King's Fund

Living Values in the NHS

Stories from the NHS's 50th year

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Publishing
11–13 Cavendish Square
London W1M 0AN

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Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1999

ISBN 1 85717 403 8

A CIP catalogue record for this book is available from the British Library

Available from:

King's Fund Bookshop
11–13 Cavendish Square
London
W1M 0AN

Tel: 0207 307 2591
Fax: 0207 307 2801

Printed and bound in Great Britain

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'... any event retold from life which appeared to carry some meaning, however small, is a story'

Reason and Hawkins. Storytelling as Inquiry. In: *Human Inquiry in Action. Developments in New Paradigm Research.*

'When we started telling stories we gave our lives a new dimension of meaning – apprehension – comprehension.'

Ben Okri. *Birds of Heaven.*

Living Values – 50 and still going

Let's all introduce ourselves and tell each other tales,
About who we know's been crucified,
And what they used for nails.
About wheeler-dealing politics, what your job title is today,
And who remembers the little things,
And on whose side it's best to play.
'Always tell the truth,' she said.
A fanciful idea she'd had taught her.
I don't think I'll be trying it,
'Til I've learnt to walk on water.

Poem written at the end of one of the storytelling workshops.

Acknowledgements

We would like to thank all of you for your rich, diverse, colourful, painful and meaningful stories. Some of the stories were hard to tell, and hard for us to listen to. Thank you also for letting us share some of these stories in this book.

We also wish to thank those that came to our Values event, to work on the themes and think about the causes underpinning the values that were demonstrated in practice: the observers, Marianne Talbot, Niall Dickson, Richard Hannaford; and Word in Action for recreating the stories in 'playlets'.

The King's Fund was new to this process of storytelling, so thank you also to those who helped to design and review the work, in particular Steve Manning, Martin Fischer and Julia Neuberger.

Introduction

The purpose of this book is to perturb you, to stir you a little, to make you think about your own values and how they translate into your day-to-day behaviour. The stories in the book were told to us as part of a King's Fund project that aimed to uncover some of the values that shape day-to-day action and behaviour in the NHS; what we call the 'living values' of the NHS. Being more explicitly aware of these values gives us a number of options. For instance, if we like the behaviours/attitudes that prevail and shape the current NHS we can reinforce the values that lead to them (consciously using these values as guidance when choosing between options). If we do not like the behaviours/attitudes, we can modify them to allow a different NHS to be created. Uncovering living values gives us a shared way of making sense of the world and a way of co-ordinating our behaviours.

The stories in this book capture the values in practice in the NHS's 50th year. They are stories told by staff and patients when asked to recount recent experiences that mattered to them. During 1998 we tried to discover something more about the complex ecology of lived and acted values in the NHS. To do this we consulted health service workers at all levels in England and Wales. Service users were interviewed. Staff were invited to one-day storytelling workshops, where chief executives, nurses, doctors, administrative and clerical staff, health authority managers, health care assistants and a chaplain were invited to tell us about events in their NHS work that had had a significant impact on them. We believed that people would remember incidents or events that had given them particular pleasure or pain, that had perhaps altered their behaviour and shaped the way they thought about the NHS. The storytelling revealed how individuals had made sense of what had happened to them, and exposed the values that shape decision-making and practice in the day-to-day NHS.

What we found

The NHS subscribes to the values of equality of access, putting patient needs first, being caring, and valuing individuals and their differences. We found that it seems to be caught in a high level debate about its values, whilst denying, ignoring, or just missing the reality of the values being lived out in day-to-day practice. People's lived experience of the NHS is desperately mixed. At the same time as feeling passionate in many instances about their work, staff themselves feel undervalued. When staff working in the NHS say they care about people, we assume that includes each other, but this is not always so. The stories produced a complex picture of the NHS, with huge contrasts and some culturally embedded patterns of behaviour.

We found that whilst there are dreadful abuses of power, particularly within the staff hierarchy and predominantly with men abusing women, there are also stories of empowerment and opportunity. Many staff feel out of their depth, and take responsibility for situations they feel unprepared for. This, in conjunction with a blame culture, leads to fear – but can also lead to courage in many instances. Stories of professionals' incredible arrogance, misunderstanding and unwillingness to listen to patients are countered by tremendous tolerance and patience with difficult patients.

There is an almost desperate misunderstanding between staff and patients, be it staff doing their utmost within the system for patients and the users/relatives not appreciating their efforts; unrealistic expectations of staff and patients; or completely different expectations of appropriate behaviour of staff by both other staff and patients.

Heroism is the order of the day. Staff describe feeling really good when they have pushed the boat out to help meet a patient's needs. There is a definite 'high' to doing the job well for a patient, and that usually means working the system to get it done.

Finally, patients' experiences of the service are incredibly diverse, but of more concern is the variety of service provision across the country. Whilst the major disparities in care are well known, the smaller disparities have incredible knock-on consequences for patients and highlight a deeper level of inequality.

How to use this book

The first section in this book is a collection of the stories told to us (edited and made suitably anonymous). Reading the stories on their own may make you think about stories that are similar to or contrasting with your own experience. Perhaps you will do something differently when you have read the stories and added your own experience to them? Discussing the stories with others who have read them will take you further. Spending time telling your stories to others and listening to theirs' will take you further still.

In the second section we briefly give our own interpretation of the stories told. Section 3, 'Commentary', gives our reactions, as well as those of other groups. If you want to understand how and why storytelling can make a difference, section 4 sets out a synopsis of the theories underpinning the work, and our own beliefs about how organisations work. If, having read the stories, you want to undertake some storytelling in your own place of work, there are some brief guidelines provided in section 5. We have all made this NHS. It is ours to change if we want to.

If you would like to contribute your own story, please see the section on contributing stories at the end of the book.

Storytelling uncovers how well people in organisations 'walk the talk'. Collectively it matters. It matters that what we talk about in terms of our values is followed through

into action. Understanding ourselves as the NHS,* or as an organisation within the NHS or as a team, is the first step to consciously developing the kind of values we want, the sort of team, organisation and NHS we want to be.

* This book refers to stories of the NHS. The process is transferable to any organisation, and the principles of living values are the same.

1. The stories

Here are *some* of the stories we were told[†] at our workshops. If we had asked people to talk to us about values, we would have had a generalised conversation more about aspirations rather than experience. By asking for stories we were able to see something of how values reveal themselves in practice. These stories are little 'epiphanies' or revelations of living values in the NHS.

We recommend that you read the stories slowly, and pause between each one, to make what you can of the values being demonstrated within the stories. As you read the stories you may find that they trigger memories of your own, either of similar experiences or of ones that are very different. You may have a more poignant story of your own. You might also find that your most memorable experiences are not covered here.

Use these stories to rediscover your own experiences, to think again about why they happened in the way they did and how they changed you (your attitude and/or your behaviour). Think about how your actions could be interpreted by others – the stories illustrate how sometimes others see our actions very differently from how we mean them. You will also find that the stories expose different and sometimes contradictory values.

[†] We have not included stories where the storyteller is identifiable because of the nature of the story.

1. A lady who was an aromatherapist was having persistent headaches and had been visiting a clinic for about 18 months. She knew that she had been written off as 'a bit weird' as soon as she mentioned that she was an aromatherapist. Eventually she said that she could not cope with the headaches anymore, and that she wanted a scan. The doctor wrote a referral for her, which, it turned out later, basically said that she was a neurotic woman who could not live with her headaches. Two days later she had a very large brain tumour removed. Luckily it was benign.

2. A nursing auxiliary told a story about going to bathe a lady with schizophrenia: '... and when I first go in, she's very violent, she sort of pushes you away ... then she comes along and sort of rushes at you ... but in the end I do manage to give her a bath, but she is very violent, and I'm the only one who goes in'. The lady will not let anyone else look after her: 'She wouldn't let anyone else do anything, but when I go, because I understand her, she allows me, despite pushing me ... she's very sweet when you get to know her'.

