Learning to mobilise knowledge collaboratively: (per)forming community, translating knowledge, and reconciling identities.

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Abstract

Mobilising knowledge and expertise across disciplinary and organisational boundaries is a long debated challenge in the organisation and management field. This thesis explores the particular challenge of mobilising management knowledge in the healthcare domain. Specifically, it examines how 'non-native' service redesign and process improvement knowledge, from other business sectors, mobilises through collaboration. In the healthcare management literature, the archetypal approach to understanding collaborative knowledge mobilisation is underpinned by a metaphor of 'knowledge transfer'. The use of this metaphor has, however, tended to promulgate the idea that collaboratives can be set up to unproblematically promote the targeted 'transfer' of knowledge across disciplinary and organisational boundaries. Yet evidence of such success is sparse, and accounts within this paradigm fall short of explaining how and why collaborative knowledge mobilisation initiatives flourish, or why they flounder.

This thesis brings a 'translation' perspective to bear on the phenomenon of collaborative knowledge mobilisation—an approach which foregrounds social and political practice, process and context. Specifically, I deploy Situated Learning Theory (SLT) (Lave & Wenger, 1991; Wenger, 1998) to conceptualise collaborative knowledge mobilisation as comprising the mutually constitutive processes of *learning* and *becoming.* To provide further insight into these dual processes, I assemble a 'conceptual bricolage', drawing from theories about epistemic cultures (Knorr Cetina, 1999) and identity work (Alvesson & Willmott, 2002; Jenkins, 2004).

The overarching objective of this thesis is:

> *To explore how participants of collaborative networks learn to mobilise knowledge across disciplinary and organisational boundaries, through situated learning and identity work in the healthcare setting.*

To achieve this aim, I ask the following overarching questions:

1. *How do instrumental collaborative knowledge mobilisation networks form in practice in healthcare systems?*

2. *How do key actors from different epistemic communities (process improvement advisors and hybrid clinician-manager 'targets' of improvement knowledge) negotiate and translate knowledge within such collaborative networks?*
3. *How do these actors reconcile their existing identities with their participation in such collaborative networks?*

I explore these questions through a practice-based methodological approach. I deploy this approach in a study of the first twelve months of the Emergency Community of Practice (ECoP), a cross-disciplinary and cross-organisational collaborative set up by policymakers in an Australian jurisdiction. The ECoP was created to mobilise process improvement knowledge, ideas, and experience. In particular, the aim was to mobilise this knowledge between designated brokers of process improvement expertise, known as improvement advisors, and hybrid clinician-managers, both within and across public hospital organisations. A longitudinal 'nested and layered' qualitative case study design facilitates the processual investigation of this initial stage of the ECoP. This complements the practice-based lens, allowing me to 'zoom in' on the micro-practices of actors and groups of actors within the real-life context of their collaborative activity, and 'zoom out' on the initiative as a whole (Nicolini, 2009b). The data comprises 31 interviews with ECoP participants (improvement advisors, and nurses and doctors in hybrid clinical-managerial roles) as well as field notes from 29 hours of direct observation of the ECoP, twelve meetings with the policymakers responsible for the ECoP, and 44 hours observing or participating in the broader healthcare context.

The major theoretical contributions of this thesis arise from my inter-disciplinary 'bricolage' approach, which couples the healthcare management literature with perspectives of knowledge mobilisation and learning from organisation and management studies in a kind of *"generative dance"* (Currie, Dingwall, Kitchener, & Waring, 2012, p. 273). First, I articulate a processual model of collaborative knowledge mobilisation that helps elucidate processes that research on SLT has tended to neglect. The model highlights how actors collectively *(per)form* collaborative initiatives, negotiate and *translate* the knowledge targeted for mobilisation within them, and *reconcile* their identities in relation to them. Through this model, I refine and extend SLT, and contribute to debates about how instrumental collaborative networks can both help and hinder the mobilisation of knowledge across disciplinary and organisational boundaries. I make a further important contribution to SLT by shedding light on the processes involved in Wenger's (1998) important but under-theorised notion of identity reconciliation. These insights are of value

not only in healthcare but in broader management and policy settings where knowledge mobilisation is critical, but which are characterised by boundaries, epistemic cultures, and status differentials.

Flowing from this is a second major contribution, specifically to the healthcare management literature. By making visible what knowledge 'transfer' perspectives black-box, and elucidating the practices and processes through which participants of collaboratives learn to mobilise knowledge across disciplines and organisations in the healthcare setting, I address the lack of research into the critical formation stage of collaborative networks, particularly when created as instrumental tools to promote knowledge mobilisation. Moreover, I contribute to what remains a very limited body of literature which explicitly engages with the particularities of mobilising 'non-native' process improvement knowledge in healthcare.

Methodologically, my thesis offers researchers a way to render legible the practices and processes which often remain invisible in collaborative initiatives. Through the observation of activities and incidents occurring in real-time on the 'front stage' of the ECoP, and the comparison of these with perceptions and reflections 'backstage' in informal conversations and interviews, I uncover many of the 'private' but nevertheless performative practices involved in community formation, knowledge translation, and identity reconciliation. Furthermore, my use of a practice-based lens in a longitudinal approach and analytical 'zooming in and out' (Nicolini, 2009b) between micro and macro levels enables me to connect participants' seemingly mundane practices with knowledge mobilisation at the broader system level.

Finally, I offer a number of practical contributions—including potential points for action, deliberation, and caution—for policymakers and management practitioners seeking to mobilise knowledge in a targeted fashion. These include the meta-processual model describing the constituent and parallel processes of *(per)forming, translating,* and *reconciling.* This model is not intended to be yet another prescription for action, but rather offers a sensitising lens for both practitioners and participants of collaborative networks. The model helps practitioners see social, epistemic, and political issues which are very often hidden, and guides them in their endeavours to collectively make a constructive context for learning together.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Adamina Ivcovici

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Key terms and abbreviations

Key term	Description / definition	Abbreviation
The Agency	Independent agency created by The Health Department to focus on improving health system performance through the mobilisation of process improvement knowledge and collaboration across organisations.	-
The Health Department	Government department responsible for health system performance.	The Department
Community of Practice	Many definitions have been proposed. The following (broad) definition is a point of departure in this thesis: *"... loci of engagement in action, interpersonal relations, shared knowledge and negotiation of enterprises." (Wenger, 1998, p. 85).*	CoP
Emergency CoP	The case study of this thesis. A cross-disciplinary, cross-organisational collaborative network created by policymakers for the instrumental purpose of mobilising process improvement knowledge.	ECoP
Emergency Department	The 'front door' of hospitals where the public can attend for emergency medical care.	ED
Hybrid doctors and nurses	Doctors and nurses with hybrid clinical-managerial roles and identities. The 'targets' of the knowledge mobilisation effort within the Emergency CoP.	Hybrid
Knowledge mobilisation	An intended outcome of collaborative networks. Through the 'translational' perspective adopted in this thesis (see 'knowledge translation' below), knowledge mobilisation is also considered to be a *"proactive process that involves efforts to transform practice through the circulation of knowledge within and across practice domains"* (Swan, Newell, & Nicolini, 2016a, p. 2).	-
Knowledge transfer	A perspective in which knowledge is seen to be thing-like and able to 'transfer' from one place to another (e.g., one mind to another).	-
Knowledge translation	The perspective adopted in this thesis, which assumes that knowledge is modified or 'translated' by agentic actors as it is mobilised. This process is considered to be social and contextual in nature.	-
National Emergency Access Target	A key performance indicator for all Australian hospitals regarding wait times in emergency departments. Improving NEAT performance was the main focus of The Agency during this study.	NEAT
Practices	*"Orderly materially mediated doing and sayings."* (Nicolini &	-

	Monteiro, 2017, p. 110).	
Service redesign and process improvement	Ideas and tools used to redesign and improve services and reduce non-value-adding steps in processes. Rooted in continuous improvement philosophies and methodologies which originate in the manufacturing sector, these are now widespread management approaches in production industries, and increasingly so in service industries. This knowledge can be considered to be ‘non-native’ to healthcare, where it sits alongside ‘native’ clinical knowledge which occupies the highest position in the knowledge hierarchy.	Process improvement / improvement
Process improvement advisor	Designated knowledge brokers within the Emergency CoP.	Improvement advisor

Acknowledgements

I made the decision to embark on a PhD with the vague goal of *“making healthcare better”* in 2015, under a flimsy umbrella on a stone terrace at the foot of the Himalayas. Perhaps the setting is insignificant, but I am almost certain that ‘decoupling’ from my everyday life, combined with the feeling of tininess induced by a landscape of such significance, had a role to play. It becomes hard not to reflect on one’s life and identity in a place like that.

This thesis is the product of three and a half years of work towards that goal, and an Honours degree before it which set me up for the ride. I feel very fortunate to have been supported by, and had the opportunity to support, many wonderful people throughout this time. Reflecting on who has contributed to this journey sets off an endless chain of associations. It turns out no journey has a clear beginning, and certainly no end.

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Ian assured me from the very beginning that I would one day hit ‘exit velocity’, and all of a sudden the thesis would be done. He was right, and it is very nice to be here. I hope that I can take this momentum into my next project, whatever that may be, and use what I have learned to do what I set out to do—take some modest steps toward *“making healthcare better.”*

Introduction

Study background and overview

“Everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it.” (Batalden & Davidoff, 2007)

***

Despite a move to more complex social ways of understanding and promoting knowledge mobilisation, there has been a general reticence within both the healthcare and generic management literature to move beyond linear, rational, objectivist models of knowledge mobilisation (Swan, Newell, et al., 2016a; Wieringa & Greenhalgh, 2015). These kinds of models suggest that knowledge ‘transfers’ unproblematically from one mind or place to another. They therefore implicitly assume that learning across disciplinary and organisational boundaries is a simple matter of increasing proximity among actors so that ideas can ‘diffuse’ among them (Amin & Roberts, 2008; Glegg, Jenkins, & Kothari, 2019) The healthcare management literature is replete with optimistic accounts of how collaboration and knowledge brokers can help to ‘transfer’ knowledge across disciplinary and organisational boundaries (Burgess & Currie, 2013; Conklin, Lusk, Harris, & Stolee, 2013; Currie, Burgess, et al., 2014; Ward, House, & Hamer, 2009). Yet, despite widespread optimism, evidence of the success of collaborative networks in terms of knowledge mobilisation remains sparse and equivocal (Bornbaum, Kornas, Peirson, & Rosella, 2015; Newman, DeForge, Van Eerd, Mok, & Cornelissen, 2020).

In this thesis, I focus on the particular problem of mobilising ‘non-native’ service redesign and process improvement (henceforth ‘process improvement’ or ‘improvement’) knowledge in healthcare. If health systems are to achieve the widely promoted triple aim of improving individual care, improving the health of populations and reducing per capita costs (Berwick, Nolan, & Whittington, 2008), organisations and frontline care providers need to continually improve service delivery. With this aim in mind, policymakers and managers have become increasingly interested in importing process improvement knowledge from other sectors (Bateman, Radnor, & Glennon, 2018). In particular, they have popularised ideas from the manufacturing sector, predominantly centred around Lean management (Brandao de Souza,

2009; Fillingham, 2007; Radnor, Holweg, & Waring, 2012; Terra & Berssaneti, 2018; White, Butterworth, & Wells, 2017). However, mobilising knowledge has long proven challenging in the complex multi-stakeholder healthcare context, and mobilising process improvement knowledge which is 'non-native' to professionals within the field is revealing itself to be a particularly troublesome endeavour (Harrison et al., 2016; Mazzocato, Savage, Brommels, Aronsson, & Thor, 2010).

At the same time, healthcare policymakers and managers have also increasingly moved to create collaborative approaches as instrumental tools to help mobilise knowledge in healthcare systems (Fitzgerald & Harvey, 2015; Sheaff & Schofield, 2016). While research about such instrumental collaborative networks has yielded valuable insights about barriers and enablers of knowledge mobilisation and learning across boundaries in healthcare (Al-Balushi et al., 2014; Henrique, Filho, Marodin, Jabbour, & Chiappetta Jabbour, 2020), these accounts have largely fallen within the 'transfer' paradigm. This has blinkered our view to a narrow set of issues. This dominant perspective usually explains the success or otherwise of collaborative networks by correlating their inputs (e.g., roles, organisations, resources) with outcomes (e.g., improved performance on a particular healthcare quality indicator). Crucially, this 'transfer' approach black-boxes questions relating to *how* and *why* process improvement knowledge mobilises through collaboration (Ferlie, 2016; Ferlie, Fitzgerald, McGivern, Dopson, & Exworthy, 2010; Rowley, Morriss, Currie, & Schneider, 2012; Van Grinsven, Heusinkveld, & Benders, 2016). This has led to calls for greater examination of the practices and processes in collaborative knowledge mobilisation networks (Kislov, Wilson, Knowles, & Boaden, 2018; Swan, Newell, et al., 2016a).

In this thesis, I focus on the practices and processes of learning within such collaborative networks, combining the insights afforded by viewing knowledge mobilisation from a 'translation' perspective with those provided by the notion of learning as a situated practice. I join scholars who view knowledge mobilisation as a process of 'translation' (Crilly, Jashapara, & Ferlie, 2010; Davies, Powell, & Nutley, 2015; Ferlie, Crilly, Jashapara, & Peckham, 2012; Fischer et al., 2016; Fitzgerald & Harvey, 2015; Rowley et al., 2012; Swan, Newell, & Nicolini, 2016b), and follow Swan and colleagues' (2016b) definition of knowledge mobilisation as both an intended outcome of collaboration and *"a proactive process that involves efforts to transform practice through the circulation of knowledge within and across practice domains" (p. 2).*

I seek to extend the ‘translational’ approach to knowledge mobilisation by using Lave & Wenger’s (1991) Situated Learning Theory (SLT) and Wenger’s (1998) concept of Communities of Practice (CoP) to better understand and explore how collaborative learning takes place across boundaries. A situated learning perspective sees actors as actively making meaning of, negotiating and modifying knowledge through situated practice with others. This approach to understanding knowledge mobilisation facilitates the interrogation of overly *“romantic”* assumptions about collaboration and knowledge brokering (Contu & Willmott, 2003; Cox, 2005, p. 530). The approach helps to ask what really goes on when collaborative networks are deliberately created to mobilise knowledge across organisational, disciplinary and professional boundaries. Through this lens, I conceptualise collaborative knowledge mobilisation as comprising the mutually constitutive processes of *learning* and *becoming*, since SLT draws attention both to the social negotiation of meaning and to how identities are negotiated and (re)constructed through participation in collaborative learning. The SLT literature, however, leaves three important issues open for investigation with regard to the collaborative knowledge mobilisation phenomenon.

First, there exists significant debate within the SLT literature as to 1) whether and how ‘community’ can (or should) be deliberately cultivated for the instrumental purposes of knowledge mobilisation (as later work by Wenger and colleagues would suggest (Wenger, 2010; Wenger, McDermott, & Snyder, 2002), 2) whether this can only occur organically (as seminal work by Lave & Wenger (1991) and Wenger (1998) would suggest), or 3) whether there is some middle ground in which the best of both ‘instrumental’ and ‘organic’ worlds might be possible to achieve (Kislov, Walshe, & Harvey, 2012). Second, while attention to relations of power is fundamental to the SLT approach, scholars working from this perspective have often sidelined conflictual aspects (Contu & Willmott, 2003; Gherardi, 2009a). Third, while Wenger (1998) draws attention to the importance of actors’ abilities to ‘reconcile’ their existing identities with participation in particular communities, what this process of identity reconciliation entails has not yet been clearly elucidated (Handley, Sturdy, Fincham, & Clark, 2006).

To understand these three issues more clearly, I assemble a ‘conceptual bricolage’ that complements and extends the SLT approach—a bricolage of theoretical resources that together create a new lens on the collaborative knowledge mobilisation issue. With neither the ‘organic’ seminal literature nor the ‘instrumental’ literature adequately explaining the formation process of communities (Kislov, Harvey, & Walshe, 2011), I conceptualise the emergence of instrumental

collaborative ‘forms’ as loci of learning, the result of a dynamic process of ‘collectively making’ the learning practices which in turn constitute them (J. Langley, Wolstenholme, & Cooke, 2018). In addition, to understand how and why knowledge is negotiated, translated, and mobilised in different ways by different actors, I deploy Knorr-Cetina’s (1999) epistemic cultures concept. This conceptual lens helps to make visible the epistemic and political nature of collective learning, and provides a way to consider status and power relations as they relate to different epistemic communities and their attendant epistemic identities. Furthermore, the epistemic cultures perspective draws particular attention to the politics of participation when certain types of knowledge (e.g., ‘non-native’ process improvement knowledge) and certain types of actors (e.g., high status-doctors) are the targets of such initiatives. Finally, I draw upon Alvesson & Willmott’s (2002) concept of identity regulation and Jenkins’ (2004) internal/external approach to identity construction to clarify the practices which constitute Wenger’s notion of identity reconciliation. I combine these perspectives to create an initial sensitising model of collaborative knowledge mobilisation which guides the analysis.

With the longstanding knowledge mobilisation challenges in healthcare and this conceptual bricolage in mind, the overarching aim of this thesis is:

> *To explore how participants of collaborative networks learn to mobilise knowledge across disciplinary and organisational boundaries, through situated learning and identity work in the healthcare setting.*

To achieve this aim, I ask the following overarching questions:

1. *How do instrumental collaborative knowledge mobilisation networks form in practice in healthcare systems?*
2. *How do key actors from different epistemic communities (improvement advisors and hybrid clinician-manager ‘targets’ of improvement knowledge) negotiate and translate knowledge within such collaborative networks?*
3. *How do these actors reconcile their existing identities with their participation in such collaborative networks?*

I deploy a practice-based methodological approach to explore these questions. In this approach, *“practices are understood to be the primary building blocks of social reality” (Feldman &*

Orlikowski, 2011, p. 3), implying a processual ontology which sees social 'reality' as a continual process of becoming (A. Langley, Smallman, Tsoukas, & Van de Ven, 2013; Nicolini & Monteiro, 2017). I apply this practice-based approach to the case study of the Emergency Community of Practice (ECoP), a multidisciplinary and multi-organisational collaborative created by policymakers in the Health Department (The Department) of an Australian jurisdiction in 2018. The policymakers' intent was to mobilise process improvement knowledge, ideas, and experience from designated knowledge brokers, known as process improvement advisors, to hybrid clinician 'targets' of the knowledge (doctors and nurses in hybrid clinical-managerial roles), both within and across public hospital organisations. The creation of the ECoP followed a decade-long attempt to 'transfer' process improvement knowledge into the sector by embedding individual knowledge brokers within individual public hospitals. This significant and sustained policy effort saw an increase in improvement activity, but effected limited spread of learnings within and across organisations. Assessments of the process improvement program found that it had been challenging to engage frontline clinicians in process improvement, mirroring experiences of healthcare improvement from around the world (Jorm, Hudson, & Wallace, 2019). It was within this local historical context—and a broader context of shifts toward collaborative healthcare policy in Australia and abroad—that the ECoP emerged (Cunningham et al., 2012; Sheaff & Schofield, 2016).

The longitudinal 'nested and layered' qualitative case study design facilitates the processual investigation of the initial stages of the ECoP, as well as 'zooming in and out' (Nicolini, 2009b) on the collaborative initiative as a whole and on the micro-practices of actors and groups of actors within its real-life context. I spent fourteen months in the field. Initially, I immersed myself in the world of healthcare improvement in the jurisdiction for two months, to undertake background research on the historical development of the policy intervention, and to understand the policymakers' objectives in mandating collaborative networks to address the knowledge mobilisation problems. I then spent twelve months using ethnographic methods to generate data from observations of the four ECoP workshops, interviews with participants, and discussions with the responsible policymakers. In parallel, I was peripherally involved in a broader parent study that sought to explore the history of process improvement capacity building within the jurisdiction. This provided me with a strong contextual understanding. The resulting data corpus comprises transcripts of 31 'backstage' interviews with ECoP participants (predominantly process improvement advisors and hybrid nurses and doctors) as well as field notes from 29 hours of 'front stage' observation of the ECoP, twelve meetings with the policymakers

responsible for the ECoP, and 44 hours observing or participating in the broader healthcare context. Policy and organisational documentation supplemented these main data sources.

I took an abductive analytical approach through the course of my research, iterating back and forth between data generated about actors' everyday practices and interpretations of their own experience, and the extant literature and conceptual lenses (Denzin, 1978; Nicolini & Monteiro, 2017). The practice-based conceptual bricolage described above emerged through this abductive process as it became clear that further theoretical resources were needed to understand what SLT did not fully explain. The bricolage then recursively informed successive phases of data collection and analysis. During analysis, combining 'front stage' observational data with 'backstage' interview data enabled me to elucidate hidden aspects of collaborative knowledge mobilisation. Throughout the findings chapters, I weave these raw data into thematic narratives which elaborate constitutive aspects of three overarching meta-processes: *(per)forming, translating* and *reconciling*. With these, I articulate a processual model of collaborative knowledge mobilisation which highlights how the micro-level domain of actors' practices is intertwined with, and shapes, the evolution of instrumental collaborative networks as a whole.

I make two major theoretical contributions. First, the conceptual bricolage I develop allows me to examine processes that research on SLT has tended to neglect. This enables me to articulate the processual model which elucidates how actors collectively *(per)form* collaborative initiatives, negotiate and *translate* the knowledge targeted for mobilisation within them, and *reconcile* their identities in relation to them. Importantly, this helps to address our lack of insight into the critical formation stage of collaborative networks, particularly when they are created as instrumental tools to promote targeted knowledge mobilisation. By elucidating these three meta-processes, I contribute to debates about how collaborative initiatives can both help and hinder the mobilisation of knowledge across boundaries. Moreover, I make an important contribution to SLT by clarifying the processes involved in Wenger's (1998) important but under-theorised notion of identity reconciliation. These insights are of value not only in healthcare but in broader management and policy settings where knowledge mobilisation is critical, but which are characterised by boundaries, various epistemic cultures, and status differentials.

Second, the above contribution enables me to make visible what 'knowledge transfer' perspectives have black-boxed in the healthcare literature. In particular, it helps to elucidate

practices and processes through which participants of instrumental collaboratives learn to mobilise particular kinds of knowledge across various disciplines and organisations. This allows me to contribute to what remains a very limited body of literature that explicitly engages with the particularities of mobilising 'non-native' process improvement knowledge in healthcare. My study sheds light on the epistemic and identity politics that result from actors working to reconcile their identities in ways that make them 'livable' (Wenger, 1998). This highlights how these issues can trouble attempts to mobilise knowledge across disciplinary and organisational boundaries, particularly where status differentials are significant. Consequently, my research underscores the substantial impact these issues may have on the outcomes of collaborative initiatives in terms of their instrumental knowledge mobilisation 'success'.

Methodologically, I offer a way to make legible those practices and processes which often remain invisible. The longitudinal case study design and deployment of ethnographic methods enabled me to observe activities and incidents in real-time, and critically over time, on the 'front stage' of the ECoP. This allowed me to compare these with the perceptions and reflections of participants 'backstage' through informal conversations and interviews. In this way, I was able to study the practices involved in community formation, knowledge translation, and identity reconciliation from multiple perspectives. Moreover, the longitudinal approach and analytical 'zooming in and out' between micro and macro levels enabled me to see how seemingly mundane practices of participants were intertwined with and influenced knowledge mobilisation at a system level. In doing so, I have been able to build a story of the ECoP as a whole over time which reveals its non-linearity and the interconnectedness of its various processual 'parts'.

In terms of practical contributions, the meta-processual framework—*(per)forming, translating, and reconciling*—provides a useful lens for policymakers, managers and participants during the process of setting up collaborative knowledge mobilisation networks. I do not intend the model to be a prescription for action, but, rather, a way to see activities that would normally remain hidden. It suggests that the 'success' of collaborative knowledge mobilisation initiatives might be redefined to include not only the intended outcomes of instrumental knowledge 'transfer', but also the effectiveness of 'translational' processes including epistemic negotiations and identity reconciliation. Alerting all stakeholders to the likelihood of divergent meaning-making, and significant dissonance between the 'front' and 'back' stage of individuals and collectives, better equips them to recognise and respond to epistemic and identity politics. Paying explicit attention

to the situated processes of *learning* and *becoming* that underpin collaboration may help facilitate their ability to collectively make a constructive context for these processes.

Finally, I lend support to a 'developmental' approach to collaborative initiatives. This sits midway between organic and instrumental perspectives, as suggested by Kislov and colleagues (2012). I extend this approach by outlining the practical potential of continual co-design, careful facilitation of epistemic conflict, and a sensitive but deliberate approach to promoting constructive identity reconciliation work. The findings of this thesis suggest that these activities are likely to be productive in paving the way for effective knowledge mobilisation in practice.

Thesis outline

In Chapter 1, I review and evaluate the literature regarding the mobilisation of process improvement knowledge in healthcare, and the use of collaborative initiatives and knowledge brokers to facilitate knowledge mobilisation in healthcare. I highlight key conceptual assumptions about knowledge mobilisation and learning within the literature, and draw out empirical gaps, particularly with regard to 'non-native' process improvement. After this evaluation of the current state, I generate the research questions that guide my research. In Chapter 2, I contrast the dominant knowledge 'transfer' perspective in the literature with the knowledge 'translation' perspective I take. I also build the initial conceptual 'bricolage' model that I use to sensitise data collection and analysis. In Chapter 3, I explain my research design and methods of data collection and analysis, describe the research site, and provide an overview of the main events and main cast of characters involved in the ECoP workshops.

In Chapter 4, I explore the formation of the ECoP, revealing the processual 'reality' of the initiative and showing how it was *(per)formed* through the practices of participants—their sayings, doings and reflections, both 'front stage' and 'backstage'. In Chapter 5, I unpack knowledge *translation* practices, showing how participants from distinct epistemic cultures negotiated and reframed what it means to do process improvement in healthcare. Chapter 6 digs deeper into the *identity reconciliation* work that participants from various epistemic communities engaged in, both prior to and throughout their participation in the ECoP. The chapter also elucidates how *(per)forming, translating* and *reconciling* are inherently interconnected. Its findings point to how the ongoing survival of the collaborative initiative depends on participants' abilities to *learn to learn together* and *learn to be together*.

In Chapter 7, I integrate the insights from my findings and discuss how they address the research questions and relate to the existing literature. Chapter 8 concludes this thesis. In it, I reiterate the main findings of my research and draw out implications for our understanding about collaborative knowledge mobilisation in healthcare and other settings. I outline the specific contributions that my thesis makes to the healthcare management literature and to SLT, along with methodological and practical contributions. Finally, I consider the limitations of the thesis and discuss suggested directions for future research which might further progress my findings, and our understanding of learning collaboratively.

Chapter 1: Mobilising process improvement knowledge in healthcare through collaboration & brokering: A review of the literature

In this chapter I establish how knowledge mobilisation, collaboration and knowledge brokering in healthcare have been thought about to date. I review and evaluate the extant literature within both the healthcare management and the generic management and organisation fields which has focused on the empirical setting of healthcare, and specifically focus on the challenge of mobilising knowledge that is 'non-native' in healthcare—as exemplified by process improvement. I begin to identify and question the assumptions embedded within different streams of research. To conclude, I outline empirical gaps and highlight assumptions which have limited our exploration of collaborative knowledge mobilisation, and articulate three broad themes that guide the areas of investigation in this thesis.

1.1 Why is mobilising process improvement knowledge in healthcare a problem?

Governments around the world face an imperative to make public healthcare systems more efficient in response to rising costs and demand pressures. To this end, policymakers and managers have become increasingly interested in applying process improvement ideas—predominantly centred around ideas related to Lean management (Radnor et al., 2012; Tlapa et al., 2020; White et al., 2017; Williams, 2017). Derived from the Toyota Production System, 'Lean management' first appeared in the publication of The Machine That Changed the World (Womack, Jones, & Roos, 1990). This book prompted the spread of the methodology which had revolutionised business processes in manufacturing (White, Wells, & Butterworth, 2013). Through an underlying philosophy of continuous process improvement and a focus on reducing non-value adding process steps (Aherne & Whelton, 2010; Drotz & Poksinska, 2014; Radnor et al., 2012; Womack et al., 1990), its overall rationale is to eliminate production defects in the pursuit of perfection and value for the customer (Ohno, 1988; Womack & Jones, 2010).

Lean has since extensively influenced operations management practice and literature. However, the application of Lean and process improvement in general is relatively new in service sector settings such as public healthcare (Gupta, Sharma, & Sunder, 2016; Leite, Bateman, & Radnor, 2020; Prashar & Antony, 2018). Healthcare policymakers and managers first began to promote this kind of knowledge in around the year 2000 (Bateman et al., 2018; Radnor, 2010) in the hope that applying it in healthcare would lead to similar operational efficiency successes as those seen in other sectors (de Koeijer, Paauwe, & Huijsman, 2014; Radnor & Boaden, 2008; Radnor et al., 2012). However, attempts to mobilise process improvement knowledge, 'non-native' to healthcare and the professionals within the field, have come with significant challenges (Harrison et al., 2016; Mazzocato et al., 2010). Gaps between the intended benefits and actual outcomes of process improvement are a common reality (Bhasin & Burcher, 2006; Radnor et al., 2012).

Within this growing body of research, scholars have helpfully highlighted a number of barriers and enablers associated with mobilising process improvement ideas into practice in healthcare. Researchers have found that enablers of mobilising Lean into practice include both top-down issues such as alignment with organisational strategy and leadership support (Al-Balushi et al., 2014; Gupta et al., 2016; Harrison et al., 2016; Lee, McFadden, & Gowen, 2018; Simon & Houle, 2017), as well as bottom-up staff engagement (Barnabè, Guercini, & Perna, 2019; Holden, Eriksson, Andreasson, Williamsson, & Dellve, 2015; Mazzocato et al., 2010), which enables ideas for improvement to flow from the frontline upwards, for instance through encouragement and reward (Centauri, Mazzocato, Villa, & Marsilio, 2018; Drotz & Poksinska, 2014).

On the flip-side, barriers include the reverse; inadequate leadership support and lack of alignment between the strategic and operational aspects of process improvement efforts (Andreasson, Eriksson, & Dellve, 2016; Centauri et al., 2018; Escuder, Tanco, & Santoro, 2018), and inadequate bottom-up engagement of frontline healthcare professionals with process improvement ideas and practices (Devine & Bicheno, 2020). Particular barriers to clinician engagement are thought to include the perception that process improvement methodologies fit poorly with healthcare culture and values as a result of Lean's origins in manufacturing and its foreign (Japanese) terminology (A. Eriksson, Holden, Williamsson, & Dellve, 2016; Henrique et al., 2020; Radnor & Osborne, 2013; Savage, Parke, von Knorring, & Mazzocato, 2016; Waring & Bishop, 2010). The multidisciplinary nature of healthcare also means that optimising 'value for

the customer', a key tenet of process improvement, is a contested issue due to differing stakeholder interpretations of both 'value' (e.g., public healthcare efficiency vs. individual patient care) and 'customer' (eg. the patient for clinicians, the purchasers of care or regulating agencies for managers), creating further tensions (Hayes, Reed, Fitzgerald, & Others, 2010; Poksinska, Fialkowska-Filipek, & Engström, 2017; Radnor et al., 2012; Shekhar, 2019; Waring & Bishop, 2010).

Limited resources in the sector have also hampered the mobilisation of process improvement knowledge. This is due, for instance, to a lack of training for staff in statistical and process improvement methods, and a general lack of enabling conditions for clinical engagement with process improvement (Al-Balushi et al., 2014; Holden et al., 2015; Jorm, 2016). Moreover, incentives for medical professionals working under fee for service payment schemes encourage them to prioritise lucrative clinical work (Fine, Golden, Hannam, & Morra, 2009). Even when salaried, clinicians have limited time to dedicate to non-clinical work, of which process improvement may be only a fraction. Sector-level support is often lacking, and there are overwhelming reporting requirements and a dearth of patient outcomes data to accurately determine the clinical impact of process improvement work (Jorm, 2016; Jorm et al., 2019; Naik et al., 2012).

Emerging from this literature is the clear theme that mobilising process improvement knowledge to the clinical frontline is a challenge (Jorm et al., 2019). This challenge entails both technical and resource aspects, and significant social issues related to process improvement being 'non-native' knowledge which is interpreted and valued differently by the many stakeholders in the healthcare domain. Medical professionals in particular, especially senior clinicians, have been consistently challenging to engage with process improvement (Al-Balushi et al., 2014; Andersen & Røvik, 2015; Mazzocato et al., 2010; Moraros, Lemstra, & Nwankwo, 2016; Stanton et al., 2014; White et al., 2013). This is especially so when interventions are mandated through top-down approaches (Choi, Holmberg, Löwstedt, & Brommels, 2011; Glasgow, Davies, & Kaboli, 2012). In addition, researchers have described clinicians' generalised skepticism of management fads (Fine et al., 2009) and characterised a *"compatibility gap"* between the assumptions underlying managerial interventions, and the professionalised, politicised healthcare context into which they *"intrude"* (Lozeau, Langley, & Denis, 2002, p. 546). Critically, the ideals of standardisation and transparency inherent in process improvement may be

perceived as a threat to autonomy, a tightly held professional value and source of medical professional dominance and status (Drotz & Poksinska, 2014).

