The Cry for Professional Intimacy

A UK Study of Changes in the Working Lives of Expert Practitioners in Health and Education during the Early 21st Century

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ABSTRACT

This is a qualitative study investigating the impact of factors affecting the working lives of practitioners in Health and Education during the period 2006-2016. It was conducted in the context of the increasing evidence of low recruitment, low retention rates and a high incidence of stress amongst expert practitioners in these two public institutions. What emerges from the data is a cross-sector phenomenon identified here as a 'cry for professional intimacy', formed as these practitioners give voice to a strong desire to be allowed to refocus on the relational aspects of their work.

A review of contextual literature and related research pointed to an argument that pressures from the application of neo-liberal principles to the public sectors of Health and Education have created a new era of commodification and business style assessment of practice. At the national level, a loss of trust in our educators and doctors has been increased by the media moral panic over events such as the Shipman and Mid Stafford cases in Health, and in Education by the Climbié case and the condemnatory PISA report by McKinsey (2007).

Government statistics and surveys by professional bodies have documented the rising experience of stress amongst these practitioners, but there appeared to be a gap in research that focused on both the cross-service nature of this phenomenon and the voices of practitioners themselves. The aim of this research therefore was to address the absence of stakeholder voices and to capture data from senior practitioners. This is the first time that research has concurrently interrogated executive-level practitioners in Health and Education. Specific questions were: firstly, what changes are taking place in the working lives of expert practitioners in Health and Education? and, secondly, is there a shared pattern of experience between expert practitioners in both sectors?

Structuration (Giddens 1979; 2005; 2013), multiple-level analysis (Jepperson & Meyer 2011) and the concept of self-efficacy (Bandura 1982) formed the theoretical framework for this investigation.

This field study involved thirty-six semi-structured interviews of practising leaders with at least ten years of management experience in Health and Education. The sample included hospital consultants, nurse directors, general practitioner (GP) partners, head teachers, Advanced Skills Teachers (ASTs) and university course leaders. Interviews were conducted in thirty institutions, including National Health Service (NHS) hospitals, GP practices, state secondary schools and universities.

Data analysis of the thematic coding showed a highly significant link (chi square $p>0.0001$) between autonomy, relationality and a consequent perception of efficacy amongst these practitioners in both sectors.

The results of this field study therefore serve as a powerful indicator of the cross-sectoral nature of the dissonance of expert practitioners in Health and Education in the UK. It indicates an urgent need for further research into the link between autonomy and relatedness to the efficacy and retention of practitioners in these public services.

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CHAPTER 1: INTRODUCTION

> Rapidly changing conditions call for wide reaching solutions and greater commitment to shared purposes. Such changes can only be achieved by people who have the skills, the sense of collective efficacy, and the incentives to shape the direction of the future. (Bandura, 1982:143)

The aims of this short introductory chapter are threefold: firstly it gives a personal account of the origin and development of the research idea and question; secondly it illustrates the importance of research to the development of knowledge, policy and practice; and thirdly it presents the aims and overview of the thesis.

1.1 Origins of the Research Idea

The idea for this research came from post-therapy conversations I had with participants over three years, as I worked with teachers, doctors and nurses using biofeedback measures to reduce work induced stress.

As one of only two Advanced Skills Teachers (ASTs) in psychology appointed between 1998 and 2010, I was invited to deliver curriculum 2008 support to psychology and biology departments across English education authorities at the National Science Learning Centre at the University of York, and the Science Learning Centre at Sheffield Hallam University.

During this support work, which I began in 2005, I became aware that, although my remit as an AST was not directly concerned with addressing workplace-related stress, teachers and senior management in schools repeatedly reported to me their own feelings of 'being stressed' and 'overwhelmed' by the changes in their role. Increased surveillance, increased paperwork and an increased standardization and control of their processes of consultation and teaching were cited as the causes of this distress.

In this context, and as part of the Association of Teachers and Lecturers' response to an alarming increase in requests for support, I was asked by the Association of Teachers and Lecturers (ATL) to create a programme of workshops on stress management. These workshops have been delivered, over a period of three years (2008-2011), to senior teachers and to members of the British Psychological Society. I also contributed to senior leadership training for the Education Department of Derbyshire County Council and delivered workshops on biofeedback and stress to members of the ATL in Sheffield, Manchester, Harrogate and Derby. This work with teaching staff, usually in groups of fifteen, for a two-hour session which included a twenty-minute debrief session, underlined for me how endemic and paramount the experience of stress was for teachers.

Over the past years, this work has inevitably brought me into constant and direct contact with a substantial number of trainee teachers, teachers and their working environments. The teachers who attended these sessions may be seen as a self-selecting group, but they included teachers of differing ages, seniority and experience, and their comments and reports have to be seen in the wider context of the evidential research undertaken in the last ten years, which parallels their commentary.

As I listened to well over 300 working teachers in the debriefing section of each workshop, I found that they repeatedly talked about the difficulty of communicating with their colleagues and with their pupils. When communication took place, it was directed by government protocols and systems to which they had to adhere. The administration of this externally designed work practice required an increase in paperwork, as incidents, practice and outcomes had to be recorded. A new area of work, which focused on the interpretation of these statistics, had burgeoned in the previous ten years, and practitioners felt that it meant that: a) there was more investment in administration, rather than the job of teaching; and b) when there wasn't this investment in appropriate administration staff, they, the teachers, had to carry out these tasks, again reducing the focus on

actual teaching. The locus of authority for them, as professionally trained staff, was under dispute.

In 2009, David MacLane, personnel officer for the ATL, described for me the standard process set in motion by the ATL when a teacher-member reports being overwhelmed by stress. The union will interview the individual teacher, give guidance on stress management and provide counselling (MacLane, 2009). They will then negotiate either a graded return to work or an exit package from employment. The aim is to protect the individual teacher from a reoccurrence of the unmanageable stress response and to reduce the financial consequences of being unable to work. This individual support is necessary and appropriate, but it does mean in practice that systemic failures are not addressed. The focus of the union response is on the individual teacher, and the deployment of the union's financial and professional skills is towards a satisfactory outcome for each individual case. The role of the union negotiator is to represent individual teachers, and to successfully negotiate for each teacher with the school and the local authority involved. This means that there is no time, funds or space to address systemic failure.

In 2009, I was asked to deliver a series of biofeedback sessions to middle and senior managers at a Midlands teaching hospital trust. This group included nursing and medical staff and I found the post-session discussions centred around the same problems as those of the teachers who had attended similar sessions. This experience of stress or dissonance, described evocatively as occurring 'when emotions hurt' by Hardy (Hardy, Carson & Thomas 1998), appeared to be cross-sectoral and, from the anecdotal evidence of these health and education employees, was leading inexorably to a staffing crisis in both sectors. If this were the case, then attempts to address the dissonance in Health and Education by focusing on the resilience of the individual practitioner would be fruitless. Resilience of the individual practitioner could not mediate the inherent failures of a system. It would indeed be counterproductive, leading in some cases to burnout or, in others, to depersonalization and cynicism (McManus, Winder & Gordon 2002).

1.2 Statistical Snapshot of the Staffing Crisis in Health and Education

In the period from 2011-2016, as the core of this research, I collected data in the form of interviews from senior practitioners in Health and Education. My research questions were:

a) what changes are taking place in the working lives of expert practitioners in Health and Education?
b) is there a shared pattern of experience between expert practitioners in both sectors?

This section deals with the statistical evidence on low recruitment and retention in the health and education sectors of UK public services. It uses government statistics and appropriate media reports and information from the reports of professional associations. Given the essential nature of the role of these practitioners to deliver health services and education to the public, it is all the more alarming that, in the first part of the 21st century, we continue to see a greatly increasing level of dissonance amongst them. As we progress through the second decade of the 21st century, both media reporting and government statistics present us with an alarming snapshot of the changes in the working lives of expert practitioners in Health and Education, i.e. our teachers, doctors, nurses and lecturers. The statistical evidence for recruitment, retention and stress-related illness in our expert practitioners of Health and Education show disturbing trends. There appears to be a crisis of poor recruitment, low retention and stress-related illness amongst the highly-qualified staff in these public services – a crisis which is unfolding in our surgeries, hospitals, schools and universities.

1.2.1 Secondary Education

Concern about the low recruitment and retention of teachers in England has been expressed since the early part of the 21st century (Barmby 2006). Low recruitment of secondary school teachers in particular is a growing trend in the UK (UCAS 2015): UCAS state that, in 2014, 28,080 trainee teachers had been

placed on courses against the Department for Education (DfE's) own target of 29,787 – a shortfall of 1,707. Information from the Teacher Supply Model (DfE & NCSL 2015) states that overall figures are satisfactory. However, a further breakdown of the 2015 figures reveals an oversubscription in primary school training applicants and secondary PE applicants, whereas only 14,330 secondary trainees have been placed against a target of 18,539 – a shortfall of 4,209. Further analysis of the secondary trainee figures during this period reveals notable shortfalls in key subjects and a lack of students entering training to become expert practitioners in key secondary subjects, such as physics, chemistry and English (Howson 2015a).

An article by Nigel Morris, Deputy Political Editor of the Independent, published on 29 December 2015, demonstrates the platform that print and electronic media can provide for the topics which are the focus of this thesis. He describes the increasing staffing crisis faced by schools and the 'soaring' cost of the increasing use of supply teachers, stating that 'schools in England spent 3.29bn in 2013-2014 to hire temporary staff, compared with £1.02bn two years earlier' (Morris 2015). He goes on to quote from a survey completed by the National Association of Head Teachers (NAHT), which found that almost four in five schools are finding it hard to recruit, and referred to DfE figures which stated that targets for recruiting teachers have been missed for three years running. 'Overall, 28,148 graduates began teacher-training courses, 94% of the target. Just 82% of the target was achieved for secondary school teachers' (Morris 2015). These figures coincide with 'record levels of departures from the profession', as 'between November 2013 and November 2014, a total of 49,120 teachers left, a rise of 3,480 on the previous year' (Morris 2015).

On 10 June 2016, as a response to the publication of figures such as those above, the Committee of Public Accounts published a report which examined the relevant data and confirmed the general shortage of teaching staff in England. This report stated the committee's disappointment that the DfE has missed its targets to fill teacher training places four years running, with significant shortfalls in some subjects (HC Select Committee 2016). The report also addressed the

growing problem of appropriate staffing in teaching, focusing on the number of teachers who are not trained to teach the subjects on their timetables. There is a shortage of teachers for certain specialisms (HC 73, 2016: Section 17). The report states that the National College for Teaching and Leadership (the National College) has changed the way it allocates training places to providers every year, making it difficult for them to plan to deliver the right courses, such as Subject Knowledge Enhancement courses, which could help to fill gaps in shortage subjects (HC 73, 2016: 17:9).

On the morning of the publication of this Committee of Public Accounts report (HC 73, 2016), Michael Wilshaw, the then head of Ofsted, interviewed on the Today programme, reiterated that the National College of Teaching and Leadership (NCTL) is not doing a good job of serving our teachers and does not understand the need to fill shortage subjects (BBC 2016). He added that the gathering of data by the DfE is flawed, in that it collects data neither on the number of temporary teachers, nor on trainee teachers who are given the £6,000 bursary to train, but who then leave their course without completion (BBC 2016).

1.2.2 Medicine

Problems in medical training mirror those described by Wilshaw in Education. There are significant shortfalls in entrants to some medical specialties, and the lack of doctor trainees completing their full medical education by pursuing specialty training is an issue in medical education. In 2008, 80% of specialty trainees had progressed straight from training (Goldacre, Laxton & Lambert 2010). In 2011, the UK Foundation Programme Office was commissioned to look in detail at the outcomes of Foundation Year 2 (FY2) doctors: the resulting survey shows that the figures from a 95%-response rate (7,168 responses from 7,533 requests) Career Destination survey published in November indicate that in 2011 only 70% of FY2 doctors went straight into specialty training, leaving almost one-third of the year group outside formal training (UK Foundation Programme Office 2011). This trend is seen among trainees at the South Thames Foundation School, only 65% of whom applied to specialty training in 2010, down from 79% in 2008

(South Thames Foundation School 2009; 2010; Smith & Low 2012). The BMA (2013) reports that it is difficult to recruit junior doctors into GP practice, and Brockington and Mumford (2002) describe the continuing recruitment shortfalls in psychiatry. Government-generated research shows that low recruitment to GP specialty training, which is part of this trend, exacerbates an already reducing level of GP provision. Official data analysed by the House of Commons Library shows that at a time of ever increasing demand for their services, the number of GPs has dropped by 356, compared with the level in 2009/10. The proportion of family doctors serving every 100,000 people has also dropped from 70:100,000 in 2009/10 to 66.5:100,000 in 2015. At the same time, GP leaders have raised serious concerns about what they say are the 'worst ever' figures on GP training, with the take-up of places having fallen to 62% of those available in the East Midlands, and little over 70% in large parts of the north of England (Parkin & Powell 2015).

This crisis of expert practitioner staffing, leading to temporary employees at high cost, is addressed in the Royal College of Nursing (RCN) report Runaway Agency Spend (RCN 2015a), which states that in the last three years, NHS agency spending increased significantly, from £1.8bn to £3.3bn for both nurses and locum doctors.

Locum doctors are used to fill the shortfall of qualified doctors in our hospitals and to cover out-of-hours' provision for GP practices. The number of locum doctor hours needed has risen yearly, partly in response to an increase in the number of junior doctors registering to work abroad, which it is feared may increase due to the protracted junior doctors' contractual dispute of 2015-2016. Stone, Medical Correspondent for the Independent, wrote, on 17 February 2016, that on Thursday 11 February, the day of Jeremy Hunt's announcement regarding the junior doctors' contract, 300 doctors applied for Certificates of Good Standing, required for working abroad – up from a usual average of twenty-six a day in February. A total of 109 doctors requested certificates the day after the announcement, and figures for the weekend after were over double those of the previous weekend. In 2015, when the industrial dispute began, 8,627 certificates

were issued to doctors – up from 4,925 in 2014, and around 5,000 in the previous three years to that (Stone 2016). Commentary in the British Medical Journal suggests that 2015 will be the year that statistics show a sharp rise in the number of UK doctors moving to Australia and New Zealand, as survey findings have suggested may happen (Rimmer 2015).

The dispute between the government and the British Medical Association over terms for new junior doctors culminated in strikes in the first months of 2016, including the first all-out medical strike in NHS history in April. This is a significant development in the relationship between expert practitioners and their employers. The government claimed an electoral mandate to meet standards of seven-day working in certain services, while representatives of the BMA argued that the contract would impose more demanding working patterns, without the resources to make this fair and safe (Nuffield Trust 2016).

On the same day as the Committee of Public Accounts report into problems in staffing in education appeared, 10 June 2016, a Health Leaders' report into issues dealing with NHS staffing was published (Nuffield Trust 2016). In this report, forty health leaders from all areas of NHS provision commented that industrial unrest amongst junior doctors would have a deleterious effect on future staffing levels of this cohort of NHS employees.

At the point of publication of this Nuffield Trust report, it was thought that an agreement between NHS employers and the BMA junior doctor committee had been reached, subject to a vote by BMA members. Since then, the junior doctors strike is set to continue throughout 2016, and perhaps beyond, after a rejection of the Department of Health offer by staff.

Published before the outcome of this dispute, the Nuffield Trust report states that the media and senior medics have expressed concerns that the intensely felt dispute will discourage junior doctors from taking up places under a new contract. A total of 64% of the health leader respondents to this survey considered that the junior doctors' strike would damage the future supply of this segment of the workforce in their area (Nuffield Trust 2016).

1.2.3 Nursing

Comparing annual figures for the nursing workforce shows a trend towards a shrinking workforce. In 2009/2010 there were 375,505 qualified nurses, and in the period between 2012/2013 there were a total of 369,868 qualified nurses working in the UK. Furthermore, there is an increase of 26% in nurses who left voluntarily from 2009/10 to 2012/13. Figures show that nurses who retired increased by 128% between 2009/2010 and 2012/2013 (HSCIC 2014; Lintern 2013). The supply of nursing staff is also under question. Problems with recruitment for nurses are reported by the RCN in the evocatively entitled report, The Fragile Frontline (RCN 2015a). Jeremy Hunt, in an earlier contribution to the debate around the shortage of nursing staff, stated, in an address to the House of Commons, that the Francis Inquiry had found 'an unacceptable delay in addressing the issue of shortage of skilled nursing staff' (Hansard Col. 908 2014). He went on to say that this issue had been addressed, and 'the latest figures show that not only are there 3,500 more nurses on our hospital wards since the Francis report, in just a year, but we now have more nurses, midwives and health visitors in the NHS than ever in its history' (Hansard Col. 908 2014). However, monthly workforce figures for November 2013 from the Health and Social Care Information Centre (HSCIC) (2015) indicate that there are 770 fewer individual, qualified nurses in the NHS in England since May 2010. The situation is that the nurses who are there are working more hours a week: therefore, there are more nursing hours being worked, but fewer nurses being employed (HSCIC 2013). According to Full Fact, an independent database which monitors government statements on public services, this 'full time equivalent' (Full Fact 2014) rise is mainly due to midwives and health visitors, whereas 'ordinary nurses have actually fallen by over 1,500 since November 2010' (Full Fact 2014).

The 2015 report of staffing of nurses in the NHS (RCN 2015b), describing the staffing situations for nurses in more depth, states that healthcare providers, both in the NHS and the independent sector, continue to report the challenges they are experiencing in both recruiting and retaining registered nurses. Struggling to recruit is just one symptom of the current shortage of nurses that exists in the UK;

a lack of senior nurses is also a problem. In April 2015, the RCN highlighted the impact that the shortage was having on the NHS in England in their report Fragile Frontline (RCN 2015b) which states that NHS workforce banding data obtained from the HSCIC shows that over the last five years, the more experienced, and most expensive, senior nursing posts have been cut disproportionately as compared to other bands, with a reduction of 1,545 band 7 and 1,317 band 8 nurses. Although numbers have increased slightly, the NHS has 2,800 fewer senior nurses than it did in 2010 (RCN 2015b). This report is supported by Lord Carter, whose findings in his June 2015 interim report on productivity in the NHS led him to assume there may not be enough nurses to meet the 'post Francis demand' (Carter 2015:12).

1.2.4 Higher Education

Recruitment is also a growing problem in certain sections of higher education. A Higher Education Funding Council (HEFC) report on the UK's academic workforce reveals that British universities are short of lecturers to teach maths, physics, chemistry and engineering (HEFCE 2010. Based on data collected by the Higher Education Statistics Agency, the report shows the number of permanent staff teaching engineering and related subjects fell by 14% from 1995-2006 and 2003-2004. For maths, chemistry and physics, there were decreases of 10%. The HEFC reported in 2010, that, although the recruitment and retention of all staff were generally unproblematic, there were some significant shortages. They reported that where problems existed, they tended to be concentrated in particular disciplines such as maths, chemistry and physics. The report further reiterated the importance of creating attractive and sustainable career pathways for academic staff, particularly for researchers (HEFCE 2010).

The lack of opportunity for sustainable career pathways is driven by the use of short-term or zero-hours contracts which have emerged in higher education (HE), and which are leading to a less cohesive and a more fragmented staff (Langenberg 2001). Langenberg (2001) also reports on the findings of a survey of the situation of postdoctoral students in Europe, carried out jointly in 1998 by the European

Science Foundation (ESF) and Nature. The concern most voiced was the uncertainty of contracts and the lack of prospects to obtain permanent positions. The survey, which consisted of people attending ESF conferences who were under forty years of age and held a PhD, revealed that only one-third were in permanent employment. The situation became little better with age and length of experience: half of those aged over thirty-five were still on fixed contracts. The greatest difficulty was found to be the uncertainty of contracts and the lack of prospects to obtain permanent positions:

> This research position was intended to be a transitory situation towards a more stable scientific career, although it is becoming a state of permanent uncertainty. There is an anguishing lack of prospect for a career in science for young researchers. (Langenberg 2001: 849-850)

So writes one participant in Langenberg's survey. The Reporter for the European Parliament Science and Culture Committee, Herr Wittbrodt, has stated that employment opportunities, especially in permanent positions, seemed to represent the most important and common problem for young researchers in Europe. Very often, young researchers were especially vulnerable to personnel cuts resulting from lower research and development (R&D) financing or company downsizing (Wittbrodt 2001).

The Education Reform Act of 1988 (HMSO 1988) abolished the principle of tenure in higher education leading to declining job security in higher education institutes (HEIs) and encouraging an increasing use of temporary contracts (Metcalf et al. 2005). In the old (pre-1992) universities, fixed-term contract research staff comprised 15% of academic staff in 1978, rising to 28% in 1988 and to 40% in 1997 (Bryson 1999). There has also been a growing resort to using part-time adjunct teachers for the performance of conventional teaching (Husbands & Davies (2000) in Metcalf et al. 2005). The ongoing effect of this employment uncertainty in higher education is that post graduates move away from a career in academia, contributing to staff shortages in key STEM subjects (HEFCE 2010).

1.2.5 Summary

In the above section, inadequate levels of recruitment in the services of Health and Education leading to the employment of inappropriately qualified staff, and an increase in temporary and agency staff, have been demonstrated through government statistics, media reports and professional association surveys. The next section deals with the statistical evidence of increasingly high levels of stress reported by employees in the public sectors of Health and Education, and its link to high absentee rates and low employee retention in those sectors.

1.3 Statistical Snapshot of Crisis of Stress and Stress-related Absence and Exit in Health and Education

Running parallel to the problems with the recruitment of staff in Health and Education is a trend for increasing rates of absence and early exit (Keogh 2013; Passey & Golden, 2010; Royal College of Anaesthetists 2016). A clearer understanding of the causes of this statistically high absence and exit rate within these public service professions is provided through evidence of the increasing centrality of the experience of stress experienced by expert practitioners, and the tendency of exiting professionals to cite stress as their reason for leaving. GP Forward (NHS 2016) and the introduction of the Practitioner Health Programme (PHP) (2013) are NHS-funded initiatives which are designed to support NHS staff who are suffering from stress and burnout.

1.3.1 Secondary Education

Evidence that stress is a major cause of absence is provided by recent surveys of teachers, such as those conducted by the Teacher Support Agency, which states that in 2012, '18 per cent of calls and emails dealt with teacher anxiety, three times the figure from 2010' (Bailey 2013). In the same online edition of this Teacher Support Agency (TSA) publication, (Bailey 2013) states that in fifteen local authorities, stress-related absence is up by 50%, while the number of teachers taking stress leave has risen 10% since 2009. Figures also show that at

least forty local authorities have seen an increase in the number of teachers taking stress leave in the last three years. The sharpest rises were in Tower Hamlets in London, Oldham and Walsall (Bailey 2013). This evidence demonstrates that stress-related absence in teaching is a nationwide phenomenon and is an increasing trend.

Not only absence, but exit from the profession is often attributed to stress by the expert practitioners themselves:

> The Education and Skills Committee states that a check on the profiles of new teachers entering the profession through the conventional post graduate route reveals some sobering trends in the working population of teachers. The figures are shocking. The greatest problem we face is not recruitment but retention. Government reports suggest that between 30% and 50% of recruits who have a full course of teacher training are not in the profession after 5 years the Education and Skills Committee (E&S, session 2003-2004, 2004) and the Teacher Resignation and Recruitment Survey state that exit interviews of teachers suggest that the majority of those who answer when asked 'why are you leaving' say, 'stress'. (Bailey 2013)

1.3.2 Medicine

Specialist hospital doctors also report a reduction in wellbeing and morale and link it, amongst other things, to the effect of low staffing levels, as this comment from a hospital anaesthetist shows:

> Not only will low staffing levels perpetuate rota gaps and prevent hospitals from meeting growing patient need but [they] will also adversely impact on the recruitment, training, wellbeing and morale of all anaesthetists ... (Spargo in O'Dowd 2016:463).

'Wellbeing' and 'morale' are recognized as essential components of a stable and productive workforce, and a lack of wellbeing and morale can be identified as components of stress, with its consequences for the health of a workforce (Cartwright & Cooper 2002). McManus' study of over 1,000 doctors from all disciplines of the profession found a link between workload and stress response, including depersonalization and desensitization. These outcomes were seen as

adaptive responses to protect these doctors from burnout (McManus, Winder & Gordon, 2002).

There is a recognition from the NHS that stress amongst doctors is a pressing problem. The Practitioner Health Programme (PHP), funded by the NHS and headed by Dr Claire Gerada, first opened its doors to practitioner patients in September 2008.

In the introduction to their five-year report, they state their belief that there are doctors and dentists with mental health and addictions issues who were unable to access the NHS though fear of stigmatization, or having to receive their treatment from colleagues. The aim of the PHP is to treat these patients and return them to a safe working environment, therefore reducing the financial pressures on the NHS for the cost of sick leave and locum cover (PHP 2013). In the executive summary, the report states that, of the doctors attending PHP, and averaged across the five years, around 80% have mental health problems (the commonest problem being depression, which accounted for 55% of mental health diagnosis) and 20% have problems with addiction (around 66% had alcohol dependence). They also state that very few patients presented with physical health problems alone (PHP 2013:4). The report concludes that:

> five years on we have learnt the following: it is emerging more clearly that certain professional and demographic groups have been identified as more likely to present as practitioner patients, such as; GPs and Psychiatrists; 25-40-year-old females; 40-60 year old males and doctors in training. (PHP 2015:21)

The PHP is available to all specialties, but GPs as a specific group increasingly cite the particularly stressful nature of their work as having a negative effect on health. That this too is now recognized by the NHS can be seen in the government commitment to providing investment for mental health services for GPs. The NHS publication GP Forward View states, under the subtitle 'Health and Wellbeing', that there:

> will be £16 million extra investment in specialist mental health services to support GPs suffering with burn out and stress, and

> support retention of GPs, in addition to the £3.5 million injection of cash to GP services already announced by government in 2016. (NHS 2016:7)

Further commentary in GP Forward View states that a common reason for poor morale is the daily struggle with the growing workload: 'GPs report that much of this workload is generated by a fragmented system, over which practices feel they have little influence' (NHS 2016:8).

1.3.3 Nursing

Nurses in the NHS show a similarly high incidence of stress and stress-related absence. HSE statistics show that public service workers, particularly those in health and education roles, such as nurses, have higher levels of stress than British workers in other occupations (HSE 2001; 2015). The Dame Carol Black review (2008) found that the NHS has one of the highest levels of days lost through sickness of employees, estimating that approximately six days were lost per employee per year. The data shows that the average UK absence is 8.01 days lost per employee per year. However, public sector bodies continue to score much higher. Local authorities are particularly prevalent: here the average figure reaches 9.40 days per year. The NHS is higher even than this, with 10.37 days lost per year (Black 2008).

Freedom of information requests by The Observer Newspaper Corporation to Health Trusts in England and Wales, and cited in Kirk (2015), provide official statistics to help paint a picture of the stress-related absentees amongst NHS nurses:

> In London, almost 1,500 nurses at 31 NHS trusts took time off because of stress during 2014, up 27% on the 1,179 who did so in 2012. That meant that one in every 29 nurses were off ill with stress. The 1,497 nurses took an average of 38 days off for stress. Some may have had anxiety or depression rather than stress, as the NHS includes those conditions in its definition of stress-related leave. The number of nurses' working days lost to stress at the 28 acute trusts and three mental health trusts rose

> from 38,654 in 2012 to 57,156 last year (2013) – a rise of 48%. (Kirk 2015)

NHS Employers, a body which represents hospitals and other providers of care, estimates that over 30% of all NHS sick leave is caused by stress, which is believed to cost the service up to £400m a year in lost productivity and the cost of replacing stressed staff (NHS 2014). Stress is believed to account for over 30% of sickness absence in the NHS, costing the service £300-400m per year. A later NHS annual survey found that 30% of NHS staff reported that they had suffered from work-related stress (Picker Institute 2015). A recent Nuffield Trust survey reports that, although it is recognized that engagement and morale are vital prerequisites for successful change in the NHS and for recruiting and retaining enough staff, a clear majority (57%) of their respondents said that morale in their organization had fallen in the past six months – and several noted that it had been poor to start with (Nuffield Trust 2016).

Absence and an increasing level of workforce sickness are also reported in the Keogh Review (2013) into the National Health Service which commented on the negative affect that absence without adequate cover was having on the NHS. They describe staffing indicators which show high levels of sickness absence, dependency on agency staff and locum doctors to cover vacant posts, and what they describe as consistently unacceptable understaffing in some areas (Keogh 2013).

Kirk suggests that this alarming trend led the employers' organization to publish new guidance on how to reduce stress in the workforce for NHS managers in November (NHS 2015; Kirk 2015). It is interesting to note that these new guidelines, designed by Robertson and Cooper of Lancaster University, focus on emotional wellbeing and staff reflection (NHS Employers 2015). This focus could be seen as an indicator of the increasing emphasis on the application of 'self-reflection', which is a benchmark of the 21st-century world (Giddens 2013:25).

1.3.4 Higher Education

Across the first fifteen years of the 21st century, expert practitioners in HE also report higher levels of stress than other comparable employees. In a report commissioned by the University and College Union (Kinman & Court 2010), which addressed the need to tackle stress in HE, a clear correlation between the figures for aspects of stress which they measured was found with the results of the HSE survey on psychosocial working conditions in Britain in 2008 (HSE 2008). In the area of peer support, a summary of the comparison of the University and College Union (UCU) data alongside the results of the HSE's survey, Psychosocial Working Conditions in Britain in 2008 (HSE 2008), indicated less wellbeing in HE than in the working population target group (including Education), in relation to the level of peer support experienced by employees.

Figure 1: Peer Support at Work (HSE Survey 2008)

HSE scale out of 5 1=low wellbeing; 5 = high wellbeing	
Further Education	3.56
Higher Education	3.40
Prison Education	3.40
HSE 2008 survey target group average 4.03	

The results show that perceptions of peer support, although at the same level for prison education (PE), are at a lower level in HE than for further education (FE) and lower (3.40:4:03) for comparable industries as assessed by the survey of the HSE (HSE 2008). These results indicate that perceptions of peer support, one of the markers of a viable work life (Cartwright & Cooper 2002) are lower than the average amongst HE workers.

A similar comparison can be seen in the responses of employees in HE to employees in other comparable industries such as FE and PE and their perceptions of their work relationships (Court & Kinman 2008: section 41).

A summary of the responses to questions regarding relationships comparing the UCU data to the data gathered by the HSE survey of 2008 (HSE 2008) indicated

less wellbeing in HE than in the working population target group concerning employees' relationships at work.

Figure 2: Relationships at Work (HSE Survey 2008)

HSE scale out of 5 1=low wellbeing; 5 = high wellbeing	
Further Education	3.52
Higher Education	3.57
Prison Education	3.04
HSE 2008 survey target group average 4.13	

The results show that perceptions of the contribution of work relationships to overall wellbeing, although at a higher level than both FE and PE, are at a lower level (3.57:4.13) in HE than the average for comparable industries, as assessed by the 2008 survey of the HSE. Again, these results confirm that, since the perception of relationships at work is a significant factor in the overall health and resilience of a workforce (Kinman, 1998; Kinman & Jones 2004; Kinman, Jones & Kinman 2006), general wellbeing at work is lower in HE than the average for comparable industries. Lack of job security is also an important issue for permanent academic staff: indeed, it leads to much higher levels of stress amongst academics than amongst staff in a range of other public sector employment (Tytherleigh 2002).

1.3.5 Summary

Statistical evidence of low retention, low recruitment and high levels of stress in the public services of Health and Education have been demonstrated in this introduction. To establish low retention and low recruitment, it was necessary to use government forecasts of staffing needs and actual figures of training and employment posts filled. The longitudinal nature of the information presented here demonstrates a worrying trend in both of those areas. To establish a differential between levels of stress-related absence and exit in these public services and other similar areas of employment, it was useful to look at the comparative figures with other similar areas of employment from the HSE. Again,

a negative relationship is made evident. Lastly, for recruitment retention and for stress-related absence and exit, it was useful to compare year-on-year figures: this uncovered an upward trend in all areas.

1.4 Relevance of the Research Questions to Knowledge Development, Policy and Practice. The Identity of The Expert Practitioner.

The research questions addressed by this thesis are:

c) what changes are taking place in the working lives of expert practitioners in Health and Education?
d) is there a shared pattern of experience between expert practitioners in both sectors?

The definition of 'expert practitioner', which I use to identify members of the Health and Education workforce who have over four years of certificated, professional training in their specific area of expertise, is informed by the work of Anne Edwards (Edwards 2010). Edwards (2010), although recognising the shifting nature of that identity, describes the knowledge-laden nature of specialist professional practices, which, she states, have to be understood in relation to professional identity and the idea of relational expertise. Wilensky (1964) and Evetts (2003) also emphasise the particular combination of specialist knowledge, moral positioning and relational capacity which defines the 'expert practitioner'. The phrase 'expert practitioner' will be used throughout this thesis to identify the cohort of the Health and Education workforce studied here.

Pay and conditions are the most frequently used measures to assess the attractiveness of a job (Jawahar & Stone 2011; Till & Karren 2011). Pay has substantially increased in real terms over the last ten years for expert practitioners in Health (doctors and nurses), and for those employed in Education (teachers and university lecturers) (Buchan, Baldwin & Munro 2008; OECD 2014a; OECD 2015a; OECD 2015b), but we continue to have a crisis of staffing both in

recruitment and in retention and we continue to have a workforce in these industries which is manifesting more stress and stress-related absence than other sectors of employment. It would appear that the conditions of the employment for our expert practitioners in Health and Education have altered so much that these well-paid, respected professional roles are no longer attractive.

Loss of expert staff is at crisis levels in these essential professions. By using the research questions as delineated above, this study seeks to determine the underlying causes of this crisis and to begin to signpost the way forward to a solution.

1.5 Overview of the Thesis

In this thesis, changes in the working lives of expert practitioners in Health and Education are explored. The Literature Review examines relevant literature using the multi-level analysis (MLA) approach (Jepperson & Meyer 2011; Bown & Sutton 2010; Cresswell 2003). It also focuses on the voice of the practitioner and what this study identifies as 'the cry for professional intimacy'; a phenomenon developed in response to the present dissonance in Health and Education.

I look first at the extent of the mapping of these changes in the working lives of expert practitioners in Health and Education, according to policy-makers, professional bodies and the media, and I detail the policy shifts that have arisen from this mapping.

I note the minimal focus on changing professional relationships relative to other research on changes in the working lives of expert practitioners in Health and Education, and also the limited work which foregrounds the voice of the expert practitioner on this topic. It is this gap to which I hope to contribute. The second phase of this study takes the form of a thematic analysis of qualitative data gathered from semi-structured interviews with expert practitioners. The coded data from these interviews is analyzed in two phases: firstly, through qualitative software-based analysis describing frequency and a mapping of dynamic code co-occurrence using SPSS to generate inferential statistics which express the

significance of the themes uncovered in the data; and secondly, through an in-depth qualitative exposition of the themes as expressed in the narrative presented by each participant.

The organization of the thesis is as follows: Chapter 1, the Introduction, establishes the remit for this research; Chapter 2, the Literature Review, examines previous research on the subject of dissonance in Health and Education and explores the debate regarding the relationship between the global, national and personal aspects of delivering the work of an expert practitioner in the public services of Health and Education in the UK. In Chapter 3, Methodology, the methodological approach is established and in Chapter 4 the Research Design and Method are made explicit. Chapter 5 offers the findings of the current research; Chapter 6, the Discussion, provides a commentary on those findings and finally, Chapter 7, the Conclusion, seeks to link this research to the wider political context, to offer possible avenues for future research and to reflect on my personal experience of the process of carrying out this project.

1.6 Summary

This chapter has presented a personal account of the origins and development of the research question. It explored government statistics showing employment trends, and stress-related absence and exit trends for the last five years amongst expert practitioners in Health and Education. The implications of the research question on practice and policy were described. Finally, an overview of the thesis was given, showing how the research question is addressed and answered, chapter by chapter.

The next chapter, the Literature Review, seeks to place these figures in the context of other changes in the working lives of expert practitioners and also seeks to explore the relationship between the personal, the institutional and the socio-political context of these changes. It also seeks to make explicit the particular nature of 'professional intimacy' which, I argue, is found in a synthesis of the 'work role intimacy' identified as existing for expert practitioners in Health and

Education (Ashforth & Humphrey 1993:104) combined with, and supported by, their substantive knowledge and training. This synthesis allows the enactment of the 'transformative nature of practice' (Stevenson 2010) as a form of dyadic exchange between the practitioner and the client.

CHAPTER 2: LITERATURE REVIEW

> Professionals find themselves between universal laws and individual destinies, between the forces of nature and the forms of culture, between the objects of the world, and all thinking subjects. And professional judgement is in constant danger of being crushed between government regulation on one hand and the market forces of competition on the other. (Heath 2012:10)

This review of literature examines various factors, such as the growth of the global market, and the direction of national policy making, which bring pressure to bear upon the working lives of expert practitioners in Health and Education in the UK. My research questions were:

a) what changes are taking place in the working lives of expert practitioners in Health and Education?
b) is there a shared pattern of experience between expert practitioners in both sectors?

The central issue examined here is the result of these pressures; the arguably negative impact on the essentially relational nature of the working lives of these practitioners. The daily experience of this negative impact on professional intimacy is described in the final section (Section 2.3) of this review where research generated by practitioners is examined, but the impetus for its emergence can be felt throughout this review. Multi-level analysis recognizes the interplay between firstly the macro, the supra national; secondly the mesa, the national level in the form of policy-making; and thirdly, what can be categorized as the micro level, where the individual practitioner experiences the personal outcomes of those policies. Principles of multi-level analysis (Jepperson & Meyer 2011) therefore provide a useful framework for this review of literature. The multi-level analysis approach focuses on the interactions between state, market and society, this macro-mesa interaction being the arena where decision-making takes place and where there are a range of stakeholders directly involved. However, multi-

level analysis also gives close attention to the micro level, where the behaviour of individual members (or potential members) of a workforce can be examined. Giddens points out that although these levels can be discerned in the organized world, it is important to examine how they interact with each other, rather than attempting to merely identify them as isolated phenomena (Giddens, 2013:139-144). In terms of the application of this research, such interactions can usefully frame specific decisions about policy and strategy in relation to challenges like the low recruitment and low retention being experienced in education and in the National Health Service (NHS) (Jepperson & Meyer 2011:13; SPRG 2013).

This three-pronged theoretical perspective, where categories can be defined but where their interactive borders are worthiest of scrutiny, is made explicit by 21st century academic commentary on the changes taking place in our public services of Health and Education. Firstly, concepts of structuration, where 'structures exist but are enacted upon by individuals' (Giddens, 2013:139-144); secondly, the notion of field, which can be used to explore the working lives of educators within the institutional and political context (Ball 2012); and thirdly, the ironies and contradictions of the postmodern world so clearly described by Alvesson (2002). The focus of Bandura (1977) on individual motivation within the social context is examined, and lastly the voices of practitioners themselves are heard through three studies on the working practices of doctors, nurses, teachers and university lecturers.

These narratives – political, academic and personal – can all provide a way of stepping outside the macro-mesa-micro distinction. It is at networking points, the very interface where these levels overlap and interact, that useful answers to my research questions can be attempted. However, I am confident that, although the boundaries between macro, mesa and micro are indeed areas of networked interactions, rather than divisions, the distinctions continue to form a reliable springboard for the examination of the present state of play for expert practitioners in health and education (Harvey et al. 2012; Giddens 2013:139-14; Giddens 1994:3)

2.1 Macro and Mesa: The Commodification of Health and Education in the UK

> ...the ultimate expression of unchecked individualism, this triumphant march of money ... (Attali 2011:33)

2.1.1 Globalisation: Supra-national Pressures on Health and Education in the UK

'Life in today's societies is increasingly affected by transnational interdependencies. Profound global changes are creating new realities' (Bandura 1982:144). Bandura's 'new realities' continue to unfold in the 21st century, as transactions such as the EU-Canada Comprehensive Economic and Trade Agreement (CETA), ratified in 2017, and the beleaguered Trans-Atlantic Trade and Investment Partnership (TTIP) (European Commission (2015; 2016) inexorably supersede the power of national political governments. This continuous thread of change towards the dominance of international trade over national political control is demonstrated in the way that, even after major shifts of political alignments due to the British vote to leave the European Union (EU), discussions continue to focus on how the UK will remain an integral part of this form of trade agreement. Chrystia Freeland, Canadian Minister for International Trade (2015-2017), stated on a post-Brexit trade visit to Europe in July 2016, that it should be possible for the UK to substantially maintain its involvement with international trade agreements after leaving the EU (Butler & Monaghan 2016). The American administration, under President Trump, indicated in January 2017 that they favour a bilateral trade agreement with the UK.

Within the context of these trade discussions, Health and Education are increasingly described as, not publicly delivered services, but as areas of business opportunity. Stevenson tells us that 'for over a quarter of a century, England has been in the vanguard of the neo-liberal restructuring of public education.' (Stevenson 2016:67). In Education, this restructuring is being led by 'edu-businesses' whose effect may be to 'siphon huge sums of public money into private hands' (FORUM 2016:150). As in Education, so in Health; an important,

and controversial aspect of these international trade agreements is that they would allow private companies from the US to access the potentially lucrative NHS market without the controls now in place (Jarman 2014). The shift away from national-level discourse is in part because of the crisis resulting from the decline of fiscal support from national entities (McGoey, Reiss & Wahlberg 2011). This positions health and education provision in the hands of what Adams describes as global health institutions which transcend the old nation-state boundaries both fiscally and geographically (Adams 2016; Adams, Burke & Whitmarsh 2014). A similar pattern can be seen in Education, where international companies take over the funding and policy space once expected to filled by dedicated national departments (Ball 2012; Stevenson 2010).

There are already long-standing bilateral and trilateral trade-based negotiating procedures in place between the US, the UK and Europe. The dialogue of negotiation for these agreements is designed to allow consultation with non-governmental organizations, such as the professional bodies which represent Health and Education, but consultation mechanisms for business have been systemically stronger than those for consumer groups and workforces. Neither public health nor public education advocates have, or have ever had, as Jarman indicates, their own dialogue mechanism within these negotiations, and so will be unable to influence these, or any future agreements (Jarman 2014; European Commission 2014). Starkly put, this means that the voice of expert practitioners will not be heard around these decision-making tables.

Broad inter-governmental trade agreements are one way in which Health and Education can become globalised through changes in legislation. A more direct route into the health and education 'market' is created when private companies, using national legislation already in place, become involved in public service areas which were once under the control of government agencies. Pearson is a multi-national company whose brands include Heinnemann, Longman and the Edexcel publishing label. Edexcel is not only a publisher, but is the largest examination body in England by the volume of its sales, with a turnover of £317m in the thirteen months from January 2010 to February 2011. Pearson also had a

contract to administer the marking of SATs tests, grading 3.8 million of these tests in 2011 (Mansell 2012). However, the unexpected decline in the market for college books in the US, an unprecedented 30% drop in the last three months of 2016, means that Pearson may have to restructure its education business. The global pressures on Pearson to regain profitability inevitably creates instability within its business structure, meaning that it cannot be regarded as a reliable partner in the delivery of educational testing or content in the UK in the future (Bond 2017). However, notwithstanding the setbacks suffered by Pearson, the international trend towards the privatisation of education continues to grow. This trend was identified by the OECD at the opening of the 21st century in a report into educational provision in World Education Indicator (WEI) countries (OECD 2010) and underlined by the commentary of Ball & Youdell in 2008. These international trends may introduce instability into the arena of public service delivery, but they also reflect a managerial and conservative culture of efficiency and profit-driven organisation which currently underpins the globalization agenda in both Health and Education (Ball 2012; Stevenson 2010).

2.1.2 The National Level

At the national level, in UK Education, the reduction of the fiscal power of the local authorities and the freeing up of control over schools through the Academies Act 2010 (DfE 2010a) was the result of the UK Government project to continue to develop an American-based business model for education provision (Ball 1993), in an attempt to improve the environment and organization of schools across the country. The business model suggests that this can be done, in a cost-effective way, through introducing competition in provision. In a speech given to the NASWT union in March 2016, Morgan, Secretary of State for Education 2015-2016, reiterated this view when she talked of the 'postcode lottery' of outcome for pupils across the UK:

> We want to put an end to the antiquated system of school funding which saw so many young people miss out on resources because of an unfair postcode lottery. (Morgan 2016)

In this speech, Morgan was introducing the white paper entitled 'Education, Excellence, Everywhere', which states the governmental aim that all schools will be centrally-funded academies by 2020 (DfE 2016), an intention which has since been delayed by adverse conditions. Nevertheless, the premise that competition will improve outcomes in what was once an exclusively publicly funded sector remains embedded in this white paper, as it was in the Health and Social Care Act in 2012 (FORUM 2016).

The effects of the Academies Act (DfE 2010a), which allows for the tendering by multiple non-local authority providers to deliver education services, reflects the post-industrial approach to public service provision supported by David Cameron (Conservative Prime Minister 2015-2016) when he listed decentralization as one of the tenets of education reform:

> Sponsored academies are failing schools taken over by independent sponsors – many of them successful academy chains, like Harris, with a track record of turning schools around.
>
> Converter academies are successful schools that have chosen to benefit from the freedom from local authority control, taking full control of their budget and making the decisions that matter. Free Schools are brand new schools, set up by groups of parents, or charities, or teachers, or bodies, including other schools, that have a passion for delivering great education. (Cameron 2015 speech)

The Harris Federation, the independent sponsor of academies mentioned in this speech, is a private company which has become a preferred provider of both the building and the administration of schools under the academy programme (DfE 2011d: 5:14). The macro market concepts underpinning TIPP and the proposed bilateral agreements which may replace it, (European Commission 2016), with their aim of promoting multilateral economic growth, are echoed at the mesa level by the language and the policies of the government, as enshrined in the Health and Social Care Act (2012). The language of the speech quoted above, and of the White Paper entitled Education, Excellence, Everywhere (2016), speak of a commitment to a new direction in public services where competition will offer the

public what it wants at a reasonable cost: that is, personalized delivery by externally monitored and audited experts (Atalli 1978; Coulter, Roberts & Dixon 2013; Morioka et al. 2013). It can be argued that this white paper is not about the single policy issue of academization. Rather, it is a continuation of the trend noted by Stevenson (2010) towards a fragmented public service: a public services sector prised open to allow commodification by the global corporate players of neo-liberalism (FORUM 2016).

2.1.3 The Demon Doctor and the Untrustworthy Teacher

'Experts' dominated the 20th century with their sure-footed application of specialist knowledge to the institutions of society such as law, health and education (Giddens 2013). These experts were 'professionals who rule[d] by virtue of human capital created by education and enhanced by ... the exclusion of the unqualified' (Perkin 1989, in Webster, 2008:116). The certified expertise of the doctor, teacher, nurse and lecturer was what distinguished them from the unqualified practitioner, and is what gave them their authority. To Perkin, this professional society decisively excluded the non-expert from serious participation in any discussion of their efficacy or of social policy (Perkin 1989, in Webster 2008:116) These expert practitioners were trusted by society to self-monitor, and they were seen to share 'fundamental assumptions ... notably the primacy of trained expertise' (Perkin 1989 in Webster 2008:116).

Within the shifting zeitgeist to the commodification of public services, and the subsequent empowerment of the consumer to make health and education choices, lies an undermining of the traditional modernist trust between the expert and his/her client. The erosion of trust has led to the autonomy accepted as part of their role by 20th-century 'professionals' no longer being offered to our present day experts in Health and Education. These experts find themselves in workforces being shaped less by the expertise of the practitioner, and more by the measurements of their clients, the consumers (Giddens 2013; Bauman 1997; Spargo in O'Dowd 2016). In turn, the measurement of these clients is affected by

reactions to specific events and the interpretation of those events by the media and by policy-makers (Cohen 1972).

The significance of Cohen's triangle of communication between government policy-makers, the press and the lay public has continued to grow in the 21st century (Cohen 1972; McCauley et al. 2012). This tripartite relationship means that any useful overview of dissonance in the working lives of expert practitioners in Health and Education has to include material from media outlets. The aim of these outlets, whose information is often sourced from government departments, is to inform both the lay public and the workforces of the relevant services.

The cohort of civil servants who prepare advertising campaigns and 'arrange publication of government literature' (OECD 1996:9) has close relations with the traditional press, and with electronic and social media. A senior government official writing in this OECD report described one of the information officers' duties as 'to use all methods of publicity – short of propaganda – to help the department or agency achieve its purpose' (OECD 1996:7).

Journalists comment that one of their most important roles is to question and critique those on whom they are reporting (Leask, Hooker & King 2010). They are wary of being employed in disseminating material which is just 'short of propaganda'. As this statement from a medical journalist demonstrates:

> The media is not the public relations wing of the health department. We are not there simply to report what they want to tell the public - though we will usually do that also. But our role is to ask challenging, independent questions (Newspaper medical reporter). (Leask, Hooker & King, 2010)

Public service remit journalists can therefore be seen as having the potential to enhance public understanding of the issues facing expert practitioners in Health and Education. McCauley (2012) suggests that public service employees can choose to treat journalists not as adversaries but as partners and colleagues in the effort to inform people about matters of mutual concern (McCauley et al. 2012). However, media reporting around the Francis Inquiry (Francis 2013; Hunt 2014) and similarly in the years after the PISA results of 2010 (Gove 2013; Gove 2014)

show that McCauley's proposed positive symbiotic relationship between practitioners of Health and Education and the press may be nothing but an imagined ideal. Indeed the press, perhaps manipulated by the civil servants who 'leak' departmental information, could be described more realistically as 'the public relations wing' of the government departments of Education and of Health (Leask, Hooker & King 2010). This drive to shape the behaviour of the expert practitioner over the last sixteen years through negative media reporting and subsequent legislation can be seen in the following exemplars.