3. A trust was relocating some of its services. It seemed an opportunity to combine genito-urinary medicine with family planning on one site because these departments often have the same client group. However, the doctors refused because of the implications for training junior doctors. Our storyteller told us, 'it doesn't matter how inconvenient it is for the patients'.

4. An elderly lady told us about the difficulties she had with a hospital doctor. 'He paid no attention to what I was saying.' She wanted some treatment for her leg, but preferred to have it at home rather than going into hospital. She told the doctor that if she really had to go to hospital she would go in a taxi, and that she was quite willing to pay for the ride. The next thing that happened was that she received a note saying an

ambulance was coming to pick her up the following day at 8.00 a.m. She said that it was too late to get in touch with the doctor and she did not want to make a nuisance of herself, so she went. She had to get up at 6.00 a.m. and it took over an hour to get to the hospital. It would have been a ten-minute taxi ride. When she got there she was told it was not worth giving her the treatment because any benefit would be destroyed by the damage done in the ambulance ride home.

5. A woman told the story of her illness. It started when she was 11-years-old, when she had very heavy periods. She was not properly diagnosed, and was passed around the health service. At school she could not play sports; when she got married she had persistently heavy periods and was told that this was not unusual when one first gets married and that it would get better once she had had children. After having several miscarriages, she found that she was unable to have children. She then went into hospital for investigations of abdominal pain and was told she had irritable bowel syndrome. Eventually, she insisted on seeing a gynaecologist, even though the GP did not think it could be justified. The gynaecologist quickly made the diagnosis of endometreosis. By this time she was 37-years-old. She went on to see another gynaecologist and to have a hysterectomy, and described the difference it made to her life: 'I've actually got energy, vitality, general good health ... its like, gosh, [being] a teenager'. 'For me it was like being born again.' She describes her meeting with the second gynaecologist (the one who knew what to do): 'it was a degree of affirmation and recognition that I had not met in all the time I had been dealing with people ... I just thought, My God, somebody's actually taking this seriously...'

6. A manager told us how staff in a learning disability unit were being hit and scratched. The occupational health consultant asked a nurse about the scratches on her arm, and she said, 'It's the residents, but they can't help it'

7. A man had had a tracheotomy. He told us how he remembered waking up at 2.00 a.m. in a dark hospital ward. 'There were two auxiliaries and one staff nurse and they were sitting at the end of the ward. I had specifically asked a number of times could they wake me up at regular intervals to clean out my tube because it kept blocking. Time after time I would wake up struggling to breathe.' When he woke this time he had not been woken earlier as requested and he described '... the feeling of absolute helplessness ... You were trying not to panic, trying to gasp for breath, you couldn't talk'.

8. A woman with a baby described how she had had to arrange her life so that she could go into hospital for an operation that was cancelled twice: 'I felt unimportant. I'm just a number; I'm just a body lying in a bed. You feel as though you want to get up and say "Hang on a minute! I want to be done. I've arranged my family life" ... at the moment I'm in limbo.'

9. Another patient described his experience of two hospitals in his area working well together to co-ordinate different operations. He was being treated at both for different conditions, and he found that they took the time to talk to each other to work out the best treatment plan for him as a whole. They treated him 'like a reasonably intelligent adult who deserved to have explained to me what had to be done'.

10. A consultant told us the story of when her young son became ill and had to go into hospital. As he got over the acute phase of his illness, she wanted to take him home because he was just going through routine monitoring of his temperature, which she felt she could do at home. She says she was made to feel dependent because she knew that if she had stood her ground she would have had to discharge him against medical advice, when actually the monitoring process had become unnecessary.

'It left us both quite tainted with the uselessness of it ... and the inflexibility of the system.'

11. A mother was in hospital with her three-month-old baby, who she was breast-feeding. The policy of the ward was that if babies were being breast-fed, then the mothers should be given food from the meal trolley. She had to get her food by subterfuge because the nursery nurse who gave out the food would say that she would serve the children first and come back to the mother, but never did. She had to find ways around this nursery nurse in order to get her food. The mother's interpretation was that it was as if this was the only thing that the nursery nurse felt in control of, and she was going to exercise her power using this mother. She made life difficult for someone who already had to cope with the illness of her child.

12. A therapist was treating a child and got to know the family very well. She happened to see the father in the hospital lift, sitting in a wheelchair. She found out that he had had a heart attack. She wrote him a card and sent it to the ward, which he subsequently told her he really appreciated.

13. A man had a stroke and needed long-term care. The nursing staff thought his wife should look after the man at home. The wife refused to have him at home. There was no long-term care provision available so he stayed in the ward until he died two years later. There was a lot of blame on the wife and little insight into why she would not care for him at home.

14. A woman told us how she was trying to act on her elderly grandmother's behalf as her next of kin. She lived four hour's drive away from her grandmother and was very concerned about the elderly lady's care in hospital, as she had noticed a marked deterioration in her condition over a very short period of time. She wanted to speak to the consultant but was told that the consultant categorically refused to see relatives on the ward, seeing them only after his Tuesday outpatient clinic, if and when he had time. The granddaughter reminded the staff that she worked hundreds of miles away and would find it difficult to get to the hospital midweek. She asked if something could be arranged for Monday, so that she only needed to extend her weekend stay. This was dismissed out of hand. Eventually she managed to see the house officer, who could not answer all of her questions.

The situation with the old lady deteriorated, with a breakdown in communications between the family and the hospital about investigations and long-term care. Despite regularly explaining to the staff that the old lady could not manage to drink through a straw, relatives and friends repeatedly found her left in bed with a full drink with a straw in it beside her bed. By the time she was discharged she was severely dehydrated. The granddaughter tried again to see the consultant. Again she was informed about when the consultant would see relatives, and that he had no slots free. It was left that the hospital would call if a slot became free that Tuesday, and another relative would stand in (with the added complication that this relative worked shifts). On the Tuesday the family had not heard from the consultant's office, and rang in the afternoon to find that someone should have been there at 2.00 p.m. As this was the hospital's fault the consultant agreed to see the family if they came immediately.

At every stage of the old lady's care, the family and relatives felt that their concerns were being dismissed by the ward sister, the doctors and the manager. At the same time they could see the old lady deteriorating because of lack of care in the very areas that concerned them – hydration, mobility, loss of motivation and poor nourishment.

15. A patient went home on weekend leave before having chemotherapy on the Monday. By the time he returned on Sunday, the bed had gone. He was promised that a bed would be found for him the next morning, but that it might be on a different ward. The nurse describes how '... we were put in front of this dreadfully distressed family ... he was crying'. The family 'screamed and ranted and raved and swore at everybody and threw things ...'. A 'more compliant patient' was moved and this patient was given his bed. Then there was 'this dreadful situation where they didn't trust anything we said'.

16. A nurse told us about a blind patient. 'I used to get him into the bath, he was a big man and every time he came out, for some reason he was really close to me and all the time I was backing off and going into the corner, and I was really frightened of him. When he didn't take his tablets, he used to get really violent.'

17. A patient was very abusive, demanding and threatening to physiotherapy staff. He had to be rotated between staff them to give them a break.

18. A middle manager described how she was involved in a project to move some continuing care patients from a NHS ward into the private sector. She went to a meeting at the health authority and listened to the decision being made about what should happen to these patients. She said that she understood the need to make a financial decision. However, she was shocked by the way 'they talked about these patients as if they were packets of frozen peas'.

19. A very sick patient was being treated by a specialist service outside her area. Her health authority decided that they did not want to continue funding her treatment, and

that they would find a local provider. In this instance the clinical staff thought the patient too fragile for her treatment to be transferred and appealed to the health authority. The staff thought there was a real danger that the patient would commit suicide. The HA refused to alter their decision. In the end it took an intervention from the chief executive of the trust, who rang up the health authority chief executive, to get the decision reversed.

20. Two junior doctors were on duty at two o'clock in the morning. They were treating a baby, and were waiting for the results of a test to come back so that they could start treatment. They decided to wait on the ward so that they could respond as soon as they had the results. Since they had not eaten they ordered a pizza from the local takeaway (the canteen was closed), to eat while they were waiting. The parents complained that the doctors were eating pizza. They felt it was unprofessional of the doctors to be eating whilst they were waiting for the test results. It was the fact that the doctors smelled of pizza that bothered them.