While other types of clinicians (e.g., nurses and allied health clinicians) may be relatively more willing than doctors to engage in process improvement and other managerial tasks and roles, much less is known about these groups, and their opportunities to engage appear to vary (Boyce & Jackway, 2016; Currie & Procter, 2005). Whereas nurses tend to be well-represented in hospital management positions, allied health clinicians face an 'access gap' with regard to leadership opportunities in which they may be empowered to engage with service improvement (Boyce & Jackway, 2016). Moreover, the allied health professions face high rates of attrition, thought to be due to limited clinical and managerial career pathways and low wage ceilings (Castro Lopes, Guerra-Arias, Buchan, Pozo-Martin, & Nove, 2017; Jorm, 2016). However, there is little research investigating how these or other issues influence their engagement or otherwise with process improvement.

1.2 The potential role of collaborative learning in knowledge mobilisation

In response to the problems surrounding the mobilisation of process improvement knowledge, and against the backdrop of more general concerns about knowledge mobilisation in healthcare (e.g., the long discussed 'bench to bedside gap' which describes an average of 17 years for clinical innovations to be taken up in practice (Z. S. Morris, Wooding, & Grant, 2011)), policymakers and managers have come to recognise that knowledge does not in fact diffuse 'naturally' or in a linear fashion among rational actors, as popular knowledge theories have traditionally suggested (e.g., Rogers' Diffusion of Innovations Theory (1995)). As a result, practitioners have increasingly turned to notions of collaboration as a potential solution (Fitzgerald & Harvey, 2015; Sheaff & Schofield, 2016). Like process improvement, ideas about collaboration have also largely been imported from the business sector. These have influenced public service modernisation agendas which have increasingly tended toward rhetorical shifts away from competition and toward collaboration (Currie & Martin, 2016; Ferlie et al., 2010). Collaborative and networked organisational forms have thus been promoted as a way to mobilise knowledge across healthcare systems, under various labels such as 'networks', 'collaboratives' and 'communities of practice' (Ferlie, 2016; Li et al., 2009). Despite the different

labels, these initiatives share the instrumental aim of promoting collaboration among different occupations and organisations in order to facilitate knowledge mobilisation across these boundaries in the hierarchical and siloed healthcare context (Bunger & Lengnick-Hall, 2018; Ferlie et al., 2010).

In both the healthcare management literature and management and organisation studies, studies of collaboration are most often underpinned by idealistic notions of sharing, synergy, exchange, and inclusion (Braithwaite et al., 2009; Ferlie et al., 2010; Glegg et al., 2019). Empirical research has tended to be situated within the social network theory domain (Burt, 1992, 2005; Coleman, 1990), a functional approach in which collaboratives are seen as an optimal structure through which to both organise and analyse *"clusters of diverse individuals, groups or organisations who aim to work together collaboratively" (Long, Cunningham, & Braithwaite, 2013, p. 2)*. Social network perspectives focus on nodes (actors) and ties (relationships between actors), and are closely related to the Diffusion of Innovations literature which seeks to determine optimal network structures for the diffusion of knowledge (Long et al., 2013). According to this structural approach to knowledge mobilisation, networks and partnerships—rather than hierarchies or markets—should be more productive forms for stimulating organisational learning since they facilitate the 'transfer' of knowledge as a discrete 'thing' from place to place (Ferlie et al., 2012).

Within this structural perspective, the development of relationships is seen to enable knowledge flows (Burt, 1992). Knowledge brokers (also known as bridges, boundary spanners, or 'hybrids') are therefore considered key players in collaborative networks (Kislov, Wilson, et al., 2018; Rowley et al., 2012). From a social network perspective, they span boundaries, connecting across 'structural holes' where two actors (whether individual or collective) are not yet connected (Burt, 2005). The potential of brokers to bridge gaps in complex social structures is considered to arise from their membership in several intersecting communities and their resultant 'hybridity' (e.g., as hybrid clinician-managers). This is seen to enable them to enhance cooperation by liaising across boundaries (Burgess & Currie, 2013; Long et al., 2013; Sartirana, Currie, & Noordegraaf, 2019; Swan, Newell, et al., 2016a). With the public policy context characterised by a growing emphasis on service integration and the dismantling of traditional hierarchies, knowledge brokering roles are an increasingly popular feature of mandated collaborative solutions to complex public policy problems (Bucher, Chreim, Langley, & Reay,

2016; Kislov, Hyde, & McDonald, 2017; McLoughlin, Burns, Looi, Sohal, & Teede, 2019; Waring, Currie, Crompton, & Bishop, 2013).

Cross-disciplinary and cross-organisational collaborative initiatives—along with the creation of hybrid and other designated knowledge brokering roles—are, from a structural perspective, appealing ways to address boundaries that constrain knowledge mobilisation in healthcare. This is especially the case with regard to connecting management and frontline clinical communities (Ferlie, Fitzgerald, McGivern, Dopson, & Bennett, 2013; Gittell, Godfrey, & Thistlethwaite, 2013; Kislov et al., 2011; Thomas, 2003). Despite the popularity of collaboratives and knowledge brokers, however, the evidence of their effectiveness in accelerating knowledge mobilisation in healthcare remains limited (Mittman, 2004; Schouten, Hulscher, van Everdingen, Huijsman, & Grol, 2008; Wells et al., 2018). Moreover, the vast majority of studies of collaboration in healthcare to date have investigated relatively small-scale initiatives within hospitals or individual hospital departments and focused on the mobilisation of clinical knowledge.

It is important to note that the structural assumptions underpinning much of the research into both the mobilisation of process improvement knowledge and the use of collaborative networks in healthcare have significant consequences for our understanding of these issues. These kinds of studies limit our perspective to the outcomes of such initiatives and to discrete barriers and enablers that impact *whether* knowledge gets 'transferred' from one place to another. This however has precluded attention to the processes that might explain *how* and *why* knowledge is mobilised (Haynes et al., 2020; Li et al., 2009). As a result, relatively little is known about how professional and organisational boundaries shape the development of such collaborative initiatives, whether their creation and success is realistic, and how deliberately created networks relate to pre-existing 'organic' communities (Comeau-Vallée & Langley, 2019; Kislov et al., 2012). In the case of mandated cross-disciplinary, cross-organisational collaboratives which aim to mobilise 'non-native' process improvement knowledge, issues relating to social and political boundaries, identities and status are likely to become particularly salient (Bresnen, Hodgson, Bailey, Hyde, & Hassard, 2014, 2017; Kislov, 2014).

1.3 Collaboration networks in healthcare

In this section, I review empirical studies of collaboration and knowledge brokering in healthcare with a particular focus on those that emphasise the investigation of *how* and *why* questions and

processual issues over outcomes. These are predominantly rooted in the social sciences and located in the management and organisation literature. These studies begin to unpack social processes that 'transfer' studies about collaborative knowledge mobilisation in healthcare have neglected. The review is organised around three core concerns regarding collaborative knowledge mobilisation—the origins and set up of cross-disciplinary and cross-organisational collaborative networks, the boundaries and politics within them, and the ways in which knowledge brokers not only 'transfer' but also strategically 'translate' knowledge.

1.3.1 Origins and setup of collaboratives

1.3.1.1 The great formation debate

As outlined above, a structural/relational approach to knowledge mobilisation assumes that relationships enable knowledge to flow or 'transfer' from place to place or person to person (Ferlie et al., 2012). Deliberately orchestrating collaborative networks, and cultivating relational synergies between actors from different disciplines, organisations and organisational levels should, in this view, help to mobilise existing knowledge and generate new knowledge (Hartley, Sørensen, & Torfing, 2013; Hurley, Rodriguez, & Shortell, 2019; Nembhard, 2012; Robertson & Swan, 2016).

However, there is now a significant body of literature which calls into question the idea that collaborative networks can simply be 'set up' as tools to mobilise knowledge. This is particularly so within the literature that has its roots in Lave & Wenger's (1991) Situated Learning Theory (SLT) and thus conceptualises collaborative learning as an organic social process. SLT proposes that learning occurs through increasing participation in Communities of Practice (CoPs). Newcomers to a practice learn through 'legitimate peripheral participation' which is not merely about acquiring knowledge from more experienced practitioners, but about participating in a sociocultural practice and becoming a member of a community of practitioners (Lave & Wenger, 1991, p. 29). Within healthcare, SLT has long been used to describe the 'organic' formation of unidisciplinary professional and occupational CoPs, where identity formation and learning are central to socialisation within the communities.

Due to the utility of the CoP concept as an analytic tool, however, CoPs have come to be interpreted as idealised models for promoting knowledge mobilisation (Cox, 2005). Straying far

from its origins, the term CoP has been applied as an umbrella term to a variety of structural forms designed as instrumental tools to achieve managerial and policy knowledge mobilisation objectives (eg. formal training sessions, informal learning groups, multidisciplinary teams and virtual communities) (Cox, 2005; de Carvalho-Filho, Tio, & Steinert, 2020; Li et al., 2009). More recent work by Wenger—who earlier eschewed the notion that CoPs could be deliberately created—focuses decisively on their value as managerial tools with innovation and problem-solving potential (Wenger, 2010; Wenger et al., 2002). In healthcare and in the generic management literature, most studies of collaboration fall in line with this instrumental approach to the CoP concept as managerial tool to achieve performance improvements (Bunger & Lengnick-Hall, 2018; Wells et al., 2018; Zamboni et al., 2020).

This tension between analytical and instrumental perspectives has resulted in a significant divergence in our understanding of how collaborative contexts form. On the one hand, seminal works conceive of formation as necessarily organic and emergent (Lave & Wenger, 1991; Wenger, 1998). On the other, later conceptual work and much of the empirical healthcare and generic management literature assumes that collaborative learning communities can and should be created to generate instrumental benefits (Li et al., 2009; Nicolini, Scarbrough, & Gracheva, 2016). Proponents of the instrumental approach argue that favourable social contexts for knowledge mobilisation can be created through the design and cultivation of collaborative forms (Wenger et al., 2002), with various labels and structural configurations (e.g., small group, intra-organisational, multi-organisational, uni-professional, multiprofessional etc.) (Ranmuthugala et al., 2011). Despite the popularity of the approach, it has also been argued that the claims of benefit lack empirical grounding (Cox, 2005; Omidvar & Kislov, 2014). The possibility of deliberately 'setting up' collaborative networks thus remains an area of significant debate (Jørgensen, Scarso, Edwards, & Ipsen, 2019; Kislov et al., 2011; Pyrko, Dörfler, & Eden, 2017).

While few studies have sought explicitly to investigate the processes involved in 'setting up' multi-organisational and/or multidisciplinary collaborative initiatives, numerous empirical studies of collaborative initiatives in healthcare point toward challenges related to their formation. These studies highlight tensions between managerial mandates on the one hand and self-regulating and organic processes on the other, implicitly reflecting the aforementioned debate (Kislov, 2014; Kislov et al., 2012; Nicolini et al., 2016). The deliberate cultivation of genuine multiprofessional CoPs may be possible, but appears to be rare (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Gabbay et al., 2003). The literature reviewed below includes studies which

highlight the ongoing tension between informal relations and processes and the direction and formalisation of collaborative networks.

1.3.1.2 Informality vs. formalisation

Empirical studies have highlighted the importance of informal relations for the development of collaborative networks. In the context of the formation of large-scale scientific collaborations, Knorr-Cetina argues that key questions about consensus formation organically emerge during their *"birth stage"* (1999, p. 258). At this time, many informal decisions are made that shape individual practices and collective forms of consciousness. Swan & Scarbrough (2005) show in their study of networked innovation collaboratives that actors are most easily persuaded to join such initiatives in their early stages on the basis of existing informal interpersonal relations. Both Gittell & Weiss (2004) and Swan & Scarbrough (2005) argue that participants need to have the flexibility to coordinate their own relations in such a way that initial groupings reflect the various interests of all of the specialist groups involved (e.g., scientific, commercial). They argue that teams from disparate backgrounds can begin to develop common understandings from this position.

In practical reality, collaborative networks must to some extent be directed if they are to achieve particular managerial or policy aims (Kislov et al., 2012). However, the ways in which, and the extent to which, collaboration should be formalised are unclear. Swan and colleagues (2002), for instance, show how managers successfully exploited the notion of 'community' as a rhetorical strategy and boundary object to facilitate collaboration across existing CoPs and to develop a multidisciplinary, multi-organisational network, driving performance improvement in healthcare. D'Andreta et al. (2013) argue that managers play a formative and directive role in selecting and enacting specific knowledge mobilisation practices. Others, however, have argued that collaborative networks cannot be designed as direct instruments of policy control, because to do so disrupts rather than supports their knowledge mobilisation capacity (Addicott & Ferlie, 2007; Addicott, McGivern, & Ferlie, 2006; Haynes et al., 2020; Kislov et al., 2011; Swan et al., 2002).

Attempts to formalise collaboration do not appear to follow linear models. Rather, they interact with the personal, political and professional agendas of their participants. Fischer et al. (2013) highlight this in their study of Academic Health Science (AHS) organisations—large-scale attempts to formalise collaboration between research institutions and healthcare providers in

order to address the ‘translational gap’ between the development of clinical research evidence and its implementation in practice (Lau et al., 2014). Their study traces how the successful mobilisation of the AHS idea into the UK health sector was in part a result of its mobilisation through medical professional networks and bottom-up professional support, rather than simply through formal top-down approaches within the management or policy domains.

Other scholars also suggest that a balance between formal top-down and informal bottom-up processes is likely to be important for the development of collaborative networks (Burgess, Currie, Crump, Richmond, & Johnson, 2019; Currie, Lockett, & El Enany, 2013). Currie and colleagues (2013) consider how involving well-regarded clinical academics with strong existing relationships helped to promote knowledge mobilisation in the initial stages of the UK Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) (like the AHS organisations, CLAHRCs represent a sustained policy focus on collaboration between the academic and health service domains (Fitzgerald & Harvey, 2015)). Over time, however, these existing relationships appeared to restrict the development of more novel integrated approaches to the production and implementation of applied health research. Similarly, in their study of multi-agency CoPs aimed at improving health and social services, Gabbay et al. (2003) argue that overly intensive facilitation and the promotion of particular types of evidence tends to diminish organic and emergent knowledge behaviours.

Also in the CLAHRC context, Kislov (2014) argues that the formalisation of boundary-spanning activities can impact trust, result in divergent meaning-making, and prevent designated knowledge brokers from fulfilling their potential in practice. In Kislov’s study, those multi-professional groups which were given autonomy were able to develop effective internal knowledge sharing mechanisms, despite the various boundaries within them. The more formalised uni-professional groups which were assumed would help to cut across inter-team boundaries, were, in contrast, not able to develop effective mechanisms.

Swan & Scarbrough (2005) also underscore this delicate balancing act. The authors demonstrate the need for managers to simultaneously develop shared commitment to an innovation across disparate communities, and, at the same time, to allow professionals (in their case hybrid professional-managers) to devise their own emergent change processes. The findings of Pyrko et al. (2017) show how too great a focus on the set up of collaborative tools (e.g., online discussion tools) can lead to the neglect of organic processes of community

development. Those charged with creating the so-called 'CoP' in their study conflated these tools with the CoP and as a result *"did not provide opportunities for interlocked indwelling and thus did not prepare the avenues for thinking together"* (p. 402).

Another highly popularised instance of multi-organisational and multidisciplinary collaboration in healthcare is the Breakthrough Series (BTS) Collaborative. Developed in the US in 1995 by the Institute for Healthcare Improvement and the Associates in Process Improvement (IHI, 2003), BTS Collaboratives aim to help healthcare organisations *"make breakthrough improvements in quality while reducing costs"* (IHI, 2020)—for example, by reducing emergency room wait times. Importantly, while most collaborative networks in healthcare have focused on mobilising clinical research into practice, BTS Collaboratives represent the most widespread attempt at mobilising process improvement knowledge within the healthcare sector. Structured multi-professional and multi-organisational collaboration and process improvement experts as designated knowledge brokers are key features (Wilson, Berwick, & Cleary, 2003).

In an early and isolated attempt to understand BTS Collaboratives from a situated learning perspective, Bate and Robert (2002) analysed Collaboratives in the UK NHS. Notably, this was the first time that SLT crossed over from the generic management literature into the health management literature and that the CoP concept was used as an analytic tool to understand collaboration (Ferlie et al., 2012). Through this lens, the authors suggested that the BTS Collaboratives failed to develop features of 'community' such as collective identity, and pointed to issues of over-direction and ineffective facilitation of knowledge mobilisation events by NHS managers, as well as the neglect of spontaneous informal processes that create energy for change and community-building (Bate & Robert, 2002). Since this time, studies of BTS Collaboratives have largely remained within the healthcare management literature, resulting in a predominant focus on their effectiveness in terms of outcomes rather than their processes (A. Andersson, Golsäter, Gäre, & Melke, 2020; Arora et al., 2020).

The studies reviewed in this section highlight the challenges and unpredictability involved in the deliberate orchestration of multi-professional multi-organisational collaboratives, and raise questions about the possibility of formalising and directing knowledge mobilisation practices. Together, this literature suggests that the early stages of collaborative knowledge mobilisation initiatives are a critical time characterised by negotiation and the creation of formative local practices and ways of learning. It points to the need for a delicate balance between formal and

informal processes (Candlin & Candlin, 2007; Wenger, 1998; Wenger et al., 2002). A significant instrumental/organic paradox persists—while the act of managers or policymakers setting up knowledge mobilisation initiatives is a practical necessity in terms of achieving their instrumental aims, this act appears to be *"insufficient of itself to produce positive translational activity"* (Fitzgerald & Harvey, 2015). However, the best means of striking this balance remains open for investigation. This is particularly so in the case of collaborative networks set up with the instrumental aim of mobilising process improvement knowledge which, due to its 'non-native' nature, may be perceived by clinicians as being imposed from the top down.

1.3.2 Boundaries and politics

Studies of collaborative knowledge mobilisation in healthcare have also revealed the challenges of bringing diverse actors together to collaboratively mobilise knowledge. In particular, scholars have argued that social and political boundaries that influence trust and motivation to learn together, as well as epistemic boundaries that relate to the different ways of knowing that characterise different communities, can hinder knowledge mobilisation (Brown & Duguid, 2001; Ferlie et al., 2005; Kislov, 2014). The AHS organisations and CLAHRCs have been particularly fruitful contexts in which to explore these issues, due to their multi-agency and multidisciplinary nature.

1.3.2.1 The ambiguous effects of epistemic boundaries

Research into AHS organisations has shown that knowledge mobilisation can be undermined by clashes between clinical and academic logics and cultures (Ovseiko, Melham, Fowler, & Buchan, 2015). Currie et al. (2014) describe inter-professional political contestations related to knowledge, specifically between health services research and organisational science research communities. Similarly, Kislov (2014) shows how the epistemic boundary between the biomedical research and social science-based implementation strands of CLAHRCs gives rise to boundary discontinuity and problematise knowledge sharing. This study shows how the structural design of collaboratives can further reproduce conflicting attitudes toward evidence—for instance, if research and implementation activities are separated into linear and sequential 'stages' of activity. While conflict may be avoided by separating epistemic communities, Kislov suggests this may also result in the loss of opportunities to negotiate epistemic boundaries and develop shared practice (Kislov, 2014).

In an extensive evaluation of the early CLAHRCs by Ling et al. (2011), the authors used a micro-level CoP approach to consider how different groups interpreted and used evidence differently. As Ling and colleagues identify, an implicit expectation of the CLAHRCs is that new and existing communities connect, and that behaviours within and across organisations change. The authors find, however, that CLAHRCs are better described as *"terrains upon which compromises, trade-offs and tensions are played out" (Ling et al., 2011, p. 124)*. Exploring examples of managers constructing instrumental CoPs as instruments of innovation, Swan et al. (2002, p. 491) also highlight this ambiguity: while epistemic boundaries between communities may hamper knowledge mobilisation within instrumental collaborative initiatives, broader networks of practice to which they connect can also help to externalise and spread new knowledge and innovations beyond instrumental collaboratives, resulting in even more far-reaching knowledge mobilisation activity.

Studies of collaborative networks have also drawn attention to how the status held by particular epistemic cultures can impact knowledge mobilisation. Mørk et al. (2008) analyse a medical research and development initiative from a situated learning perspective, as a multidisciplinary constellation of CoPs with distinct epistemic cultures (medical specialities, engineers, allied health, and nurses). Their analysis shows how the level of status associated with particular practices (e.g., the relatively high status of 'doing research') marginalises certain types of knowing (e.g., nurse's experiential knowing). The authors show how these epistemic status differentials present obstacles for learning. For instance, scientific ideals *"scared away"* nurses and radiographers who lacked research training and culture and limited their access to negotiations about what knowledge counts and what research gets done.

The AHSs, CLAHRCs and other studies of research mobilisation initiatives reveal epistemic tensions in collaborative networks between different types of researchers and clinicians. Nevertheless, attempts to use collaboration as a tool for the mobilisation of management knowledge are likely to generate further potential for epistemic 'clashes', due to major differences between the nature of the clinical evidence base and management knowledge (McGivern et al., 2016; Nilsen, Ståhl, Roback, & Cairney, 2013). This is because, on the one hand, clinical evidence is characterised by methodological unity, and explicit and quantitative evidence is accorded the highest levels of status and 'validity'. On the other, management knowledge is looser and more contested, and struggles to meet the scientific requirements that

underpin the hegemonic, evidence-based discourse in healthcare (Bresnen et al., 2017; Ferlie et al., 2010; Oborn, Barrett, & Racko, 2013).

While the aforementioned BTS Collaborative model seeks to mobilise process improvement knowledge, because most studies of them reside within the healthcare management and implementation science literatures, they are underpinned by the preoccupation with outcomes and assumptions of linear knowledge 'transfer' that is characteristic of the field. Despite the evidence for their success being mixed (see Aveling, Martin, Herbert, & Armstrong, 2017), critical examinations of BTS Collaboratives that consider how best to organise and manage them are rare (A. Andersson, Idvall, Perseius, & Elg, 2014; Dückers, Spreeuwenberg, Wagner, & Groenewegen, 2009). As a result, the particularities of mobilising 'non-native' process improvement knowledge in these collaboratives have not been a focus.

1.3.2.2 Political boundaries: Clinicians and managers/policymakers

The literature has documented considerable professional resistance to the general incursion of management discourse into clinical domains (Bartram et al., 2020; Doolin, 2001; Freidson, 1984). Political tensions between those cultivating collaboratives (usually policymakers or managers) and those who are the 'targets' of knowledge mobilisation activity (e.g., clinical professionals or researchers) also appear to be ubiquitous. Kitchener (2002) shows how the resilience of medical autonomy stifles attempts to bridge the divide between managerial and professional logics in an AHS. The author suggests that the political tensions arise in part from pressure on healthcare executives to adopt managerial innovations in order to build organisational legitimacy. This pressure springs from broader political agendas which seek to repress the prevailing institutional logic of professionalism in healthcare.

The work of Gabbay et al. (2003) also highlights the issue of broader political contexts. These scholars show that political agendas can also influence managerial/participant relations in the context of multi-agency collaboration on evidence-based health service policy development. Further, Fischer and colleagues (2013) elucidate the political tensions between professional and managerial logics during the development of an AHS organisation. The authors show how strong professional engagement can result in 'upwards pressure' which can sustain professional dominance and advance local ownership and visions of the AHS organisation through 'counter-colonisation' of the managerial domain. In considering how Lean management knowledge is mobilised in healthcare organisations, Waring & Bishop suggest that Lean is *"unlikely to survive*

the translation to practice fully intact" because doctors *"corrupt, 'game', and capture attempts to introduce process improvement ideas in order to maintain or extend their influence, or counter the interests of others"* (2010, p. 1339).

These studies highlight relations of control and resistance, especially between those tasked with organising collaborative knowledge mobilisation networks (managers/policymakers) and those who are the 'targets' of them (professionals). They suggest that political and epistemic boundaries can reinforce one another, and that they are likely to come to the fore during attempts to promote collaboration. While these studies suggest various forms of resistance on the part of professionals to managerialist ideas and agendas, they have largely focused on the 'translational gap' between clinical research and practice. We might expect that mobilising process improvement knowledge collaboratively might exacerbate such relations, but these issues have not been taken up in the literature.

1.3.3 Brokering and translation

In seeking to help clinicians and managers work collaboratively across fraught boundaries, scholars argue that knowledge brokers play an important, boundary-spanning role (Burgess & Currie, 2013; Fitzgerald & Ferlie, 2000; Kislov, Hodgson, & Boaden, 2016). In particular, 'hybrid' clinical-managers have received much attention for their potential role in spanning the clinical-managerial divide (Croft, Currie, & Lockett, 2015; Kislov et al., 2016; Llewellyn, 2001; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015; Sartirana et al., 2019; Waring & Currie, 2009). Alongside hybrids, non-clinical knowledge brokers (including process improvement experts) are increasingly being tasked with mobilising 'non-native' knowledge such as managerial practices within healthcare (Kislov, Humphreys, & Harvey, 2018). I next review relevant studies investigating the role of hybrids and non-clinical knowledge brokers in collaborative mobilisation in healthcare.

1.3.3.1 Hybrids

Initially referred to by Freidson (1984, 1994) as 'administrative elites', hybrid clinical-managerial roles are positions in-between top levels of (usually non-clinical) management and frontline clinical management. Role incumbents often maintain their clinical practice and therefore their professional legitimacy, while also contributing to the implementation of organisational policies (Fitzgerald et al., 2006). Owing to their formalised participation in both management and clinical

communities and to their 'two way windows' into both worlds (Llewellyn, 2001), scholars consider hybrids able to broker across the problematic boundaries of mismatched knowledge, paradigms, experience, and culture (Kislov et al., 2016; Long et al., 2013; Sartirana et al., 2019).

Despite the potentiality of hybrid identities for facilitating knowledge mobilisation, research has also shown their 'in-betweenness' to limit their effectiveness. A significant challenge faced by hybrids can emerge from tensions between managerial principles and the professional principles to which they have strong loyalty as members of professional communities (Croft et al., 2015; Kitchener, 2000; Spyridonidis, Hendy, & Barlow, 2015). Like those outlined in relation to collaborative networks, these tensions can be sociocultural, epistemic, and political in nature (McGivern et al., 2016). Research from a social identity perspective has found that frontline 'rank and file' staff can perceive that hybrid clinician-managers have 'gone over to the dark side' (Croft et al., 2015; Fischer et al., 2016; Ham, Clark, Spurgeon, Dickinson, & Armit, 2011). In terms of epistemological issues, medical professionals view the general management domain as weak and potentially contestable due to its lacking a scientific knowledge base. Clinician-managers may therefore need to work to counter the status-lowering effect of the managerial aspects of their hybrid positions and identities, by ensuring, for instance, that they adequately maintain their clinical practice (Llewellyn, 2001).

Moreover, tensions are also found between macro-level influences and the micro-level of hybrid work (Currie, Finn, & Martin, 2010). Currie, Koteyko & Nerlich (2009) show, for instance, that when nurse hybrids are associated with government policy to drive organisational change, they suffer diminished influence both over their own professional rank and file and over doctors who already benefit from an elevated position in the professional hierarchy. The lack of a community in which to belong appears also to generate identity challenges and undermine the effectiveness of hybrids (Croft et al., 2015; Wenger, 1998). Moreover, hybrid roles tend to be characterised by narrow operational management tasks rather than wider strategic management, change management, and service improvement tasks, potentially limiting their opportunities to participate in productive boundary spanning activities. Currie and Proctor (2005) highlight the importance of socialisation processes in hybrids being able to fully participate in such strategic organisational issues.

Research also suggests that the willingness, experience, and effectiveness of clinical-managerial hybrids is highly varied. Waring's (2014) study of hybrid doctors highlights how their various contexts and interests result in different types of elite hybridity and heterogeneous motivations. Each of Waring's hybrid doctor 'types' displays different brokering practices with respect to their interaction with other clinical, managerial, research, or political elites. McGivern et al (2015) provide further evidence that some 'willing hybrid' doctors more easily discern the status benefits of their hybrid roles. Those who do so identify as operating at the interface between profession, organisation, and the state to be a potentially powerful network position (Noordegraaf, 2007; Waring & Currie, 2009).

Individuals' willingness and ability to act as boundary spanners also appears to be influenced both by professional identity and existing intra- and inter-professional relations of power and status. In a study of hybrid nurses and doctors, Currie, Burgess & Hayton (2015) show that low-status hybrid nurse middle managers lacked the legitimacy and opportunity to broker knowledge outside of their specialty, whereas higher status hybrid doctors lacked the motivation to do so. Similarly, Croft et al. (2015) demonstrate the struggle they face in constructing a positive 'liminal space' in order to effectively move between professional and managerial identities. In the context of a CLAHRC, Spyridonidis et al. (2015) reveal that senior doctors are more easily able to transition into hybrid roles compared with junior doctors because—as professional identities are often central to self-esteem (Kellogg, 2014)—their secure 'cross-cutting' identity as competent clinicians means that hybrid roles present less threat to their clinical status and identities. Within this context this had implications for their willingness to engage in collaborative knowledge mobilisation.

These studies indicate that hybrid identities can be characterised by the experience of liminality, as well as a lack of power, affiliation, recognition, and opportunities for learning for incumbents (Kippist & Fitzgerald, 2009; Swan, Scarbrough, & Ziebro, 2016). Hybrid identities can, nevertheless, also be sites of increased power and control, especially for dominant professions. Llewellyn (2001) finds that the managers in her study were unable to move into medical arenas and impinge on professional autonomy, yet hybrid doctors could 'roam' the organisation freely. Hybrid roles can, however, also be sites of increased power and control *over* professions. 'Elite' hybrid identities emerge through processes of professional restratification and may therefore also represent a site of control over rank and file professionals (Freidson, 1984, 1994). Foucauldian perspectives suggest that hybridity involves professionals becoming co-opted or

enrolled within the discourses of management, and actively spreading these discourses among rank and file colleagues (Waring, 2014). Brokering across the clinical-managerial boundary can thus increase medical incumbents' status within both the medical profession and the broader healthcare field, but may simultaneously and paradoxically undermine the autonomy of the profession.

The discussion above has drawn attention to the heterogeneous nature of medical and nursing hybrids as knowledge brokers in healthcare, and the polyvalent nature and effects of their brokering practices. It has also alluded to the work of identity reconciliation inherent in the construction, performance, and experience of hybridity. However, empirical studies have largely focused on hybrids' identity work within single organisations. Those studies that have considered brokers within collaboratives (Evans & Scarbrough, 2014; Kislov et al., 2016; Rowley et al., 2012) have rarely focused analytically on how hybrid identity issues impact collaborative processes.

1.3.3.2 Non-clinical knowledge brokers

Knowledge brokering in healthcare is also undertaken by clinician hybrids other than nurses and doctors, and non-clinicians are increasingly taking up knowledge brokering posts (Kislov, Humphreys, & Harvey, 2017; Kislov, Hyde, et al., 2017; McLoughlin et al., 2019). Process improvement practitioners tasked with mobilising this knowledge within healthcare may have non-clinical professional backgrounds, for example in manufacturing, engineering or business (Soekijad & Smith, 2011). In other cases, clinicians may gain managerial expertise, move into hybrid clinical-managerial roles, and then exit their clinical careers to focus on management. This is particularly common among members of the lower-status clinical professions such as nursing and allied health (Jorm, 2016). However, very little research has focused specifically on hybrid knowledge brokers with clinical backgrounds other than nursing and medicine, or on non-clinical knowledge brokers with specific process improvement expertise (Harvey & Kitson, 2015; Harvey & Lynch, 2017). The following studies are notable exceptions.

First, Kellogg's (2014) study of cross-professional reforms suggests that low-status non-professionals (in this case community health workers with no formal qualifications) can buffer higher-status professionals (lawyers and doctors) from the collaborative learning required to engage with new tasks during service redesign. This appears particularly important when change creates professional 'dirty work'. Through their buffering practices, non-professionals

may emerge as ‘brokerage professionals’. Whether emergent brokerage professions can sustain and succeed in their professionalisation projects remains open for investigation.

Second, in a study of micro-level institutional change within primary healthcare, Kellogg (2019) shows how the favourable structural position of ‘semi-professionals’ (in this case medical assistants), with regard to the professionals who are the target of change (doctors), can help bring about shifts in professional practice. Kellogg argues that their positions can be ‘activated’ if managers equip them with tools to minimise the target professionals’ concerns about threats associated with change, thereby helping to implement new care delivery models.