Victoria Climbié: Exemplar 1

The Children's Act 2004 was a radical response to the shortfall seen in the provision of Health and Social Care to children after the tragic death of Victoria Climbié. It drew together the services of Health, Social Care and Education under one umbrella and this change in the delivery of social policy can be seen as example of the direct effect on the working lives of practitioners of the symbiotic relationship between the media, the public and policy-makers. This relationship is described by Cohen (1972) as the cycle of 'moral panic', where the public reaction to events is both escalated and crudified by media reporting and where subsequent government response is magnified. The Children's Act 2004 responded to the public horror at the apparently unreported suffering of Victoria Climbié and was designed to facilitate communication by providing for a designated Director of Children's Services in each local council. It highlighted the need for multi-agency working and clear communication between agencies as a response to what was perceived as the problem of numerous uncoordinated official powers and functions within and between local authorities (DfES 2004 24.16-18). However, the Children's Act of 2004 did little to add to the practical functioning of the previous act of 1989 (DfES 2004), although it engendered a radical shift in local government hierarchy in that it completely removed the separate command structure for Education from within local councils. Its greatest effect, therefore, was not a measurable improvement in the delivery of services to children, but the removal of a dedicated local government platform for the particular concerns of teachers as a profession (Rose, Smith & Yan 2009).

The Climbié case also had a second and profound effect on the daily working lives of teachers. Although failures in the services of Health were seen to be particularly significant in the failure to safeguard Victoria Climbié (Laming 2003), the teachers who failed to report their concerns were also seen to be at fault. In an immediate response to this case, government consultation papers advised that the monitoring of the responsibilities of ordinary teachers in every classroom was necessary. Practices were put in place to ensure that the services involved in the education and health of children and young people were fully integrated and 'talking to one another'. The report concluded that every professional involved in this work was responsible and was to be monitored (DfES 2004a; DfES 2004b; Rose, Smith & Yan 2009). The thrust towards the monitoring of the competency of teachers embedded in this initial report stills resounds today, and can be seen in the most recent update of those safeguarding instructions for teachers in state schools. In 2015 (DfE 2015a), in proposed amendments to the Children's Act 2004, individual responsibility is emphasized, as is the need for communication between the services. This 2015 report reiterates that it is essential for every teacher in schools and colleges to be aware of their 'individual responsibility' to safeguard the children in their classrooms (DfE 2015a) and states that staff have a 'vital role' in the safeguarding of their pupils. Individual teachers were now to be accountable for any failings to the pupils in their care. This specification of 'individual responsibility' is a move away from the concept of corporate responsibility, which was the accepted legal interpretation of the role of the expert practitioner in our public institutions of Health and Education in the years preceding this event (Vize 2010).

Harold Shipman: Exemplar 2

Since the incident of Victoria Climbié's death, the idea of 'individual responsibility' for safeguarding has become central to the role of the teacher (DfE 2015b), but this is a concept which has always been central to the public perception of the role of the GP. It was the betrayal of this perception of the 'benevolent paternalism' of the GP (Smith 2002; 2003; 2005) which made the actions of Dr Harold Shipman all the more shocking to the public. In 2000,

Shipman, a GP of twenty-five years' duration, was found guilty of the murder of fifteen, mainly elderly, female patients.

The extensive Shipman Inquiry (Smith 2002; 2003; 2005) indicated that his behaviour was made possible partly by the lack of inter-professional supervision by GPs of GPs. The Shipman Inquiry led to recommendations for a new way to measure the competence of doctors, which took the emphasis away from traditional practitioner, peer-led assessment, and requiring a systematic observation of a practitioner's performance against a validated criteria of competence. In 2007, proposals were outlined for the revalidation of doctors (Hewitt 2007), which would include an input from patient representatives. This was made in the context of a patient-led NHS, indicated by the introduction of patient choice in 2006 (DH 1991; DH 2008). McKinley, Fraser and Baker (2001), writing immediately after the Shipman event, listed the scope of assessment available for medical practitioners, including observations, overt or covert, live or recorded, real or simulated, with patient involvement. They proposed that peer assessment was a crucial element in an effective assessment system. However, the post-Shipman climate meant that 'lay' assessment was increased at the expense of peer assessment (McKinley, Fraser & Baker 2001). As with teachers after the Climbié case, it could be argued that employment conditions affecting the daily lives of GPs were altered by Government reaction to one event. This new direction of social policy again indicated an increasing lack of trust from the Government in the capacity of these expert practitioners, described as autonomous and capable by Edwards (2010), Evetts (2003) and Wilensky (1964), to continue to self-monitor.

2.1.4 Monitoring the Expert Practitioner

This loss of trust in the expert practitioner which can be seen developing over the first fifteen years of the 21st century has led to the formation of a number of independent bodies to monitor of the competency of expert practitioners. Government bodies such as the Care Quality Commission, Monitor and Ofsted, with a remit to act as part of the wider application of 'watchdoggery' (Gay &

Wintrobe 2008) have come into being. Policy-makers and the media continue to express increasing concern about the competence of expert practitioners in Health and Education, which issue, they indicate, springs from flaws in the practitioners themselves, these being a low level of 'professional skills' and a lack of empathy and compassion in delivery (Wilshaw 2014; Francis 2013).

These practitioners are now located, both professionally and physically, in an institutional setting, with the 'concentrated monitoring' (Giddens 1991:14) that the institutional structures of modern society inevitably require. As Giddens comments:

> What distinguishes modern organisations is not so much their size, or their bureaucratic character, as the concentrated, reflexive monitoring they both permit and entail. (Giddens 1991:14)

Expert practitioners, through observations of patient, pupil and student responses, and through the assessment of practice success against targets, are expected to function as intermediaries between their own practice and the institution in which they are located. In this way, they are part of the general approach to the assessment of the modern workforce through observation, as 'surveillance in the capitalist enterprise is the key to management' (Giddens 1987:175). However, Ball, when writing about the expert practitioner in Education, suggests that this requirement for information on performance 'legitimizes the withdrawal of aspects of their autonomy' (Ball 2013:131) and is part of the disempowering of the practitioner. He suggests, that, in Education, the request for information on the performance of the expert practitioner is preceded and maintained by the tacit 'construction of the untrustworthy teacher', which 'creates the basis for the assertion of more accountability and more control over their (teachers') education and their certification and performance' (Ball 2013:131). Using prescribed data-gathering systems, practitioners provide information to the institution about the success of their practice, and it is upon this information that they are judged. That this information is perceived by the institution as reflecting the reality of their practice can be seen by its subsequent use by institutions as indicators for performance management, including the forming of new targets. This process can

be seen in practice in Education, since the late 1990s, as the perceived need for accountability by policy-makers to provide the legitimation for greater oversight, control of, and intervention in, teachers' work (Ball 2013). In Education, this change of emphasis towards performance targets means that:

> teachers are caught between the imperatives of prescription and the disciplines of performance. Their practice is both 'steered' and 'rowed' … One of the key elements in the new policy ensemble … is the use of highly prescriptive systems of accountability – performance indicators, inspections, league tables and achievement targets. (Ball 2013:173).

Data-based assessment systems are also established practice in the Health Service, where information gathered in this way is accepted by its recipient, the institution, as not only indicative of individual performance but as also reflecting the structure and offering possibilities for change in that structure (Moffat, Martin & Timmons 2013). They go on to state that performance targets can be actively linked to funding, as 'anxieties over the management of NHS resources have existed for many years and concerted government efforts have been made since the 1980s to create a less paternalistic, more business-like service' (2013:696). They describe 'changing government expectations of doctors' (2013:696) which are situated in what Rosen and Dewar (2004) describe as 'growing expectations of accountability for productivity and performance' (Rosen & Dewar, 2004 in Moffat, Martin & Timmons 2013:696).

2.1.5 New Fiscal Responsibilities and the Business Model

This reshaping of the role of the expert practitioner from the clinical to include the fiscal can be enacted through local intervention by hospital, school or university management, or by the national intervention of government through social policy, which couches the role of the expert practitioner in the language and milieu of fiscal targets rather than clinical outcomes. Recent productivity documents such as Value for Money in the NHS (HC Health Committee 2009), Improving NHS Productivity, More with the Same Not More of the Same (Abbleby et al. 2010) and Can NHS Hospitals Do More with Less? (Hurst & Williams 2012), assert the

responsibility of practitioners, doctors and nurses to accept 'individual and collective accountability for the performance of the health service and for the appropriate use of resources in the delivery of care' (DH 2008:60).

Therefore, the 21st-century expert practitioner in Health and Education sits between the intimate and unique nature of face-to-face interaction with clients and the transformation of these 'instantiations' (Giddens 2013) into abstracted events, assessed on a quantitative scale of success. Their perception of the reality of their role has to accommodate the request, first to make, and then to explain, defend or justify these abstracted ordinal interpretations of their behaviour. These abstracted ordinal interpretations of their professional actions, where care, attention and professional judgment are quantified into aims and targets, are made all the more compelling as 'the language of expertise [the expertise, in this instance, of the data interpretation of accountancy] plays a role here; its norms and values seeming compelling because of their claim to be a disinterested truth' (Miller & Rose 2008:35).

The NHS-directed productivity documents listed above indicate that this accountability is seen by government as a useful strategy to ensure better public services. As Moffat, Martin & Timmons (2013) say, 'linking productivity and efficiency to the notion of care is a persuasive rhetorical tactic in advocating individual and organizational change' (Moffat, Martin & Timmons 2014;695). They state that 'productivity, efficiency and minimizing waste are the new buzz words' (Moffat, Martin & Timmons 2013:696). Importantly:

> this form of control translates the objectives of one party (in this case the state) into terms acceptable by others (the professions) to such an extent that certain norms, such as service and dedication, may be supplanted by others, such as competition and financial rationalisation. (Moffat, Martin & Timmons 2013:696)

This in turn will mould the role and behaviour of the expert practitioner. The expert practitioner in Health and Education 'finds that the arguments of another practice [again, the data interpretation of accountancy] become consonant with and provide norms for its own ambitions and actions' (Miller & Rose 2008:35).

Castells proposes that society is being transformed by informational labour, within which description Castells includes the knowledge economy of the traditional professions, now fed by the technological capacity to gather large amounts of data (Castells 1996, 1997, 1998). Zuboff (1998), however, suggests that this new data-led professional has become reduced to a nervous screen-watcher; seeking to identify any flaws in personal delivery or in departmental costings which may be picked up by data analysis further up the command chain (Zuboff 1998). Webster, while accepting the significance of the new technology of surveillance, suggests that the role of the professional has been undermined in more deliberate ways, as 'since the 1970's there has been assault on many professions (university teachers, architects, researchers, librarians and doctors, for example)' and suggests that 'a great deal of this testifies to the power of the market' (Webster 2008:117).

This new model for the provision of public services is a manifestation of the new public management (NPM), which is a hybrid set of organisational practices (Gruening 1988; Dunsire, 1995:21-23; Marginson 2013). It combines neo-liberal business models and market templates, with on one hand bureaucratic control systems that emphasize audit and accountability, and on the other hand ideas of transparency and individuation that Marginson suggests owes as much to the 1960s New Left as the 1970s New Right (Marginson 2013). The neo-liberal movement to involve business, and particularly the skills of the marketplace and the lay public in the organization and development of Education, is seen in the introduction of business-leader governors to school management boards, which has been extended by amendments to the original Academies Act of 2010 (DfE 2011). A recent decision to convert all schools into academies is central to the White Paper entitled 'Education, Excellence, Everywhere' (DfE 2016), although the government has slowed the speed of delivery (Richardson 2016).

The business model of public services has, at its core, a dichotomy which is implied in Marginson's comments on the 'ubiquitous' international application of the NPM model, with its inherent clash of market-led action and high levels of practitioner audit (Marginson 2013). It is difficult for practitioners to pay attention

to the fine-tuning of the delivery of services that are at the mercy of a volatile market-led funding model. This is described as the central difficulty of the public/private mix, where the public services ideal of needs being met, regardless of cost, meets the free market ideal of competition and profit. Public services operating within the business model 'must be brutally downsized because [they] cannot obey the basic law of competing for profits or for market share' (George 1999). This is a confusing world for the expert practitioner, whose expertise is concentrated in his/her own particular field. However, in this new world, expert practitioners such as nurses, teachers, doctors and lecturers must all become cognisant of the language of the market, the bank and the accountant (Ball 2013). The structures of checks and balances, which have always surrounded Health and Education, but which have previously been centred on practice and delivered by professional associations like the British Medical Association (BMA) and the Educational Institute of Scotland (EIS), are now administered by government departments and have become instruments of fiscal control. It is indicative of this change of emphasis towards this market mentality that Monitor, a body set up to overview the quality and delivery of service in the Health and Social Care Community Health and Standards Act 2003 (DH 2003) is redesigned in a secondary, but highly significant, amendment in 2012, to direct itself now to costs:

> The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use health care services by promoting provision of health care services which (a) is economic, efficient and effective, and (b) maintains or improves the quality of the services. (DH 2012 1:90)

Monitor is now to watch over the economic efficiency of the Health Service, rather than, as before, solely the suitability of clinical delivery.

2.2 The Micro Level: Professional Intimacy and The Profound Effect of Practice

> Emotional labour: '[Reduced to] the management of emotions for pay'. (Hochschild 1983: 89)

Bandura (1997) proposes that self-efficacy, which he defines as beliefs about one's ability to accomplish specific tasks, influences the tasks employees choose to learn and the goals they set for themselves. Self-efficacy also affects employees' level of effort and persistence when performing difficult tasks. Whether perceptions of self-efficacy increase or reduce can be determined by a number of factors, including past performance, vicarious experience, verbal persuasion, and emotional cues (Lunenburg 2011).

The following section looks at commentary on the profile of the expert practitioner in Health and Education, and examines how the dichotomy between the qualities perceived in that profile and the all-pervading expectations of a market economy may lead to the experience of stress and burnout, which seems to be prevalent in the present public services structure. It uses the concept of efficacy or self-efficacy (Bandura 1997) to understand the difficulties which can occur when the expert practitioner feels unable to perform the role to which he/she ascribes. It also examines the concept of emotional labour (Hoschchild 1983), and the effect of the increase in demand for personalized services embedded in relational dialogues between practitioners and clients, in order to further understand the conflicts that are present in the working lives of these practitioners. It looks at individualization and the forging of the self in the technologically driven postmodern world. It also looks at system lag and applies it to Health and Education organizations in the UK, where it would appear that change towards a more relational individualized delivery is promoted by policy-makers and is happening, but not at an even rate, and without the necessary supporting changes surrounding it. It also examines the appropriation of relational behaviour by the neo-liberal approach to the delivery of Health and Education, and asks to what extent that contributes to the dissonance amongst expert practitioners in Health and Education.

Growing from an awareness of that appropriation, this review (Section 2.2.1) examines Ashforth and Humphrey's concept of 'intimacy' as part of 'practitioner work role behaviour', and their commentary on the effect of its loss (Ashforth & Humphrey 1993:104-106). Their work on Hoschchild's concept of 'emotional

labour' (Hoschchild 1983:89), can be applied to the working lives of expert practitioners in Health and Education today. I suggest that this professional intimacy could be argued to be the core of practice, and is to be found in a relational approach combined with, and supported by, substantive knowledge and training. It can be argued that it is this 'professional intimacy' which underpins the enactment of the 'transformative nature of practice' (Stevenson 2010), taking the form of dyadic and therapeutic exchange between the practitioner and the client. Its loss causes great distress to the practitioner (Ashforth & Humphrey 1993: 104-106).

Practitioner commentary in this section of the literature review indicates that a sense of the lack of this professional intimacy exists in both sectors, and the tone of practitioner commentary indicates that it may be at the heart of the dissonance felt by expert practitioners working in Health and Education at the present time.

2.2.1 Profiling Professional Intimacy

Kelchtermans (2005) writes that more than any other profession, apart from medicine, teachers' thoughtful actions reflect emotional involvement and moral judgement, and that their emotional reactions to their work are intimately connected to the view they have of themselves and others. Kelchtermans' use of the word 'intimate' here implies the profound effect that performing the role of teacher or healer has on the psyche of the individual enacting that performance. His language depicts accurately what has been described as the 'holistic,' all-pervading nature of the roles of the 'teacher' and 'healer'. Expert practitioners in Health and Education, teachers, doctors, nurses, and lecturers, cannot separate themselves from the emotional experiences of their work and continue to be successful in that work (Ozan & Sener 2014). In a self-reporting study of interactions between the service provider and the client, Ozan and Sener used the categories of emotional labour proposed by Hoschchild (1983):

a) superficial behaviour.

b) in depth behaviour, or deep role play (Hoschchild 1983:54)

They added a third category:

> c) intimate behaviour, or natural emotions (Ashforth & Humphrey 1993:104)

This third category was originally proposed by Ashforth and Humphrey (1993). This intimate, real behaviour, or display of natural emotions, is present (in a practitioner/client meeting) when the feelings engendered by the moral perceptions of the role of teacher, doctor or nurse are commensurate with the feelings engaged during the moments of that interaction and is an important factor in the nurturing of professional intimacy. The investigation which is the subject of this thesis has been carried out in the context of the increasing distress in health and education practitioners. Ashforth and Humphrey's third category of work-role behaviour, 'intimate behaviour', can offer an explanation of this distress, as it explains the practitioner's struggle to convert anger, boredom, fear (which he/she feels to be incompatible with the role of teacher or healer) into the morally acceptable natural emotions of intimate behaviour (Ashforth & Humphrey 1993). Successful teachers measure highly on the scale of 'openness' (Nias 1996) and good teaching practice requires openness, as effective communication requires an openness to those with whom one is in interaction (Blasé 1988). Vulnerability is defined as an openness to being hurt and 'hurt' would therefore be a possible outcome of the enactment of the role of the teacher. Van Veen and Sleegers (2006) describes the personality of the teacher as being one where the rapidly changing emotions raised by doing the job are part of the daily professional experience and are embedded in the teachers' view of themselves. As with professions involved in healing, he says, teachers' personalities are intertwined with the daily success of their work (Van Veen & Sleegers 2006). These writers are describing the melding of the public and the private sphere, the crossover between behaviour required by the workplace and the 'personality' of the expert practitioner.

2.2.2 The Clash between the Market and Professional Intimacy

The commentary of Van Veen & Sleegers (2006), Kelchtermans (2005) and Nias (1996) point to the particular nature of the work of these public service professionals, these expert practitioners, which means that we have to assess their contribution to the working of our society in a different way from how we would assess the contribution of journalists or bankers. We have to look at the dynamics of their individual interactions and relations with their clients to understand the nature of their work (Kelman, 1958; Tajfel 2010; Deutsch & Gerard 1955) and, most importantly, to understand the problems they encounter in the present fragmenting climate of our public services (Harvey 1989). This fragmentation, where a multiplicity of suppliers competes to provide the functions which were once the sole arena of the publicly employed expert practitioner, brings with it the increased need for the reiteration by each practitioner of his/her professional identity (Poire & Sable 1984). However, there is a danger that the complex interplay between professional identity, the idea of the dialogic mechanism, the conflict between deep role play and the need for intimate, real communication between a practitioner and a client, a professional intimacy, is not acknowledged within public service systems. Advice for expert practitioners working in this stressful milieu can be simplistic. The importance of communication skills for doctors for their own reduction in stress is emphasized in this extract from the British Medical Journal (BMJ) careers website, where aspiring doctors are blandly told that 'good communication leads to more satisfying interaction with colleagues, helps you to manage your time better, and makes you a more effective team member and leader. Learning to communicate effectively means … to be able to deal with demands and the difficult emotions they cause' (Green, Parrott & Crook 2012). There is a superficiality about these words: low recruitment levels in Health suggest that the increasing demands on practitioners and the difficult emotions they incur require a closer analysis than this advice implies (Dixon-Woods et al. 2013). A greater emphasis on engagement with individual clients, requested from a system which is still set up for the mass delivery of health, is particularly demanding of practitioners.

A similar scenario can be seen in Education, where the issues of recruitment and retention are addressed at the micro level of individual personality traits of the practitioner. Research, over the last ten years, into the working lives of teaching staff shares a common thread of concern with an identification of the nature of resilience. With that common thread, the attention of the social policy-makers and the academic community continues to be focused on the difficulties experienced by the individual expert practitioner in maintaining the necessary motivation to fulfil the demands of their role (Day et al. 2007, 2010; Day & Gu 2010; Day 2012) rather than broader systemic problems. However, that the findings of this research have also to be seen in the larger, systemic context is addressed by Day (2012), who states that bringing a 'passionate, competent and resilient self to teaching' requires 'organizational support', and that 'resilience is a quality that arises through interactions between people within organizational settings', indicating that there is a responsibility of government, or governance, to direct policy towards the resolving of systemic failure.

2.2.3 The Apportioning of Blame for the Failure of Public Services

Notwithstanding this commentary, the view of policy-makers remains that the failure of public service systems is due to the failures of individual practitioners, and not problems inherent in the system in which they operate, continues to dominate the discussion of dissonance within Health and Education. To policy-makers, solutions to this dissonance are to be found in choosing the right candidates. This view is made explicit by examining the introduction of a personality test for prospective expert practitioners in Education. When the DfE introduced Initial Teacher Training (ITT) tests for competency in numeracy and literacy in 2010, it also introduced psychometric testing. Psychometric tests are designed to measure the personality and attitudes of prospective candidates, and variations of these tests are offered to ITT providers by international companies such as Pearson, and, since 2015, by the private company Learndirect. The introduction of such tests demonstrates the continued focus by policy-makers on the failings of badly- chosen or badly-trained individual practitioners (Wilshaw 2014) and runs in tandem with commentary regarding poor training by the

universities. This introduction by the DfE, in September 2010, of psychometric testing for the non-cognitive occupational suitability of prospective teacher trainees was driven by the pressing need to find a way of improving the retention of trained teachers (DfE 2010). The solution to the problems with retention and stress was to be that institutions training those candidates for teaching should weed out those who were unsuitable before they entered professional training. The Initial Teacher Education (ITE) Inspection Handbook, intended for use from September 2013, states that:

> for each trainee observed, it would be helpful to have a brief pen portrait available for inspectors during the inspection week. This is likely to include a synthesis of information gathered during selection and in the early stages of the training to determine the trainee's potential, strengths and specific training needs. (Ofsted 2015 1:26.11)

The phrase 'the trainee's potential' is given a clearer definition by the comments in the Importance of Teaching, a white paper published by the DfE in 2010. It states:

> We know that highly effective models of teacher training (including those of Finland, Singapore, Teach First and Teach for America) systematically use assessments of aptitude, personality and resilience as part of the candidate selection process. We are trialling such assessments and, subject to evaluation, plan to make them part of the selection process for teacher training. (DfE 2010b: 2.11.21)

Measuring the personality of potential workers, rather than, or as well as, their academic qualifications, originates in occupational psychology practices from the US, where in the 1950s it became a popular way of assessing the suitability of a candidate for a job (Mayo 1993). Measuring personality can include quantifying affectivity and such factors as introversion/extroversion (Eysenck & Eysenck 1969) or measuring behavioural traits such as resilience, as in observation schedules designed by Mischel and Peake (1982). A parallel development to this introduction of psychometric testing in education can be found in the Health Service. As with the psychometric testing of a potential teacher, the Myers Briggs

Type Indicator (MBTI) personality questionnaire is used to assess employees entering, or being trained in, the health sector. This test is an instrument for the measurement of emotional, motivational, interpersonal, and attitudinal characteristics, as distinguished from abilities (Anastasi & Urbina 1997). Examples of major private employers that have used the Myers-Briggs test in the US are Apple, AT&T, Citicorp, Exxon, 3M, Allied Signal, and Honeywell (Stabile 2001) and it has been used over the last ten years in the Australian Health Service and in the NHS as part of training procedures (Boyd & Brown 2005; Brown & Reilly 2009). Psychometric testing is viewed as a way of assessing potential trainees, as a tool to assist policy-makers in their attempts to recruit expert practitioners with the mix of knowledge skills and the right personality to be expert practitioners in Health or Education (Locke & Latham 2002). While the policy-maker focus is fixed on the qualities of individual practitioners, the systemic problems, which may cause practitioners to fail, continue to be ignored.

In a neo-liberal economy, as knowledge or health become more readily available, they lose their intrinsic value and the delivery of them becomes paramount (Sen, 2002; Culyer & Wagstaff 1993:431-457). An increasing demand for these personalized services is welcomed by what is described as 'big pharma' (Iheanancho 2006; Gagnon & Lexchin 2008; Goldacre 2012, 2015; EUROPEANCEO 2013) and by the satellite support industries of Education, such as Pearson's academic publishing arm, as there is business potential in the increasingly demanding and personalized consumer (Ball 2014). In the new business-led management of the public services of Health and Education, accurate, numerate measurement, which establishes need, is an essential prerequisite to funding (Moffat, Martin & Timmons 2014). However, not only clinical outcomes influence funding; patient satisfaction is an important measure that can impact the reimbursement rate for any hospital or healthcare system (Vocera 2016). What is not measured may not be included in costings therefore, to enable 'reimbursement', quasi-qualitative measurements of the relationship between the expert practitioner and the client in Health and Education have been introduced and have taken the form of cost-effective client satisfaction

questionnaires (Boyer et al. 2006); the design of these questionnaires having been developed in service industries such as catering and banking (Farris et al. 2010).

Hay, in his survey measuring patient response to their experience of care, finds that the process of asking for feedback triggers a critical response. His study recognises that requesting feedback is in itself a negatively weighted procedure (Hay 2008). Therefore, before qualitative judgments of the provision of care or teaching are made and used as assessment tools, it is essential to understand that in health services, clients, when asked for feedback, show a statistically significant inclination to continually 'ask for more'.

It would seem that our expert practitioners now exist in a new landscape of jurisdiction, where both policy-makers and clients (Giddens 2013) assess practice, both apportioning blame for the failure of the delivery of service to the individual practitioners concerned. Using a plethora of government statistics on performance, league tables and waiting times, both the policy-makers and the consumers judge the delivery of Health and Education. In consequence, at the mesa, the national level, practitioners report that their autonomy is being eroded, and this erosion of professional autonomy may be a contributing factor to the increasing unattractiveness of the role of expert practitioner in Health and Education to prospective doctors, nurses and teachers (Giddens 2013; Bauman 1997; Spargo in O'Dowd 2016).

2.2.4 New Freedom and Opportunities Struggling in the Mire of System Lag

The individually negotiated relationships of late modernity and postmodernity are described by Alvesson as one of the tenets of postmodernity, and, according to him, rather than attacking the autonomy of practitioners, they offer tremendous freedom and opportunities (Alvesson 1990, 2002). To Alvesson, as with Aglietta (1979) and Attali (1978), the postmodern world will inexorably move us towards opportunities to forge more intimate personal relationships with practitioners, untrammelled by hierarchy. Certainly, commentary does support a sense of social change amongst practitioners; Hughes (2008) found that nurses are seeking to build a greater autonomy into their work practice. In her critique of the Institute of

Medicine (IOM) 2004 report, Hughes also found that nurse participants identified an increasing practice requirement to offer a more personalized, emotionally based service/relationship with their patients. Williams (2001), addressing the same issues a few years earlier, comments that attempts to promote a more holistic approach to care have altered the dynamic between nurses and patients, from one in which nurses might have found it acceptable or even desirable, to distance themselves from the emotional needs of the patient to one where the development of a nurse-patient relationship is considered essential and welcomed by staff (Williams 2001). Alvesson suggests that this desire for more intimate relationships will cause a fundamental change in the role of the expert practitioner, who now will both create and accommodate individually negotiated relationships with clients (Alvesson 2002).

However, Alvesson recognises that this negotiation will often take place in a system still set up for the delivery of a universal, standardized programme. This creates a disharmony that may also produce 'insecurities that lead to normalization strategies', which can include vastly differing responses. People, both practitioners and clients, may voluntarily cling to consumer identities offered by commercial forces, or, particularly in the case of practitioners, individuals may cling to organizational and occupational selves orchestrated by corporate cultures and professional standards (Alvesson 2002:31-35). This side-by-side existence of multiple, opposing approaches, old and new identities, and the fear and insecurity caused by fundamental role change (Goffman 1990) creates dissonance in a workforce, particularly one that is open to being defined by external social and policy-based concepts of 'professional identity' and 'institutional' roles, as with the doctor, the nurse and the teacher (Kelchtermans 2005; Van Veen & Sleegers 2002). For those practitioners who embrace the change to a more relational dynamic to their role, there can be a debilitating absence of harmony between the desires, the hopes and expectations they have as expert practitioners, and the reality of the unreconstructed workplace in which they find themselves (McManus, Winder & Gordon 2002). This can be particularly true of trainee practitioners: Milbank, Ryall and Lishman (2016) describe the workplace of the NHS hospital as a system in difficulty, offering extremely challenging

circumstances in which the trainee practitioners, in a tradition where it is not seen as acceptable to show vulnerability, may, in order to cope, harden themselves to their experiences, with the result that they become emotionally cut off. They go on to suggest that creating a culture where people feel safe and where they can share their concerns can lead to the start of a radically different way of communicating (Milbank, Ryall & Lishman 2016).

The post-bureaucratic features desired by the contemporary expert practitioner, with more mixed, flexible organizational virtues (Alvesson 2002:31) are still hampered by the old 'modernist' organisational principles – division of labour, hierarchy, mass production – which still exist in some health and education institutions (Alvesson, 2002:31-35). Clegg (1990:203) describes the contrast as follows:

> The organizational dimensions of modernity/postmodernity ... are specialization versus diffusion, bureaucracy versus democracy, hierarchy versus market, disempowerment versus empowerment, inflexible versus flexible, individualized versus collectivized and mistrust versus trust. (Clegg 1990:203)

Clegg's postmodern argument for a more flexible, emotionally responsive workplace can be seen going into practice in the philosophy behind NHS Change Day, with its emphasis on 'bottom-up' change and more interaction between practitioners and clients (NHSIQ 2014), and is accepted in this RSA report on Social Care:

> Amidst this shifting set of policies and realities, there has been remarkable consistency around the need for greater personalization of public services and a bottom up, integrated approach. (Fox 2012:5-6)

Fox goes on to describe how fiscal resources will be directed towards this change, affecting the very funding processes around the delivery of healthcare, giving financial support to local initiatives led by practitioners and their clients. This is the approach to delivering health services being developed by the Change Day initiative, where the disruption of the top-down hierarchical system by practitioner

groups such as the online School for Health and Care Radicals is hoped will reshape the NHS (NHSIQ 2013; 2014). This approach in social policy – the decentralization of funding allied with the empowerment of local communities – is applicable to Education, and can be in the new academy schools with their local lay boards and their direct fiscal control (DfES 2004). The link between the personalization of public services and flexibly funded neo-liberal 'decentralized' and fiscally unprotected public services is welcomed by Fox:

> The personalization agenda encourages innovation, offering the potential to create new markets around localized and individual needs, to focus fiscal resources directly and discretely, and to enable small groups of individuals to 'positively disrupt' a complex and opaque system. These are all developments to be welcomed. (Fox 2012:5-6)

The link between personalization and funding is made clear here. Fox, however, offers some reservations about this fundamental change:

> Yet the success of the personalization agenda in future will depend upon answering some even more fundamental questions about the nature of future supply and demand for public services. (Fox 2012:5-6)

Although Fox questions whether sufficient and appropriately directed funding will be made available for this change to the 'personal', nevertheless, there is a general consensus amongst commentators that we are inexorably progressing through what Castells dubs the informational revolution driven by interactive communication technology (Castells 1998; Castells cited in Webster 2008:282). Waterfield (1997), focusing on the delivery of public services, suggests that among other things, increasing technological advances and higher expectations for services on the part of citizens have fuelled the agenda for change in the delivery of public services. This agenda for change is particularly apparent in our altered requirements of interaction with the 'expert' (Giddens 1993:122). It is no longer enough for our expert practitioners to be skilled: they must also be engaged (Attali 1978 in Husson 2001). The focus of Health and Education delivery is shifting to relational, individualized factors, away from the universal application

of systems. This can be evidenced in initiatives such as Social, Emotional Aspects of Learning (SEAL) (Humphrey, Lendrum & Wigelsworth 2010), which led to a focus on individualized learning and Every Child Matters (DfES 2003b), which in turn led to an attempt to give the institutions of Education and Social Care directives to ensure that individual cases were treated with a coordinated and close attention. Patient Voice (DH 1991; 2001; 2002) was also part of this shaping of the behaviour of the expert practitioner, introducing the concept of the expert patient, capable of contributing to the direction of his/her care, as was Patient Choices (NHS & Finance Directorate 2014), introducing the idea of increased autonomy and critical facility for the patient.

But, although there is a polity rhetoric directing our services towards the privileging of the 'individual', 'the personal', and the monitoring of delivery to this client, the public services system is not adapting quickly enough to allow a smooth transition into this new 'age'. The requirements of a client-based neo-liberal approach, with a funding system that is still partly centralized (NAO 2013), and which continues to purport to be a universal provision, mean that the expert practitioner is caught in this difficult terrain between societal shift and the outdated practices still apparent in the structure of the delivery of Health and Education. Workplace stress for expert practitioners may be caused by the increase in the demand for emotional labour (Hochschild 1983) and a personalized delivery (Giddens 2010) within an outdated structure (Shaohui & Hong 2012). As this outdated structure deteriorates, due to lack of appropriate staff, environment or simply funding, even less opportunity can be given to moments of professional intimacy; simultaneously, the public clamour for personalized delivery grows.

This changing narrative towards personal, individualized delivery can be seen by comparing legislation introduced directly after the Second World War with more recent legislation (Gorsky 2008). In 1947, the Labour Government introduced the National Health Service Act (Bevan 1948) and in 1948 the school leaving age was raised to fifteen (Wilkinson 1947). Both pieces of legislation could be said to express a post-war nationwide desire to reach for the twin goals of a sound

universal education and good health care for all: a group objective (Jones 2003). Moving forward fifty years, the shift away from a group focus towards a focus on the individual is evident. In April 2009, the introduction of Choose and Book (an e-referral service) to the NHS was couched in language which empowered the individual, explaining that patients could choose which hospital they were to be seen at, in accordance with what mattered to them most, whether it was location, waiting times, reputation, clinical performance, visiting policies, parking facilities or other patients' comments (DH 1991; NHS 2009; Greener 2009). This consumer-led approach was also evident in the introduction of the Parents' Charter in 1991 (DfE 1991). The introduction to the 2007 amendment to this document states that the Parents' Charter signalled the start of an 'information revolution to extend parental choice and raise standards' (DfE, 2007:i). The use of the phrase 'information revolution' is significant. The writers of this document are tacitly conflating the idea of the physical 'information revolution', which addresses new technology and how it affects the speed and the quantity of our communications, with the social idea of an 'information revolution', and its implication of a transformative process. Parental choice will be 'extended' and 'standards will be raised'; information will not simply exist as 'data' but will act as a catalyst for change. The assumption is that 'information', or rather, being given information, is in itself a positive factor in any experience which the client may have in any interaction within the public sector. Information becomes part of a 'good' experience, and by default, those expert practitioners who inform the client are 'good' practitioners. But, there is a duality in the language used here and in the action by government in creating the Parents' Charter (1991) and NHS Choices (2009). Both of these pieces of legislation simultaneously encourage the twin concepts of individualism and universal provision. The patient is simultaneously part of a group with rights and an individual who can make decisions pertaining solely to himself/herself, by making a 'choice'. The question is – can these twin concepts be served at the same time? Can the client in the public sector have collective rights to a unique experience?

The personal critique of the system by this client will be monitored through the instrument of feedback, as in 'student voice' (BIS 2011b:3.7) and 'patient

experience' data (DfH 2007:3.12). This public sector client does not have the educational or medical expertise to make a substantive judgment of practice, and therefore judges the personalized experience not on the educational or medical outcome of the event, but on his/her 'feelings of being engaged with', further described by Giddens as 'facework' (Giddens 1990:80; Giddens 1994:196). The substantive outcomes of medical care and teaching are monitored through target-setting and data gathering. However, as our expectations of relation events are made higher by the barrier-free, informational world of social media (Castells 2012), our practitioners are under pressure to offer both expert skills and an emotionally positive experience for each client and in each interaction in which they are actors.

The pressure, the 'turbulence' within our public services, as the Chairman of the Association of Head Teachers described it (Hunter 2013), may be caused by this perfect storm. The increase in monitoring by non-professional auditors, usually clients or lay members of boards, exacerbated by a shrinking autonomy, due to protocols and targets, and a greater requirement for a relational approach, as a response to the public perception of uncaring professionals, and fuelled by the events described in Chapter 2, Sections 2.1.4 and 2.1.5, is a potent mix of factors. Most significantly, this relational approach is to be delivered in a setting not conducive to it, that is, a health service and schools service caught in an increasingly acrimonious debate over the pay and conditions of vital staff members. The most recent ONS (Office of National Statistics) analysis of labour disputes in 2014, including working days lost, stoppages and workers involved, shows that the number of days lost in the UK in 2014 was 788,000 (days lost per 1,000 employees) and was mainly attributable to large-scale public sector strikes (ONS 2014a).

2.3 The Voice of The Practitioner: The Need for Professional Intimacy

> Fraught with variability, full of possibility, yet fragile with individuality. (Lu & Lange 2014 on Foucault's 'The Birth of The Clinic' 1976)

The final section of this review of literature examines research and commentary directly generated by practitioners themselves. This gives the reader an unfiltered glimpse of the challenging realities of working as an expert practitioner in Health and Education in the UK today and allows the need for professional intimacy to be explored.

Amongst the plethora of government statistics, media headlines and theoretical constructs exists the narrative of the daily lives of those hospital consultants, GPs, nurse practitioners, ward nurses, school and university teachers who continue to provide healing and teaching to our society (Giddens 2012; Wallenstein 2005). This section privileges the experiences of these expert practitioners by examining research and reports generated by working health and education professionals themselves. Their voices demonstrate their level of dissonance and their desire for better working practices to be implemented and, also, their continuing commitment to the health and education services.

In this section of the literature review, I intend to explore the following three studies of the state of play in Health and Education, all of which have been either commissioned or created by practitioners working in the field:

1. Martin et al. (2015): research commissioned by Scottish consultants, which reports the voice of those practitioners regarding NHS provision.
2. Solomon et al, (2012): a study of GPs and prescribing.
3. Ball (2012): research created by practitioner/researchers in higher and school education.

Each of these studies highlights the responses of expert practitioners in Health and Education to the changes taking place in the workplace and practice. These

responses are often negative, and such negative responses may indicate that practitioners have ceased, or will cease, to perform effectively. The ultimate effect of this low performance means that these practitioners may leave their profession (Bandura 1982), become desensitized or suffer burnout (Bandura 1982; McManus, Winder & Gordon 2002). The concept of self-efficacy (Bandura 1977) provides a theoretical context for the voices of the practitioners caught up in this negative spiral and the identification of their need for professional intimacy provides a better understanding of the negative perceptions expert practitioners have of their daily working lives in these two public institutions.

2.4 The Desire for Autonomy and Relatedness

Efficacious organizations place trust in and sponsor the autonomy, competence and relatedness of their leaders and associates (Ryan & Deci 2003 in Hannah et al. 2008).

The success, the efficacy, of these organisations is built upon the efficacy of their workforce (Bandura 1982), and this interplay between structure and agency (Giddens 2013:25, 1993) means that Bandura's concept of self-efficacy is particularly relevant to an examination of the working lives of expert practitioners in the institutions of Health and Education. Self-efficacy can be defined as 'beliefs in one's abilities to mobilize the motivation, cognitive resources, and courses of action needed to meet situational demands' (Bandura & Wood 1989:48). Efficacy, the ability to utilize skills and knowledge effectively in a role, depends upon perceptions, 'beliefs', held by an individual about his/her levels of autonomy and control; his/her self-efficacy. Workers at the managerial and executive level believe that their organizations are controllable maintain their competency levels, whereas those who believe that their organizations are difficult to control display consistently low levels of managerial competency (Bandura & Wood 1989).

Self-efficacy can be seen as a kind of self-confidence (Kanter 2006) or a task-specific version of self-esteem (Brockner 1988). Strong positive relationships between self-efficacy and various criteria of human performance in organizations

have been demonstrated in research. For example, in their meta-analysis of 114 studies, Stajkovic & Luthans (1998) reported an average weighted correlation of .38 between self-efficacy and work-related performance (Hannah et al. 2008).

An employee's sense of capability influences his/her perception, motivation, and performance (Bandura 1997). A sense of capability for expert practitioners rests upon their ability to apply their substantive professional skills to influence outcomes for their client – the students and patients with whom they work (Perkin 1989; Giddens 1993:122).

In 2015, the BMA Scottish Consultants Committee commissioned research from the universities of Dundee and Glasgow to determine the extent to which consultants felt their traditional authority and leadership role in clinical matters had been eroded. The committee's concern was the that this erosion was affecting patient care (Martin et al. 2015). The key results of this study were that consultants felt that 'the balance had tipped too far towards business and financial decisions dominating how work was organized and evaluated' (Martin et al. 2015 Section 10:v). This clash between business-related and political rationales on the one hand, and medical professionalism on the other, appeared to be the underlying cause of relatively widespread feelings and expressions of deprofessionalisation among the interviewees and survey respondents (Martin et al. 2015:11:6) and supports commentary on the introduction of NPM to the public services of the UK (Marginson 2003). The consultants also commented on the increase in regulation which they had experienced over the last few years. This is the increased regulation in which 'box ticking' had caused appraisal to lack validity amongst appraisers and appraisees. The consultants reported that appraisal is now carried out by those other than their peers and, according to the report, the 'issue of who was selected to fulfil the role of appraiser was frequently raised, especially in relation to the appraisers who were thought to align with a business or financial model' (Martin et al. 2015: 11:vii). This supports the commentary of McKinley, Fraser and Baker (2001), who offer suggestions for more peer-centred appraisal system.

The consultants also commented in a change in the relationship between themselves and their patients/clients. Consultants saw increased patient demands as challenging, and in some cases misplaced. They attributed such views to a political rationale, to the role of the media in promoting 'bad news' stories about the NHS, and to enhanced access to self-diagnosis through the Internet in creating a 'want it now' culture. Nevertheless, such challenges did not cause consultants to feel that their status with patients had been diminished. Indeed, interview accounts and the survey data suggested that consultants felt they still enjoyed high levels of respect and trust in their judgement, and perceptions of integrity, despite what they saw as the constant media attention on failings in the healthcare system. Moreover, many consultants welcomed more informed patients and the challenge to the previous image of doctors as omnipotent and distant (Martin 2015: 11:vi).

'Consultants saw the increase in patients' demands as challenging and in some cases misplaced'. However, rather than attribute 'blame' for this deteriorating relationship to the patients themselves, the consultant respondents 'attributed such views to a political rationale' (Martin 2015:11:vi) Their comments provide evidence that when policy-makers introduce and support the concept of consumerism into the provision of health care, they should be aware of the unintended consequences at the most intimate level of the functioning of that public service. The daily interactions between the patient and the doctor are shifted along an unwanted trajectory to the milieu of the marketplace. The patient is a consumer and, as such, to successfully 'perform' the role of the consumer, has a responsibility to 'demand' the best care (Giddens 2013). This is a manifestation of the phenomenon observed by Sen (2002), who posited that when education is improved in a society, health care is demanded more vociferously and satisfaction in health care drops.

The voices of practitioners seem to describe the new assessment and monitoring of their professional behaviour as something akin to surveillance. This can be seen in the commentary of GP participants in Solomon's 2009 study of prescribing (Solomon 2009). They describe how the introduction of information technology into their consultations with patients, in the simple form of the computer, alters

the dynamic of the consultative meeting. There is now a third party or presence in the room. This presence is the policy-maker: government guidelines, protocols and targets are present as the patient and practitioner speak. And, again these practitioners, as with hospital consultants and nurses, are concerned with the loss of autonomy that this causes. There is also a sense of the lack of professional intimacy – how can two people speak honestly and unselfconsciously when a judgmental and controlling third party is present?

> In the partnership model, consultations are generally seen as a negotiation between the patient and the prescriber. However, guidelines bring a third decision maker – the policy-maker – into the equation. What appears to be a negotiation between two parties, is in fact, a negotiation between three; this, then, reduces the chances of all three stakeholders being in agreement and the choices available to the patients. (Solomon et al. 2012:275-281)

Although the GP practitioners in Solomon's study use the phrase 'patient demands', unlike the Scottish consultants' study, Solomon (2009) comments on the meaning of the language used to describe the changes in the doctor/patient relationship. She suggests (Solomon 2009:239) that it would be useful to explore what the term 'patient demands' covers and whether it would be better to use the term 'patient requests' or 'patient choice'. The implication here is that the term 'demands' is inappropriate, either being inaccurate or unnecessarily negative. Her sense of the need to address the negative quality of the word 'demands' relates to the dichotomous comments by the Scottish consultants, who welcomed the more informed patient, while still feeling overwhelmed by their 'demands'.

Ball (2003), when writing about the changes in the working lives of practitioners in higher and secondary education, describes the everyday 'horror of performivity' inflicted upon practitioners in education. Thus, the experience of expert practitioners in education is seen to reflect the experiences of the monitoring of their performance by GPs through system-based criteria (McKinley, Fraser & Baker 2001).

One reason for the low entry levels into teaching may be the over application of the monitoring of 'competence', which can have a deleterious effect on those who practice within the public services.

Competencies are a list of factors which would be deemed necessary for a hospital consultant, nurse, GP or a teacher to fulfil in order to practice his/her profession (DfE 2011a: DH 2007b). As the participants of the Scottish consultants' study state, 'their medical judgments are becoming routinized, with new bureaucratic procedures and the control exercised by non-clinical management limiting their clinical freedom' (Martin 2015:11: vii), and in education, 'the teacher, the researcher, academic are subject to a myriad of judgments, measures, comparisons, and targets' (Ball 2003:222). Furthermore:

> There is a flow of changing demands, expectations and indicators that makes one continually accountable and constantly recorded. We become ontologically insecure unsure of whether we are doing enough, doing the right thing, doing as much as others, or as well as others, constantly looking to improve, to be better, to be excellent. (Ball 2003:220)

Ball goes on to state that, and here you can hear the voice of a practitioner caught up in appraisal:

> We become uncertain about the reasons for actions. Are we doing this because it is important, because we believe in it, because it is worthwhile? Or is it being done ultimately because it will be measured or compared? (Ball 2003:220)

Ball is speaking here as a teacher in HE and from his own experience in secondary education, and so is an authentic voice for practitioners in this skills area.

This structural and individual dichotomy between values and purposes, and the potential for inauthenticity and meaninglessness, is increasingly an everyday experience for all practitioners. The dilemma Ball describes as facing educators is similar to the dichotomy of EBP (evidence-based practice) and 'shared decision making' described by Solomon et al. (2009, 230:237) in her work with GPs. In

discussing the prevalence of evidence-based medicine practices, Solomon comments on the dichotomy between this and the 'shared decision-making approach' which policy-makers ask to be applied to practitioner patient relationships. The practitioner is, at the same time, asked to engage in a dialogic relationship with the patient (individualized shared decision-making), whilst adhering to criteria already laid down by EBP, based on population studies. She goes on to say that the shared decision-making approach does not allow the practitioner to step into the 'life world' of the patient, but rather invites the patient into the EBP of the world of the doctor, which makes the relationship between the practitioner and the patient inauthentic and one sided (Solomon et al. 2009). Professional intimacy is lost.

And so in Education, where, as Ball says, there are pressures on individuals, formalized by appraisals, annual reviews and data bases, to make their contributions to the performativity of the unit. In this, there is a real possibility that authentic social relations are replaced by judgmental relations, wherein persons are valued for their productivity alone: their value as a person is eradicated (Ball 2003:224). He goes on to give an evocative quote from Lash and Urry: 'this contributes to a general 'emptying out' of social relationships, which are left 'flat' and 'deficient in affect' (Lash & Urry 1994 in Ball 2003:15).

The 'emptying out' of social relationships will leave educators and clinicians feeling that their jobs are meaningless. Healing and learning are ultimately one-to-one transactions, formal but intimate social relationships, which rely on trust in the practitioner for success (Misztal 1996). Martin (2015) comments on the workplace of the Scottish consultants, the NHS, as 'a low trust' environment (Martin et al. 2015:13:ix). The voices of the consultants, the GPs, the nurses, the educators heard in the studies above all speak of a fear that the authenticity of their practice is being eroded by false targets and crude misinterpretations of their role. Even given this condemnatory landscape of performance, surveillance and commodification, research into the attitude of expert practitioners to their role shows their continuing commitment to the job, to their clients and to each other. Laine (2005) describes the continuing commitment of nurses to the values

inherent they see in their role and, contrary to what might have been expected in organizations characterized by low trust dynamics, both the interviews and survey data on engagement of the Scottish consultants showed that these consultants were 'highly engaged with their jobs, with their clinical colleagues and with the values of the NHS' (Martin et al. 2015:13:ix).

In Solomon's study, the GP interviewees commented on how much they valued training that was directed by other GPs, not by government directives (Solomon 2009:234); teachers talk of the importance of colleagues and good relationships with students (Razak, Darmawam & Jeeves 2009). This commitment is precious, its meaning understood and shared by practitioners and clients alike, and, historically, the professional intimacy it engenders has underpinned these two public services in the UK.

However, commitment to the role of expert practitioner in Health and Education, due to the heavy investment of time, effort and resources it requires, has to be supported by a sense of self-efficacy (Bandura 1982:142). Without it, and there is evidence from the voices of practitioners heard here that this is fading, the practitioner ceases to be an active, productive member of the organization (Solomon, 2009: 238:257). Dr Thompson, Chair of the Scottish Consultants Committee, comments:

> while consultants are overwhelmingly committed to the NHS and to our patients, there is a sense of hopelessness over how we can speak and be heard on their behalf. (Hill 2015)

This literature review suggests that 'a sense of hopelessness over how we can speak and be heard' is a statement which could be applied to all expert practitioners working in Health and Education at the moment. The possibility that that this 'sense of hopelessness' may be ubiquitous throughout the working lives of our health and education practitioners in the UK is alarming. Yet there are minimal records of the reflective voices of these practitioners; it is to this gap in research that I wish to contribute.