21. A ward staff nurse was anxious when a confused patient left the ward. This was not a rare occurrence: he usually went home, only to be retrieved later and brought back to the ward. This time, however, he started to leave the hospital by the wrong route. The nurse was concerned that he would get lost, and sent one of her nursing team to be with the patient. He could not legally be restrained, and hospital security would not restrain him. The nurse went with him as he wandered onto a busy city road. She stopped the traffic and managed to get a policeman to help her get him back to the hospital. On their return the patient's relatives were very angry and verbally abusive to the nurses involved. The nurses felt they had gone out of their way, beyond what was expected, to ensure the man's safety. The relatives felt that the hospital should have kept him in the ward.

22. A family were upset by the background chatter of the nurses on an ITU whilst their son who had tried to commit suicide was being treated. The mother could not believe 'that people could be talking about life outside ... her son was there and potentially not going to survive ... talking about the fact that they'd been down the pier the night before'.

23. An elderly man was discharged from the hospital by ward staff who thought that they had done everything it was reasonable to expect from a hospital in arranging services at home. As part of the discharge they had arranged for the heating to be put on. The man's son, who lived miles away, wrote and complained because the elderly man's flat was cold when he got home because the radiators had been turned on, but were not bled. The son expected someone from the hospital to go and check that the radiators were bled. The staff nurse said, 'What do people expect from an acute hospital? ... [they have] very unrealistic expectations'.

24. One service prescribed a special chair for a child with a particular disability. '[T]he family had this chair for a week and they'd let their other children fiddle with it and they'd broken it. So they rang me up and said, "we want a new chair, because it's broken".' There was no money for a new chair. 'People don't realise the cost in real terms.'

25. A man was admitted to hospital with a heart flutter. He was furious because he was not washed by a nurse, but given a bowl to wash himself. He expected to have everything done for him. 'It was really very funny, but that's what people expect.'

26. A patient was interviewed as part of a quality initiative. He said that what staff need to remember is that, unlike other consumer services where you choose to go in and buy something because you want it, patients/users do not want to be ill in the first place. They do not want to be using the health service.

27. A senior manager told us about how shocked she was when she started going to public meetings to talk about the services the trust offered and how these were going to change. She found that local people did not believe her.

28. Relatives of an old lady could not accept that the nursing staff would not tie her to the chair to stop her wandering, which is what they did at home.

29. A doctor told us about the impact of being challenged by fundholding GPs over waiting times for their team's child psychiatric services. The team thought that if the contract was moved to another provider it would be detrimental to patients. They also thought there was nothing they could improve on, but agreed to provide better access to all GPs. They found that, actually, they could do better and were genuinely surprised. Their views about what was a 'set in stone' approach to managing care were wrong.

30. A chronically disabled man moved from London to a large provincial city. In making the move, he had not considered that the health service would be different in the two cities. In London he had had access to a pain management team and to a lot of help and advice. In his new city he had to wait months to see a pain specialist and then another 30 weeks to see a clinical psychologist, during which time his pain was not being well managed. There just was not the same level of service.

31. A woman was having her long-term cardiac problem treated and monitored by a hospital some distance from where she now lived. Her health authority was not prepared to pay for her care at this hospital, and so she was referred for local care. The local cardiologist was very busy and, having seen her, wanted her to be monitored by her GP. When she attended the original hospital she felt secure: 'if anything was wrong, I could call them and they'd see me'. ' I could just bleep the Sister and ask her for advice.' Now her blood pressure is raised. Whereas before she would be monitored and possibly kept in for a few days until it decreased, now it is rising and she feels that she is not getting the same quality of care. She does not feel in safe hands and she feels unwell more of the time. 'Even if I went to my GP's surgery, they don't have the facilities for this.'

32. While living in a northern city, an elderly lady was having physiotherapy and acupuncture for the pain in her hip. A district nurse visited every month to see how she was getting on. The lady was advised to have a hip replacement, but then moved to London where she had the operation. After the operation the physiotherapist came out twice to see her, and then stopped coming. She did not know why the physio stopped coming. She is immobile and has no regular access to community services, so she thought she would get a wheelchair. She rang the physiotherapy service to check how to go about getting a wheelchair and they said she could order one through her GP, which she did. The physio had not suggested one when she came out, 'because I

think her idea was that I should get about, but I just don't think it is really possible. If I do, it's very painful and I don't think it's worth it'.

33. An elderly lady was being treated in a surgical ward. Her relatives and friends repeatedly expressed concerns about her care, in particular that she was becoming immobile and dehydrated, and was losing weight. Despite their concerns, they were told repeatedly that she was adequately nourished and hydrated. Eventually she was discharged to a nursing home. On arrival the deputy matron noted that the old lady was malnourished, dehydrated, debilitated and had a urine infection. Within hours she was seen by the GP and admitted to another hospital as an emergency admission with dehydration, malnutrition, and chest and urine infections. The lady was fully cared for by a multidisciplinary team and she needed total parental nutrition and 12 days of intravenous fluids.

34. A patient described having completely different experiences of treatment and care in the renal units of two hospitals. In the first one he said it was unprofessional. He was concerned about hygiene in the unit, and kept getting fevers after using the dialysis machines. The second unit was a complete contrast; it was efficient, had highly motivated staff, and provided top-quality care. Both the units were in the same city.

35. One mother told the story of her daughter, who had had several renal transplants as a child, and subsequently developed liver failure as an adult. The care she received as a child was in stark contrast with that she received as an adult. As an adult she found herself being cared for mostly by agency nurses, there was poor communication about her care, the ward was dirty, observations after investigations were missed, and her notes went missing. Although the care as she had as a child had been very

'medical' (she was treated as a kidney not a person), the quality of care had been much better.

36. A therapist told us: 'I can remember one time when I had a client (with learning disabilities) who was the daughter of an Italian lady. She had a couple of odd habits, had her own language. Her mother wanted to take her to Italy. She'd gone through all the bookings, everything was going very well and I'd given her advice on things that she could do with the daughter when she was away and I went to see her to wish her well two days before she was going off and she was in tears. Because she was wheelchair bound the airline had to get authorisation from the GP. The GP had written saying that he would not like to sit next to her on an aeroplane and had offered the mother a new wheelchair as compensation. At that stage I contacted our senior psychiatric registrar. He came out of clinic, prescribed something to sedate her slightly and contacted the airline, so that they went on their holiday. I still think this is one of the best things that happened to me, one of the most effective things that I did ... because after that they went all over the place. They went to France, they went to Spain, they went everywhere.'

37. A surgeon did no more operations than the minimum he was required to do, so his waiting list was building up. He then contracted personally with all local GP fundholders, undercutting his own service in the hospital by a small amount per patient. He gathered up patients who had been on the waiting list and took them in a bus to the private hospital, where he operated on them and was paid for private practice. When it came to waiting list initiative money, he had a waiting list and so got the list down by doing the work from his own list, privately. A colleague commented: 'But the system allows it, it's not fraud, it's allowing him to do it'.

38. A patient described having a breathing tube. The neurosurgeon had 'left explicit instructions that if there was the slightest problem, she was to be called at home. But because the doctor on duty did not want it to reflect badly on her, they left me

without water for 18 hours rather than try and unblock the tube without calling'. It was sorted out after the family made a fuss about it.

39. A manager wanted a lock for a bookcase. 'You can't get a lock for a bookcase via supplies. You can get a bookcase with a lock that costs £157; we wanted a lock for a bookcase. It costs five quid at the hardware shop down the road.'

40. A hospice agreed to admit a patient who was dying. The patient died in the ambulance en route. The patient should have gone straight to the city mortuary, but out of consideration for the family the hospice admitted the dead patient and rang the GP to come and certify the death. This way the family had a better experience of the death and the staff could care for them in their grief. The hospital manager complained that the staff had not followed hospital policy. The medical director for the unit said that, given the circumstances, he would expect them to do exactly the same if it happened again.