Third, in Kislov’s (2014) study of a CLAHRC, non-clinical ‘change agents’ and management academics were expected to act as designated knowledge brokers in the implementation of research evidence into cardiovascular medical practice. The brokers’ ability to transform from potential to actual connectors in the collaborative initiative were undermined by structural conditions including overformalisation and infrequency of interaction, as well as the inability to develop effective knowledge mobilisation mechanisms that cut across inter-team boundaries. In particular, the study supports earlier findings by Ferlie et al (2005) and Kislov et al. (2011) which suggest that formalised uni-professional knowledge brokering groups may struggle to mobilise knowledge across different communities. Kislov’s study does not, however, explicitly consider the relevance of the non-clinical knowledge brokers’ identities or their relative status levels in relation to the participant ‘targets’ to whom they were charged with brokering clinical evidence.

Fourth, Kislov, Humphreys and Harvey (2017) show how non-clinical knowledge brokers’ roles as facilitators of service improvement shift over the course of a collaborative program designed to mobilise existing health research into day-to-day practice—from ‘enabling’ (frontline facilitation of service improvement) to ‘managing’ (more abstracted project and performance management). Clinical facilitators, on the other hand, shifted from ‘enabling’ to ‘doing’ (with more direct involvement in service improvement rather than supporting or coaching). The authors suggest that non-clinical brokers lack legitimacy in comparison with their clinical counterparts, but that both kinds of knowledge brokers tend to experience a problematic ‘distortion’ of their roles over time, characterised by three issues: prioritisation of measurable outcomes over interactive processes, reduction of multiprofessional engagement, and erosion of the interactive, enabling, and facilitative aspects of brokering service improvement knowledge.

Finally, McLoughlin et al (2019) draw attention to the lack of influence faced by those tasked with brokering 'foreign' service redesign and improvement knowledge, as a result of their non-clinical backgrounds, or backgrounds in less prestigious clinical specialties. The authors show how this affects the behaviour of brokers, for instance with regard to the ways in which they attempt to enlist higher-power actors to legitimise their change efforts.

Non-clinical and non-medical or non-nursing knowledge brokers remain under-investigated overall. Where they have been acknowledged, as in the studies above, their identity, status and practices are rarely treated as the object of analytical interest. As a result, many questions remain in relation to how the identity and status of these other clinical hybrids and non-clinical knowledge brokers influence collaborative knowledge mobilisation.

1.3.3.3 Strategic translation practices

The studies above also allude to the agentic, strategic nature of knowledge brokering. Brokers who succeed in bridging, in social network theory parlance 'structural holes', may experience tangible manifestations of social capital. Paradoxically, however, brokers may also gain from buffering knowledge flows across boundaries, whether deliberately or not (Kellogg, 2014; Van Grinsven et al., 2016). However, studies considering the strategic potential of brokers still tend to reflect structural network approaches (Van Grinsven et al., 2016). Limited studies have investigated the nature of specific strategic knowledge brokering practices in everyday work in relation to mobilising knowledge in healthcare, how knowledge and practice are 'translated' through these practices, and particularly with regard to process improvement knowledge. These few relevant studies are reviewed here.

Evans & Scarborough (2014) focus on 'bridging' and 'blurring' as two different approaches to knowledge mobilisation within the NHS CLAHRCs. The authors show how the use of these two practices is shaped by the specific socio-historical attributes of the local knowledge mobilisation context, which legitimise and shape particular forms of action. In contexts where there was pressure to secure the support of high-status hybrid doctors, formally designated brokers 'bridged' the gap between research and clinical communities, such that boundaries between research and clinical practice were sustained and neither community was required to significantly alter their work practices. In a different local context, hybrid academic-clinicians in the senior management team actively legitimised new practices that were not tied to professional norms. Here, brokers worked to 'blur' boundaries between the various hybrids

(e.g., allied health and nursing), academics (e.g., sociology and economics), and clinicians (e.g., nurses and doctors), enabling them to collaborate on the new practices.

Kislov (2018) further develops our understanding of strategic knowledge mobilisation work by considering mechanisms of boundary construction and reconstruction. The study shows how boundary spanning can coexist with boundary buffering and reinforcement in large-scale collaborative initiatives such as the CLAHRCs. The study also examines how the tension between strategies of engagement and disengagement results in the continuous reconstruction of external boundaries of teams within collaboratives, and how their various configurations result in the ‘selective permeability’ of boundaries. This selective boundary permeability between teams depends on various agentic and structural aspects of boundary work. These include not only individual boundary work, but also team-level factors such as shared in-group identity and boundary spanning strategies, organisational factors such as deliberately orchestrated structural and functional inter-team integration, and extra-organisational features of the broader boundary landscape.

In another study of CLAHRCs, Kislov, Hyde and McDonald (2017) explicitly address issues of context. They demonstrate how government-led initiatives that aim to alter professional and organisational jurisdictions (in order to improve efficiency and effectiveness of health service provision) can exacerbate the challenges of mandated collaboration in the healthcare context. Deploying a Bourdieusian lens, they argue that the legitimation of boundary spanning roles and practices is a transformative, collective, and political process that may enhance the capital of individual boundary spanning agents, but may also lead to the erosion of the very roles and practices being legitimised. In so doing, they elucidate some of the issues that may arise from the ‘mandatedness’ and formalisation of knowledge brokering roles and activities, and highlight that the strategic practices of brokers are always situated, and therefore mediated, by their context.

In the context of the implementation of Lean in a hospital, Andersen & Røvik (2015) show how local translation creates different versions of Lean in different contexts within a hospital. While the authors do not focus on designated knowledge brokers, they demonstrate that the effectiveness of Lean depends on how local stakeholders actively translate the management concept, and whether they are able to do so in a way that both fits the local context and ensures that the core elements of Lean are not ‘washed out’ in the process. As seen in Evans &

Scarborough's (2014) study, Andersen & Røvik (2015) leverage the implicit proposition that all stakeholders are involved in brokering processes that result in translations which either help connect existing local practices with new ones, or hinder their mobilisation.

Finally, in a similar context, Van Grinsven et al. (2016) borrow the view of brokers as a 'strategic third' who can unite or separate across boundaries from functional network studies. The authors use this notion as a sensitising heuristic for their practice-based approach to understanding how brokers translate the Lean management concept across professional and managerial boundaries in a hospital setting. They demonstrate how various formally nominated boundary spanners championing Lean use micro-practices of translation (positioning, labelling and channelling) to align meanings of Lean across professional and managerial boundaries. The authors extend our understanding of knowledge translation by outlining three strategic modes of translation: bridging, buffering, and blending. They demonstrate how the strategic orientations of knowledge brokers shape micro-practices of translation, highlighting brokers' agency and intentionality. Their study also draws attention to the processual nature of translation, in which brokers continuously translate back and forth across professional and managerial boundaries. While their work provides insight into knowledge brokering processes and practices—which is lacking in the literature in general—the authors do not distinguish the characteristics of these boundary spanners. This again raises the question of how the identity of boundary-spanners might impact their knowledge mobilisation practices.

Van Grinsven et al. (2016) caution that studies like theirs which focus on brokers may paradoxically obscure the brokers themselves from view, since their identities are often not considered outside of their relationship to others. Evans & Scarborough (2014) support this view, arguing that the 'bridge' metaphor used to describe knowledge brokers in social network theory obscures the broader context in which brokers exist. As such there is a need to consider how their identities and embeddedness in existing relations of power and status influence their knowledge brokering activity. Van Grinsven et al. (2016) also suggest that the mechanisms involved in buffering (as a paradoxical yet significant mode of translation) is in need of further exploration. This lends further support to the aforementioned critiques of the tendency to romanticise collaboration, and the need to focus on conflictual relations to understand the development of collaborative networks.

1.4 Underexplored themes: Forming, conflict, identities

The studies reviewed in this chapter progress our understanding of the sociopolitical and epistemic issues inherent in collaborative knowledge mobilisation. Many implicitly problematise and move us beyond the linear models of knowledge 'transfer' that dominate the healthcare management and much of the generic management literature—toward what I call a 'translational' approach (see Table 1.1 for a brief comparison of 'transfer' vs. 'translation' approaches). These perspectives are further articulated in the next chapter where I outline my theoretical approach. However, within this literature on collaboration and knowledge mobilisation, there remain a number of issues requiring further investigation.

First, there persists significant debate as to 1) whether and how a 'community' can (and/or should) be deliberately cultivated for the instrumental purposes of knowledge mobilisation (as later writing by Wenger and colleagues (2010; 2002) would suggest), 2) whether this can only occur organically (as seminal work by Lave & Wenger (1991) and Wenger (1998) would suggest), or 3) whether there is some middle ground in which the best of both 'instrumental' and 'organic' worlds might be possible to achieve (Kislov et al., 2012). While the act of policymakers deliberately 'setting up' collaborative initiatives is a practical necessity, it appears to be insufficient for knowledge mobilisation. What exactly these other necessary practices are, however, remains unclear.

Moreover, it is evident that top-down mandates of knowledge mobilisation initiatives are fraught and have the potential to stifle the organic knowledge mobilisation processes they try to promote. This is especially the case when they aim to alter professional and organisational jurisdictions in order to improve the efficiency and effectiveness of health service provision (Currie, Koteyko, et al., 2009; Kislov, Hyde, et al., 2017). Despite the significant ambiguity surrounding the formation process of collaborative initiatives, studies have tended to neglect the micro-level everyday work of the various stakeholders involved. This is, however, particularly important to consider when cross-disciplinary, cross-organisational collaborative networks are set up for instrumental purposes (Kislov et al., 2011, 2012; Pyrko et al., 2017).

Second, within the management and organisation literatures, research in the healthcare context has highlighted epistemic and political clashes that emerge during attempts to collaborate across boundaries, including in multidisciplinary and multi-organisational collaboratives such as the CLAHRCs and AHSs. However, these have largely related to the 'translational gap' between clinical research and practice. Given the challenges of engaging clinicians with process improvement knowledge, even starker epistemic clashes are to be expected among the epistemic communities creating instrumental collaboratives to mobilise this 'non-native' knowledge (e.g., policymakers and managers), those charged with brokering this knowledge (e.g., non-clinical knowledge brokers and hybrid knowledge brokers) and those who they seek to engage in process improvement (e.g., other hybrid clinicians and clinicians more broadly). Yet, very few studies have engaged explicitly with this particular epistemic issue in general, and to date no studies have considered this issue in the context of collaborative networks.

Moreover, the studies reviewed also highlight political relations of control and resistance, especially between knowledge mobilisers and their 'targets'. However, further exploration is needed to understand how the 'mandatedness' of collaboratives and the mobilisation of 'non-native' process improvement knowledge influence engagement with collaborative learning processes—particularly with regard to autonomous actors such as medical clinicians. This kind of analysis will also help to enhance our understanding of how instrumental collaborative initiatives relate to preexisting 'organic' CoPs (Comeau-Vallée & Langley, 2019; Kislov et al., 2012).

Third, the review of brokering studies reveals that, with the exception of medical and nursing hybrids, scholars largely overlook the identities of designated knowledge brokers. Where non-clinical and non-medical/nursing knowledge brokers have been acknowledged, their identity, status and practices have not been predominant analytical foci. However, they are likely to impact individual knowledge brokers' motivation, opportunity and ability to broker knowledge across boundaries (Currie et al., 2015; Van Grinsven et al., 2016). This in turn is likely to impact how learning occurs across boundaries in collaboratives. In particular, the identities and practices of the non-clinical knowledge brokers with relatively low status in healthcare, who are increasingly tasked with mobilising non-native process improvement knowledge, require further investigation. While studies have explored how management concepts such as Lean change through translation (Andersen & Røvik, 2015; Van Grinsven et al., 2016), there is still a need to

better understand how and why the actors themselves are also transformed as they learn to collaborate (Hultin, Introna, & Mähring, 2020).

Finally, it is important to note that in contrast with studies in the healthcare management and implementation science fields which tend to employ survey methods and seek to 'objectively' measure the effectiveness of collaborative networks, studies within the management and organisation fields have embraced qualitative methods (mainly interview-based) to better grasp the experiences of those involved in collaborative networks in healthcare. While this has helped to illuminate many of the social, political and epistemic challenges involved in knowledge mobilisation, there remains significant opportunity to deploy more immersive methods which will enable us to better recognise and more fully explore the substantive themes outlined above, and explain *how* and *why* knowledge is mobilised collaboratively (Haynes et al., 2020; Li et al., 2009).

The three themes requiring further investigation are summarised as follows:

1. Formation: exploring the early stages of collaborative initiatives and their instrumental/organic tension; considering how the 'mandatedness' of collaborative initiatives influences their formation and actor's participation.
2. Negotiation: exploring the knowledge brokering practices of brokers with different hybrid or non-clinical identities, epistemic clashes between various participant communities, epistemic issues surrounding the mobilisation of process improvement knowledge, and political issues of control and resistance.
3. Identity: exploring the recursive relationship between learning and becoming, and the impact of belonging to different epistemic communities on actors' engagement with the collaborative mobilisation of 'non-native' process improvement knowledge.

In the next chapter, I develop a conceptual framework to help guide the further exploration of these issues through this thesis, and articulate the specific research questions of the study.

	Knowledge 'transfer' stream	Knowledge 'translation' stream
Key research foci	Inputs/outputs of the process of knowledge mobilisation; barriers/enablers	The process of knowledge mobilisation
Analytical object	Knowledge to be mobilised and the structures of collaboration	Actors, their agency and interactions, with knowledge and each other
Analytically obscured	Micro-practices, agency, context	Outcomes in terms of quantifiable 'effectiveness' of knowledge mobilisation networks
Types of research questions	*What* are the discrete barriers and enablers that influence knowledge mobilisation / collaboration? (inputs) *How effective* are these initiatives in mobilising knowledge? (outputs)	*How* and *why* does knowledge mobilise? (process) *How* and *why* do different actors collaborate? (process)
Types of research design and methods	Randomised controlled trials Controlled before and after studies Interrupted time series Surveys, review of medical records and databases to determine whether desired improvement was achieved (see Wells et al., 2018)	Qualitative case studies, often longitudinal Mixed methods approaches Interviews and focus groups Documentary analysis Observation (less common) (see Kislov, Wilson, et al., 2018)
Research fields and key theories	Evidence-based medicine Evidence-based management Health service management Social Network Theory Diffusion of Innovations Theory	Social sciences Sociology of professions Situated Learning Theory Theories of identity Sociology of Translation
Visual model of collaboration	Actors collaborate more easily when more proximal. Brokers (B) can help to connect others and facilitate knowledge mobilisation	Epistemic and political boundaries can challenge the process of collaborative knowledge mobilisation, and the work of brokering

Table 1.1: Categorisation of the literature on knowledge mobilisation through collaboration in healthcare.

Chapter 2: Conceptualising knowledge mobilisation and collaborative learning

To address the under-investigated issues exposed in my literature review, in this chapter I assemble a conceptual bricolage, drawing most centrally from SLT (Lave & Wenger, 1991; Wenger, 1998), as well as theory about epistemic cultures (Knorr Cetina, 1999) and identity construction (Alvesson & Willmott, 2002; Jenkins, 2004). Informed by this bricolage, I develop an initial model of collaborative knowledge mobilisation and articulate the research questions that guide the study. Then, given the methodological weakness of studies of collaborative knowledge mobilisation in healthcare identified in chapter one, I develop a practice-based approach to exploring the phenomenon more fully in the next chapter.

2.1 Switching lenses

In the previous chapter, I pointed to the assumptions about the nature of knowledge mobilisation and collaborative learning that are inherent to much of the healthcare management literature. In this section, I further examine and critique these, arguing that the dominant knowledge 'transfer' approach has resulted in a limited understanding of the social processes involved in collaborative knowledge mobilisation networks. To explain how and why they develop, and to explore issues surrounding the mobilisation of 'non-native' knowledge and various knowledge brokering identities, I argue that we need to adopt an alternative 'translation' perspective.

2.1.1 From knowledge transfer…

The healthcare and generic management literature has largely been disinclined to move beyond linear, rational, objectivist models of knowledge mobilisation. Although the term 'translation' is commonly used in the health services management and implementation science fields (e.g., 'translational gaps', 'translation of evidence into practice'), a metaphor of knowledge 'transfer' mostly underpins these dominant models (see Table 2.1 for a visual comparison of approaches). Knowledge is implicitly assumed to be 'thing-like' and to flow more or less unproblematically, passively, linearly and *without* translation from one rational actor to another (Carlile, 2004). This objectivism has been attributed to the 'cultural proximity' of these fields to the natural sciences, evidence-based medicine and evidence-based practice movements,

where research involves determining the effectiveness (outcome) of discrete interventions, preferably through experimental methods (Nilsen et al., 2013; Swan, Newell, et al., 2016b). Moreover, the wider western Lean management literature from which it draws also errs toward investigating operational rather than socio-technical concerns (Joosten, Bongers, & Janssen, 2009). This has resulted in research tending to focus on the outcomes and effectiveness of management innovations, rather than on understanding the processes involved in their eventual uptake (or commonly, their lack thereof).

A widely extolled theory situated within this perspective is Rogers' (1995) Diffusion of Innovations Theory, which views diffusion as the spread of ideas among rational people—predominantly by imitation, since 'beneficial' knowledge and ideas are assumed to move among people and places 'naturally' (Ferlie, 2016; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). The theory assumes boundaries to be relatively unproblematic, because it takes for granted stable conditions of understanding between 'sender' and 'receiver' (Carlile, 2004). It consequently considers 'knowing-doing gaps' as arising from problems with the type and quality of the knowledge or evidence being mobilised, poor implementation, or the characteristics of actors (Swan, Newell, et al., 2016b; Unnithan & Tatnall, 2014). Within this view, a key issue for process improvement knowledge is the poor 'fit' between its principles and origins in manufacturing and the ethos of a professionalised service setting (Al-Balushi et al., 2014; Bateman et al., 2018; Stanton et al., 2014; Waring & Bishop, 2010). The solution is thus to find 'better' evidence to persuade actors of the benefits of process improvement.

While valuable in highlighting discrete barriers and enablers to mobilising knowledge, the dominance of 'transfer' perspectives in healthcare research has obscured many critical social aspects of collaborative knowledge mobilisation in general. In particular, this has occurred in relation to clinician engagement with process improvement knowledge. Crucially, questions of *how* and *why* the mobilisation of process improvement knowledge does or does not happen have been 'black boxed' (Ferlie, 2016; Rowley et al., 2012; Van Grinsven et al., 2016). The practical consequence of the assumptions underpinning 'transfer' approaches is that many policy initiatives that attempt to improve processes and standardise practice in healthcare have failed (Swan, Newell, et al., 2016b). It is for this reason that scholars have argued that *"'flow' is a radically inappropriate image to describe what are erratic, circular, or abrupt processes…" (Ferlie et al., 2005, p. 123)*.

2.1.2 … to knowledge translation

In search of an alternative metaphor that can produce more nuanced insights about social and political practices, processes and context, some scholars within the social sciences and management and organisation studies have conceptualised knowledge mobilisation in more dynamic 'translational' terms (e.g., (Crilly et al., 2010; Davies et al., 2015; Fischer et al., 2016; Fitzgerald & Harvey, 2015; Rowley et al., 2012; Swan, Newell, et al., 2016b). This has contributed to what Ferlie et al (2012) refer to as an 'epistemological turn' in which hierarchical models of evidence in the healthcare literature are slowly being challenged by qualitative and narrative forms of evidence. Following Swan and colleagues, I understand knowledge mobilisation to be both the intended practical objective of collaboration, and also *"a proactive process that involves efforts to transform practice through the circulation of knowledge within and across practice domains" (2016a, p. 2).*

Underpinning the 'translational' approach to understanding knowledge mobilisation are three key assumptions (see table 2.1 for a visual comparison of approaches). First, knowledge is not a separable 'thing'. Instead, *"what is known, the one who knows it, and the context of action are bound together"* (Tooman, Akinci, & Davies, 2016, p. 19). Such notions as 'knowing in practice' (Nicolini, 2011; Orlikowski, 2002; Rennstam & Ashcraft, 2014), 'knowing-in-practice-in-context' (Gabbay & le May, 2016), and processual conceptualisations of how knowledge comes into being (A. Langley & Abdallah, 2011), replace thing-like ideas about 'knowledge'. Second, in contrast to the passive, rational characterisation of actors within 'transfer' models, actors are seen to be active negotiators of meaning. They are embedded in broader societal contexts which ensure they have various and conflicting interests, and they variously interpret the 'benefits' of mobilising knowledge, and even what constitutes knowledge itself (Heusinkveld, Sturdy, & Werr, 2011; Swan, Newell, et al., 2016a, p. 2; Wenger, 1998).

With this consideration of actors' situated agency comes a closely related third key assumption: that whenever knowledge is mobilised it is always also translated in the process. Translation studies such as those drawing on insights from Actor Network Theory and the Sociology of Translation (Callon, 1986; Latour, 1986; Law, 1992, 2009) highlight how ideas are modified by agentic actors in relation to the specific contexts and social realities within which they are situated (Czarniawska & Joerges, 1996; T. Morris & Lancaster, 2006). Variation and change are the rule while stability and order are the exceptions that need explanation (Latour, 1986). Actors

are therefore seen as ‘translators’ with diverse interests and influence. They actively make meaning of, negotiate, and modify knowledge in practice, shaping it *“according to their different projects”* (Latour, 1986, p. 268). Moreover, actors’ translation practices can also be considered existential, as actors do not simply resist or transmit knowledge *“in the way they would in the diffusion model; rather, they are doing something essential for the existence and maintenance of the token…” (1986, p. 268)*.

With these three assumptions in mind, the translational approach to understanding knowledge mobilisation offers a lens through which to understand the social reality of collaborative networks, as well as the knowledge targeted for mobilisation, not as a given but as processual, contested and bound up with actors’ situated translation practices. In contrast to ‘transfer’ approaches which assume that knowledge is a ‘thing’ and take for granted that it flows by virtue of its inherent benefits, a ‘translation’ approach assumes that any purported benefit is always contested: “*The spread in time and space of anything—claims, orders, artefacts, goods—is in the hands of people; each of these people may act in many different ways, letting the token drop, or modifying it, or deflecting it, or betraying it, or adding to it, or appropriating it.” (Latour, 1986, p. 268)*. As a result, a ‘translation’ approach promotes a focus on the ways in which actors interact with and change knowledge. This means that where ‘transfer’ perspectives can only report on *whether* knowledge mobilisation has or has not occurred and associate this outcome with particular characteristics of the context or actors involved, a ‘translation’ approach invites the exploration of *how* knowledge mobilises and *why* this is the case. Since Latour suggests that *“there is no inertia to account for the spread of a token” (1986, p. 267)*, how and why knowledge gets mobilised needs to be explained.

I therefore take a translational approach in this thesis in order to better understand how and why actors, as situated within broader overlapping fields of practice that make up the ‘complex ecology’ of healthcare (Swan, Newell, et al., 2016a), mobilise knowledge in collaborative networks. This lens allows me to interrogate the idealistic assumptions about collaboration within structural network theories and consider what actually goes on when collaborative initiatives are deliberately created to mobilise ‘non-native’ knowledge across organisational, disciplinary and professional boundaries. Through this lens, I can assume that tensions, conflict and negotiation are inevitable and that both knowledge and actors will be subject to ongoing translation and change *“through the flow of practices rather than as a result of deliberate implementation efforts” (Hultin et al., 2020, p. 2)*.

2.2 Conceptual bricolage

I now flesh out the 'translation' perspective further by building a bricolage of theoretical resources grounded in concepts from SLT (Lave & Wenger, 1991; Wenger, 1998), theory about epistemic cultures (Knorr Cetina, 1999), and identity (Alvesson & Willmott, 2002; Jenkins, 2004; Wenger, 1998). In doing so I create an initial sensitising framework (figure 2.3) that will help me to address the underexplored themes outlined in the literature review.

The idea behind this approach derives from Levi-Strauss for whom bricolage involves reviewing the tools one has at hand, engaging *"in a sort of dialogue"* with them, and pulling them together to make something new (1966, p. 18). I develop a conceptual bricolage in preference to taking a unified theoretical approach for two reasons. First, it avoids the trap of deductively searching for theoretical 'fit'. Second, and relatedly, all theories foreground some aspects of a problem and in so doing obscure others. With this approach, I can pull together aspects of numerous traditions in a way that sheds new light on previously underexplored empirical and theoretical issues (Currie, Dingwall, et al., 2012).

2.2.1 Collaborating as learning

2.2.1.1 Situated learning in CoPs

Lave and Wenger's SLT (1991) is a theory of *learning as participation*. In their monograph, 'Situated Learning: Legitimate Peripheral Participation', the authors foreground social practice in analyses of learning. Their work breaks with dominant learning theories of the time, which were based on conceptualisations of learning as the cognitive transmission of abstracted knowledge, and of learners as internalisers of such knowledge. From an SLT perspective, learning is characteristic of, and integral to, *all* social practice (Wenger, 1998). Moreover, learning is not merely about acquiring knowledge from more experienced practitioners, but about participating in a sociocultural practice and becoming a member of a CoP (Lave & Wenger, 1991).

The SLT perspective emphasises the relational interdependence of *"agents and the world, and of activity, meaning, learning, and knowing"* (Lave & Wenger, 1991, p. 50). Importantly, the SLT lens encourages processual conceptualisations of knowledge mobilisation and learning together (Pyrko et al., 2017). It is for this reason that scholars have argued that translation studies, with

their emphasis on how knowledge is translated, and SLT, with its emphasis on the learning process, can enrich each other to better understand learning in organisations (Fox, 2000; Swan et al., 2002).

In the context of this thesis, SLT shifts us away from the assumption that collaboration will 'just happen' when policymakers who seek to direct and control the flow of knowledge bring actors together. SLT recasts the issue of collaborative knowledge mobilisation in terms of learning, defined as increasing participation in CoPs as loci of *"engagement in action, interpersonal relations, shared knowledge and negotiation of enterprises" (Wenger, 1998, p. 85)*. Learning communities are not to be taken as given. Rather, they emerge when the *mutual engagement* of participants pursuing a *joint enterprise* is sustained for long enough that they come to share some significant learning, and, through this, they begin to develop a *shared repertoire* (Wenger, 1998, p. 86).

2.2.1.2 'Making' collective learning practices

The SLT perspective suggests that, in order to learn how to mobilise knowledge collaboratively, actors must participate in a system of practices where they collectively 'make' knowledge mobilisation a core practice. Lave & Wenger (1991) and Wenger (1998) themselves caution against romantic, reified conceptualisations of CoPs as idealised learning contexts—rather than an analytical lens focused on practice. Nevertheless, researchers deploying the CoP concept often fall into a 'romantic trap' for which the term 'community' is arguably responsible owing to its harmonising connotations (Brown & Duguid, 2001; Contu & Willmott, 2003; Cox, 2005). Gherardi (2009a). Gherardi and Nicolini (2000) suggest that foregrounding engagement and participation helps to overcome this by focusing analytically on the *practices* of so-called 'communities' rather than on a supposed unitary and objective 'community'. Returning to the practice-based underpinnings of the SLT approach can help avoid the pitfalls of assuming that organisational 'structures' such as knowledge mobilisation collaboratives are coherent, reified forms, or that a context for learning already exists (Gherardi, 2009a) (for instance by virtue of labels such as 'collaborative' or 'CoP').

With regard to meaning-making in CoPs, Wenger (1998) refers to an interplay and constructive tension between participation and reification. The meaning-making process begins in participation and is reified when actors make common understandings into more abstract and concise artifacts. These reified understandings are then available for further negotiation. This

thesis extends the application of this duality, to understand the emergence of collaborative 'forms' as loci of learning through the interplay of these dual processes. It therefore views the 'reality' of such collaborative initiatives as emergent and processual, as participants engage in 'collectively making' the learning practices that constitute them (J. Langley et al., 2018).

SLT alerts us to the notion that practices are, however, a site for negotiation (Wenger, 1998). As such, collectively making a context for learning through social practice does not imply harmonious relations. Neither, for instance, does it imply the 'success' of a collaborative with instrumental knowledge mobilisation aims as intended by any particular actor or group of actors (such as policymakers creating such initiatives). SLT problematises the assumption that collaboration is the means to a separable end of 'beneficial' knowledge transfer, because what is 'beneficial' is always up for negotiation. With this in mind, focusing on participation can help to avoid the 'romantic trap' by drawing attention to division. This is critical in the context of collaboration across disciplinary and organisational boundaries since different groups of participants have different configurations of tightly interwoven 'textures' of practices (Gherardi, 2009b). These are thus a means of distinguishing among various groups of participants and their different forms of participation in collaborative networks.

2.2.1.3 Tensions and negotiations: Power, legitimacy, status

2.2.1.3.1 Economies of meaning

Actors' situated and repeated practices are what create the contexts for learning where social relations among people and the material and cultural world can be stabilised (Gherardi, 2009a; Latour, 1986). As outlined in the section above, however, making a context for learning requires constant renegotiation of practices. Lave & Wenger's (1991) central notion of 'legitimate peripheral participation', and Wenger's (1998) notion of 'economies of meaning' within CoPs, offer conceptual tools with which to consider negotiations of meaning and the relations of power, legitimacy and status that go along with them.

Legitimate peripheral participation describes the *"multiple, varied, more- or less-engaged and -inclusive ways of belonging in the fields of participation defined by community."* These create *"a landscape—shapes, degrees, textures—of community membership" (Lave & Wenger, 1991, p. 35)* and various 'trajectories' within communities (Wenger, 1998). Within this textured landscape, 'economies of meaning' exist, in which some meanings achieve 'special' status.

Wenger argues that the ability to negotiate which meanings achieve greater status is shaped by relations of 'ownership of meaning' within communities. This 'negotiability' relates to *"...the degree to which we can make use of, affect, control, modify, or in general, assert as ours the meanings that we negotiate"* (Wenger, 1998, p. 200). Within communities, meanings have varying degrees of currency and participants have varying degrees of control and ownership over the meanings a community produces.

Negotiating what counts and shaping the economies of meaning within collectivities requires both ability and 'facility', or legitimacy (Wenger, 1998). Legitimacy can take many forms, such as having control over resources or knowledge domains, being useful, being sponsored, or being feared (Lave & Wenger, 1991; Wenger, 1998). Economies of meaning constantly change in ways that reflect ever-changing relations of legitimacy and power. They therefore shape participation, constraining and enabling actors' abilities to negotiate processes of mutual engagement, the joint enterprise, and shared repertoire of communities (Wenger, 1998).

Researchers' use of SLT to analyse relations of power and legitimacy usually positions such relations *within* a unitary conception of community (e.g., between 'central' masters and 'peripheral' apprentices in unidisciplinary CoPs), rather than *between* various disciplinary communities (Contu & Willmott, 2003, p. 287). As Contu & Willmott (2003, p. 292) argue, Lave & Wenger—despite their self-proclaimed 'critical stance' and their theory of practice, which considers relations of power through such concepts as legitimate peripheral participation and Wenger's (1998) ideas about negotiability and economies of meaning—deploy interpretations to illustrate SLT theory which tend to overlook wider institutional contexts. This has made it easy for popularisations of the theory to pursue a conventional managerialist agenda which conceives of CoPs as consensual and coherent objective organisational forms.

In the context of multidisciplinary, multi-organisational collaborative knowledge mobilisation initiatives, however, economies of meaning are likely to be diverse and contested—as a result of the various epistemic communities involved (Currie, El Enany, et al., 2014; Kislov, 2014; Kislov et al., 2011; Kislov, Hyde, et al., 2017). Some meanings will become more peripheral; others more central (Wenger, 1998). Meanings that come to prevail are likely to differentially constrain and enable actors' abilities to participate in the 'collective making' of the learning practices that constitute the emergence of such collaborative 'forms' (J. Langley et al., 2018). To hone this thesis' focus on how different practices create tensions and negotiations, I introduce

Knorr Cetina's concept of epistemic cultures next (1999). This helps me conceptualise how existing concentrations of power afforded by different ways of knowing might 'discipline' negotiations of meaning.

2.2.1.3.2 Epistemic cultures

Thus far, I have characterised collaborative knowledge mobilisation initiatives as a process of collective learning. This has served to conceptualise such initiatives as inherently processual and conflictual, and in a constant state of becoming through ongoing negotiations of economies of meaning within them. Taking seriously the idea that focusing analytically on the *practices* of so called 'communities' can draw attention to relations of power (Gherardi, 2009a; Gherardi & Nicolini, 2000), the addition of the epistemic cultures concept (Knorr Cetina, 1999) to the conceptual bricolage helps to further foreground difference.