2.5 Summary

In Chapter 2, I have outlined the broader socio-political context within which this study was conducted, remarking that over the last fifteen years, the role of the expert practitioner in Health and Education has undergone a number of significant changes, notably in the shift in emphasis towards a culture of competition, accountability, and measurable outcomes. Examining events at the international, or macro level, allows the developments in the UK public services of Health and Education to be seen in a global context. Neo-liberal policies and the opening up of a trans-national market for the provision of health and education, move, seemingly inexorably, towards the commodification of these services.

At the mesa, the national, level, I have made the point that, during these initial years of the 21st century, the Francis report (2013) into the failure of the Mid Staffordshire NHS Foundation Trust, the McKinsey report (2010) into the low performance of the UK on the PISA scales, the shocking case of Victoria Climbié (Laming 2003) and that of Dr Harold Shipman (Smith 2002; 2003; 2005), have served to alter our perception of nurses, doctors and teachers. Another shift in emphasis has taken place and the centrality of the inter-relational nature of the role of the expert practitioner in Health and Education has become a matter of debate and concern. As discussed, the delivery of individualized, personal care and teaching has become the matter of government reports, media coverage and internal debate amongst professional bodies. This study has also to be seen in the context of the low retention, low uptake and rising exit rates due to stress-related disease in regard to practitioner posts in Health and Education, again described in this chapter. Lastly this study also has to be seen in the context of its identification and exploration of what I have described as the need for professional intimacy. Literature from practitioners from both sectors indicate this need for professional intimacy as a response to the focus of their work being moved from its intrinsically relational nature to the servicing of systemic requirements. However there is a lack in the literatures of meaningful analysis of the responses of expert practitioners to their experience; the intention of this study is to provide this analysis.

The following chapters will make explicit my ontological and epistemological base, my rationale for choosing thematic analysis and my process of choosing the research design and sample participants.

CHAPTER 3: METHODOLOGY

> Unlike the movement of mercury within a thermometer, social data are never only an 'index' of an independently given phenomenon but always at the same time exemplify what it is that they are 'about' – that is the processes of social life. (Giddens 2013:334)

In this chapter, I discuss the methodological background to this study. I begin by reviewing the aims of the study and identifying the research questions. Secondly, I define the ontological position of structuration and the epistemological approach of 'critical realism' as applied to social research, and identify some methodological considerations arising from this, including the effect of using the perspectives of 'critical realism' and 'structuration' to guide the process of theory generation, data categorization and analysis. Finally, I discuss the rationale and theoretical foundations for using the methodological approach of 'thematic analysis' in this study, and explore the strengths offered by this approach for research into the experience of working life by expert practitioners in Health and Education.

The aim of this research is to gain insight into the effect of the critical changes taking place in the working lives of expert practitioners in Health and Education, seeking to establish whether there is a significant similarity between the experiences of practitioners in each sector of the public service. By interviewing senior practitioners who describe themselves as 'having undergone and/or implemented significant change in the workplace in the last ten years', this study seeks to shed light on the working lives of expert practitioners presently engaged in the delivery of health services and education to our communities. The rationale behind the focus on the voice of senior practitioners, rather than early- or mid-career professionals, is that senior practitioners have a professional responsibility for the whole practitioner cohort and a practical, executive experience of implementing change. These factors therefore create amongst this group an opportunity to reflect upon change in the working lives of all expert practitioners

in the areas being studied. Blumer states that it is important to study the best informed members of social groups. He proposes that researchers should seek and question the most acute observers of a group or aspect of social life to gain in depth information about that group, since 'a small number of such individuals, brought together as a discussion group, is more valuable many times over than a representative sample' (Blumer in Haralambos, Holborn & Heald 2000: 996). It was not practical to bring together expert practitioners from Health and Education into a discussion group for this research. However, the use of semi-structured interviews with standardized procedures and settings allowed a data corpus to be created, which offered cohesion and comparability with similar qualities to a discussion group.

The key research questions which guide this research are:

a) what changes are taking place in the working lives of expert practitioners in Health and Education?
b) is there a shared pattern of experience between expert practitioners in both sectors?

These research questions are explored through interview questions which ask participants for reflections on three broad areas of experience: firstly, the form of change in terms of environment and practice; secondly, the cause of change, whether it be bottom up from the practitioners and the clients, or top down from the policy-makers; and thirdly, to examine whether or not these changes have had a positive or negative effect on the working lives of these practitioners.

3.1 Ontology: The Theoretical Perspective

Braun & Clarke (2006) describe thematic analysis as having the capacity to be a 'contextualist' method, 'sitting between the two poles of essentialism and constructionism' – a position 'characterized by theories such as critical realism' (Brown & Clarke 2006:9). Critical realism acknowledges, or wishes to be acknowledged – the dynamic relationship between the individual and the structure of society. Archer (1982) suggests that the polarized positions of positivism and

interpretivism were revisited in the latter part of the 20th century by, among others, neo-Marxists seeking a richer explanation of human behaviour than the purely structural, and by interpretivists recognizing that patterns in human behaviour could not be usefully explained solely by the idiopathic approach.

The continuing debate between positivism and interpretivism led to two perspectives emerging in social theory which sought to directly address the relationship between structure and action in human behaviour. Firstly, growing from the positivist/interpretivist debate, and from the application of general systems theory (Maruyama 1963), the theory of morphogenesis was proposed originally by Buckley (1968). Morphogenesis was formed as a response to the failure of the positive-functionalist movement in social theory to address the effect of time and the historic nature of change, particularly the effect of events before and after a phenomenon on that phenomenon. Morphogenesis seeks to explain the duality of action and structure through 'analytical dualism', which explores the complex interchange between components of a system as it goes through change. 'Analytical dualism' presupposes an end product, 'structural elaboration' (Archer, 1982:458), where the essential nature of a structure is changed. Analytic dualism also proposes that this change can be witnessed, and that these changes can be recognized as sequential in nature.

The second major sociological perspective proposed during the latter part of the 20th century is Giddens' 'distinctive theoretical approach of structuration' (King, 2010: 253). In presenting his explanation of the relationship between structure and action, Giddens (2013), while accepting, like the morphogenetic proposal, the centrality of the interaction between action and structure as an understanding of human social behaviour, also proposes that the relationship between structure and action has a dynamic quality. He describes this as structuration – 'the fundamentally recursive character of social life, expressing the mutual dependence of structure and agency', a 'duality of structure' (Giddens, 2013:13). This duality is an active process, a constant traffic between agents of ideas and nuances drawing on, and in turn, shaping, the rules and resources available to

those agents: it is a continuous, circular flow of action upon structure and of structure upon action. He describes this process using an evocative image:

> When I utter a grammatical English sentence in a casual conversation, I contribute to the English language as a whole. This is an unintended consequence, but one that is bound in directly to the recursiveness of the duality of structure. (Giddens 1979:7)

This concept of 'recursiveness' – a dynamic, circular flow between structure and agency – is fundamental to structuration, and is where it parts so clearly from the 'sequential' nature of morphogenesis. It suggests that there is no objective reality which we have the capacity to observe: rather, that 'there are a multitude of potential alternative reality constructs – our everyday life unfolds but one of them', and that 'inner models are not representations of an outer reality but subjective dynamic constructions that, by complex feedback paths within the observer and environment, move the system towards its emergent goals' (Bishop & Natsuto 2005:1311).

Structuration's central principle of the 'duality of structure' differs from morphogenesis' 'analytical dualism' in two other important ways. Structuration incorporates elements of linguistic analysis and of hermeneutics (von Wright 1971) into its lexicon; the importance of the hermeneutic tradition to Giddens is made explicit, when he states that: 'in structuration theory a hermeneutic starting point is accepted' (Giddens 2013:2). Structuration is an ontological approach, where the study of both text and behaviour stem from the perceptions of the agents involved in their production, but also accepts that the perceptions of those 'purposive' (Giddens 2013:3) agents will have consequences on the structures those agents inhabit.

Giddens, in referring to Durkheim, describes 'norms' as 'the commitments [he has] entered into … obligations which are defined in law and custom and which are external to [himself] and [his] actions' (Giddens 2013:172). In going on to develop an argument which supports rejecting the centrality of the 'norms' of functionalism as the prime directing force of human action, Giddens is suggesting

that it is necessary to recognize the validity of the individual's perception of his/her autonomy. In saying 'to be a human being is to be a purposive agent', Giddens (2013:3), while accepting the instrumental nature of rules and resources, is suggesting that they can be transformative rather than constraining and that, above all, the re-interpretation of rules by agents, and their innovative use of resources, constantly shape and reshape our social lives. These rules, therefore, are not only transformative but are constantly 'transforming' (Giddens 2013:19); and 'one of the main propositions of structuration theory is that rules and resources drawn upon in the production and reproduction of social action are at the same time the means of system reproduction (the duality of structure)' (Giddens 2013:19). His conception of the social system differs from that of functionalists, in that he proposes that these rules are capable of being constantly reformed in a social life which, although it can be superficially observed as a 'snap shot' of a set of reproduced practices, is more truly a dynamic process in constant flux.

3.2 From Ontology to Epistemology

This concept of the duality of structure, wherein takes place a constant motion between structure and agency, is fundamental to the ontology of structuration (Giddens 2008). As Kaspersen says: 'instead of focusing on how reality is to be understood, we must instead realize that we are part of reality and that understanding takes place through language and is thereby to a great degree a question of interpretation' (Kaspersen 2000:15).

Kaspersen's use of the word 'interpretation' confirms that, for Giddens, there is no fixed reality, only our interpretation of reality. Giddens' research focus on the ontological, the 'interpretation' of the world around us, has many instances of connection with Bhaskar, who, like Giddens, places ontology at the centre of research into human behaviour (Kaspersen 2000). Bhaskar introduced his transformational model of social activity (TMSA) in similar terms to Giddens' restricted account of the structuration approach (Jessop 2005). Critical realism, unlike the scientific approach, is defined by Bhaskar (2008:14-15) as 'an ontology

which recognizes the provisional nature of the categories researchers employ to understand reality'. Bhaskar sees the task of the critical realist as: 'freeing these sciences from the intellectual grip of theories secreted by the flat, undifferentiated ontology of empirical realism' (Bhaskar 2008:253). As Bhaskar developed the methodology of critical realism, he explicitly pointed up the parallels between his own TMSA and the structuration theory of Giddens (King 2010:255). And Giddens, in aligning himself with the development and application of Bhaskar's critical realist approach, describes the actions of the social researcher as 'firing salvos into reality (Kaspersen 2000:13). Critical realists recognize that the language they employ in the categorization of objects in the perceived reality which they choose to study are not synonymous with the objects themselves. This implies that, for critical realists, unlike positivists, it is admissible to include in their explanations of the social order 'theoretical terms that are not directly amenable to observation'. The envisaging of 'hypothetical entities' – unseen but powerful 'transitive generative mechanisms' (Bhaskar 2008:4), that according to Bhaskar, account for observable patterns of behaviour in the social orders – are acceptable for realists but not for positivists. In describing the 'two dimensions' of knowledge which, for him, are both 'generative mechanisms' that drive human behaviour, he delineates a 'transitive' dimension, in which the object is the material cause or antecedently established knowledge which is used to generate the new knowledge; and an 'intransitive' dimension, in which the object is the real structure or mechanism that exists quite independently of men (Bhaskar 2008:4). Bhaskar is suggesting that 'intransitive generative mechanisms' are like the neurological basis of disease, which will not change regardless of the human interpretation of the cause of that disease. These are the usual subject of the natural sciences. However, 'transitive generative mechanisms' are created by human agents in regard to their social behaviour and will, in turn, change that behaviour.

They are not directly observable, but for critical realists, their study is admissible on the grounds that their effects are observable:

> People do not only make social products, but make the conditions of their making, that is reproduce (or to a greater or

> lesser extent transform) the structures governing their substantive activities of production. (Bhaskar et al, 1998:218)

To attempt to measure and understand this 'transformational' capacity of the human endeavour to form social structures lies at the heart of the methodological approach of critical realists.

'What makes critical realism critical is that the identification of (transitive) generative mechanisms offers the prospect of introducing changes in a 'social' situation that can transform the status quo' (Bryman 2008:15). By gathering the experiences and reflections of expert practitioners in Health and Education, I hope to offer some insight into the causes of the dissonance in lives of these practitioners: an insight which could then lead to changes that enhance the working lives of these practitioners.

3.3 Epistemology

As Braun and Clarke suggest, 'critical realism acknowledges the ways individuals make meaning of their experience and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality' (Braun & Clarke 2006:9). Understanding how practitioners 'make meaning of their experience' as they go about their daily work in large complex institutions can benefit from the capacity to use a broad range of qualitative methods in conjunction with statistical evidence (Creswell & Plano Clark 2011).

The NHSIQ white paper entitled The New Era of Thinking and Practice in Change and Transformation (Bevan & Fairman 2014) tells us 'that organizational leaders are seeking greater connectivity with customers, more opportunities for co-production and more personalized relationships' (Bevan & Fairman 2014:13). In seeking to make their ideas for change explicit, the writers use a number of vignettes, events of change, described in written form, contained within a narrative, which is in sharp contrast to the exposition of quantitative data

employed by previous DH white papers on Health (DH 2010) and on Education (DfE 2010).

This emphasis on relationships and, subsequently, the measurement of the quality of relationships, and indeed, the methodology of measuring relationships, can also be seen in the Royal College of General Practitioners (RCGP) policy paper on GP practice (RCGP Policy Paper 2011:5). Here, it is stated that 'relationship continuity' and the nature of a relationship per se, '[are] by definition subjective and hard to measure', and yet it is recognized that in the present climate of public service accountability, these measurements are essential to the direction of change in Health and Education. In a similar shift of emphasis from exclusively calculative measurement to a mixed approach, the DfE research survey of 2010 on the workload of teachers (Deakin et al. 2010) used transcripted excerpts from teacher commentaries, alongside statistics of time allocation, to task categories to make the teacher response explicit. In a series of prescribed categories, 'spending more time with pupils' was the second most frequently chosen 'possible improvement' to teachers' workload, and when asked about what had a positive impact on their working lives, they often commented on relationships:

> Working alongside good, friendly colleagues. Children's behaviour, enthusiasm to learn and being happy in the classroom. Having a good relationship with parents and having them praise your work. (Deakin et al. 2010:29)

These participants expressed a desire to reflect on the relationality of the job of teaching; and the methodology employed in this research survey, while offering a series of statistical accounts of time allocation within the working day, also invited these teachers to record their reflections on practice and so produced a richer depiction of the events being described (Lincoln & Guba 1985). Similarly, as commented above, the innovative white paper published online in January 2014 (DH 2014), offers narratives or stories. These narratives, ranging in subject matter from community action to hospital procedures, offering four examples of bottom-up change described in detail, also offer a 'thick description' of the events which are the subject of discussion and reflect the usual practice of qualitative research (Bryman 2008), rather than the evidence-based, numerical nature of

previous white papers from the DH. In its policy on Improving Quality (IQ), the NHS has stated that its intention is to 'engage hearts and minds' through this 'personal' approach (NHS 2014).

One of the fifteen proposed 'actions for leadership' in this paper is 'to purposefully *seek to build relational approaches* to change as well as logic based, rational leadership' (DH 2014:35) (my italics), and there is a recognition that 'leaders who utilize dialogic methods start from the premise that organizations or systems are *socially co-constructed realities* (DH 2014:28) (my italics).

This is a socio-political landscape of 'co-constructed realities', a world where institutions are moving to the 'personal' rather than the 'public', in which the possibility of a 'personalized public service' first mooted by the Demos think tank at their Westminster conference of 2008 (Leadbetter 2008), becomes the language of a government white paper in 2014 (DH 2014). It is appropriate that an appraisal of the experiences of expert practitioners in our public services springs from their individual reflections rather than from an analysis of government statistics. However, it is also appropriate that the information gathered in this way, i.e. through the spoken words of the practitioners, is seen as having a dual capacity: the capacity to give a rich understanding of the individuated experience and the capacity to show trends and indicators of change within the active, interrelated social system of which they are part. The theory of structuration proposes that 'the constitution of agents and of structures are not two independently given sets of phenomena, a dualism, but represent a duality,' and as such, 'according to the notion of the duality of structure, the structural properties of the social systems are both medium and outcome of the practices they recursively organize' (Giddens 2013:25). This would suggest that, to be fully rounded, a study of the reflections of working practitioners in Health and Education should address, or be situated in, the institutional context.

3.4 Rationale for the Choice of Thematic Analysis in this Study

The phenomenological ontology of Brentano and Husserl (Davidsen 2013) underpins many strands of qualitative methodology: its underlying principle of 'seeking to preserve the first person nature of its explananda' (Walsh 1972) being expressed most prominently in the methodologies of interpretive phenomenal analysis (IPA), grounded theory and thematic analysis. As Davidsen suggests, 'a whole family of qualitative methods is informed by phenomenological philosophy' (Davidsen 2013:318). This philosophy intends that 'the focus [of the researcher] is on the way consciousness is turned out on the world and on the relationship between a person's consciousness and the world, including the relationships between people' (Davidsen 2013:321). Qualitative methodology privileges 'the understanding of meaning or phenomena formed [by] participants and their world views' (Creswell & Plano Clarke 2011:40) and develops from a 'different world view' than that of post-positivists, whose researchers make claims for knowledge based on 'determinism' or on reductionist 'cause and effect thinking' (Cresswell & Plano Clarke 2011:40). IPA '[uses] concepts from this philosophy to interrogate the findings and to enable greater theoretical analysis' (Davidsen 2013:322) and as Smith states, supports a theoretical commitment to the person as a cognitive, linguistic, affective and physical being while assuming that a chain of connection exists between people's talk, their thinking and their emotional state (Smith 2008), and is therefore a methodology firmly set in the qualitative camp.

This research design intends to treat each participant as a 'cognitive, linguistic, affective and physical being', and therefore is cognisant of the ontological principles of phenomenology and IPA. However, this design also seeks to trace patterns of response, experience and behaviour between expert practitioners in two large public institutions, and as such has a database of transcripts drawn from thirty-six participants. 'IPA studies have been published with samples of one, four, nine, fifteen or more' (Smith 2008:56), but 'our current thinking is that for this form of analysis 4-10 is a comfortable sample size'. This is only a recommendation, but it indicates a trend in the design of IPA studies towards

smaller samples and even to individual case studies (Smith 2004). In terms of the substantive nature of research areas chosen, IPA is effective when exploring personal experience of trauma, as can be seen from titles taken from Smith, such as: 'How do people come to terms with the death of a partner?' (Golsworthy & Coyle, 1999)'; 'What forms of support are helpful to people in pain? (Warwick et al. 2004)'; 'What is the relationship between delusions and personal goals' (Rhodes & Jakes 2000)' (all in Smith, 2008:55).

The focus of this research, like the examples listed above, is on personal experience, but it differs in one important aspect. The experience of my participants is particularly mediated by a public environment, i.e. the institutional workspace of our public services of Health and Education. I seek to understand better not only the changing perceptions of individuals, but the relationship between those individuals and their work environment. The 'locale' (Giddens 2013) of a public institution is the shared setting for each narrative, and my participants have a professional 'role' in these institutions, which informs their perception of their work experiences. Their narrative is therefore not only 'personal' but 'public' and focused on what Goffman described as the 'front region', the space where people interact with each other in 'performance' of their roles. In this space people are 'colleagues … defined as persons who present the same routine to the same audience but who do not [necessarily] participate together' (Goffman 1990:159) and are sharing 'the 'supra-individual' durée of the long term existence of institutions, the *longue durée* of institutional time' (Giddens 2013:35).

IPA researchers 'usually try to find a fairly homogenous sample' (Smith 2008:55), whereas the present study proposes to explore the possibility that expert practitioners in the fields of Health and Education have similar experiences of institutional change. I do not, therefore, initiate this study with the homogeneity of my sample established. The analysis of themes uncovered by my relatively large sample of participants may show shared trends and patterns which indicate homogeneity, which is why thematic analysis, with its capacity to be applied to a

larger sample than IPA (Guest, MacQueen & Namey 2012) offers me the best methodological fit. Smith tells us that:

> IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing, how they are making sense of their personal and social world. (Smith 2008:55)

Although the methods of the present study do not include an attempt to 'produce an objective statement of the object or event itself' (Smith 2008:53), the specific focus is on the changing workplace, not the 'personal' or 'social' world of my participants. It is therefore appropriate that the validity of responses made at a semantic level, i.e. descriptions of new buildings, rooms, ward or classroom systems, be accepted and incorporated into the data corpus in order to allow 'the identification of both explicit and implicit themes within the data' (Guest, MacQueen & Namey 2012:10).

Grounded theory, a method I also considered using, has been productively associated with the epistemological stance of constructivism (Charmaz, 2014), developing an emphasis on what Charmaz (2014) calls 'iterative, emerging strategies'. Guest suggests that 'the emphasis on supporting claims with [qualitative] data is what links applied thematic analysis to grounded theory' and to IPA (Guest, MacQueen & Namey 2012:12).

Like applied thematic analysis, grounded theory in its original conception held a broad epistemological base. In an overview of the history of grounded theory, Stern (Morse 2009) suggests that it had moved away from this broader base first conceived by Glaser and Strauss in their seminal text (Glaser & Strauss 1967), where an argument was made that both qualitative and quantitative measurements could be useful in allowing researchers to reach a fuller understanding of the world of their participants. At the time of the publication of the edited collection in which this article appeared, Stern also suggested that Glaser was working towards a text describing how one can apply grounded theory techniques to statistical data (Morse, 2009:56-57).

The debate surrounding the relationship of grounded theory to qualitative and quantitative data collection, including the use of analytic software in qualitative research, is part of a greater ontological debate about the division between micro/interpretative and macro/system theories of society. In the introduction to the second edition of New Rules of Sociological Method, Giddens simply states that 'the micro-macro differentiation is something I place in question' (Giddens 1993). Understanding the dynamic interaction between macro, meso and micro social phenomena is more useful than merely pointing out their existence. In stating this, he is reiterating the theory of structuration, where the ontological division between 'interpretive' and 'positivist' perspectives, and the epistemological division between their, often co-occurring, methodologies are seen to be obsolete (Giddens 2013). Also commenting on this false divide between interpretive and positive perspectives, and applying that critique to methods, Olsen states that:

> In the realist view, constructionism and empiricism are not adequate theories of what exists, but as bundles of techniques they can be utilized in a pragmatic and well-grounded way. Both theory and practical experience will help you to work out which techniques are going to be useful in a given context, e.g. discourse analysis from the constructivist tradition and tabulated matrices based upon qualitative categories, perhaps, from the empiricist tradition. (Olsen, Holborn & Haralambos, 2004:12)

Boyatzis (1998:4) has observed that thematic analysis is 'not another qualitative method but a process that can be used with most, if not all, qualitative methods'. However, thematic analysis has been recognized for some time as a method in its own right, particularly by researchers in health and psychology (Braun & Clarke 2006; Thomas & Harden 2008). Thomas and Harden (2008:13) report on its usefulness in their working paper for the ESRC National Centre for Research Methods on the need to use qualitative research 'in the evidence base to facilitate effective and appropriate policy and practice'. They demonstrate how what they describe as the thematic synthesis of a number of interview-based studies allowed them to apply a 'rigorous, transparent analytic system' (Thomas & Harden 2008:11), with the opportunity to generate 'higher order themes' (2008:13) from

qualitative material. They conclude that thematic synthesis, built upon 'years of methodological development' (Thomas & Harden 2008:13), is a robust technology; their success with this technique suggests that evidence-based research, central to health and education policy-making, can be generated by a variety of methodologies, including those which would be deemed qualitative. They further comment that, although systematic review methods are well developed for certain types of research, such as randomized controlled trials (RCTs), methods for reviewing qualitative research in a systematic way are still emerging amongst much ongoing debate (Thomas & Harden, 2005). In their later working paper, Thomas & Harden (2008) offer a positive critique of thematic synthesis as a useful method of bringing qualitative research into the framework for evidence-informed policy and practice.

Unlike IPA, with its base in phenomenological philosophy (Davidsen 2013), or grounded theory used and developed by Strauss and Corbin (1990), and later refined by Charmaz (Morse 2009), thematic analysis has not developed from a narrow ontological base and can be a method which works both to reflect reality and to unpick or unravel the surface of 'reality' (Braun & Clarke 2008). Therefore, given the position of my participants within institutions, it is a useful methodological application for the research undertaken in this study. Thematic analysis allows for the exploration of the ways these expert practitioners of health and education work within their institutional context, allowing a reflection of the reality they experience and an understanding of the 'hidden structures' (Lévi-Strauss 1974 in Archer 1982) which underpin their action and experience. The choice of thematic analysis, as a flexible method with the capacity to encompass a number of levels of interpretation, allowed me to approach the data gathered from my participants using an exploratory, content-driven approach (Guest, McQueen & Namey 2012), but not confining my direction of analysis to a constructionist or empirical method. Each transcript is unique, and offers a rich pool of information, ideas and emotion and has to be sensitively approached as such. However, each transcript also contributes to a pattern of trends and shared commentary, which helps to define the issues inherent in the role of the expert practitioner and which could lend itself to quantitative analysis.

It is this sense of methodological duality, rather than a separation of the empirical and constructionist approach to research, which I found in Guest's exposition of thematic analysis. Freed from epistemological debate, by including in its range of research techniques 'presenting numbers and talking about how the data are structured, in addition to providing an engaging narrative' (Guest 2011:13), thematic analysis has drawn on practice from those areas of social research where the transcription of language, either spoken or written, forms the basis of the data corpus. Out of successful instances of practice, particularly in the fields of health and education research (Thomas & Harden 2007; Harden & Thomas 2005; Patel et al. 2015), it has emerged as a robust system for the analysis of qualitative material, which crucially allows for a quantitative interpretation of that data where appropriate (Guest, Namey & Mitchell 2012). Thematic analysis is a flexible method which allows for the assessment of text (and visual or aural material) on a semantic level, where the researcher is required to gather the surface meaning from the material provided by participants. Therefore, it can be an essentialist or a realist method (Braun & Clarke 2006; Braun & Clarke 2014) and can focus on the reports made by participants of their lived reality, as in a research study into the use of CCTV in car parks, where both qualitative and quantitative methods were used to establish patterns of behaviour (Tilley, 1993, 2000). However, thematic analysis can also allow a full and sensitive account to be built of the 'latent' meaning within the commentary provided during research interviews. As such, it can be employed as a purely constructionist method to examine the ways in which events, realities and meanings derived by actors in them are the effects of a range of discourses operating within society (Braun & Clarke 2006). Boyzatis (1998:vii) describes themes as something which 'may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon). The 'latent' level referred to here by Boyzatis can be understood in relationship to what Halton calls 'the unconscious aspects of organisational life' – 'hidden aspects of human mental life, which, while remaining hidden, nevertheless influence conscious processes' (Halton 1994 in Obholzer & Roberts 2003:11) – the unconscious at work. There is a further link here to the 'hidden structures' of the social world as described by Lévi-Strauss (1963) and sought for

by Archer through the structure of morphogenesis (Archer 1982), and named by Giddens (1989) as the 'unintended consequences' of action.

In relating these concepts to the working lives of expert practitioners in Health and Education, it is useful to engage them as tools to unpick the assumption that the individual can usefully be seen as an actor without due reference to a) his social context, b) the reflexivity of his actions, and c) the dual, and sometimes unknown, nature of the interplay between structure (that is the institution) and the actor (that is the practitioner).

The 'unknown' aspect of the nature of this interplay is the concern of thematic analysis at the latent level. Braun and Clarke (2006) suggest that increasingly, a number of discourse analysts are 'revisiting psychoanalytic modes of interpretation'; and they comment that thematic analysis 'would be compatible with that framework' (Braun & Clarke 2006:13).

Halton discusses inter-group dynamics from a psychodynamic perspective. According to Halton, what plays the prime role should be the institutional dynamics between various groups. As he describes, 'it is often easier to ascribe a staff member's behaviour to personal problems than it is to uncover the link with institutional dynamics' (Halton in Obholzer & Roberts 2003:18); but it is in precisely uncovering this link that a real understanding of the relationship, sometimes the dysfunctional relationship, between the individual and the institution is to be found. His suggestion of the way in which, by the using of the psychoanalytic concept of 'projective identification', it is possible to identify 'unconscious inter-personal interaction' (Halton 1994 in Obholzer & Roberts 2003 :16), could be usefully applied to people sharing the 'bounded time and space', the 'locale' of Giddens' institutional workplace (Giddens 1989). The school, the hospital, the university and even the GP practice, are bounded by the physical structure of their buildings and by the time keeping of the routine which guides each day. However, Giddens argues, in a second caveat to psychoanalytic theory as applied to institutions, that 'this reductive theory of consciousness', in 'wanting to show how much of social life is governed by dark currents outside the scope of actors' awareness, cannot adequately grasp the level of control which

agents are characteristically able to sustain reflexively over their conduct' (Giddens 2013:5).

To discover how the working lives of expert practitioners are changing, it is necessary to talk to them with an awareness that they are not passive recipients of change, but instigate, perform and explain change as a constant factor of their working lives. Working lives being transformed by a changing zeitgeist (Castells 2004), by instrumental change instigated by social policy (Audit Scotland 2013) (Alpha Sprint conference, GDS 2013) or by the behaviour of expert practitioners themselves. To discover the extent to which Giddens describes as 'the level of control which actors are characteristically able to sustain over their conduct' (2013) has been, and is part of, the 'transformation of our public services', it is also necessary to go below the surface of their commentary to explore the dynamics of their experience: to understand what is latent in their descriptions and assessments of working procedures, environment and relationships, whilst remaining cognisant of the theories and philosophies which feed into the methodological approach of thematic analysis (Guest, Bunce & Johnson 2006).

3.5 Rationale for Analysis of the Findings Using Computer-Assisted Qualitative Data Analysis Software (CAQDAS)

CAQDAS (computer-assisted qualitative software) can enhance the application of the thematic analysis approach (Guest, Bunce & Johnson 2012). However, it may change the nature of qualitative research in that it can handle very large numbers of codings and separate code words. In purely mechanical terms, the computer can help with more comprehensive and more complex code-and-retrieve tasks than can be achieved by manual techniques (Guest, Namey & Mitchell 2012). Guest also comments on this new capacity offered by software, stating that now, 'advances in software permit efficient analyses of in-depth interviews, observation and focus groups' (Guest 2005). He goes on to suggest that 'sampling strategies beyond the typical purposive sample [can] also [be] used in qualitative research. Sampling of an entire population (e.g. all decision-makers in a Ministry of Health) is possible' (Guest 2005). This is an important point: in-depth

interviews, such as those generated in IPA (Guest, Bunce & Johnson 2012) are traditionally taken from small sample sizes, and the analysis of those interviews is undertaken by the interviewers in order to maintain the authenticity of the interviewee voice and sensitivity to the underlying meanings to be gleaned from the interaction between the interviewer and the interviewee (Bryman 2008). If sample sizes are to be increased by the use of technology, then what effect will this have on the qualitative process of eliciting understanding of the 'other' through developing that ability to glimpse the world through the eyes of another, the 'verstehen' of Weber (Weber 1949)?

Thematic analysis, as used here in conjunction with computer aided qualitative data analysis software (CAQDAS), seeks to preserve the opportunity for in-depth detailed analysis of individual responses and also gives the opportunity for quantitative identification of trends, patterns and outstanding phenomena. In exploring the use of using CAQDAS software and hypertext/hypermedia formats within ethnographic study, Coffrey, Holbrook and Atkinson (1996:1) propose that the 'purpose is not to abandon altogether established modes of analysis, thought and representation' but to use the 'possibilities of information technology' to 'help create flexible modes of data analysis and reality-reconstruction' (Coffey, Holbrook & Atkinson 1996:14). The flexibility that the use of CAQDAS software offers to ethnographic research applies to all qualitative research which relies upon transcripts as a basis of analysis (Guest, MacQueen & Namey 2012) and so can be usefully applied to the data corpus of this study.

The generation of themes through 'grounded dimensions' (Leiber 2009:223) arrived at through the familiar method of coding transcribed interview material through 'the iterative process of hypothesis testing, evaluation and revision until a valid and useful code system emerges', is central to this study; and the application of CAQDAS software to these 'systematic, reliable and direct representations of the qualitative data' allowed me to use a number of techniques of data analysis, including an exploration 'of the psychometric characteristics of these variables which allowed bi and multi-variate analyses' (Leiber 2009:223). By the use of CAQDAS, the full transcripts, the coded excerpts from individual interviewees

and the quantitative relationship between the coded themes, are available throughout the process of data interpretation and can be organized in a number of different ways:

> The grounded nature of these variables [coded themes] provides for deeper understanding of the results from the analyses. Where questions regarding group differences or bi-variate relations arise, one can seek answers by returning directly to the qualitative data on which the study bases these variables. (Leiber 2009:223)

The above excerpt describes the practical effect of using CAQDAS with transcripts. It is possible to move quickly between levels of data collection, i.e. from the full transcript to a particular excerpt within the individual transcript, or from the coded themes to the grouped excerpts pertaining to each theme. The process of thematic analysis, 'comparing code frequencies, identifying code co-occurrence and graphically displaying relationships between codes within the data set' (Guest 2012a:10) is facilitated by the software. This ease of overview includes any statistical and mathematical analyses of text which can be re-examined for validity by comparison with the original text excerpts on which they were based. In this way, the use of CAQDAS software does not alter the research process of a thematic analysis, but underpins its versatility and, by supporting the iterative process inherent within it, increases its rigour.

Guest (Guest, Namey & Mitchell 2012) suggested that in understanding the relationship between data and data analysis, researchers fail to make the distinction between the data itself and the analyses performed upon data:

> It is what you do with qualitative data and not the methods themselves that define whether you are engaged in a research endeavor that is interpretative, positivist or a hybrid of the two. (Guest, Namey & Mitchell 2012:5)

The data collected for this study has no inherent numeric value, and was taken from semi-structured interviews using guiding questions which allowed open answers on a number of broad topics, and therefore can be defined as fitting the traditional data-collection procedures of the interpretive perspective (Bryman

2008). However, recognizing the distinction between data type and the type of procedure used to analyse data broadens the range of 'qualitative' research and opens up an additional category of analytical procedures that other conceptual frameworks exclude (Guest, Bunce & Johnson 2012:165). It is accepted in thematic analysis that 'qualitative data can be and often are quantified. Text or themes can be numerically coded and put into matrices, for example, and various data reduction techniques and statistical methods used' (Guest, Bunce & Johnson 2012:165).

I propose to present both qualitative and quantitative expressions of the data corpus generated by this study, and by using the range of analytic tools available in thematic analysis, this research will explore those 'transitive generative mechanisms' (Bhaskar 2008:2) which are created by human agents with regard to their social behaviour and will seek to find patterns of behaviour which co-occur in expert practitioners in the health and education services.

Figure 3.1 below gives a widely used graphic image of the range of analytic methods available to the qualitative researcher (Bernard 1996 adapted in Guest Bunce & Johnson 2012; Bernard 1996 adapted in Ryan 2005). Guest (Guest, Bunce & Johnson 2012:6) suggests that 'most definitions of qualitative research include only the top left quadrant of the figure and miss an entire group of analytic strategies available to them – that is, those that utilize quantitative analytic procedures on qualitative data (lower left quadrant)'.

Figure 3: Qualitative and Quantitative Data Analysis (Adapted from Bernard 1996)

Qualitative and Quantitative Data Analyses (adapted from Bernard 1996) Type of data		
Type of analysis	**A Qualitative** (text, picture, sounds) A Interpretation of meaning in text or images Item of analysis – images sounds text (size and precision of unit varies with technique) Examples -Grounded Theory -Cultural Models -Hermeneutics Ethnographic Mapping	**B Quantitative** (ordinal, interval, ratio) B Interpretation of patterns in numeric data Item of analysis – graphs, diagrams Examples -Epidemic Curves -Social Network Graphs
Qualitative Quantitative	**C Statistical and mathematical analysis of text** Item of analysis – numeric data (e.g. similarity matrices): well defined, small units of text (e.g. frequencies, truth tables) Examples -Content Analysis -Pile Sorts -free Listing -Cluster Analysis -Chi-square	**D Statistical and mathematical analysis of numbers** Item of analysis-numeric data (e.g. ordinal, interval, ratio) Examples -Correlation Measures (e.g. regression) -Comparison of Means (e.g. ANOVA)

Cell A summarizes the qualitative analysis of qualitative data, where researchers may 'deconstruct a text [interview transcription], look for hidden subtexts and try to let their audience know the deeper meaning or the multiple meanings behind it' (Ryan 2005:28). The quantitative analysis of qualitative data is described in the lower left quadrant, in cell B, where 'words, images, sounds or objects can be turned into numbers' (Ryan 2005:28). This is where researchers can 'code' text to look for 'patterns' or 'predictors', where 'emergent categories or styles can be identified' (Ryan 2005:28).

Olsen argues that qualitative methodologies are not inherently different from collecting tabular data, as 'we code the interview, we seek patterns, we summarize these in a one-page diagram, or summary table, and we develop a line of argument which is rooted in the data and can be grounded in those data' (Olsen, Holborn & Haralambos 2004:104). She suggests that the distinction between qualitative and quantitative methods delineated by Silverman (2009) is questioned by critical realists such as Sayer (1992) and Braun and Clarke (2006), who reject the polarity of positivist and interpretivist methodologies and ontologies.

My research is qualitative in its design of the data collection, but has gathered statistical evidence during analysis, which can point the way for discussion. In this approach I am supported by Harding's comment that:

> The interpretation of social statistics from a more thoughtful, critical and reflexive standpoint can reach a more acceptable version of objectivity than does the idea that statistics are facts that speak for themselves. (Harding 1995; Harding 2001)

3.6 Truth Telling in Interviews and the Role of the Researcher

The participants for this research come from the executive and higher managerial bands of practitioners working in Health and Education, and have been described as belonging to a group referred to as 'elite' participants in sociological research (Bourdieu, 1984; Perkin 1989; Perkin 1996; Bottomore, 1993). Yet, as Ostrander (1995) has noted, elite interviewing is greatly underrepresented in the literature: 'Social scientists rarely "study up". For example, the list of names of sociologists who have written about upper-class elites is too short and too easily recalled' (Ostrander 1995:133)

Kezar states that although elite interviews are an important tradition in the social sciences, literature on the epistemological issues involved in such research is scant (Kezar 2003: 396). She asks 'How do these social identities impact the elite interview uniquely from other interviews?' (Kezar 2003:409).

These university course leaders, hospital consultants, medical and nurse directors, GP partners and head teachers share certain roles, responsibilities and attitudes (Perkin 1989 in Webster 2008; Heath 2012). This is the particular haecceity – the 'just thisness' - of social practices within the prescribed domains of professional knowledge and action of these two groups of expert practitioners (Lynch 1993). These shared characteristics of a high level of professional certification, an ethos of public service and integrity (Heywood 2012) are impacted by the current pervasive climate of fear amongst this public service elite, 'where their professional judgment is in constant danger of being crushed between government regulation on one side and the market forces of competition on the other' (Heath, 2012:10). The condemnatory Francis review into whistle-blowing in the NHS of 2015 (Francis 2015), and the Health and Safety Executive (HSE 2015) statistics reporting high levels of stress in the services of Health and Education, lend credence to the probability that we have a toxic mix of high demand and high surveillance, which means that conducting research with these elite participants has its particular pitfalls and opportunities.

Dexter tells us that elites value the opportunity to talk to an understanding stranger (Dexter 1970). Because the interviewers have researched the issue at hand, they can be more versant and empathetic than a stranger on the street, but have less stake in the issue than if the elite were to talk to a colleague, assistant, or even a spouse. Dexter (1970) found that elites enjoyed the interview more than many other people he had interviewed, and believed this may be based on a deep loneliness that results from the nature of their position and power. However, although deep loneliness may lead an interviewee to 'want to talk', power inequalities, as perceived by the interviewee, may have the opposite effect.

Kezar (2003) tells us that when conducting interviews with individuals with lesser power, sharing information about the researcher is a way to equalize power. Does this help in equalizing power when the researcher is of a lesser status? Aldridge 1993) explored these notions when interviewing Anglican clergy. He revealed information about his identity as a sociologist and his life in a prestigious university to have the elite see him as occupationally similar and equal, and

believed that equalizing power was imperative to his gaining access to information. He purposefully emphasized elements of his experience and background that were similar to the elites he was interviewing, in order to develop trust (Kezar, 2003:405). Yet, as Kezar says, this is an area where there is virtually no information to guide decisions, as few researchers have developed or tested strategies (Kezar 2003:406).

In designing this study, I was aware that it was necessary to attempt to deal with the difficulty recognized by Atkinson, Coffey and Delamont (2003), i.e. that interviewees, particularly elite interviewees, may not want to tell the truth. The interviewees in this study are highly competent practitioners holding senior positions in their chosen professions and therefore constitute a cohort which presents particular problems to the researcher, as they are skilled communicators. My main concern was that the interviews would only produce a controlled, mediated, impression of their working lives: the one which they wished to present.

In order to overcome this problem of 'honesty', I was aware of two possible positives on my side. Firstly, I recognized that my role as an expert practitioner in the field of education, and previous experience in the field of health, gave me the authority and knowledge, or at least the impression of the authority and knowledge (Goffman, 1990) to elicit 'honest' answers from my cohort.

Jacobsson and Akerstrom (2012) examine a failed interview carried out by an undergraduate researcher in Rosengard, a poor suburb of Stockholm. This failure, they felt, was due to the inexperience of the interviewer. However, they describe how it is not only the experience of the novice undergraduate to fail to interview successfully. The interview they describe is an example of the asymmetry of power in the interview situation, being more in favour of the interviewee as opposed to the dynamic which is more commonly highlighted in the methodological literature. Mostly, the assumption is that the interviewer is the more powerful party (Briggs 2002; Rapley 2004). However, Jacobsson and Akerstrom posit that this is an idea that is not always recognizable to researchers in 'concrete interview situations', as they struggle to get people 'to agree to an

interview' and then find they will not talk about things 'they don't wish to talk about' (Jacobsson & Akerstrom, 2012:728). There are several factors that may explain why this happens: for instance, when the researcher is considerably younger than the interviewee, or when a researcher is interviewing powerful members of a community (Odendahl & Shaw 2002). Interviewees with an agenda might take control of the interview for the purposes of correcting perceptions they deem unfair; or losing control of the interview may well be due to the inexperience of the interviewer (as with the inexperienced interviewee in Rosengard). But Odendahl and Shaw also describe how many researchers, and not just inexperienced ones, experience situations where they have felt inferior to the interviewee and have felt the control of the interview agenda slipping away from them (Odendahl & Shaw 2002). I was aware that these issues were more likely to occur with the elite participants in my interviews. As Alvesson states, 'the interplay between two people, with their gender, ages, professional background, personal appearance, ethnicities, puts heavy imprints on the accounts produced' (Alvesson 2003:19).

Parker (2000) states that his age, when he was interviewing participants of a similar age, led them to see him as a 'confidante'. There was a close match between the age, ethnicity, experience, appearance (formal work clothing) and, for at least half of my participants, gender, between me as an interviewer and my participants. Their expectation was that I would be aware of at least some of the realities of working in a large public institution at a professional/managerial level. The likelihood of my being able to elicit an 'authentic' response was reinforced by the fact that the initial participants were known to me through work and the later participants were gathered using the snowball method, through connections made by the earlier participants. My participants represented a network, or rather two networks – one in Health and one in Education – with some crossover points, in which channels I appeared as a co-traveller.

The second strength of my research design in reference to the problem of 'truth telling', as posited by Atkinson, Coffey and Delamont (2003), was epistemological in that I did not seek to elicit an objective truth about the

changing role of the expert practitioners. Tullis Owen et al (2009) state that, in relation to life histories, 'a definitive, non-dialogic understanding of truth ignores any possibility for multiple, truthful perspectives' (Tullis Owen et al 2009), and this can be true for interviews about the personal response to work made by my interviewees. Unlike the neo-positive approach expressed by Glaser, that a researcher should remain objective and could and should capture reality (Glaser & Holton 2007), I did not expect participants to tell 'the truth' about their changing world, but to give their perceptions of their changing world, a world which I also inhabited. Following the interpretive tradition (Bryman 2008), this research is concerned with perceptions of participants of their role, not in establishing the actuality of that role. In exit interviews and surveys of teachers, doctors and nurses, it can be argued that their comments show that it is their perceptions of their roles which have caused them to make the decision to leave their profession and the public services in which they trained (Doran et al. 2016; Gu & Day 2007; Wilshaw 2014).

I was also aware that interviewing as a research technique has come under scrutiny and that, during the debate about the purpose and function of the research interview, three distinct approaches to it have emerged. The first one of these is the minimalist neo-positivist approach to interviewing, where the interviewer actively seeks to avoid bias, and sees the object of the interview to find an existing 'truth' (Steier 1991). A reaction against this approach has led, in turn, to the emergence of what Alvesson (2003) describes as 'hyper-romanticism' that is 'escalating efforts to accomplish "depth" and authenticity by turning the interview into a "moral peak"'. He goes on to point out that although this approach may sound sympathetic, it may lead to interview outcomes which are 'strongly tied to the idiosyncrasies of the situation and the mores of the interviewer' (Alvesson 2003:16). I recognize and see as a strength my involvement with my subject and participants, thereby refuting the claims of the neo-positivists (Oakley 1981 in Roberts 1981). However, I recognize the dangers of 'hyper-romanticism' and I sought to avoid these pitfalls by standardizing the setting, the topics and the length of each interview in order to reduce the effect of some of the 'idiosyncrasies' (Alvesson 2003) of the interviewer or the interviewee.

A third critique of the validity of the interview as a research tool is described as 'localism', which seeks to present the interview as something which has no more ontological significance than any other interactive event such as buying food, negotiating a contract or exchanging pleasantries (Hammersley 2005). From the 'localist' point of view, the interview may be studied as an event in itself but cannot be seen to have any significance elsewhere. However, Bryman (2008) states that although the ritual of interview must be seen as a factor in determining the content of that interview, nevertheless the interview has a substantive element at its core. It is this core which forms the data corpus of this research.

Similar to the localist approach, the ethnomethodological approach to interviews considers them to be an unproductive technique which purports to report on an external reality displayed in the interviewees utterances. To ethnomethodologists, however, the interview offers, at the best, a glimpse of the 'internal reality which is constructed as both parties seek to produce the appearance of a recognizable interview' (Fielding 1993 in Haralambos, Holborn & Heald et al. 2000:1007). In other words, for ethnomethodologists, as for localists, the interview is an event and its contents are secondary to the attempts by the two people present to replicate what they consider to be representative of this kind of event. This was a danger in my interviews, as arguably, all my participants were adept at giving and holding interviews; they were all trained in the techniques required to present themselves in such a situation, and were therefore able to construct the interview.

The interviewee is not a passive subject and an interview is an interactive process. (Silverman 1985; Kezar 2003)

My participants were also able to assess the style and capabilities of the interviewer. I was under as much scrutiny by them as they were by me. I was conscious that each of us sought to measure the other, especially in the first few moments of the interview. This proactive stance of my participants, wherein they would terminate the interview if they felt it reasonable to do so, and where they expected some control over the output of the interview, was made explicit to me when one interviewee (KM) asked to use his own recorder so that he would have a true record of our discussion. He also took a photograph of us together as a

visual record of our meeting. Through post-interview discussion it was made clear that one of the main purposes for this assessment of me was to ascertain whether or not the time being given to this interview was useful to the participant. After one interview, the participant, a head teacher (MA) told me that I would have only had ten minutes if she had felt the interview was a waste of her time. Many participants asked me after the interview what use would be made of the data (MJ, YP, BP), and commented on their personal response to the crisis in the NHS and in Education. On reflection, I am surprised and pleased that these participants trusted that I would not misuse the information which they gave to me.

According to the theory of social desirability bias, as applied to interviews (Holbrook, Green & Krosnick 2003; Loftus & Palmer 1974), and theories of moral identity (Kohlberg 1963), which were developed using semi-structured interviews, interviewees tend to shift their self-narrative towards the morally 'right'. Because of an inclination to avoid 'moral threats' (Jordan & Monin 2008), interviewees are more likely to 'tell the truth' when asked to recount an experience from their recent past which is not situated within a perceived moral judgment of their particular behaviour. Bearing this in mind, the guiding questions in the initial section of the interview were designed to direct attention away from the success of the particular participants' work to the general nature of the work of someone in their role. In this way, I hoped to avoid the inclination noted by Alvesson of interviewees to take part in 'moral storytelling', where the interviewee has an overriding interest in 'promoting' themselves (Alvesson 2003:15).

I found it useful to continue to re-examine the validity of my interview structure throughout the process of question generation, pilot study and during the interviews themselves. It is necessary to examine the conventional acceptance of the open interview as a way of finding 'truth'. People in interviews are not just 'truth tellers' or informants, but they use their language to do things 'to order and request, to persuade and accuse' (Potter & Wetherall 1987:32). Interviews can be described as moments of 'performance' for both the interviewer and the interviewee (Shopes in Denzin & Lincoln 2011: Denzin 2003; Denzin & Lincoln

2011). To Shrager, these are cultural performances which look both backward using well-rehearsed accounts of the past, and forwards, to the audience of future users whom the interviewee wishes to inform, inspire, or persuade (Shrager 1983). What is described as the 'radical critique of interviewing' (Hammersley 2005:9; Murphy et al. 1998) proposes that researchers treat interviews as socio-discursively constructions rather than as sources of evidence. In exploring the radical critique of interviewing as a research method, Holstein and Gubrium see the constructionist impulse as a positive force, guarding against crude, simplistic interpretations of interview data, and instead '[call] forth minimalist analytics to sensitize researchers to the myriad elements of reality construction rather than to continue seeking definitive descriptions of social settings or causal explanations' (Holstein & Gubrium 2008:392). Hammersley proposes that, in following this radical critique, we should treat interviews with 'severe methodological caution', and questions the validity of treating what people say in interviews as indicating stable attitudes or perspectives (Hammersley 2005:9).