41. A consultant was timetabled to do a clinic and an operating list simultaneously. Another consultant thought that there had been a misprint. The manager assured him that there had, but he was told by the consultant concerned that it was not a misprint and not to be stupid. So at a meeting the second consultant asked the manager if he too could double up on his commitments. The first consultant had to back down. The second consultant, as the 'good guy', now felt he was in a position to ask for other changes in the timetable that he wanted.

42. A manager told us that her hospital was using a new build to rearrange beds and change long-standing practices that they thought were outdated. They needed to reduce surgical beds, and the obvious way was to close the urology ward and combine it with general surgery, reducing three wards to two. The waiting list initiative came along in the middle of very difficult discussions, and the only way they could meet the initiative's targets was to keep the urology ward open. Six month's work to change practice and develop a strategic way forward had gone out the window. The hospital's priorities were skewed by the short-term gain of the waiting list initiative.

43. A patient needed community OT support. Because she was being looked after by a specialist centre and not a local centre, community services would not provide the support on discharge. Two years later, they have a community OT attached to the specialist service to get round the problem.

44. A GP surgery advertised a private medical scheme. A NHS manager picked up the leaflet and realised that her community services staff (health visitor, district nurse) were advertised within the scheme!

45. A lady told us how she saw a doctor three years ago about a neck problem. She had physiotherapy but it made the problem worse. She went back to her GP and asked to be referred to a consultant. The waiting list was nine months. She was under a lot of pressure from her boss to get the problem sorted out because she was off work, so she asked when she could be seen privately. She was told, next week. Her mother-in-law paid for her to go privately, and the consultant said there was not much they could do for her and recommended osteopathy or chiropractice. She was also put on the waiting list for a MRI (a type of scan). In the meantime she was having difficulty with her legs and finding driving impossible. She did not go back to work and was

struggling to manage her home life and children. Eventually she had the MRI, which showed a deteriorating condition affecting all the body's muscles. All of this took a year.

46. A doctor told us about how he refused to work at the weekend to privately treat patients from his own waiting list, to meet waiting list initiative targets. Instead, he undertook the extra work during the week under the NHS.

47. A psychiatric nurse felt a client should be discharged into the community, but no one else agreed. Eventually, after a period of years, he won through and got the client discharged. The client is managing well, and the nurse got a lot of satisfaction knowing that it was worth persisting.

48. A manager told us about reviewing a service for learning disabilities. Once the board realised the savings that could be made, they asked her to accelerate the change plans to deliver the changes within a year. She did this, but on reflection said that the 'challenge of doing it successfully' was 'more important than questioning what we were actually doing'. The users and public involved in the initial review were shocked, and she realised well into the change that it was the wrong thing to do. The thrill and excitement of leading a substantial change had overtaken common sense.

49. A manager working for both a health authority and a trust was arranging an event which attracted a lot of interest, and which was highly successful. The manager had kept both her employers fully informed, but one had taken more interest in the event than the other. After the event, the manager was summoned to the office of the line manager from the organisation that had taken less interest. 'He became very rude and very angry with me.' He accused the manager of keeping facts about the event from him. 'It culminated with him banging his fists on the desk and telling me that if I didn't understand there was more to come of what I had already received so it got ... almost violent ... I remember feeling frightened at one point.'

50. A consultant clinical director insisted that the directorate's general manager have lunch with his firm once a week in the postgraduate medical centre. She found this a gruelling experience and felt that it was designed to humiliate her: 'I was just sport'. She decided that, rather than put herself through this every week, she would write and say that she was not going to the lunches because she did not think that they achieved anything. 'He hauled me in in the middle of his outpatients' clinic into his consulting room and bellowed at me and told me that I had thrown down the gauntlet and how dare I ... he was shaking with rage and I managed to get myself out and throw myself in a more senior colleague's office.'

51. A medical records officer was surprised when 'I actually got some praise at this meeting [to sort out records], the first time in 17 years working in the NHS, a consultant praised me and it shook me rigid'.

52. A manager went to work in the laundry to find out what it was like and volunteered to answer the telephone. The people ringing up had no idea they were talking to a manager. 'Everybody rang up and gave me hell ... they called me all sorts

of dreadful names and terrible things because they had frustrations too, and I suppose that made them rude.'

53. A senior nurse was asked by the chairman to present to the board the results of a study leave piece looking at strategy that she had prepared while abroad. First there was some confusion over what she should present, with the chair expecting her to talk about nurse recruitment. She agreed to do this, rather than present the work she had done on strategy. She prepared overhead projector slides (OHPs), and just before the meeting the chair said to her 'you've only got two haven't you?' She had four, but she prepared herself to shorten her presentation. At the board meeting, she found that the projector was in the middle of the room, and needed to be moved if she was going to show her OHPs. No one moved, and when she indicated that she needed to move the projector, still no one moved. She could feel everyone getting annoyed with her, so she had to give her presentation without the OHPs. 'So I stand there and I give my presentation without the OHP, which is about stuff which I hadn't really been looking at, and it was fine ... but I just remember being so mortified.' After her came a doctor with OHPs, presenting on waiting times. Immediately the chairman and chief executive moved so that he could use the projector.

54. A manager offered her ward nursing staff personal organisers instead of diaries because she thought it would make her staff feel good, as they would use them every day of their working lives. But they only ordered the refills, 'because they thought that was what I meant, that they could have the inside but not the outside'. They were carrying around bits of paper held together by rubber bands because they thought they would have to go out and buy their own binders.

55. A nurse told us: 'I was thinking back to when we won this national award. We didn't get a single letter from anybody in the organisation, nothing. I got letters from people I'd never heard of, in the great big world, but we didn't get anything at all. And I was really appalled by that.'

56. A chief executive told us how the trust had taken a risk in developing their medium-term strategy by involving all the their staff at a whole system event and series of workshops (300 attended). The staff involved in making change happen had to learn how to facilitate these events and how to make it all run smoothly. People still talk about the experience and events two years later. Their impact has lingered in the trust and has become part of the trust's identity. There were tangible results and it illustrated what a talented group of people worked in the trust.

57. A manager attended a ward round at which a consultant was asked about a diagnosis by a patient who was to be discharged. The consultant refused to answer and said he would write to the patient's GP. The manager was shocked and said, when they were on their own, that she thought it was unreasonable that this patient could not know his diagnosis. They argued about it. The next time the manger went onto the ward to join the ward round, the consultant lost his temper in front of the nursing and medical staff and said he never wanted to see her on the ward again.

58. A young woman had a cardiac arrest and died on a ward. The houseman came in the morning to take the patient's blood. No one had informed him that the patient had died. He burst into tears in the middle of the ward.

59. A middle manager wanted to do something in the hospital to celebrate the NHS's 50th anniversary. 'We can't have a momentous occasion, 50 years of service for everyone in this country, and not do anything about it.' She used the Internet to find out what other trusts were doing; there were balls, garden parties, and big corporate events. However, there was no budget for a big event and not much enthusiasm at the top. They managed to get the catering staff to put on a special menu, they buried a time capsule, found old photos and made banners and put them up. On the Sunday evening before the big day, she was putting balloons up and she said patients, staff and the GPs who ran the primary care clinic just watched. It made her feel that it was all futile.

60. A manager described how wanting a chartermark had been a carrot for getting a fragmented service to work as a multidisciplinary team. Initially all the therapists fought over territory and money, which meant that the budget did not go as far as it could have done. Several years down the line, however, the money is being better spent and the staff are enjoying working collaboratively. They got the chartermark.

61. A service manager had led proposals for changes to a learning difficulties service at the request of the trust board. At an open meeting of the board, a question was asked about the changes. The chairman asked a manager in mental health services to take the question. He did not know the answer and so proceeded to bluff his way through. The manager concerned thought that she should answer the question and so indicated to the chairman that she wished to speak. He did not recognise her and thought she was another member of the public wanting to ask a question. She was devastated that she was leading very sensitive and controversial change for the trust and the chairman did not know who she was.