According to Knorr-Cetina, epistemic cultures are:

> *"those amalgams of arrangements and mechanisms- bonded through affinity, necessity, and historical coincidence—which, in a given field, make up* how we know what we know*. Epistemic cultures are cultures that create and warrant knowledge..." (Knorr Cetina, 1999, p. 1)*

While notions of epistemic communities and CoPs are often discussed in relation to one another, or used interchangeably, Meyer and Molyneux-Hodgson (2010) suggest that using them together can help to develop theory relating to the epistemic and political nature of collective learning practices and processes. As Knorr Cetina (1999) argues, the concept of disciplines (such as the various professional disciplines involved in multidisciplinary collaborative initiatives) is important for capturing the differentiation of knowledge, yet does not sufficiently capture the strategies and policies of knowing that inform expert practice. The notion of epistemic cultures is a more powerful sensitising device for considering status and power relations as they relate to different epistemic communities and their related identities.

In accordance with practice-based approaches, Knorr-Cetina's emphasis is not on knowledge as a reified output, but on the construction of the machineries of knowledge construction. This includes the logics, procedures and arrangements through which knowledge comes into being, and is circulated, approached, and collectively reorganised within expert communities (Evers,

2000; Jensen, Nerland, & Enqvist-Jensen, 2015). The epistemic machineries through which knowledge is pursued differ across communities as a result of their belonging to different broader epistemic cultures which are socially, historically, culturally, and materially situated (Mørk et al., 2008).

The concept of *epistemic practices* describes the specific ways in which knowledge is approached, developed and shared within a given epistemic culture (Jensen et al., 2015). This concept helps to understand the different investigative processes, modes of inquiry and principles for verification of particular epistemic cultures. In the context of multi-disciplinary and multi-organisational collaborative initiatives, such concrete practices are likely to shed light on real world ‘epistemic clashes’ (Mcgivern & Dopson, 2010), and on relations of power and negotiability between epistemic communities.

To bring a focus on how belonging to particular epistemic communities may constrain or enable actors’ legitimacy and negotiability in collaborative knowledge mobilisation, Osbeck and Nersessian’s (2017) conceptualisation of ‘epistemic identities’ is helpful. These identities are *“important to understand the values and implicit hierarchies in science practice, and how these, in turn, influence practices”*. Osbeck & Nersessian assert that identity is enacted around the machineries of epistemic cultures and their epistemic practices—around theoretical frameworks, forms of data collected, methods of analysis, research goals, and epistemic values concerning what is to be counted as adequate evidence and inference. This suggests that, within multidisciplinary collaborative initiatives, not only epistemological commitments, stances, or even values are negotiated within hierarchies of epistemic practice. Epistemic identities, inscribed with and embodying these values, are also at stake.

The economies of meaning at play within landscapes of practice shape and are shaped by issues of power, status and legitimacy. In the healthcare context, different ways of knowing are afforded different ‘ranks’ of trustworthiness in a hierarchy of epistemic cultures and practice (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The epistemic communities of nursing and allied health, for instance, tend to produce descriptive forms of knowing which are ranked lowest in the scientific hierarchy; the randomised controlled trials which produce ‘valid and reliable’ knowledge are afforded the highest status in medicine (Albert, Laberge, Hodges, Regehr, & Lingard, 2008). Epistemic identities associated with lower-status epistemic practices

are likely therefore to be constrained in their ability to negotiate meaning within multidisciplinary collaborative initiatives.

The concepts introduced in this section have helped to understand collaborating as learning and are summarised in figure 2.1 below.

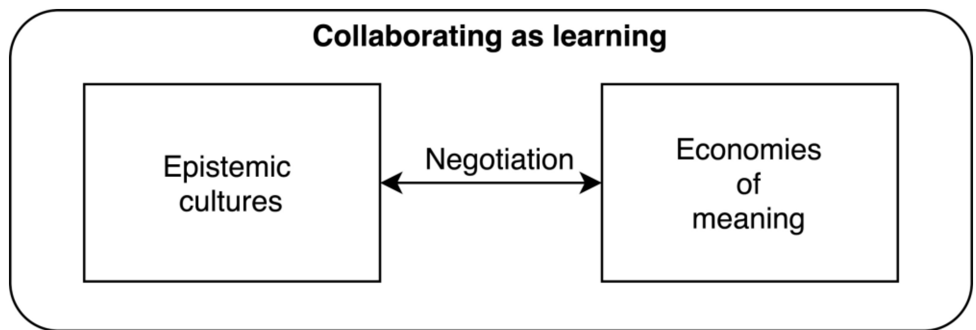

Figure 2.1: Collaborating as learning

2.2.2 Collaborating as becoming

I have now framed collaboration as a process of learning laden with epistemic and political tensions. This section draws on concepts that help view collaboration also as a process of becoming—a process through which actors must reconcile their existing belonging in various ‘organic’ epistemic communities, with their participation in instrumental collaborative initiatives which target particular kinds of knowledge (e.g., ‘non-native’ process improvement knowledge) for mobilisation.

> *“[CoPs] are about knowing, but also about being together, living meaningfully, developing a satisfying identity, and altogether being human.” (Wenger, 1998, p. 134)*

SLT views actors not only as participants in sociocultural communities of practice, but as members of these activity systems (Lave & Wenger, 1991). Actors both define and are defined by the systems of relations within communities. As a result, learning always involves the construction and reconstruction of identities. Since identities are concerned with *“the social formation of the person”* (Wenger, 1998, p. 13), they become an analytical pivot point between agentic actors and their social context. focusing on identity makes it possible to zoom in and out on the becoming process—the *translation* of individuals, their interrelations, and organisational forms (Hultin et al., 2020).

2.2.2.1 Reconciling the 'nexus of multi-membership'

> *"... we engage in different practices in each of the communities in which we belong. We often behave rather differently in each of them, construct different aspects of ourselves and gain different perspectives." (Wenger, 1998, p. 159)*

Wenger's (1998) concept of the 'nexus of multi-membership' provides the perspective that actors are always carriers of a multitude of practices as they participate in numerous partially overlapping CoPs. The experience of the nexus of multi-membership always requires actors to do 'reconciliation work' to maintain a sense of a coherent and 'livable' identity, both temporally and across landscapes of practice (Brown & Duguid, 1991; Handley et al., 2006; Wenger, 1998). This reconciliation work is of great importance, and, like learning, is inherently conflictual. Negotiations of the self may generate both intra-personal tensions and instabilities within communities (Handley et al., 2006).

It might be assumed that identity reconciliation work is of particular significance in the context of multidisciplinary and multi-organisational collaborative initiatives. Yet, despite (or perhaps because of) its significance and complexity, identity reconciliation happens privately, is never complete, may not be consciously acknowledged by the individual, and is rarely viewed as part of a community's enterprise (Wenger, 1998). As a result, the influence of individual participants' identity reconciliation practices on knowledge mobilisation is rarely attended to in practice or in research. Moreover, neither SLT (Lave & Wenger, 1991) nor Wenger's seminal work on CoPs (1998) provide guidance as to how to theorise what is involved in identity reconciliation and how it influences actors' participation in collaborative initiatives (Handley et al., 2006).

To elucidate the practices involved in identity reconciliation, Jenkins' work on identity is a helpful starting point. Like Wenger (1998), Jenkins (2004) argues that collective and individual identities occupy the same space. Identities are attributes of individuals, but they are necessarily collectively constituted at varying degrees of abstraction. Jenkin's central argument is that it is through an *"internal-external dialectic of identification"* which all identities, individual and collective, are constituted. Jenkins (2004) contends that actors both identify with and differentiate from others, categorise themselves and others, and accept, reject, or negotiate labels applied to them. What this internal-external dialectic suggests is that identity reconciliation is not merely an internal achievement, but one which entails a process of synthesising both internal and external definitions of oneself.

2.2.2.2 Identity regulation and identity work

Handley et al. (2006) propose the use of Alvesson and Willmott's (2002) dual notions of identity work and identity regulation to better explain identity reconciliation, and to understand the motivations behind why actors embrace or reject opportunities to participate more fully in learning in specific contexts. Identity work refers to the ongoing efforts of actors to form, repair, maintain or revise perceptions of the self (Alvesson & WIllmott, 2002). However, as Jenkins' (2004) internal-dialectic highlights, these negotiations are not merely internal. Instead, they occur at the boundary where external categorisations, motives and pressures meet internal identifications, motivating attempts to maintain a coherent sense of selfhood, continuity and coherence across time and situations (Alvesson, Hardy, & Harley, 2008; Alvesson & Willmott, 2002; Jenkins, 2004; Wenger, 1998; Ybema et al., 2009).

For Alvesson & Willmott (2002), identity regulation encompasses the effects (whether intentional or not) of social practices (such as organisations, institutions, rewards, organisational structures, induction, training and promotion procedures) on the processes of identity construction. The concept invites an appreciation of the interplay between identity-regulating mechanisms and other elements of actors' belongingness within their 'nexus of multi membership'. Moreover, the notion helps to address the issue that externally defined dimensions of identity are often sidelined (Czarniawska, 2008; Jenkins, 2004; Soekijad & Smith, 2011). In the context of instrumental collaboratives, certain practices may be usefully analysed as potentially identity-regulating (e.g., policymakers designating individuals to knowledge brokering roles).

The notion of identity regulation helps call attention to broader social and power relations that interpretations of SLT have tended to neglect (Contu & Willmott, 2003; Handley et al., 2006). Jenkins argues that the classification of individuals and populations is at the heart of modern, bureaucratically rational strategies of organisation and control—*"a practice of the state and other agencies [that] is powerfully constitutive both of institutions and of the interactional experience of individuals"* (Jenkins, 2004, p. 24). The 'labelling' perspective of identities, emerging from studies of deviance and control, further explicates the power relations involved in identity regulation and reconciliation. Again focusing on the interaction between internal self-definitions and external definition by others, this approach considers how individuals may be authoritatively labelled within institutional settings (for example, labelled as 'knowledge brokers' within collaborative initiatives), but also how reconciliation and identity shifts occur only if individuals internalise and self-identify with the designation (Jenkins 2004). The regulating

capacity of others (individuals, organisations, or institutions) becomes a matter of whose definition of the situation counts—once again about relations of negotiability and power. Practices of identification by others have the capacity to generate consequences of control and make labels stick, but they can also evoke resistance if actors reject their internalisation.

Identity regulation as described by Alvesson & Willmott (2002) is part and parcel of modern organisational life. In the context of this thesis, it appears an especially pertinent concept for the analysis of collaborative initiatives like the ECoP which are organised in a 'top-down' fashion, by bureaucratic agencies, as apparently neutral and beneficial instruments to control the flow of knowledge and assign 'membership' to those who might best further their cause.

The concepts introduced in this section have helped to understand collaboration as a process of becoming and are summarised in figure 2.2 below.

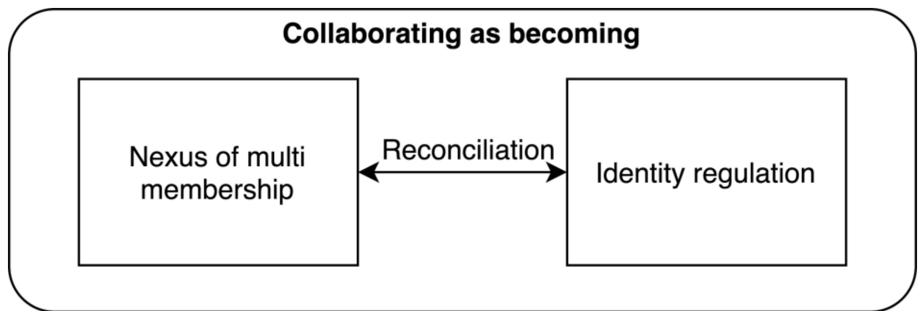

Figure 2.2: Collaborating as becoming

2.2.3 An initial model of collaborative knowledge mobilisation

The bricolage outlined in this section builds on a 'translational' approach to understanding knowledge mobilisation by pulling together strands from SLT, theory about epistemic cultures, and identity work. This is represented in Figure 2.3 below. SLT has provided the basis for viewing collaboration as constituted by the dual processes of learning and becoming. SLT theory has, however, predominantly been used to explain how learning and identity change occur in unidisciplinary contexts. Since issues surrounding the negotiation of meaning are likely to be especially pronounced in cross-disciplinary, cross-organisational collaborative settings, and especially in healthcare in which status hierarchies based on ways of knowing are ubiquitous, Knorr-Cetina's (1999) epistemic cultures offers a lens through which to view the

willingness and ability of different epistemic identities to participate in knowledge mobilisation. This provides a way to account for the potential for conflict arising from different worldviews and relations of power between them, and especially to explore the politics of participation that ensue when mobilising particular types of knowledge among diverse groups (e.g., 'non-native' process improvement knowledge in healthcare).

To further explicate the processes involved in identity reconciliation, which have been argued to be lacking in SLT, I take up Handley et al's (2006) suggestion to consider Alvesson & Willmott's (2002) conceptualisation of the dual processes of identity work and regulation. In combination with Jenkins' *"internal-external dialectic of identification"* (Jenkins, 2004), this helps me take account of broader social and power relations that interpretations of SLT have tended to neglect (Contu & Willmott, 2003; Handley et al., 2006). This critical contextual focus is particularly relevant for the analysis of an instrumental collaborative initiative created to facilitate policy imperatives of performance improvement. Viewing identity as an internal-external dialectic also avoids taking for granted that designations applied by external authorities necessarily result in unproblematic self- and other-identifications as such (e.g., policymakers labelling an initiative a 'community', or designating certain participants as 'knowledge brokers'). Moreover, even if actors internalise such labels, they can 'do' and 'be' knowledge brokers in various ways, depending on their broader identifications within unique 'nexuses of multi-membership'.

In sum, this initial framework helps to conceptualise collaborative knowledge mobilisation as a process of *learning to learn* together with diverse others, and *learning to be* someone who does so, since learning is predicated upon identity change. What this lens allows us to see in terms of knowledge mobilisation is presented in Table 2.1 below. Using this model to sensitise my analysis helps guide attention to the social construction of collaborative organisational 'forms', the negotiation of meaning within them and the centrality of identity in collaborative knowledge mobilisation.

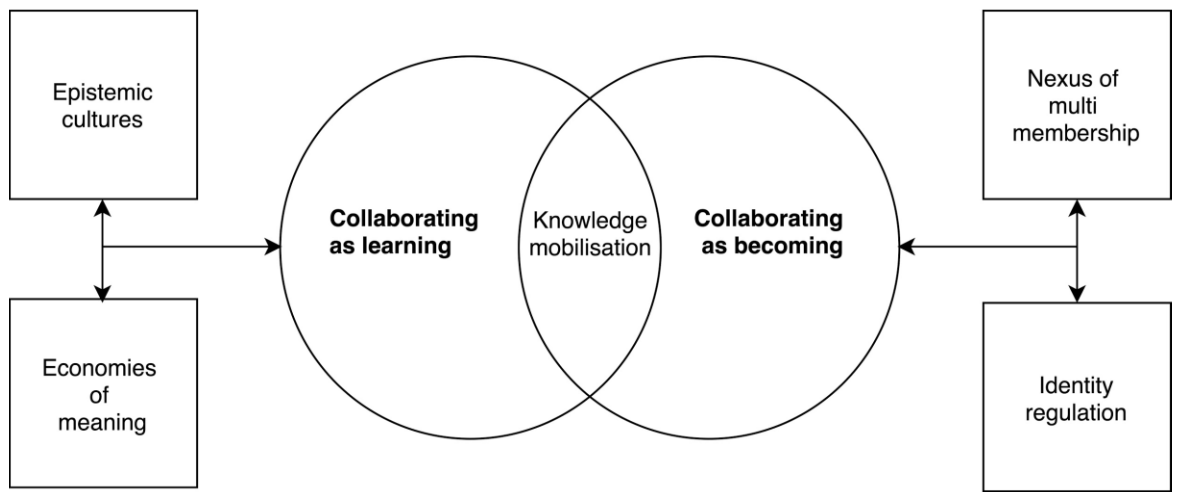

Figure 2.3: Initial model of collaborative knowledge mobilisation: Learning and becoming

	'Transfer' lens	**'Translation' lens**	**Translation + SLT + conceptual bricolage**
Visual model of how knowledge mobilises through collaboration K = knowledge A = actor P = practice	Knowledge is acontextual and apolitical and flows or 'transfers' into practice in linear fashion. Actors are passive carriers of knowledge. K → P	Actors are translators with interests who negotiate and 'translate' knowledge in different ways resulting in various interpretations of knowledge. K → A → K1; K → A → K2; K → A → K3	Knowledge, practice and actors are negotiated and mutually transformed, within context. Collaborating as learning A, K, P, context Collaborating as becoming

Table 2.1: Visual comparison of models of how knowledge mobilises

2.3 Research questions

In light of the conceptual bricolage and initial framework, the specific research questions I seek to address are:

1. *How do instrumental collaborative knowledge mobilisation networks form in practice in healthcare systems?*
2. *How do key actors from different epistemic communities (improvement advisors and hybrid clinician-manager 'targets' of improvement knowledge) negotiate and translate knowledge within such collaborative networks?*
3. *How do these actors reconcile their existing identities with their participation in such collaborative networks?*

Informed by the conceptual bricolage, these questions guide the investigation in this thesis as I seek to elucidate how the various learning and becoming practices of participants coalesce as a process of ongoing formation of collaborative networks, and what this means in terms of how knowledge mobilises. In the next chapter, I outline the practice-based research methodology and specific research design and methods which allowed me to operationalise the research questions and more fully explore the processes they inquire about in order to contribute to our understanding of collaborative knowledge mobilisation—as both *learning* and *becoming*.

Chapter 3: Researching knowledge mobilisation and collaborative learning: Methodology, research design and methods

In this chapter I outline and justify the methodological approach I take to operationalise this project, and the research design and methods I adopt. Throughout the chapter, I reference how the tenets of the practice-based approach and their ontological and epistemological underpinnings informed my methodological choices. The chapter is organised into five main sections. First, I introduce my practice-based research methodology, and contextualise the research questions within this approach. I follow this with the overarching research design, and introduce the research site and the methods I employ to generate qualitative data. I then describe my abductive approach to analysis and the thematic-narrative approach I adopt in the presentation of my findings. I provide a discussion regarding research quality and a reflexive consideration of some of the methodological challenges I encountered while undertaking this research. Finally, I outline how the findings in chapters four, five and six are structured.

3.1 A practice-based methodology: Practice-process-becoming

> *"Practice approaches foreground flow and sequence, the learning process that allows newcomers to attune to the shared understanding of a community of practitioners and the dispositions and practical wisdom that comes with being part of an ongoing regime of activity." (Nicolini & Monteiro, 2017, p. 117).*

I have so far shown why the dominant before/after approach of 'transfer' studies has come at the expense of exploring how collaborative initiatives actually succeed (or fail) to mobilise knowledge, through practice. To understand *how* and *why* mandated collaborative initiatives form and function, an understanding of the everyday translation practices of actors is needed, along with consideration of how such practices constitute processes observed at macro levels. I attempt to open the 'black box' of practice and process by drawing on, as a foundation, the growing family of practice-based approaches: *"Orientations that take orderly, materially*

mediated doings and sayings ('practices') as central for the understanding of organisational and social phenomena" (Nicolini & Monteiro, 2017, p. 123).

Practice-based approaches are embodied in the cognitive traditions of Actor Network Theory (Callon, 1986; Latour, 1986), Situated Learning Theory (SLT) (Lave & Wenger, 1991, Wenger, 1998), and activity theory (Engeström, Miettinen, & Punamäki-Gitai, 1999), all of which converge in their focus on practice (Gherardi, 2000). To find some order in what is a plurivocal and 'unsettled' landscape (Feldman & Orlikowski, 2011; Schatzki, 2001), three key interrelated tenets of practice based studies ground the approach taken in this thesis. These are:

1. Practices as building blocks of social reality; reality as process.
2. Knowing as a situated activity.
3. Practices as situated, 'oriented and concerned'.

First, and fundamentally for this thesis, *"practices are understood to be the primary building blocks of social reality" (Feldman & Orlikowski, 2011, p. 3)*. The 'practice turn' recognises the pivotal function of actions and interactions, allowing us to focus neither exclusively on individual minds and actions nor on social structures and systems, but on things which are said and done. This gives practice-based approaches utility for analysing the overarching formation and evolution processes of collaborative initiatives. This is because exploring how collaboration unfolds, and how collaborative forms emerge over time, involves understanding collaboration as a socially constructed, processual phenomenon (Berger & Luckmann, 1991; A. Langley et al., 2013). As Langley and colleagues describe, 'reality' is the point at which *"'process' meets 'practice'"* (2013, p. 5). Empirical 'entities' such as collaborative knowledge mobilisation networks can be considered 'things' only insofar as they are continually constituted and 'fabricated' through the events, experiences and ongoing participatory work and practices enacted by situated actors (A. Langley et al., 2013, p. 5; Latour, 1987; Nicolini & Monteiro, 2017, p. 121). We can thus best understand organisational 'forms' as *"a continuing process of movement"* (Hassard & Wolfram Cox, 2013), always in a continual state of becoming (Tsoukas & Chia, 2002).

Second, practice-based approaches reject objectivist assumptions that knowledge is 'out there' and can be abstracted from practice and context (Geiger, 2009). As such, they are critical of cognitivist approaches which implicitly assume that knowledge is situated in brains (Gherardi,

Nicolini, & Strati, 2007). Knowing is therefore considered an activity rather than a thing—a *"process of continuous enactment, refinement, reproduction and change" (Geiger, 2009, p. 134)*. This view serves to guard against the reductive tendencies of methodological approaches used in 'transfer' perspectives, which seek to control, abstract from, and erase social complexity (Nilsen et al., 2013; Swan, Newell, et al., 2016a). In contrast, it provides utility for examining the processes of knowledge mobilisation within multidisciplinary and multi-organisational collaborative initiatives, as well as *how* and *why* ideas are modified and negotiated by agentic actors in relation to the specific contexts and social realities within which they are situated (Gherardi, 2000; Van Grinsven et al., 2016).

Finally, practices are *"oriented and concerned"* (Nicolini, 2009b, p. 1402). That is, they are performed with directionality and purpose, with affect and attachment, and with a sense of morality regarding what ought to be done (Gherardi et al., 2007; Nicolini, 2009b). These orientations and concerns emerge from actors' situatedness within *"well-oiled nets"* of activities, people, and materials (Nicolini & Monteiro, 2017, p. 115). While some have critiqued certain practice approaches (e.g., ANT) for their neglect of context and its role as *"a setting or backdrop that envelops and determines phenomena"* (Schatzki, 2002, p. xiv), others view practice-based approaches as ideally equipped to consider how practices are both embedded in, and also create and reconfigure, social, cultural, and historical contexts (Rivera & Cox, 2016).

These three tenets support the 'translation' approach, which sees knowledge mobilisation as both an outcome and an *active* process—contingent on and occurring through the practices of actors who necessarily translate knowledge, and themselves, as they engage with it. Instead of looking for reasons for behaviour inside 'rational' individuals, a practice-based approach provides a way to zoom in on actors' practices and also zoom out to take a broader view of the empirical 'object' at hand in this thesis, the ECoP, to see how *"actors, environments and organisations are all in constant and mutually interacting flux"* (A. Langley et al., 2013, p. 5). Observing the generation of assemblages (how actors, practices and objects form 'precarious wholes') can help to explain how actors fabricate new social 'realities' and make existing ones more durable (Müller, 2015).

3.1.1 A practice-based approach to the research questions

By focusing on the *how* and *why* of what people do (Creswell, 2018; Yin, 2014), the research questions I pose seek to grasp the practices that people engage in in specific situations—such as when collaborative knowledge mobilisation is mandated (A. Langley & Abdallah, 2011), as well as *"what their import is" (Geertz, 1973, p. 10)*.

Research question one asks: *How do instrumental collaborative knowledge mobilisation networks form in practice in healthcare systems?* Through a practice-based approach, this question seeks to elucidate actors' practices—including their doings, sayings and reflections—and the ways in which these practices aggregate as processes that underpin the formation of collaborative networks, over time (Gehman et al., 2018; A. Langley et al., 2013; Van de Ven, 1992). This question serves to encourage a shift away from 'transfer' approaches in which organisational 'forms' are presupposed, and toward a constructivist perspective in which they are 'collectively made' (J. Langley et al., 2018).

Following the identification of these central formation processes, research question two inquires as to the nature of the tensions that emerge within them, asking: *How do key actors from different epistemic communities (improvement advisors and hybrid clinician-manager 'targets' of improvement knowledge) negotiate and translate 'non-native' process improvement knowledge within such collaborative networks?* In keeping with my conceptualisation of collaborative initiatives as a process of *learning to learn together*, this question maintains a commitment to focus on the 'practices of community' as sites for negotiation, avoiding the trap of romanticising collaboration (Gherardi, 2009a). The question focuses on how participants' epistemic cultures (Knorr-Cetina, 1999) inform their various practices of collaborative knowledge mobilisation. Rather than assuming unitary or objective benefits of collaboration, the question draws attention to broader social and power relations that impact collaborative practices, which interpretations of SLT have tended to neglect (Contu & Willmott, 2003; Handley et al., 2006).

Research question three seeks to explore the notion of collaborative knowledge mobilisation as a process of *learning to be together.* The question asks: *How do actors (improvement advisors and hybrid 'targets') reconcile their existing identities with their participation in such collaborative networks?* The question facilitates a practice-based approach to understanding identities as 'precarious' (Byrkjeflot & Kragh Jespersen, 2014) and constructed in practice through an

“internal-external dialectic of identification” (Jenkins, 2004, p. 24). This dialectic is understood to be replete with tensions and negotiations, safeguarding against the assumption that identities can be authoritatively designated from outside (Alvesson & Willmott, 2002).

3.2 Research design

Since my research is motivated by the aim of ‘getting at’ actors’ experiences and practices, its methodological objective is not to manipulate or control aspects of the collaborative knowledge mobilisation initiative or its context, nor to precisely predetermine categories that I use to describe it (Patton, 2015). Whereas surveys, experiments and other strategies of abstraction are appropriate means when the end is the de-contextualised specification of relationships among variables (Gephart & Rynes, 2004), *“only humans can gather and evaluate the meaning of complex interactions”* (Tullis Owen, 2008, p. 547). Accordingly, I needed to operationalise my practice-based study through a *“small n”* approach, facilitating abductive theory refinement rather than deductive theory testing in order to achieve a ‘clearer view’ of the collaborative knowledge mobilisation phenomenon (Tsoukas, 2019). I achieved this through the case study design outlined in this section, and the ethnographic data generation methods and abductive approach to analysis described in subsequent sections.

3.2.1 A nested, layered and longitudinal case study

Working from a practice-based ‘translation’ perspective on knowledge mobilisation called for a research design that would emphasise social interaction, negotiation, and change. I chose a longitudinal approach to facilitate a processual investigation of the policy initiative as a whole, and also of its subunits (e.g., actors, groups, organisations, events and decisions) within their real-life context (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Miles, 2014). For the processes of learning and becoming to have the chance to emerge and be available for analysis, I needed to observe, interact with, and accumulate data about the case over time. Rather than taking a ‘snapshot’ of participants’ experiences at a particular moment in time, this provided insight into the practices, events, and decisions that constituted actors’ trajectories (Pinsky, 2015). In particular, the richer understanding of subjective experiences that longitudinal studies provide supported my aim of exploring processes of identity construction (McLeod, 2003).

With the ‘nested relationality’ of practice in mind (Jarzabkowski, Bednarek, & Spee, 2015)—where context and case are seen as mutually interacting and in constant flux (MacKay & Chia, 2013)—the case study design needed to be flexible enough to attend to multiple overlapping ‘domains of action’ (Swan, Newell, et al., 2016a). A *“nested and layered”* design enabled me to build a holistic understanding of the case (Patton, 2015, p. 536). The case study consisted of the macro case of an instrumental collaborative knowledge mobilisation network, within which were were nested ‘mini’ cases of participating organisations and various epistemic communities, ‘micro’ cases of events, individuals, and their practices, and various ‘observational units’ such as meetings, activities, and spaces (Patton, 2015) (see figure 3.1 for visual representation of the nested, layered design). All of these were further acknowledged to be nested within broader social contexts (the healthcare sector, political and societal contexts).

Critically, this nested design enabled me to zoom in on the micro, a necessary move to also be able to zoom out and see the case as a whole. As Patton (2015, p. 536) argues, while we cannot disaggregate data from the macro level (e.g., a network as a whole) to construct an understanding of the experience or practices of individual actors, we can build an overarching understanding of the case from its smaller constituent units (e.g., events, actors, groups of actors, their practices). I found this vital to remaining faithful to a practice-based approach under which I problematised the notion of reified networks and smooth knowledge ‘transfer’ (A. Langley et al., 2013). This nested, layered, and longitudinal approach promoted attention during analysis to the histories of actors, their belonging in an existing ‘nexus of multi-membership’ (Wenger, 1998), and the institutional arrangements surrounding the collaborative network. It enabled actors’ agency to be foregrounded for analysis, but always also recognised as ‘situated’ (Lave & Wenger, 1991; Wenger, 1998).

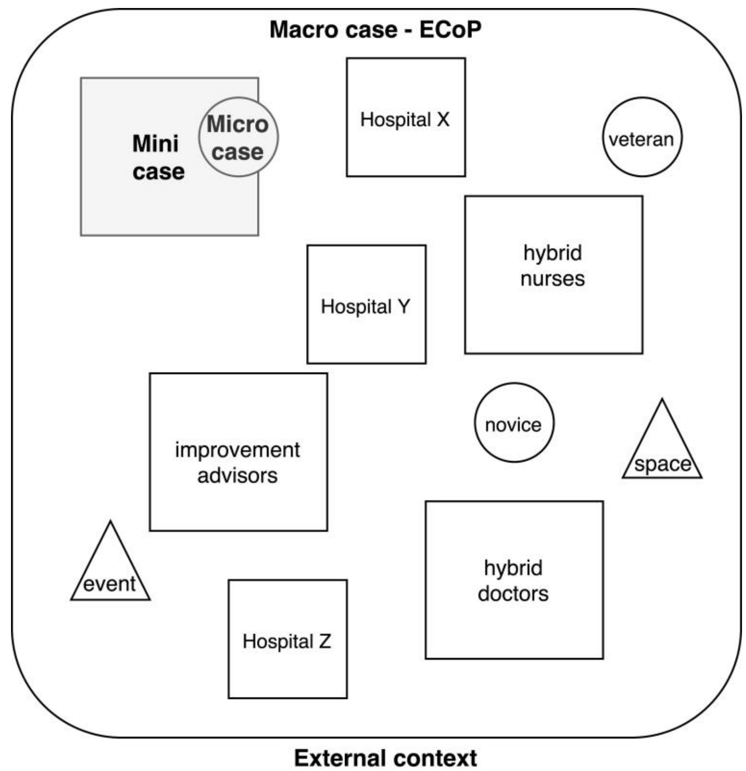

Figure 3.1: Nested and layered case study design

3.2.3 Units of analysis: Practices make processes

In contrast to 'transfer' studies, Nicolini (2009a) describes practice-based approaches as a powerful theory/method package for turning the ethnographic gaze on work and organizational practices. To construct an understanding of the ECoP and the phenomena of collaborative knowledge mobilisation as processes of learning and becoming, I needed to elaborate arrangements of their smaller units. Since reality is the point at which *"'process' meets 'practice'"*, I pursued the social 'reality' of the ECoP through attention to participants' practices and interactions, and their aggregations (A. Langley et al., 2013, p. 5). Maintaining this focus on practices as the building blocks of a socially constructed reality facilitated the problematisation of realist ontological positionings underpinning instrumental approaches to collaboration, and my questioning of the notion that the ECoP was a 'thing' that could be brought into being by way of a policy mandate. Moreover, it helped to challenge the idea that the actors involved were rational adopters of 'beneficial' innovations, as promoted by transfer perspectives.

Practically, achieving a focus on situated practice in fieldwork required close attention to the relations between actors and the knowledge targeted for mobilisation, as well as accounting for

broader contexts. This entailed noticing what people did, said, made, and believed (Durdella, 2019). In this way, I built up the case study from its nested components by exploring, detailing and interpreting the facets of social life that constituted the first twelve months of the ECoP.

3.3 Research site and data generation

To operationalise the practice-based approach and research design, I needed to access rich descriptions of what actually happens when collaborative initiatives are 'created' for instrumental purposes. This would allow me to zoom in on the practices of actors from different disciplines and organisations, and zoom out to see how they aggregate as processes (A. Langley et al., 2013; Nicolini & Monteiro, 2017). The Emergency Community of Practice (ECoP) fit the criteria to enable me to operationalise a practice-based approach to addressing the research questions.

3.3.1 The case of the Emergency Community of Practice (ECoP)

The ECoP was a cross-disciplinary and cross-organisational initiative set up by policymakers in the public healthcare system of an Australian jurisdiction, in early 2018. Initially a twelve month pilot, the ECoP was created as a continuation of an earlier more structured, intensive and funded twelve month collaborative (The Collaborative). Its aim was to continue to mobilise process improvement knowledge, ideas, and experience both within and across public hospital organisations in order to achieve performance improvements in terms of emergency department efficiency. In particular, the policymakers hoped to facilitate the mobilisation of process improvement expertise from designated knowledge brokers known as improvement advisors to the 'targets' of the knowledge—hybrid nurses and doctors.