Furthermore, Alvesson states that 'language constructs rather than mirrors phenomena, making representation and thus empirical work privileging data a basically problematic exercise' (Alvesson 2003:13). While bearing this qualifying commentary on the usefulness and purpose of the research interview, Alvesson describes his stance as pragmatic, and states that the method of interviewing respondents about their experience remains a valid and important approach to understanding human experience. However, he suggests that we should be modest about empirical claims; more usefully, 'careful methodological reflection on what interviews can do might limit our hubris and encourage the use of empirical material for inspirational or illustrative purposes' (Alvesson 2003:123). If we claim that empirical work and results are important in a study, then we should have a 'reasonable idea about what we can expect from language, the interview and the interviewee subject'. He suggests that if any claims to understanding are to be made, then it would be better to see the interview data as a collection of 'ambiguous illustrations' and that seeing data in this light is a productive step, as it means 'that the pressure to develop really interesting theoretical ideas becomes stronger' (Alvesson 2003:123).

3.7 Summary

Using CAQDAS, it has been possible to use computer-generated data to identify themes and clusters of themes between practitioners in Health and Education. Coffey, Holbrook and Atkinson (1996), in their overview of the use of CAQDAS in qualitative research, state, 'there is no great conceptual advance [in using software] over the [manual] indexing of typed … transcripts'. However, they recognize that 'in practice the computer can add many advantages [since] the speed and comprehensiveness of the searches is an undoubted benefit.' (1996:8). I did find that using CAQDAS aided the search for patterns and the 'deep mining' of the coded material (Braun & Clarke 2006) and Guest (2012) suggests that, not only sample size but that 'the full range of inquiry', including choice of topic and theory generation, may be influenced by the use of software. I had chosen my sample, manually transcribed my interviews and carried out theme refinement before entering my data into Dedoose, so for this research, CAQDAS did not aid or influence the sample size, the choice of topic or theory generation. However, I would have to be aware of its influence on these areas during the design of any future research.

One advantage of the Dedoose CAQDAS system used in this study is that it was created to facilitate anthropological research techniques (Leiber 2009) and as such offers the researcher the facility to attach analytic or other memoranda to specific points in each transcript. This allows for a closer engagement with the text than a simple code and retrieve system, and replicates more closely the nature of non-digitised qualitative textual analysis (Braun & Clarke 2006).

CHAPTER 4: METHOD AND RESEARCH DESIGN

> All so-called quantitative data, when scrutinized, turn out to be composites of 'qualitative' – i.e., contextually located and indexical – interpretations produced by situated researchers, coders, government officials and others. (Giddens 2013: 333)

This study consists of a thematic analysis of thirty-six interviews with senior practitioners in Health and Education. My research questions were:

c) what changes are taking place in the working lives of expert practitioners in Health and Education?
d) is there a shared pattern of experience between expert practitioners in both sectors?

The interviews are semi-structured in form, with the same topic headings being offered to each participant for discussion, and took place in the workplaces of each participant. The areas covered by the interview schedule focused on the experience of change within the workplace over the last fifteen years. The analysis of the content of each interview was undertaken using the thematic analysis approach supported by CAQDAS software.

This study spanned two major policy-led institutions and sought to explore the possibility of similarities between the experience of expert practitioners in both institutions. It therefore required a research method which allowed insight to be gained into the lives of practitioners, but also had to indicate any trends, both in change and in response to change, made by these participants. The use of semi-structured interviews enables the focus of the interviews to follow a similar path, thus allowing the identification of trends, while offering participants the freedom to give in-depth responses and to elaborate on individual experience (Bryman 2008).

4.1 Finding Participants

> One of the main characteristics of elites is that they are busy and have limited time. Trying to gain access to these individuals for multiple interviews may be desirable but not feasible. (Kezar 2003:404)

The approach to potential participants was tested during the first pilot study and a snowball sampling technique, using word of mouth, followed by an introductory letter, was found to be an effective way of recruiting participants. Snowball sampling is an example of non-probability sampling and is not representative as it involves using personal contacts to build up the sample group. It is, however, an appropriate approach to take when a sampling frame cannot be applied (Bryman 2008). With the cohort I wished to study, it was the only practical way to obtain the sample participants. I was conscious that the interviews would be a drain on the time of a workforce whose time is allocated in minutes rather than hours, and a snowball sample allowed participants to recruit their colleagues after themselves having a positive experience of the interview process. Not all those I contacted agreed to take part, and this was a time-consuming and frustrating part of the research process. Letter writing was more effective than phone calling or emailing, but all were only effective after an initial contact by a friend or colleague who knew of the research and had already taken part or was about to take part (Appendix 1: sample of the recruitment letter).

4.2 Composition and Selection of the Sample

Sample Size

In qualitative research, data collection is not bound by the need to provide a probabilistic sample. This research was qualitative in the nature of its data collection but, in that I sought to make multi-variate comparisons, it was necessary to find a sample size which did not compromise the one (in-depth analysis) with the other (group comparison). The participant numbers (thirty-six) in this research were not large enough to allow confidence intervals acceptable for inferential analysis. However, the frequency of code applications (1,267 over

sixteen codes) did support a useful exploration of response clusters. For a significant number of respondents, change to a more relational work practice (code 3), a greater perception of autonomy (code 6) linked to a feeling of greater efficacy (code 12). This juxtaposition of coded themes informed my understanding of the behaviour and attitudes of my participants. In this section, I offer a rationale for my choice of thirty-six participants in this qualitative study.

A comprehensive list of the range of recommendations on sample size in qualitative research is given by Guest, Bunce and Johnson (2006):

> Bernard (2000:178) observed that most ethnographic studies are based on thirty six participants while Bertaux (1981) argued that fifteen is the smallest sample size acceptable in qualitative research. Morse (1994:225) outlined more detailed guidelines. She recommended at least six participants for phenomenological studies approximately thirty five for ethnographies, grounded theory studies and ethnoscience studies; Cresswell (1998) suggests between five and twenty five interviews for a phenomenological study and twenty-thirty for a grounded theory study. (Guest, Bunce & Johnson 2006:6)

In an experiment with data saturation and variability, Guest, Bunce and Johnson (2006) carried out a cross-cultural study of the perceptions of health using a purposive sample of sixty women at high risk of contracting HIV in Nigeria and Ghana. Their findings were that data saturation is reached when twelve data sets have been analysed. Of the total of 109 codes, 80 (73%) were identified after the first six interviews and 100 (92%) were identified after twelve interviews, indicating that the code generation which happens in the earlier transcript analysis of a purposive sample maintains its validity throughout the analysis. Code definition is similarly stable: of thirty-six code revisions throughout the analysis process, seventeen occurred during the second round of analysis and after conducting only twelve interviews. In this study Guest, Bunce & Johnson (2006):

> made the assumption that the number of individuals expressing the same idea is a better indicator of thematic importance than the number of times a theme is expressed and coded. (Guest, Bunce & Johnson 2006:5)

Code frequency, analysed using the categorize function in IBM's Statistical Package for the Social Sciences (SPSS) to divided the code use into low, medium and high, showed that high frequency codes in the early stages of analysis 'retained their prevalence over time' (Guest, Bunce & Johnson 2006:15). Of the high frequency codes, only 3% were established after the first twelve interviews. Guest, Bunce and Johnson (2006) describe results which indicate that the possibility of generating large sample sizes while maintaining the in-depth quality of the data corpus is possible, but may not be useful or even necessary. This would indicate that computer-generated qualitative research, facilitating larger samples, will not enjoy results with enhanced validity.

4.3 Sample Homogeneity and Sample Size

However, these were homogenous, purposive samples. The research had 'fairly narrow objectives' (Guest, Bunce & Johnson 2006:17) and centred on female sex workers in two African cities and 'these similarities seem to have enough to render a fairly exhaustive data set within twelve interviews (Guest Bunce & Johnson 2006:18). They suggest that the research aim was to measure the degree of association between two or more variables it would be conducive to a more reliable result to have a larger sample than twelve. I wished to gather data from two distinct areas of specialized work – expert practitioners in Health and Education – and therefore, on these recommendations, I intended to gather a minimum of twenty-four participants:

> If one wishes to determine how two or more groups differ (or coincide) along a given dimension … then you might purposively select twelve participants per group of interest. (Guest, Bunce & Johnson 2006:18)

In the event, I was able to gather thirty-six participants, six in each subgroup, representing a variety of disciplines amongst practitioners in Health and Education.

4.4 Sample Population: Numbers

Table 4.1 below shows the numbers of participants for each subgroup of interviewees. This shows the distribution of my sample of thirty-six participants. There are three substantive areas covered in Health and in Education. The size of each group (six) allows for an in-depth analysis of that group's response to change, and the size of the subgroup (six) allowed me to make bivariate predictions of difference at a probability of 0.05 across all groups or individually.

Table 1: Sample Population: Numbers

Role	Number interviewed
Medical Consultant	6
Medical GP	6
Medical Executive Nursing	6
Education Senior Leadership Team	6
Education AST	6
Education University Course Leaders	6

4.5 Sample Population: Age and Gender

All participants were senior practitioners with at least ten years of full time employment in roles commensurate with their certificated, professional training. A prerequisite of participant involvement was that they perceived that their work group had undergone instigated change, of work practice, and possibly work environment, over these ten years. The question on work environment was used as an introductory question, encouraging focus on general change at work. All participants were between forty and sixty years of age. All were employed by local authorities or hospital trusts, universities or were partners in GP practices.

There were six specifically identified groups to cover all of these thirty-six practitioners, plus a control group of six highly-qualified staff working in institutions of Health and Education, but not practitioners, based in hospitals and educational institutions: three in Northshire, one in Westshire and two in Eastshire.

The population this study sought to investigate were those expert practitioners working in the NHS and in state education, i.e. doctors, nurses and teachers and lecturers, who had a professional, certificated training and continuing practice based on their interaction with 'clients', i.e. patients, students and pupils. The participant group was chosen from senior practitioners working in the health and education services. As stated in Chapter 1 (Section1.4), the definition of 'expert practitioner' in this study is informed by the work of Anne Edwards ((Edwards 2010) who, although recognising the shifting nature of that 'expert practitioner' identity, describes the knowledge-laden nature of specialist professional practices, which, she states, have to be understood in relation to professional identity and the idea of relational expertise. Wilensky (1964) and Evetts (2003) also emphasis the particular combination of specialist knowledge, moral positioning and relational capacity which defines the 'expert practitioner'.

The rationale for this participant focus is that this study was conducted with an awareness of the context of the increasing dissonance among expert practitioners with this particular remit in both institutions: a dissonance which is demonstrated through commentary from professional bodies such as the Association of Teachers and Lecturers (ATL), the Teacher Support Agency (TSA), now the Education Support Partnership, the Royal College of Nursing (RCN), the British Medical Association (BMA), and underlined by government statistics indicating low retention, low uptake and increasing evidence of stress-related disease and absence.

Although this dissonance in and with our health and education services is widely discussed by policy-makers and reported on by the media, a literature search reveals that there is little formal research using the reflections, knowledge and experience of senior practitioners to help us understand this situation. The voice

of this group is underused and under researched and this study seeks to go some way to addressing that omission.

4.6 Gender

In total there were twenty male practitioner research participants and sixteen female practitioner participants. However, all the nurse directors and senior nurses were female, whereas only one hospital consultant was female. GPs were split evenly between three male and three female. This distribution by gender in the three jobs indicated in the medical group reflects the demographic in the NHS at this moment. All nurse directors in NHS England are female (at the time of this study) and only 35% of the hospital consultants in NHS England are female (NHS Digital 2016). Approximately 50% of GPs are female and that number is rising (Office of National Statistics, 2014). Senior Leadership Team members (SLTs) in Education consisted of four male and two female participants; and there were four male and two female ASTs. The pilot study group consisted of three females working for a publicly-funded institution with a distribution of over 60% female workers of first-degree level in the education sector.

Table 2: All Participants: Role Age and Gender

Role	Gender	Age 35-50	Age 51-65
Medical Consultant	Female 1 Male 5	4	2
Medical GP	Female 3 Male 3	4	2
Medical Executive Nursing	Female 6	6	
Education Senior Leadership Team	Female 2 Male 4	4	2
Education AST	Female 2 Male 4	2	4
Education University Course Leaders	Female 2 Male 4	2	4

4.7 Sample Population: Job Type and institution

4.7.1 Health: Hospital

The participants in this group worked in a variety of hospital settings. The hospital trusts ranged in size from one of the largest in NHS England to a small trust in a mainly rural situation. All the hospitals were teaching hospitals, which meant that all the consultants interviewed had a responsibility to teach medical students. One of the consultants was a medical director, which meant that he had an executive duty to represent his colleagues on the hospital board (see Table 4.2: Medical Hospital: Role, Age and Gender).

4.7.2 Health: GP

The GP practices in this research were in a range of locations. Two were in rural settings, in villages with less than a population of 1,000, although serving a

population of 6,000. Two of the practices were in small towns, with populations of 9,000 and two were in a city of 20,000 in population. All the GPs interviewed were GP partners and had both managerial and clinical responsibilities within their practice. Each GP, bar one, had a specialism which he/she brought to the practice.

4.7.3 Health: Nursing

The hospital trusts where these senior nurses worked formed a fairly homogenous sample, as five of them were situated in large towns. Only one hospital trust was located outside a large town in a new build. Four of the senior nursing staff interviewed here had executive responsibilities on their hospital trust board. The remaining two nurses were seconded onto the hospital trust board to represent their departments.

4.7.4 Education: Schools SLT

The schools where these participants worked ranged from two rural 'green leaf' schools to two schools in urban areas and two schools in suburban settings. They were all over 700 in capacity and would therefore be classified as medium in size. Three of the schools had undergone a new-build programme, and one had failed to get the new-build programme started before a government change. Two schools were the result of a merger and therefore were under capacity. The members of senior leadership teams who took part in this research all had teaching responsibilities as well as management commitments. Their subject specialisms included history, geography and mathematics.

4.7.5 Education: ASTs

The schools where these ASTs were based ranged from rural to urban. Most of the ASTs had a countywide remit to provide teaching support.

4.7.6 Education: University Course Leaders

Four of the universities in this sample were part of the Russell Group consortium, one was a new university and one was a Cambridge college. The university course leaders had specialisms including mathematics, psychology and education (see Appendix 1, Table 6, Education: University Course Leaders).

4.7.7 Pilot Studies, Changes and Final Design

The interview schedule was interrogated during two pilot studies. Elements of the process, such as identifying and contacting participants, the overall timing of the interview topics and the format of the topic descriptions were devised and tested during a first pilot study with three degree-qualified practitioners working in management roles in the British Council. This group was felt to operate with an equivalent of the expertise and public responsibility exercised by the eventual participants in this study. The second pilot study was carried out with three teacher colleagues who did not take part in the subsequent research.

4.7.8 The Interview

The Length of the Interview

During the pilot study, the proposed timing of the interview was discussed with participants. A length of one hour was found to be acceptable, i.e. the questions fitted into my idea of one hour of interviewing, and participants in the pilot study felt that they had enough time to respond to each question, but that any more time would have eaten too much into their work schedule. Therefore, this length of time was deemed to be the best fit between my needs as a researcher and the constraints on the time of my participants. However, in reality, the interview time varied from 45 minutes to 80 minutes. The mean time for interviews was 55 minutes. Expert practitioners working in the state sector, i.e. doctors, head teachers and senior nurses, have busy schedules and even to offer an hour of their time was generous. One hour is the equivalent of six 10-minute GP consultations (Royal College of General Practitioners 2014), four hospital doctor consultations

(Scottish Government 2003) and four individual student/teacher meetings held by head teachers (DfE 2014).

During the research interviews, some participants wanted to talk further, after the last question was over. I was happy to accommodate this, but did not use any of this material in the coded transcripts of data. Informal outtakes would be an interesting area of study for future attention.

Interview Schedule

The final interview schedule was designed to have three phases, as follows:

Phase 1 was an introductory phase consisting of two 'buffer' topics, which would serve the purpose of allowing the interviewee to only not identify themselves but situate themselves in the interview process and begin to reflect on their perception of their role. Phase 2 comprised the main body of the research questions, consisting of five questions dealing directly with the purpose of the inquiry of this research, i.e. to explore the commentary of this participant group on the form of change, the cause of change and the effect of change on the working lives of our expert practitioners in Health and Education.

Figure 4: Interview Schedule

A. Could you give a brief resume of your background and present role in this workplace?

B. How would you describe the particular professional expertise (PPE) required for your job?

Can you describe events during your working week where your particular professional expertise has been essential to the outcome of an event?

C. Has the physical environment in which you work changed recently?

Can you describe those changes?

D. Have these changes been the result of national or local government policy directives related specifically to your category of workplace, or have they been the result of decision-making at an internal level?

E. Have there been any significant changes in recent years to the work practice of someone in your role?

F. Have these changes been the result of national or local government policy directives, or have they been the result of decision-making at an internal level?

G. Consider again the description you gave of your PPE.

Have the changes in your workplace which you have described had an effect on the efficacy of your professional practice?

Have they changed the way you deal with those incidents which require your PPE?

First look at changes to the environment and then at changes to work practice.

H. What are the personal drivers behind your relationship with your work?

How does your answer here relate to the description you gave in answer A of your role at work?

Phase 3: this phase was designed to take a different direction from Phases 1 and 2 and to close the interview with an explicit focus on the participants' perception of their efficacy at work. The concept of 'learned helplessness' states an action

failing to produce the expected results can lead to an internalization of the failure and to the belief that one cannot produce the performances (Maier & Seligman 1976; Abramson, Seligman & Teasdale 1978).

Bandura suggests that collective efficacy, being the success of a team or organization, is rooted in the self-efficacy of each member of that team, since 'inveterate self-doubters are not easily forged into a collectively efficacious team' (Bandura 1982:143). Since my participants worked in public services as part of interacting teams, their sense of efficacy was crucial to the successful outcome of events. Expert practitioners, per se, possess knowledge and skills at a high level; their feelings of efficacy should therefore, if realistic, be at a commensurately high level. Expert practitioners are decision-makers, they expect to enact change, particularly at the personal level of their pupils, patients and clients. 'If they cannot enact change, and therefore have low efficacy, they will desert environments that are unresponsive to their efforts and pursue their activities elsewhere' (Bandura, 1982:141). Thus, low perceptions of efficacy may have a bearing on the low retention and low recruitment into these public service sectors.

Interview Schedule Phase 1: Introductory Topics

Questions A and B were buffer questions designed to bridge the uncomfortable gap when interviewee and interviewer were moving into the purpose of their meeting (after meet and greet). These first questions allow the interviewee to recount straightforward factual historical information about themselves (CV) and then move into reflecting on the generic nature of the role they play. However, these initial questions also are designed to establish 'truth telling'.

Question A: Could you give a brief resume of your background and present role in this workplace?

This introductory question asks about past experience and present job. Expert practitioners are expected to give accurate answers to questions of their education and their experience; this is part of professional ethics established and maintained by their professional bodies (British Medical Association; General Teaching Council; Royal College of Nursing).

Question B: How would you describe the particular professional expertise (PPE) required for your job?

Can you describe events during your working week where your particular professional expertise has been essential to the outcome of an event?

Question B asks participants to elaborate on the role they take, by requiring them to define their particular professional expertise. In the second part of question B, they are asked to give an example which focuses them on the actual day-to-day life they lead at work. This secondary question asks for an example of participants performing that expertise recently. The focus here is on the general nature of the role of the expert practitioner and its application.

Interview Schedule Phase 2: Main Body of Interview

This is where I expected to begin to gather data pertinent to the questions asked by this research. One of the criteria for participant involvement was that they perceived themselves as having undergone work practice, and possibly environmental change, in the preceding ten years. The question on environmental change was intended to act as a precursor to commentary on work practice change.

Question C: Has the physical environment in which you work changed recently? Can you describe those changes?

Question C allows the interviewees to reflect on changes in the space which they inhabit at work. This question was intended as secondary to questions on work practice which followed. The justification for its inclusion is that space changes can interact with social change on two levels: as a cause of changing practice and as an effect of changing practice. Many school, university and hospital buildings were altered or renewed during the period from 1990 to 2014 and there was an opportunity for practitioners and users to be involved in that environmental change (Patel 2005). The Building Schools for the Future (BSF) programme was a UK government investment programme to provide secondary school buildings in

England in the 2000s. By December 2009, ninety-six local authorities had joined the programme.

On 5 July 2010, the Secretary of State for Education, Michael Gove, announced that following a review, the Building Schools for the Future programme was to be scrapped. Projects which had not achieved the status of 'financial close' would not proceed, meaning that 715 school revamps already signed up to the scheme would not go ahead. He also announced that a further 123 academy schemes were to be reviewed on a case-by-case basis (Richardson 2016). One of my interview participants talked about his disappointment on finding out that the BSF initiative for his school had been cancelled. In a report entitled Better Spaces for Learning (Plotka 2016), the need for improvements in school buildings and for more imagination in creating good learning spaces is addressed.

Hospital and GP new builds have followed the same principles of involving community and private financial support in their construction. In 1992, the Conservative Government of John Major in the UK introduced the private finance initiative (PFI) (House of Commons Treasury Committee 2011). It offered the first systematic programme aimed at encouraging public/private partnerships in the provision of public sector infrastructure. The Labour Government of Tony Blair, elected in 1997, expanded the PFI initiative but sought to shift the emphasis to the achievement of 'value for money', mainly through an appropriate allocation of risk. However, it has since been found that many programmes ran dramatically over budget and have not presented as value for money for the taxpayer, with some projects costing more to cancel than to complete. Latest developments mean that more sophisticated relationships between developers and practitioner groups such as GP consortia have been set up. One of my participants, a GP partner, described in detail the pitfalls of becoming involved in a public/private mixed funding scenario without an understanding of marketplace vagaries. The King's Fund report on the PFI initiative (Edwards 2013) describes the difficulties of providing adequate funding for health and marrying that with profit-based companies' requirement to show a profitable return to their shareholders.

Although, as stated earlier, this question on environmental change was intended as secondary to, or as a precursor to, the main questions on work practice, in the event, this question produced some of the most intriguing findings. These findings are explored in Chapter 5.

Question D: Have these changes been the result of national or local government policy directives related specifically to your category of workplace, or have they been the result of decision-making at an internal level?

Questions E and F follow the same format as C and D.

Participants were asked to reflect on changing work practice and then asked to say where the impetus for these changes came – bottom up or top down. These questions asked the participants to reflect on the impetus for change. Where did the ideas for change come from? Top down or bottom up?

Question E: Have there been any significant changes in recent years to the work practice of someone in your role?

Question F: Have these changes been the result of national or local government policy directives, or have they been the result of decision-making at an internal level?

Question G asked the participants to consider practice and its efficacy. Have these changes, which they have described, improved the practice they identified at the beginning of the interview? At this point, I read out the written transcript of their reply to B. This brought together interviewees' answers to the environment question and the practice question, and allowed them to consider themselves as experts applying change to their practice, wherever it originated. The use of the word 'efficacy' is deliberate, as it underpins Bandura's theory of social learning (1982), wherein he describes how confidence and self-efficacy increase and decrease in response to the interactions one individual has with others.

Both question G and H asked the interviewees to review the commentary they had offered earlier. I read out their answers to earlier questions to remind them of the comments they had made, and to give them time to reflect on the meaning of their commentary. Revisiting a topic at a later stage in the interview can be a useful way of increasing validity (Alvesson 2003). The possibility that interviewees may describe their experience in familiar, institutionalized language is discouraged by the revisiting of earlier topics. I considered using prompts such as 'Can you put that a different way?' to trigger responses less caught in script coherent expressions (Watson 1994), but rejected this approach as it might have broken the flow of the interview. However, I did ask for further information on comments that were minimal or unclear.

Question G: Consider again the description you gave of your PPE.

Have the changes in your workplace which you have described had an effect on the efficacy of your professional practice?

Have they changed the way you deal with those incidents which require your PPE?

First look at changes to the environment and then at changes to work practice.

This was the question that took most pre-reflection before answering. It required the participants to address how well they performed their job in light of the changes which they had undergone. Some participants expressed anger at the changes they had experienced, while others were happy to reflect with satisfaction on the events relating to change in their working lives. Personality has to be seen as a confounding factor. However, the fact that participants' mood here was not always linked to a perception of positive or negative change demonstrated that their commentary was about external factors which affected their practice (objective), rather than internal personality or even transient mood factors (subjective).

Interview Schedule Phase 3 Exit Topic

Question H: What are the personal drivers behind your relationship with your work? How does your answer here relate to the description you gave in answer A of your role at work?

The final question was an exit question designed to allow the participants to freely explore their emotional response to their work, and address the personal significance of the reflections they had made during the interview. It addressed the fundamental relationship between professional practice in the nurturing areas of Health and Education and the experience of being a practitioner in those environments. Participants here sometimes expressed great emotion when describing the motivation behind their work.

As a researcher, I was aware that, as Alvesson states 'no non-trivial account about the organization one works in is produced outside of or abstracted from identity' (Alvesson, 2003:20). However, the questions in phases I and 2 of this interview schedule did not explicitly ask for a focus on identity from the interviewee. This last topic asks for an explicit explanation of personal motivation and ethos, and elicited an emotional response from many participants. It therefore offered me a way of triangulating the implicit earlier responses from my participants (Alvesson 2003), which were in an unconscious building of identity throughout the interview process (Alvesson 2003), with their response to this explicit question on identity. Any mismatch between the two descriptions would indicate that the construction of identity by the interviewee was unlike the explicit 'story' of identity given later. Silverman counsels caution when seeking to establish the 'authenticity of the participant voice, since perhaps 'we feel that people are at their most authentic when they are in effect producing a cultural script' (Alvesson 2003:20). This internal triangulation, through using four guiding questions on the working lives of my participants which required an objective, descriptive response (questions A, B, C, D) and one final question (H) which addressed the affective, personal experience of work, was one way of establishing the 'authenticity' of the voices of my participants (Bryman 2008). A homogeneity of response would indicate authenticity.

4.7.9 Flaws in Construction of Initial Topics

The first pilot study determined flaws in the construction of the interview schedule. Two questions were found to be ambivalent (D and F). In the original question set, question D was worded 'Have these changes been the result of policy directives related to your workplace or of external factors?' and F was worded 'Have these changes been the result of policy directives related to your workplace or of external factors? D was changed to: 'Have these changes been the result of national or local policy directives related specifically to your category of workplace *or have they been the result of decision making at an internal level*?' and F was similarly altered, thus ensuring that my questions followed the same structure, were unambiguous and produced the sort of information required (Young & Willmott 1961). The whole question schedule was then piloted for a second time with expert practitioners in education. No changes were made after this second pilot.

Setting

The thirty-six interviews were carried out in the workplace, usually the office, of the participant being interviewed. As Circourel states (in Bryman 1988), it can be questioned whether interviews can capture the reality of the everyday working lives of practitioners, as interviews are in themselves an artificial situation. However, by using the usual workplace setting for each participant, I sought to locate the interviews in the natural work environment. Each participant was invited to use his/her own office space for the interview and only two of the thirty participants and none of the pilot group suggested taking the option of meeting in a quiet workplace café situation.

Process

I decide, after trialling the system, to use eight cards with the topics printed on one side and lettered from A to H. I handed each card over to the participant and then read out the question from my own list. The three British Council participants of the pilot study gave positive feedback on the use of cards, one saying that it allowed her to gather her thoughts during a busy work day (RM pilot

study participant 2013) Another said that it made 'the discussion easier as there was a focus to each part, and I felt that I was able to give more considered and fuller replies because I could pause and think between each question' (AS pilot study participant 2013) and a third commented: 'I felt in control' (JB pilot study participant 2013). None said that they felt unduly restrained by the cards, and all were able to elaborate and enjoy the qualitative element of the process. None felt that the cards depersonalized the interview or created a barrier to communication, which had been my concern.

Apparatus and Recording Procedure

During each interview, I recorded using an iPhone with an iTalk app, after trying a separate larger recorder which was more intrusive, and I transcribed notes as the interview proceeded. One interviewee preferred not to be recorded and his contribution was transcribed directly from notes taken during his interview. I realized that note taking affected the process of interview substantially. Although it reduced eye contact, which could be seen to be a negative effect, my note taking also made the face-to-face experience more varied and intermittent, which gave freedom to the interviewee (Alvesson 2003). I made eye contact with the interviewee when it felt natural to do so, i.e. when I wanted them to elaborate on a point, or when I felt that they had invested emotion in what they had just said and expected an immediate response. A one-to-one interview, with its reliance on constant eye contact, is an unnatural event, and note taking allowed the replication of the usual intermittent, dialogic use of eye contact (Macionis & Gerber 2011), which both encouraged interviewees to speak and alleviated the stressful nature of the process of being interviewed.

4.7.10 Geographical Context and the Ethics of Confidentiality

In compliance with the ethical codes of the University of Nottingham, procedures were followed in a prescribed way and confidentiality was assured. Participants were told that they could withdraw themselves or their data at any time from the research. All participants read and signed a sheet informing them of this prior to the interview and in the presence of the interviewer (Appendix 2). The specific

geographical location of the participants is varied. In total, three pilot interviews, thirty-six practitioner research interviews took place in twenty-one workplaces ranging from Edinburgh to North London, although the majority of interviews took place in the East and West Midlands. When interviewing specific consultants in small trusts, where perhaps only one specialist was assigned to a particular hospital, I realized that it would be possible to identify these participants by their commentary on the locale of their practice: for instance, mentioning a particular event or place could allow their identity to be ascertained. The same was true of some university personnel, nurse directors and senior teachers, all of whom could be identified by locale. In order to protect participant anonymity, I awarded all participants and workplaces, such as trusts, GP practices, LEAs, academies and universities with pseudonyms. The areas involved are described as Midshire, Northshire, Westshire, Southshire, and in one case Midmidshire. The participants were assigned initials which are not their own and no linked biographical data has been included in this report.

4.7.11 Workplace Context

Schools

Interviews with six Senior Team Leaders and six ASTs took place in ten schools. All schools were state funded and mixed sex. All were under local authority control, although one became an academy during the time of this research, and one was in process of debating academy status. All schools were non-selective comprehensives covering 11-18-year-olds. There were eight teachers in Midshire, two in Eastshire and two in Westshire and Southshire. Major factors of change for these schools over the last ten years are a continuing process of legislative uncoupling from local authority control, leading, in turn, to a change in funding, in both allocation and provider, and an increasing focus on performance monitoring through quantitatively measured targets. Schools also are experiencing an increased level of parental and pupil involvement and control through policy-led initiatives and through the use of communications technology. The use of technology to generate data and to monitor pupil attendance, behaviour and academic outcomes has increased. The training of new teachers has been under

scrutiny, particularly in the area of classroom discipline, and has undergone change, with more apprentice-like systems, devolved from the universities, being put in place. The teaching profession is experiencing problems with the retention of appropriately qualified staff in some geographical areas, some subject areas and in management.

Hospitals

Interviews with six nurse directors or senior nurses and six hospital consultants took place in seven hospitals. All hospitals were part of NHS trusts, two in Midshire two in Northshire, Eastshire, and three in two trusts in Westshire and Southmidshire. Major factors of change over the last ten years for these hospital trusts are the increasing involvement of private providers in patient care, including ambulance services, the change in the locus of financial control from hospital trusts to GP-led commissions, and the increase in the need for multiple strands of care for a growing elderly population. There has been an increase in the use of computer-generated data to diagnose, treat and to monitor patient outcomes. The Francis report (2013) has led to a focus on the quality of care given in hospitals, and has led to more patient involvement in assessing this care. The training of nursing staff has undergone change with more degree-level and more disease-specific nursing posts now in existence. There has been debate over the quality of nursing training, in particular the training in nursing 'basics'.

GP Practices

Interviews with six GP partners took place in six GP surgeries, all of which were part of local consortia and serviced their immediate area. Five GPs in in five different locations throughout Midshire and one in Southshire were interviewed. Major factors of change in the working lives of GP practitioners are the new commissioning responsibility with its commensurate increase in involvement in patient and funding management, and changing rules on funding, which seeks to shape GP behaviour. Other changes include: increasing need for coordination with other health related professions, such as social workers and housing agencies; deregularisation of GP partner/patient ratios, leading to growth in size of practices; the increasing request for data to monitor outcomes; and increasing

demand from patients with multiple needs. These demands are fed by technology, which permits faster and more varied tests and by communications technology, which allows more patient contact through telephone, Skype and email. There is an increasing shortfall in the number of GPs in practice and a reluctance to take up this specialism by newly-trained doctors.

Universities

Interviews took place with six university course leaders in five universities. All universities were centrally funded, one in Midshire two in Northshire one in Southshire and two in Eastshire. Major factors of change for this group of participants include: the changes in funding allocations and the increasing emphasis on a financial measurement of research programmes (REF) and the subsequent pressure to publish; increased communications caused by technology; the increase in data-led monitoring of student outcomes and experience; the higher expectations of teaching support from students; the growth of student numbers, including international and indigenous students with varied previous learning experiences and needs; and the changing relationship between staff and students due to fee increases and the scrutiny of university outcomes through league tables and other monitors.

4.8 Gathering, Organising and Coding the Data

At the simplest level, questions of a semantic nature which allow for little or no elaboration, can more easily be categorized and the reoccurrence of material be quantified (Bryman 2008). In terms of the generation of codes from transcripts, the more structured an interview schedule the more quickly will data saturation be reached. In Guest, Bunce and Johnson's study (2006), the interview schedule was based on six structured questions and sixteen open-ended main questions. The type (initial six structured) of initial and number of subsequent questions (sixteen open ended) used indicates that the interview schedule was conducted with a high level of control residing in the interviewer. The resulting dialogue would be firmly shaped by the schedule.

The study I undertook allowed for extended replies to three main broad categories, with three sub-questions and three demographically-oriented introductory questions, the latter not intended to be used in the analysis.

Thus, the main areas of interest were open to development by the participants in the tradition of interpretive research (Bryman 2008), although guided questions led them to focus on three key areas: the form of change, the cause of change and the effect of change. Aldridge (1995) in his research with clergymen, noted: 'if I had presented myself with a highly-structured interview schedule, I am sure it would have endangered rapport. Clergymen are used to being in a position of authority, leading discussion rather than following it' (Aldridge 1993:99)

Data Collection

Data were collected between September 2012 and September 2014. Interviews were conducted in English (all bar one of the interviewees were native English speakers). All interviews were digitally recorded, listened to twice within four hours of each completion, and verbatim responses to each question were transcribed within twenty-four hours of each interview.

Listening, Transcribing

After each interview, the audio material was listened to twice within four hours of the interview and checked with the notes taken during the interview. This short timescale allowed the material to be still fresh in my mind. This listening was undertaken in the train on the way home, or in the café, waiting area or car park of the institution visited. Within twenty-four hours of the interview, the transcription was made, by means of the sound files, transferred to iTunes from iTalk App, and by checking with the notes written both during the interview and immediately after the it (see Appendix 3). This transcription took about four hours per every one-hour interview. The transcription attempted to record all words spoken by the interviewee and, where relevant, pauses, confusion or lack of clarity were indicated. Since there would be only one researcher, no formal schedule, such as the one described by Silverman (2009:398-399) was used to delineate pause, or confusion. However, natural linguistic indicators (i.e. dashes to indicate speed and

comments such as ‘bashes table for emphasis’) were used. The identification of each question used in the interview (A, B, etc.) with the flash cards was also used to identify sections of the transcript, which made for clarity.

4.8.1 Coding, Analysing

‘The process (of code formation) starts when the analyst begins to notice and look for, patterns of meaning and issues of potential interest’ (Braun & Clarke 2006).

The study described here used the inductive approach towards thematic analysis, in which the research was data driven, rather than being placed under an overarching methodological theory (Boyatzis 1998). This approach is identified and its use in a research project given a practical form by Braun and Clarke (2006), who provide a guided five-phase structure to carrying out an inductive thematic analysis of transcribed interview data. Internal validification requires a demonstration of rigour (Fereday & Muir Cochrane 2006) and transparency regarding the process of moving from verbatim transcription, to codes and then to overarching themes. I will demonstrate this through making clear my application of the five phases of theme generation and analysis delineated by Braun and Clarke (2006).

Phase 1: Familiarising Yourself with the Data

Although indicating five phases for the development of a rigorous thematic analysis, Braun and Clarke (2006) state that processes are not always discrete. The formation of codes, in particular, may happen at any point in the research process, including during the data collection. Cognisant that ‘analysis involves a constant moving back and forth between the entire data set, the coded excerpts of data and the analysis itself’ (Braun & Clarke 2006:15), I found that, by moving between the growing data set, coded excerpts and preliminary analytical concepts, useful initial codes were generated after transcription had been carried out for about 50% of the interviews. This supports Guest’s critique of code generation (Guest, Bunce & Johnson 2006) discussed earlier in this chapter. These core codes, with their particular dual aspect, which I will discuss later, remained as the

backbone of my analysis throughout the creation of this thematic analysis. However, code creation was an iterative process and the codes were refined and their focus sharpened with many steps along the way. The transcription itself was a vital component of my familiarising myself with the data. As Braun and Clarke state, 'analysis requires immersion', which 'usually involves 'repeated reading' of the data and reading the data in an active way' (Braun & Clarke 2006:16). I also found it useful to keep a diary with comments about each meeting, and to write rough notes as I read each transcript. This material formed a substantial and varied body of field notes (Appendix 4), similar to those used by ethnographers, to which I could usefully refer at any point in the transcribing process (Bryman 2008; Silverman 2009).

Phase 2: Generating Codes

'The process of coding is part of analysis' (Miles & Huberman 1994:1) which happens as you are organizing your data into meaningful groups (Tuckett 2005). Codes refer to 'the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis 1998:63). However, coded data differs from units of analysis (themes), which are often broader. The epistemological grounding of this research is interpretivism, which supports codes being created inductively to 'step into more complex and contested territory than is the case with RCTs (Thomas & Harden, 2008:4). In their meta-analysis of qualitative research for public health promotion, they state that the development of descriptive and analytical themes can be carried out in a rigorous way through the use of a stepped coding process (Thomas & Harden 2008:11). The initial codes for the present research were formed during a detailed reading and rereading of each transcript, and by the coding of each sentence or phrase using Boyatzis' criteria, whereby 'codes refer to the most basic segment or element of the raw data that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis 1998:63). Coding was carried out in the context of the tripartite framework of three headings: changes in work space, changes in work practice and changes in efficacy, which were the topics of the guided questions. The process of paraphrasing or summarizing each piece of data by transforming it into a coded format enters information 'into your unconscious, as well as

consciously processing the information' (Boyatzis 1998:45). A snapshot (below) of two sets of codes generated during the reading of the transcripts makes explicit the process of code generation.

Figure 5: Initial Code Generation

Main Code	Secondary Code	Tertiary Codes – All Weighted
PE Physical Environment	PE1 Formal work space changes	PE1a Client-centred changes PE1b Institution-centred changes
	PE2 Informal work space changes	PE2a Client-centred changes PE2b Institution-centred changes
WPC Work Practice Changes	WP1 Interrelational changes	WP1a Closer client relationships WP2b Closer colleague skills
	WP2 Data-gathering changes	WP2a Client-centred changes WP2b Institution-centred changes
	WP3 Communication technology changes	WP3a Client-centred changes WP3b Institution-centred changes

Initial codes.

The main codes shown here relate to the guided question (c) in the interview schedule: 'What changes have you seen in your workplace environment?' There is already a recognition on my part of a division between the responses to this guiding question, as both formal and informal spaces are coded as being described as either changing towards being client centred, or towards facilitating the institution.

There is also a recognition in the secondary code attached to the main code, 'work practice changes', that the use of data gathering and of technology in general could be significant factors in the responses of participants

Table 3: Codes into Themes

Primary Code	Secondary Code	Tertiary Code
Environment change Interrelational 1-5	EnvC lead Practitioner/client 1-5	Efficacy 0-5
Environment change Protocol/systemic 1-5	EnvC lead Policy-makers 1-5	
WorkPC Client expert Interrelational 1-5	WorkPC Client expert Practitioner/client 1-5	Efficacy 0-5
WorkPC Client expert Protocol/systemic 1-5	WorkPC Client expert Policy-makers led 1-5	
WorkPC Expert to expert Interrelational 1-5	WorkPC lead Expert expert Practitioner/client 1-5	Efficacy 0-5
WorkPC Expert to expert protocol/systemic 1-5	WorkPC lead Expert Policy-makers 1-5	
WorkPC Trainee expert Interrelational 1-5	WorkPC lead trainee expert Practitioner/client 1-5	Efficacy 0-5
WorkPC Trainee expert Protocol/systemic 1-5	WorkPC lead trainee expert Policy-makers 1-5	
Technology change Data 1-5	TechC lead data Practitioner/client 1-5	Efficacy 0-5
	TechC lead data Policy-makers 1-5	
Technology change Communications1-5	TechC lead comms Practitioner/client 1-5	Efficacy 0-5
	TechC lead comms Policy-makers 1-5	

In Table 3 *Codes into themes*, the codes have now become themes, i.e. broader categories which have identity, but which can be related usefully to each other in establishing the pattern of responses. At this stage, I applied a summated ratings scale (Likert 1932) to assess efficacy; this was later replaced with a full free code, as efficacy itself was too significant to be satisfactorily explained through a scale attached to behaviour.

This second version of coding shows how coding developed and was refined throughout the combined process of reading and rereading the transcripts, and designing the categories for the thematic analysis. In this second version of coding there is still a hierarchical tree formation. The codes in the final version were 'free' codes without a hierarchical structure, as it became apparent that the establishment of links using code usage frequency and code co-occurrence through CAQDAS would be a more effective approach to the dynamic process of interpreting the data into themes.

In Figure 5 *Initial Code Generation*, 'Data gathering changes' and 'Communication tech changes' were categorized as daughter codes to the mother code, 'Work Practice Changes'. In subsequent coding schemes they were treated separately, as more data concerned with that topic was recorded, and the topic grew in importance both in quantity and in the length of time given to it by participants. As stated, the coding of 'efficacy' as a tertiary summated ratings scale (Likert 1932) in relationship to the secondary codes was found, due to frequency, to be inadequate and coding was further refined to categorize efficacy as a free code in its own right. However, the basic dual structure of the coding of responses is clear even in this mid-stream version of coding.

Phase 3: Searching for Themes

In establishing that these linked patterns can be regarded as themes, it was useful to apply Patton's (2002) dual criteria for judging categories, i.e. internal homogeneity and external heterogeneity. Patton proposes that categories or codes can be judged by two criteria: firstly, whether they have internal homogeneity, concerning the extent to which the data that have been placed in a certain category cohere in a meaningful way; and secondly, external heterogeneity, concerning

whether the differences between the categories are clear. Using these principles, the establishment of validity in the phases of coding development becomes a process of (a) creating codes; (b) judging those codes on Patton's criteria by relating them back to the individual transcript of origin and then to the whole data corpus; and (c) restructuring codes by blending or separating categories, rewriting code names where appropriate; and finally (d) rereading the data corpus to test the alignment of the coding system with the original data.

The establishment of internal homogeneity can be seen in examples of 'rolling up' (Patton 2002) in Table 3, where previous codes (in Figure 5) had divided 'formal' workspace and 'informal' workspace, these two sub-topics becomes one major code 'workplace'. The frequency of comments from participants on these sub-topics showed that no appreciable weight was given to this as a category, therefore 'formal workspace' and 'informal workspace', as seen in Figure 5, became simply, 'workplace'.

Referring to Table 3, an example of the establishment of external heterogeneity (Patton 1990) can be seen. Here, technology was separated from communications into a sub-setting (as technology often referred to equipment which facilitated content delivery, such as interactive whiteboards), the practical measurement of such clinical factors as blood pressure, respiratory function or eye telemetry, and was separate from communications technology. Technology was maintained as a separate code throughout, as the frequency of its occurrence as a discrete theme was high across both participant groups.

Phase 4: Reviewing the Themes: Informing the Process

Braun and Clarke (2006), when describing the process of reviewing themes, state that if, after reading all the collated excerpts for a theme, some data excerpts have a coherence separately from the main data set, for that theme a subset should be created. Technology and communications were discernible as themes which occurred with a significant level of frequency, and which had external heterogeneity and could therefore be usefully applied as separate codes. They were not confined to one topic area, but occurred throughout the interviews in topics relating to workplace and in topics related to work practice

Communications also appeared as a code threaded through out the interviews – although more frequently appearing with 'work practice'. 'Communications' could be usefully further subdivided into data led and face to face, to reflect the distinction recognized by participants.

The replacement of face-to-face communication with email or video conferencing was seen as a negative trend, although, where email facilitated communication, i.e. where there had been none before, it was welcomed as helpful in the general communications with clients, i.e. patients or students and their parents.

Phase 5: Defining and Naming the Final Themes

Frequency reports were useful in managing data and revising the codebook, shaping the perception of the significance of transcribed material and therefore the development of themes. This can be seen from Figure 4.3 and Table 4.3, which describe snapshots of two stages of coding the data. Although the topic prompts used during the interviews were neutral and non-directional 'describe changes in workplace/practice', the answers and discussion raised by participants appeared, after the initial coding in CAQDAS, to demonstrate a duality in that there were two opposing forms of change. This duality was expressed in the language used when examples were given of change in the workplace and in work practice. The duality which emerged reflected the duality in government legislation and guidelines about behaviour in schools, hospitals, GP surgeries and university departments. As discussed in the literature review of this thesis, government white papers on Education and Health can be divided into two camps: one promoting individual personalized care and learning, and the other demanding more data-led evidence of outcomes whether in school classrooms, universities seminar rooms, hospital wards or GP surgeries. Further definition of coding refined these dual themes of change as:

Relational: that which indicates change towards the promotion or maintenance of 'real time' personal relationships/interactions between client/expert and expert/expert in both workplace and work practice as in (a) the development of a cancer treatment centre with user-friendly spaces and meeting areas or (b) in the increase in opportunities to meet informally with colleagues to discuss individual

students. Relational was used to describe moves towards people-centred behaviour instead of interrelationality, as it occurs more frequently in texts to do with Education and Health and therefore is more accessible to an audience. Gu and Day (2007:1302) talk of 'teaching as emotional practice … and resilience' as 'a multidimensional, socially constructed concept that is relative, dynamic and developmental in nature'. The same focus on relationality can be found in the literature of the NHS Improving Quality initiative (NHS 2013; 2014).

Systemic: that which indicates change towards the promotion or maintenance of the structure of the work space or of work practice as in the construction of cubicles to speed up the process of examination (transcription: Medical Consultant, PY) or the creation of a testing system which involves data-driven software rather than teacher observation (transcription: Education SP, Senior School Leader). Giddens (1990) talks of 'expert systems' which are 'systems of technical accomplishment or professional expertise that organize large areas of the material and social environment in which we live today' (Giddens,1990:27) and cites medicine and engineering as examples. He describes these systems as 'disembedding mechanisms', which allow many aspects of social life to proceed without the need for personal relationships between those involved.

Efficacy: refers to Bandura's Social Learning concept of self-efficacy, and is used in the language of management to describe the capacity to perceive oneself as motivated and successful (Bandura 1977). It is also used throughout literature concerning the measurement of interventions in education and medicine (Watters et al. 2015).

Technology: refers to equipment which facilitates the expert practice of the practitioner in the field of education or health such as scanning machines, whiteboards or any other apparatus or machinery which is used for the practical application of the substantive nature of the work of the expert practitioner in Health and Education.

Communications: Face to Face: that which indicates change toward or maintenance of face-to-face communications, including 'hands on' diagnosis and

assessment. Phone conversations are not 'face to face' by definition, although they are in real time; Skype or FaceTime communications are both 'face to face' and real time, and the technology used here may be seen to facilitate more real time, 'face-to-face' communication (Gund et al. 2013).

Communications: data-led: electronic communication not real time (i.e. email, electronically-generated questionnaires, statistics) which replaces face-to-face or introduces new data-led communications (recording targets, assessments).

4.9 Summary

This chapter has focused on the practical issues raised by following a qualitative route in research. Interviewees at the executive and managerial level are adept communicators, and my concern was that interviews would be shaped by their agenda not the research questions which are the focus of this research. In order to resolve this problem, I paid attention to the opening guiding questions in my interview schedule and so used a brief CV resume as a way of setting the focus towards truth telling. I was also aware that my presence in the interview space would influence my participants, and hoped that my age, appearance and experience of working in both the public sectors under scrutiny here, would build trust.

I followed the five-step process of coding and analyzing data set out by Braun and Clarke (2006) and used Patton's approach to establishing heterogeneity (Patton 2002). I am confident that the final codes reflect the themes generated by my participants. The highly significant pattern of relationships between those themes quickly became apparent after the identification of code co-occurrence using analytic software to uncover code clusters.

CHAPTER 5: FINDINGS

> How do all the codes and themes relate to each other? What is the big picture, and how does it relate to each theme or code? Where does one begin to tell the story? (Miles & Huberman 1994:306)

In this chapter, I present and discuss the findings from the analysis of the data collected in this investigation. My research questions were:

e) what changes are taking place in the working lives of expert practitioners in Health and Education?
f) is there a shared pattern of experience between expert practitioners in both sectors?

Findings indicate changes in work environment and in work practice which may affect the quality of the working lives of expert practitioners in Health and Education. These findings are presented in three sections, as follows:

1) The first section identifies the workplace changes which impact on the experience of the working life of expert practitioners, and demonstrates the links between variables concerned with the type of change, the causes of changes and these practitioners' perceptions of increased or reduced efficacy. This section also addresses the cross-sectoral phenomenon of practitioner response.
2) The second section examines the importance of technological innovation to practitioners, showing their ambivalent responses to the effect of technology on their work practice.
3) The third section identifies the work practice changes which impact on the working lives of expert practitioners, and demonstrates the links between variables concerned with the type of change, the cause of change and these practitioners' perceptions of increased or reduced efficacy. Again, the data,

both quantitative and qualitative, demonstrate the cross-sectoral nature of practitioner response to changes in work practice.

a) This subsection, nested within work practice, addresses the overwhelmingly negative response of practitioners, particularly in the Health sector, to the reduction of face-to-face communication and the rise of the use of electronic communication in their daily interactions.
b) This second subsection, also nested within work practice, addresses the category of initial training in which changes were seen to be negative. The response to this category came exclusively from Health participants.