62. A young man returned home from his mental health day hospital and encountered his brother, who was a drug addict, intimidating their mother. The young man raced to another house where his father lived. Although the father was drunk, he returned to the family home. A fight ensued and the young man killed his brother. The chief executive who told this story was certain from the evidence that the young man was under the care of a dedicated and committed team. Of course, some errors had been made but none of these could be connected to the extraordinary circumstances of the day. The clinical staff were submitted to an expensive, emotionally and physically exhausting external review. Given the genuine dedication and competence of the team and their willingness to learn from mistakes and errors, the chief executive questioned the value of such a punishing investigation. The staff continued to visit the patient when he was readmitted to a forensic psychiatry unit after the incident, to make sure that he had good continuity of care. The psychiatrist subsequently retired under the pressure.

63. A staff nurse described her story of being in charge at the weekend when one of the junior members of the nursing team turned up under the influence of alcohol. She did not know what to do and had no one to help her decide, so she rang the ward sister at home. She then took the action of sending the nurse home and completed all the relevant documentation, all the time feeling out of her depth. Since then, disciplinary action has taken place and things have been sorted out. At the time, however, she felt the need to have feedback and to talk about what was a very difficult situation. It was not a situation that she felt trained to cope with, but no feedback or discussion was forthcoming.

64. A junior nurse was in charge of a ward. A lady had a CT scan that showed a tumour. The lady and her relatives suspected the truth about what was wrong with her and asked the junior nurse. It was the weekend and there were no senior medical staff

available who knew the patient. She decided to tell the patient and her family, but felt out of her depth. Whilst she was sure it was the right thing to do, she was still anxious on Monday when she told the medical staff what she had done.

65. A nurse had given a sub-cutaneous heparin injection at the wrong time of day. 'It was the right dose, right patient but the wrong time of day. She had got the most appalling disciplinary action, for this very small drug error, and she said that what happened was that the whole staff were left feeling, well we are not going to report any errors now.'

66. A staff nurse made a drug error. It was a simple human error, but it caused her a great deal of personal upset. She went through the usual procedures and everything was resolved. The patient was fine. When the nurse came back from her days off she asked to speak to the sister. She was concerned about what her peers were going to think of her and whether they would trust her. The staff had all been very supportive, so it was nothing they had done, but a fear of failure had somehow been 'bred' in the staff nurse during her years in the health service.

67. A ward clerk told us about a nursing auxiliary who was told by the nurse in charge to turn off a constantly 'beeping' pump. She turned it off to wash the patient then forgot to ask the nurse to turn it back on again. She was suspended and ended up leaving the health service before her hearing because she could not take the strain.

68. A chaplain was on call when a group of Moslems wanted to see the body of a dead relative. He assured them they could, but when they turned up, as quite a large group, he found out that the deceased was a coroner's case. He did not know what to

do. He did not think that they could see the body, but the relatives were vociferous, quoting their rights and the Patient's Charter at him. In the end they had to go away without seeing the body and he felt terrible about the mess he felt he had created.

69. A ward clerk decided that the records service could be improved. She 'went home one day, and wrote an action plan and I sent it off to the chief nurse and ... I told her a bit about myself and what I'm doing and what I'm involved with on the ward, and to my great astonishment she said I could take action on it'. The ward clerk was given a lot of support by the chief nurse and the chief executive, and was seconded to turn her plans into action. She sorted out her own training needs and ran a development plan for other ward clerks. She now has a pager and co-ordinates the ward administrator's work and tackles other problems creatively.

70. A hospital chaplain wanted to re-invent the chaplaincy service, to make it into a service to meet spiritual needs. As part of this change he applied for a hospital research grant to go to America to look at how hospitals meet patients' spiritual needs, 'and to my amazement, I found myself at the Airport, pinching myself thinking I can't believe they're actually paying me to go to America'. He brought back lots of good ideas, went on to develop an audit of the service and had his work published in a health journal.

71. One woman manager told of wanting to spend more time with her husband, who had retired and who was 20 years older than she was. 'So I talked to my chief executive and said that I would really appreciate working part-time as a run down to retirement because it was very important to me that I started to have time with my husband and I'd never forgive myself if something happened and we couldn't have this time together and I've just met with nothing but co-operation from her [the CEO], and from the rest of the trust, and I remain in my executive post on the board, working three days a week, as a run in to retirement with the necessary support that I need to be able to do that.' 'I've been impressed by how people have supported me to do that and made it as easy as possible for me and I'm grateful.'

72. A ward clerk told of how he had injured his back as a heath care assistant and had to have surgery, how his manager was incredibly supportive during his eight months' sickness, and how he used that time to make the transition to a ward clerk job.

73. A doctor was working as a GP in a 'pool' practice. She had two children and was pregnant with her third. She met up with a colleague who was a public health consultant. He made several remarks about what an easy time GPs have, so she said 'come and see then!' They shadowed each other for a day. She did not know him terribly well, but he said to her when she was shadowing him in his public health role, 'You could do this if you want'. It had not occurred to her before that she could. It was a turning point for her: she ended up getting onto a management programme, leaving the practice and becoming the medical director of a community trust.

74. A mental health patient made his way into the administrative block from a clinic and tried to use the telephones. He became increasingly angry and pinned one of the secretaries against the wall in her office. As a result, one of the nurses had a meeting with the administrative staff to talk things through. Many of them felt vulnerable, particularly as they were female and in isolated offices. From this meeting a programme was developed where the administrative staff work for a time in the patient areas, to get a better perspective on mental health and to learn some techniques for handling situations.

75. An administrator told us how she had got to come on the workshop: her chief executive came in to her workplace and asked her whether she would like a development opportunity, because she thought that the administrator was one of the most talkative people in the trust!

2. Interpreting the stories

In our interpretation of the stories (those you have read in the previous section and others we could not reproduce here for reasons of anonymity), seven themes emerged. In each theme there were contradictory stories. We have tried to capture these contradictions here, in our summary of what we heard, as well as presenting the dominant values in action. In the final paragraph of this section we describe how we arrived at these themes.

Theme one: Attitudes (stories 1–19)

One important emergent theme was that of attitudes. Attitudes matter – they play a large part in defining patients' experiences of the service; they potentially disable professionals in finding alternative options for individual patients. It makes a positive difference when people are treated with respect, listened to, communicated with and given information. Negative stereotyping or unthinking attitudes can be obstructive, fostering poor respect, lack of communication, and exacerbating power differentials between staff, patients and relatives. At times in the stories, staff were behaving in ways that they felt were perfectly reasonable, when clearly patients were finding their experience distressing. The 'norm' of behaviour in the NHS and the expectations of staff (discussed further below) are different from those we experience in the rest of our lives. A half-day wait for an investigation is nothing to NHS staff. For a parent with children to care for, or someone taking time out of work it can be an incredibly long period of time, especially if it is unexpected/unplanned.

Sometimes patients' attitudes to staff can be equally problematic. Patients can be very difficult or even violent towards staff. Staff overcome negative and stereotyping attitudes with courage. It is difficult to do this and staff who attempt it may find they have little support. There are staff who manage to provide care in very difficult

situations but because of the nature of the care, the tenacity, courage and commitment of these staff is rarely commented on outside the NHS.

We heard of:

- arrogance of staff (particularly doctors), coupled with misunderstanding and an unwillingness to listen or take seriously others' concerns or points of view
- a lack of patient-centredness – even in good services
- difficult patients and situations being met with courage and care from some staff.

The stories, even those told by staff members, provide evidence that it is mostly staff who are arrogant to patients, and not vice-versa.

Theme two: Mismatched expectations (stories 20–29)

Clashes in expectations are underwritten by professional paternalism and the need for control, and by the anxiety underlying any public discussion about what goes on between patients and NHS clinical staff. The reality of everyday health care is that it is about mess, pain and suffering, and how to overcome these. If these are taboo subjects then patients cannot know what to expect. Poor communication and misunderstanding about what can in reality be provided, on the part of both patients and staff (for whatever reason) causes tension and feelings of being misinterpreted.

