frontline participants as distinct agents within particular frames. However, there is little on how the frames presented by these various agents challenged (or supported) each other. What are the various interests and conflicts and what is at stake for them? The literature emphasises the interactive and negotiated aspects of the framing process – however I currently get little sense of this from the data presented.
- It is claimed that the event allowed 'free expression' as many of the communications took place online. But this does not take into account neither the political environment in which such expression takes place, or the performative nature of online, as well as offline, communicative acts.
- Based on the above, I feel the (several) strong endorsements of radical change made in the discussion are not justified.
- Overall, I feel that there needs to be greater critical engagement with the data, taking into account the interests and agendas of the different groups involved.

Reviewer: 3

Comments to the Author

Thank you for letting me read your manuscript. I too empirically study healthcare settings, and with a keen interest in knowledge mobilisation. I am less familiar with social movement literature, but nevertheless have 'toyed' with incorporating it into studies where I can see it gives us additional valuable insight. Hence, I hope I am well placed to review your submission. I do very much like the empirical case setting and the dimensions of framing you derive. However, can I offer a few comments in the spirit of constructive criticism as follows:

1. The NHS Change Day movement lends itself particularly well to the

application of social movement literature. However, I feel the emphasis upon the empirical setting is too great. The empirical setting is merely a context from which you provide more generic insight for Organization Studies readers, who are not health care experts or perhaps even that interested in health care research. While worth mentioning in the introduction, I would then leave any details of NHSCD to the research design section. In essence, the front end of the manuscript should review and critique a more generic literature about knowledge mobilisation and social movements. This parochial perspective then spreads into the discussion and conclusion, both of which are very NHS specific. The overall tone of the manuscript thus feels empirical and descriptive rather than theoretical and analytical.

2. I am not entirely sure the case if made for this being knowledge mobilisation, it seems more service improvement. You might convince me more here. However, if we do assume this is about knowledge mobilisation, then review relevant literature, again avoiding a concentration on that which is just health care specific. Everyone accepts knowledge mobilisation is not linear so no need to take us through this in detail. Cut through this and review/critique literature about collective knowledge mobilisation, before a segue into social movement and framing literature. You make a reasonable case for the framing perspective on pages 7/8, but you might drop a line into the introduction to satisfy the reader that you are not merely drawing upon a trendy literature to satisfy some need for theoretical exoticism.

3. The knowledge characteristics of online data may be useful to discuss given its increasing use in knowledge mobilisation, and this might aid efforts to enhance transferability of the specific NHS case.

4. In the research design you highlight the longitudinal dimension of the case and cite Ann Langley's work, which raises expectations of some sort of process model. This is not realised, but might be a way of 'lifting your head up' to theorise more generically.

5. On one hand, you claim a wide set of interviews, on the other the number of interviews are limited. Then quotes from interviews seem to constitute much of the primary data presented. You should make more of observations and of social media in line with the claims made about a rich and longitudinal data set.

6. Regarding coding, you tell me about it and show me the coding to some

extent. Regarding Figure 1, which captures the latter, I would expect at least one other column to highlight the theoretical dimensions you derive. Also Figure 1 doesn't relate to Tables 3 and 4 very well.

7. The data is presented well and I do like the frames you derive. However, take care with setting too many concepts running as you discuss the data. For example, collective responsibility and distributed leadership are complicated concepts in their own right, rather than phenomena you can just present empirically.

8. The discussion, as highlighted above, is much too NHS focused.

9. The conclusion is very weak, and lacks a statement of the theoretical contribution necessary for Organization Studies.

Good luck with development of the manuscript, whether or not reviewers and the editors request a revision. As I stated earlier, the empirical context, use of social media, and its link to social movements are interesting.