The macro case of the ECoP consisted of nested 'mini' cases (e.g., various disciplinary groups), 'micro' cases (e.g., individual participants, events, practices), and various 'observational units' (eg. meetings, collaborative activities, physical spaces) (Patton, 2015). The twelve month pilot period consisted of a co-design consultation workshop and three substantive quarterly workshops, held onsite at participating health service organisations in June, August and December of 2018. Attention to this layering within the ECoP case was analytically valuable for how it facilitated 'zooming in and out' (Nicolini, 2009b), and for the holistic, processual view of the initiative that it helped build. This was critical in terms of addressing the research questions which sought to connect micro-practices with macro processes over time.

3.3.1.1 Background: The history of process improvement in the jurisdiction

The ECoP case was nested within a decade-long history of attempts to mobilise process improvement knowledge within and among the jurisdiction's hospitals (further detail on the history of improvement in the jurisdiction is found in Appendix 3). In 2008, the jurisdiction's health department (The Department) had embarked on a jurisdiction-wide program to improve service delivery in public hospitals. Like other governments around the world, the jurisdiction was increasingly struggling to address growing cost and demand pressures, but needed to do so to ensure equitable access to healthcare services for citizens. The state's government had been keenly focused on improving, among other inefficiencies, its performance on the National Emergency Access Target (NEAT)—a national performance target measuring the efficiency of emergency departments (EDs) in terms of patient access to services. The NEAT stipulates that 81% of patients presenting to EDs must be admitted, discharged or transferred within 4 hours. The target is highly politicised and overcrowded EDs are often fodder for news outlets. In line with the efficiency aims, the program was largely developed around process improvement knowledge, predominantly with 'non-native' roots in the Lean methodology.

3.3.1.2 Knowledge brokers, their 'targets' and collaboration

A key component early in the policy program had been the creation and funding of designated process improvement advisors who were trained in and charged with brokering this knowledge within individual health services. Their core function was to facilitate the mobilisation of process improvement knowledge to frontline clinical 'targets' within their health services to encourage clinician engagement in service redesign and improvement work. Over time, it became clear that embedding individual improvement advisors in individual organisations resulted in poor visibility at the policy level over the improvement work being undertaken. Any improvements in efficiency and effectiveness of service delivery that were gained in individual health services were not easily captured and their spread was not supported by an effective means of knowledge mobilisation to other health services. Mobilising process improvement knowledge within and across health services became a key policy priority and in 2016, The Department established The Agency, an independent agency dedicated to this cause. The Agency embarked upon its collaborative knowledge mobilisation program in late 2016 with The Collaborative, the first of its kind in the jurisdiction.

The collaborative policy program was accompanied by a concerted effort on the part of The Agency to 'reinvigorate' the original improvement program. As part of this, the policymakers worked to find the advisors a home under The Agency's brand as the latter had, to greater or lesser extent, become 'lost' to The Department through successive restructures, and reabsorbed into health service operations. While health services had continued to receive funding to employ improvement advisors, the advisors had been left with little support or direction over a number of years.

In spite of this, having gained traction within their organisations, some 'veteran' advisors had continued to build improvement capacity internally and become increasingly independent of the policymakers' program. On the other hand, process improvement was still perceived in many health services as a non-essential component of their organisational structures and so other advisors, especially 'novices' (see Table 3.1 for the distinction between veterans and novices, and a description of the key categories of ECoP participants) continued to endure precarious positions or returned to their substantive roles, usually as mid-level allied health or nursing clinicians. This presented an engagement challenge for the policymakers who had to track down who exactly made up the existing cadre of trained knowledge brokers, and where they could be found.

On the background of the funded pilot Collaborative, the purpose of the ECoP was to help maintain the knowledge mobilisation momentum gained, with a much lower financial investment (health services had been funded $100,000 each by The Agency to participate in the initial Collaborative, but not in the ECoP). The ECoP would meet quarterly and continue to focus on reducing variability in ED performance on the NEAT KPI across the sector, while reducing the financial and capability-building support that The Agency needed to provide over time (see appendix 4 for comparison of pilot Collaborative and ECoP).

In particular, the policymakers intended that clinicians would become core participants. They very strongly encouraged health services to ensure that ED clinicians (especially senior hybrid nurses such as Nurse Unit Managers (NUMs) and senior hybrid doctors such as ED medical directors) attended ECoP workshops alongside their organisation's designated improvement advisor and other operational roles. These included what I term 'novice' hybrids and 'veteran' hybrids. The co-presence of these categories of actors, they hoped, would encourage

collaboration between these groups and make the challenging knowledge brokering work of the improvement advisors easier.

If the ECoP were successful as a continuation of the initial Collaborative, The Agency's resources could be redirected toward addressing key strategic areas beyond NEAT through the more resource-intensive Collaboratives. Importantly, the policymakers could then replicate the Collaborative-to-CoP transition as a cost-effective way of sustaining knowledge mobilisation among health services, on various foci of importance (see Appendix 5 for timeline of the collaborative, ECoP, and planned future initiatives).

In sum, the key policy intentions for the ECoP were to:

1. Build a low cost, sustainable collaborative learning environment to mobilise process improvement knowledge, ideas and expertise across health services, and reduce the competitive culture of the jurisdiction's public health sector
2. Re-engage the improvement advisors with the policy program, increase oversight over their performance, and increasingly direct their practices
3. Facilitate the ability of the improvement advisors to broker knowledge across the boundary with clinicians in order to increase sector-wide engagement of clinicians with process improvement

The features of the ECoP case and its history provided me with a rich case through which to build an understanding of collaborative knowledge mobilisation as a multi-layered process comprising various actors and activities within their historical context. Specifically, this case could facilitate a practice-based approach to my research questions which required access to actors from different epistemic communities who would undertake different practices and experience different identity-reconciliation demands during the early stages of a collaborative initiative aiming to mobilise 'non-native' process improvement knowledge.

Hybrid doctors	'Targets' of process improvement knowledge in the eyes of the policymakers as they were seen as having the ability to mobilise process improvement knowledge more broadly among doctors within their organisations. Senior doctors who practice clinically but also have a management role (eg. ED Director). Some in the ECoP had formal management training (e.g., Master of Public

	Health, Master of Health Administration or similar) but this is not a requirement of the position. 'Novice' hybrid doctors are characterised as relatively more junior and have only recent experience with managerial work (e.g., through improvement projects or minor administrative roles). 'Veteran' hybrid doctors are relatively more senior and have significant managerial responsibilities (e.g., administering whole departments).
Hybrid nurses	'Targets' of process improvement knowledge in the eyes of the policymakers as they were seen as having the ability to mobilise process improvement knowledge more broadly among nurses within their organisations. Nurses who practice clinically but also have a management role. Some in the ECoP had previously undertaken management training (e.g., in-house process improvement training or short courses). 'Novice' hybrid nurses are relatively more junior (e.g., Associate Nurse Unit Managers (ANUM)) and have little administrative responsibility beyond their unit. 'Veteran' hybrid nurses are relatively more senior (e.g., Nurse Unit Manager (NUM); many in the ECoP were in their roles for more than a decade) and have significant administrative responsibility at a broader organisational level.
Improvement advisors	Designated brokers of process improvement knowledge. Most funded as part of the policy improvement program, first by The Department (2008-2016) and then The Agency (2016 onward). Improvement advisors are employed within individual hospitals to facilitate service redesign and process improvement activities (eg. to improve access to emergency departments, and flow of patients through the hospital) and to broker process improvement knowledge to frontline clinicians. Some hospital organisations employ 'extra' improvement advisors beyond those funded at the policy level. The title and scope of these roles varies significantly across different organisations involved in the ECoP depending on the relative importance placed on improvement or the maturity of an organisation's improvement program. Improvement advisors in the ECoP included those with clinical backgrounds in allied health or nursing, and those from non-clinical backgrounds, mostly in manufacturing. 'Novice' improvement advisors were not necessarily new to process improvement, but were relatively new to the jurisdiction's decade-long improvement program (usually less than 2-3 years). Novices were most often from non-clinical backgrounds (5 of 6 novice advisors). 'Veteran' improvement advisors had been involved in the decade-long policy improvement program for many years. Veterans most often had backgrounds in lower status clinical professions (11 of 12 veteran advisors had allied health or

	nursing backgrounds).
Executive sponsors	Individuals in key leadership roles who sponsor particular improvement projects or programs within their hospital organisations. Executive sponsors were welcome to attend ECoP workshops but were not a key 'target' for policymakers. Usually non-clinical operations executives (although those inhabiting the roles often have clinical backgrounds). Usually have formal management training (eg. Master of Business Administration / Master of Health Administration).

Table 3.1: Description of participant categories

3.3.2 Data generation

I generated the data for this thesis over a fourteen month period, from March 2018 to May 2019. This period encompassed the planning of the ECoP by policymakers at The Agency, the first workshop (a co-design consultation), three quarterly substantive workshops, and a follow-up period during which further interviews were conducted. To gain insight into the experiences and situated practices of the ECoP participants, I generated and collected data from the ECoP case over this time in purposefully selected multiple 'domains of action'. This included 'front stage' activities and behaviours within the ECoP workshops and at other health service and sector-level events, 'back stage' perceptions and reflections on the lived experience of individual participants, and field-level contextual conditions.

The distinction between 'generation' and 'collection' is worth noting here. While in 'transfer' studies, there is a reality 'out there' to 'collect', the ontologically relativist and epistemologically relationist positioning of this study always sees empirical material as *constructed* (Alvesson & Kärreman, 2007). From my position as part of the actor-network within the field of study, I was one of the many agents actively and inseparably involved in co-creating the account of the ECoP that is presented in this study. As Czarniawska (2004) suggests, I, as a reader, interpreted, and reconstructed each policy document, even before I knew I had done so. Likewise, narrators and doers constructed each spoken word and each action I noticed, and I reconstructed these as I documented them. My values, position and social context all influenced the account that I ultimately constructed and presented. This is not to be taken as a weakness of the study, but did result in a number of challenges, discussed in Section 3.5.

3.3.3 Ethnographic methods and data sources

To 'capture' and 'construct' social practices as research objects (A. Langley & Abdallah, 2011), my study needed to take place in the natural setting in which the ECoP unfolded: *"... the complexity of human interaction is available only in the settings of everyday life, not in a controlled laboratory setting or through created instruments" (Tullis Owen, 2008, p. 547)*. Importantly, my extended co-presence within the field made the local knowledge and situated practice increasingly legible to me, and consequently more accessible for analysis (Luders, 2004). The two main sources of data were retrospective historical background data—in large part gained through my involvement in the parent study mentioned in the introductory chapter—and prospective primary data generation as the ECoP unfolded. I generated the data through a range of ethnographic methods, including observational methods (field notes) and interviewing (verbal data, transformed into transcripts). I also included documentation from various domains (e.g., media, policy and organisational documentation).

3.3.3.1 Collecting historical background data

Involvement in the parent study during the development of the proposal for this thesis provided important background and contextual data, as well as opportunities for familiarisation with the field. Over a number of years, the parent project had developed a deep understanding of the historical policy context and top-down policy push to introduce process improvement capability-building that preceded the introduction of the collaboratives. Interviews with designated knowledge brokers in the jurisdiction had demonstrated the extent of the challenge they faced, in particular with engaging both senior hospital administrators and frontline clinical staff in process improvement, and with sharing successful improvement activities with peers across organisational boundaries. This study provided an opportunity to further investigate these issues in the context of the new collaborative policy. Furthermore, researching the frontline engagement issue from clinicians' own perspectives had been challenging to address as a result of access difficulties. I make an empirical contribution toward understanding these issues through this thesis.

3.3.3.2 Observation

As Latour argues, to understand how different groups form, we need to *"follow the actors' own ways and begin our travels by the traces left behind by their activity of forming and dismantling groups." (2005, p. 29)*. To get proximal to the practices and processes that made up the social

reality of the ECoP and its participants, I undertook participant observation. Schensul, Schensul & LeCompte describe participant observation as *"the process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the researcher setting"* (1999, p. 91).

The policymakers informed the ECoP participants of my presence and activities at ECoP workshops, and I had the opportunity to introduce myself and my project in person. Following this, I systematically described events, behaviours, activities, and artifacts in the social setting of the ECoP *(Marshall, 2006)*. I generated data in the form of hand-written field notes, during 29 hours of observational fieldwork at the four ECoP workshops and at two related Collaborative workshops. I also created field notes during time spent in natural settings (e.g., while visiting health services for interviews) and at health sector events related to CoPs, collaboration, innovation, and improvement, both in the jurisdiction and interstate (total of 44 hours). This helped to build a picture and sense of the macro case of the ECoP and context in which it was nested.

The kinds of observations I recorded included both seemingly important and seemingly unimportant 'doings and sayings'—the kinds of ideas being presented formally, those being discussed informally, the kinds of language used, who spoke and when, and how people interacted. I described situations using multiple senses in an attempt to generate 'written photographs' of the scenes I was participating in (Erlandson, 1993), and later typed these into electronic documents. I added analytic memos and reflections to them over time as ideas and connections emerged abductively through my engagement with the literature, participants' reflections during interviews, and emergent concepts and connections. I uploaded the field notes and memos generated from all of these activities onto NVivo. This made handling and organising the large amounts of data more efficient (L. Spencer, Ritchie, & O'Connor, 2014).

3.3.3.3 Interviews and conversations

"Grasping the viewpoint of actors is necessary for understanding interaction, process, and social change" (Strauss, 1987, p. 6). The interviewing process was complementary to my observational activities and allowed me to build 'front stage' and 'backstage' pictures of what was happening in the ECoP. Observing the activities of the ECoP enabled me to see what participants themselves, as a result of the often 'unconscious' nature of practice, did not notice or were unable or unwilling to articulate (A. Langley & Abdallah, 2011; Willems, 2004). This

meant that I could construct data about social practices as they arose (Alvesson & Kärreman, 2007), avoiding reliance on partial reconstructions produced by participants later (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2014). However, as the research was also interested in what insiders *could* say about their experiences, interviews provided an opportunity to unpack, from the participants' own perspectives, moments that had piqued either their own or my interest during the workshops (Luders, 2004). I could then compare these with observational data and preliminary explanations.

Between March 2018 and May 2019, I carried out a total of 32 face-to-face, in-depth, semi-structured interviews with participants of the ECoP. Interviews enabled private in-depth discussions regarding participants' perceptions of what was taking place within the unfolding ECoP, how they were making sense of it, and how it related to their everyday practice. Each interview lasted between 30 minutes and two hours (on average, 45 minutes) and was usually conducted at participants' workplaces. To arrange the interviews, I contacted all participants who had attended an ECoP workshop—and some who were on the ECoP contact list but had not attended a workshop—directly, either by email or in person at workshops. All participants who responded agreed to be interviewed (5 participants did not respond). I provided a description of the project, approved by the Monash University Human Research Ethics Committee, along with the participation consent form by email prior to the interview. I also provided a consent form in hard copy, signed at the time of the interview (these documents are displayed in Appendix 1).

I spoke formally with: 18 process improvement advisors with both clinical (n = 12) and non-clinical backgrounds (n = 6), one executive sponsor, 5 hybrid nurses (mostly ED nurse managers), and 7 hybrid doctors (mostly ED directors). The sample of interviewees represented all of the nine organisations involved in the initiative (Table 3.2 below provides a summary of the interview and observational data sources).

As the study was discovery-oriented, *a priori* sensitising concepts from the initial literature review only loosely structured interview guides—in a kind of 'light touch' deductive theoretical sampling approach (Hallebone & Priest, 2009; Patton, 2015). I mainly designed the interview guides to capture participants' experiences of the ECoP and the meanings attributed to their own and others' involvement in the ECoP, as well as other process improvement activities they had been involved with in their organisations or at the sector level (Appendix 2 displays the

initial interview guide). The guide evolved over time as *emic* sensitising concepts emerged from the field and provided a better sense of ‘where to look’ (Blumer, 1954), but remained relatively unstructured to allow interviewees to follow threads that were important to them. It often transpired that we covered only a few of the questions, and the discussion followed another path entirely.

I digitally recorded verbal data generated through the interview process using a hand-held device. I produced the transcriptions where possible and found that this provided opportunity to be immersed in the raw data (Patton, 2015). I used a professional transcription service when time became short. I checked transcripts for accuracy and returned them to participants for their review and approval, with the option to amend or withdraw the transcript from the study. I also documented reflective memos after all interviews, capturing initial impressions and reminders to follow up particular threads in future interviews, or in the literature. Memoing in this way also facilitated intuitive analysis work—*“the most private, least confirmable, yet richest approach”* to qualitative data analysis (Firestone & Dawson, 1988). I uploaded all transcriptions onto NVivo for analysis once approved by participants, along with the memos.

Aside from formal interviews, countless informal conversations provided invaluable insight, both prior to and after the more intensive fourteen month data collection period. Regular visits to The Agency offices, for instance, provided the opportunity for many enlightening conversations with the policymakers. I met with the policymakers twelve times over the course of the research and completed field notes after each of these meetings. Attending other health sector events (and sometimes non-health sector process improvement events) within the jurisdiction also provided opportunities for informal discussions with ECoP participants or other actors with insight into the field. I generated field notes as soon as possible after a conversation of interest, and uploaded these onto NVivo.

Semi-structured interviews (0.5 - 2 hours)	Participant type	No. of interviews
	Process improvement advisors - veterans (11 of 12 had clinical backgrounds in allied health or nursing)	12
	Process improvement advisors - novices (5 of 6 had non-clinical backgrounds e.g., manufacturing)	6
	Executive sponsor	1
	Hybrid nurses - veterans	3
	Hybrid nurses - novices	2
	Hybrid doctors - veterans	5
	Hybrid doctors - novices	2
Total interviews		**31**
Observation type	**Description**	**Hours**
Participant observation	Meetings with The Agency project owner	16
Observation	CoP and related workshops	29
Observation	Industry events / other contextual observation	44
Total observation hours		**89**

Table 3.2: Summary of interviews and observational data

3.3.3.4 Documents

Various documents complemented the data generated through observation, interviews and conversations. These included publicly available documents (e.g., policy documentation, independent reviews and evaluations, health service annual reports), documentation provided by research participants (e.g., unpublished reports and evaluations, private correspondence, and organisational process improvement documentation) and the (very few) posts on the ECoP's online platform for knowledge sharing.

As part of the familiarisation process with the field, The Agency's reports on the policy programs of the preceding decade and the independent evaluation of the pilot Collaborative of 2016-17

provided contextual background as to how and why the agency and its collaborative approach had come into existence. In addition, examining the documents on The Agency's website made it possible to compare the 'reality' I observed through 'backstage' observation and interaction with the policymakers against the public face they presented to the world.

Organisational documents from health services also provided useful context, indicating, for example, the importance that different health services placed on process improvement (e.g., by examining the location of improvement in organisational charts and the relative emphasis placed on reporting improvements in annual reports and on websites). In addition, I observed developments in the broader healthcare context both in Australia and overseas through industry reports, media, and email subscriptions to various policy and healthcare organisations and peak bodies. Due to the enormous volume of data in these documents, deciding what was important and reducing them to make them analytically useful was necessary (Newton Suter, 2012). I sometimes generated summary notes, but most often the information in these documents simply helped me to develop a 'feel' for the field or informed my analytical memoing processes in dialogue with the primary data I generated through observation and interviewing (P. Eriksson & Kovalainen, 2015).

3.3.4 Ethical considerations

The Monash University Human Research Ethics Committee approved this study as a low risk project. The study did not require access to sensitive personal or patient data nor pose any significant risks to participants. As outlined in Section 3.3.3.2, I informed participants of my presence and introduced my project prior to the commencement of observational activities, and provided background information on the study as approved by MUHREC. I sought written consent from participants prior to audio recording interviews or taking photos (e.g., of relevant process improvement artefacts or documentation).

I ensured participants' anonymity and confidentiality by storing data securely on password-protected devices (Creswell, 2018). I kept the names of research participants and their corresponding codes separately from the data. To avoid the possibility of quotes being attributable to individual participants, in some cases I altered minor personal or contextual identifying details in the presentation of the data (e.g., gender, recognisable turns of phrase). Outside of the ECoP workshops, it was not always practicable to inform people about the

research study: for example at other meetings, forums, or during observation of natural settings either before or after pre-arranged observational activities. As for all other data, I took care to ensure that details or quotations could not be attributed to particular individuals or organisations. I used data generated from such incidental observation as background to inform the study, rather than presenting it as supporting data in my empirical chapters.

3.4 Data analysis and presentation

With a practice-based approach being a theory/method package through which to construct narrative accounts of a processual 'reality' (Nicolini, 2012), the aim of my analytic process was to transform the data into findings that tell a story (Golden-Biddle, 2007; Patton, 2015; Van Maanen, 2011). The following section details how I made these transformations and how I came to construct, organise, and present the account of the ECoP in this dissertation.

3.4.1 Abductive analytic strategy

To achieve the aim of this thesis, I needed an approach to analysis that enabled a dialogue between the messy social reality observed and existing concepts already at play in the literature. Whereas deductive approaches seek to test existing theories, and inductive approaches seek to identify empirical patterns in order to make general statements (Kennedy & Thornberg, 2018), abductive approaches are more flexible. They are open to the data but also sensitive to pre-existing theories: not for the purpose of hypothesis generation, but as a source of inspiration, and to help identify and interpret patterns (Alvesson & Sköldberg, 2017).

This approach aligns with the perspective I take in this thesis. As the researcher generating the data and analysing it, I could not separate myself and my previous history, knowledge, experience and reading of the literature from the process of analysis. As Patton (2015) points out, the distinction between data gathering and analysis is blurry. Data that we consider to be 'raw' has always already been transformed in some way, always analysed according to some framework as we generate it (Czarniawska, 2004). From this perspective, it would be difficult to argue that either a purely deductive or purely inductive approach is ever possible, or fruitful.

Blumer (1954) argues that practice-based approaches are inherently abductive, as they seek to build explanations that are grounded in the observable, by tracing phenomena back to the

“arrangements of concrete elements that produce the state of affairs under investigation” (Nicolini & Monteiro, 2017, p. 123). In the course of this project, interesting events, doings, and sayings stimulated this process of working backwards. *“That’s interesting”* moments (Weick, 1989) in the field prompted unpacking and attempts to explain how and why actors undertook particular practices in the field. I returned to the literature to strengthen these explanations, and returned to the field to narrow the range of plausible explanations. This explanation-building process was iterative, moving back and forth between the ‘puzzling’ empirical findings and existing literature and theory (Bryman & Bell, 2015; Yin, 2014).

Abduction is thus a creative process through which concepts and theories can be inductively derived from social actors’ everyday conceptualisations and practices (Hallebone & Priest, 2009), and used to construct explanations in combination with deductive notions. This triangulation of emic and etic perspectives helped me to notice divergences (Flick, 2018), or ‘mysteries’ which inspired *“the construction of a variety of alternative ‘stories’" (Alvesson & Kärreman, 2007, p. 1269)*. I assumed none of these passively mirrored ‘reality’, but some were more plausible ‘bets’ about what was really happening than others (Boje, 2011). Ultimately, they helped to refine existing theory, and build a *“clearer view”* of the processes involved in forming mandated collaborative initiatives (Tsoukas, 2019, p. 386).

3.4.1.1 Abductive content analysis

To put some order around what was in reality a rather unstructured process, I describe below the data analysis procedures that I undertook in this study, as three phases. These did not, however, always proceed chronologically. Analysis began the moment I entered the field and continued long after I left it (Czarniawska, 2008).

I employed content analysis to reduce and make sense of the large volume of qualitative material. I operationalised this through coding which reduced, condensed and integrated the data, so that I could distil meanings from it and stimulate interpretation (Hallebone & Priest, 2009). The coding process surfaced patterns (descriptive consistencies) and themes (more abstracted categories that entail interpretations of the meanings of patterns). Each phase of coding became more analytical and abstracted (Miles & Huberman, 1994). I used NVivo software initially to aid the coding process as it helped to handle the large amounts of data (L. Spencer et al., 2014). However, I resorted to pen and paper more often, as I found that hand-writing helped greatly to move actors, codes, and categories around, so as to see the big picture

and to find patterns more easily (see figure 3.2 for a 'tidy' visual representation of the abductive process and figure 3.3 for a sample of early analytical work).

Phase One

In the first phase of analysis, I applied two kinds of *descriptive codes* to the data in NVivo. I drew 'emic' or 'in vivo' first order constructs from the participants' own language and point of view (Patton, 2015; Schutz, 1972). I elicited these through a relatively open-coding process (Strauss, 1998). At the same time, I brought 'etic' constructs to the data: for example from the literature and existing knowledge of the context, since, without expectations of what the data ought to look like, there would be nothing 'puzzling' to explain (Givon, 2014).

Through this process, I turned the practices that I had recorded during fieldwork into discursive objects by describing, grouping, thematising, and representing them as codes in NVivo, in field notes, in the margins of papers, and as tentative visual models of what I understood to be happening in the data (Nicolini & Monteiro, 2017) (Appendix 8 displays an early version of the codebook from NVivo).

During this stage, I became sensitised to the CoP concept as a first order construct that the policymakers were using to describe the 'thing' they were hoping to create: one associated with collaboration, harmony, and knowledge transfer. I began to compare this with the many uses of 'CoP' in the literature, and found that an explanation of what goes on when mandated CoPs are created was lacking. This sparked my search for a way to consider the phenomena under investigation as process rather than entity.

Phase Two

During the second phase of analysis, my coding became more *inferential* (Miles & Huberman, 1994). I progressively collapsed first and second order codes from the first phase into higher order categories as patterns emerged (Patton, 2015). Ongoing interaction with the evolving ECoP and its different members helped me ask *"What is actually happening in the data?"* (Glaser, 1998, p. 140) and make sense of the rather unstructured corpus of qualitative data and the large number of codes that had emerged in phase one. Here I was trying to make what seems to be obvious 'dubious' (Schlechty & Noblit, 1982), since a good deal of the data seemed obvious, mundane and barely worth attention. However, continually asking questions of the data along the lines of "*What do these practices mean? What can they be interpreted as? What are*

these actors actually doing?" led to experimentation with numerous analytic tables, typologies and tentative process models. These surfaced interesting and plausible interpretations.

At this stage, focusing on the different participant groups separately also enabled the emergence of a sense of their distinctiveness and patterns in their practices, and enabled me to develop themes particular to them (L. Spencer et al., 2014). This process led to epistemic identities emerging as a key driving factor behind the different ways in which participants were making sense of, and engaging within, the ECoP. Moreover, changes in the ECoP story over time and the mechanisms that might be driving these changes began to emerge (Gehman et al., 2018). *Learning to learn together* and *learning to be together* were key processual motifs.

Phase Three

Coding and classifying in the earlier phases produced a mostly descriptive framework of what was going on in the ECoP. These descriptions were the foundation for the third and more interpretative phase of analysis, in which I built explanatory accounts of the ECoP and tested explanations (Alvesson & Kärreman, 2007; Patton, 2015; Yin, 2014). Abduction was foregrounded in this phase as I sought convergence and divergences between the findings of this study and those described by others in the literature.

At this stage, constantly 'zooming in and out' of different levels and between different domains of activity of the ECoP helped me understand the situated micro-practices of participants within the broader context of the evolution of the ECoP as a whole: to see how practices aggregated to make processes (Nicolini & Monteiro, 2017). As Van de Ven and Poole (1995, p. 534) suggest, figuring out the relationships among the 'motors of change' that are nested in different levels of analysis requires such macro-micro links to be specified.

Alongside the zooming in and out, the third phase involved looking for relationships between themes (Patton, 2015), building explanations from these relationships using the sensitising conceptual bricolage outlined in Chapter 2 (and refining the bricolage recursively as the data spoke back to it) and connecting them with the research questions (Miles & Huberman, 1994). Ongoing 'verification' cycles further qualified the findings (Guba & Lincoln, 1994). The abductive process was highly generative and resulted in many early versions of the empirical chapters and many more explanations and findings of interest than have been included in this thesis.

In this stage, three overarching process elements that fleshed out the notions of *learning to learn together* and *learning to be together* emerged: *(per)forming the ECoP, translating the knowledge* and *reconciling identities.*

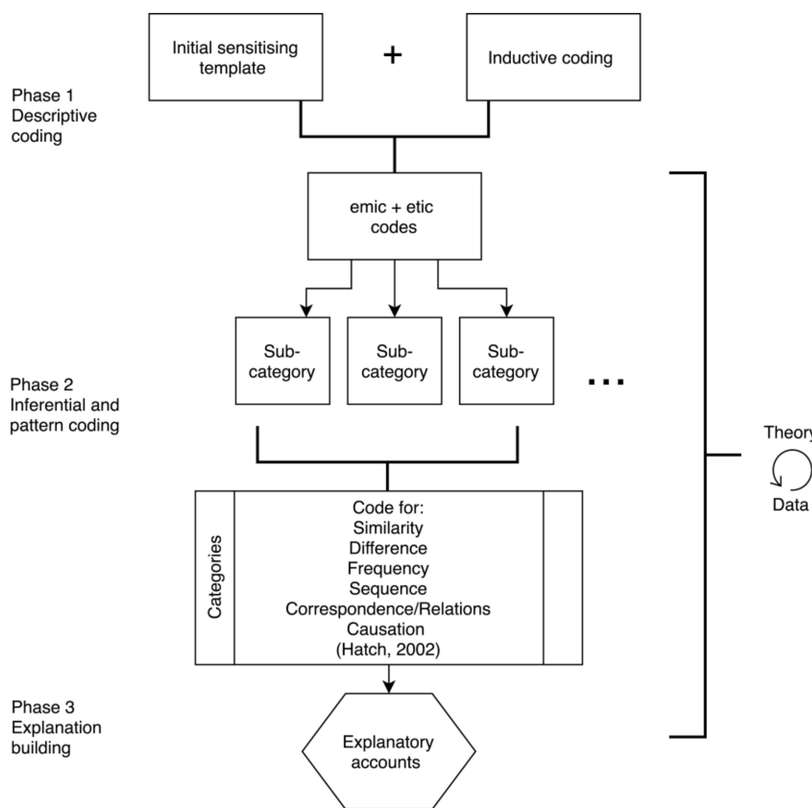

Figure 3.2: Data analysis strategy

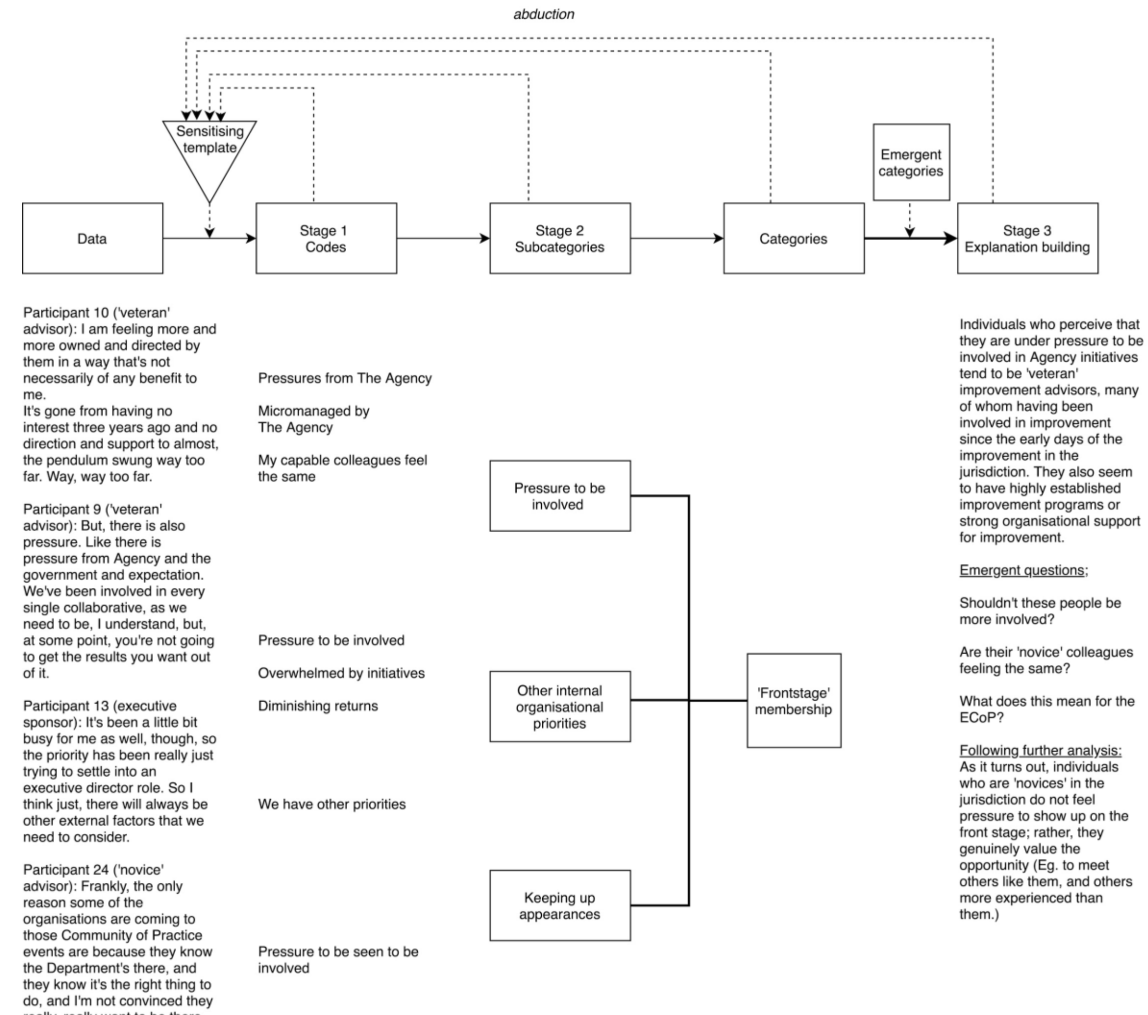

Figure 3.3: Sample of early analytic process

3.4.2 Narrativising the findings

With the phases of coding described above becoming more analytical and abstracted (Miles & Huberman, 1994), they had the potential to reduce out the complexity with which the practice-based approach to knowledge mobilisation of this thesis was concerned. To remain true to the practice-based approach and richness of the social context I was analysing, I sought to construct the empirical chapters in a way that enabled the theoretical contributions to emerge through partial but rich descriptions of the actors, practices, and 'world' of the ECoP. Following a small body of literature that has used narrative approaches to represent and understand change in healthcare (Currie & Brown, 2003; Currie, Humpreys, Waring, & Rowley, 2009; Mcdonald, Waring, & Harrison, 2005; McDonald, Waring, & Harrison, 2006), I used narrative components

produced throughout the analytic process to give coherence and depth to my presentation of the research findings.