Staff have high expectations of what they would like to do for patients. Sometimes they can actually perform to their own high expectations but often they cannot, and they expect patients to understand and forgive this as well as being suitably grateful for the effort staff have put in beyond the call of normal duty. However, staff seldom, if ever, articulate this to patients. As staff are thwarted in meeting their own expectations, they begin to lower their expectations, with a resultant knock-on effect in their daily work.

Patients do not necessarily have high expectations of staff, although many staff think that they do. Patients sometimes get angry because they do not understand what has happened or what they are entitled to. Expectations can be much greater or lesser than what can actually be provided or should be realistically expected. Staff then feel aggrieved that patients expect too much, or do not appreciate what is being done for them. In some situations, however, challenges to expectations can be creative and challenging.

It seems from the stories that expectations can be unrealistic and that this mismatch in expectations is demoralising to staff and confusing and aggravating to patients/users.

Theme three: Disparity in care (stories 30–35)

This theme emerges in many interviews with patients. It is clear that patients get very different levels and kinds of resources and care according to geography, the nature of the services offered, changes in health care organisation, the ethos of services, personalities involved in giving care, social influence (e.g. 'I used to be a nurse so ...'), the effort put in to services, attitudes to treatment, etc. In many ways, users lack any real choice about the sort and amount of services they get and where they get them. They can actually lose services that they appreciate and depend upon. Continuity of care and carers is often of vital importance to the peace of mind of users, yet this is often ignored by service planners and providers. GPs are particularly popular because they know the patient and take time to listen; they are trusted by patients. A lack of basic communication can have a disastrous effect on some patients, particularly when they are in pain or need a preliminary diagnosis to reassure them about what is going on. Disparities in care can have enormous consequences, and the services provided by hospitals in the same area can be very different. Basic caring practices are important to patients' confidence in the service, which has a knock-on effect in their progress to independence. Poor care leads to complications, a prolonged need for treatment and care, and, potentially, longer-term care needs. A patient's care needs can be met

differently even by different wards in the same hospital. Attitudes of staff play a major part in feelings of disparity.

Theme four: Working the system (stories 36–48)

The NHS is a large, complex organisation that is often resistant or indifferent to meeting the needs of both staff and users. To prosper and get what they need, individuals and groups must know how to 'work the system' for their own good. In the case of patients, this means getting the care they need; for staff it comes from wanting to meet their care. Some staff also work the system for their own gain. Gains may include:

- financial gain if they can find ways of working that allow them to make more money
- a sense of heroic achievement if staff get things done for patients, or get services provided that would not otherwise be given to those individuals
- a sense of relief that the patient has got what they really need against the odds.

It must be said that, often, people get a real sense of achievement from working the system to their own perceived advantage (albeit that this may be in the good cause of other people's health care needs) and there is sometimes a feeling of the thrill of the chase – 'I went after it very hard on behalf of this patient or this group and we won through!'

There was a definite sense in all those who contributed stories with this theme, that there was an acceptable 'bottom line'. The bottom line defined behaviour in working the system that was acceptable and ethical, and behaviour that was not (usually because it was about personal gain). However, it seemed to be different for different individuals. In some instances it was clear to everyone that the system was being exploited unacceptably and unethically. In other instances things were more 'fuzzy'.

There is no clearly defined and articulated ethical bottom line in the NHS. Some who told stories clearly thought they were ethical in their behaviour and a 'goody' in the world of 'goodies and baddies'. Others would regard their behaviour as less good!

Working the system can be criminal, venal, self-interested, immoral, altruistic, expedient or just plain necessary in the face of particular needs.

Theme five: Being valued (stories 49–61)

The NHS seems to find it enormously difficult to value staff. In a large, very hierarchical organisation, what staff seem to want more than anything is approval of a very basic kind (not money or other kinds of tangible reward, just people acknowledging they are here by saying thank you, recognising effort when it has been put in, etc.). When people do try very hard and put in a lot of effort, the NHS seems to treat them with suspicion and to distrust success, so that people who are 'excellent' may feel dismissed, ignored or ostracised. They often feel discouraged.

A lot of the behaviour of doctors and senior managers (in the stories we heard) goes beyond simply not valuing and recognising people and their efforts. Some doctors and managers are abusive bullies. They create a culture of indifference and even fear that cascades through the organisation from the top. This means that many staff members feel not just ignored but actively put down, particularly if they work for constructive change. There are some countervailing tendencies to the culture of non-support and occasional bullying, e.g. some people do take the trouble to say thank you and people can seek external recognition by way of national awards, but there remains a powerful sense that people feel under appreciated and that they desperately want approval, praise and recognition from above.

Theme six: Taking responsibility (stories 62–68)

People who work in the NHS are inevitably thrust into positions of responsibility of a very serious kind. Sometimes they find themselves badly out of their depth because they have not had enough training or because they do not have the right kind of support. This does not let them off the hook of having to make immediate real choices and take swift action. Things are made far more difficult if there is a culture of blame and fear, which there often is in the NHS: their best-intended actions and decisions may become the subject of organisational disciplinary procedures, or even of professional or public investigation. Often, individuals blame themselves for making the wrong decisions or for making genuine mistakes. In all cases, people can become demoralised and lose confidence in their own judgement and ability to do the job. The culture of the NHS appears to one of fear and blame with low risk and low learning in which individuals at all levels are expected to take responsibility, but are then not to trusted or supported.

Theme seven: Opportunity (stories 69–75)

This is a very positive theme. Over the last 10–15 years opportunities have opened up for staff to develop and grow in the NHS. There are many new kinds of posts, e.g. in management, and there is more training and more development for those who have the capacity and drive to grasp opportunities. To receive support and development, individuals must have good relationships with their superiors (and this sometimes has the feeling of patronage about it). They must also be prepared to work hard for their privileges – much is expected of those to whom much has been given. Successful support and development can transform the lives and working relationships of those who receive it. Many workshop participants testified to the ways in which they had grown and developed over the last decade, often with the active encouragement of their superiors, who had spotted their gifts and talents and developed them.

How we arrived at these themes

Here, we give a short description of how we went about making these interpretations. Both authors were at every workshop. All the workshops and patient interviews were taped and these tapes transcribed. The workshops were also videoed. We then worked independently of each other, reading each workshop's transcripts and writing the values that emerged from every piece of storytelling. We sent these to each other and then met several times to work out themes and check what we had heard. We then took the dominant storylines and grouped them using an affinity diagram process. The seven main themes emerged. The stories in each theme were captured in playlets by a drama company and played back to a primarily NHS audience at a large event. We also asked the audience to listen to each other's stories. At this event we used a similar affinity diagram process to capture themes. The themes that emerged from the event were the same as previously, with some additions.

Comments from the whole day event for the NHS

We took the stories, in the forms of playlets, to an event attended by 150 NHS staff and some user groups. At the event we asked those attending to tell their own stories, and came up with much the same themes as before. During the day the attendees grouped their stories, much as we had with the stories told in the workshops and interviews, and talked about the themes. A number of additional points came up:

- staff are not equipped to deal with the conflict of values that come up in their work
- a lot of time is spent passing data around the health service (memos, talking at people, notices, meetings) but not enough time is spent communicating (in the sense of co-ordinating behaviour) and forming relationships
- staff are better with patients than with each other
- should staff continue to collude with systems that they think are not working?

3. Commentary

Turning values into action

One of the things that struck us whilst listening to the stories was the diversity of values being played out within the NHS. It seems as though professional (mostly individual) autonomy and values have become intertwined. Decisions about how to behave are formed from personal experiences and beliefs (cultural/religious), both inside and outside the NHS. The nature of the work is deeply personal and staff apply their whole selves to the decision-making. There seems to be little discussion going on in workplaces about how values are being enacted. One person's view about what is acceptable (e.g. the waiting list story, no. 37) may be entirely different from a colleague's in the same department. This difference is part of the NHS. It is rarely brought out into the open, perhaps because it has got muddled with autonomy. Of course there should be autonomy in terms of deciding what is best for the patient but this should be within the set of values that make up the NHS's total identity. It does seem to be a deep-rooted problem. There is no agreed 'bottom line'. The danger of values statements in the NHS is that there is always an 'if' or 'but' that allows someone to behave differently.