I seek to place this commentary in the light of the literature reviewed, demonstrating how major changes in society at the macro level of neo-liberalization inadvertently affect expert practitioners in Health and Education. The data demonstrates that these practitioners recognize that their work practices are affected both by this international context and by the national level of policy-making. It also shows the awareness of these practitioners of the way in which these factors impinge on their practice at the intimate, micro level of the relationships with colleagues and clients; a phenomenon I describe as professional intimacy. I also show how the subthemes of subversion, and the recognition of the importance of informal space, indicate possible ways forward for improving the job satisfaction and retention rates of our expert practitioners.

Once data was coded for themes. the results were presented in frequencies (Appendix 5). Code frequencies represent interpretive summaries of data, and are not primary data in themselves and are therefore limited in their useful application in a qualitative analysis. However, having applied Patton's criteria for establishing the validity of coding (Patton 2002) and followed Braun and Clarke's rigorous five-phase process of theme formation (Braun & Clarke 2006), I am confident that the coded themes applied do relate to the media and demonstrate a real phenomenon of shared perception amongst my health and education participants.

The first research question raised by the data gathered in this investigation was: 'How have changes affected perceptions of efficacy amongst health and education

practitioners?' The frequency distribution chart (Appendix 5) would suggest that education and health participants perceive that changes in workplace have increased efficacy (71%) and that changes in work practice, although at a much lower level, have also increased efficacy (57%). This would indicate a workforce in Health and Education that is more positive about the changes taking place than negative – a workforce more satisfied with change than a workforce unhappy with it. But, there is no indication in this frequency chart of what elements of change have led to a perception of greater efficacy, or what elements of change, have led to a reduction in the perception of efficacy for those participants. Neither does it act as a vehicle for the range of emotions: the anger, fear, humour and sometimes despair, with which participants spoke about the negative aspects of their working lives. Moreover, almost half of code applications for efficacy (43%) indicated that participants were feeling less efficacious in terms of work practice, and this is a substantial proportion of the workforce in these two sectors. The frequency data raises the question of what factors make 43% of the health and education practitioners who took part in this investigation feel less efficacious about their work practice when reflecting over the last ten years. Is there a pattern of relationship between certain factors and perceptions of increasing or decreasing efficacy?

For the first research question to be answered, the themes were grouped using qualitative analysis software (Dedoose) for code co-occurrence across all practitioners (Appendix 6). All participants were allocated codes for their overall perceptions of efficacy for both workplace and work practice. These were derived from answers given to guiding Question G:

Consider again the description you gave of your PPE (particular professional expertise).

Have the changes in your workplace which you have described had an effect on the efficacy of your professional practice?

Have they changed the way you deal with those incidents which require your PPE?

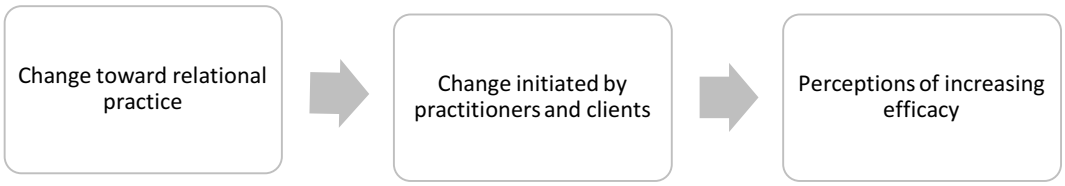
First look at changes to the environment and then at changes to work practice.

Participants often chose to respond to this central question in a binary way: either the effect of a particular change had been 'good' or it had been 'bad'. However, there were multiple responses from each participant on a rich variety of self-selected topics which meant that a range of positive and negative comments were gathered from each participant. It was practical, and reflective of content, to group these responses into perceptions of change leading either to increasing efficacy or decreasing efficacy. Individual participants' responses were coded by frequency, establishing links to overall perceptions of increasing or decreasing efficacy (Appendix 7). The linked frequency distribution chart, Appendix 7, demonstrates that this link exists, showing the distribution and relationship of workplace and work practice codes to perceptions of efficacy per participant.

The visual representations of data in Chapter 5 is in the form of flow charts and in tables which refer to workplace and work practice. These make explicit the distribution and frequency of commentary on the major themes used by participants. These visual representations also allow a demonstration of the dynamic relationship between change, the causes of change and the effect of that change. The similarity in the patterns and the strength of these relationships in both sectors is also made evident.

Figures 6 and 7 are flow charts, which show the relationship of major themes to the perceptions by participants of increasing or decreasing efficacy. The frequency of code co-occurrence between workplace change being towards the relational, being client-practitioner led and producing greater efficacy can be seen; the flow charts also make evident the co-occurrence between workplace change being towards systemic, being policy-maker led and a perceived decrease in efficacy among participating expert practitioners.

Figure 6: Flow Chart of Code Application Showing Impact on Perceptions of Efficacy: Part 1: Efficacy Increasing



The relationship between perceptions of increasing efficacy and decreasing efficacy and the other codes can clearly be seen in these flow charts (Figs 6 and 7). The pattern is that of a converse mirror image, where a move towards more relationality in the working environment, led by the staff and by their clients, more frequently lead to perceptions of increasing efficacy (Fig 6). Conversely, changes which are put in place to support systemic change and are led by policy-makers, their directives and targets, are seen to more frequently lead to perceptions of reducing efficacy (Fig 7).

Figure 7: Flow Chart of Code Application Showing Impact on Perceptions of Efficacy: Part 2: Efficacy Reducing



The flow charts above (Figs 6 and 7) describe the patterns immediately discernible in the CAQDAS code co-occurrence data (Appendix 6). Participants expressed a tripartite relationship between the direction of change, the initiators of that change and the relationship of those two factors to perceptions of efficacy. The nature of these relationships is explored through the quantitative and qualitative data examined in this chapter.

Each of the following sections: (a) Workplace Change, (b) Technological Change and (c) Work Practice Change is introduced by visual representations of the quantitative data which was generated by the software analysis programme, Dedoose. The results were analysed using both the frequency data to explore relationships between categories (Bryman 2008:545) and chi-square for association, to provide evidence for the significance of relationships between the themes and between health and education responses (Namey et al. 2007).

The following tables and relevant chi-square analysis show that the relationships presented in the thematic maps are statistically significant. The patterns of cause and effect inherent in these statistically significant patterns are brought to life by the commentary of practitioners on their individual experience of changes to their working lives.

5.1 Workplace Change: Factors Affecting Efficacy

5.1.1 Workplace Change Data Analysis: Quantitative

Table 4: Workplace Change: Factors which Affect Practitioner Efficacy in Both Sectors

Workplace Change Factors: Efficacy Increase				
	Prac/client	Systemic	Relational	Policy-maker
All	40%	6%	41%	13%

Workplace Change Factors: Efficacy Decrease				
	Prac/client	Systemic	Relational	Policy-maker
All	17%	34%	14%	35%

Table 4 demonstrates the percentage distribution relating to increasing and decreasing efficacy in both public sectors for workplace change. There is a highly significant code co-occurrence between workplace change being towards the relational, being client-practitioner led and producing greater efficacy. It also shows that there is a highly significant co-occurrence between workplace change

being towards systemic, being policy-maker led and a perceived decrease in efficacy ($x^2 = 55.0\ p < 0.0001$).

This makes evident a tripartite link between (a) the perceived direction of change, (b) the instigator of that change and (c) the effect of that change on efficacy. It is worth noting that this was made more significant by the design of the interview in which these topics were discrete, introduced at different points of the interview, and where the participants were not led to link them together, but did so spontaneously.

5.1.2 Workplace Change: Health and Education Comparison

The second research question raised by this investigation is 'Do expert practitioners in the public sectors of Health and Education share these perceptions?' In order for this question to be answered, the results were then split to compare education with Health code co-occurrence (Table 5).

Table 5: Workplace Change: Comparison of Factors which Affect Practitioner Efficacy in Health and Education

Workplace Change Factors: Efficacy Increase				
	Prac/client	Systemic	Relational	Policy-maker
Health	39%	6%	39%	16%
Education	40%	5%	46%	9%

Workplace Change Factors: Efficacy Decrease				
	Prac/client	Systemic	Relational	Policy-maker
Health	14%	29%	14%	43%
Education	20%	40%	13%	27%

Table 5 demonstrates the percentage distribution relating to increasing and decreasing efficacy per public sector for workplace. Both education ($x^2 = 49.2\ p < 0.0001$) and health participants ($x^2 = 42.84\ p < 0.0001$) show an independent and highly significant relationship between workplace change being towards the relational being client-practitioner led and a perceived increase in

efficacy. It also shows that there is an independent and significant relationship between the education ($x^2 = 3.34\ p < 0.05$) and health responses ($x^2 = 5.14\ p < 0.05$) regarding workplace change being towards systemic, being policy-maker led and a perceived decrease in efficacy.

5.1.3 Workplace Change Data Analysis: Qualitative

In the following qualitative data, participants make explicit their awareness of the larger political context of changes to that environment. Government initiatives such as PFI were introduced in 1992 by the Conservative Government led by Sir John Major, but became widespread under Labour after 1997. This funding formula has dominated the building of public sector workspaces for Health and Education, increasing in importance over the last fifteen years. This can be seen in the frequency of references to it in participant commentary on the changes to their workspace. Informal workspace can also be seen as an important part of the workplace: its loss due to cost efficiencies is lamented, and its replacement by corridor meeting moments and break-out spaces is evidenced. A subversive push to make informal spaces out of officially designated workspace can also be seen. Workspaces have become multi-use – commodification of Health space, in particular, is evidenced by mentions of Costa Coffee and Greggs. Multinational companies share the workspace, along with other retailers, of health practitioners and of the practitioners in university education; this not apparent in secondary education at the time of writing.

All thirty-six participants talked to me about how their workspace has changed or was about to change, and were aware that the changing environment would have an impact on their experience of work. They were all aware that their workplaces were affected directly by the social policy of each succeeding government, one of their major concerns being the need for new buildings and the funding of this change. My first participant, a senior GP practitioner, sets the scene by recalling the front room surgery he visited as a child in the 1960s:

> Long dark corridors and a roaring gas fire. Awful, awful. There were dingy waiting rooms in the front rooms of terraces. (GSP, GP Partner)

He describes the great improvement in the primary care environment brought about by policy directives in the 1990s (Carrier & Kendall 2016), which allowed building to be financed by GPs, and rent on those buildings to be paid by the NHS to the GP owners:

> Our two surgeries were built twenty years ago. The government gave you a rent equivalent to the rent you paid and that money included professional fees as well so if you could find land you could build a superb working environment. We had autonomy, provided they agreed with what you suggested and it was within the guidelines – and we had the full support of an administrator – but you only dealt with one administrator. We were on completely cordial terms – he had vast duties but he seemed to carry that mantle comfortably. And you knew him – when I first came to the practice I was taken to meet him – there was mutual respect, trust (nods head) – yes there were just less layers of management then. (GSP, GP Partner)

This GP and his partners were able to use government financial support to build a surgery which was dedicated to their use and which they owned. Twenty years on, a different way of funding new buildings in Health has been implemented and the commentary of a King's Fund report on NHS buildings describes the difficulties facing practitioners caught up in the PFI building programme (Edwards 2013). The responses from the medical cohort in this section echo this disquiet: the GP talking below tells us that her workspace has been funded through PFI initiatives. The space is not owned by the partners but by a property developer, with the GPs leasing the property for twenty years. Although the rental is partially supported by the NHS, these GPs are effectively landlords for their property developer. And this has its pitfalls, as she tells us:

> It took eight years to move and during that time the financial crisis locked in. Now other practices couldn't do it (move). Couldn't, wouldn't, do what we have done. We lease the whole building but the developer had to build to a certain size, including much more space than we need, and we are contracted to generate income from this space. We are acting as landlords for the developer. This building cost 1.3 million and there was no way we could afford to build it. The NHS pays us a notional rent each month which we hand over to the owner of this building. We have a whole floor above which we have to rent out (pause). This is a huge responsibility; we are struggling between us to manage this building. We can't find tenants

> (pause) there is a lot of health space available for rent out there. (DH, GP)

She and her partner colleagues are burdened with a responsibility to act as landlords. This is a responsibility which they don't want and which has become more onerous in the present recession, but it was the only option on offer which would allow them to build this rural surgery. She could not see any opportunity to change this situation: 'we have a whole floor which we have to rent out' and 'we can't find the tenants'. It would appear that she and her colleagues, in a state of 'learned helplessness', have forgone autonomy as they have no way of applying it (Seligman 1975). The financial drain on this GP practice is substantial and the detrimental effect on the partners' job satisfaction is significant. As she said:

> If I could get out I would. I don't want it to be this way ... but it is ... (DH, GP Partner)

This expert practitioner does not perceive herself to be autonomous: 'I don't want it to be this way', and this is linked to an ambiguity in her judgment of the effect of these new workspaces.

> Yes, the change in the environment has made me more efficacious but because we don't rely on much equipment in consultations it hasn't made that much difference. People expect, because of this new building, they were going to get a much broader service, with more doctors and more treatments. But it is still just us. (DH, GP Partner)

'But it is still just us' and the new custom-built accommodation will not alter this GP's dissatisfaction with her work practice, as she explains later in the interview, telling me: 'if I could find another job, I would do it.' (DH GP Partner). However, the building is magnificent. On the day of this interview, I parked by a white, gleaming asymmetrical façade and entered a large auditorium. Looking to my right, I saw a bank of velvet-backed waiting chairs, sweeping away down a large hall. Ahead was a lilac and gold reception area with, behind it, bright screens advising which direction you should go for the Sexual Health or the Ante-Natal clinics. It is impressive. I was reminded of the comments of another of my

participants, a medical director of a large, midlands teaching hospital trust, who told me:

> In the States they put a lot of effort into front of house – walnut reception desks, flowers, etc. and this affects patient perception – things like good car parking as well. In the past we haven't done that in the NHS ... (CSR, Medical Director)

The provision of health care in the US is very much a public/private mix and the implication of the words of this medical director is that we may be moving towards that kind of customer-led, profit-underpinned healthcare system in the UK. His concern is that patients cannot make accurate assessments of healthcare provision, but are affected by the peripheral aspects of attending hospital, such as the walnut reception desk and good car parking facilities. In fact, 'they assume they are getting the right treatments'. He is concerned that patients don't look beyond the environmental façade to the core provision of appropriate professionally delivered medical care.

However, the provision of new buildings can make a positive difference to the workplace. DH, although unhappy with the financial situation in which she and her partners find themselves, told me that her daily working environment and the patient experience of the new environment is good:

> The design is good ... it is pleasing on the eye. the architects have taken on design from GPs and we visited other places that have been done before. The newer [surgeries] the modern ones, in these ones, the designers know what they are doing. Having actual wheels on the examination couch is good. We couldn't have wheels before as the room was too small and we had carpet. Now we can get round patients. (DH, GP Partner)

The new environment has made the practical aspects of work practice better for this GP, but not enough to alter her negative perception of her role. If the tipping point is reached she will leave and the outcome of her personal story will join the growing statistics as evidence of low retention in the NHS. Her personal experience of debt is echoed by the larger effects of public/private government initiatives: the funding of public service buildings through PFI has brought with it a legacy of increasing debt. Hospital trusts applying the public/private mix fear

financial issues following the enforced rescue of Hinchinbrooke Health Care Trust by central government (NHS 2016) and academy trustees grapple with the legacy of the expensive maintenance of schools provided through Building Schools for the Future (DfES 2003a; Patel 2005: Building 2014).

However, one of my participants, from the education cohort, was distressed because of a change in government policy, when Michael Gove halted the Building Schools for the Future programme in 2010. As a result of this change, his workplace, an overcrowded urban secondary school due to be rebuilt under this scheme, would now no longer be rebuilt. His concern was not with the cost, as unlike GPs he would not be directly involved in managing the financial aspects of this change; rather, he was disappointed that the possibility of transforming the daily experience of pupils had disappeared:

> We are not getting new buildings ... the school is very full ... so there [continues to be] a real difficulty in timetabling rooms, that is very difficult ... we do not take children out of the classrooms, the hall is a space for PE so we can't use it – you can't get a computer room for a long enough stretch ... (BD, AST English)

His school was the next one in line for change, so the demise of the programme was dispiriting:

> We were on the Building Schools for the Future programme ... we had visited other schools [to see what they had done] but the Coalition Government cancelled Building Schools for the Future. I do believe children deserve a better environment, some of our children come from the bottom 2% of social disadvantage and they need support. (BD, AST English)

However, the management of the school soldiers on, seeking money and space: 'and although BSF has stopped, the school has been quite active – in touch with MPs to get funding and new buildings' (BD AST English). The new space would have been good and is wistfully described: 'There were going to be more communal areas for students and a better sports space. We visited some schools [which had used the BSF programme] where there was a really innovative use of space' (BD AST English). Meanwhile, he and other teachers in his school continue to make changes in their workplace towards a less hierarchal

environment: ‘but even within these rooms [gestures around space] these tables are very light and can be used in different ways ... A school has to develop the attitude that a school is a learning environment ... I hate hierarchies’ (BD AST English).

This participant was keen to see the ‘more communal’ spaces which the programme would have delivered, but in the meantime, is using and adapting the classroom space he has, to create opportunities for a less top-down form of delivery. His words imply that he is implementing a fundamental change in the work environment: the school as an institution is moving towards a less formal demarcated space. BSF would have assisted this change, but it will happen anyway.

A senior team leader, in another secondary school, values the physical space of the institution and worries that financial pressures may mean that schools will be seen as too expensive to run:

> (pauses) I worry for my daughters – you can set up lessons on the VLE – people say why can’t my children learn at home?… someone is going to say – why do we need these buildings? They are too expensive – I would be saddened – the social element of the school is important. It is about the feel of this (laughing – the bell has gone for the end of the day, there is a lot of noise outside the door) I am on bus duty. (We get up.) (SP, Senior School Leader)

He would be loath to see education become oriented away from a shared experience of time and place, and recognizes the centrality of the social element to attending school. He points out that for some pupils, the school environment may be safer and more nurturing than the home environment:

> Our cohort is like any other school – with some problem kids ... students who can’t really access the curriculum – for home reasons or other – so we have a support area where there can be a quick cuddle, cup of tea in the morning with strict guidelines on discipline. It’s that mix. (SP, Senior School Leader)

Creating space for informal, relational, moments, which complement the formal organization of each day, is seen as helping the school to function as an

institution. There is also evidence of an awareness from this participant that the environment has to change to accommodate an evolving society. An experienced senior team leader in a suburban secondary school, he goes on to say:

> Our environment has to be less traditional – the teaching environment has to change – let's not kid ourselves, the old traditional 1950s classrooms with four walls 1 door, you know, few windows, isn't switching on children – we have very creative ways of teaching children – you take this building – it is a newer building and we have a number of classrooms where classrooms are only separated by a divide – so we have a lot of opportunities. (SP, Senior Team Leader)

SP is indicating that teachers are responding to social change, not leading it. 'The teaching environment has to change': here, the use of the imperative gives a sense of urgency to this commentary, and also implies a relationship between the client's demands and the professional response of the practitioner to those changing demands. By describing these changes as offering a 'lot of opportunities', SP is demonstrating that his response to change is positive. That these recent changes in the environment offer a chance to increase efficacy for the body of teachers, not simply for him as an individual, is implicit in the use of the inclusive 'our' and 'we'.

In the same way, GSP, a GP partner in a rural two-centre practice, describes the positive effect of new buildings on the client and the practitioner. He links the 'modern' buildings firmly with running 'effective modern medicine'. Again, there is the use of an imperative, as he describes how the new 'functions' which can be offered from a GP surgery to drive the 'need' for 'modern' buildings:

> They (the new buildings) – offered better patient experience for patients and for ourselves – you need modern buildings to carry out (new) functions – you can bring in professions similar to medicine, like chiropody, counselling – so we expanded because we needed rooms. (GSP, GP Partner).

And for this GP, with a surgery in a busy affluent town, the PFI worked. She talks about a 'better patient experience for patients and for ourselves', one which facilitates co-working; and a second GP makes a similar statement, although in

this case the desire for a more relational workspace is made explicit through a practical example:

> We moved from an old 1970s building into a super state of the art building ... it has enabled us to do a lot more GP training and offer things like counselling – as much as we want to. It is nice that we can house people. We can have educational meetings here. I personally would say that I gave the same service in our old dusty carpeted workplace but the patients who come here ... it is better ... when I fit a coil I can get around both sides of the table. We used to do these procedures in a little tiny room with the couch against the wall ... it was pretty dire really. (WR, GP Partner)

This change in the working environment was not led by policy-makers: it came from the practitioners themselves and involved other health workers:

> This was not from above ... No, it came from us the discussion went around a long time ... an awful lot of liaison and at our old practice we had the Health Visitors, they all wanted to move, as well so we had a combined need. (WR, GP Partner)

Since the move was part of a PFI initiative, it could therefore be described as a policy-maker-led project, but this GP doesn't see it like that. For her, the impetus for this change to a more relational space came emphatically from her and her colleagues. She feels she has autonomy and this practitioner-led change gave her a greater feeling of efficacy:

> Because of changes in the environment ... am I more efficacious? Definitely more – I think I can work better ... more ... I am a generalist GP like all of us here although I think I could ... we could handle most of what comes in our door … so I might go and ask one of my colleagues here about something neurological but I am sexual health. Particularly I would be the one doing the sexual health thing. The space allows me to provide the service more safely ... It is a more safe environment for the patients, and we can have more training. (WR, GP Partner)

The GP above is satisfied that there has been a link between the environmental change to her workplace and her efficacy. An AST working in Education describes a more troubled journey to efficacy. He has had to take matters into his

own hands as he sees the institutional environment of his school as conservative, and its culture lagging behind changes in society. In order to be in tune with the 'democratization of space', he sees happening in the world outside the school, he has used his skills to create a virtual platform to share his ideas and approach to learning:

> In a sense the Ofsted view is Platonic – there is a perfect form and all schools should conform to that, but in reality, society is a developing democratization people are giving themselves greater voices, power, finding authority. My effort is spent trying to get round those obstacles (Ofsted and top down control which I mentioned before) I've used the Internet as a way of sharing influence through cooperating with larger groups – wrapping round my work environment which is not going to stop being conservative – where it is possible to make a breakthrough, you make it – now you can put something on your website and 10,000 people can get involved in a discussion and that is fostering the change. The environment is not the school, it is everybody. (BC, AST)

This excerpt indicates that the expert practitioner (an AST in IT) will subvert a system of which he feels he has had no voice in the creation, and will use his organizational skills or his particular professional skills, to make these changes. It is worth noting that these expert practitioners, perhaps due to their executive roles, have the confidence to be comfortable in enacting change across the whole system wherein they work – be it for all the staff of a hospital, or on the platform of a chat room on the Internet. There are unintended consequences to the interventions of policy-makers in the function of public institutions (Giddens 2013) and one of the unintended consequences of an attempted imposition from an outside authority on my participants is, at times, a deliberate subversion by them of the new order.

This deliberate subversion of the system by these expert practitioners is most evident when they are altering the space which has been allocated to them by a change in their environment. Where expert practitioners have a say in the changes (see Appendix 4), they are moving their workplaces towards a more relational friendly space. However, where decisions have been made by external bodies, and these practitioners have not been involved with the restructuring of their environment, the narrative of their interviews with me suggests that they take a

proactive stance and make subsequent changes to the top-down design. This is particularly clear in the use of informal and in interactive spaces, where meetings with colleagues and clients take place.

First, an example of how it can work, when the practitioners are given a say in the design of their own workspace and there is a harmony between government initiative, building design and the consulted practitioners, is given by one university course leader.

He describes how his workspace was changed by a move into a new build. He uses phrases like ‘more common spaces’ and ‘the communication is better’, and words such as ‘random’ and ‘informal’, denoting a shift away from the traditional, although here, for the university leader, the client/expert practitioner relationship seems to be less important than the practitioner/practitioner relationship:

> This new structure has more common spaces, shared spaces than our old offices. It has been engineered to affect the way people behave. Communication, because of building change, is better. We were more isolated before, now the workplace is more informal. Random meetings are facilitated with other staff because we share break-out spaces or go to coffee machine stations ... random meetings with students are less likely, though they do happen, and we can arrange an informal meeting at one of the break-out spaces. (BP, University Course Leader)

The ‘we’ he is describing are the staff, who were ‘more isolated from each other’ before but who now share ‘break-out spaces’. His focus is on the expert practitioner to expert practitioner, the peer group relationship, rather than the relationship between the practitioner and the client. However, he does comment that random meetings can happen with students, and ‘we’, the practitioners, can arrange ‘an informal meeting’ with these students. The qualitative nature of the language leaves an impression that environmental change has certainly caused behavioural change to take place. New relationships have been forged, but not as often, or at such depth, with the client as with the fellow practitioner. However, this practitioner is happy with the involvement he has had with the design of this space, and with his involvement in that design. Unlike this second example, a hospital consultant, who, later in his interview also describes the top-down nature

of decision-making regarding space in this PFI new build, but here is describing the loss of the staff canteen:

> The old hospital had a staff canteen where staff could chat. Now any private spaces are small windowless cupboards. And in our department, we had a staff canteen staffed by two people – paid a minimum wage but they did put an effort in – who produced home-cooked food and we had a place to eat privately. It was closed down because one of the line managers had a target to bring down numbers. I calculated that a subsidy of 50p per person would have kept it open. These informal meeting spaces are much more important than people give them credit for ... these spaces lubricate the system. (YP, Hospital Consultant)

The replacement of 'home-cooked food' in a convivial atmosphere with a 'small windowless cupboard' is painfully felt. This participant feels nothing but what he described as 'venomous disdain' for the 'perpetrator of this abomination', this 'line manager who had a target to bring down numbers'. However, his colleague, recognizing the need for informal meeting spaces, is already, only less than a year into the new hospital, being proactive. She is subversively carving out an informal space for the team:

> Places to meet informally? No, we had that at the old Royal, a common room. We had to fight long and hard to use an office here as a meeting room space. We have fallen foul of Health and Safety – they did an audit and the standard of fridge hygiene was not very good. Because it is a designated office area the cleaners won't clean the fridge. But for our staff to go to the dining room by the time they go to their locker area to take their lab coats off it uses their 20-minute break so we definitely have to have this space here. (ML, Hospital Consultant)

At this point in the interview, my participant looked me firmly in the eye and gave a brief rap on her desk top to affirm her intention of fighting bureaucracy. So, the fight goes on for an informal staff meeting place. Another consultant, interviewed separately, but in the same hospital, sees a possible conspiracy behind this control of space. The cause of change for him has been the public/private mix of funding which, he feels, has led to the demise of the old 'doctors' mess':

> And now it's Costa Coffee for everyone! (YP, Hospital Consultant)

The PFI financing of projects like new hospital builds means that, for this consultant:

> As far as space was concerned it was politically and financially driven. In order to ensure the continued income stream, it is made expensive to make small changes. (YP, Hospital Consultant)

In this excerpt, the changes in the use and allocation of space are seen as firmly in the control of those with political and financial power, and the result is viewed negatively. However, this consultant does recognize that this same new build had been successful in other ways:

> The change in environment has made my work practice better – yes, in lots of respects – I am nearer my colleagues. And if you ... speak to cardiologists. They have a huge suite, state-of-the art diagnostic equipment ... and speak to any other specialty ... but not the labs (her area of authority). (ML, Hospital Consultant)

However, she is still prepared to fight 'long and hard' to carve out a space for this informal meeting room. This disquiet at the loss of the use of the space, and time, to meet informally was also expressed by education participants:

> Physical environment? One thing is the staffroom in our school. It is like the Marie Celeste ... we used to get together in the staff room for meetings at break time and after school. That doesn't happen now. Hardly anybody sees each other after school, not now. (BS, Senior Team Leader)

She goes on to say that the staff are all in their departments now:

> ... working their backsides off through their break times, lunch times and late into evenings. (BS, Senior Team Leader)

You could be forgiven for imagining a political Mr Gradgrind rubbing his hands with glee at this picture. Staff should be 'working their backsides off' at all times, particularly staff paid for by the taxpayer. But this would be to misunderstand the collegiate nature of the work of the expert practitioners. Talking to colleagues, in an informal setting, is a way to unwind, to offload and share the difficulties faced in a day of intense interaction with clients: an opportunity to use the 'back space',

where roles do not have to be maintained (Goffman 1990; Giddens 2013; Clarke 2015; Clarke 2017). One hospital doctor describes the way informal meetings outside but nearby the workplace can underpin good practice and have a therapeutic role:

> We could go to the pub on a Friday and huge amounts of informal discussion could take place. There was lots of camaraderie, because back in the clinical situation, particularly if there were difficult decisions to be made you had a rapport, you knew your colleagues, you knew where you were coming from ... it also gave you the chance to stick your neck out ... and know that your relationship would survive this when you went back into work. (ML, Hospital Consultant)

For this doctor, the move to the new build hospital on the edge of town has meant that some unaccounted-for interaction of a relational nature has been lost, and with it an important process which underpinned good practice back in the work situation. This new build has not created a similar informal space within its structure and this has had an effect on the morale of the participants to whom I spoke. One consultant explained to me that decisions about the use of space are being made on what can be measured, whereas:

> Staff morale is difficult to measure and so is ignored. (PY, Hospital Consultant)

And yet, it is this lowering of staff morale which so alarms expert practitioners (Heath 2012; Martin et al. 2015) and so, a finding of this study is that the effect of environmental change on staff morale should be 'measured'. Attention should be given to those informal transitional spaces which connect the active spaces of a building together and give 'break-out' time. A recent report on the provision of new school buildings highlighted a similar problem in Education. The survey showed that teachers were concerned that attention is focused on the design and size of classrooms, so corridors and meeting spaces become smaller, which leads to more behaviour problems out of class (Building 2014).

The frustration which can be felt by practitioners whose needs are not taken into account can be seen in this excerpt from a university course leader:

> This building has been designed around a certain matrix of concrete posts ... therefore the rooms are shorter on one side than the other ... therefore rooms are shaped completely wrongly to teach, designed with no consideration for teaching but consideration for the pillars. Every time you teach here you have to move the tables so the tables get broken ... other considerations which are irrelevant to teaching take precedence over teaching. (GRP, University Course Leader)

The link between this dissatisfaction with the outcome of design and the lack of involvement of the expert practitioner in making design decisions can be seen, as this participant goes on to say:

> I don't believe staff were invited to take part in any decision-making about the building ... can't remember it ... I have walked behind architects, hearing them saying 'we have got to get these academics off the idea of spaces for a particular usage'. (GRP, University Course Leader)

It is interesting to note, that, for this university course leader, the changes to the workspace have made his practice more difficult. He comments on the lack of soundproofing in the offices, which means that it is difficult to have a private conversation with a student:

> The wall construction is cheap … not a problem in itself, but I might be having a conversation with a member of staff or a student ... for instance if Joan (tutor in adjoining room) has a Skype tutorial I hear every word ... if we had open plan there might be somewhere (built in) where I could take students for some privacy. (GRP, University Course Leader)

He chooses to imagine an open-plan arrangement rather than simply better soundproofing in the walls. He is finding a new, systemic solution to the problem. This creative problem-solving is the hallmark of the expert practitioner, member of the professional class, those 'intellectuals and technical intelligentsia' (Gouldner 1978:53 in Webster 2008) who are able and willing to contest the control of business and politics over their domains. It might explain the frustration obviously felt by the participant GP above, when unable to be involved in decision-making. The expert practitioner expects and wants to direct the work situation. Contrast this dissatisfaction with the positive comments made by

another university course leader in a different university, regarding the changes to his working space, which was designed with the input of staff:

> In the discussions about this new space the departmental manager initiated this discussion about space. The original plan was for the offices to be open plan but nobody wanted it. However, the general agreement was for wide corridors, where people could stop and chat or pass by each other easily, and break-out spaces for informal meetings. We have coffee stations with machines, easier than storing special departmental cups. (BP, University Course Leader)

He is happy with the organization of the workspace he has partly chosen. I found it interesting, given that he had been party to the redesign of a large city-centre office block into a fully-fledged university, that he chose to talk about informal non-practice spaces, such as corridors and break-out spaces, rather than the design of the new formal teaching areas. This choice of subtopic was made by many participants, demonstrating the importance of these informal spaces and informal meetings to the working lives of expert practitioners in Health and Education.

For BP, a hospital consultant, the staff asked for, and were given, corridors designed to be big enough to 'stop and chat'. Did the designers of that city hospital new build commented on earlier realize how important these informal moments are to practitioners? In another hospital, the space for these informal meetings has been built in:

> Well, the distances involved are much less – we are all nearer to others in the department. You can talk to people face to face – and I think because of this morale has improved – there is more focus on the actual work – because you now are not having to work your way round an inconvenient building. The design has allowed for … design has allowed more face-to-face contact. And you meet people on the corridors… you can mention something … or carry on a conversation. This has made a difference. Yes, it is different. Very different from the old hospital (laughs and grimaces). (CM, Senior Hospital Consultant)

He goes on to comment on the design of the practice space such as theatres and consulting rooms:

> We also designed our rooms – well, we didn't actually have a say in the size of our offices but in terms of how everything fitted together. For example – people can now go on one level to theatre from beds, that's much better. We wanted that – going up and down in the lifts adds stress to the patient … and the staff. (CM, Senior Hospital Consultant)

This commentary shows how the needs of the patient and the staff overlap, demonstrating the closeness between the expert practitioner and his/her client. But it is noteworthy that his first thoughts when asked about workspace was to think of the informal spaces, the corridors, where colleagues can meet and discuss. This underlines the collegiate nature of the work of doctors, nurse and teachers, which has to be given unmonitored space to flourish.

More evidence can be found that new structures for the HE sector also incorporate more informal spaces. In a Midlands university, a lecturer muses on the changing space around him:

> The space is very different – our old building felt like secondary school. Here in the new building the atrium is open and airy. Staff and students meet in this atrium – it is a bigger space, this allows more freedom of use, and of course, we are now a 'pick and mix' society. The atrium can be anything. It is a place to consume, we have shops around its edge and we can eat there. I eat in the atrium, there is always the worry that students will waylay you and want to talk but most students respect the semiotic code – if you have a newspaper and food they realize that you do not want to interact. This large, mixed informal space means that they are learning to negotiate their own interactions, which is different. Different from the old set up. (RG, University Course Leader)

He indicates the close relationship between space and behaviour, the open informal space of the multi-purpose atrium means that people have to negotiate the way they use the space. In this way the students are learning to recognize the signs which indicate whether or not they should approach a member of staff who is also in this space. This sharing of informal space is very different from the traditional separate staff canteen and student union, possibly indicating a change in our perception of hierarchy (Paluski & Waters 1996).

In participant narrative concerning the building of new hospitals, there is evidence that the traditional hierarchy of top-down decision-making has been discarded and that space is often designed by an interaction between staff, patients and charity funding. This excerpt from a senior nurse with responsibility for oncology nursing services in a large teaching hospital describes in fascinating detail how successful this can be:

> The Day Case area was specially designed. One influential commissioning group in our trust are patients who run charities. For these charities, the focus is on the patient. In this case, they provided questionnaires for patients, asking what they wanted, and, based on the results, now we have got break-out rooms, quiet rooms where patients can see each other.
>
> Also in response to what they told us, we took this massive ward space and changed it to areas separated by half walls – wavy walls with differing heights and now people can sit privately, in small groups. It feels quite insular, comfortable and safe. We have an art project under way as well where local art providers are creating art based on this town – so it is focused on local links. (AG, Senior Trust Nurse Oncology)

This is an example of clients and practitioners working together to shape the spaces where treatment is given and, according to this participant, has improved the outcome for patients and the perception of efficacy amongst the staff. She went on to describe other changes to the environment initiated by patients through a charity:

> Breast Cancer Action ladies who collected money and who have a strong voice in the delivery of oncological services here chose, with some money which they had raised that, instead of a plaque with target to be reached placed in prime position in the entrance that we should have a sculpture. This sculpture has a roll-on programme with donations on it, which is constantly changing so we can all see how fund raising is progressing. (AG Senior Trust Nurse for Oncology)

The earlier excerpt described the decision to bring in work by local artists which was made by staff, and the decision to put a sculpture in place instead of a sterile plaque, a decision made by patients. Here is an instance of the harmony between practitioners and clients when allowed to be decision-makers about the

therapeutic space. When asked further about her role in decision-making regarding the workspace, this senior nurse gave a very clear reply:

> We are in agreement with the general direction of government initiatives towards patient-centred care and we brought our own ideas to it. Changes to the workplace and to work practice have made me more efficacious. They are closely interlinked, environment and work practice. I don't think you can separate them – out of necessity we moved into a new building and we had to change practices. I wanted to take a key role and wanted to influence how it was going to be. I made it, them – these decisions – it's very much mine.

This practitioner sees a harmony between her actions and government initiatives, post Mid Staffs, regarding patient-centred care. However, most importantly, she sees herself as autonomous, as a decision-maker. This is in great contrast with this participant, a senior hospital consultant, who had had no involvement in the design of her building. The space for professional practice in this workplace, where the practitioners have had no say in the design, is seen to be inadequate is described by a hospital consultant:

> This new build is anonymous, every corridor, when we first moved in, every corridor looked like every other one – the same. Very sterile. Layout was completely different (from the old hospital). The labs took a big hit in terms of space, we got a smaller footprint, a reduction in space, 50% reduction in bench space. 'Who decided on the allocation of space?' I presume the decision was made at the national executive level. There were five templates for hospitals ... there were opportunities for consultation but we won very little of the argument, sorry, the negotiation (sardonically said). (ML, Hospital Consultant)

This sounds as if lip service was paid to the notion of involving staff in decision-making about the new build, and is a great contrast to the experience of the senior trust nurse for oncology. In Education as in Health, when involvement is there, expert practitioners are much more inclined to feel that change has made them more efficacious. Here is a senior school leader, director of sixth form, talking about a move to a new building:

> The initial change to a separate building allowed me to develop an 'ethos' of sixth form study to grow. It also allowed better delivery since it was a specialized area. We had time for more

> personal relationships, between staff and staff and with students, particularly on the pastoral side. It is a difficult time for students making that transition from school to university ... and we could carry out more specialised work procedures; we asked for and were given our own suite of computers – the kind of thing particularly relevant to sixth form. So, I would say that the separate environment allowed greater efficacy – for everyone. (BP, Sixth Form Director)

Again, this is an example of a practitioner having a central role in the design of the workspace, and the perception of an increased efficacy which that brings. There is a constant thread of concern from practitioners for the needs of the client, as can be seen in these words from a GP:

> The new build had more space, for students, for conferences, for patients. We designed ten surgery spaces all around a central hall. There was more space and more privacy – this was us thinking about patients' needs. (MJ, G P Partner)

This GP partner is identifying the focus of his GP practice on improving the experience of the surgery visit for their patients. A hospital nurse also demonstrates this focus of the expert practitioner on the needs of the client:

> Cancer patients used to arrive in A&E and not come to dedicated place – so now they come to a specialised area where there is haematology and cancer ... cultural education ... and all this has made pathway changes for patients. It is a much better experience for patients. (AG, Senior Trust Nurse for Oncology)

She explains how a pathway has been created for cancer patients, which means that instead of their initial arrival being in A&E, they now have a dedicated space, which is more private, calmer and therefore less stressful for patients. This change has sprung from the staff's knowledge of their patients' needs.

In Education, too, the needs of the pupils are paramount:

> But the school is evolving to make everything better – i.e. our dining area has more American-style seating – it is quick and accessible to change and can be packed away – we need outside covered spaces – to be a bit more – I'm not going to say 'trendy-er' (smiles) but it's all done to give the children more comfortable places, informal spaces – and static table tennis

> tables are to be introduced to give them something to do. (SP, Senior School Leader)

In this school, as in the schools, universities, GP surgeries and hospitals already mentioned by participants, it is the design of the informal areas which is of interest to my participant. The school leadership team are ensuring that pupils are given more comfortable, informal spaces. The dining space is adaptable and attractive. However, sometimes the attempt to provide healthy, happy spaces for clients/patients to eat can go awry, as in this hospital, where the patients show their own capacity to subvert an environmental decision made without their involvement:

> Eating places for patients are important. We, it's horrible to say it, but we have a Greggs which is not healthy at all … you see, in the Heart Lung Centre there's a beautiful outlet there. It's called 'Escape' and they do healthy choices – just a snack bar like Costa – it's not Costa but like that, but its healthier ... so it's got fresh baguettes, salads, fruit salads, healthy foods and guess where the queue is? … Round Greggs! (EC, Nurse Director)

So, Gregg's wins, at least, for now.

5.1.4 Workplace Change: Subthemes

Following Braun and Clarke (2006), the themes most commonly raised have been categorized in this investigation. However, I felt that two further subthemes, although low in frequency of occurrence, and nested within major themes, raise issues that are worthy of consideration.

Subversion

Subversion appeared as a response to top-down directives, often, but not exclusively, about the use of space. Practitioners in both Health and Education were prepared to circumvent instructions, rules, with which they were not in agreement. Office spaces were turned into canteens by the introduction of a fridge; dogs and parrots were brought into wards, and virtual reality platforms allowed freer communication.

Informal Spaces

The loss of informal spaces to meet both with clients and with colleagues was felt dearly by some participants. New builds were streamlined for space efficiency and had no 'nooks and crannies'. There were no undesignated spaces to be taken over and fashioned to the liking of participants. There was less opportunity for unscheduled meetings with colleagues. The importance of the need for informal spaces to allow communication is supported by the findings of Clarke (2017) in her work with a therapeutic community.

The increase or improvement in informal spaces in their particular workplace was welcomed by others, and it contributed to their feelings of efficacy. Doctors could carry on conversations with each other in wider hospital corridors, and teachers could create a safe space with 'a cup of tea and a cuddle' for challenged pupils.

5.1.5 Summary

This section has examined the words of participants regarding their experience of changing environments. Where they have control, expert practitioners will move their working environment towards a more relational, less hierarchal arrangement, which they perceive as improving morale. Where they do not have control, they will attempt to subvert the system. They perceive open communal workspaces as offering a more appropriate workspace for contemporary society, and show a great interest in and sadness for the passing of informal spaces where colleagues could meet and talk. Government initiatives using a mixture of public and private capital to fund new builds has had the unintended consequence of exposing expert practitioners to the vagaries of the commercial marketplace. They, in some instances, are struggling to be successful landlords and business managers and resent the way this role takes them away from their clinical practice.

5.2 Technological Innovation: Factors Affecting Efficacy

There is a substantial body of academic writing that addresses the significance of technological development, whether in equipment to support the delivery of Health or Education, such as whiteboards or electronic blood pressure monitors,

or in the software to track the appropriate application of health and education policy, such as electronically-measured target compliance, as an important factor in changes in public services.

O'Neill (2000) contends that advances in technology are significant drivers of institutional change in the 21st century. Osborne and Brown (2005) propose that technology is an important driver of public service change in that it realigns work organization, connects groups separated by distance and gives rise to new organizational forms such as 'boundaryless organisations' linked through 'cyberspace' (Osborne & Brown 2005:55). These 'boundaryless organisations' are the product of the alteration in the way space and time interact in the workplace due to technological developments such as video conferencing, email and Skype. They allow much of the work of public services, particularly executive functions involving decision-making, to go on without the necessary co-presence of early modernity (Giddens 2013). Armstrong (1998) sees a clear link between the use of cutting-edge technology and economic advantage in the world marketplace, arguing that information and communication technologies have made knowledge a major source of competitive advantage in the public service. Interview comments from practitioners in this field study also show that technological advance is important to practitioners in both sectors, and had altered their experience of their practice – enhancing the success of the application of their skills. However, communications technology had had a detrimental effect and reduced face-to-face contact and increased friction between the client and the practitioner. There was disquiet in both sectors about this. Technology was seen to be adding a great deal to the successful practice of each profession's skills. Advances in technology underpinned clinical practice in ophthalmology in haematology; in Education it had transformed the classroom; interactive whiteboards, shared web-based worksites, YouTube and flexible classrooms had altered and added to the repertoire of the teacher. The Internet allowed vastly improved access to information and to other colleagues.

5.2.1 Technological Innovation: Data Analysis, Quantitative

A theme which ran throughout the transcripts was the influence of technological developments on the substantive practice of practitioners in Health and Education. Technology occurred as a theme at a high frequency of 140, however, it did not appear linked to either the themes of relational or of systemic change. It was not seen as a part of a deliberate attempt to change either the workplace or work practice, rather as result of scientific and technical development, an inevitable part of social progression, with far-reaching consequences. However, technological advances can be seen in the responses of my participants to be divided up into three strands. These are: firstly, how technology supports work skills; secondly, how technology affects training adversely; and thirdly, how technology affects communication by reducing face-to-face encounters.

Participants certainly welcomed the improvements in their work practice made by technology. However, they were less positive about the effect of technological change on communications in its use as a vehicle for the collection of data about work practice, finding it intrusive and misleading. They also felt that collecting this data took them away from the focus of their work, the client.

Technological change can be seen to concern developments in the equipment which facilitates the professional practice of the expert practitioner, such as blood pressure monitors, scans, whiteboards and computer-led learning. It is perceived by participants separately from the technology which facilitates communication, such as email and phone, and is also perceived separately from software which facilitates the gathering of target-led data. However, there are crossovers – at what point does monitoring vital signs become a piece of target-led data rather than information appertaining to the progress of a patient's recovery? In this study, after the iterative process of examining the thirty-six transcripts from participants, it has been understood that, to expert practitioners, technology only becomes a phenomenon they describe as data when it is gathered from a quantity of clients, i.e. students, pupils or patients, in order to observe the success and efficacy of practitioners for an outside body such as the CQC or Ofsted, when its purpose is to assess the practitioner, not to assess the client. It is the end use of the data, not the data in itself, which denotes in which category it sits.

Table 6: Technological Innovation: Frequency Distribution

Technology Change: Comments			
	Participants	Frequency	%
Health	14 of 18	62	44
Education	16 of 18	78	56

Technology Change: Effect on Efficacy			
	Frequency	Efficacy Increase	Efficacy Decrease
Health	62	23	0
Education	78	39	0

The change in work practice and workspace towards the use of technology was commented on 140 times throughout transcripts, in response to any of the guided questions, and is therefore described as a free theme. It is the most frequently occurring theme in this research, and participants described the use of technology in classrooms, in operating theatres and consulting rooms. The increasing use of more sophisticated technology to support practice was overwhelmingly seen to be a positive phenomenon, particularly by education participants, who had embraced the use of technology like whiteboards. However, while there were no comments which rejected the use of new technology, there were ten comments which could be described as ambivalent, in that technology was seen to be both a useful change and a danger, a factor which could cause problems if not managed properly. Although positive comments were made, they were followed, in some cases, by a rider: pupils could suffer 'death by interactive whiteboard' and patients could be 'preceded by their data' wherever they went. These ambivalent comments came mainly from the Health participants and expressed their unease at the depersonalization of their work practice and relationships.

5.2.2 Technological Innovation: Data Analysis, Qualitative

These participants showed an awareness of the need to embrace new technologies, as the words of this head teacher demonstrate:

> Back to the environment ... cause of change? I think it is a combination. Technology is such a part of society and there are such opportunities for technology to enhance learning now and

> internally schools have worked very hard to respond. (SH, Assistant Head Teacher)

and this hospital consultant:

> Technology has had a huge impact ... we are now delivering a lot more technically-driven care if you like ... both in terms of diagnosis and in terms of treatment. We rely a lot more on technical gadgets than before ... We can be more exact. Science is what we can deliver. Technology has supported delivery. (KN, Hospital Consultant)

But technology, although neutral in itself, brings with it unexpected consequences, as described by the same consultant, who goes onto express the ambivalence towards technological development which a substantial number of participants expressed:

> Gradually I have seen a dependence on technology in preference to clinical skills. One could easily call it a worrying trend or a welcome change. I don't know, I have my reservations. We have been giving so much to technology that now we would be totally lost without it. New technology is to us what fire was to our ancestors. Before you had fire everything had to stop at dusk but then fire came and you became dependent on fire. Similarly, now, for us with technology ... yes ... clinical skills, that is lost and that is a big worry. (KN, Hospital Consultant)

If the practitioner in Health and Education is relying on technology to disseminate knowledge, to diagnose illness – where does the role of the expert practitioners sit? There is a sense of a 'losing of place':

> All the work is put on the Internet. The teachers have iPad technology in the classroom students use their own mobiles for analyzing performance in PE or technology classes ... but it has very much shifted the emphasis because the students are the experts ... it changes the relationship between staff and students. (MA, Head Teacher)

The same effect is felt by practitioners in Health:

> Now they come to me with ready-made ... 'I have checked on the Internet I have an anterior' ... The patient has changed now. Many patients are very well informed ... they are not looking for

> my advice, they are looking for an end product. (KN, Hospital Consultant)

In the best scenarios, technology brings the client and the practitioner together:

> The way that we record data, the way we can track data, that is a massive move to technology now. We can identify a number of students who are underachieving in certain areas, we can move quickly. The days when people came to a meeting with their mark book – that wasn't good – that wasn't an efficient way of identifying a problem. Technology has absolutely underpinned this change in work practice for me – that is very important. (SH, Assistant Head Teacher)

Here, technology as a change in the workplace can have a positive effect on the work practice of the practitioner – when it is under his/her control. John Tomsett, co-founder of The Headteachers' Roundtable think-tank, addresses the need for practitioners to have control over the data producing technology used in their workplaces, by suggesting that data can help us ask better questions; and he warns that 'if we don't use the numbers in this way then simplistic, crude interpretations of assessment will create a culture of fear: teachers will play it safe and stop developing their practice (Tierney & Tomsett 2016).