Narrative approaches encompass many and varied strategies for design, data collection, and analysis (Creswell, 2018; Rogan & de Kock, 2005). Here, much of the data generated took the form of personal and collective narratives. We tend to make sense of the world by organising experiences in the form of narratives (Bruner, 1991). Therefore, using narrative as an analytical device (writing and rewriting stories) was a fruitful way of doing analytical work that helped to bring coherence to a messy empirical reality which included many actors, interactions, intersecting networks of relations, and background contexts (Bruner, 1991; Czarniawska, 2004; Polkinghorne, 1988).

Moreover, with a key aim of the findings chapters being to illuminate how practices constituted processes in the ECoP, narrativisation helped to reveal how actors' micro-level practices aggregated and cumulatively effected processes of learning and becoming. I was cautious, however, knowing that academic 'emplotments' which translate messy stories into neat, rational accounts can impose counterfeit coherence (Boje, 2001). To avoid this, I embraced Boje's notion of 'antenarrative': *"fragmented, non-linear, incoherent, collective, unplotted, and pre-narrative speculation, a bet…"* (2001, p. 2). The ECoP story was not a singular or coherent one: it changed with every interaction and observation, and every specific person, place or situation in and by which it was authored (Clandinin, 2013; Creswell, 2018). Producing a single story would always be one-sided.

Instead, I engaged with fragments of data that helped to *"draw attention to the inherent story-like character of the fieldwork accounts" (Van Maanen, 2011, p. 8)*. As Czarniawska (2004) suggests, I carefully 'emplotted' the data to facilitate logical connections and create coherence, as well as to link the micro-level domain of actors' practices to the evolution of the ECoP as a whole. I emplotted each of the findings chapters thematically (rather than chronologically, for instance), using the connections and categories that emerged during the analysis phases described above as organising devices. Together, these fleshed out an overarching processual meta-narrative of the ECoP, consisting of *(per)forming, translating* and *reconciling.* This is a story of the ECoP as a whole over time, but one which also reveals non-linearity and the interconnectedness of its various parts.

3.5 Considerations of quality

From the ontologically relativist position this thesis takes, I recognise that the 'clearer' view of collaborative knowledge mobilisation is but one of many alternatives. 'Reality' is relative to the position/perspective from which it is perceived (Hassard & Wolfram Cox, 2013). As Deetz argues, it is not a question of which approach *"is right or better, but which languages and processes address whose and which problems, and the consequences of addressing them in this way." (2009, p. 22)*. In accord with the motivations of this thesis to better understand how knowledge is mobilised in healthcare under the conditions of a policy mandate to collaborate, it is my hope that this clearer view can help those tasked or targeted with mobilising knowledge to do so in a way that ultimately improves our ability to provide timely access to quality healthcare.

3.5.1 Trustworthiness and transferability

The relationist epistemology of the study entails the recognition that the account of the ECoP produced in this thesis is a relational product that was created in dialogue between the values and position of myself as the researcher, the research subjects, the immediate context of the research, and broader societal contexts (Hassard & Wolfram Cox, 2013). I recognise that the narrative I have produced is performative (Denzin, 2003): *"No matter how we stage the text, we: the authors: are doing the staging" (Richardson, 1990, p. 12)*.

While positivistic 'transfer' approaches seek to erase such subjectivity, the practice-based approach I take here relies upon insights from rich, contextualised, and detailed narratives (Tullis Owen, 2008). It was precisely the emphasis on situational details unfolding over time that allowed this qualitative study to uncover, describe, and explain many of the processes involved in mandated, collaborative knowledge mobilisation. As Geertz asserts, a researcher's worth is characterized by *"the degree to which he is able to clarify what goes on… to reduce the puzzlement."* (1973, p. 16).

I achieved this clarification through fine-grained understandings of micro-level practices and processes, gained from prolonged and deep engagement, reflexivity and analytical rigour. This helped to ensure the credibility of findings (Guba & Lincoln, 1994). I used member checking as part of the iterative process of explanation building and triangulation to verify hunches and assess the trustworthiness of qualitative results (Carlson, 2012). This involved asking, for

example: *"How does this idea sit with you?"*. These kinds of processes allowed me to systematically investigate rival explanations and enhance the trustworthiness of findings (Gehman et al., 2018; Yin, 2014).

Moreover, triangulation was a key strategy I used to ensure trustworthiness. The mix of data generation tools outlined above resulted in the triangulation of both sources (e.g., different actors, groups of actors, organisations, documentation, events) and methods (Patton, 2015). Triangulation was a means to a number of different ends: a validation strategy (achieving convergence), a way of generalising discoveries, and a way of extending knowledge of the research issue of interest (Flick, 2018). Triangulation also facilitated seeing divergence. Rather than only using triangulation as a tool to 'check' the accuracy of findings, sensitivity to divergence enabled me to observe the findings emerging from the ECoP case from different perspectives (Flick, 2018). For instance, observation of actors' 'front stage' participation in workshops and their 'backstage' meaning-making in interviews sometimes resulted in conflicting accounts of their participation in the ECoP. Without triangulation of methods, these different angles on the narrative would not have been available for analysis.

In addition to *trustworthiness*, interpretive qualitative research aims to produce principles that are *transferable* to other domains and settings (Gehman et al., 2018; A. Langley & Abdallah, 2011). In contrast to more positivistic studies, interpretive work does not try to abstract out messiness. Instead, to achieve transferability, the rich accounts produced in this study provide access to the details of the ECoP story, so that the reader may judge the potential transferability of the theoretical ideas that have been drawn from it.

3.5.2 Challenges in and out of the field

As noted previously, an understanding of micro-level practices and processes required prolonged and deep engagement with the field. While this study used ethnographic methods, achieving deep engagement was a challenging balancing act. Deciding where to focus attention and data collection efforts was an ongoing question. Ultimately, I generated deep descriptions of four 'snapshots' during the ECoP's first year (all of the ECoP's formal events). Interviews with participants 'filled in' the gaps.

I could have made different decisions. For instance, I might have taken a ‘stricter’ ethnographic approach, following particular ECoP participants in their day-to-day work, for example. However, it was difficult to learn who and how to follow, or into which organisations to peek. Gaining access would have been very challenging, particularly to observe clinicians in various organisations going about their clinical work with patients. Ultimately, I might have produced a richer *micro* account of collaboration/translation practices *outside* of the formal ECoP events, but it would likely have been more difficult to produce a holistic picture. Had the ECoP continued, and had this dissertation been written over six rather than three years, a richer account might have been achieved. Whether it would have been ‘better’ is hard to know.

In addition, studying practices with a view to understanding mechanisms and processes, rather than looking at ‘things’, was challenging to operationalise. A process view is a very different way of looking at the world. Our everyday use of language is dominated by nouns and we try hard to ‘pin down’ phenomena and make the uncertain more stable and certain (A. Langley et al., 2013). In addition, to ‘get at’ processes of learning, meaning-making, and identification, I was faced with the ‘other minds’ problem (Wisdom, 1968)—the challenge of trying to know what is going on in others’ minds. This involved a lot of digging into what often seemed like very ordinary action and interaction in the ECoP meetings, and often led me to doubt whether there was anything to be ‘found’ at all. It was mostly through creative rather than formal analysis (in situ, writing field notes, reflecting, in discussions with my supervisors and colleagues) that the central themes and a way of weaving the findings into a story emerged.

3.6 Structuring the findings chapters

I assembled the findings chapters that follow so as to show my commitment to the practice-based perspective, to evidence the analytical process, and to make the most of the rich observational and interview data. Each of the three findings chapters considers one of the overarching meta-processes that emerged: *(per)forming, translating, reconciling.* Each is structured by two or three key motifs.

Chapter 4 begins with further detail about the backdrop to the ECoP, to provide insight into the policymakers’ world as they worked to set up the initiative. This sets the stage on which improvement advisors and hybrid clinicians from various health services played their parts in *(Per)forming the ECoP*. I then describe three constituent practice assemblages in turn, using

representative fragments from my observational data to illustrate each. I build each assemblage into a ‘precarious whole’ (Müller, 2015) by weaving together participants’ responses to the observed incident, other related observational data fragments, and participants’ more general reflections in relation to each theme.

Tensions in Translation is structured in a similar fashion. I explore two narrative themes, introducing each using ‘antenarrative’ fragments from my observational data. I then build the story of each through participants’ responses to the front stage incident, other observational data, and other backstage reflections.

With a focus largely on private identity work, *Identity Reconciliation* draws more dominantly on participants’ backstage reflections. I organise key themes around each of the epistemic communities involved in the ECoP, in order to elucidate their unique *epistemic expansion* practices and *modes of identity reconciliation*, as well as their divergent trajectories in relation to the ECoP.

I draw on quotes and observations from a range of participants, but name and predominantly focus on a fairly narrow cast of characters (see Table 3.3 below for profiles) for two reasons. First, naming and making some characters familiar helped to bring coherence to a narrative disjointed by necessary thematic reduction and punctuated by various sections and headings. Second, the characters I chose often offered particularly salient or powerful ‘proof’ quotes (Pratt, 2008). However, to evidence the ‘trustworthiness’ of my analysis, I provide a summary table in each findings chapter with convergent data from other participants, which lend support to the findings (Tables 4.1, 5.1 and 6.1).

Pseudonym	Profile	Category	Organisation
Neil	Lifelong bureaucrat Aware of long-term improvement program in the jurisdiction but has never worked directly with health services No specific experience in process improvement Non-clinical background	Policymaker	The Agency
Martina	Neil's manager No specific experience in process improvement Non-clinical background	Policymaker	The Agency
Colin	Host of second workshop at Big Metro New to the jurisdiction but with significant expertise in process improvement gained in the manufacturing sector Non-clinical background	Novice improvement advisor	Big Metro: large prestigious metropolitan hospital
Malcolm	Host of first workshop at Edgeside New to the jurisdiction but with management education and overseas experience in health sector Non-clinical background	Novice improvement advisor	Edgeside: rapidly growing outer-suburbs hospital
Dr Jason	Director of ED at Edgeside	Veteran hybrid doctor	Edgeside: rapidly growing outer-suburbs hospital
Dr Benjamin	Co-host of third workshop at Outerside Executive Director of Organisational Redesign at Outerside	Veteran hybrid doctor	Outerside: rapidly growing outer-suburbs hospital

Table 3.3: Main cast of characters

Chapter 4: (Per)forming the ECoP

"... no community is yet in place… [it] is still a set of dividing possibilities."
(Knorr Cetina, 1999, p. 195)

***

In this findings chapter I seek to address my first research question: *How do instrumental collaborative knowledge mobilisation networks form in practice in healthcare systems?* Through the deployment of the practice-based lens described in Chapter 2, I sensitised the analysis to the apparently mundane micro-level of formation of the ECoP, through the examination of both 'front stage' and 'backstage' practices of the different groups of participants that constituted it. Crucially, rather than taking as given the ability of the policymakers to *form* the ECoP by virtue of a label and mandate, this chapter considers how the actions, interactions, and reflections of its various participants *(per)formed* the ECoP.

The findings presented in this chapter coalesce around three practice assemblages: *making a space of potentiality, comparing,* and *noticing the 'nexus'.* Together, these assemblages begin to build a picture of the invisible but under-investigated background processes involved in building the ECoP 'community'. They reveal how the processual 'reality' of the ECoP emerged through the relations and practices of the totality of actors involved.

The chapter proceeds as follows. First, I provide further detail about the backdrop to the ECoP with insight into the policymakers' practices early on, as they worked to set up the initiative. This sets the 'mandated' stage on which improvement advisors and hybrid clinicians from various health services played their parts in *(Per)forming the ECoP*. I then describe the three practice assemblages in turn, introducing each with a representative fragment of my field notes. I build the story of each using participants' responses to the incident, other related observational data fragments, and more general reflections of participants.

4.1 Setting up The ECoP…

While the policymakers described their correspondence with health services about the ECoP as an ‘invitation’, suggesting that participation in the ECoP was voluntary, such a stance was not reflected in their behaviour. Their response to the one organisation that dared to decline was telling. In his email, the CEO cited his organisation’s already strong performance on the NEAT KPI and an internal focus on *“other organisational priorities”* as justification for opting out and withdrawing his improvement advisors’ participation in the sector level collaboration. Neil, the mid-level policymaker responsible for administering the ECoP made it clear in a meeting I attended that this was an audacious move, and the issue was duly escalated to the senior management of The Agency.

Relations between The Agency and ‘their’ cadre of improvement advisors clearly remained tenuous and subject to the whims and control of health service leaders. With one of the key aims of the ECoP being to help poorer performing organisations improve by learning from high performers, this was extremely disappointing for the policymakers. It was a stark reminder of the competitive culture the policymakers believed they had been making headway against.

Nevertheless, the other organisations responded positively and sent representatives to the first of four ECoP workshops in 2018—a brief, hour-long ‘co-design’ session. Here, Neil and his manager at The Agency, Martina, aimed to collectively define the priorities for the ECoP based on the needs of health services. Like their invitation, however, their interpretation of ‘co-design’ was somewhat narrow. Martina and Neil had already met to think of ideas for the content and structure of the upcoming substantive ECoP workshops, and mostly asked the participants to prioritise these using sticky red dots on butcher’s paper. Given the limited time available, the result was that there was little time for ideation or discussion, and confusion about the policymakers’ suggestions which they had no time to resolve.

At the shared tables I heard things like: *“What do they mean by sustainability? Like environmental? Or sustainability of projects kind of sustainability?”* Likewise, when Neil analysed the butcher’s papers after the workshop, he found that he could not interpret the participants’ responses. He spoke of this in a meeting at The Agency some weeks later as he talked Martina and the team through the results: *“I don’t actually know what they meant by ‘models of care’... and ‘mental health’”.* Priorities like these that confused Neil failed to make it

onto the policymakers' final list of priorities for discussion in the ECoP. This was justified by the argument that the ECoP ought to be about *"applying improvement knowledge to improve services. It's not about clinical improvement."* The 'co' in co-design appeared to be questionable.

None of the 91 contacts on the ECoP email list returned feedback on the priorities Neil collated or the 'ECoP Agreement' he created. Only three agreed to join the ECoP working group, and at no point during the life of the ECoP did the group meet. As became evident to the policymakers, labelling a collaborative network and producing some documents did not automatically translate into a situation that people would "*walk into"* (Lave, 1991, p. 66) and participate in. With a measly response rate to Neil's emails, it was clear that at this early stage, the ECoP had a label and an intended practice (to mobilise service redesign and process improvement knowledge collaboratively), and a thinly veiled mandate to attend, but there was no 'community' yet to speak of.

Questions abounded in these early stages, during which the ECoP was characterised by precarity: Would a health service offer to host the first workshop? Would people turn up to the workshops? How would they mobilise process improvement knowledge if and when they did? It was Neil's job to get the ECoP up and running in the first twelve months and to deliver an evaluation to the board of The Agency, which would then take the decision as to whether or not to support continued funding of the ECoP, and, moreover whether it would support scaling the model around other substantive policy issues. But first, the formation of the ECoP depended on finding a place to run workshops and having improvement advisors and hybrids attend and begin to learn to collaborate. Through the three intertwined practice assemblages that follow, I start to build the story of how participants began to *(per)form* the processual 'reality' of the ECoP.

4.2 Making a space of potentiality

Through their actions, interactions and reflections, participants began to 'make' the context for their own learning—a 'space of potentiality' that was conducive to thinking about complex system issues. A warming up process became evident over time in the ECoP, as my field notes reveal in figure 4.1 below. Despite awkward beginnings, by the end of each workshop there was always a sense of 'aliveness' to the room. By the final workshop, this relational buzz was

present even at its beginning. A novice improvement advisor, Colin, attested to this longitudinal relational effect in his reflection on the previous year's Collaborative: *"the first three or so workshops… were forced... then all of a sudden, the barriers started coming down."*. I found three key elements constituting the collective making process of the ECoP: responding to the *'rare' gift' of sanctioned time, decoupling from the frontline,* and engaging in *silo-busting encounters*.

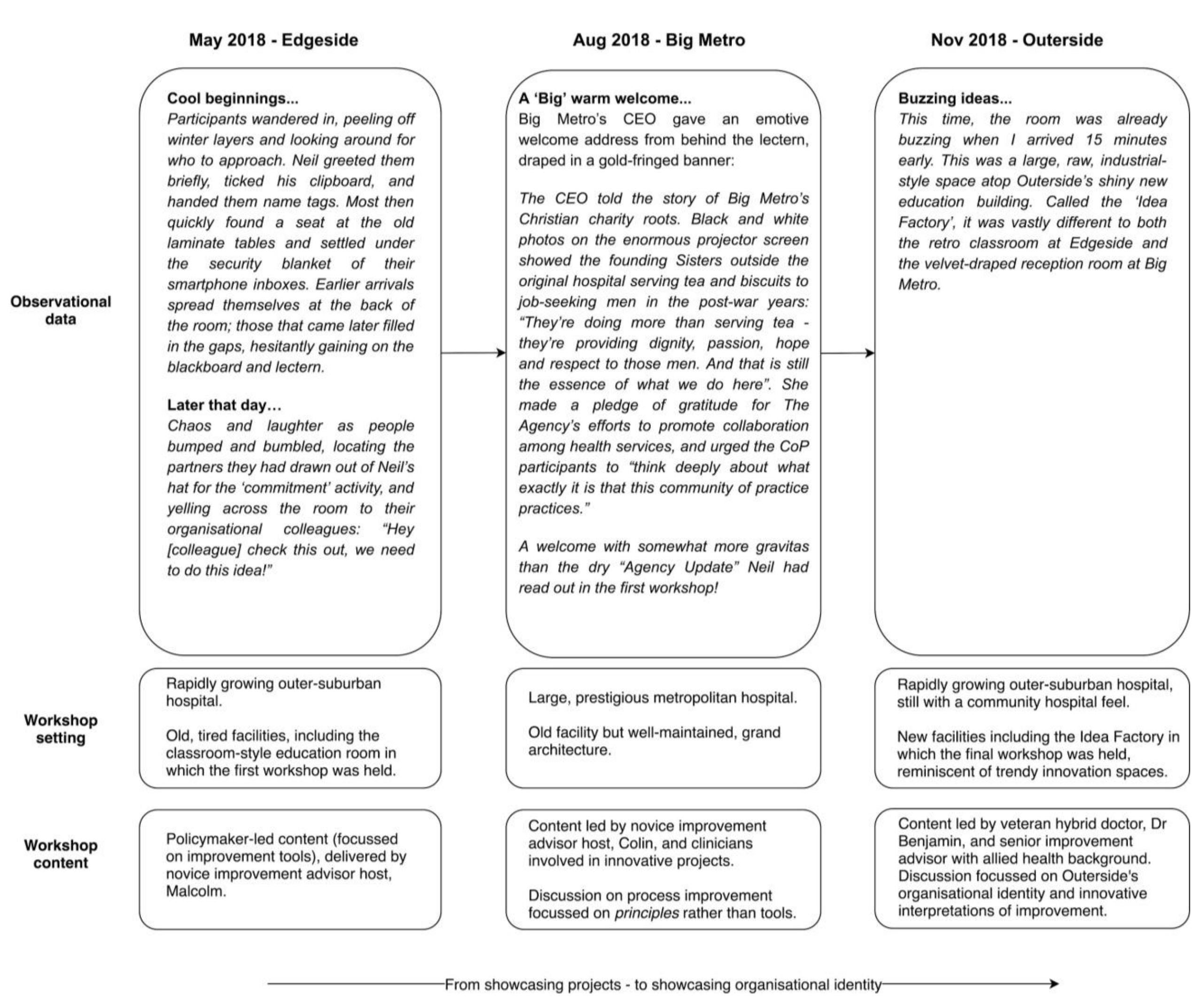

Figure 4.1: Warming up on the front stage.

4.2.1 The 'rare gift' of sanctioned time

During the first ECoP workshop at Edgeside, a rapidly growing outer-suburban hospital, Dr Jason, the medical director of ED said: "Senior ED doctors are interrupted every three

to six minutes and always have a line of people behind them waiting for their advice and input". *I had thought Dr Jason's statement to be an exaggeration, but when I visited him at Edgeside, it took us no less than five minutes and three interruptions to walk from the double doors of the ED waiting room, past patients in beds, beeping machines and endless taps on his shoulder, to the relative quiet and 'safety', as he put it, of his office. In the ECoP workshops, in contrast, hybrid ED doctors and nurses could relax and even stay seated(!) for hours at a time.*

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EDs never close their doors to patients. ED hybrids, whether NUMs or medical managers, are called on to 'fight fires' whenever physically present. The line between hybrids' managerial and clinical work and identities is always blurred. The clinical, with its relentless pace, urgency and professional priority always comes first. Interviewing the NUM at Edgeside, she lent agreement to Dr Jason's statement by describing the morning she had already had, on what was supposed to be *"an office day": "A little lady went missing… so while [associate NUM] was running the ward… I said, 'I'll sort this out. I'll ring the son, ring the police, do the search of the building'..."* As she explained, this was not unusual. *"The days we've got seven discharges it's all hands on board—wheelchairs going everywhere… [I'm] out helping… [it's] important that people see you out on the floor and [role]modelling." (participant 14, veteran hybrid nurse)*

For this reason, many of the hybrid doctors and nurses in the ECoP reflected on their appreciation of the rare gift of time away from everyday work that the ECoP provided. Critically, the ECoP created not only *"a space in the calendar" (participant 31, veteran hybrid doctor)* for clinicians to dedicate to improvement, but also a sanctioned warrant for taking time out. As a medical director of ED said, *"It's nice to be able to say [to organisational leaders], 'Look, we've got to present at a Department of Health level event…'" (participant 31, veteran hybrid doctor).* The ECoP was used as legitimate justification to step away from operational imperatives in order to engage with other organisations regarding issues around process improvement in EDs. This was important, because hybrid clinicians' time away from their organisations had to be absorbed into their non-clinical time and budget allocation, and organisations provided resources and support for process improvement to varying extents. Where organisational improvement programs were relatively immature, the top-down policy mandate was especially appreciated for its perceived ability to legitimise external collaboration.

The improvement advisors were also busy, and their roles were hugely varied with many competing priorities. However, they recognised that none of their duties were so pressing as those experienced by the clinicians involved in direct patient care in EDs. Comparing the pace of his own frontline to clinicians' frontlines, an improvement advisor from a major metropolitan hospital put it this way: *"[Clinicians are] firefighters… Tuesday, for example, [our ED] saw 300 patients. [Clinicians] don't have time to write a business case... do I have time to do that? Not really... but I can flex." (participant 6, novice improvement advisor).* As a result, finding the protected time to think through strategic issues was not as great a struggle. Moreover, many improvement advisors also had other more or less mandated interactions with The Agency outside of the ECoP, with most of their roles at least partially directly funded by The Agency. As a result, rather than sanctioned time out, some of the advisors, particularly veterans, interpreted the ECoP at times as an obligation that took time away from their internal organisational improvement work. Nonetheless, all the advisors, both novices and veterans, appreciated the increased opportunity to network across organisations.

4.2.2 Decoupling from the frontline

As Dr Jason's statement highlights, the value of the ECoP lay not only in the sanctioned time it generated, but also the opportunity to go to a place distant from participants' frontlines (whether clinical or process improvement frontlines). In the ECoP workshops, pagers were off and participants did not flinch during emergency announcements. Even participants from the hospital hosting the workshop were off-duty. Decoupling from their usual frontlines meant that participants' full attention could be dedicated to the discussions happening in the room, and this generated the potential for new perspectives. Participants were lifted from the metaphorical trees of their day-to-day organisational work lives, and they could start to see the forest of the broader system. The combination of sanctioned time and a different place emerged as a 'space of potentiality'.

The hybrid doctors I spoke with, all already somewhat 'willing' hybrids (McGivern et al., 2015), revealed that they already actively sought places away from their clinical work where they could *"get away from being a clinician" (participant 17, veteran hybrid doctor).* They recognised that distance from their usual place of work was a prerequisite to shifting into the proactive mode required to *"look at system level stuff,"* since it removed the risk of their being reactively

redrafted into their clinical teams when problems arose. An ED director explained that he was resorting to *“taking a sabbatical to [do improvement]!” (participant 1, novice hybrid doctor)* as this was the only way he could see himself managing to take on a project—*“Can you imagine doing full time work and [improvement]?”.* Another ED director told me that he created his own opportunities for learning across organisational—and even jurisdictional—boundaries, even when this impinged on his meagre time with family on holidays: *“Sad but true! I'm originally from [another Australian jurisdiction], so [on holidays I visit] my colleagues running emergency departments and they have the same problems, but they have different solutions and some of those solutions I'm going to bring back here and we're going to use.” (participant 31, veteran hybrid doctor).*

For these already willing hybrids, the ECoP was an easily justifiable opportunity to decouple from their frontline pressures and gain the distance they already sought, and the perspective that this brought. By going elsewhere, participants could temporarily decouple from their everyday work pressures, practices and selves. However, participants’ ‘recoupling’ with day-to-day imperatives and regularities of their work on their return to their home organisations easily disrupted this constructive ‘decoupling’. Participants’ return to everyday work in their home organisations always disrupted the potential of new relations, practices, and experiences gained in the ECoP to live on beyond the workshops. As an improvement advisor told me, *“you step out of the space and you go back and do whatever you were doing and you then don't always take that chance to ring somebody back.” (participant 20, veteran improvement advisor)*

Despite this, there was also a perception that longer-term participation in collaborative initiatives could have lasting effects on participants’ willingness and ability to cognitively decouple from the frontline and prioritise improvement work. Colin was a novice improvement advisor at Big Metro—new to the jurisdiction’s health system but with significant Lean experience in manufacturing. He relayed to me how the medical director of Big Metro’s ED had previously resisted engaging with process improvement, but that during The Collaborative of the previous year he had slowly warmed up to it. Now, he was one of the ‘converted’. When I spoke to Colin the day after the first ECoP workshop at Edgeside, he told me that his ED director had already been *“shooting emails around today”* trying to garner support to try out a new process he had learned about from Dr Jason at the workshop. Evidently, ongoing exposure to process improvement ideas and collaborative learning through The Agency’s initiatives had some sustained effects. What might otherwise have been only fleeting activations of new ways of

thinking and being were, with greater exposure, perpetuated beyond the sector-level workshops. Colin described the ED director as different now: "*He wasn't like that a year ago!*"

4.2.3 Silo-busting serendipitous encounters

An immediate material benefit of going elsewhere and decoupling from the frontline was the potentiality that this created for new interactions and relations. My field notes below capture a serendipitous encounter on the 'front stage' of the first workshop at Edgeside. The encounter reveals how participants' interactions began to perform the knowledge mobilisation potential of the policymakers' initiative:

> *Hot drinks, morning tea and mingling bodies saw the cool stiffness in the room begin to thaw. Making my coffee, I overheard a baffled exchange between an improvement advisor from a prestigious metropolitan hospital, and a contemporary who had recently left the same hospital... they had never met and wondered how that could be. As they talked through the mystery together it emerged that although they had worked there at the same time, one had worked in the 'Transformation' team (the stewards of Lean management knowledge in the hospital); the other in the 'ED Access Improvement' team (working on process improvement in the ED). The 'Transformer' had worked there for many years and had been instrumental in introducing Lean management to the organisation. As it turned out, the 'Accesser' had long been seeking support for her work from the Transformation team, but said that her attempts at cooperation across the internal silos had been stifled by senior management who, for some puzzling reason, had wanted to keep them apart.*

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Chatting to the 'Accesser' after the workshop she told me, obviously irritated at the discovery, that she had *"never met anyone from the Transformation team." (participant 23, veteran improvement advisor)* When they had first started doing ED access improvement work in the previous year's Collaborative, she said to me, *"I was saying, 'I need someone from Transformation,' [but] we were [kept] separate from Transformation, and that was a big mistake for sustainability. And also for the ease of the work... to be able to speak to Transformation and say, 'We're planning on doing a project about this.' And they can say, 'Oh, well, X's been doing*

this, and Y's been doing this and so and so's been doing…' You know there was no kind of... the hospital doesn't know what everyone is doing." But, she told me, it became evident through her serendipitous encounter with the 'Transformer' that this was not merely a matter of the usual kind of internal disunity that results from organisational silos. The leadership of their health service had deliberately intervened to direct how internal process improvement work got done, who was involved, and between whom interactions were fostered. She had learned from the Transformer that, *"Transformation were actually told that they weren't needed… our CEO removed their expertise and their skills from us…"*

My own review of this health service's organisational chart revealed that the 'Transformation' unit does not appear in the formal organisational structure, despite it being the home of Lean expertise within the organisation, and despite it being an organisation known for its extensive Lean training program. This prestigious metropolitan hospital was considered to have led the charge in the early days of process improvement in the jurisdiction almost a decade earlier when an ex-ex-ex-CEO wholeheartedly adopted the Lean methodology (CEO turnover was also a problem for the continuity of process improvement in the jurisdiction). The most recent CEO *"focused basically on direct patient care issues"* and did not prioritise access and flow issues or the benefits of the *"patient [spending] less time within the organisation"*. Evidently, improvement methodologies still struggled for structural legitimacy and consistent organisational support in the jurisdiction over time, despite the long-term policy level support. Like the CEO who rejected the policymakers' 'invitation' to the ECoP, senior leadership at this hospital had also intervened in a way that reinforced the status of improvement as a peripheral and separable activity, and reinforced intra-organisational silos.

The problem of intra-organisational silos was widespread and, unsurprisingly, the divide between clinical and improvement worlds was particularly pronounced. After the second workshop at Big Metro, I drove out to a regional hospital to interview the four participants who had attended: two novice hybrid ED nurses and two improvement advisors. As it turned out, they had driven the three hour round trip to the city in pairs—not by choice, but because neither pair had been aware that the other would be attending. In fact, despite both of them being involved in ED process improvement work at this hospital, the two pairs had never met. And they may never have, had they not found themselves in the same group for an activity in the ECoP. As this hybrid nurse suggested, an *"environment"* where people could *"get to know one another"* was absent in their own organisation *(participant 8, novice hybrid nurse)*. The ECoP

provided them with an 'elsewhere' in which they could decouple from their usual organisational patterns of relating—which reproduced disciplinary silos—and perform new relational patterns.

Critically, such encounters in the ECoP, which *"interrupted a certain regularity"* of usual relations (Rodriguez-Barbero, 2018, p. 9), had the potential to translate into newfound abilities to reach across silos when participants returned to their home organisations. It became evident that participation in The Agency's collaborative initiatives generated some durable relational benefits. As a hybrid allied health manager from Big Metro told me, *"because of the work that was done in The Collaborative, by engaging [clinicians] and making them see the benefit of [improvement]" (participant 3, novice improvement advisor)*, clinicians who had been given the time and space to engage in The Collaborative the previous year were now highly engaged in improvement in their hospitals. Even if they no longer had formally dedicated time to do improvement work, their previous exposure motivated them to actively *"make that time for it to work".* In this way, the front stage interactions in the policymakers' collaborative initiatives also had longer term performative effects, mobilising relations and process improvement knowledge within organisations.