Values can only be reflected on and developed within the NHS if behaviours and experiences are discussed in the context of the values championed as part of the organisation. If one of these values is 'we care for people', then it is obvious that when people behave in what some would see as an uncaring way, it needs to be aired and discussed in order to reach an understanding about what is actually meant by 'caring for people'. The next step is to decide if either the espoused value or how people interpret that value needs to be changed. We would suggest that where staff do not 'walk the talk', they usually actually think that they are. They just have a different interpretation of the 'talk'. If the NHS is to develop a more integrated approach to its values, then it needs to discuss some of the messy situations that it is

in, without getting caught up in issues of autonomy. The NHS needs to work on what it is. It can use stories as a way of beginning that dialogue, and of exploring its own 'bottom line'. Perhaps it would see itself differently. We suggest that it is the very diversity of enacted values that can contribute to a better understanding of how the NHS works and how best to intervene to make it a more effective organisation.

It is apparent from this work that there is much more scope for exploring and understanding the value ecology of the NHS, in its parts and as a whole, particularly at the point of delivery of its service. The use of storytelling seems to be a penetrating way of exploring the experience of the everyday values enacted and espoused in the NHS. Before producing official values statements, the NHS would do well to confront the reality of the day-to-day practice that prevents people from performing within organisational values, and the individual values that are in conflict with organisational values.

4. Why stories? Why this approach?

Why stories?

'When we have made an experience or a chaos into a story we have transformed it, made sense of it, transmuted experience, domesticated the chaos'
Ben Okri. *Birds of Heaven.*

Leadership can be defined as identifying the story in the chaos. Leaders understand that projecting a story can turn a system around. Most of us find out about 'the way things are done round here' by listening to stories; stories demonstrate the values in action in the workplace, and how close these are to the ascribed values.

Stories offer us a way in to seeing living values or values in action. A story calls upon us to identify with it, and this process changes us by prompting us to re-interpret our views, to rethink the impact of our actions. Whilst our response to a story tells us something about ourselves, sharing our responses moves us beyond where we are. Do you not find that sometimes you can hear the same story as your friends and think it meant something completely different? Our response to a story demonstrates how we have made sense of an experience or event, how we have interpreted what has gone on. It connects with our identity as part of an organisation, as part of a profession, as ourselves. These interpretations in turn help us think about how we behave, and they play a part in the choices we make in our day-to-day work.

Stories are part of how we make sense of the NHS and our part within it. They describe what happens in our day-to-day lives, and help shape our decisions about our own actions. They also show how values compete in our own self-understanding. Values are complex like we are.

Why this approach?

In setting up this values initiative, we built a piece of work based on a set of beliefs and values of our own. We believe that you cannot explore values without being clear about your own understanding and beliefs about how organisations work and, more importantly, the role of organisational identity. Our approach to how organisations work, and therefore how to make a difference in organisations, led us to this particular approach to values. We wanted to make a difference to those individuals and organisations involved in the project, to be analytical, respectful, and thoughtful; and so we had to be clear about our own assumptions about what can change people and organisations.

The approach we used came from an understanding of living systems. The main assertions/assumptions underlying this work are:

- The system (the organisation – NHS trust, health authority, etc.) reproduces itself. The components of the system work jointly to produce each other in order to sustain the identity of the whole. The relative importance of the components will change over time but the identity of the whole will remain – it will be recognisable as the same system (organisation) even though significant parts of it will have changed over time. For example, you as a person change dramatically (physically, mentally and spiritually) from birth to death, but will still be known as a named person, and recognised as that person. Think about a hospital: we get frustrated by the impact of its history, but to the community it serves, the fact that it was a poorhouse at the beginning is part of the hospital's identity. We also know as we move between organisations that different hospitals, community trusts, PCGs, health authorities, have different approaches, different ways that things are done. Ashworth Hospital is an example of how an organisation's identity is bigger than any individual chief executive – its problems recur year after year despite high profile investigations and changes in management.

- Change is not externally imposed. Rather, the external world can perturb a system. The system will use its own identity to make sense of any perturbation, to understand it in the context of itself, and then to choose action. This is true on a personal/individual level as well as an organisational level. Individually, we will receive the same piece of information, e.g. a questionnaire about our child's school uniform. We will react differently, each 'reading' it differently. Some will be trying to work out what the governors want, by how they slanted the questionnaire; others will comment on the poorly put-together questionnaire, which reflects on the quality of the governors; other will see it as a plot to rid the school of trousers for the girls; others as a way of getting a whole new approach to uniform. We will all read the questionnaire, internalise it, making (unconsciously) a reference with our previous experience of the school, of the uniform debate, of questionnaires from the top of the hierarchy and so on, and then interpret it, before deciding how to respond. Organisations also act like this. A letter might be sent to all trusts about the waiting list initiative. Some trusts might see it as an opportunity to get more money, others as a stick to beat them with. Others may put it in the pending pile, thinking that it will make no difference to them. Some trusts will decide to massage their statistics and take no action, others will make it a top priority and reorganise their entire services to meet the demands of this letter. In these accounts, the same data was available but was interpreted differently. *The choice for action was internal.*

- The reality of how the system is organised and reproduces its identity, how it goes about its daily business, is as a network. Stories form a central part of how the network communicates. Communication in this sense is co-ordination of behaviour (the outcome not the process!). However much an organisation may attempt to set up a hierarchical structure to run the business, in reality people take daily actions as part of a network, using informal lines of information and relationships across the organisation to get things done. Whilst rules play a part in the choice of action, so, too, do accounts and stories. When we start a new job, we usually try to get a

picture of 'how things are done round here'. When trying something new, we ask about the last time someone tried something similar. When trying to make sense of a change in another part of the organisation (e.g. the sacking of the chief executive) we listen to the official reason and then we tell stories of our own experience of the chief executive, and we listen to others. From these we try to work out why we think he or she was sacked. This may change our own behaviour in the future, or shape out attitude to the next chief executive. It may confirm our views about this organisation and the sort of place it is to work. It will contribute to the organisation's identity. Stories help us find meaning in actions.

- Evidence of the organisation's identity can be seen in the way it behaves or in its values in action. How it behaves in turn shapes subsequent behaviour. The day-to-day practices of an organisation are writ large in the stories told by members of the organisation, or by those who form a temporary relationship with it. In the case of the NHS these two are staff and patients/users.

- Stories are themselves a means to create identity, not just a way of understanding identity. Stories can be amplified (i.e. retold) in order to enable a set of behaviours seen as beneficial to the organisation. For instance, when merging two trusts, creating a joint event (be it a fund-raising event, a party, a joint venture to secure funding) is useful in the moment for forging new relationships and joint working, but is even more useful in the longer term if it creates stories within the organisation where 'we' did something positive together. Finding space for those stories to be told is, we would argue, a critical part of forming the merged organisation's identity.

- One way to uncover the values driving action and underlying identity is to let these values emerge through storytelling. The process therefore requires living in the storytelling mode without recourse to analysis and discussions about causes for as long as possible, until key themes emerge. The idea is that a story of a

meaningful/significant event in the member's experience of the organisation is told. This will trigger stories in others. They then tell their stories, without explaining why these are linked. They could also tell the original storyteller's story back as they heard it. From these processes of living in the stories, over a period of time, the links between the stories become apparent. These may not have been the links that the storytellers thought would emerge. For instance, if asked what the core problems of the NHS were, the answer might be poorly motivated staff. The reason for this might be too many patients, not enough time or not enough pay for the effort put in. In telling stories about experiences of the NHS a very different picture emerges, one in which huge amounts of effort are put into working the system, making heroic achievements, and where some staff are undervalued and even bullied. The symptom of poorly motivated staff might be correct, but the reasons behind it might be more complex and less apparent. These more subtle causes, we think, can be uncovered in storytelling.

- Telling stories and being listened to seems to enhance self-respect. This is valuable in itself.