So, technology can be seen to have the potential to be intrusive, not supportive, and teachers, according to Tierney and Tomsett (2016), have to guide those who interpret statistics about their performance to be more sophisticated in their analysis. For general practitioners, even before these statistics are gathered, the very presence of the computer in the consulting room is having an effect on their relationship with their clients:

> Because one thing a patient doesn't necessarily want to do is to be with a doctor typing away on a keyboard – 'I've come in with my rash and aren't you going to look at it doctor?' – I believe its slowed consultations up – I find it quite difficult (WR, GP Partner)

The PC is the third presence, the third person in the room described by Solomon's participant GPs (Solomon 2009). For these GPs the computer in the consulting room is the surveying eye of the policy-maker and directs the attention of the

expert practitioner away from the client in front of them towards the targets set by the government. Face-to-face consultation becomes a three-way connection, with the client becoming the third and least important party.

5.2.3 Summary

The perception by participants that their environment is changing towards being more relational and more led by practitioners and clients seems to lead to a commensurate perception of greater efficacy. In contrast, a perception that the environment is changing towards support of systemic needs, and that that change is being led by policy-makers, leads to a perception amongst expert practitioners of less efficacy. Technology is understood to be an important driver towards change: it can offer a quicker, better, more accurate measurement of a patient's needs or a student's success, but can also lead to issues such as the development of a culture of fear through the crude use of statistics in the form of targets to police the expert practitioner and to shape behaviour. This is the tick-box culture so hated by expert practitioners in Health and Education.

5.3 Work Practice Change: Factors Affecting Efficacy

5.3.1 Work Practice Change: Data Analysis, Quantitative

Table 7: Work Practice Change: Factors which Affect Practitioners in Both Health and Education

Work Practice Change Factors: Efficacy Increase				
	Prac/client	Systemic	Relational	Policy-maker
All	23%	12%	54%	11%

Work Practice Change Factors: Efficacy Decrease				
	Prac/client	Systemic	Relational	Policy-maker
All	13%	34%	22%	31%

Table 7 demonstrates the percentage distribution relating to increasing and decreasing efficacy for both public sectors for work practice change. As with data on workplace changes, there is a highly significant code co-occurrence between work practice change being towards the relational, being client-practitioner led and a perceived increase in efficacy. There is a highly significant co-occurrence between work practice change being towards systemic, being policy-maker led and a perceived decrease in efficacy ($x^2 = 82.50\ p < 0.0001$).

This makes evident a clear tripartite link between (a) the perceived direction of change; (b) the instigator of that change; and (c) the effect of that change on efficacy. Again, it is worth noting that this was made more significant by the design of the interview in which these topics were discrete, introduced at different points of the interview, and where the participants were not led to link them together, but did so spontaneously.

Table 8: Work Practice Change: Factors Affecting Efficacy: A Comparison between Health and Education Practitioners

Work Practice Change Factors: Efficacy Increase				
	Prac/Client	Systemic	Relational	Policy-maker
Health	19%	13%	56%	12%
Education	29%	12%	49%	10%

Work Practice Change Factors: Efficacy Decrease				
	Prac/Client	Systemic	Relational	Policy-maker
Health	14%	32%	24%	30%
Education	11%	39%	18%	32%

Table 8 makes it clear that a similar pattern showing links between the form of change, the causes of that change and perceptions of efficacy exists in both sectors. For practitioners in both Health and Education, relationality and a sense of autonomy are linked to an increase in perceptions of efficacy. Again, there is a reverse mirror image where an increasingly system led work practice with less autonomy leads to a perception of reducing efficacy.

Table 8 demonstrates the percentage distribution relating to increasing and decreasing efficacy for work practice. Both education ($x^2 = 37.56\ p < 0.0001$) and health participants ($x^2 = 50\ p < 0.0001$) show an independent and highly significant relationship between work practice change being towards the relational, being client-practitioner led, and a perceived increase in efficacy. It also shows that there is an independent and significant relationship between the education ($x^2 = 10.9\ p < 0.001$) and health responses ($x^2 = 6.88\ p < 0.01$) regarding work practice change being towards systemic, being policy-maker led and a perceived decrease in efficacy.

5.3.2 Work Practice Change: Data Analysis, Qualitative

What do practitioners have to say about their changing work practices? What daily events do they use to describe these two related trends? The tripartite link between relationality, autonomy and increased feelings of efficacy are made clear in the words of this participant, a head teacher from the midlands. When asked in what way had his workplace changed, he was positive about it. He had implemented a more relational work practice in his school:

> The role of the head teacher is changing. There is a recognition amongst head teachers now that we have to get back to our core business. Five, six, seven years ago a head teacher would say 'I am strategic – you won't find me in a classroom, I am managerial'. That has changed and I am clever enough to know that whatever I attend to they (the staff) will attend to – 'Teaching and Learning' is the core business – I will give you a concrete example (gives work book to FB). I wrote that book – basically, I have described what a good lesson is, what a good plan is and I talk endlessly with staff and every week we observe staff – all senior staff do this – on timetable: there I am (points to timetable). Every fortnight we are watching lessons – there (pointing to timetable) we are looking at English, German, A-level sociology – and there – we are observing together to standardize and to improve the skills of the co-observer … Almost 50% of the staff do observations – heads of departments, key stage heads, the management team, and in addition to that we have peer observation. If we are teaching in modern languages (in addition to being head he is a member of the modern languages team) – and there is something you want to share, you might say 'come and see me next week'. I am observed … everyone is observed … that's a change. (CM, Head Teacher)

This change to a more relational, collegiate practice was put in place by him and his colleagues. This kind of observation is not the judgmental eye of the policy-maker, but part of a supportive work practice:

> What has driven that change? It is that complete focus on teaching and learning. We see the feedback as important not as a judgment but you say 'Listen to that bit ... that develops you as a fellow colleague ... they are here to help you not to put you down'. I say, 'In time they will be watching you and they will be learning from you …' After school meetings? – none! Except for one after-school meeting on pedagogy. We have some breakfast meetings … having a dialogue between staff is important.
> (CM, Head Teacher)

He is sure of his own input into this change:

> Yes, I made the decisions. I guess I have picked up changing mood and tone from fellow head teachers, I have definitely been picking that up, but much of it has come from me. (CM, Head Teacher)

And the upshot was an expert practitioner who felt more efficacious and positive about his role:

> Work practice? More efficacious? Yes. At my level, as a head, there is no come down, nobody is telling me what to do. Let me qualify ... there are parameters within I must work ... legal, employment law, so yes, those things fashion my strategies to some degree but I have a huge autonomy. I can stand on my head if I want to – I have a school improvement partner from the local authority to check up on me, but he is not my superior and I have a governing body, but governing bodies only know what the head teacher tells them ... turn the recorder off and I'll explain ... (CM, Head Teacher)

Perceived self-efficacy for this participant has been underpinned by his judgment that 'he has huge autonomy'. This perceived freedom makes him a proactive head teacher, able to undertake and perform with assurance actions he judges himself capable of managing (Bandura 1977). At this point in the interview, he asked me to turn off the recorder as he wished to share some of the strategies he used to ensure that his decisions were enacted by unwitting officials. He recounted the

anecdotes with glee, and here was another example of the subversive nature of expert practitioner behaviour, when faced with obstacles to what they consider good practice.

Contrast this experience of headship with that of this head teacher, whose school has recently become an academy. Far from enjoying the new found professional freedom, which that was meant to bring, she now feels that her work is controlled even more closely by policy-makers:

> Work practice change? Massive. It's government – the change to environment is exciting, it is to do with people. But changes to my role are from top down. I have a live Twitterfeed getting a daily update from the government; there are eight pages of changes every week coming. I consider myself as someone who keeps up to date with national developments and, although we are an academy we have to be judged by the same national outcomes, like private schools. But in terms of keeping up to date and communicating, filtering the changes coming in to the people who need to know is one of the biggest challenges I face every day. (MA, Head Teacher)

She is capable of leading change and managing her school:

> I have a strong idea of what I want to do – but I am hampered by the government. I find that with this government (Coalition 2014) the planning side, well it's become a challenge. My plans have to change all the time – my plans are now fluid – I get emails from the DfE about changes on a Sunday night – never happened before. I went to a conference recently – and I watched the team behind Michael Gove as he announced a change – they were suddenly all on their Blackberries, tapping away. One head teacher I spoke to afterwards said – 'Yes, nobody knew he was going to say that!' (MA, Head Teacher)

There is a feeling that policy-makers do not have the professional expertise or organizational skills to direct the public service of Education. She is frustrated by the arbitrary application of practice change, without consultation with the expert practitioners in the field:

> And there is this ethos that comes from them that 'one-size-fits-all' You will carry on doing your Eng[lish] and maths until you get it – but I have children here who will never get it (GCSE) – then they have taken away tiers of exams and now we have one

> long exam – three hours – when we queried it they said give them a break in the middle – take them for a walk in middle! (MA, Head Teacher)

She describes a Kafkaesque nightmare of top-down, arbitrary, micro-management:

> (Interviewee becoming animated/outraged here on) Because I know, and it is awful, that there are certain criteria to meet or boxes to tick and if you don't nail those … it… whatever happens nothing else we do matters because the category you are in if you don't hit those boxes, if you don't – my problem is that the government keeps changing the framework we are working towards each term. My frame work used to be planned for over five years now I have one a term. (pause) There's no triangulation, though – when I plan things and you look at the key stake holders, the students – and if you are not doing it for the students and that's it – when the government comes out with the next thing I have to ask - how does it link with the Ofsted framework? School improvement and raising standards? How does it link with students making progress? Because that's what it should be about and they are forgetting that the clients we deal with – the students – are all different. (MA, Head Teacher)

In the Health sector, another practitioner struggles with a policy-maker led, systemic change brought to bear on the daily routine of a hospital in one of the largest trusts in England.

This participant has a senior role as nurse director in this trust and has a national reputation for her innovative work. She describes the way in which wards are not dedicated to one medical or surgical discipline, partly because of the increase in elderly patients with co-morbidity, and partly for cost reasons. She also describes the changing structure of nursing rotas, explaining that public perceptions of these changes mean that patients feel that they are not receiving good, continuous care. First, she described the fragmentation of the attention given to patients caused by improvements in surgical techniques, but also by a cost-led drive for the efficient use of space and nursing personnel:

> We have eight to ten consultants on one ward, not just one. Our nurses work three 12-hour shifts a week, and are off for four days. A patient stay is on average three days, in the 80s it used to be twenty-one days for a gall bladder operation. This means

> that they may only see a particular nurse once. That whole 'getting ready for surgery', you came in the night before, then after the operation your time was spent on the ward, rehabilitating etc., that's gone. The world is more transitory now. Because of that, nurses spend more time admitting and discharging patients than caring for them. In the old days, you would see a patient coming in, take them to theatre, be there when they came back and probably work another three days and see them. (FK, Nurse Director)

Nothing can fully replace that continuity of care, but she has produced a directive for all hospital staff that they should see themselves as having the right, the capacity, to do a 'care round'.

> Yes, everyone can do a care round ... if you go into have an interaction with a patient you should not leave the patient in a less stable, less balanced place. Everyone can do a care round not just a nurse. Any doctor or physio that goes can ask 'Is there anything you are worried about?' You don't have to have the answer but you can signpost to someone who has. At every opportunity, you can ask, 'Do you need a drink?' These sorts of things are key. (FK, Nurse Director)

She has taken the opportunity to move the work practice of the whole workforce towards the relational in order to combat the effect of fragmented care imposed by a systemic change to the work environment brought about to rationalize the lack of nursing staff. This is an example of an expert practitioner actively changing the work practice of her staff, which had been moved towards the systemic by policy-makers' decisions around finance, back towards the relational, in line with her perceptions of good care.

Here is the voice of a senior school leader explaining the collegiate approach that has been put into their school to deal with behavioural issues:

> We have an intervention scheme which is cracking – really addresses the needs of the individuals – lead by middle managers – there were CPD opportunities there – they came up with individual learning programmes for the students which were causing concern – we were – all the subject leaders got together and setting up which subjects were going to have them ... it was very proactive ... it was not people saying '10B are driving me round the bend.' Nowadays it is 'Ken Colclough is driving me round the bend, let's look at what we can do and see

> if other people are having the same problems with him'. (BS, Senior School Leader)

This is an example of the way in which my participants describe events in their working lives which express their perception that practitioner-led intervention towards the individual, coupled with privileging the relational aspects of a situation, can lead to a more efficacious work practice. The impression is given of a well-motivated team; the language is inclusive: 'We have an intervention scheme' and ... 'all the subject leaders got together'. The description of 'Ken Colclough' immediately conjures up a picture of this difficult, individual pupil which the generic denominator '10B' simply does not; BS is making a witty but apposite vignette, encapsulating the ethos of the concept of 'individual learning'. She goes on to describe this in more detail below:

> You have to address the needs of individual learners. Looking at pupils not as a cohort or a group, but it is an ethos – independent learning, individual learning. We are seeing these pupils as individuals. I think that staff are having to understand the way in which young minds are working more than ever before – we have a strong behavioural side here – strong team of support staff, so work is shared down the lines so we can address the needs of individuals. (BS, Senior School Leader)

Again, we are hearing about a team with good links to each other, working together so that this more relational way of teaching can be delivered through team-led decisions which will in turn lead to a more efficacious working practice. This good practice is able to flourish because government funding for CPD opportunities in managing the initiatives Individual Learners and Assessment for Learning have been made available, thus shaping the management objectives of the secondary school as an institution, but not stifling the entrepreneurial spirit of the expert practitioner (Perkin 1989). Contrast this useful interaction with the picture drawn here:

> Everything is so results driven, you know that if your results are in the slightest bit changed, it could go either way ... Ofsted is always there ... We were hearing in a meeting that this is a fantastic school but there are going to be 'no notice' inspections. They (Ofsted) can't do the no-notice inspections to the same criteria as the week's-notice inspections, otherwise it will drive even more people out of the profession. Good teachers, a lot of

> my colleagues who have been teaching since they left university, are being ground down; they are trying to find any way to get out. (BS, Senior Team Leader)

This is the same participant talking about the same school, but the emphasis here is on the top-down intervention of Ofsted and the fear and dismay caused by arbitrary changes in rules which determine the status of the whole school. This is policy-maker led intervention, which is perceived as serving the system, not the relationships between those practitioners whom it will effect. According to this participant, the result is that 'good teachers' will leave, as their perception of their work practice becomes that it is less efficacious and they lose their professional confidence.

In the work practice of Health staff, the same contrasting experiences can be seen. A GP has been explaining the variety of calls upon her time, including demands from data to underpin funding and increasing demands from patients for consultation time. Now she describes the fear she feels at missing something vital because of her workload:

> There are so many tiers of how people are communicating to me now ... there are so many ways they are doing it ... of course what is hanging over you all the time is that worry that ... if I just miss that phone call ... if I miss that phone call … if I just miss that day book message ... those are the results I have to act on ... is that the result I have just missed? I don't think about litigation or I couldn't do the job ... but my husband (a GP in another practice) will come home and say 'I don't know if I've ticked all the boxes, I don't know ...' that sort of thing. (WR, GP)

The fear she is expressing echoes the fear felt in the voice of the senior school leader, BS, who realizes that the inspection body in Education, Ofsted, have moved the goalposts. Policy-makers, with their legislative power, can instigate fundamental changes to work practice in our public services. The direction of these changes is not in the control of the expert practitioners, yet they are required to instigate and maintain these changes, changes which carry with them the threat of arbitrary punishment. Another senior school leader describes the cycle of fear

which occurs when the autonomy of the expert practitioner is replaced with an unreasonable accountability:

> The wider aspects of opening students up to opportunities, still having that concern on the ground and knowing the students as individuals, I have just seen eaten away ... by the academization process and its total reliance on 'We are a big academy chain, here's the folder, this is how we do it' and the climate of fear – fear! Where everyone feels that they have to record everything in triplicate. People printing all their emails and storing them because they might have to prove that they have or they haven't done something to somebody. (SH, Assistant School Head)

This fear causes not only an increase in defensive bureaucracy, but an eating away of what is the core of education to this participant, that is, 'knowing the students as individuals'. And so, Ken Colclough will fade back into 10B and the opportunities which would have been afforded him by an individualized programme of work will be blown away on triplicated sheets of data. And, the pleasure and satisfaction of relating successfully, with a professional purpose, to a client will have been lost to the expert practitioners working in this system.

There is a dichotomous nature to the commentary made by these expert practitioners, often be found within the same transcript, as with the senior school leader, BS, who described above a good behavioural management programme set up internally, then went on to describe the negative experience of Ofsted. Practitioners report that they are experiencing a wide range of responses to the changes to their work practice. Some good, some bad. This can explain the ambivalent results of the frequencies of measurement of efficacy, which, although it indicates eighty-six instances of commentary which supports that work practice is becoming more efficacious because of change, also offers sixty-four instances of commentary which indicates that work practice is being made less efficacious by change. The dichotomous nature of the responses of individual participants is an important indication that positive or negative responses to change are not driven by individual affect or personality types, but by externally driven, independent events.

The links made by code co-occurrence, however, make the reasons for this dichotomy clear. When given, or when they take, the opportunity, to have control

over events, expert practitioners can have a productive experience of change at work. An increase in efficaciousness occurs frequently with an indication of change towards a relational way of working, which has been led by the practitioner or/and the client. A decrease in efficacy is often linked to change in work practice, which is beneficial to the systemic organization of the work practice, to the detriment of the client/practitioner relationship. These widely differing experiences of change are again expressed in the responses of this individual participant. As another example of this dichotomy, here are two excerpts from a GP who is describing work meetings. First she describes her own arrangements for further training, which was delivered by other practitioners, and had a positive effect on her practice:

> For example, I went to a Hot Topic course in the autumn in Liverpool. It was well worth my time. If I didn't do something like this I would lose my spark, you come away with a CD and a reference link to a website and then I can input that ... that's really helpful, doing things like that. It's always a group of medics or GPs who run these courses. Without linking between professionals, it would be very hard to do this job. We had an evening meeting here with a cardiovascular surgeon with other colleagues from around here … that was good. (WR, GP)

She is demonstrating the practitioner-to-practitioner relationship and the way in which it is essential to her practice as a doctor. In one case, she is leaving her surgery to attend training which is directly related to her clinical skill set as a GP; in the other, GPs are coming together in her surgery to listen to another specialist colleague for the same reason. This is practitioner-to-practitioner work, which is relational in its nature, and which allows the sharing of expertise, and which she describes as enhancing her perception of her own efficacy.

But, in the next excerpt she is describing a very different meeting, in relation to the reorganization of NHS funding by Health and Social Care Act 2010, which requires her presence, or the presence of one of her colleagues:

> And one of my partners goes off with of our practice manager to all of the CCG meetings. And suddenly ... he's been sitting there passively and suddenly they've pointed at him to take on a big role ... and I feel for him ... we've all had to take on something (in management of commissioning under the Health and Social

> Care Act 2010) and it's not necessarily your choice. What we feel should be the rock, the bedrock of practice, should be the clinical practice. I am not saying I don't see the value of the other things but they pull us away from what is most important in the job
> (WR, GP)

Top-down organizational intervention is seen as having a detrimental effect on the work of the expert practitioner. This GP is not made more efficacious by it, nor do these meetings extend the opportunity for him to build relationships with colleagues. The doctor sits 'passively' in the hope of not being noticed. This is not the active responsible behaviour of a professional; rather, the response of a disengaged school child – a Ken Colclough, perhaps? The doctor is 'pointed at to take on a big role' and it is clear that the policy-makers have the lead in this transaction. The introduction of CCGs through the Health and Social Care Act of 2010, a political decision which purported to empower GPs, has made them perceive themselves less in control and less efficacious as they struggle to cope with the unwelcome demands of commissioning. This participant suggests that GPs are caught between a public who is more demanding, with expectations fed, in their perception, partly by government initiatives encouraging more patient contact, without allowing the time for it to take place:

> I think the government driven aspect (of increased patient demand) is huge because at the end of the day if you go back several years they are the ones who drove the patient expectation up ... in matters of open access, feeding back on your GPs ... but politicians may not recognize what is sustainable here ... if they just gave us the time. (WR, GP)

Running in tandem with these initiatives to increase access for patients are government initiatives to increase accountability and assessment. These initiatives require a completely different focus from the practitioner, as more time has to be given to 'box ticking' (WR, GP) and to work on the government requirements for Compliance for Clinical Quality Commissioning:

> I feel we are drowning under the amount of work which we are meant to be taking on ... but if you don't comply you would lose your licence to practice – there are a whole raft of measures which apply to a reapply warning (similar to Special Measures for schools) – several practices have been closed, haven't they?

> GPs who want to make an objection (on the grounds of their professional judgment of the process) would lose their licence. I feel we are boxed in to a corner in that way. (WR, GP)

This doctor's fear is similar to that of the senior team leader (BS) who may want to non-comply with some of the new demands of no-notice inspection by Ofsted. If she does this, the school is immediately rated down and so loses its standing on performance league tables, or, in the worst-case scenario, is put into Special Measures. And, if that happens, the following scenario, as described an assistant head teacher (SH) could result:

> Ofsted require that you produce enormous, vast arrays of tracking data, that you have identified issues and that you have addressed those issues and that you are measuring impact … very much short term impact ... if you are a school in Special Measures, you are expected to review your emergency plan data fortnightly ... it is up on what is called in some schools the 'war wall', because that's what it is ... a battleground.
> (SH, Assistant Head Teacher)

In the last ten years, programmable technologies have become increasingly evident in the monitoring of pupil performance through national testing EACEA (2009). Health workers have also become 'informative' workers Duckett (2005). And so, the dilemma continues: how to apportion your time to produce the amount of data required to satisfy the measurement of your practice by external government-led bodies, and how to also satisfy the greater demands for one-to one-contact made by those same government bodies, but also by the patient, the student and the pupil:

> My practice manager and I have spent hours preparing for Clinical Qualities Commissioning and I need to set even more time aside ... I think all of us make ourselves accessible as we can be, but the general trend is towards more accessibility, isn't it? ... So, they (patients) do ring up and they and they do try to have a more personal relationship, which can be challenging. (WR, GP)

One AST describes this dilemma as evidence of a larger conflict. First, he talks about the specific effect of the policy led demand for data, which in turn, he suggests, produces a conformity of practice:

> The work practice of teachers has narrowed down quite a lot – teachers used to decide what they did in a class room – I have noticed over the years what happens in classrooms is more prescriptive; there is a 'What, When and How' to teach now – there is much more control, much less spontaneity and the ratings percentages are all important. Frankly, that (the ratings percentages) is an abasing and a corrupting influence. In our school, recently all resources are going into English and maths to alter the [School League Tables position] figures but there is no investment in training in how people learn, what is good practice
> (BC, AST)

His argument that the School League Tables are an 'abasing and corrupting' influence is reinforced by the words of an Assistant Head Teacher who has seen this top-down, policy-maker-led drive towards the improvement of ratings at all costs in the schools where she has worked:

> It is my personal belief that most Ofsted inspections could take place without anybody walking into a building – they come with a vision of the school based on data. If you have good data and they see things they are not happy with then they assume that's a blip and if you have bad data and they see brilliant teaching, then they assume that it is not happening all the time. And you are in a constant battle to fight that corner with them. It is short term … you may have an impact in twenty years' time but that is not in Ofsted. The data only tells them one aspect of what real education is. (SH, Assistant Head Teacher)

For her, this battle and the dissonance it creates, is seen to be between the senior leadership team, their professional ethos, and the external examining body, Ofsted. But BC's second point is that he sees it as having a broader significance. He sees the present situation as a struggle, a clash between two demands: on one hand, the top-down control demanded by ever closer scrutiny on teachers and, on the other, the move to a more egalitarian society driven, in his view by information technology and its influence as a levelling factor. While agreeing that there is a battle, he sees that the dissonance in the teaching profession is caused by a build-up of pressure between two structures – the system-faced structure of the school, imposed by top-down government directives, and the changing social structure which brings other pressures to bear on the teacher:

> The role of the teacher is definitely changing, underneath (all this government intervention). All parents, not just the fluent educated middle-class ones, feel the right to challenge the teachers' judgments. On the one hand, this is a development in greater society, i.e. parents, children and some of the teachers too are challenging traditional roles and relationships and so on ... (BC, Advanced Skills Teacher)

We are no longer inclined to go to one 'expert' for an answer but to many for a 'debate'. A sharing of ideas and good practice (Reedy & Goodfellow 2012). This advanced skills teacher went on to say that in this world:

> The teacher as someone who stands at the front and delivers the truth is quickly undermined ... because the students and their parents and the teachers don't believe that and so there has been the development of the teacher as a facilitator ... a guide. (BC, Advanced Skills Teacher)

He describes what he sees as the absurdity of the mismatch between this naturally developing state of affairs in the classroom as the teacher becomes 'the facilitator', but then is only allowed to deliver the imposed system of the four-part lesson:

> But the four-part lesson is not anything you see in the real world – teachers themselves go out of the classroom, go into their departmental offices saying 'What worked with so and so?' What did you do? Would you help me with this and I'll help you with that'. Immediately, working in a cooperative, intelligent way – having just had kids sitting in rows ... sitting there and waiting while they (the teachers) tell them something from a four-part lesson plan. (BC, Advanced Skills Teacher)

He explains the disenfranchisement of the parents from this world of imposed systems and intimates that change will eventually have to come:

> Pressure (towards a less prescriptive teaching system) is coming from outside – from students, from parents. From the reflections in the media. Not from the government, because the government is Ofsted, with its very 'here is £15,000 for networking infrastructure' – specific directives – (short term, not the whole picture) – whereas the student and their parents feel they are living in separate worlds. The pupil calls his teacher a Dickensian 'Sir', whilst in the real world, the parent calls his boss by her first name or by Mrs Jones. (BC, AST)

This is a clear description of the dissonance perceived by practitioners to be at the heart of the teaching profession. Firstly, there is a drive to greater relationality from wider society, expressed clumsily by government through policy initiatives such as Assessment for Learning, which may or may not be enacted well by individual schools; and simultaneously, there is a greater demand for accountability and control enacted through the new technologies of data gathering and surveillance and again supported by government initiatives and legislation such as School League Tables and Ofsted inspection regimes. The first requires more face-to-face encounters with clients, more emotional labour (Hochschild 1983), and the second requires the completely different (diametrically opposed) skills of data gathering and audit (Zuboff, 1988). In schools, GP surgeries, universities and hospitals, wherever these two public services of Health and Education function, they are under the strain of feeding this two-headed hydra.

A consultant describes a similar development in his work practice, and how the combination of these two pressures impacts on his practice as doctor:

> So, the teaching role for consultants has increased, we are talking to colleagues, younger colleagues, more, actually talking to them about their experiences, their reactions I suppose, we didn't get that. This has its problems … it takes time. We spend more time talking to patients too. There has been a big change in through put. It's changed … We see [fewer] patients, because of all these checks and balances. We have to give a lot of explanation and a justification of our actions – there's a big difference from past. When I first started, colleagues then didn't get questioned all the time. There wasn't this atmosphere of … of … what they call, what everyone calls … accountability … you have to count everything ... you are accountable, anyway. We always were. Doctors did their best and that was that.
> (CM, Hospital Consultant)

The last sentence – 'you are accountable anyway. We always were' – encapsulates the ethos of the professional practitioner (Perkin 1989). Accountability is built in to the work that is being done and 'having to give justification' of their actions takes the practitioners away from their actual practice. This consultant states, 'you have to count everything', and that simple statement carries with it connotations of the arbitrary nature of the data gathering now being requested. You 'have to count everything', and there is no

discrimination as to what you count: it is the process which matters. A process underscored by the development of increasingly sophisticated data-gathering software like Cometrica, which makes anything 'countable'. He is, however, 'talking more to younger colleagues' and 'spending time teaching them', which would seem to offer a more relational way of working; but he sees that as an unwelcome change: 'we didn't get that' and 'it takes time'. His dissatisfaction appears to be that this is an imposition and not time given willingly the consultant; it is part of the change in junior doctor training put in place by the European Work Directive; it is not under his control but has been imposed on him.

Another consultant from a hospital trust over 300 miles away, in a very different, rural, trust, agrees:

> I don't remember all my junior doctors now, because they train so quickly their relationship with me is not all that strong. Now it is all done in lectures, Internet, tick boxes, appraisal and so on ... when I was training I would sit down and talk to my consultant for hours about this patient and that. (KN, Hospital Consultant)

The tick-box culture was a phrase used by my participants in Health and Education:

> There is one other area over the last thirty years where there has developed the idea of quality assurance (QA) which initially started off well in the in lab/med side. It was quite sensible: if you didn't monitor what you were doing, you [didn't] know if what you are doing [was] a good job or not or not; but this has now been taken to extreme. It has become the tick-box culture, where all that happens is that you have to tick the right boxes. (YP, Hospital Consultant)

And the tick-box culture and QA targets have, for this GP, altered his relationship with his clients:

> [Targets] altered the patient doctor relationship – because the patient would come in and say I'm a bit worried about my hip – and you would say … don't worry about that Mr Smith – do you smoke or do you have your five fruit a day? And let me take your blood pressure – oh not much time left to talk about

> your hip – never mind – come along next week … but I'd achieved my target. (GSP, GP)

This GP, within this cynical anecdote, is exposing target culture and its insidious effect, as it undermines the authenticity of the relationship between an expert practitioner and a client. For this hospital consultant, the tick-box culture and the effect of the ghost of Harold Shipman are examples of an out-of-touch civil service making decisions about ever-closer monitoring and control by central government:

> The perspectives are wrong – the most extreme example is that in some sectors of civil servants was the belief that Shipman could somehow been prevented by [a] tick-box culture. I believe that many disasters have been caused by a loss of the prominence of professionalism – the denigration of professional attitudes. There has not been a willingness to listen to professionals. There is the issue of what makes professional attitudes and we are not talking merely medicine here, but teachers law social workers and all, and that if only lip service is paid to the need to support the endeavours to the highest professional standards … then the whole thing crumbles. (YP, Hospital Consultant)

He makes the point that this is a problem which runs across sectors, mentioning 'teachers, law, social workers and all'. His fear is that 'only lip service' is being paid to the concept of the expert practitioner and without a willingness to listen to experts, 'the whole thing crumbles'.

However, he does say that some targets, like the two-week cancer target, are good.

This senior nurse manager also sees the benefits of what the previous participant calls this monitoring by a 'tick-box culture', because, as she says, it can lead to a focus on good targets – or at least it did in the past:

> But it can be good ... some of the [original] targets I think the four-hour target, eighteen-week wait, were some of the best targets we had ... are some of the best things that ever happened. It's not focusing on the target, and it's not about the government looking good, it's about the patient. It's focusing on the patient. (PK, Senior Nurse Manager)

So, targets are not bad per se; there can be a harmony between society, the practitioner and government directives. But, above all, the removal of the face-to-face interaction between the client and the practitioner, where an assessment can be made through a telephone conversation or a sheet of tick boxes, can exacerbate client/staff relations for Health staff.

5.3.3 Training: Factors Affecting Efficacy

i) Training and Efficacy: Data Analysis, Quantitative

Initial training was only of consequence to the medical participants, as most teacher training still takes place outside the workplace. Apprenticeship type training in Health takes place in hospitals, both for doctors and nurses, and to some extent for doctors in GP clinics. Of the total comments on training, 9% (4) were from education and 91% (41) were from health participants. Of the total 45 comments regarding in what way changes in training had affected efficacy, 75% were negative.

Table 9: Training: Frequency Distribution of Comments

Training Change: Frequency of Comments			
	Participants	Frequency	%
Health	9 of 18	41	91
Education	2 of 18	4	9

Training Change: Effect on Efficacy			
	Frequency	Efficacy Increase	Efficacy Decrease
Health	41	4	14
Education	4	1	1
Total	45	5 (25%)	15 (75%)

The majority of the forty-one comments on training from Health-sector participants came from hospital doctors and nurses who focused on the training of new doctors.

Training is perceived by these hospital practitioners to be reducing in efficacy at a significant rate. The strong links here, which are made apparent during mapping code co-occurrence, are similar for those of the major themes, being between system led training designed by policy-makers and a reduction of the efficacy of that training (see codes 17-22 in Appendix 5: Final coded themes with frequencies).

ii) Training and Efficacy: Data Analysis, Qualitative

Systemic, data led training formulated by policy-makers is seen to lead to a drop in efficacy and junior doctors are:

> losing out on the opportunity, or the fun, of doing things the humanistic way ... It's become like the airline industry – I got you from London to Dublin and I don't know where you (the junior doctor) went afterwards ... it's fragmented. (KN, Hospital Consultant)

The training of healthcare professionals is being influenced by communications technology (Duckett 2005). The traditional structure of training in one in which professional education is based on a 'just in case' model of attempting to acquaint students with skills and knowledge to prepare them for a wider range of conditions than might possibly be faced in practice. This is a process which

centres around the successful transfer of a body of knowledge from an experienced, qualified practitioner to a recruit; and entry into the profession is based on a rigorous testing of that knowledge. Duckett's proposal is that the 'just-in-case' model of training, where an HCP (healthcare professional) taught through knowledge transfer may be replaced by a JIT (Just-in-time) system using protocols. Since 2005, the protocol care delivery system has been introduced into UK medical practice. This is the educational method being implemented by McMasters in Canada and St Georges in London, using PBL (problem-based learning) (Januszewski & Pearson, 1999), where connecting within the study group and connecting to knowledge through communication technology is seen to be a more effective way of teaching, than positioning the teacher as the central repository of all knowledge. But, a hospital consultant gives her blunt evaluation of this training system:

> The European Work Directive. It's a disaster. These trainees are going to be looking after me and God help me. It's not through lack of willingness from them, but they know no other way (they have not had hands-on experience). The ethos has changed because of the educationalists – experiential training has been completely devalued. Everything has to be scenario delivered ... over the last ten years sweeping changes have been brought in by the [Postgraduate Medical Education and Training Board], and that board is full of educationalists who have no idea of what is really important in making a good doctor. They have completely devalued experiential training. Completely. (ML, Hospital Consultant)

She feels that experiential training is important: time spent working in a hospital team learning on the job in the traditional apprentice style of medical training no longer happens, and this has led to a reduction of the effectiveness of medical training.

Although participants working in schools, in universities and in GP practices were concerned about the prescriptive teaching methods being advocated for new professionals, they did not show the same level of dismay revealed by these hospital doctors about their junior colleagues. The frequency charts on initial training (total comments Education 6, Health 59) indicate this imbalance, as does the code co-occurrence between initial training being perceived as the changing

towards systemic and a decrease in efficacy (17 co-occurrences, 100% of possible occurrence). Only senior nurses share this disquiet about training in their profession. This nurse director mentions junior doctors and reinforces what has been said by the previous participants, but she goes on to describe similar problems for nurse training:

> We are struggling to get people into these roles (junior doctors) part of the workforce ... now they are a transient part of this organization. Like a tribe that walks through, they are like nomads they come and go. They just do their rotation and they are gone. (RL, Nurse Director)

And this fragmentation of the training schedule can affect the morale of staff, both the trainers and the trainees, as this consultant shows:

> Staff morale is not the most important thing but it is quite an important thing. The problem is that it is difficult to measure so insufficient effort is made to examine why morale is high. It is quite important but difficult to measure – so much of medicine is give and take. The sense of a collective spirit. The sense of people being prepared to go out of their way. A sense of collective endeavour. (YP, Hospital Consultant)

The senior nurse also seeks to describe the reasons for low morale in the workforce, for the disconnectedness of young staff:

> And for nurses, too ... in the past you went into school, you did a module and you came out ... we were part of the workforce but now students come in and they observe, they are not part of the workforce. (RL, Nurse Director)

However, the resilience of the expert practitioner is made apparent here. This senior nurse is looking for solutions to this systemic led change:

> How can we get them to want to get this organization to deliver? Not just do the job and not give a damn about anything else? Well, we've tried to engage with junior doctors with our 'Listening to Action' programme and we have put our consultants through a development programme ... I went to the final day and every one to a man was saying 'the practical thing I have learned is handling difficult conversations. But they are doctors! You'd think they would know how to handle a difficult

> conversation! But it is different with patients, this was with colleagues. The power base is different than with patients. It is personal relationships. (RL, Nurse Director)

This nurse director is acutely aware that individuals who are the end users of the services of Education and Health are vulnerable, and that the relational aspect of the delivery of these services is fundamental to its success:

> Care is not academic – is it hell academic! You are dealing with individuals in a vulnerable situation. I think what matters to people who come into hospital is that if you get it right and you do it with some compassion, that's what it is about. And in fact, it (care) has come into vogue now. Mid Staffs has worked in our favour. Something good can come. (RL, Nurse Director)

An assistant head of an academically successful school, rated outstanding by Ofsted, echoes this perception that relationality is central to the role of the expert practitioner in Health and Education when, in answer to guided question B, she describes the work she does throughout the week:

> Thinking about a particular example? Well, last week I saw a member of staff who had personal issues which were affecting her professional practice and I was able to reassure her. It was a short-term issue and she just needed some time out of the building. Another thing I dealt with last week was a child protection issue and being given some information about a girl by her friend and her parents and having a very difficult conversation with that girl's parents. For me these are what the government might perceive as soft skills but actually, they are the things which make an organization work effectively. And, which we need to be trained to deliver (SBH, Assistant Head Teacher)

These 'soft skills', the nurturing of a relational way of working, the reflective, empathetic approach, is what these practitioners want to employ. They are aware that society is changing and with it the hierarchy of the professional has gone. A new dialogue between practitioners and their clients is needed and wanted by these practitioners. So is a new dialogue between practitioner and practitioner.

This senior teacher goes on to explain one of the main areas of her job:

> Another very key part of my job is interaction with people, because people are the singular biggest resource that we have as educationalists, both in terms of the students and the parents, but also in terms of the staff. So, for me a lot of what I do and what I feel I have a strength in is that ability to build relationships with people, to support them in seeing ... vision ... seeing where change is necessary and ideally to kind of coach them on board. (SBH, Assistant Head Teacher)

'Coach' rather than prescribe, implying that management of change is seen as a shared objective by this senior teacher. A consultant describes how work practice is becoming more integrated, more shared, with the primary practitioners, as practitioners seize the changes in the work environment to change their work practice:

> It means that we can really push on various agendas – like having more outpatient clinics. We go out now to GPs, because they have the facilities which allow us to do this. We have learnt how do surgery outside the hospital. And they are hoping to build more of these centres – like satellites. Polyclinics, you know ... (CM, Hospital Consultant)

There is a perception that these practitioners see themselves as having the skills, the ideas, but not the time to use them effectively. As this GP says:

> I could do this. I could be the doctor they want if I had the time. If somebody would give me the time and the training. (WR, GP)

Time, or lack of it, is mentioned by participants, like the doctor above, often due to increasing patient or student numbers and increasingly diverse responsibilities to record events, as a factor in preventing the practitioner being more efficacious:

> It takes time. (CM, Hospital Consultant)

and:

> They train so quickly. (KN, Hospital Consultant)

> Work practice? Better ... I suppose, as long as health wise you can keep up with the fast pace of change and training. (BS, Senior School Leader)

This greater speed and range of communication can be a source of excitement, as this head teacher recalls when he describes decisions he made about the new build of his school:

> I wanted the library to be at the centre of learning and I wanted IT to be at the centre of learning and I am thinking about it as 'information technology' ... I mean that you can have access to the libraries of the world ... we can get information straight away .... I remember thinking 'Wow! We can log in and get information from America. The library is like spokes going round the world. We all ned to learn how to apply this new way of learning. (WR, Head Teacher)

5.3.4 Communications: Factors Affecting Efficacy

i) Data Analysis: Face-to-face and Data-led Communications and Efficacy

This was another thread which ran throughout the commentary of participants, and, similar to the comments on the fragmentation and depersonalization of training, the focus of these comments was on the detrimental effect of the increase in data-led communication on the practice of everyday work in both sectors. Communications technology, where it replaced one-to-one or face-to-face communication, was seen to be a negative change in work practice. Participants commented negatively on email and on the use of Twitter by patients and parents as a form of complaint. Students and parents using instant mobile communication to report issues and expecting immediate replies all added to the weariness of practitioners.

Table 10: Communication Changes: Frequency of Comments

Communication Changes: Frequency of Comments			
	Participants	Frequency	%
Health	16 of 18	83	79
Education	11 of 18	22	21

Changes in communication were mentioned by 16 of the 18 health participants and eleven of the 18 education participants, indicating that while this topic was of interest to practitioners from both sectors, it was of more concern to health practitioners.

Table 11: Communications: Face-to-face Reducing

Reduction in Face-to face Communications: Effect on Efficacy			
	Frequency	Efficacy Increase	Efficacy Decrease
Health	34	1	33
Education	4	0	4
Total	38	2 (3%)	37 (97%)

A further analysis of the total 105 comments (Table 10) on communication shows that a particular concern was the loss of face-to-face communication; this concern was much more prevalent among Health participants, who offered 89% (34/38) of the comments on this topic. An overwhelming 97% of comments from both sectors indicated that this decrease in face-to-face communications was leading to a consequent decrease in efficacy and job satisfaction (Table 11). Although Health participants made the majority of comments on this topic, the nature and direction of the comments was the same for both sectors. A strong link in terms of frequency between the reduction in face-to-face communication and a subsequent decrease in job satisfaction was made by both education and health participants.

Table 12: Data-led Communication Increasing

Increase in Data-led Communications and its Effect on Efficacy			
	Frequency	Efficacy Increase	Efficacy Decrease
Health	49	2	35
Education	18	1	14
Total	67	3 (6%)	49 (94%)

Participants from both sectors also commented on the increase in data-led communication. This data led communication was often described as replacing the face-to-face experiences which had been usual in these workplaces. No participants said that data led communication was decreasing. The commentary on the increase in data led communication came from both sectors: 28% (18/67) of the total comments came from the Education and 72% (49/67), (Table 12), from the Health sector. The greater frequency of comment would indicate that participants from the health sector were more concerned with the effect of this data-led communication; of those comments 94% (49/52), (Table 12), indicated that data led increase was leading directly to a reduction in their efficacy and to lower job satisfaction.

ii) Communications and Efficacy: Data Analysis, Qualitative

The alteration of time and space afforded by communications technology (Giddens 2013), where response time can be instantaneous, and the space of a practitioner client conversation about an incident can be a virtual meeting on windy playground using a mobile phone, rather than face to face in a school office, can be a source, not only of resentment, but of increasing tension between staff, pupils and their parents:

> You can have at the beginning of break a member of staff can challenge someone about wearing trainers. By the end of break you can have a parent on the mobile saying 'somebody has just had a go at my son – I can't buy him trainers because his feet are growing so fast'. I've noticed that you will get parents phoning up and saying 'five minutes ago, my son was bullied'.
> (BS, Senior School Leader)

This senior school leader went on to explain that the leadership team had put in a two-teacher team to police such events, and minor disputes between pupils, which is time-consuming and, as she said, may only increase the incidence of such events:

> (because of parent to child mobile contact) we now have two people who go round and not only pick up the 'three strikes and you are out kids', but sorting out minor fallouts. In some ways that's good, but some of the kids are becoming so reliant on other people.
> (BS, Senior School Leader)

Instant communication from government departments, too, can be a source of stress.

Participants from both Education and Health described how unfiltered communication can be overwhelming, whether on email or from Twitter.

> Email? I'd like to blow it up – too much of it … it's useful but it has stopped people talking to one another. It's a nightmare – I do sift them a bit, there are three forms one: CYA or 'cover your arse' … email, 'I am telling you so you can't say you didn't know'; then there is asking permission, then there is the offering 'we want to you be involved', then there is .... well, back to cover your backside! ... the trouble is there are rubbish emails ... but it's quite hard to sift them. (FK Nurse Director)

This nurse director sifts her emails into groups: the CYA or 'cover your arse' email of the large blame-driven institution; the 'permission' and the 'invitation' email. But she is ambivalent towards emails: they can be a useful perhaps irreplaceable, tool:

> I sift them, but I guess I'd never be without email – and another thing (points to Blackberry) we've got one of these mobile day or night I am attached to call; I mean I could choose not to look at them but you don't do that. So, I've got one in this pocket and the one for home in the other pocket. So, I've got the old man telling me we've got a table on Friday and I am thinking that is great because it's the only day I've got off. I think that whole accountability thing you know. We have twenty-four-hour accountability for your service and we ... now we have patients who complain on a Sunday and wonder why you haven't responded: 'I'm up, why aren't you up?' and I have been known ... I will actually contact people on a Sunday, depending how serious it is. (FK Nurse Director)

Tracing negative communication, and dealing immediately with the problems it could cause through bad pupil or patient feedback, can be time-consuming too, as this nurse in another trust explains:

> Within this organization (a large teaching hospital), we have somebody watching Twitter all the time. One weekend, somebody tweeted about their experience. The staff were able to work out exactly where the patient was and tweeted her back and actually physically went down to talk to her straight away. It goes back to that culture shift ... not only are we expecting

> technology to ... not only are we communicating differently ... but we are expecting responses differently ... when we say timely, for a lot of people it is immediate.
> (PK, Senior Hospital Nurse)

In HE, accessibility brings problems:

> Other academics have told me that they are at the beck and call of students through email and phone. Students who didn't do well and got their results by email, emailed this academic back to say, 'Why didn't you tell me to do more work!' The words used are 'accountability', 'accusative', 'because I'm paying', 'there's a contract there'. It is a deskilling of the workforce, a 'marginalization' and a 'slavification'.
> (HV University Course Leader)

This participant feels there has been a 'slavification' of academics, now in the thrall of instant communication with 'accusative' students. Similar stories are told by senior nurses in major hospitals:

> Last week, one patient was complaining by email. He started to send harder and harder emails. Last week, he ultimately started sending emails in capitals. So, I thought I would take it over and I sent an email 'Very sorry etc.' and suddenly he turned on me – he's never met me – it was very personal – but the thing was to meet him face-to-face, earlier on ... the interesting thing is we put a persona on the complainer: 'he's mad', 'she's not very nice' ... the one thing that resolves most of these things is one to one, not the phone, not email but face to face ... talk to him or her and it is defused. (FK, Nurse Director)

An Assistant Head offers the same advice:

> I would say that a vast amount of my communication – more than it should – takes place through email now. And maybe it is just another vehicle (instead of a piece of paper), but it is very easy now to let email replace face to face. It is important that we don't lose that contact with people.
> (SH, Assistant Head Teacher)

A senior nurse leader describes how her work practice has changed:

> I've gone from meetings that I do face to face to speaking to people on teleconferencing ... I really need those face-to-face

> meetings ... to know the mood of a person ... I would know if I was in the room. (PK, Senior Nurse Leader)

However, the assistant head also recognizes that there is a need to manage the mix of face-to-face and remote communication:

> Actually, with parents it has helped – you can could easily spend a day trying to track down a parent: if it is pinging on the phone they find it harder to ignore you ... and students can email a query instead of waiting until the next day. But it is just about remembering the importance of emotional intelligence when actually some things have to be done face to face. It is about time efficiency as well. You don't have to see everybody face to face. (SBH, Assistant Head Teacher)

And here is the emphasis on the discrimination of the expert practitioner in managing the explosion of technical communication and putting it to good use.

But, time is also described as having altered, in that new media and, to a certain extent, technological advance in diagnosis and in knowledge gathering, have altered the time scale of communications between the expert practitioner and their clients, and between the practitioners themselves:

> People want instant answers and instant contact and instant feedback ... well we live in a new age of technology ... I have talked about patients demanding instant answers but I demand instant response from all my technology. (WR, GP)

These demands can be a source of resentment, as the same GP comments:

> There is no sense of waiting ... I think the people here personally they have ... they are lucky in the access they get. (WR, GP)

The GP above admits that she, like her patients, wants 'instant' answers from her technology.

5.4 Last Words: Relational Skills, Decision-Making and Empowerment

Expert practitioners also use relational skills to manage situations pertaining to guiding the direction of practice, which arise in the day-to-day process of working with clients. That capacity of expert practitioners to lead decision-making for their patients, pupils and students is encapsulated in this description to the response of a senior practitioner to proposed changes to geriatric wards in a busy city hospital:

> There was a government directive for single rooms ... We argued that for the elderly their recovery is dependent on socialization – and we argued vociferously and we changed it ... we got down to 44% single rooms ... we started the Dignity in Care Initiative ... we have done a number of projections like 'Delirious about Dementia' and 'A Cup of Tea and a Slice of Cake'. On our wards, we now have dining tables ... where patients can meet, eat and talk. The other day we did a proper afternoon tea with a teapot (not an urn). It was a great success and you know – this is an acute hospital ... not a hospice ... but we did it. You wouldn't think that there was time for this. (FK Nurse Director)

This senior manager appreciates the autonomy her role on the trust board gives her:

> They all look to me for an opinion and I think that that is a very powerful place to be. Not just the negative side of care, i.e. 'Why didn't we get this right?' but also the positive 'How can we improve this? (FK, Nurse Director)

She is working in a team, with a clear decision-making role, and is prepared to alter government directives to suit what she sees as best practice; to subvert top-down decisions because she has confidence in her own expertise. As does this head teacher, who recognizes his authority and his responsibility. Rather than implement the many initiatives put out by the DfE, he has chosen to focus on one government directive, The Importance of Teaching (DfE 2010c), which he sees as useful:

> There are no meetings in this school except about teaching and learning. With one exception, the teachers have got back to talking about teaching and that wholesale change has led to

> improvements, and when teaching and learning improves this leads to behaviour improvement, there is a moral, a virtuous spiral where everything improves. It is a good news story right across the board. If I have a history teacher: he loves history; he wants to see people go on to study history at university; it's my job to empower the teacher to do it. I say 'just teach history well, every day, every lesson'. That's the essence of my job. (CM, Head Teacher)

The Importance of Teaching, while being the title of a government initiative (DfE 2010b), for this head teacher is also the core of his staff meetings. Discussing teaching and learning with colleagues is at the relational core of the job of being a teacher. There is a melding here of the government directive and the personal ethos of this head teacher. The Improving Quality initiative for the NHS is also a move to relational working, and was instigated by the School for Health and Care Radicals. This is an organization set up within the NHS, centrally funded, but intending to promote bottom-up change in the NHS. It seeks to nurture the sense of autonomy felt by the staff of the NHS, from consultants to porters (DH 2014). These are the words of a leader of this change initiative:

> If you work in this way you can build bridges with people ... connect and it makes you more effective in your job. You can put your hand up and say I need help because the help doesn't come with fear – the help comes with empowerment. (PK, Senior Nurse Manager)

The 'climate of fear', 'tick-box culture', 'death by paperwork' and the 'world of watchdoggery' are all phrases I heard used by these expert practitioners in Health and Education to describe their everyday experience of work. But, behind these negative phrases, conjuring up images of a neurosis-ridden workforce, I could glimpse two other powerful themes: a) a desire for real communication with both clients and colleagues; a professional intimacy which is, within reason, unwatched, unmonitored and untrammelled by time directives; and (b) a capacity and a determination to subvert a system which doesn't allow this to happen.