4.3 Comparing: Seeing similarity and delineating difference

In this section, I explore the performance of comparing practices in the ECoP, revealing how processes of identification and differentiation (Jenkins, 2004) were ubiquitous in the early stages of (per)forming the ECoP. These practices emerge as a vital motor of knowledge mobilisation and mechanism through which participants came to understand how they 'fit' and through which they positioned themselves and others within the ECoP.

4.3.1 Positioning oneself in relation to others

4.3.1.1 Assigning roles and responsibilities

My field notes reveal how, during the first workshop at Edgeside, Neil inadvertently sparked a lively group discussion with an apparently mundane report from The Department. Participants invoked comparison as a mechanism through which they made sense of their organisations'

position in the jurisdiction's healthcare field—seeing both similarities and differences. They also deployed comparison to position the policymakers as active participants of the ECoP who, by virtue of their relatively more central and influential position, ought to take on certain responsibilities:

> *Apologising for how dry it was, Neil read out a multi-page update that The Department had requested he provide to the ECoP participants. It was about the looming threat that the upcoming flu season presented in terms of higher rates of acute emergency presentations that they were all likely to experience in their EDs in the coming months. While intended as a top-down update, with Neil merely the messenger, the enthusiastic discussion that ensued among the hybrid ED doctors and some of the improvement advisors in the room made it clear that all of the EDs represented in the ECoP, even those considered to be top performers, struggled with flu season preparedness. But, rather than engaging with this problem together within the ECoP, the group asked Neil to feed back to The Department that they wanted more guidance on what exactly to do to prepare. Neil, whose role was simply to administer the ECoP for 12 months, was now positioned as a broker. It was assumed that he would be willing and able to do some knowledge mobilisation himself and act as go-between—between the ECoP members and The Department.*

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This front stage incident reveals some of the ways in which some used comparison to position other participants in terms of their similarities, differences, and unique characteristics. Backstage later, I spoke to a junior nurse hybrid from a regional hospital with a relatively immature improvement program. She expressed that it had been *"really enlightening to see… [that] the challenges that [Big Metro] face are similar challenges that we face." (participant 26, novice hybrid nurse)*. While it was not entirely a surprise that organisations shared similar struggles, they usually experienced their challenges in isolation—in the day-to-day of their own hospitals. Reflecting on one another's challenges in a room *together* served as a more proximal instantiation of this understanding.

Along with a greater understanding of their shared struggles, participants also experienced revelations of cross-organisational difference through comparison: *"It was interesting to hear*

how much variability there was [for flu testing and isolation]…" (participant 17, veteran hybrid doctor). Whatever 'best practice' processing of flu presentations in EDs might entail, they could not be sure they were doing it. The 'standard' processes described by the ED directors had all been different, and this was of great concern to the group. It was through this comparison of difference that the emergent ECoP's first joint problem to solve emerged.

Interestingly, cross-organisational comparison about flu procedures had the effect of drawing Neil into the ECoP as a participant and positioning him as responsible for problem-solving. An ED director reflected to me later that, *"a lot of people were… saying what we really want from the Department of Health is someone to say 'This is the requirement, so do it, and this is the standard'" (participant 17, veteran hybrid doctor).* Both front stage statements and backstage reflections of participants positioned knowledge mobilisation responsibility for process standardisation squarely within the policymakers' domain, rather than viewing them as passive administrators of the ECoP.

An ED medical director explained to me why positioning the policymakers as responsible for clinical guidelines was important: "*If [The Department] did [provide guidelines] we could set that standard and we could say, 'Well this needs to be funded, we need to provide that space, we're expecting people [in other parts of the hospital] to provide space…' so on and so forth." (participant 17, veteran hybrid doctor).* The legitimacy provided by a Department mandate would give him and other ED directors more scope and authority to establish more exacting processes within their own EDs. These hybrid clinicians—who would benefit from decision-making aids and the authority to request more resources for flu preparedness within their organisations—thus positioned the utility of the mandated nature of the ECoP, along with the policymakers' (presumed) clout within The Department, as valuable.

Talking to the policymakers backstage also revealed the negotiability of such attempts at assigning roles and responsibilities in the emerging ECoP. While the policymakers' explicit aim was to eventually reduce performance variation in terms of ED efficiency, their intention in creating the ECoP had been to facilitate knowledge flows between organisations which performed well on the NEAT KPI and those who performed poorly. Neil had not anticipated being drawn into the knowledge mobilisation process, nor that comparison across organisations might reveal *clinical* processes to be cause for concern. As he put it to me in a debrief meeting at The Agency: *"We've got to make sure we keep it narrow and about process improvement, not*

clinical stuff." The policymakers refused to perform the role of knowledge broker that the participants hoped they would and I heard of no attempts by them to resolve the flu process problem. Moreover, other instances of clinicians approaching The Agency for help to develop ED guidelines (e.g., for low back pain which was *"all a bit ad hoc… CTs being done unnecessarily, people getting irradiated, lots of money being spent…" (participant 1, novice hybrid doctor)*) were also met with disinterest from the policymakers. Ultimately, a clinician took a sabbatical to complete the low back pain task himself.

4.3.1.2 Positioning oneself and one's organisation in the field

The work of differentiating also enabled participants to position themselves and/or their organisations relative to others with regard to variation in process improvement capability (which the policymakers *did* want to address). My fieldnotes capture an exchange during the second workshop between an improvement advisor from a suburban hospital with a relatively immature improvement program, and Colin from Big Metro.

> <u>Novice improvement advisor:</u> *So I just wanted to ask… we've started our Daily Operating System as a tier one huddle in the last couple of months but it keeps falling down… so I'm wondering how you've managed to sustain engagement with it at Big Metro?*
> <u>Colin:</u> *Uh… (clearly trying not to sound surprised at her misunderstanding the point of a DOS) we need to remember that having a tier one meeting isn't a DOS. That's just a meeting. If there's nowhere for whatever gets raised in that meeting to go, that information is stuck. There's no feedback loop. You won't get engagement because people realise when they're not actually being heard.*

After the workshop at Big Metro, I had stood with Colin as he surveyed the people milling around the sandwiches. He said to Neil and myself: *"Wow. That was really eye-opening. I didn't realise how much farther ahead we are at Big Metro, compared with some of the others."* When I interviewed him later, Colin reflected on the exchange with the advisor above. He told me that, having heard how others in the workshop spoke about process improvement within their organisations, he had come to realise that in his 'Big Metro bubble' they had done a good job of engaging both executives and clinicians. This comparison enabled him to position his organisation within the field as one with relatively mature improvement capability. It was easy for those like him to forget that this was vastly different to many other health services which

struggled with the basics of process improvement, had no real improvement systems in place, and were far from having the right culture to support this kind of work at the frontline. The ECoP's materialising of such differences motivated Colin to make *Big Metro* an *"exemplar of mature practice" (Lave, 1991, p. 72)* so as to help other organisations build their improvement capability.

The comparative data provided to participating health services also helped to facilitate comparison of other organisations' performance with regard to the NEAT KPI. Participants referred to the NEAT league table as *"the racetrack"*. These data acted as a 'boundary object', enabling cross-organisational differentiation. An operations executive from Edgeside said to me that, *"When you've got 11 health services on one page… you can see from a trend point of view how you've been going relative to others." (participant 5, executive sponsor).* He described the data package as *"a very important little piece of information that we carry around,"* as it had a *"competitive nature component to it."* Through their engagement with this differentiating data in The Collaborative the year prior, Edgeside had connected with ideas from better-performing organisations, changed their ED model, *"started to then get some good results"*, and *"reached our [NEAT] target for four hours for the first time in history!"* From an organisation defined by *"absolutely terrible performance at the most basic of measures through now to actually reaching the national benchmark for the 81% for the four hour NEAT performance,"* Edgeside's organisational identity had begun to transform *"from one that was learning to actually one that was teaching."* As such, Edgeside and their star novice improvement advisor, Malcolm, like Colin at Big Metro, identified themselves as having the responsibility to lead others to success. They positioned themselves as core and committed participants of the ECoP at an early stage.

Others' engagement with comparative practices, in contrast, led them to question whether there was value in the ECoP for them. In particular, some 'veteran' improvement advisors from organisations with strong improvement programs questioned how participation in the ECoP would help them in their work of brokering improvement knowledge and engaging their clinicians. One veteran advisor asserted in an interview that *"most of our ED doctors, I don't think they've learned anything [from The Collaborative and ECoP]." (participant 10, veteran improvement advisor)*. Her veteran colleague supposed that this was *"because we've [already] taught them and we've kind of got them engaged [here]." (participant 11, veteran improvement advisor).* They thought that comparing methods and practices across organisations might well have served to diminish their hard-won engagement and consistent messaging, saying *"We've*

got systems and processes within our hospital that, when you try to do this [jurisdiction-wide]... there's a potential that we teach something [here] and then they go to this workshop and it's not our methodology. And not that it's wrong, but it's we've spent all this time trying to get them to use ours…" (participant 10, veteran improvement advisor). From these advisors' perspectives, the practice of comparing themselves to others in the ECoP made legible their unique position in the field, and reinforced their inclination to maintain their more mature and privileged status quo.

However, through their comparison practices in the ECoP, others realised that their organisation was missing fundamental pieces of the improvement puzzle. A hybrid ED nurse I spoke to explained how, during the second workshop at Big Metro, he had come to the realisation of just how unsupportive his organisation was of improvement work. Differentiating his own organisational culture from Big Metro's, he said: "*The thing that I loved about Big Metro [was that their] med team all get together in the morning and they have that big meeting…" (participant 8, novice hybrid nurse).* A photo *"of them all sitting around the table…"* had stuck with him as material evidence of a more desirable organisational culture. In this way, participants performed and judged organisational identities on the ECoP stage, leading to comparative reflections and imaginings of possible futures. This hybrid was happy to perform his role as 'novice' learner, imagining how he could contribute to creating an organisational culture like those he saw in the ECoP.

4.3.2 Empathising with others

Making comparisons in the ECoP also created opportunities for some participants to empathise with others, both from other disciplines and other organisations. Late during the first workshop at Edgeside, I witnessed the following:

> *The group of five participants I was huddled with were all from different organisations and disciplines. They were supposed to be (according to the activity Neil was facilitating) comparing their organisational 'improvement readiness scores', but spent most of the time lamenting the challenge of engaging medical clinicians with improvement work. The sentiment was shared by obviously frustrated improvement advisors and hybrid nurses, but also by the senior hybrid doctor who vindicated their complaints, saying: "Consultants are the most recalcitrant people you'll ever meet. I know—I'm one of them!"*

> Exasperated, she said of doctors' resistance to process improvement data and statistical approaches, *"They will say to me, "I do not believe that data." They will say to my face, literally, "I don't believe you.""*

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When participants compared experiences with one another in the ECoP workshops, it often had the effect of mobilising empathy across disciplines and organisations. Venting frustrations invoked relational encounters that helped establish shared understandings and led to supportive gestures. With her firsthand experience of engaging other senior clinicians, even in her privileged position as a senior doctor herself, the hybrid above empathised with others' experiences of medical pushback to process improvement initiatives. A young nurse hybrid reflected on how helpful it was to hear others raise this issue: *"I thought it was just me [thinking doctors are hard to engage]..." (participant 8, novice hybrid nurse).* By sharing her experience, the hybrid doctor had given voice to and validated the other participants' experiences. She had provided an explanation by explicitly pointing to the epistemic culture of medicine as a reason that others, like this young nurse, found that *"barriers [to improvement] come from upper management in medicine."* In these empathic moments, I witnessed shared meanings emerging.

A young hybrid doctor told me that this kind of 'exposure therapy' to other disciplines had ongoing performative effects on cross-disciplinary interactions into the future. He had long sensed a combative stance between improvement advisors and clinicians that was characterised by differentiation: *"I used to think 'them' and 'they' and… no-one ever listens…".* Now, however, he now understood that their goals were the same. He found himself reassuring his colleagues, telling them: *"No, no, no, they're actually really supportive… they're going to be cool about it… we're all on the same team, it's cool." (participant 4, novice hybrid doctor).* Sharing his own positive experiences with other novice hybrid doctors effected a virtuous cycle in which he enhanced their engagement with process improvement, as well as their ability to empathise with the 'other' epistemic community. Paying forward his positive experience had downstream effects—reproducing more effective interdisciplinary relations between future generations of improvement advisors and doctors.

Despite the happy picture this young doctor's experience paints, I also witnessed occasions where the mobilisation of empathy on the front stage of the ECoP reinforced more negative perceptions of and relations with 'others'. One such moment occurred during a small-group activity discussing the value of Daily Operating Systems (DOS), a Lean management approach aimed at enabling problems to be quickly identified and escalated through a 24 hour reporting cycle using standard work, visual controls, and a daily accountability process (Donnelly, 2014). I heard a senior ED doctor talking about the horizontal 'layers' in his organisation. Experience told him that even if DOS provided a way for the frontline to escalate issues or ideas for improvement upward, *"exec"* would simply boomerang the ideas back down with a mandate attached—*"You do it." (participant 1, novice hybrid doctor).* He had little faith that the senior leadership at his organisation was interested in those at the frontline. Everyone in the group had nodded in solidarity of understanding. Talking about this together on the front stage of ECoP workshops substantiated participants' backstage reflections. This seemed to arouse a sense of shared understanding and mutuality, but may also have had the potential to reinforce and reproduce unconstructive relations within organisations.

4.3.3 Competing for resources

Comparative work in the ECoP served to rematerialise existing disparities between organisations too. It highlighted to participants that decision-making by The Agency and The Department about resourcing health services was opaque, and sometimes inequitable and *"unfair"* for particular organisations. Field notes from the co-design workshop prior to the ECoP's launch reveal participants trying to figure out who was in the room and why.

> *Much of the informal interaction in between the formal co-design activities was about trying to figure out where they and their organisation fit within the collaborative architecture that The Agency was attempting to scaffold. When the policymakers mentioned one of the new Collaboratives, for instance, a flurry of whispered questions ensued at my table: "What's that one? Are you in that one? Why aren't we in that one?" Not knowing why they had been included or excluded was clearly a point of intrigue requiring explanation, and rationalisations materialised quickly at participants' tables—"Oh, we must have been the crap ones!" *laughter*—accompanied by more questions—"How come you get to do it and we don't?"*

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This sense of confusion was echoed in many interviews. A veteran improvement advisor shared with me her perception that these unknowns were a real issue for senior clinician engagement with policy-led improvement initiatives. She argued that clinicians *“want that transparency, and they want to see why [other health services] got $100K and we got $10K…” (participant 7, veteran improvement advisor).* However, she maintained that such cohesion would be hard to achieve without transparency from The Agency with regard to which health services were invited into which activities, who was funded, how much, and why. Another improvement advisor reflected on the inequities of resource distribution perpetuated by The Agency, saying to me, *“it's ridiculous how rich organisations are actually able to get these electronic medical records in” (participant 12, veteran improvement advisor)* while her organisation would have to wait years until it had adequate funding to implement an EMR. She felt strongly that such inequities resulted in clinical quality and safety problems, but that the jurisdiction did not recognise these or take them seriously.

Another veteran improvement advisor from one of the largest and most prestigious metropolitan services in the jurisdiction told me emphatically that the funding for involvement in the initial and more recent Collaboratives was inequitable, and particularly unfair for larger health services such as her own, because *“every health service, no matter how many hospitals you have [gets the same funding]. So we have six hospitals. We're about to have seven, and we get funded for one person… it's very different to fund a small health service one EFT… as opposed to funding [us] one EFT. So the funding is not necessarily equitably distributed…” (participant 22, veteran improvement advisor).* Such realisations translated into the perception that the policymakers did not understand—or worse, care—how their funding distribution decisions impacted on the development of organisational improvement capability.

Even the workshop spaces were a physical manifestation of how well-resourced an organisation might have been, as this extract from an interview reveals:

> *Me: So you attended the second workshop?*
> *Hybrid doctor: Big Metro?*
> *Me: Yes.*
> *Hybrid doctor: Nice meeting room.*

Me: *It was… stark contrast between there and Edgeside.*
Hybrid doctor: Yes indeed.

Like Big Metro's mature improvement program, their "*nice meeting room" (participant 30, veteran hybrid doctor)* with its ceiling roses, velvet drapes, and lectern draped in a gold-fringed banner, did not go unnoticed by participants from less prestigious organisations. What might appear a benign observation (after all, what might the quality of furnishings have to do with the 'transfer' of knowledge?) became important through a practice-based lens, as it instantiated reflection, comparison, and positioning within the ECoP field.

These kinds of comparative practices reveal the challenges the policymakers faced in understanding, from their abstracted point of view, the actual needs and expectations of organisations. Because most of these reflections occurred 'backstage', their ability to capture perceptions about their interventions—and the effects of these more proximal to practice within organisations—was limited. As Dr Jason said to me with regard to the resourcing issue: *"It's always in the back of my mind [but] I don't think any of the collaboratives have ever talked about resourcing… we do [in our informal discussions]."* Even when the policymakers did access this insight, however, they struggled to take it on board. During a meeting at The Agency, Neil asked me about the feedback I had received in the early interviews (the opportunity to learn from the 'backstage' insight I was privy to was part of the reason they had granted me access to research the ECoP). Mentioning this sense of inequitable resource distribution and concerns about the lack of transparency, I referred to a conversation with an improvement advisor at a large metropolitan who had told me, *"We put in an expression of interest to be involved in one of the Collaboratives but we have no idea why we didn't make it in."* To this, Neil's manager Martina responded: *"Quite honestly, it's about moving the numbers. So it might have been that their ED is unlikely to move the statewide NEAT average because they already do well. But yeah… we don't tell the health services that."* Neil's response was defensive. He felt that the 'big metros' like this one were greedy: *"If they can afford whole improvement teams, we don't need to be giving them any more money."*

Evidently, the proximity of participants to one another in the ECoP invoked varied and widespread practices of comparison. They sparked simultaneous identification and differentiation practices, with both positively valenced knowledge mobilisation effects (e.g.,

empathy and care), but also had the potential for negatively valenced consequences (e.g., competition and distancing).

4.4 Noticing the nexus

This final practice assemblage reveals how participation in the formation of the mandated ECoP (re)materialised existing forms of belonging. It foregrounded one's 'nexus of multi-membership' of *"other tangential and overlapping communities of practice"* (Lave & Wenger, 1991, p. 98) that existed prior to and contemporaneously with the new mandated 'community'. This assemblage sheds light on how participants compared the value of their existing forms of belonging (or lack thereof) to the perceived potential value of belonging to the ECoP. Such value judgements rarely revolved around 'transferring' knowledge, but, rather, centred on the benefits of mutual support, political influence, and the ease and spontaneity that came from well-worn communication channels based on shared understanding, histories, and trust.

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My field notes from the fourth and final ECoP workshop in 2018 show how participants' performed their existing forms of belonging through talk on the front stage:

> *At the end of the day, the ECoP participants gathered around a whiteboard for a brief 'co-design' session (Neil had only been given a half hour slot on the agenda by the hosts at Outerside). The aim was to figure out what the participants wanted the ECoP to look like next year (assuming the policy sponsors decided to keep funding it). Dr Jason took the opportunity to question the value of the ECoP, saying to the policymakers,* "When it comes to collaboration, the collaboration [of the ECoP] is very good, of course, but we have to recognise that there is already plenty of offline collaboration." *He told the policymakers:* "We [the ED directors] go out to dinner and I know the ED NUMs catch up too… we already have a Whatsapp group, the ED NUMs have a Whatsapp group… in ED we collaborate a lot already."

4.4.1 Mutual support among peers

Dr Jason's point was that the policymakers' assumptions about the value that the ECoP brought to the sector—the facility to mobilise knowledge across organisations—neglected to take account of the 'organic' backstage knowledge mobilisation mechanisms already in place in the jurisdiction. Reflecting on his front stage statement later in an interview, Dr Jason revealed that they had started their tradition of biannual ED director dinners as a result of the ED directors realising that they all had *"similar challenges, similar frustrations…"*. He said that *"collaboration naturally occurs"* in the context of shared struggles, and so their organic CoP had emerged *"well and truly before any [formal collaboratives]."* In other words, the policymakers were late to the party.

Similarly, the ED NUMs had developed an informal group over the years. This had also emerged organically through the recognition of their shared struggles as pressures on EDs had changed and increased over time, and as they came to realise that they could address the variation in experience by coming together. As a NUM said to me, *"There's a wide range of ED NUMs, you know you've got [X] from Big Metro, who's been doing that for 20 years, some that have been doing it for a year… so everyone went, "Okay as ED NUMs let's get together"..." (participant 16, veteran hybrid nurse).* A highly influential ED NUM had then led the development of a more structured network, which continues today in the form of regular email communications and occasional face to face meetings, *"study days",* and Christmas celebrations.

'Veteran' improvement advisors also very often reflected on their existing support network during interviews, again highlighting their shared histories and struggles. The Department—to whom they officially 'belonged' despite being embedded in organisations—had initially created and paid for many of their roles. However, many had struggled with little organisational support, especially in the early years of the jurisdiction's improvement program. Then, during the program's transition from The Department to The Agency (2016), they became marooned out in health services with little policy support too. Attempts by The Department and Agency to formalise and regularise communications between the improvement advisors ebbed and flowed; the political preference for more or less control over the group of advisors changed with each successive (and regular) reorganisation at the policy level. Moreover, veteran improvement advisors were also very likely to have worked across a number of health services, due to the

precarious nature of improvement work which was characterised by short-term project-based contracts. Organisational support for improvement varied as CEOs came and went, and as resources were won, lost, or redistributed. The advisors could neither rely on central support from the policymakers, nor on organisational support. Their roles remained precarious and peripheral.

However, during their time out in the early days of improvement in health services, the veteran advisors had sought support informally among themselves, such that their 'home' became the other improvement people in the jurisdiction. A handful who had been in their organisations long enough had also managed to grow internal improvement teams and no longer felt like lone wolves. All of this meant that The Agency's renewed attempts to centralise 'ownership' and control over the improvement advisors and their practice were met with consternation. A veteran advisor said to me: *"It's gone from having no interest three years ago and no direction and support to almost, the pendulum [has] swung way too far. Way, way too far." (participant 10, veteran improvement advisor).* The Agency's historically inconsistent support underscored for this cohort the importance of their organic community of advisors, especially at a time when they were feeling *"micromanaged"* by the policymakers on whom they were loath to rely for support.

In contrast to the veteran advisors, veteran hybrid nurses and veteran hybrid doctors—for whom participation in the ECoP made visible to participants their existing networks of mutual support—novice improvement advisors and novice hybrid nurses and doctors rarely mentioned existing cross-organisational networks. With regard to process improvement issues, they relied on the improvement structures and cultures within their organisations, which varied significantly, and on self-education to learn more about process improvement. With regard to process improvement, 'novice' hybrid clinicians were clearly still looking for their 'tribe'.

Advisors who had come into the jurisdiction's healthcare system from other industries reflected that they tended to reach back outside into the worlds they had come from to both get and give support with regard to improvement: *"Yeah [I don't network] within health so much but yeah definitely the [Regional] Quality Council." (participant 18, veteran improvement advisor).* Unlike for the veterans, reflecting on the potential to belong to the ECoP made more apparent the novices' lack of community with regard to improvement.

4.4.2 Existing influence in the sector

Beyond mobilising support with regard to process improvement, existing 'organic' CoPs—or the lack thereof—also highlighted the importance of belonging to a community for the collective influence this could help to generate. Dr Jason explained that their bi-annual doctor dinners were more than a support-giving and knowledge-sharing mechanism. They were also a space in which these senior doctors actively sought to garner high level political influence. The veteran ED doctors already held a position of relative power in the jurisdiction, and their requests for resources were taken seriously, since ED overflows make for sensational but politically undesirable headlines. As Dr Jason told me:

> *We've actually had the Minister of Health come up to our meetings… in a restaurant… dinner… we've had the Minister of Health three times, we've had the Secretary of Health… A lot of what we try and do is actually bring people together to talk.*

In contrast, novices who did not know where they 'fit' in the improvement community lacked a sense of belonging and were unable to establish how they could influence the improvement agenda. They appeared as 'lonely' figures, passionate about improving the system they worked in, but relegated to thinking through such matters in their own heads. In an email responding to my invitation to interview, a novice improvement advisor introduced his unsolicited e-rant about the problems in the jurisdiction with: *"Your research topic is something I think about on the way home from work each night… [rant ensues]..." (participant 6, novice improvement advisor)*.

A novice nurse hybrid explained that, despite feeling that his voice was somewhat *"louder"* now—he had moved from a purely clinical into a hybrid nursing/administrative position—he still felt he had little influence in his organisation: *"If there is anything in the hospital where it's a big meeting for change, I don't know about it." (participant 8, novice hybrid nurse).* Similarly, a novice hybrid doctor told me that he often felt like a one-man-band in relation to process improvement, always pushing uphill through endless organisational layers, without peers with whom he could discuss and mobilise this knowledge into practice. Upon receiving my email invitation to participate in an interview, he immediately phoned and spent fifteen minutes talking excitedly about how fantastic it was to find that there were *"other people out there interested in making things better" (participant 1, novice hybrid doctor)*. He was keen to talk to me about the prospects for the ECoP, but also his own improvement career. When I first met him, prior to the

first ECoP workshop (his interview lasting two hours!), he told me he was excited by the idea that he would meet like minded people at the ECoP, and finally be able to make the changes he wanted to.

4.4.3 Frequency & spontaneity of peer relations

As Dr Jason said to the policymakers on the 'front stage', the ED directors and NUMS *"collaborate a lot already."* An ED nurse corroborated the frequency and spontaneity with which she could engage with those in the existing community of NUMs, telling me: *"We meet once a year and have a Christmas dinner and they have guest speakers and whatnot. [And] if I suddenly go, 'I need to know what other hospitals use as ratios for short stay,' all I have to do is send a global email to all the ED NUMs and they get back [to me]..." (participant 16, veteran hybrid nurse).*

Likewise, veteran improvement advisors reported that they could *"routinely pick up the phone and speak to other health services [and say], 'Have you got any ideas, what are you doing around managing your increased demand or your increased presentations?'".* They reflected that *"there are always those opportunities to share information informally… the sector is pretty small... so I know my counterparts at [Big Metro, Edgeside and so on]." (participant 13, veteran improvement advisor).*

Participants clearly valued the spontaneity and informality of 'organic' CoPs. Colin, the novice advisor from Big Metro, surmised that over-regulating and over-formalising collaboration had the potential to *"really stuff up"* knowledge mobilisation across the sector, by intervening in what was very often spontaneous, informal and frequent activity: *"We also need to be careful… there potentially is an underground, a black market of information that's happening that we can't see. We often talk about unintended consequences… what would we lose?"*

Clearly, the 'mandated' ECoP intersected with 'organic' CoPs as participants reflected on their existing nexus of multi-membership and made sense of the value they thought participating in the ECoP could bring them and their organisations. These sensemaking practices begin to make apparent that participants from different disciplinary communities engaged in *(per)forming the ECoP* in different ways.

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This chapter has revealed three practice assemblages which, while comprising apparently mundane actions, interactions, and reflections, paint a picture of the continuously negotiated and socially constructed processual ‘reality’ of the ECoP. Through the practice-based approach, we have seen how activities and claims on the ‘front stage’, alongside ‘backstage’ reflective sensemaking work, were performative and mutually constitutive. As participants engaged in the ECoP activities, they reflected on the value of these, and of interacting with the ‘others’ in the room. This continuously shaped their perceptions and participation.

We have met a number of key actors in the ECoP and seen how the key policymakers, Neil and his manager Martina, set the stage for what was purported to be voluntary engagement with the ECoP, but in reality a strong expectation which many perceived as a mandate. We have met Dr Jason, the outspoken ED director from Edgeside who was not afraid to put forward hybrid doctors’ high pressure/high privilege reality on the front stage. Colin and Malcolm, highly engaged novice improvement advisors from Big Metro and Edgeside respectively, have given us insight into their enthusiasm to share their knowledge and learn from others.

All of this has helped to show how the ECoP was *(per)formed* by all of its participants, not simply ‘formed’ through a policy mandate and label. In the next chapter I dive deeper into participants’ knowledge translation practices, and how these influenced the ongoing formation of the ECoP.

Table 4.1: Supporting data—(Per)forming the ECoP

(Per)forming the ECoP ECoP as a processual dialectical ‘reality’ rather than reified form.		
Themes	**Sub-themes**	**Data**
<u>Making a space of potentiality</u> How participants	<u>Sanctioned time</u> For ‘willing hybrids’, mandated collaborative network offers	*I had to leave [the ECoP workshop] early because I had clinical commitments.... [it’s] always difficult for clinical managers to get large bodies of time... (participant 30, veteran hybrid doctor)*

create the context for their learning through reflection, action, interaction	micro-emancipation from day to day pressures and organisational constraints.	*The problem is, I lead by example… if there is a shortage of staff on night shift I will do a night shift… They know that my door is always open… [if they say] 'I can't get this cannula,' I go out and do that. I'm visible… [if] they say 'I need to leave early', I say 'Go… I'll cover you'. (participant 16, veteran hybrid nurse)*
	<u>Decoupling</u> Cognitive emancipation from everyday work pressures and selves enables 'zooming out' on bigger system issues.	*Getting [doctors] buoyed and talking about what we can do and seeing things from different points of view is really really valuable. (participant 24, novice improvement advisor)* *I need it because I get so busy in the day to day running of the hospital. (participant 23, veteran improvement advisor)*
	<u>Relational potentiality</u> Suspension of usual configurations of actors makes space for new serendipitous and contrived relations—with potentially durable relational implications beyond ECoP.	Hybrid nurse: *Did you notice how we were sitting clearly away from [the improvement people from our hospital]?* Me: *I didn't.* Hybrid nurse: *So they were on the other side of the room… I didn't know who they were [but]... I'd definitely go and sit with them now… there's that segregation [within our organisation] again. We don't know one another because… there's no [intra-organisational] environment for us to get to know one another. There is now [thanks to ECoP].* *(participant 8, novice hybrid nurse)* *First [the ECoP helped the] local community in [my] hospital… And I think it opened it up to [our] ED pharmacists, or physios, or any allied staff... Everyone was there… And then it was that bigger picture community for serving the state…" (participant 27, veteran hybrid nurse)*
<u>Comparing</u> Comparison as a relational mechanism of knowledge mobilisation	<u>Positioning</u> Negotiating roles and responsibilities within the ECoP; Comparing similarities/ differences in organisational or individual improvement capability 'maturity' results in varied interpretations of value of participation in the	When problems were raised on the 'front stage' about the interface between ambulance and health services, participants positioned the policymakers as responsible for engaging the ambulance organisation: *"Maybe this is a way for The Agency to help us with working out the whole patient journey beyond health services? Maybe there's a place for the ambulance association in the ECoP?" (participant 24, novice improvement advisor)* Participants hesitant to expose *"embarrassing"* lack of organisational improvement capability: "*I wasn't really looking forward to today because after everything I've told you about [my prestigious hospital]... I'm like 'I haven't even got the basics right yet how can I talk about [sustaining improvement]!'"* *(participant 23, veteran improvement advisor)*

	ECoP.	*I think particularly in an emergency department, you're often told "You're doing it wrong, you're doing it badly, people are unhappy." And I guess for me that's probably the biggest thing I took out of that particular session was that we all have struggles. (participant 26, novice hybrid nurse)*
	<u>Caring</u> Empathy as a mechanism underpinning knowledge mobilisation through trust and empathy—within and across epistemic communities.	Curated, digestible performance data invokes empathy: *"[The racetrack diagram] kind of shows you how you're going… I look at it and I go, 'Awwww, what happened to them?' And I go 'Oh Colin, what happened? You were doing really well and now you're doing really bad!!!'… The Collaborative has given me those relationships where you see the data and you either cheer for them and wanna know what they've done... 'Come on, gimme gimme'... or you go, 'Oh my gosh I feel so sorry for you.' Because we've all been up, and we've all been down… you'll be like, 'Hey… notice you've picked up here, what have you done? What are you doin'?'. So it's kind of giving you, gives you that transparency over who's doing really good things."* *(participant 23, veteran improvement advisor)* *You take people out of their little silo, their context, and you put them in a room full of other people who are in the same situation, and it's pretty powerful, I think, what happens. You realise, "Hey, la la la, we've got the same issues." (participant 21, novice improvement advisor)*
	<u>Competing</u> Comparing enables detection of inequities in resource distribution in the system; reinforces sense of top-down policy control.	*I think we need to stop the competitiveness... if the health department wants to implement something… implement it across the state. It's ridiculous how rich organisations are actually able to get these electronic medical records in… from a state level, I think we're quite disjointed. (participant 12, veteran improvement advisor)* On the front stage of the first workshop at Edgeside, the NUM of ED at a small outer-suburban hospital argued that 'best practice' flu-testing procedures was impossible due to lack of access to testing resources outside of metropolitan areas: *"We have to recognise that [best practice] just isn't possible for all of us. Most EDs don't even have access to [that blood test]."*
<u>Noticing the nexus</u> How existing 'organic' CoPs interrelate with	<u>Mutual support</u> Experience of existing 'organic' community support varies. Veteran hybrid doctors, nurses and improvement	On existing support: *"And one of the other things that we've started doing is that the equivalent of these roles at health services, these [senior operational] type roles, there is a small group coming together now… something initiated by us to share some ideas… So that's something that's gained a little bit of momentum. So we'll see where that all goes. Now again, that's not to say that there isn't a role for the [ECoP], I'm mindful of*

instrumental collabora-tive initiative	advisors have strong existing CoPs; novice doctors, nurses and improvement advisors 'alienated' from engaging collaboratively in improvement.	*that. But it's just these things that have also evolved and have found their feet as well…" (participant 5, executive sponsor)* On lack of community: *"We were going to schedule some more meetings [about an ED improvement project] and then they just kind of fell [away]…" (participant 1, novice hybrid doctor)*
	<u>Existing influence</u> Belonging to particular 'organic' communities bestows varied levels of influence in the broader field of improvement.	*I try and drag as many of our [doctors] along to [the ECoP] because… they're the ones… who if they really want to they can effect change, today. They get to go out and tell their peers "Alright we'll just do something different," and we can pretend like the hospital can tell them not to and we've got standard ways of working but, if [a doctor] goes out onto the floor in our emergency department right now, and tells the consultants, tells the doctors "We're doing this now," it will happen now. Right now. (participant 24, novice improvement advisor)* *What's a [frontline nurse] going to get out of this, unless they have that… upward influence… [so] I think it's really imperative you have [unit] leaders going [to the ECoP]. (participant 12, veteran improvement advisor)*
	<u>Frequency & spontaneity</u> Value in the 'random', difficult to capture 'black market' of knowledge mobilisation occurring already through 'organic' communities—potential for over-regulation and control to 'stuff things up'.	*I actually speak regularly with the advisor from [other health service], we have sort of a fortnightly just half hour phone chat… sometimes the conversations I want to have with [colleagues in other health services] are very different from the ones that I would want to [have front stage]. Very different… much more specific… not just this general, "Who's got a form for [X,Y or Z]..." (participant 10, veteran improvement advisor)* *[Improvement colleague at another hospital] heard something about our capability strategy, picked up the phone to me and said, "Can we come out and have a chat?" That's what a Community of Practice looks like. That [he] feels comfortable that he can just call me… "Can we come and have a coffee or something?" That's a Community of Practice, not [formal things like the ECoP]. (participant 24, novice improvement advisor)*

Chapter 5: Tensions in Translation

"Instead of transmission *of the same token—simply deflected or slowed down by friction—you get… the continuous* transformation *of the token"*
(Latour, 1986, p. 268 emphasis in original)

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With the findings in this chapter, I seek to address the second research question: *How do key actors from different epistemic communities (improvement advisors and hybrid doctors and nurses, the 'targets' of improvement knowledge in the ECoP) negotiate and translate process improvement knowledge?* Analysing the data through the practice-based lens described in Chapter 2, and specifically sensitised by Knorr Cetina's epistemic cultures concept, I reveal an ongoing 'collective conversation' (Knorr Cetina, 1999, p. 178) between participants. This is characterised by various tensions. Through this ongoing dialogue, different epistemic communities negotiate and translate the meaning of the process improvement knowledge targeted for mobilisation in different ways. The findings in this chapter reveal unexpected and potentially transformative effects for the enterprise of process improvement in healthcare, and for healthcare more broadly.