5. What we have done so far

During 1998 we collected people's stories of experiences and events that have shaped their lives in the NHS – as staff members or as users. This section describes what we have done so far, and gives an outline for a workshop and a process for collecting stories.

Workshops

We invited NHS staff to participate in day-long workshops (by personal letter and by asking chief executives to ask for local volunteers), during which they told their 'defining moment' story from the last few years.[‡] These included experiences with patients, relationships with colleagues, situations where they had to make a hard decision, moments of realisation that the NHS does not work quite in they way they had thought it did, their own experiences as a user. At each workshop participants told their own story and also 'replied' to other's stories, with stories from their own lives that complemented/contradicted, or seemed to have some connection with, the story that had been told. We did not enter into any discussion about why they thought these stories were important, or what should be done. Participants had the opportunity at the end of the day to summarise what they thought the themes of the day had been. Each workshop was attended by a mixture of staff (nurses, medical records staff, clerical officers, chief executives, doctors, managers, therapists and all combinations of these). They worked in hospital and community services, health authorities, and acute, rehabilitation, mental health and learning disabilities services. All the stories were taped and videoed.

We undertook workshops until we thought we were uncovering the main underlying values coming though in the stories (seven workshops with thirty-seven participants).

[‡] We did not specify negative or positive stories.

Interviews

Volunteer patients/users were interviewed about their main experience of the NHS (we advertised for interviewees and asked King's Fund staff if they knew anyone who had been a recent user of the NHS). These interviews were taped and transcribed. All patients who volunteered were interviewed (26).

Video box

We had a video box running at the Fund for the last two months of the project, for anyone to come in and tell us their two-minute story. This attracted a mixture of staff and users.

Analysis

The workshops were facilitated by one of the authors; the other took field notes and intervened in the facilitation as necessary. Working alone, each author read and crudely coded each transcript. The authors then read each other codes and discussed what they had heard/seen. As the reading continued, themes began to emerge. We found 26 themes (values in action), which were reduced when we took out ones that occurred only once or twice and combined some themes to make more sense (for instance putting abuse of power into the theme on valuing staff). We did this by writing a brief synopsis of every story, cutting them out and then putting them up on the wall in an affinity map. Seven main themes emerged.

Large event

We 'tested' these themes at an event attended by over 100 NHS staff from all parts of the system. The event took place under the watchful eye of some observers, who commented on the day from a non-NHS viewpoint.

Workshop process

10.00 a.m.–10.30 a.m.	Explain the reason for the work, and why it is being done in this way. Introduce yourselves. Explore joint expectations.
10.30 a.m.–11.00 a.m.	Explain how you are going to work and do a dummy round of storytelling, with participants telling stories of their journeys to the workshop.
11.00 a.m.	Storytelling.

The process for telling stories is as follows:

- Everyone writes their (defining moment) story down, so that the stories are not lost or remade by other stories as the day goes on.

- Someone tells his or her (defining moment) story ('I remember when ...') without interpreting it.

- Everyone has a few minutes to think about connections to anything in their own work experience (internal sense-making and interpretation) – quietly and on their own – and to write it down. They tell their stories, which will be similar or contrasting. From here the storytelling flows until their stories are exhausted or the time is up for this section. Ask for connecting/contrasting stories – and for these stories to be told without the storyteller explaining the connection/contrast ('I have a similar story ...' 'I have had a different experience ...').

- If participants get stuck, ask the group for a volunteer to tell the story back (from this the interpretation of the person 'replying' is 'exposed' – but probably only when you carry out analysis and replay the video – as you can see how the 'replyer' places different emphasis on the story).

- Ask if anyone else wants to have a go at telling the story back.

- If participants get stuck on either of the last two steps, break them into threes to talk and 'unblock', and then get them to come back and try again.

- Having exhausted this round, start again, having a 15-minute coffee break after every two rounds.

- Start again at the beginning – each round should last half an hour (or more if there are fewer participants).

- If the process gets boring, and the group is willing, have the 'telling-back' change shape, or the initial story change shape – draw it, tell it as a poem, etc.

- At 3.15 p.m. have a go at the 'whole day story' – ask participants to make up a story that captures all the parts discussed (facilitate this by asking neutral questions). Get them to write individual poems or draw a picture of the day.

- Finally, let participants make comments on the day and make interpretations if they are burning to do so, and remind them of the what next

Break for lunch at 12.15 p.m.–12.45 p.m. Coffee and tea should be plentiful throughout, as should snacks. The room layout should be as informal as possible, with comfortable chairs arranged in the round. Tables should be small coffee tables only.

Timetable

10.00 a.m.	Introductions
10.30 a.m.	Explanation of process and dummy run
11.00 a.m.	Storyline 1
11.30 a.m.	Storyline 2
12.00 p.m.	Coffee
12.15 p.m.	Storyline 3
12.45 p.m.	Lunch
1.30 p.m.	Storyline 4
2.00 p.m.	Storyline 5
2.30 p.m.	Coffee
2.45 p.m.	Storyline 6
3.15 p.m.	Whole day story
3.45 p.m.	Comments/thoughts and what next
4.00 p.m.	Close

Ideally go for six stories. It is possible to do eight and the minimum is three.

Collecting stories for a small workshop or storytelling meeting

You might like to organise a storytelling event/meeting/workshop locally, or within your own team. Collect some stories to start you off. At the meeting you might want to agree Chatham House rules (the issues can be discussed outside the group but are not attributable). Certainly, some ground rules should be agreed about confidentiality before you start the pre-meeting work of collecting stories.

Your story

First, your own story. Think of an event/situation in which you have been involved in the NHS in the past two years (as a member of staff or as a user) and which has really made an impact on you. It might have altered your views of how you should go about your job, affirmed a view you passionately held, or affected how you think about the NHS or your own behaviour. It should be something at the forefront of your memory, and something that you are willing to share with others.

Once you have remembered a 'defining moment', write it down. This is for your own record only or you can send it to us at the King's Fund to be included in our collected stories, if you wish.

Someone else's story

Now choose someone who will be able to tell you their story without feeling intimidated or wanting to hide any of the details. Perhaps it could be a work colleague, or a friend who is a NHS staff member or user, or someone who volunteers from within your organisation.

We have found that people have really enjoyed telling their stories and being listened to. It seems rare for people to share the important moments/experiences that have shaped their thinking and actions. Stories usually last for only a couple of minutes. This is not a time consuming task, but you do need to give it your full attention. You should:

1. Explain to your storyteller that you want to listen to their story and that you will be telling it at an event to a small group of health service staff and users, but that it will not be attributed to them

2. Ask them to tell you about an event in which they have been involved in the last few years that has made a lasting impression on them. It can be a 'good' or 'bad' story. It should be easy for them to recall and could be about anything – from a story about an incident involving a patient or relative, about a relationship with a colleague, to a story about something they fought for. The story can be about something seemingly quite small, or a major incident. Whichever it is, we are not looking for anecdotes, but for tales about events that carry some meaning for the storyteller, something they will not forget

3. Take notes of the story and tell it back to the 'teller', to make sure that you have captured the essence of the story

4. You may find that the story you have been told triggers a memory of yours – something similar or a direct contradiction from your own experience. You may then want to share your story with the other person. If not, then at least make some notes to remind you of your 'reply' story.

5. Finally, ask the storyteller what their story means to them and what impact it has had on them, again taking notes. These notes are for your own use at the workshop, to help you remember. Please make sure that you destroy the notes you have made after the workshop.

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Contributing your story

If you have a story to tell us, please write it down just as it comes into your head. Please do not edit it. Tell it as you remember it. If your story was triggered by one of the stories in this book, write down its number when you have finished writing your story. If possible, please type your story. Please put your name, address and contact number on the sheet(s) with your story and send it to us in an envelope marked 'Confidential, please forward to addressee'.

Your story will help us to continue to build up a picture of the living values in the NHS. If at anytime we wish to use your story, we will make it anonymous, so that it is not possible to attribute the event to you or to people you have identified in the story. A copy of your story will be kept in the King's Fund archives.

Please send your story to:

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ISBN 1-85717-403-8