5.5 Summary

Technology, where it enhances the professional skills of the expert practitioner, is welcomed. Work practice is made more efficacious by the elements of autonomy and relatedness being to the forefront. Government initiatives have leached away the relational aspects of work, particularly the informal meeting times and spaces, and have eroded the element of trust in the relationship between client and practitioner. NPM and The Health and Social Care Act of 2012 (DH 2012) have had an unintended effect of demoralizing expert practitioners such as GPs, who now have to run large budgets, a role they did not expect and do not want.

The research questions addressed by this thesis are:

a) what changes are taking place in the working lives of expert practitioners in Health and Education?
b) is there a shared pattern of experience between expert practitioners in both sectors?

The answers to the first research question raised by the data gathered in this investigation i.e. 'what changes are taking place in the working lives of expert practitioners in Health and Education?' focus on the nature of the causes of the dissonance amongst health and education practitioners. Frequency distribution demonstrates that participants in Health and Education offered more positive comments about changes in the workplace than negative ones. Participants were also slightly more positive about changes to work practice than negative. This would indicate a workforce in Health and Education, which shares an overall positive view of change in the institutions of Health and Education, and would seem to belie the evidence presented in the introduction to this investigation of dissonance in these public-sector workforces. However, 43% of participants were negative about changes to work practice in Health and Education: this is a substantial proportion of these expert workforces. When major themes are linked to the perceptions of efficacy by participants, a clear pattern emerges. Changes to the workplace, or work practice, which are towards relational space, and which are led by practitioners and their clients, in turn, lead to perceptions of increasing efficacy through supporting professional intimacy; whereas changes to the

workplace, or work practice, which are seen as for the benefit of the organizational system and led by directives from policy-makers, are more frequently linked to perceptions of reducing efficacy by participants.

Data analysis of the answers to the second research question raised by this investigation 'is there a shared pattern of experience between expert practitioners in both sectors?' shows that there is a significant relationship between the linked pattern of response from both sectors. This indicates that expert practitioners in both Health and Education share the same reasons for dissatisfaction with changes to their working lives. This indicates that the problems faced by these sectors are endemic, and not based on the result of individual failures on the part of the practitioners themselves. These results would suggest that interventions such as resilience training or increased monitoring of individual practitioners will not ameliorate the dissonance in these sectors of public service.

The requirements of recent legislation ask for a more individualized learning and caring approach from individual practitioners, and simultaneously require a highly-monitored and protocol-led form of accountability for Health staff (NHS 2013b; HC Health Committee 2009), and for education staff (Assessment Reform Group 2002: Black & William 2004; DfES 2005; Ofsted 2014). The findings here indicate that this focus on the individual practitioner, without a recognition of systemic factors which influence performance, may be a factor in the dissonance amongst these expert practitioners.

However, there are examples of a harmonious mix of government-led initiatives, practitioner input and implementation, and a subsequent increase in perceptions of efficacy and of confidence on the part of practitioners (see Appendix 3). These examples, where professional intimacy is supported, although occurring less frequently than other trends, are important as examples of what could be useful applications for the future.

CHAPTER 6: DISCUSSION: THE CRY FOR PROFESSIONAL INTIMACY

> We are now trapped in a permanent state of identifying, addressing and manufacturing risk. (Thomson 2009:4)

6.1 Aim and Research Questions

This research asked thirty-six senior expert practitioners in Health and Education to reflect on changes in their working lives, practice based and, in some cases, environmentally based, over the period from 2000-2016. The participants were hospital consultants, GP partners, nurse directors, head teachers and university course leaders – experts who still practice daily with clients but who also have executive power, and who could therefore reflect on changes in their services over the last fifteen years through a combination of practitioner and managerial experience. The questions were asked in the context of the spiralling crisis of staffing and health problems which have been apparent in these UK services in the first quarter of this century. The research sought to look at both Health and Education, as my work as a practitioner offering stress biofeedback counselling in both these areas had indicated to me that these services were facing similar problems. In the context of this cross-sectoral dissonance, my aim was to listen to the voices of these expert practitioners in both Health and Education, to hear their reflections on changes in the role of the practitioner over the last fifteen years. In this way, I hoped to discern trends and patterns, an interpretation of which might lead the way to stem the flow of highly qualified staff from our health and education sectors. My specific questions were:

a) what changes are taking place in the working lives of expert practitioners in Health and Education?
b) is there a shared pattern of experience between expert practitioners in both sectors?

6.2 The Remit for a Cross-Sectoral Study – Two Services in Crisis

It is useful to research this phenomenon of low recruitment, low retention and increasing stress in these public sectors as primarily a cross-sectoral phenomenon, as this approach may offer a greater understanding of the underlying problems being experienced by our practitioners. During my literature search, I could find only one study which addressed both Health and Education and this was a literature review (Bajorek, Gulliford & Taskila 2014) commissioned by the then TSA to establish a link between teacher health and wellbeing and student outcomes. This study looked at health literature separately and only incidentally. Therefore, there was a gap in the body of knowledge about the cross-sectoral nature of this phenomenon – a gap which I wished to fill. The problems of low recruitment, low retention and high levels of stress in these public services have been addressed separately, but similarly, as mainly problems of the personality or attitudes of individual staff, with solutions ranging from more discerning recruitment procedures (psychometric testing) to resilience building among staff (Day & Gu 2010). My premise is that if a cross-sectoral phenomenon exists it would indicate systemic problems within the public services of Health and Education, possibly exacerbated by the pressure of a wider societal shift in attitudes on the part of clients, rather than failure on the part of individual practitioners. Government statistics offer two clear, entirely separate, but similar pictures of the crisis of staffing in Health and Education, which serve as a context for the present research. A meta-analysis published in July 2016 by the Committee of Public Accounts confirmed the general shortage of teaching staff in England. This report stated the committee's disappointment that the DfE has missed its targets to fill teacher training places four years running, with significant shortfalls in some subjects (H of C 2016 Section 73) The report also addressed the growing problem of appropriate staffing in teaching, focusing on the number of teachers who were not trained to teach the subjects in their timetables. There is a shortage of teachers for certain specialisms (HC 2016).

Media reports also use government statistics to make explicit the problems facing the DfE. Morris, writing in The Guardian, described the increasing staffing crisis faced by schools and the 'soaring' cost of the increasing use of supply teachers,

stating that 'schools in England spent 3.29bn in 2013-2014 to hire temporary staff, compared with £1.02bn two years earlier' (Morris 2015: npn). He goes on to quote from a survey completed by the NAHT, which found that almost four in five schools were finding it hard to recruit, and referred to DfE figures which stated that targets for recruiting teachers have been missed for three years running. 'Overall, 28,148 graduates began teacher-training courses, 94% of the target. Just 82% of the target was achieved for secondary school teachers' (Morris 2015:npn). These figures coincide with 'record levels of departures from the profession', as 'between November 2013 and November 2014, a total of 49,120 teachers left, a rise of 3,480 on the previous year' (Morris 2015:npn). In the final Ofsted Annual Report to be published under his auspices by Sir Michael Wilshaw, in December 2016, comments on the crisis in staffing and attainment which continues in our secondary schools, suggested that the focus of government should be on capacity not structure (Wilshaw 2016).

Over the same time period, this staffing crisis in Education is mirrored by a similar crisis in Health: both medical and nursing staff are in short supply. In 2015, GP leaders raised serious concerns about what they say are the 'worst ever' figures on GP training, with the take-up of places having fallen to 62% of those available in the East Midlands and slightly over 70% in large parts of the north of England (Parkin & Powell 2016).

An example of the increasing trend amongst trainee doctors to discontinue medical training can be seen among students at the South Thames Foundation School, only 65% of whom applied to specialty training in 2010, down from 79% in 2008 (South Thames Foundation School, 2009; South Thames Foundation School, 2010; Smith & Low, 2012). The incidence of similar recruitment problems across these two sectors indicates that these problems are not caused by personal inadequacy of individual doctors or teachers, but by factors which impinge on both the services of Health and Education. Problems of recruitment and retention indicate the dissonance amongst these practitioners. That this shortage of qualified staff is linked to the endemic nature of stress amongst practitioners is delineated in a three-year longitudinal study with a cohort of 331 hospital and GP) doctors by McManus et al. (2002). The conclusions of this study were that these doctors faced a stark choice: either become disengaged and

cynical and carry on or attempt to maintain engagement and burn out. A similar link can be made for teaching staff (Education Support Partnership 2016). However, studies seeking to understand the stresses faced by practitioners in Health and Education give only an incomplete picture, as they are rarely cross-sectoral. The structure of academic funding and the siloed structure of government departments mean that previous academic research into dissonance, and reporting from professional bodies such as the BMA and the ATL only cover either Health or Education.

6.3 The Focus of Previous Research on Individual Failure Not Systemic Issues

Perhaps because of their narrow focus, these single-sector studies do not place the experiences of expert practitioners in their social or political context. Such studies primarily start from the conceptual basis that problems amongst these cohorts have answers of personality which are to be found (a) in the choice of appropriate candidates for the work (psychometric testing); or (b) in development of coping strategies, such as resilience, in the staff already employed (Day et al. 2007; Day & Gu, 2010; Gu & Day 2007; Hughes 2008; Martin et al. 2015). This previous work has been valuable in helping to establish the extent of the problem as experienced by practitioners in each service, but fails to position the phenomenon of the public service staffing crisis in a large enough context. The study presented here seeks to build on this previous work and take the focus of research into these practitioners to a broader understanding of the working lives of the expert practitioner in Health and Education. These practitioners share the experience of the macro context of the neo-liberal landscape, the national arena of social policy at the organizational level and finally, at the core of both the problem and the answer, they share that individual response which Evetts describes as ‘occupational professionalism’ (Evetts 2009:252) the core of which, I propose, lies in the exercising of professional intimacy. In their working lives, they inhabit the role of doctor, nurse or teacher – roles which emphasize relationships over structures, and demonstrate an orientation to work where ‘the needs and demands

of audiences, patients, clients, students and children are paramount' (Evetts 2009:252).

If a cross-sectoral pattern of commentary was to emerge in this study, it would indicate that something more than simply individual failure on the part of particular practitioners was at work (a stance taken by policy-makers and the media) but that we face a cross-sectoral structural failure, possibly set within a more fundamental social change. It is vital that we analyze strains on the delivery of these services now occurring in the increasingly beleaguered landscape of our public services. It is unproductive for policy-makers to assume that problems lie with individual practitioners, just as it is unproductive to offer resilience training to workforces dealing with systemic failure.

6.3.1 Data: Frequency and the Paradox of the Positive Return

Perhaps surprisingly, given the established context of unrest and 'turbulence' (Hunter 2013) in both sectors, initial reporting of the frequency distribution of 740 code applications after thematic analysis indicated that there was an overall positive response to changes in the workplace and to work practice – 34% indicating workplace change reducing efficacy and 65% indicating that workplace change had increased efficacy. For work practice, 43% of respondents indicating work practice change reduced efficacy, while 57% indicated that work practice change had increased efficacy. Some participants commented that their workplaces had made a transition to better function and facilities and the positive experience of staff in these situations was made apparent by their commentary on change and efficacy. One nurse director was managing the transition to a new build and was confident that this physical move could be accompanied by changes in work practice, which would improve the operation of the cancer wards which were her responsibility. She described in detail her plan for a better system, which allowed for a continuous flow of patients from one station to another, thus reducing patient stress and streamlining their clinical care. Importantly, she had been fully engaged in the design of the new workspace and had autonomy with regard to the organization of her workforce. A head teacher described the introduction in 2000 of a large computer suite to the new school library. He

described this innovation as one of the most important events in his teaching life: his school was now connected to the world and his pupils could access the Library of Congress in the US and the British Library, even although they lived in rural communities without transport. The building campaigns in the public services put in place by previous governments, although fraught with issues over their cost, have improved the daily environments of practitioners in Health and Education.

However, overall, 47% of participants did report a decrease in efficacy and this statistical split may be a manifestation of system or culture lag which occurs when, as Roland (2004) described, change in large government institutions like Health and Education moves at an erratic and uneven pace. The strain apparent between two parts of a culture that change at unequal rates of speed was originally identified as 'cultural lag' by Ogburn and Nimkoff in 1947. This is a useful description of what my participants identified as piecemeal change. Lightman (2013) and Davies (2012) have described the 'piecemeal' nature of changes taking place in both Education and Health as damaging to students and patients. Research commissioned by the National Assembly for Wales (2014) found that the piecemeal application of change was also damaging for practitioners working in these institutions in the UK. The fragmented and irregular implantation of change may go some way to explain the distress reported from each of these workforces. Participants of the present study supported these findings, commenting on the differences in institutions within Health and Education in terms of funding and of practice, and in the application of government initiatives. A head teacher explained that his leadership team had had to prioritize the implementation of particular initiatives proposed by the DfE, as it was not possible to implement them all. He recognized that the priorities of his school would differ from those of other schools, and that this meant the transference of students and staff between schools was more difficult. One AST described his disappointment at a change in government policy, which meant that the new school build, for which he had planned, was cancelled. The focus of his response was at the micro level of his day-to-day experience of using outdated, crowded classrooms. Meanwhile, the leadership team in this school were managing the build cancellation on a practical level, by readdressing the use of their

overcrowded space and, on an emotional level, by monitoring a drop-in morale amongst the pupils and the staff.

New builds in Health and Education embody cultural shifts in succeeding policy-makers' perception of the appropriate use of these public spaces: the individually designed 'atrium' schools of the last Labour Government have been vilified as a waste of public money by the 2016 Conservative Government (Richardson 2016). However, one head teacher interviewed in the present study was pleased to have been one of the 'lucky ones', as he put it, who got a new school. During 2016, the DfE and the Education Funding Agency (EFA) stated that new school plans have to be standardized as a way of keeping down costs (EFA 2016). However, in the present study, interviewees from both Health and Education seemed to reject standardization and described the ways in which they personalize the new spaces they inhabit. This personalization of space indicates that standardization may not offer expert practitioners the freedom to shape their environment in ways that they want and that allow them to practice more effectively. One school head teacher explained that he had used a room in his school to create into a drop-in centre for pupils whose home lives were disrupted by family breakdown, and who needed a 'quick cuddle and a cup of tea in the morning'. A consultant talked about her fight to alter the faceless, standardized new build workplace she had moved to by creating a pop-up canteen in a redundant laboratory.

This hospital consultant also commented that, although her training was clinical, she increasingly functioned as a manager, citing her responsibility to implement the Working Time Directive introduced by EU legislation. Under NPM directives, the expert practitioner in Health and Education is now expected to offer both 'organizational professionalism' and the more traditional 'occupational professionalism' (Evetts 2009). Evetts comments that the former uses professionalism as a form of occupational control within hierarchical structures, and is a feature of NPM in public service sector work. New practice spaces under these rules often bring with them new fiscal responsibility for practitioners and may leave little time for the exercise of the particular professional intimacy of practice. These new ways of funding the public space of hospitals, surgeries and schools can have a deleterious effect on practitioners given responsibility to manage estate budgets. A GP participant, reflecting on changes to his

environment, described the funding and building of his new surgery fifteen years ago as a smooth journey supported by an NHS official throughout. Another GP partner, housed in an attractive new rural surgery built in 2014 under the PFI initiative (participant WR), explained the constant worry caused to her and her GP partners by being responsible as landlords for the profitable letting of the rest of the surgery space. This was a role she felt untrained to handle. Her concern was echoed by another GP in a city practice, who felt that he was not capable of managing the complicated budget for his practice space. A head teacher talked about the responsibility for budget brought about by the academization of her school: she felt her attention was being diverted from the staff and the pupils to spreadsheets. I found that the narrative of interviewees and the pictures they painted of their working lives brought to life the theoretical commentary of Attali (1978) Giddens (2013) and Ball (2014) on the effect of the commodification of Health and Education.

My participants live and work in the milieu of NPM and they demonstrate an acute awareness of the importance of the piecemeal nature of the allocation of funding to their public services. They are also aware of the power of media 'panics' in arbitrarily directing government policy. A senior nurse participant explained that the return of hospital wards to single-sex provision (DH 2002) was caused by a media campaign led by a television presenter whose mother was distressed by being put into a mixed-sex ward. Another nurse director told me that in her trust, one of the largest in England, all new builds would now offer patients a private room with an en-suite bathroom. She also saw this as a continuing response to the media campaign about single-sex wards. She then pointed out that some of the older hospitals in her trust still had Nightingale wards, where patients shared a single ward space. What kind of ward experience you would have as a patient depended entirely on the hospital to which you were admitted. Staff are, of course, also affected by this 'lottery' of ward design, since nursing staff implementing new, universal DfH directives over patient monitoring may have to do so in very different workspaces. The irregular allocation of government funding and the piecemeal implementation of directives will mean that working experiences for staff in both Health and Education can vary widely. This erratic nature of change may have contributed to the divided response by participants of

their perception of their efficacy, since practitioners experiencing the most effective management of change and funding will have a positive experience and those who do not have that advantage will report a negative experience, which will impact or their own sense of efficacy. However, I found that this interpretation is not universally valid: as one university professor said in interview, his professional practice remained as the central core of his behaviour, whatever the environmental circumstances.

6.3.2 Data: The Ethos of Service and Occupational Professionalism

It is possible to interpret his comment as supporting a second possible explanation for the dichotomous nature of the frequency reporting of efficacy. The ethos of service and of 'occupational professionalism' (Evetts 2009), the job satisfaction inherent in enacting a role imbued with professional intimacy, which my interviewees made apparent, remains a strong motivator for expert practitioners in Health and Education. Over the last fifteen years, there have been fundamental changes towards a business model (Moffat, Martin & Timmons 2014) in the role of these expert practitioners. However, the frequency statistics of the present study, where a majority of participants express a positive response to their assessment of their capacity to fulfil their role as expert practitioners, whilst also expressing serious concerns about the functioning of their institutions, would support the view that these individuals continue to adhere to a personal interpretation of the concept of service and the values of their profession. As the 2016 General Medical Council (GMC 2016b) report commented, to say that it is not possible to do your job, if you are a professional practitioner, is to say that you are at fault. When faced with overwhelming difficulties, an expert practitioner will respond with increasing attempts to achieve self-efficacy (McManus, Winder & Gordon 2002; Bandura 1982) and this is what leads to burnout in these professions. When doctors or nurses have to admit to being unable to do their job, they are admitting to both a personal and a professional failure. A particular melding of personal and professional identity is described by Kelchtermans (2005), in his study of teacher behaviour, where he proposes that for a teacher to admit to failing to maintain efficacy is to admit to a failing of self, with all the psychological consequences that would entail. Practitioners from both Health and

Education who were interviewed for the present study, when asked about their work practice, preceded their commentary with phrases like: 'I am the kind of person who …' or 'My belief is …' – indicating that they placed their work experience in the personal domain. The GMC annual report on training of doctors for 2015-2016 (GMC 2016a) showed the paradox of doctors who were so unhappy with their present working and training conditions that 98% of them responded to a ballot called by the BMA by voting to take industrial action. Yet, 83% of this cohort of doctors were surveyed about their experience of training and reported 'excellent' or 'very good'. The report goes on to suggest that reasons for this paradox are likely to be complex, but explanations could lie in the essentially melded nature of the identity of the expert practitioner in Health and Education. Dr Thompson comments, in her introduction to the Scottish consultants' study, that 'consultants are overwhelmingly committed to the NHS and to our patients' (Hill 2015) and yet the study itself is condemnatory of organizational practices within the workplace, and consultants talk of these practices as reducing their efficacy. The Teachers Workload Diary configured by the University of Cardiff (DfE 2014b) contains the same dichotomy – reports of incidences of distress and dissatisfaction in the workplace, coupled or contrasted with positive comments about personal commitment to the role of the teacher.

Laine (2005) describes the continuing commitment of nurses to the values inherent they see in their role. One nurse director participant in this study summed this commitment up, when she described the need for nursing staff to treat patients, 'not as if they were like your mother but that this is your mother'. The NHS has been described as a low trust institution (Martin et al. 2015). However, contrary to what might be expected in an organization characterized by low trust dynamics, both the interviews and survey data on engagement of the Scottish consultants showed that these consultants were 'highly engaged with their jobs, with their clinical colleagues and with the values of the NHS' (Martin et al. 2015 13:9). The comments of the 53% of participants in the present study who reported increased efficacy support this seeming paradox of the dissatisfied practitioners who 'loves their job'.

In Solomon's study, the GP interviewees commented on how much they valued training which was directed by other GPs, not by government directives

(Solomon, 2009:234). Echoing Solomon's participants, one GP interviewee in the present study commented that, whereas she dreaded statutory meetings which were part of the new DH commissioning directives, she valued and enjoyed GP-led training, as it led directly to an improvement in her clinical practice. Teachers talk of the importance of colleagues and good relationships with students (Razak, Darmawam & Keeves 2009) and relationships between practitioners were seen as supportive by the majority of my participants. Relationships with clients were also seen as supportive: a head teacher in the present study felt that the effects of good teaching were appreciated long after pupils had left school, as he had been approached more than once by ex-pupils wishing to thank him. This feedback was a source of great joy to him and one of the reasons for his continued commitment to his job. Another head teacher described how she would leave her office and go and 'hang out' in the dining hall when the paperwork got too much. Being amongst the pupils was, for her, an energizing experience. One GP, rather sadly said that she could be the GP they (the patients) wanted and the GP she wanted to be, if only she was given the time to do it. She remained committed to her chosen profession, but was frustrated by what she considered to be system-based issues which led to her inability to do the job properly. Another GP partner told me that she would leave her job if she could find a way to retrain. She felt that this was a dreadful admission to make, and was bitterly disappointed by her experience of being a GP. The Annual GMC report on training (GMC 2016a) stated that doctors were 'alienated' and that we could be in danger of doctors leaving their profession. This would entail a heavy national cost in terms of wasted training and a heavy personal cost to those who have chosen to commit to long arduous training to become public servants.

Commitment to a professional role as an expert practitioner in Health and Education, due to the heavy investment of time, effort and resources it requires, has to be supported by a sense of self-efficacy (Bandura,1982:142). Although the present study showed an overall 53% perception of an increase in efficacy, there were significant negative responses to aspects of both the changing workplace and the changing work practice. These anomalous findings replicate those of teacher satisfaction surveys, where an overall positive attitude to the role of being a teacher is belied by the more detailed responses to particular serious problems

being reported as in the workplace (DfE 2014). Lambert, Smith and Goldacre (2014) surveyed 2,507 doctors about their work in a thematic analysis, using open-ended questionnaires and found a similarly positive response to the role of doctor. My findings also replicate those of Martin et al. (2015), who reported, in a questionnaire survey of sixty-eight consultants, that overall, they regarded the NHS in a positive light. However, both those studies also reported high levels of dissatisfaction with certain aspects of the changing work role of doctors. For example, although in Lambert, Smith and Goldacre's study, out of 196 code applications for job satisfaction, 58% were positive while 42% were negative, respondents also reported 100% dissatisfaction with NHS management, and 146 out of 148 comments on government policy were negative. For both cohorts of consultants, the training of junior doctors was seen to be inadequate (Martin et al. 2015; Lambert, Smith & Goldacre 2014). The present study also shows that dissatisfaction with the training of junior doctors is high amongst hospital doctors and nurses; 78% of the responses by members of hospital workforces (medical and nursing) indicated that changes to the training of junior doctors had led to a decrease in efficacy.

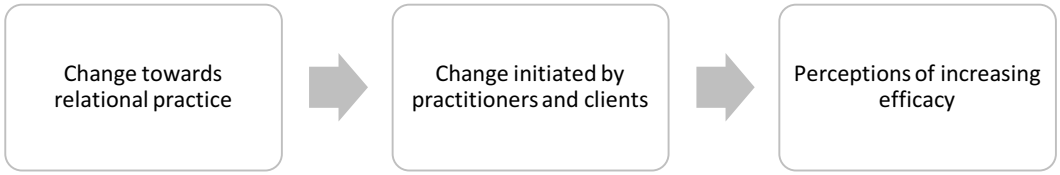
6.3.3 Data: Code Co-occurrence as a Three-way Pattern

However, these dichotomous outcomes, mirroring the 'paradoxical' commentary reported by the GMC (2016b), are offered in a linear, discrete manner with no exploration of the relationship between them. The question which has to be asked is: Why do these practitioners repeatedly express dissatisfaction and yet also express a positive attitude to their work? The frequency results of the code application of my research showed a similar pattern to previous research, both satisfaction with the role of the practitioner and dissatisfaction with the everyday experience of practice. However, I propose that it is in the relationship between other factors and these responses that an understanding of the construction of dissonance is to be found. The present study used a semi-structured interview design and gave participants guiding questions in three areas: the nature of change, the cause of change and the effect of change. It is when the links between these three factors are made explicit that a meaningful explanation for the dissonance in expert practitioners in Health and Education can be discerned.

6.3.4 Data: Code Co-occurrence per Participant

An exploration of code co-occurrence goes some way towards providing a probability-based framework for answers to these questions. In this investigation, code co-occurrence showed a significant pattern consisting of a significant three-way link per the majority of participants, and per cohort, between perceived changes, causes of those changes and feelings of increased or reduced efficacy $(x^2 p => 0.0001)$

Figure 8: Flow Chart Showing Code Co-occurrence which Leads to Perceptions of Increasing Efficacy



Increased efficacy was perceived by participants who had reported a direction of change towards a more relational workplace and who reported these changes being led by practitioners and clients rather than by government directives and initiatives (Figure 8). There was a converse pattern, also statistically significant, $(x^2 = p > 0.05)$, which showed that participants who expressed reduced efficacy commented on their workplace changes as being more designed for the benefit of the system rather than for supporting or enhancing relationships of the people within that system. This cohort also reported that they felt that workplace-change decisions were taken out of their hands and were made through the application of top-down government directives (Figure 9).

Figure 9: Flow Chart Showing Code Co-occurrence which Leads to Perceptions of Decreasing Efficacy



The qualitative data which gave a deeper understanding of these themes showed that workplace and work practice change towards relationality was initiated by practitioners when they had the opportunity to have control of those workplace changes. Relationality and autonomy lead to perceptions of increased efficacy, whereas top-down decision-making and system-benefiting change were linked to increased feelings of reduced efficacy. The opportunity to speak to a colleague about a patient, student or pupil was important to these practitioners: the collegiate nature of work in Health and Education, would be built in to everyday practice when practitioners were given the opportunity to design their own time allocation.

When these links are made explicit, further questions present themselves: does a particular combination of factors need to be present in order to cause expert practitioners to leave their job? Does that overall positive response in terms of frequency mask those particular individual experiences, or combination of factors, which will lead some practitioners to leave their posts? If this research had stopped short at recording the frequency of increased or decreased efficacy, the full explanation of the underlying causes of the vanishing public sector practitioner would not have been made apparent.

6.3.5 Data: Code Co-occurrence per Sector

The frequency and co-occurrence of code application demonstrated that there are sector parallels ($x^2 = p > 0.0001$) and that there is a similarity in the factors, and in the significance of those factors which may be the cause of the dissonance in these workforces. For both Health and Education practitioners, the occurrence

of the three-way link between relationality, autonomy and increased perceptions of efficacy was significant ($x^2 = p > 0.0001$).

A close examination of qualitative data, during the process of forming a thematic analysis, made more explicit the pattern of code clusters in the computer-assisted qualitative software analysis. The themes sprang to life. Participants described in detail ways in which hospital wards, doctors consulting rooms and classrooms could and were being designed, often with practitioner and client input to allow a freer, more effective, flow of communication between clients and practitioners. New builds, hospitals, schools and surgeries, while fraught with costing problems, often offered better workspaces for these practitioners and their clients. At a local level, without any change in building, or dedicated funding input, senior nursing staff were implementing changes which gave more opportunity for patients and staff to communicate by actions such as putting a dining table in a ward so that everyone could share mealtimes. Even where a reversal of government policy meant that a new-build school was not going to go ahead, the staff in that over-crowded school were pursuing ways of using their space. Conversely, where a new building had not involved the practitioners in its design, there was often dissatisfaction with the result. One university lecturer describes trailing behind architects as they carry out a site visit. He overhears them talking about the difficulty of working with academics who erroneously believe they should have an input into the design of their new building. Changes in work practice are described as allowing better communication often when they have been linked to practitioner-/client-led design. The practitioner-led decision to use an informal space as a break-out zone for children who had difficulties accessing the curriculum was described and the importance of corridor conversations and face-to-face discussions were underlined. The impossibility of accessing a patient's needs in a prescribed ten-minute consultation was a matter of concern and the difficulty of having a real one-to-one conversation with that patient when the computer, with its need to have a data input, was an ever present third party, was also discussed.

The 2016 GMC report came to the sombre conclusion that the anger and frustration evident in the dispute between the Junior Doctors Committee of the

BMA and the NHS in England suggest levels of alienation that should cause everyone to pause and reflect (GMC 2016b: 111). The stark reality is that these practitioners are leaving their posts and fewer trained staff are entering these professions to replace them. The crisis in staffing which was central to annual reports from professional bodies in 2015 has not abated in 2017. Emergency medicine (EM), paediatrics and enterology join psychiatry and GP training in reporting a drastic lack of staff (GMC 2016b). Likewise, head teachers in the East and West Midlands cannot find qualified staff to teach the natural sciences or maths (Wilshaw 2016). By going beyond statistics of low retention and low recruitment, and behind the frequency of reports of dissatisfaction; by examining both what factors make practitioners satisfied with their working lives and conversely what makes them dissatisfied, it is possible to begin to find answers to these problems.

6.3.6 Data: The Contribution of Technological Change to the Lack of Professional Intimacy Within These Sectors

Technology was the most frequently occurring theme in the present study, at a frequency rate of 192 occurrences of coded category. This was a free theme, occurring throughout participant commentary (Braun & Clarke 2006); the attitude to technology by participants from both public sectors was ambivalent. Technology, which allowed better, quicker more accurate practice was welcomed. Whiteboards, YouTube demonstrations and shared worksheet databases facilitated teaching. More accurate methods of analyzing blood had transformed haematology, allowing speedier and more extensive diagnosis. Ophthalmologists could measure the retina in seconds whereas before, laborious processes would have been carried out. A university professor was able to access colleagues across the world to discuss a paper, and a secondary school Internet-led project allowed an AST and his students to access the work and ideas of other schools on a daily basis. For one deputy head, the identification and assessment of pupils with problems could be made quickly by analyzing whole school data, rather than laboriously poring over spreadsheets. However, underlying the excitement which technological advance could bring was an uneasiness about the way it distanced the practitioner from the client. Diagnosis was made by instruments, blood was

analyzed by machines and the rating of a university or a school's success as an institution was made by data collection. There was a sense of the de-professionalization of practitioners, as assessments of their practice were made elsewhere by non-professional judges. One consultant talked about how 'the fun' of being a doctor had gone: he was no longer at the centre of the patient's experience, making a correct diagnosis based on his particular expertise (Appendix 3 Dedoose transcription).

6.3.7 Data: Technology and the Individualized Client

There is a general consensus amongst commentators that we are inexorably progressing through what Castells dubs the informational revolution (Castells 1998). It is proposed that increasing technological advances have created higher expectations for services on the part of citizens, and that this in turn has fuelled the agenda for change in the delivery of public services (Waterfield 1997). Government departmental directives show that the focus of health and education delivery is shifting to relational, individualized factors, away from the universal application of systems. This can be evidenced in initiatives such as SEAL (Humphrey, Lendrum & Wigelsworth 2010) which led to a focus on individualized learning, and Every Child Matters (DfES 2003a), which intended to give the institutions of Education and Social Care directives that would ensure individual cases were treated with a coordinated and close attention. The commentary of teachers in the present study demonstrated how these initiatives had been assimilated into the management and direction of school development. Meetings are held to discuss the progress of this implementation and salary increases, and management points are allocated to staff prepared to lead initiatives in a school. One senior teacher felt that this focus on the individual child was a positive change, leading to improving outcomes for particular children and more harmonious classrooms. Teachers were able to shift their focus from pupils as 'sets' or 'cohorts' to pupils as individuals. A nurse director described how the concept of the expert patient (DH 2001b; 2002) also part of this shaping of the behaviour of the expert practitioner, is introducing the concept of expert patients, capable of contributing to the direction of their own care. However, practitioners in both sectors bemoaned the introduction of these demanding approaches without

a reasonable allocation of time or money. Patient Choice (DH 1991) cannot work if there are no beds available in your chosen hospital, and the GP failing to offer it has to deal with the frustration of his/her patient. This is the beginning, the root, of the paradox described earlier: a willingness on the part of expert practitioners to implement change which can eventually turn to disillusionment, and sometimes anger, as the practical underpinnings to support change fail to appear. I sensed the desire amongst practitioners in both sectors to use technology to make these changes towards individualized provision, and the frustration amongst them because of the lack of funding or time.

6.3.8 Data: The Contribution of Communication Technology to the Current Lack of Professional Intimacy Within These Sectors

After becoming familiar with the data, I decided that 'communication technology' was worthy of a separate code trail, although it nested both within technology, and within the linked work/practice/change tripos (Braun & Clarke 2006). Communication technology presents another paradox in the narrative of expert practitioners. In the newly individualized service, they are expected to offer a more involved service, but communication technology has distanced them from each other and from their clients. Paradoxically, practitioners feel isolated by communication technology. The loss of face-to-face communication and its replacement by data-led communication was felt to be particularly negative change by practitioners in Health. It may be that face-to-face communication, while being eroded by the computer in the classroom, has not yet changed the nature of the school day, with its classroom of one teacher facing many pupils. In Health, however, diagnosis is often made in the GP surgery and by the hospital bed by using complex machinery which has to be closely watched by the expert practitioner. There is a feeling that all eyes are on the machine (Zuboff 1988). Because of time pressure, data has also to be analyzed during the client/practitioner meeting and so detracts from the face-to-face nature of the job. One senior nurse talks sadly of using video conferencing because it facilitates her work, but regrets its coldness. Video conferencing does not allow her to sense of the mood in a room or gauge the way body language indicates the attitude and responses of the other participants in a meeting. The increasing use of emails was

altering the relationship between colleagues and between practitioners and clients. Particularly in hospitals and in universities, emails within institutions were part of a defence mechanism, as a nurse director commented, often being sent out to protect the sender from blame. They were increasingly sent as complaints by clients in both Health and Education and had made the practitioners more visible and more available. A senior team leader in Education described the hundreds of emails he received from parents per week, and the time it took to deal with each one. One senior practitioner found that complaints were often escalated by email exchange, whereas one face-to-face meeting could diffuse them. A university course leader talked about the 'slavification' of her colleagues to ever-more-demanding students who had constant email access to their tutors. To her, this phenomenon related directly to the commodification of higher education: a university education had become another product to acquire on the way into adulthood. The informal use of mobile technology by pupils was of concern to senior teaching staff. An incident could occur in a playground and within seconds pupils could text or phone their parents or carers to deliver their version of events. This had led to a change in the way in which pupil free time was staffed, and to the introduction of surveillance cameras to record events. The speed at which communication could spread information was of concern to hospital staff. One teaching hospital practitioner described how a member of the hospital communications team staff followed the hospital Twitter feed throughout the day. Because of this close monitoring, they were able to identify a disgruntled patient and resolve his problem – and alter his commentary on Twitter. As she said, one adverse comment can lead to an avalanche of complaints. In both sectors, communication technology had led to an increase in surveillance at many levels: the institution monitored the practitioners, the clients also monitored the practitioners and the staff had to think of protective measures to record their own behaviour in response.

6.3.9 Data: The Lack of Unmonitored Time and Space and its Contribution to the Lack of Professional Intimacy Within These Sectors

This increase in the amount and the multiple sourcing of this monitoring has made the need to have the space and time for unmonitored activity all the more

necessary for expert practitioners. For both health and education practitioners, the importance of informal meetings and informal spaces was made apparent in the qualitative data: this subtheme appeared in participant commentary about work space. Informality allowed colleagues to get to know each other, but also gave safe space for 'sounding off' behaviour, an activity which participants felt was much needed in these interpersonally intensive sectors of practice. Informal space also allowed further free discussion of difficult topics which may have arisen during the formal working day. This could lead to a better outcome for clients, students and patients because this free exploration of possibilities without the institutional sanction of the formal space could throw up better solutions. One area of difficulty was the lack of meeting spaces for practitioners to share these informal meetings and down time, which had underpinned their practice in the past. Staff rooms were no longer visited, and teachers no longer met informally after work to socialize. In the past, doctors could always rely on the nearest pub for a place to meet and iron out any differences which occurred during the day, but new, out-of-town sites and altered shift patterns meant that this was more difficult to arrange. Teachers and doctors regretted the passing of this way of reinforcing the collegiate nature of their work. Work practice change away from these informal serendipitous moments was seen as being instigated by policy-makers and enacted for the convenience of the system and perceived as leading to a less communicative, coherent, team-based workforce.

Institutional sanctions were a constant bedfellow of these practitioners. They felt that they were under surveillance and that accountability had been turned from a natural part of being a self-regulating professional to an enactor of as externally regulated set of protocols. Both the requirement to offer a three-part lesson, and the requirement for the adherence to the protocol to explain the percentage likelihood of death or injury because of a proposed medical procedure, were various parts of the same external interference in the practitioner/client relationship.

6.3.10 Data: The Training of New Doctors and its Contribution to the Lack of Professional Intimacy

There was only one theme which did not apply in frequency distribution to both cohorts. This was the training of doctors in hospitals, and was mentioned by hospital staff, both senior nurses and consultant doctors. There was disquiet about the training of junior doctors amongst both these hospital consultants and hospital nurses. Training, particularly of doctors, was seen to be less successful than in the past, since these doctors were no longer part of a team but only with wards and specialties for a short time on an ever-changing rota. The directives which have reshaped the training of junior doctors have meant that these students spend less time with each team and do not get to know, or be known by, staff. In describing this change, my participants echo the words of the doctors surveyed by Lambert, Smith and Goldacre (2014), who also showed concern for their junior colleagues. Senior hospital nurses also showed concern for trainee doctors. As a senior nurse said, they are 'ships that pass in the night': a 'lost tribe'. One consultant talked about the old apprentice system of doctor training where a trainee was supported through difficulties until a satisfactory level of expertise was reached. He recalled spending hours discussing cases with his mentors. This system has been replaced by end-of-year make-or-break examinations. This alters, weakens, the relationship between the trainee and his teachers and also reduces the sense of trust and respect which has underpinned medical education in the past. Now, there is an emphasis of assessment of learning rather than assessment for learning (Nath, Seale & Kaur 2014). A consultant talked about seeing the PBL approach being used at McMasters University in Canada, commenting that it couldn't transpose well to the UK as we have younger medical students, who have not completed a first degree before entering medical school.

The introduction of algorithm-based rota systems into ward staffing is seen as an insensitive application of technology. As one senior nurse said, this is a system-based change which looks good on paper but which doesn't work in reality. The algorithms have not been designed to take into account the human needs of shift workers and the training needs of trainee doctors. They sit uncomfortably in the day-to-day running of a hospital and create anomalies, where one doctor can work a long run of night shifts, with very little downtime between that and the next

block of day shifts. A medical director explained that when, in the past, consultants designed rotas for trainees they took into account the individual needs of each trainee where possible, knowing them well enough to do this. One hospital consultant in Wales described the world of the algorithm-based hospital rota system as 'fragmented' and a senior nurse in Staffordshire described junior doctors as a 'nomadic tribe', never settling long enough to become part of the ward team.

6.3.11 Data: Surveillance and the Thread of Subversion

The excerpts showed a thread of commentary about subversion. This was a hidden theme, appearing behind commentary on practitioner led change. Sometimes, that change was enacted by the expert practitioner in conflict with top-down directives. Self-development of efficaciousness requires mastery of knowledge and skills that can only be attained through long hours of arduous work (Bandura 1982:142). Moreover, maintaining proficiency in skill areas which constantly change with social and technological advances demands continued heavy investment of time, effort and resources. Expert practitioners have invested heavily in developing their expertise, so perhaps it is not surprising that they respond to unwanted top-down control by subverting it. Participants' reactions to what they perceive as change which benefits the system at the cost of staff relationships, such as the reduction in informal meeting space in new builds, is an example of this subversive response. It seems that expert practitioners are proactive and will make their own spaces where they can, and where they see it to be beneficial to their practice in hospitals by commandeering a room and putting a fridge in it or in schools using Internet technology to create a virtual meeting room. One participant asked me to turn off my recorder while he described a subversive practice of a more substantive nature and his own, professional justification for it. Several participants talked freely about 'bending the rules' or 'ignoring directives' after the formal interview was over. Unable to enact control over their working experience through legitimate means, expert practitioners may become a 'factional influence' (Bandura 1982). This factional influence may wish to enact change, but may do it through subversive means and at a cost to the collective endeavour.

6.4 Theoretical Framework

The ontology of structuration, where the interplay between agency and structure is recognized, was a useful theoretical framework for this research (Giddens 1994; Giddens 2013). The institutions of Health and Education are the largest public sector bodies in the UK, but the everyday experience of the expert practitioners (the doctors, nurses, teachers and university lecturers working within these large institutions) is of intimate, often one-to-one, transactions. The experience of Health workers is visceral, sometimes overwhelmingly so, as one young doctor writes: 'We are permitted to vicariously experience our patients' situations and share their burdens. The visceral nature of our job allows us to be in touch with the crux of our lives – our mere existence' (Shah 2014), and the work of teachers has that same feel to it. Practitioners describe their work as touching the core of the lives of the people they teach (Keltchermans 2005) and the parallels between the experience of practitioners in Health and in Education are apparent. As one of my participants said: 'every day you are a teacher you are touching mortality ... every day we are giving people opportunities that they would never have had … every time I read a speech day list or someone comes up to me in the streets and says "excuse me do you remember me, sir?" … I know it. There is only one more important job to being a teacher – that is, being a doctor – we make lives, doctors mend them' (WR, Head Teacher).

The tension between the desire for autonomous control inherent in the training and experience of these practitioners, and the needs and demands of the structure they inhabit to function as a universal unit, will always create moments of dissonance and disagreement. Solving them is part of the nature of this work, but the statistical evidence provided in Chapter 1 indicates that we are facing an unprecedented long-term trend of increasing dissonance in these public service sectors. The overwhelming evidence of the link between loss of autonomy, loss of the relational aspects of their work and the perception of a loss of self-efficacy for expert practitioners pinpoints the way to understanding the problem being faced in both the public service of Health and Education today.

Bandura's concept of self-efficacy was pertinent to the personal experience of participants in this investigation. Expert practitioners did see themselves as either

becoming more efficacious or less: it was a binary response for many of them. According to Bandura (1977), one of the sources of self-efficacy is past performance. Employees who have succeeded in job-related tasks are likely to have more confidence to complete similar tasks in the future (high self-efficacy) than employees who have been unsuccessful (low self-efficacy). Self-efficacy can be boosted through providing professional development and coaching, goal-setting, supportive leadership, and rewards for improvement (Lunenburg 2011). According to participants in this investigation, the prevailing climate of constant monitoring in the NHS and in Education with patient/pupil feedback, and ever-changing targets, and also in universities, through the monitoring of research programmes and now scrutiny of teaching quality, do not create a workplace which nurtures the raising of efficacy. Importantly, the observation of the dissonance in the working lives of expert practitioners, may, through vicarious reinforcement (Bandura 1977), discourage new recruits from entering these professions.

The process of multiple-level analysis was useful in the present study in offering a sociopolitical context to the experiences of my participants. It is an approach which addresses the relationship between individual, structural, and institutional processes (Jepperson & Meyer 2011), thus complementing the theory of structuration, and is particularly useful in exploring the factors which affect the daily lives of expert practitioners in Health and Education. Their working lives are increasingly affected by the global trade system and by national legislation regarding work practice. They are also affected in their daily interactions by their dyadic one-to-one relationships with clients – clients who also find themselves situated in the global and national context (Scott et al. 2008). The theoretical case for social policy which applies neo-liberal economics, which proposes that a more economically efficient workforce in our public services is possible through involving practitioners in market competition and cost efficiencies, is questioned by this research. The GP struggling to understand the financial implications of the PFI deal which has funded his new surgery has an extra stressor in his working life, as has the head teacher attempting to generate income by letting out her school hall. Furthermore, by failing to recognize the importance of the less tangible qualities present in working life, such as camaraderie, the pleasure of

face-to-face meeting and of conversational time, and not building these 'soft requirements' into costings or timetables, the strategies to improve services are failing. As participants said, only what can easily be measured is measured by large government departments, and this may lead to a skewing of the perception of institutional realities. The subversive nature of the responses to top-down imposition by policy-makers may indicate the backlash to neo-liberal policies described by Martin Jacques in a recent Times article (Jacques 2016). As the global financial situation stays in long-term decline, economists such as Stiglitz (2002), Fukuyama (2016) and Wolf (2016) have questioned the forward motion of neo-liberalism. Jacques, examining the situation from a neo-Marxist perspective, proposes that there is already a discernible seam of popular unrest. He suggests that the financial crisis of 2008 has seriously undermined our faith in the governing elite. Fukuyama writes that there is an atmosphere of popular revolt in the industrial world, commenting that 'populism is the label that governments attach to policies supported by ordinary citizens that they don't like' (Fukuyama 2016:npn) since populism is a movement against the status quo (Jacques 2016). My participants were aware of themselves in the wider meso context (Guy & Shove 2000; Southerton, Chappells & Viliet 2004) and spoke at length about the directives imposed on them by government departments – and the negative effect of media reporting on their service (Cohen 1972). They also positioned their commentary in the larger global context, showing an awareness of broad social change and the effect of US policy and practice on their workplace and work practice. They were conscious of the development of Education and Health as commodities and as themselves as providers of those commodities, as proposed by both Attali (1978) and Aglietta (1979). They did not feel that the monitoring of expert practitioners by outside bodies may not produce better practitioners. There was a consensus amongst both cohorts that in order to solve the problems of staffing in these institutions, it is not useful to blame individuals for inappropriate or unproductive behaviour; rather, it is necessary to look system wide in Health and Education to understand the sources of the dissonance which now prevails. They were aware of the destructive effect of the present escalation of surveillance, citing 'good' colleagues who had 'gone to the wall'. It is not useful to seek to increase resilience amongst these practitioners – their personal characteristics are not the problem. The failure of the system around them leads to two devastating

consequences for these practitioners, burn-out or depersonalization, as can be seen in the work of McManus, Winder and Gordon (2002).

6.5 Methodological Choices

Thematic analysis provided a practical framework which allowed the voices of these practitioners to be heard. The usefulness of thematic analysis is recognized in health and education research: it is used to inform and facilitate appropriate policy and practice (Thomas & Harden 2008). However, as they suggest, its application has to be considered in the light of issues such as appropriateness of the context and in the rigour of its application. The design, which incorporated the use of qualitative data gathering but qualitative and quantitative data interpretation, was appropriate when looking at two sectors and attempting to find similarities between them (Braun & Clarke, 2006; Guest, MacQueen & Namey (2012) In the context of public sector participants, I deemed it to be an appropriate method to carry my research question: the melding of qualitative research with a baseline of quantitative indicators allowed me to be aware of the wider implications of research. These wider implications can only be indicated to useful future directions of research; it is not possible to purport to make statements about thousands of public sector employees from a sample of thirty-six. The size of sample was chosen to support a practical attempt at a useful thematic analysis – it produced over 1,000 code applications from dense, complex interview transcripts, and so does support an effective initial measurement of trends and meaningful commentary. It follows the theoretical basis of structuration and critical realism, both of which posit that only by using measurements which take into account the interplay between institution and the individual can we hope to understand the role of expert practitioners. By looking for patterns throughout public services, we are more assured of finding the fundamental problems facing our practitioners and the solutions to those problems. Our public services sit within a national framework with varying financial and resourcing issues, but also in a global framework with a changing zeitgeist, so any understanding of the role of the expert practitioner has to be undertaken in this wider context.

6.6 Summary

In light of this practitioner commentary, I would suggest that the theoretical case for assessing changes in the work practice of these expert practitioners through quantitative means such as questionnaires or employment statistics also needs to be readdressed. Government statistics on low recruitment and low retention show that there is a crisis, but they are not enough to help us understand why this is happening. I would suggest that the information gleaned through qualitative material such as interviews with relevant leaders in these services can let us understand why these expert practitioners feel so alienated and distraught. Professional bodies such as the GMC and the Educational Institute of Scotland collect snapshots annually of staff attitudes, but these are political documents to be used in the fight for funding, or to defend the position of practitioners within the national framework. A study like this one, which invites individual practitioners in Health and Education to speak about their experiences in a reflective manner, is more likely to offer meaningful commentary on the effects and the causes of the present crisis of staffing and morale they face in their everyday working lives. It also has allowed the nature of 'professional intimacy' to be identified and understood through listening to the voices of practitioners.

This the first academic study to embrace the workforces of both Health and Education; the key findings are that:

a) practitioners in both services demonstrate a highly significant similarity in their commentary on workplace change, indicating that systemic, not individual, failure is the cause of the present crisis of staffing and morale in these services.

b) both workforces emphasise the centrality of building and maintaining relationships between colleagues and between practitioners and clients. The participants in this research also offered one, all-pervasive finding, a sorely felt lack of 'professional intimacy' in their working lives.

c) both workforces seek increased autonomy and reject a top down approach by policy makers.

d) both workforces state that whilst technology can enhance work practice, when crudely applied can foster a 'tick box' culture, leading to a depersonalization of practice and a reduction in efficacy.

These findings demonstrate a significant similarity in the challenges causing workforce exodus in both these public services. They identify areas of pressure for expert practitioners feeling de-personalized and disassociated from their clients and colleagues and indicates the negative impact of the failure to nurture the relational nature of their work which, at its core, relies on humans working together.

CHAPTER 7: CONCLUSION

> What started out as important, meaningful and challenging work becomes unpleasant, unfulfilling and meaningless. Energy turns to exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness. (Maslach, Schaufeli & Leiter 2001:397-422)

This thesis was written in the context of increasing dissonance across the public sectors of Health and Education in the UK during the first years of the 20th century. Policy-makers, professional bodies and the media have expressed a deepening concern that low recruitment, low retention and high exit rates means that a crisis in staffing amongst expert practitioners is leading to a breakdown in the delivery of these services to the population. The dual approach of policy-makers towards these public services and this crisis, that is, a closer monitoring of expert practitioners as individuals and the introduction of competition into provision, has failed to provide a robust foundation for the maintenance and development of Health and Education in the 21st century. Whilst there has been much discussion about health and education policy over the last fifteen years, from policy-makers and from the media, the voices of expert practitioners in these fields have not been heard and this research sought to redress that imbalance. My personal experience as a practitioner working in Health and Education suggested a parity in the negative experiences of expert practitioners in both areas. This parity implied that the problems they faced were structural and cross-sectoral, rather than the fault of failing individual practitioners. The implication of this would be that, if any positive changes are to take place in recruitment and retention of our doctors, teachers, nurses and lecturers, policy-makers should redirect their focus from individual practitioner behaviour to addressing system-wide failures.

In order to privilege the voices of expert practitioners in the current debate, surrounding the provision of Health and Education, my research study was based on a thematic analysis of data gathered from thirty-six semi-structured interviews of hospital consultants, GP partners, nurse directors, head teachers and university course leaders working in the relevant state sectors.

My research questions were:

g) what changes are taking place in the working lives of expert practitioners in Health and Education?
h) is there a shared pattern of experience between expert practitioners in both sectors?

I found in answer to research question (a) that the major changes reported by expert practitioners were: (i) the reduction of autonomy, evidenced by an increase of monitoring of practitioner behaviour; (ii) the increase in demand fuelled by the commodification of Health and Education into consumable products; and (iii) the focus on the personalization of delivery, again increased by the commodification of Health and Education.

One overall finding, which imbued the commentary of participants across all topics, was the need for professional intimacy to be given a central position in the daily working lives of these practitioners. This professional intimacy being a phenomenon of practice which is found in a relational approach combined with, and supported by, substantial knowledge and training. I argue that this synthesis allows the enactment of the 'transformative nature of practice' (Stevenson 2010) as a form of dyadic, therapeutic exchange between the practitioner and the client.

These findings exemplify the thrust of the literatures surrounding changes in our public services. Neo-liberal polices, globalization and the rise of the public/private funding mix in the design and delivery of what were originally created as purely 'public' services have brought pressures to bear upon practitioners in the fields of Health and Education. The three-level analysis of the present situation into macro, meso and micro sociopolitical categories by Jepperson and Meyer (2011) is borne out by the evidence of the legislation instigated by policy-makers in response to (a) global market pressures and (b) media moral panics over individual practitioner failure, and ever-closer monitoring and interference in the relationship between practitioner and client.

Question (b), related to whether or not practitioners in each service share these experiences, is answered positively by the statistical evidence showing a similarity between the frequency of commentary on themes by each sector. However, the training of junior doctors is seen as significant to health practitioners working in hospital settings.

My work contributes to the literatures by showing a cross-sectoral similarity which demonstrates that the issues facing expert practitioners are structural and not the fault of individual practitioners.

These findings could be of use in redirecting policy affecting these practitioners, which at present binds them in increasingly tight constraints and feeds back in a negative way on their practice, to creating more autonomy in practice. It also suggests that these practitioners benefit deeply from interaction with each other and from unmonitored interaction with their clients. Peer assessment seems to offer a more realistic method of monitoring behaviour than close, non-practitioner protocols and directives.

My experience of directing this research has altered my own approach to these expert practitioners, this section of the workforce in Health and Education, the nurses, doctors, teachers and lecturers who use their specific areas of professional expertise to enact change in their clients, students, patients. My understanding of the pressures being brought to bear on these practitioners and the fundamental interlinking between personality, identity and practice which they experience has deepened. An awareness of this fundamental interlinking is central to our understanding of the nature and needs of people who go about the work of healing and teaching in our society. My personal journey was exciting, terrifying and profound. Taylor and Hamdy (2013) talk about disruption being an essential but uncomfortable early component of learning, and I certainly found this to be the case. I was knocked out of my comfort zone as a successful, respected practitioner into becoming a raw recruit, a novice. Fear of failure loomed large.

Most importantly, I began this research with a strong identity as an experienced practitioner and ended it as a fledgling researcher. I entered the process of designing research as someone who was instinctively inclined as a practitioner to

find immediate solutions to work based problems. But this proactive behaviour often provides only immediate solutions, 'sticking plasters'; a distraction from the main point – which is that the structure has to change. Ironically, we must move the focus of politicians to the political; away from the practice of individuals to the system-wide nature of the issues we face. I hope that the research which follows this initial examination of the cross-sectoral nature of the phenomenon of dissonance in Health and Education will tell us more.

I was aware that in this research there was only one researcher, therefore there was no possibility of establishing theme credibility through interviewer inter-rater reliability (Thomas & Harden 2005). Without interrater reliability, Leininger (1994) advises that researchers can turn to the participants to establish credibility with them as primary informant sources. However, there are drawbacks to this route, as 'member checks can become the participants' response to a new phenomenon, namely the researcher's interpretation' (Sandelowski & Barroso 2002:114) Alternatively, the credibility of the themes chosen and results generated can be verified externally by member checks with the target population, following Schutz's advice that to find 'consistency between the researcher's constructs and typification and those found in common sense experience, the model must be recognizable and understood by the 'actors' within everyday life' (Schut 1962: 44-43). Sandelowski & Barroso (2002) propose the construct of direct application, where participants (or other members of the target population) measure the credibility of the research through use of the knowledge generated by the research in their practice. In this way, through direct application, practitioners can become the critics of the research findings and, by default, critics of the themes generated by the researcher. Although it is too early to record any use of the findings of this research, it is possible to gather retrospective evidence of instances where the approach indicated by this research, that is, to encourage a relational, practitioner-led approach to change in the workplace, had been used to support efficacy. Meetings with practitioners in Health and Education established credibility and tested the robustness of both the method and results through the process of peer debriefing (Lincoln & Guba 1985).

Figure 10: Peer Review Opportunities

1. 22 January 2013: presentation and discussion: 'The Cry for Professional Intimacy', 'Education, Emotions and The Future' Conference, University of Leicester. Positive feedback from audience of practitioners and education researchers.

2. 10 March 2013: presentation and discussion: 'The Cry for Professional Intimacy', Graduate School Queen's Medical Centre (QM).

3. 8 April 2013: presentation and discussion: 'The Cry for Professional Intimacy', School of Health Sciences QM. Both of these presentations to staff at QM resulted in positive feedback and useful discussion about the findings of this research.

4. Concurrent validity: the 2014 NHS staff survey of the Blood Transfusion Centres in Scotland shows an increasing dissatisfaction with interrelational matters, i.e. answers to questions such as 'Are staff well informed?' 'Are staff involved in decision-making?'

   A number of staff at Ellen's Glen and the Royal Infirmary, Edinburgh, were participants in my PhD research. Their results show a higher incidence of a perception of 'reduced efficacy' amongst them than present in the 'medical/hospital' cohort overall, which supports the results of the 2014 NHS staff survey.

5. 2015, University of de Montfort, MSc in Medical Leadership Course: General workshop for mid-career doctors: anaesthetists, cardiologists and GPs.

6. 2016, University of de Montfort MSc in Medical Leadership Course: presentation of findings.

7. 2016, University of de Montfort Designing module in Assessment for Learning MSc level: emphasis on medical training, using material from data analysis of this research.

The above examples of the cohort group response to the methods and findings of this research demonstrate that external heterogeneity, and therefore validation for the findings of this research regarding the changing experience of the working life of expert practitioners in Health and Education, was established.

Perhaps the greatest limitation to this research was my own experience as a practitioner. It was also the greatest asset I possessed, in that it allowed me to draw on experience in both sectors to support the direction of my research.

However, being an experienced, senior practitioner meant that my mindset was to listen to a problem being described and immediately go on to look for a joint solution with the speaker. It took me some time to act as a researcher rather than a practitioner: to search for explanations, to be reflexive rather than to enact solutions.

There were practical issues in carrying out this research in the field. I was always conscious that each interview could have been better. I was conscious that it was difficult to get enough time with each participant, or sometimes a quiet workspace in which to meet. One participant dictated a small café meeting space, which made the recording of her responses near unintelligible. In one instance, I shared the classroom with my participant and his class, who were exceptionally well behaved and highly motivated GCSE candidates, but their presence altered the dynamic of that conversation. Sometimes I had a technical hitch – my recorder didn't work and had to be changed; sometimes I didn't know until I left, so nothing could be done about it. I transcribed as people spoke, which made a backup copy of each interview. The practical problem of recording each interview was solved eventually by using my iPhone and an App. Before that, I used a cassette recorder, a digital recorder and, at a transition point, a CD recorder and an iPhone at the same time. The later interviews were smoother to start because of the increasingly better, smaller and simpler technology. Sometimes, events overtook the interview, as when in one hospital a rescue helicopter slowly and noisily descended to a landing strip within a few feet of the window of my interview room. An emergency took place during one hospital interview: my participant had to leave, and I was left alone in her office for twenty minutes. Sometimes interviewees suddenly became tearful when, towards the end of the interview, they recalled what had made them want to be doctors, teachers or nurses in the first place. At those moments the interview setting of an office in a large hospital or school seemed a very small, intimate space.

Sample size is another limitation of my research. Although thirty-six participants constitutes a reasonable number for qualitative work, it is not large enough to give any useful confidence intervals for any quantitative data. My sample had to be large enough to gain some indication of trends or similarities between sectors, and yet small enough to be manageable by one researcher, given that over thirty

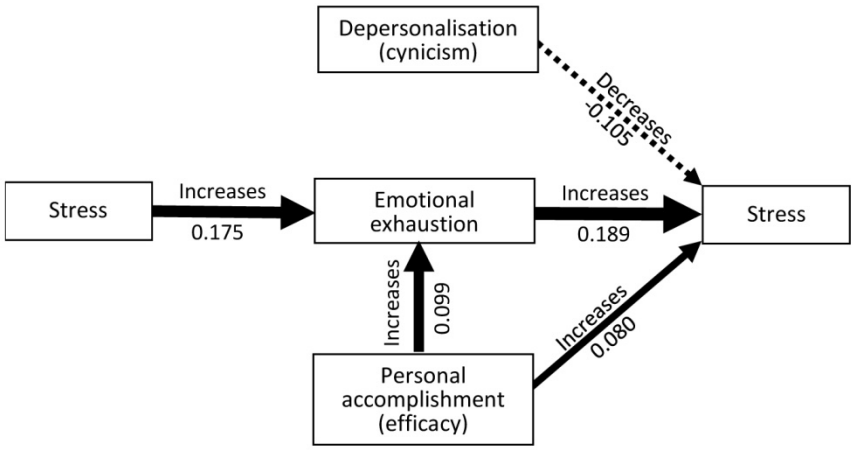
workplaces were visited over the course of the interviews. Although I recorded over 1,000 code applications, the size of the participant sample meant that the quantitative data I have presented here can therefore serve only as an indicator of profitable areas for further research.

The semi-structured interview questions themselves were a successful part of the research, as they allowed some structure to the interview and a feeling of control to the participants who were all under time pressure. The provision of eight guiding questions written on cards meant that they could quickly assimilate the meaning of each question and give time to a full answer. The introductory questions helped to lead the interviewees into the more probing questions later. However, the length of the interviews, and the semi-structured design, were compromises in order to fit into the timescale of the interviewees' working day. Further research would benefit from an ethnographic approach, with a researcher embedded within a school, hospital or university, thus allowing for a richer, more complete, understanding of the daily lives of these practitioners.

All institutions, by their nature, have to balance the needs of the staff and the clients with the requirements to run that institution, whether the restraints be financial or ideological (Giddens 2013). Although these findings indicate that there is a schism between the practitioners and their institutional policy-makers, which has led to dissonance, there is also evidence here that a recognition of the autonomy required by expert practitioners, and the nurturing of an entrepreneurial approach which these practitioners display, is the way forward. The introduction of the School for Health and Care Radicals and NHS Improving Quality (IQ) show a willingness to address the need for relationality to be central in the working practice of expert practitioners (NHS 2014). Collegiate ways of working, and a supportive background of inspection, could lead the way forward in both sectors to a retention of the present workforce and an increase in recruitment. The need to address the erosion of the autonomy of the expert practitioner has been addressed in a large ESRC-funded study of the changing experience of work of consultants in NHS Scotland. This study could be usefully repeated for the teaching profession, talking to the managerial and executive level of that workforce.

Is subversion an inevitable result of the breakdown of trust between the policy-maker and the expert practitioner? The subtheme of subversion can be found within the narrative of these expert practitioners. When a top-down decision about the workspace (as in the lack of canteen facilities), or in the need for relational actions (as in the provision of a table for all to share in a ward), or the creation of a virtual site to voice the ideas of a dissatisfied practitioner, these practitioners were prepared to take action. As indicated earlier, more serious breaches of policy directives were described to me off the record. In everyday life, people often exercise 'proxy control', where they avoid the risks of authority by relinquishing it to another body (Bandura 1982:142); but that is not in the remit of the expert practitioner. Expert practitioners, by the nature of their role (Perkin 1989: Giddens 2013), must bear personal responsibility for the negative consequences of their decisions and actions, some of which have serious consequences for their individual clients. Bandura goes on to suggest that 'attractive incentives, privileges, and heady social rewards are required to get people to seek control involving complicated skills, laborious responsibilities and heavy risks' (Bandura 1982:142). There is a social contract between policy-makers and expert practitioners in Health and Education (Webster 2008), which may be in danger of being breached by the commodification of healing and learning (Attali 1978; Ball 2013; Stevenson 2016). The 'heady social rewards' of being a teacher, a doctor a nurse or a university lecturer seems a hollow concept in reference to the daily lives of these professionals in today's social climate. The 2016 junior doctors' strikes, unprecedented in NHS history, and the, again unprecedented, strike action by primary school teachers over the new SAT tests, in June 2016, may herald a new age of subversion (Stevenson 2016). Could this be the end of neo-liberalism as posited by Jacques (2016)?

Figure 11: McManus, Winder & Gordon 2002

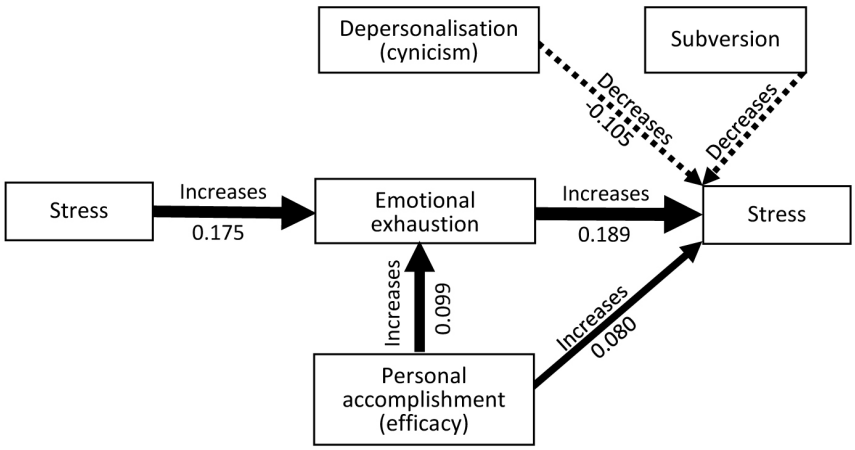


Significant casual paths (standardised path coefficients; significance level in parentheses) between variables at time$_1$ (1997) and time$_2$ (2000). The width of arrows is proportional to the size of the path coefficients. Dotted lines indicate negative values. Auto-correlations have been omitted for clarity.

The longitudinal study of a representative sample of 331 UK doctors carried out by McManus, Winder and Gordon (2002) led the authors to conclude that burnout and stress are common, linked problems in healthcare workers. They assessed stress and the three components of burnout (emotional exhaustion, depersonalization, and low personal accomplishment) in a three-year longitudinal study. Their results illustrated that emotional exhaustion and stress showed reciprocal causation: high levels of emotional exhaustion caused stress and high levels of stress caused emotional exhaustion. High levels of personal accomplishment increased stress levels, whereas depersonalization lowered stress levels (McManus, Winder & Gordon 2002).

I would add to this sequence a possibility suggested by the responses of my participants, and by behaviours such as failure to comply with directives or the taking of strike action. For expert practitioners in Health and Education in the 21st century, subversion could act as an alternative de-stressor to depersonalization (Figure 12).

Figure 12 How subversion may fit into causal paths – after McManus Winder and Gordon: Birkbeck 2016



Significant casual paths (standardised path coefficients; significance level in parentheses) between variables at time1 (1997) and time2 (2000). The width of arrows is proportional to the size of the path coefficients. Dotted lines indicate negative values. Auto-correlations have been omitted for clarity

The phenomenon of the extended junior doctors' strike of 2015/2016 has no precedent in the history of the NHS; the collusion in May 2016 of some primary school teachers with a parental campaign to disrupt the application of SAT tests is equally unprecedented. These phenomena can be usefully described as subversive acts. Stevenson argues that 'the potential of teachers to work in a critical and transformatory way means that they are always a threat to the social order' (Stevenson 2016). I would expand that definition to include all expert practitioners in Health and Education. Subversion amongst expert practitioners in these public services is a dangerous outcome both for policy-makers and for society as the commitment of these practitioners and the trust we place in them may be eroded to the point of no return. The relationship of subversion as a

response to the stressors experienced by practitioners in both Health and Education should be further researched.

It would also be productive to research the cross-sectoral nature of the experiences and reflections of senior practitioners, as the focus of the present study across these two services points the way towards a recognition of fundamental issues shared by expert practitioners in Health and Education. The interface between policy-makers, practitioners and clients in these two institutions could provide a useful context for this research.

There should be a recognition of the interdependency of these services, and the particularly relational aspects of delivering Health and Education. The ability to communicate emotionally difficult or intellectually challenging information is part of the 'soft skills' of these expert practitioners, as is the capacity to innovate and to imagine. These soft skills, used in conjunction with experience and expertise, must continue to be central to decision-making about our public services in the 21st century; software and quantitative measures alone cannot be allowed to shape and dominate the delivery and the evaluation of these services.

A 2016 NHS staff survey found that NHS staff were 'engaging more', and this was seen as a positive development by the Parliamentary Under Secretary for Health, pointing out that 'staff morale scores show increasing engagement in the NHS' (Hansard 2016). However, according to Michael West, writing for The King's Fund,

> Engagement underlies effort, involvement, flow, mindfulness and intrinsic motivation. The good news then is that levels of engagement, as recorded in the NHS Staff Survey, have increased since last year. While the survey results can be presented from a 'glass half full' perspective, if we see the glass as half empty then the results are disturbing. (West 2016)

He goes on to analyse the information from this survey further:

> 70% would not recommend their trust as a place to work and 57 per cent say they are unable to meet the conflicting demands on them at work. (West 2016)

This investigation illustrates that using descriptive statistics, even taken from large cohorts, as above, may not let us see the whole story. The clustering of relevant codes shows how there are varying trends in the data which are then supported by the individual commentaries of practitioners. While trends can be identified through frequency and clustering, it is the qualitative element of this investigation which allows to be heard the more complex responses of expert practitioners to their service.

There are multiple pressures on expert practitioners in delivering Health and Education to the 21st-century UK population. Has there been a zeitgeist shift to personalized interactions in commodity exchange? And has this spread to our public services? The exhausting effect of lack of resources to meet an increased demand for emotional labour (Hochschild 1983) from clients can certainly be heard in the weary voices of the GPs and teachers who talked to me. In this commodified world, do clients, patients, students and pupils expect, demand, to have a say in their education or treatment? As the narrative of my participants shows, the introduction of extensive monitoring by lay examiners as a government response to the four major events outlined in Chapter 2, Section 2, has eroded the perception of professional autonomy amongst teachers, doctors, nurses and academics. Their response is a controlled but hard-felt and clearly articulated anger. One university participant called this shift to a consumer led service as a 'slavification' of fellow academics. A teacher described the demand for data from central government as an 'abasing and corrupting influence', and an exasperated consultant described the requirement to offer percentile-based choice to patients, who don't understand the concept of medical risk. As he says 'we are told we are accountable, well, of course we are accountable, we always have been. That's what being a doctor is!' The desperate tone of feedback from practitioners in the field, as with the use of the word 'hopelessness' by Dr Nikki Thompson, to describe the mood of her colleagues (Hill 2015), online material from the Headteachers' Roundtable (Tierney & Tomsett 2016) and the Education Support Partnership (2016), added to negative commentary from the media and from politicians, may be having a negative effect on recruitment into these professions. The use of temporary staff created by the shortage of these key workers may contribute to a vicious downward spiral of ever-increasing dissonance within and

about our services of Health and Education. With regard to the NHS, the Keogh Review (Keogh 2013) commented on the dependency of managers on agency staff and locum doctors to cover vacant posts, and consistently unacceptable understaffing in some areas (Keogh 2013). Similarly, in spite of the TeachFirst campaign, an increasing number of supply teachers, previously commented on in a review of a survey by the NAHT (Morris 2015), work in our schools. These temporary teachers, and the increasing number of part-time, short-contract university staff (HEFCE 2010), cannot offer the continuity of professional care and attention which underpins the delivery of Education and Health (Keller 2008; James & Biesta 2007; Hughes 2008).

Health and Education share fundamental properties. They are 'transformational' for individuals (Slavich 2005; Slavich & Zimbardo 2012) and that enactment of transformational change, which is a move towards healing or learning, is a one-to-one transaction, between a practitioner and a client (Beach & Inui 2006). Using the sociobiological prism of Rose (2013), the roles of the 'teacher' and the 'healer' (Boesch 1991: Trivers 1971) can be seen as fundamental to our society, necessary to group survival, their function enacted through daily 'instantiations' (Giddens 2013), meetings between practitioners and their clients. The neo-functionalist Hass, examining pan-European health and education systems, stated that the essential face-to-face nature of these meetings serves to reaffirm the centrality of 'intersubjectivities' (De Haas 2010) in melding together a social group. To Goffman, role-based interaction with accepted expectations of intent, application and outcome form the very fabric of human social traffic (Goffman 1990). Within that daily traffic, what is described as human altruism is, to Trivers (1971) not an incidental, heroic element of human behaviour, but an essential tool for group survival. Our public services of Health and Education, the school, the hospital, the university, can be seen as the contemporary sociopolitical manifestations of the social drive towards the altruism described so eloquently by Dr Iona Heath (Heath 2012); the role of the teacher and healer within these structures could therefore be seen to be an ongoing application of human altruism. The Committee on Standards in Public Life (CSPL online) set up in response to the public perception of the erosion of ethical standards in public life (Nolan 1995), although primarily concerned with the behaviour of civil servants, can be

seen in its recommendations to encapsulate the ethos of altruism expected from the expert practitioner in Health and Education. The committee's Seven Principles of Public Life: selflessness, integrity, objectivity, accountability openness, honesty and leadership, became a guiding framework for all public sector activities and are designed to work within the traditions of the public sector ethos (Heywood 2012). These seven principles could be seen to be a blueprint for a practical expression of altruism through public service.

The economist Julian Le Grand, who was Health Advisor to the Labour Government of 2001-2005, offers a metaphor for the two opposing economic systems which exist in the neo-liberal landscape and which profoundly affect the role of the expert practitioner in Health and Education. He compares a 'central economy' – in which professionals are seen as 'knights', acting altruistically, while those receiving services are 'pawns', passively grateful for the services they get – to a 'market economy' – in which pawns become 'queens' because the customer is always right, and professionals are recast as 'knaves', seen as acting in their own interests unless constrained by regulation (Le Grand 1997). Dr Iona Heath, when delivering the Michael Shea Memorial Lecture to the Royal Society of Edinburgh in 2012 (Trueland 2012), referred to Le Grand's metaphor in reference to the role of all public servants:

> Having been a GP for more than 30 years, Dr Heath acknowledges that when she talks about 'professionals', her knowledge is mainly of those working in health care. When talking about how society is 'straitjacketing' professionals, however, what she has to say applies equally to teachers and social workers and, indeed, to any group previously described as 'public servants. (Trueland 2012;1)

Dr Heath offers one innovative twist on Le Grand's metaphor by envisaging, rather than the stark options proposed by Le Grand, where only one side in this battle between expert and client can win, instead, a state of productive equity between them, where each benefits from his/her interactive exchange. In her speech, she refers to the 'gift economy' first described by anthropologists in the 20th century (Malinowski 1922; Hann 1998; Weiner 1992), where skills and possessions are transactions rather than discrete entities; the expert skills of the doctor, the academic, the nurse and the teacher are valueless and do not come into

being without the client with whom they interact. Heath suggests that the relationship between the expert practitioner and the client should be, as Trivers identified, one of reciprocal altruism (Trivers 1971), but that the uncontrolled rise of the 'market economy' has stifled the essential nature of this relationship.

> When I embarked on my career as a doctor in 1974, to be a public servant was to be doing something good, By the end of the 1980s the same role had become, through a painful and demoralising process, somehow despicable. What had disappeared was any idea of a 'gift economy', where professionals could be knights, but recipients could be queens – and once altruism wasn't recognized, it began to disappear. (Heath, 2012:3)

> That is why we must do everything not to lose the commitment, the courage, the willingness to keep thinking, all of that is what makes up the love of our professional labours. (Heath, 2012:13)

In this thesis I argue that there is a discernible, all-pervading tone in the words of the practitioners to whom I have spoken. A tone which permeates these words (above) of Dr Heath and which I have chosen to describe as a 'cry'. A 'cry', sometimes of anger, sometimes of despair, which has, at its core, the desire of these practitioners to be allowed to practice their skills, to apply their knowledge, to further their research: a cry for professional intimacy. Their sense of self-efficacy is fed by the successful practice of their skills and the recognition by their employers, their peers and their clients, that they are practising successfully. These highly-trained and motivated practitioners find that excessive and inappropriate monitoring is counter-productive, creating fear, anger and reducing self-efficacy. The 'professional intimacy' they seek is the one-to-one moment of discovery and transformation which happens when thoughtfully applied knowledge or skill changes the life of the recipient. These are reciprocal moments: they are transformational for the teacher, the healer, as well as for the student, the patient (Deci & Ryan 1985; Hughes 2012; Goold & Lipkin 1999) and they are vital to the success of our national institutions of Health and Education.

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APPENDICES

Appendix 1: Letter to Doctors req.

Fiona Birkbeck
Room C17
Dearing Building, Jubilee Campus
Woolaton Road
University of Nottingham, NG8 1BB
email ttxfb3@nottingham.ac.uk

Thursday 12th June 2014

Dear……,

Doctoral research participation request

Having spoken to Dr ….. ….. I hope that you also will be willing to participate in this doctoral research. The initial part of this research consists of in-depth, semi-structured interviews with key professionals, GPs, hospital consultants, nurse directors, head teachers and senior lecturers in the National Health Service and in Education, and has ranged from Edinburgh to Cambridge. The responses of GPs to change are particularly important as their role is central to the future development of the NHS.

If you are happy to go ahead, your involvement would consist of one interview of about forty-five minutes given in your work environment which I will transcribe manually or record digitally, according to your preference. The questions asked relate to the changing environment in which you work, changing patterns within your work structure, and your reflections on the impact of these changes on the working practice of someone in your role.

This research has been ratified by the ethical committee of the University of Nottingham. All transcriptions, manual or digital, will be held at the University of Nottingham for the duration of the research and destroyed upon its completion. You have, of course, the right to withdraw your interview data from the research at any time.

I realise that you have a full work schedule and appreciate your willingness to get involved. I understand holidays are coming up, which makes staffing even more difficult, but let me know if you have any time in July. Please use the email address above to contact me. I am looking forward to hearing from you.

Best wishes
Fiona Birkbeck
PhD research student
University of Nottingham

Appendix 2: Ethics Documents

PARTICIPANT INFORMATION SHEET

Aim: This project is Section 1 of the data collection for doctoral research which is an exploration of institutional change in the early 21st century and its effect upon the workforce. The specific aim of Section 1 is to gather first-hand accounts from key employees currently working in a changing environment in the National Health Service and in state education. A pilot study has been carried out with staff from the British Council.

NB: the phrase 'changing environment' refers to changing physical environment and to change in work practice.

Procedure: the participants will be required to take part in a semi-structured interview of one hour in duration. An audio recording of each interview will be made to facilitate accurate data analysis.

Confidentiality: data gathered from these interviews will be stored at Nottingham University, including hard and electronic copies generated of audio recordings, or of transcripts of audio recordings. All audio recordings will be destroyed on completion of the project. During the project, F. Birkbeck and Dr Gary Winship will have sole access to audio recordings. Participants will not be identifiable in any subsequent publication of this material.

Participation: participation in the research is completely voluntary, and participants are at liberty to withdraw at any time without prejudice or negative consequences; non-participation will not affect any individual's rights/access to other services in regard to Nottingham University.

Protection from harm: potential risk to participants, as assessed using the guidelines of British Educational Research Association's Revised Ethical Guidelines for Educational Research (2004), is minimal. Participants may be assured that the data gathered will be the minimum required for purpose. Confidentiality and free access of participants to material developed from the data they provide, combined with a right to withdraw their data at any point, should remove measurable risk.

Potential benefit: participants should be aware that their involvement in this research will measurably increase understanding in the public domain of the response of the workforce in their particular institutions.

Should you require further information please contact:

Researcher: Fiona Birkbeck ttxfb3@nottingham.ac.uk
Supervisor: Dr Gary Winship Gary.Winship@nottingham.ac.uk

Should you wish to make a complaint on ethical grounds please contact:
School of Education Research Ethics Coordinator:
andrew.hobson@nottingham.ac.uk

PARTICIPANT CONSENT FORM

Project title: The Cry for Professional Intimacy: Changing Relationships between the Client and the Expert practitioner in our Post-industrial Public Services.
The response of key members of the workforce to recent environmental and structural changes within the National Health Service, Education, The British Council

Researcher: Fiona Birkbeck
Supervisors: Dr Gary Winship, Dr Andrew Townsend

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that an audio recording may be made during the interview.
- I understand that data will be stored at Nottingham University, including hard and electronic copies of transcripts, but that any audio recordings made will be destroyed on completion of the project.

  During the project, F. Birkbeck and Dr Gary Winship will have access to full transcripts.
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed ……..
(research participant)
Print name …… **Date** ……

Contact details
Researcher: Fiona Birkbeck ttxfb3@nottingham.ac.uk
Supervisor: Dr Gary Winship Gary.Winship@nottingham.ac.uk

School of Education Research Ethics Coordinator:
andrew.hobson@nottingham.ac.uk

Appendix 3: Dedoose Document identity 15, K. N…..

Transcription KN….. , Consultant, W….., March 12th 2014

GQ It's become like the airline industry - I got you from Dublin to London and I don't know where you went afterwards…. fragmented… But it's a journey, isn't it? You want to meet somebody and say, 'Oh right, how are you? how did you do?' … I don't remember all my junior doctors now, because they train so quickly their relationship with me is not all that strong now it's all done in lectures, internet, tick boxes, appraisal and so on…… when I was training I would sit down and talk to my consultant for hours about this patient and that.

B PPE I am a trained ophthalmologist; I am equipped to diagnose ophthalmic conditions and offer help and advice in correcting those problems i.e. the population ranges from children of 6 months old to somebody who is 95 years old – (an example of PPE) take an 85-year-old person with a condition such as a cataract that needs attention as an ophthalmic surgeon I am the 'ultimate roundabout' (organizer of the journey) that is the essence of my skill – through me that operation will be delivered and of course everything that takes place before and after that procedure.

C Physical environment changed? Yes when I first came here we were in a different part of the hospital …the site was different. We have moved from north to the south side of the hospital – this is a relatively new department if you like… obviously with time and technology the instrumentation and technology we deliver has changed. Technology has had a huge impact … we are now delivering a lot more technically driven care if you like, both in terms of diagnosis and in terms of treatment. We rely a lot more on technical gadgets than before. Yes we have… (indicates consulting room) for instance, if you look at this room when I first… we didn't have this computer here (indicates), we had half the drops (indicates shelf of ophthalmic drops) we didn't have half the lenses, only one opthalmoscope, we now have four or five or in the department. We only had one slip lamp (?) now we have three in place. We can be more exact. Science is what we can deliver. Technology has supported delivery.

D What caused it? It's a welcome change. It's a nation or a people keeping in with the advance of technology. The advance has been spread out to the betterment of the population by and large. The profession has led and told the Govt that this now what we can do therefore the Govt has had to respond to these advances.

E Work practice has changed, yes, because of technological advances and so many gadgets which are now required and so on – I alone cannot do it all so responsibility has to be shared. There has been a gradual increase in the role of nurses for example – in 1987 we used to do cataracts in a particular manner so that the incision was quite big… the patient stayed in hospital for anything up to three or four days. Now, because of the technological advances we are now able to do, effectively, pin hole surgery and the patient goes home same afternoon. So that has been a huge, a sea change, really. We see so many more patients – we can do so much more for so many more people now. FB does this mean that you don't

have as much time with patients? … And yes, I have to establish a relationship very very quickly … this works because we have shared responsibility. For example if I was seeing somebody (in the past) I was responsible for their total journey so from when they first came here for basic complaint until they received their treatment and then came for the final check-up I was doing it all, but now because there is so much more, more is required, some of the things that I was doing is done by, is now being done by optometrists, nurses and so on… and nurses, their role has changed. A nurse (in the past) was looking after the patient in the hospital environment now they are taking on more technological aspects of care… FB how does this affect relationships ? They (nurses) are more technical partners rather than just carers. Previously they were just carrying out instructions but now they can input into the decision-making, that's a huge difference. For example, the sister can give me the dimensions of an particular implant that I am going to use and because she does it more often I have to respect her judgment, her calculations and her technical skills.

F Cause of change? I think the profession has seen its role change. If you were a nurse twenty years ago you were providing more care, moving patients from place to place and so on. Because that is not happening or required so much and also because now doctors needed more help with what they were going to do - for instances, diagnostic or therapeutic skills they have welcomed this change. Many things that were traditionally done by doctors are now done by nurses…it is a huge shift – it changes (relationships) it is just the way that technology has… we can't stand still… it's like the internet and say, sending an email, I don't like sending emails but it is part of the change!

G Efficacy – better or worse? Gradually I have seen a dependence on technology in preference to clinical skills. One could easily call it a worrying trend or a welcome change. I don't know, I have my reservations We have been giving so much in to technology now that we would be totally lost without it – (analogy) new technology is to us what fire was once for our ancestors – before you had fire everything had to stop at dusk but then fire came and you became dependent on fire, similarly now for us with technology… yes, clinical skills, that is lost, that is lost and that is a big worry. Yes, we are losing the human skills, if you like. I can communicate with you by writing a very nice printed out Times font letter in a general sense but I can't write you a hand note. I can take a picture of you but not draw your face with my impressions. If I don't have the camera how can I describe you? FB new generation of doctors Ans I am very excited about the change that is coming to them but at the same time I am concerned that they are losing out on the opportunity, or the fun, of doing things the humanistic way. You (in the past) would operate on somebody …. well, (first of all) you came up with 'this is my diagnosis!' and that is a huge reward and now the diagnosis is made for you by machines, the scans, it is in front of you, and so forth. It is very common for today's doctors to be presented with a patient with the ready-made diagnosis from instrumentation … from specific task masters, the nurse in OCT or ultra sound - you have the patient and the data, and the data walks in front of the patient ….in the past, I will see somebody that comes to me. I would be interested in asking them 'what are your problems, describe your symptoms, concerns?' … Now they come to me telling me, with a ready-made diagnosis from the optician… that 'the operation I need is …. I have a got a cataract .' or 'I have

checked on the internet I have an anterior….' So my opportunity to discover - that is going and is making our relationship (between the practitioner and the client) unromantic, if you know what I mean…. that gave me (a great satisfaction). Humanity is all about interacting with another human being. Isn't it? I want to respect you for something that I don't know so your skills are what I perceive and you come to me because you want to listen to what I have to tell you. You tell me your problem, and I can help you because I have a knowledge base and I will start talking. You would listen and say 'how wonderful! How fascinating!' But now if you already know that 'fascination'…. 'why will I come to you? I know it already!'…. like the grandfather saying 'I want to tell you a story' to his grandchildren but the grandchild says – 'I have already heard it' ….. The patient has changed now, the patients, many patients are very well informed. They are not looking for any specific advice, advice, they are looking for a definite end product … 'if I have I a cataract why don't you remove my cataract… because I have read or I have seen…. my auntie had a cataract operation and she was playing golf the next day'… they are not interested in options, in your advice…..everybody has been fed ..,it is driving… and this is increasing the demands on the NHS is… because of this… and as a doctor I cannot definitely say that somebody who has come to see me is heeding my advice …is going to heed my advice …. if he doesn't like what I say he may go elsewhere… and I think that we (practitioners) have (also) changed over a period of time… (respect for consultant as repository of knowledge is gone) to a certain extent we expect that… We expect patients to be well informed but on the other hand there is a little skew in this (new) relationship… we don't know if this person, this patient is, is she trying to respect you or is to examine you? Has she come to seek your knowledge or is she trying you out? Testing your knowledge, expertise, status… yes, because the patient has become the client now. They come with the notion that they know exactly where they want to go… they have already mapped their journey and they are just looking at you to point them in the right direction… They would come (in the past) to say 'should I go left or right?' now they know they want to go left… they just want you to just point them that way.

H I genuinely believe in spite of that I have had to say that I have a role to increase the happiness of the people I see, the population here… and I have a job which it pays me well and respects me also… in spite of all the bad publicity and so on I have no… everybody who meets me and they talk about medicine as losing its place and becoming not so glamorous a profession … I still feel that it is it a tremendous privilege. You can't really fault people (for using the internet etc) if I had a sat-nav it would be crazy for me to turn it off! FB are new doctors driven by same desire as you? Ans. I have mixed views about that (wanting to do the job) A good thing technology has brought is more certainty. It is a good thing, we can do so much more quickly and we don't have to worry about it. It is a very good thing to go home and be able to switch off… but it is also demotivating people to some extent from the care aspect of the job… they are looking at it as a job, it's an opportunity, a money making thing, i.e. I have invested so much in it so…

Career guidance?… I had no idea why I was going to be a doctor. I got good marks, it's a valuable skill, not easy to become one… and so on… now the next generation, we are investing in our children…

FB Senior nurses have said that junior doctors appear and disappear Ans. junior doctors don't stay long enough, they don't have the time to develop that, that total package… It's become like the airline industry - I got you from Dublin to London and I don't know where you went afterwards… fragmented… But it's a journey, isn't it? You want to meet somebody and say, 'Oh right, how are you? how did you do?… I don't remember all my junior doctors now, because they train so quickly their relationship with me is not all that strong, now it's all done in lectures, internet, tick boxes, appraisal and so on… when I was training I would sit down and talk to my consultant for hours about this patient and that… (FB could the excitement of doing the job be lost? is it difficult to create individual relationships) Ans. it is hard to do (treat patients as individuals)… because that is how the politics of the land is driving things. David Nicholson, (outgoing Chief Executive of the NHS), is talking about investing in super cardiac centres… he is talking about investing big money... major trauma centres but really society is not dependent on major trauma - how many heart transplants actually take place? The bread and butter (of health care), the basic thing, is for someone to, to have some tablets and get through life… but because technology is so exciting it is taking the eye off the real social issues. And this is what concerns me… I have children and I am well to do so I will buy education for them, they go through private school this that and the other… they will never see the real misery or difficulties of the a very basic population, they will always be in this top layer. They went to private school, then Cambridge, on to Oxford to do their thoracic surgery…only treating the very wealthy people with heart problems or diabetes. They did not actually see the measles, the cough and the common cold – these things are trivialized - but that is what medicine is all about. You are my friend, if you are my doctor - and I can come to you with my little sore finger… but that has been trivialized, if you have a common cold 'well, go and see the pharmacist' – so the doctor never sees these things… so the relationship in primary care is changing very much… FB litigation etc. do people feel trust has gone?… Ans. team work or trust or continuity… these things have gone - particularly in primary care. In general practices you may actually see that there is a Nurse Practitioner who cares for diabetics so the GP is losing touch with caring for diabetics… the GP is losing the chest problem, they(the patients) only see the Nurse Practitioner. Everything is compartmentalized. The GP is losing knowledge of chest infections… now a Nurse Practitioner sees chest infections… and (indicates signing off a sheet) if you have a chest infection do this, this and this…

Appendix 4: Extracts from Field Diaries

Field Research 1: Preliminary Interviews

1 Date: 1st August 2012

Present: Fiona Birkbeck, …. …..

Venue: ….. Education Offices

Content: overview of project and history of project

Report:

First impressions

The small B-------- train station leads directly into the main shopping area – large clear writing on prominent instructions on how to get to official buildings – indicating that a) people need to communicate with officialdom – that could be their prime reason for getting off the train, and b) that they need simple directions to make it! All feels gently patriarchal. Dependency culture.

B--------- Education Offices are small, smack bang in middle of shopping centre – right opposite MacDonalds. Gives impression of run down sixties built secondary modern school as I go in. Well – they don't spend money on themselves, anyway.

I G is adept at describing his project. The right mixture of enthusiasm and realism – 'this will either work or fall flat on its face' He talks about the problems B------- faces. Education is not a prime motivator for pupils. Fourth-generation unemployment is part of pupils' experience. The black market in cigarettes, alcohol and drugs is the main part of the economy. He tells me that at night four-by-fours stand outside the MacDonalds I had sat in earlier, and trade. 'Criminals run the real economy of B--------- Criminals and the government in the form of benefits,' he says. This has given I G the only edge which might kick start this project – an economic edge – family benefits are to be linked to educational achievement – i.e. completion of tasks etc. this will be done using another key component of this project – ICT – each pupil will be given a laptop and this lap top will be linked in to the benefit system – targets for attendance at lessons and completion of work will be linked to benefits for the whole family.

I G has obviously relished the involvement with central government and big hitters like Microsoft which the project has brought. His background is in the Army and then teaching geography. He talks about using army motivational techniques and seems to expect concrete results from this initiative. Concrete in the sense that the pupils of B------- should increase their pass rate at GCSE. Motivating staff to first implement and then manage this changed teaching environment is one of his biggest problems. B------- has already increased its GCSE pass rate by more conventional methods and teachers are asking - 'Why change everything now? We are already beginning to sort problems' – but the improvements have not been sufficient. In order to lead this change eight architects of change have been chosen. These eight key teaching staff will be given training and support from the DfES and QCA. I G suggests that I could set up action research which will allow feedback from these members of staff into the

whole project. On leaving the offices I have an almost overwhelming desire for a MacDonalds. I resist. Must remember the guiding principles of delayed gratification.

Monday Nov. 26th 2012 phone call with R D, who has direct responsibility for cohort of teachers leading change. They have been on training course down south – London – run by DfES? – [name] is working with them – idea is to grow a group ethos of support – some possibility of them taking modules towards Masters at E------ College – one of which would be to reflect on process of change they are going through – possibility for my involvement here as mentor /as recorder of reflections/ as feedback agent/as liaison between teachers and Council.

Appendix 5: Final Coded Themes with Frequencies

Final coded themes	Education	Health
Workplace towards relational	52	64
Workplace towards systemic	19	20
Workplace change led by prac/client	52	63
Workplace change led by policy-makers	21	39
Workplace change reducing efficacy	16	16
Workplace change increasing efficacy	28	52
Work practice change towards technology	78	62
Efficacy increased	39	23
Work practice change prac-to-prac & prac-to-client relational	71	140
Work practice change prac-to-prac & prac-to-client systemic	39	62
Work practice change prac/client led	46	53
Work practice change led by policy-makers	32	59
Work practice change increasing efficacy	32	56
Work practice change reducing efficacy	23	44
Training towards relational	1	11
Training towards systemic	1	12
Training changes prac/client led	1	6
Training changes policy-maker led	1	12
Training changes increasing efficacy	1	4
Training changes reducing efficacy	1	14
Comms: face to face reducing	4	34
Job satisfaction increased	0	1
Job satisfaction decreased	4	33
Comms: data led increasing	18	49
Job satisfaction increased	1	2
Job satisfaction decreased	14	35

Appendix 6: Code Co-occurrence

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Tot
WORKPLACE CHANGE															
1 Towards relational		5	105	27	3	78	11	3	15	2	7	1	11	2	**270**
2 Towards systemic	5		7	29	32	1	4	1	1	2		1		2	**85**
3 Led by prac/client	105	7		31	5	69	12	5	13	1	7	1	10	1	**267**
4 Led by policy-makers	27	29	31		28	18	4		6	3		1	4	2	**153**
5 Reducing efficacy	3	32	5	28			4	1	1	3		1		2	**80**
6 Increasing efficacy	78	1	69	18			3	1	13	3	5	2	10	3	**206**
7 Towards technology	11	4	12	4	4	3		26	11	3	15	4	13	3	**113**
8 Efficacy increased	3	1	5		1	1	26		3	1	3	1	3	1	**49**
WORK PRACTICE CHANGE															
9 Prac-to-prac & prac-to-client relational	15	1	13	6	1	13	11	3	32	5	102	10	91	8	**311**
10 prac-to-prac & prac-to-client systemic	2	2	1	3	3	3	3	1	5	10	6	75	9	63	**186**
11 Prac/client led	7		7			5	15	3	102	6	0	10	64	4	**223**
12 Led by policy-makers	1	1	1	1	1	2	4	1	10	75	10	0	10	59	**176**
13 Increasing efficacy	11		10	4		10	13	3	91	9	64	10	0	3	**228**
14 Reducing efficacy	2	2	1	2	2	3	3	1	8	64	4	59	4	0	**153**
Totals	**270**	**85**	**267**	**153**	**80**	**206**	**113**	**49**	**311**	**186**	**223**	**176**	**228**	**153**	

Key

20-50
51-105

Appendix 7: Identity Code Matrix

ID	Workplace towards relational	Workplace towards systemic	Workplace change led by prac/client	Workplace change led by policy-makers	Workplace change reducing efficacy	Workplace change increasing efficacy	Work practice change to relational	Work practice change to systemic	Work practice change prac/client led	Work practice change led by policy-makers	Work practice change increasing efficacy	Work practice change reducing efficacy	Totals	
52	1	0	2	2	0	0	3	1	2		2	1	19	E
51	1	3	1	1	2	0	0	4	0	4	0	3	21	E
50	3	0	2	0	0	2	13	0	1	1	2	0	24	E
49	2	2	0	1	1	2	0	3	0	2	0	4	20	E
48	1	4	1	2	2	0	1	1	3	1	0	0	25	E
47	6	0	5	0	0	2	2	0	2	0	1	0	20	E
46	1	1	1	2	2	0	5	7	4	6	4	6	43	E
45	0	1	0	1	1	1	8	4	5	3	6	0	37	E
44	4	0	4	2	0	2	3	0	3	1	1	0	26	E
43	1	4	3	3	6	0	2	1	3	0	2	1	42	E
42	4	0	2	2	0	2	7	1	6	0	4	0	32	E
41	2	0	2	1	0	0	5	0	2	0	1	0	19	E
40	12	0	12	0	0	8	4	2	3	1	3	1	49	E
39	3	1	4	2	0	3	3	2	2	1	1	0	26	E
38	2	0	3	0	0	2	2	0	2	0	1	1	18	E
37	3	1	4	1	1	1	4	6	1	3	1	2	37	E
36	3	1	4	1	0	1	7	3	5	3	3	1	45	E
35	4	1	2	0	1	2	2	4	2	5	0	3	26	E
27	5	1	2	2	0	0	4	1	3	0	2	0	20	M
26	5	0	6	4	0	6	15	4	7	3	6	3	64	M
25	5	3	5	3	2	3	18	1	6	0	1	0	50	M
24	8	0	9	2	0	5	5	1	0	0	2	0	35	M
23	1	0	1	0	0	1	16	1	3	1	7	0	31	M
22	3	0	4	1	0	2	9	3	4	5	4	2	40	M
21	3	0	3	0	0	2	14	0	7	0	7	0	48	M
20	2	1	1	3	1	2	3	3	1	3	0	3	24	M
19	6	0	6	1	0	6	11	6	2	7	4	3	59	M
18	3	0	4	1	0	6	2	3	4	5	1	3	35	M
17	9	1	9	2	0	9	8	6	2	6	6	1	63	M
16	1	2	1	2	1	1	1	4	0	3	0	3	23	M
15	1	0	2	0	0	1	1	4		2	0	4	30	M
14	3	3	2	2	1	3	9	4	2	5	2	4	45	M
13	1	6	1	10	8	1	4	9	5	5	4	6	64	M
12	1	0	1	1	0	1	3	3	2	4	2	4	22	M
11	4	1	3	3	1	3	13	2	3	3	6	3	46	M
10	3	2	3	2	2	0	4	7	2	7	2	5	39	M
Totals	117	39	115	60	32	80	211	101	99	91	88	67	1267	