I explore the *tensions in translation* in this chapter through two themes. *Problems of proximity* highlights a significant epistemic divide that emerged between the improvement advisors and policymakers. *Tweaks to transformation* reveals how participants mobilised different translations of process improvement knowledge on the front stage of the ECoP—in ways that effected radical conceptualisations of health'care' and with potentially 'ontology-breaking' effects (Knorr Cetina, 1999, p. 192). I begin each section with a fragment of observational data, and build the thematic narrative with participants' responses to the front stage incident, related observational data, and more general backstage reflections of participants.

5.1 Problems of proximity

My field notes from the first and last ECoP workshop at Edgeside reveal undercurrents of epistemic troubles that improvement advisors and hybrids faced in the mobilisation of improvement knowledge:

> *Malcolm was an enthusiastic 'novice' improvement advisor, new to the jurisdiction's health sector but with postgraduate business qualifications and process improvement experience. At Neil's request, he had volunteered to host the first workshop. He had no clinical background but was considered a 'rising star' advisor according to Neil and Martina at The Agency. In an entertaining Powerpoint presentation, Malcolm explained how he had applied the Project Assessment Tool (which Neil wanted to promote to the ECoP participants) to retrospectively score four of Edgeside's recent patient flow initiatives. He had asked five staff to rate the success of each initiative and his slides displayed the results of his self-titled survey creation: "A Very Scientific Survey of Perceived Project Success (n=5 respondents)". Two of the projects were "Huge Hits" on his tongue-in-cheek success spectrum; two scored closer to "Total Flop". Careful to ensure his performance included 'science speak', he proudly reported: "I found a perfect correlation between the Project Assessment Tool scores and n=5 peoples' perceptions of the success of each of the initiatives! So, the analysis, with an R^2 of 0.9964, kind of validates the assessment tool."*
>
> *Following his performance, the two hybrid doctors representing Edgeside at the workshop felt compelled to respond aloud. Dr Jason the ED medical director spoke first. Despite his own improvement initiative scoring as a "Huge Hit!" and despite its substantial impact on Edgeside's performance on the NEAT KPI, he publicly critiqued Malcolm's quantification. Moreover, he called into question its relevance, since Malcolm's scale measured the 'wrong' thing—performance against management and policy measures, rather than clinical quality ideals.*

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5.1.1 Performance vs. Practice

Hybrid doctors and nurses were seen by the policymakers as the key 'targets' of improvement knowledge in the ECoP, as they were believed to be best positioned to spread process improvement among the clinical rank and file within their organisations. However, the epistemic 'problem of proximity' between clinical and improvement communities emerged as a fault line between actual clinical practice and (necessarily) aggregated, abstracted, and practice-distant performance measures and management rhetoric. Backstage of the ECoP, Dr Jason referred to the front stage negotiation above, saying: *"I don't know if you were there when we were talking about our ED model of care, but I still have this debate with Malcolm, who is our process person, to say, "We did this without any Lean." And he goes, "Well, you did [Lean]." And I go, "No, we didn't."* Dr Jason had no interest in how well his project conformed to management change models, and never mentioned the extraordinary improvement on the NEAT KPI that his *"Huge Hit"* project had precipitated.

Dr Jason described clinicians' experiences of the performance/practice tension, referencing the internal struggles that clinicians faced when asked to engage with process improvement focused on efficiency, as well as performance measures such as the NEAT KPI. While he himself was a 'willing hybrid', highly engaged in improvement work in his ED and a regular ECoP attendee, he said: *"I think clinical communities, clinicians… there's always this inherent debate that [clinicians] have about, you know, "I'm not a processing factory, I'm dealing with patients, so don't tell me about waste, don't tell me about how to optimise [processes]."* Further, he explained the widespread perception among doctors that it was up to the improvement advisors and administrators of hospitals—*"to fix X, Y and Z [so] I can do my job".* This indicated a perceived separation between autonomous professionals and the system, and the ideal that 'the system' should act as a supportive but unobtrusive background.

When I saw Dr Jason finally present the details of his Huge Hit model of care, six months later in the final workshop, his emphasis was on the organic nature of the change and on how he had given his staff the freedom to iterate and make changes autonomously: *"They did all this themselves because we gave them the freedom."* Dr Jason made plain that medical clinicians did not receive authoritarian mandates for change well, especially when they came from those who were not professionally proximal enough to healthcare practice. He explained that the frustrations between clinicians and improvement people around change processes could be in

part explained by *“the pace of change… change in healthcare occurs very, very slowly. So what [is]… so bloody obvious from a Lean person’s [perspective]… [well they] get frustrated because change is not occurring at the pace [they] want it. And then it becomes more authoritative—‘Well, you need to do this change. That's when clinicians lose their engagement.”*

The widespread perception of process improvement methodologies, even among ‘willing’ hybrid doctors, was of an impatient ideology and command and control tools which aimed to secure control over professionals through identification with and commitment to ‘foreign’ managerial discourses. Other senior hybrid doctors also reflected on the pace and pressure on them from improvement advisors and policymakers trying to engage them with process improvement:

> *I certainly don't have the capacity to have constantly [asked of me], "What are you going to do now that's new?" I don't have that in me because I have plenty of other aspects to my role that are very important and I can't... it's just too much. I like what we developed. I want to continue to work at it. I'm very interested in what other hospitals are doing… [but] I can't be constantly presented with new new new project to do. (participant 15, veteran hybrid doctor)*

A further contributor to the performance/practice problem was that clinicians were wary of the aggregated performance data (e.g., ED wait times, average lengths of stay) that were the primary tool at the disposal of the improvement advisors’ epistemic community. These data were important in terms of evidencing advisors’ own performance to policymakers and their organisations, for learning from their peers, and in trying to engage clinicians. The advisors highly valued curated comparative performance data (e.g., the *“racetrack diagram”* of NEAT performance). Not only did it help them to position themselves in the field—as revealed in *‘Positioning’* of the previous chapter—but this kind of objectified evidence of performance variation made it possible to ‘sleuth out’ who they should be learning from. Before the first workshop at Edgeside kicked off, I saw this in action. I observed improvement advisors huddled around the racetrack chart, following the wiggly coloured lines to determine who the steep improvements belonged to so that they could probe the right advisors and figure out the improvement practices they would do well to *“copy”*.

Moreover, improvement advisors also saw granular data on the performance of the various processes contributing to the NEAT KPI as helpful to home-in on particular clinical units in their

hospitals, where targeted improvement work might help to shift overall organisational performance measures. This also appealed to some NUMs. A NUM at Edgeside explained to me that granular data at the level of individual wards and clinicians was useful for exposing variation. She said that she thought her organisation should *"list people… We [already] track [doctors'] performance around discharge and length of stay and discharges before 10 o'clock, that's the indicator [improvement advisors] like to use a lot… So that's where you could start… if you put up all the data… you can map it out and you go, 'Okay. [Dr X], when she works on all these wards, it varies because of the different cohorts, but when she gets here, she is consistently better on this ward regardless. And everyone is consistently better on this ward. So unpack some of that…'" (participant 14, veteran hybrid nurse).*

In this way, improvement advisors and NUMs tried to use abstracted, quantified performance data to lead them closer to the actual practices behind good performance. This desire for data appeared to stem from a belief that transparent, individualised representations of clinicians' practice—represented as abstracted performance data—had the potential to change practice and behaviour, particularly that of the hard to engage frontline senior clinicians. However, sleuthing the practices behind the quantified performance measures always meant crossing over into the territory of frontline disciplines and getting buy-in from clinicians. The NUM quoted above told me that, despite her ardent campaigning, doctors had resisted the idea. Thus, she said: *"We actually never get in the room together and talk about [performance data]."*

An ex-NUM turned improvement advisor had enjoyed greater success, having managed to implement comparative data for both nurses and doctors in the ED at a health service she had previously worked at. This had reportedly led to their ED transitioning *"from the worst performing ED to the best performing"* in the jurisdiction in terms of the NEAT. However, the granular transparency at the practitioner level had not been without issue:

> Veteran improvement advisor (participant 12): *[I would] send it out [in an email]… "Please find below where you're sitting compared to other staff. The KPI is this. Some staff find it helpful in their practice, please feel free to come and speak to me."*
> Me: *And did they come and speak to you?*
> Veteran improvement advisor: *No, they improved their performance. They said, "Holy sh*t I'm there, look where everyone else is."... There's obviously some natural attrition that occurred…*

This improvement advisor had not been concerned by the *“natural attrition”*. If clinicians left, they were not the right fit for the improvement culture that organisations ought to be striving to create. She believed that, unlike at her current health service, organisations needed to set clear performance expectations of their doctors. She said: *“there needs to be a tighter rein put on that [senior medical] group… and say [to them]… ‘This is where you should be sitting [in terms of performance]. Why are you doing this operation? This is your length of stay when the same person is doing the same operation and they’re much shorter.’”* An improvement advisor from another hospital also reflected on the problem of *“medical accountability”*, saying *“that’s not something I’m shy in discussing… data and holding people to account, you know. So if you knew that Joe Blow was [the doctor] on last night and you only had two [discharges this morning]... you know…”* She also, however, had reservations about the finger-pointing approach: *“Do we have to get to that? … Name and shame people… does that work? Not sure.” (participant 9, veteran improvement advisor).*

These kinds of discussions, which tended to occur backstage as people reflected to me in interviews, suggested that one pathway to improvement was to influence clinician behaviour by translating more of their practices into more and more granular data—data that could get those charged with leading improvement (but experience-distant from the frontline) closer to the actual practices of individual (experience-near) clinicians. Yet even while the improvement advisors and NUMs advocated for greater use of comparative data, they realised that data were not sufficient. They also realised that success in engaging clinicians involved much more than providing ‘hard’ data and logical reasoning, and expecting rational behaviour changes in response. Most who advocated for more data also recognised the tension that abstracting practice upwards into performance measures produced; translating performance back down in a way that motivated concrete practice changes at the frontline was not so simple.

5.1.2 Efficiency vs. Quality

At the final workshop at Outerside, Dr Jason brought the efficiency vs. quality issue (that he had pointed to in Malcolm’s ‘Very Scientific’ presentation) squarely back onto the front stage. Neil’s short co-design session at this last workshop aimed to gather feedback on how the participants wanted the ECoP to continue the following year—if the policy sponsors were indeed to fund its continuation. During this session, Dr Jason reiterated that the use of proxy measurements

focused on efficiency and time was a serious problem in the policymakers' and improvement advisors' approach to improvement:

> *We need to bring quality into this… how do we know that our surrogate measures about time are working? When we're looking at the timing of care for [hip fractures] or getting analgesia in time, or time to antibiotics, how do we know what is working? We do have some quality measures in aggregate, but they're not reportable. BUT that doesn't mean we shouldn't look at them. We need to think about what it means when we aren't actually looking at quality measures and we're just looking at time as a surrogate for quality.*

In interviews with hybrid doctors, not a single individual mentioned the need for more performance data. Instead, they all prioritised an explicit rhetorical commitment to healthcare quality. When Dr Jason had presented his new ED model of care in the final workshop, he had emphasised qualitative improvements in day-to-day work—from his clinicians' perspectives. He said that he knew they had achieved improvements not because of any effect on the *"racetrack"*, but because "*it made my clinicians' work lives better from day dot".* This quality-over-efficiency theme was evident in all of my backstage discussions with hybrid doctors.

Dr Jason's front stage claim in the Outerside workshop suggested to the policymakers that the time for such a limited view of process improvement as efficiency improvement had passed. Talking with me about Dr Jason's statement a few weeks later, the director of ED at Outerside corroborated his view, suggesting that efficiency-based performance measures were too narrow and reductive, and that it was time to move on to more nuanced measures that could tell them about clinical care quality:

> *I think that NEAT and access performance is probably, it was a hot topic two or three years ago. I think we've probably evolved a little bit… we know that access is a good... sort of a good proportion of quality and safety for patients, but really spreading that scope and saying, "Okay, yes, it's in there, but what else can we do to really proactively solve quality issues?" I think that that's going to be the future… (participant 31, veteran hybrid doctor)*

Albeit late in the game for the ECoP, Dr Jason's front stage proposal to reframe matters of measurement was suggestive of new ways for the policymakers and improvement advisors to

approach process improvement in the jurisdiction. This was particularly the case if they wanted to achieve their aim of more widespread clinical, and especially medical, engagement. As a senior hybrid doctor from a large suburban hospital summarised: *"From a values point of view, the one thing that clinicians engage with tends to be things that relate to quality and safety. Not necessarily efficiency." (participant 30, veteran hybrid doctor)*

In advocating for quality to be privileged over efficiency, the hybrid doctors also argued that oversight ought to be maintained not by practice-distant non-clinical managers, but by people with *"at least some clinical background [who understand] the health or the biological ramifications of what we're doing and what the results of delays or time changes can have for a patient. That's really important."* Ideally, as the ED director at Outerside said, this would be medical oversight:

> *I think it's very easy for people to sit in an office and say "everything's fine" [but] I'm a strong believer that any decision that we make for a healthcare system needs to be focused around the patient, it needs to be focused around the quality of care that they receive. If you're making a system go faster, which is to the detriment of quality of care for a patient then that's wrong, and sometimes that can be very difficult for a manager to detect. Does it need to be a specialist emergency doctor? Ideally, because this is what we specialise in and this is what we understand and we get the nuances of it. (participant 30, veteran hybrid doctor)*

Dr Jason also reiterated to me the imperative that, *"You've got the right people, who can actually understand both… I think when you've got process improvement people who come from a predominantly non-clinical background, I think it brings a lot of value, but you need to get the right people to understand what the challenges are within health."* The hybrid doctors claimed epistemic jurisdiction over the 'detection' and judgement of quality. They once again justified this by their proximity to the actual practice and the all-important recipient of care.

5.1.3 Merging: Efficiency & Quality

The improvement advisors (many with clinical backgrounds themselves) were certainly not adverse to discussions of quality. However, the notion was difficult to account for within their abstract management language and difficult to measure with the blunt tools of process

improvement methodologies that they were trained in, which often centred around the measurement of pace and flow. Moreover, the policy pressures on the advisors—and organisational pressures on the data-desiring NUMs—related to time-based measures of access and patient flow. They recognised the tension between quality and efficiency rhetorics, but were somewhat caught in the middle.

Bubbling away in the background, however, were glimpses of improvement advisors—novices in particular—grappling with this issue and attempting to reframe the quality/efficiency divide as a false dichotomy, in order to merge the two perspectives, achieve broader clinician engagement, and, as Malcolm from Edgeside suggested, all *“start to try and speak the same language.”* Backstage of the ECoP, Malcolm was searching for something to bridge the faultline between efficiency and quality. Despite having taken Edgeside’s horrible performance on over-24-hour ED ‘breaches’ from over 300 per month two years ago to zero today using process improvement, Malcolm reflected that he had been unable to persuade clinicians that *“these methods can improve quality and their outcomes, not just productivity and flow and wait times…”* He was certain that *“these tools absolutely can help improve quality and outcomes, we just haven't got enough runs on the board yet, I think, to convince clinicians that that's the case. Maybe we have… but we haven't advertised it enough.”*

Malcolm and others recognised the epistemic boundary at play and surmised that overcoming it would require changing how they marketed ‘non-native’ knowledge. Colin, the novice advisor from Big Metro, also came to this understanding midway through one of our interviews. As he reflected on the challenges of engaging clinicians with process improvement, he landed on the problem that while the link between efficiency and quality outcomes was crystal clear to him, advisors and policymakers may never have made the connection for clinicians. He realised that they had never made clinicians aware that the NEAT KPI was actually, from his point of view, *“a clinical measure”.*

> *They don't understand that 81% was because that's where your standardised mortality bottoms out on your graph… I don't think we've done a good job of [explaining] it. I don't think the Department [of Health] has done a good job of it. On reflection I don't think we've really explained why we actually even want to [improve our NEAT performance]...*

Similarly, Malcolm recognised that part of the reason Edgeside's great leaps in performance on the government's mandated KPIs were of little *"advertising"* value to clinicians was that *"[that's] a process thing, that's an access thing and I don't think clinicians deep down care as much about access as they do reducing infections and falls and things like that. I don't think we have yet, in the medical literature, published successful safety improvement initiatives using these approaches. Using the language of improvement science."*

The solution, then, was to begin to apply process improvement tools in ways that 'proved' that they could be used to advance clinical quality outcomes. Malcolm was an early mover in this regard: *"We're starting to do that [at Edgeside], with the [Value Based Healthcare project] looking at hospital-acquired complications. That's the first real foray into quality improvement using this lens."* Value Based Healthcare (VBHC) was coined by Harvard Business School management guru Professor Michael Porter around 2005. It appeared to be of growing interest but was not yet a priority for policymakers. In the VBHC perspective, care costs are calculated at a granular level to disincentivise poor-quality care (such as that which results in hospital acquired complications), and incentivise high-quality care. Malcolm's focus on reducing hospital-acquired complications was, in Lean parlance, still about reducing *waste* in the system. However, this approach focused on reducing *harm* first and foremost, rather than increasing pace and using efficiency as a proxy for quality. Malcolm could therefore still improve efficiency (having always been *"sort of limited to my job description, which was patient flow stuff"*), but via the route of improving care quality, which would hopefully engage clinicians. Going outside of his role scope was, as he said, *"kind of sneaky"*, and he had craftily *"used the excuse of, 'Complications increase length of stay. Let's try and reduce complications to reduce length of stay.'"*

VBHC, while never mentioned on the front stage in ECoP workshops, appeared to spread organically 'backstage' in the jurisdiction. Colin told me that, as a result of a random background conversation about VBHC with Malcolm at the Big Metro Workshop, *"Our approach to [improvement] was very, very different to what it will be [in future]… just the entire angle that they're coming from is different and because it's such a different approach we didn't see it. Perhaps we weren't even looking for it. I'm not sure… And [because of that interaction] we will provide better care to our patients next year and the year after… ten years down the track."*

At morning tea at the final workshop late in 2018, I overheard Malcolm talking to one of The Agency's Lean consultants about VBHC. At the end of the year, Martina announced in a meeting at The Agency that she and some colleagues from The Agency would be heading to Harvard Business School to be trained in VBHC, in order to bring the knowledge back to the jurisdiction. VBHC was politically palatable as it produced economic performance measures. At the end of 2019, twelve months after the final ECoP workshop at Outerside, The Agency released a jurisdiction-wide strategy for VBHC. Their website stated that the approach would *"reframe the conversation from volume to value"* and focus on better outcomes for patients, not just cost reductions.

For advisors and policymakers, VBHC appeared to have the potential to bridge the quality/efficiency divide, and to expose the false dichotomy inherent in the apparently 'opposing' perspectives of process improvement and clinical care communities. The spread of the concept demonstrates a growing realisation that merely hammering high-level performance data without clearly linking it to quality of care was not an effective way of mobilising improvement knowledge across the epistemic boundary with senior doctors.

5.2 Tweaks to transformation

Through the emergent efficiency/effectiveness tension, it became clear that merely responding to increasing demand pressures by tweaking processes to reduce 'waste' in the system could not be the entire answer to more fundamental problems in the way the system functioned. While improvement advisors tended to make presentations in abstract performance terms or talk about improvement tools and theoretical aspects of methodologies, clinicians increasingly brought the 'human' side of improvement into the ECoP workshops. In the second workshop, at Big Metro, signs began to materialise of a radical shift in the conceptualisation of what improvement in healthcare is 'really' about. This moved far beyond *"tweaks around the edges" (participant 6, novice improvement advisor)* and cut deep to the institutional identity of healthcare. My field notes portray the front stage performance of a group of social workers and mental health peer workers who told the stunning story of creating their 'Big Metro Tea Room':

The Tea Room team stood at Big Metro's gold-fringed podium, shoulder to shoulder, and presented together. The team's lead social worker described the initiative as a 'popup' Tea Room in Big Metro's art gallery, across the hall from its ED. It was open on Friday evenings and

Saturday and Sunday afternoons. With a growing population of homeless people in its local area, Big Metro's ED regularly saw people attending ED suffering from extreme loneliness, despair and distress, but not necessarily experiencing an acute mental health episode as medically recognised. This had the effect of filling the ED with challenging patients who clinicians were ill-equipped to deal with in the traditional emergency medicine model. The Tea Room was targeted at providing more human support for these people.

Tea Room's social worker described the three usual outcomes for this cohort of patients. First, they might be admitted to an inpatient bed to avoid a NEAT KPI 'blowout'. Second, they might experience a long wait in the ED waiting room. This had the potential to lead to further distress which could escalate to aggression, leading to the third outcome—confinement and possibly restraint in an isolation room in ED (likely to further exacerbate their condition), and even police involvement. She summarised the experience of these patients: "Basically it's a really bad, really cold experience for these people." Mulling on the problem, they had come to the realisation that in providing medical 'care' to these patients, Big Metro and other EDs often inflicted harm. She talked not about their poor performance in terms of KPIs, but care quality.

This admission of failure had led them to want to "transform the patient experience". The Tea Room had been comprehensively 'co-designed', with consumers informing the design of the physical space, the processes and the kinds of roles involved. Through the patient engagement process they had found that what these people were looking for, usually, was simply human connection: "They actually come here for the people, the lights, the warmth and the care. So now we put that stuff up front." Only clinicians and non-clinical 'peer workers' with lived experience of a mental health condition could work in the Tea Room.

Two hundred and fifty people had come through the Tea Room's doors to date, and of those only two had been diverted back to ED. Envisioning the potential impact for performance measures, one of the improvement advisors in the audience asked whether the impact on Big Metro's NEAT performance had been quantified. The team's response was that their greatest concern was that Tea Room was "qualitatively making a difference". A "heavy evaluation" was yet to come, but translating the obvious qualitative improvement in quality of care into 'hard' performance measures was clearly of secondary importance to the team.

5.2.1 Firefighting heroes in a wicked system

The Tea Room presentation was a front stage admission of a failure of organisational process, and of the healthcare system as it was currently designed. During this same workshop, Colin's series of Lean Lightning Talks focused on deploying the principles underpinning Lean (in contrast to Malcolm and the policymakers' tool-based approach in the first workshop) in order to explicitly call attention to healthcare's culturally ingrained fear of failure and the problem this presented for improvement in the jurisdiction. As Colin explained, the reactive habit clinicians had of 'firefighting' problems that came up in day-to-day practice was, from a Lean point of view, a hindrance to learning and improvement:

> *Because we identify as firefighters, having no problems is exactly what we're always aiming for. But if we want to get rid of our fear of failure and culture of hiding and workarounds, we've got to see that the fire is actually a problem. Continuous improvement isn't firefighting. It's about having direction, control and capability.*

Interviews with clinicians revealed their perception that the firefighting problem was an inevitable result of working within a pressured system that conspired against patients, as the Tea Room team had emphasised. The ED director from Outerside explained:

> *It's not people, it's the system… People will often say… "Oh, you know, that patient died. One of the doctors or nurses must've made a mistake." No no, it was probably because there was no beds in the transit lounge for the person who was waiting to go to subacute and there was no beds in ICU for the person to come out of ICU to go to the medical ward, and there was a patient in the ED who needed to go to ICU but there were no ICU beds, so that patient stayed in resus and then the person on the ambulance trolley couldn't even get a bed. The person on the ambulance trolley stayed there for an hour and we did the best we could with what we had, but unfortunately the system let the patient down. They had nowhere to be treated. (participant 31, veteran hybrid doctor)*

Fearing failure (which has potentially mortal implications from the perspective of clinicians) was intimately entwined with the workaround culture. Moreover, interviews revealed that cross-boundary interactions between clinicians and non-clinical management—which doing process improvement, of course, often instantiated— particularly heightened fears of failure. A young

hybrid doctor at Big Metro expressed to me how he had felt when he first started reporting to senior non-clinical managers on projects, especially when they were not on track: *"[I thought] oh they're just going to... they're going to think I'm failing!" (participant 4, novice hybrid doctor).* Fortunately for this hybrid, Big Metro was working hard to transform this fearful culture. As Colin's manager commented during the Big Metro workshop, the single most important focus of Big Metro's improvement program was trying to eradicate this endemic fear of failure. This would ensure staff were comfortable to speak up and report problems; the only way they would create a true culture of continuous improvement.

Unfortunately, a number of participants felt that the clinical-management divide in their organisations culturally reinforced this already prevalent fear of failure. A senior hybrid doctor described a lack of effective mechanisms for escalating problems, and the lack of a "*culture of psychological safety where you can just say anything to the executive and provide ideas…" (participant 1, novice hybrid doctor)*. This stifled improvement at his outer suburban hospital. He relayed to me an incident he had experienced the day before, which had exemplified the problem. Unable to directly negotiate a transfer for a patient in a critical condition requiring specialist services his hospital did not have, he had called on a senior executive to assist him in negotiating the transfer with the other hospital. This executive, however, rebuffed his request for assistance. It had only been by *"screaming on the phone"* to the other hospital that he had been able to get the patient transferred in time to prevent a certain morbid outcome. He said: *"That's probably really the most important thing when you have an issue with patient safety and patient care… [and here] you just can't get the executive to get involved."*

Working in a system that seemed to thwart clinicians' ability to provide adequate care resulted in the construction of the identity of clinicians as heroes. By contrast, they constructed the system in which they worked, and which they worked around (and included 'practice-distant' actors such as laissez faire leaders) as 'villainous'. Big Metro's front stage performances indicated how a more principled reading of process improvement methodologies, as opposed to a narrow tool-based approach, had the potential to create cultural change.

5.2.2 Questioning the 'care' in healthcare

The Tea Room presentation indicates how Colin and Big Metro's principled version of Lean appeared to be able to provide a safe space for clinicians to problematise and problem solve.

The Tea Room presenters could therefore boldly articulate that, in the process of delivering health 'care', harm is very often done. The flaws exposed by the presentation were in themselves unsurprising, but the jaws of the audience still dropped in its wake. What was 'innovative' was the public airing of such systemic failures, and the move to publicly question medical dominance in acute mental health 'care'. Big Metro was deferring to the expertise of lower-status professionals, and even non-professional 'peer workers', and it was precisely the non-professional status of the peer workers that enabled them to provide the beneficent care that higher-status medical professionals could not. During the Tea Room presentation, the peer worker, Norman, described his role as such:

> *"My job is I sit in ED as a peer worker and I try to identify the people who could go to Tea Room. I'm a conversationalist basically. And I'm sorry… I feel bad for saying this, but when I talk to them I normally start by telling them that the Tea Room isn't run by doctors and nurses. It's kind of a disarming thing and I get them onside with that pretty quick."*

Knowing smiles from the audience met Norman's statement. Implicitly, he was saying that *"clinicians do harm in these cases"*, and they knew it. Talking to a senior hybrid doctor from a large suburban hospital later reinforced the support for Tea Room that I had witnessed on the front stage. He said that Tea Room's approach to improvement aligned with clinicians' consistent argument that they should bring quality, rather than efficiency, to the fore. The doctor was enthusiastic about the presentation, saying that their approach to *"caring for the community and trying to provide care that's based on the needs of the consumer… just seemed to me [to make] a lot of sense." (participant 30, veteran hybrid doctor).* Critically, he did not interpret the radical de-medicalisation of ED mental health presentations that Tea Room represented as a threat. In fact, he welcomed it: *"And also the enthusiasm… the fact it was led by a social worker… I thought, 'Great, that's exactly the sort of model. Expanded scope of practice [for other disciplines]…'"* In contrast to the resistance that the desire for more granular data in the predominant efficiency-focused approach invoked, he perceived Tea Room's version of process improvement as a positive representation of *"the values of [Big Metro] as an organisation".* As its CEO had imparted in her welcome speech at the start of the second workshop, Big Metro was committed to providing struggling members of the local community with *"dignity, passion, hope and respect… [that has always been] the essence of what we do here."* Big Metro's approach to improvement exemplified and reinforced its organisational identity.

Importantly, Tea Room made the intersection between clinical ‘care’ and access issues very clear. Critically, the presentation made public the mechanisms by which the ‘system’ systematically lets patients down. Highlighting the limits of the narrow efficiency-based approach to process improvement that Neil and the policymakers promoted, an improvement advisor from a large metropolitan hospital reflected to me: “*Ultimately you go through the same process and you're more doing tweaks around the edges instead of solving root cause issues.” (participant 6, novice improvement advisor).* With its more ‘principled’ translation of what it means to do process improvement, the Tea Room team focused on real problem solving and prioritised quality of care. The initiative introduced a transformative discourse onto the front stage, through which they could legitimately broach a move beyond process ‘tweaks’. The Tea Room solution was not resource intensive, but it was innovative and ‘ontology-breaking’ (Knorr Cetina, 1999). It rested upon a radical translation of the meaning of mental health ‘care’. By implication, it transformed traditional healthcare from ‘hero’ to ‘wicked’ system, in order to resolve the pragmatic issues caused by traditional practices.

5.2.3 *Real* system change

The final workshop for the ECoP’s first year was at Outerside, and the front stage transformation of healthcare from hero to villain was even more radically pronounced. The first and second workshops had been hosted by novice improvement advisors Malcolm and Colin—experienced process improvers but relatively new to the jurisdiction’s healthcare improvement program. The final workshop, in contrast, was hosted by two former clinicians. One was a senior improvement leader with an allied health background, and Dr Benjamin was a charismatic former doctor and Outerside’s Executive Director of Organisational Redesign. Captured in my field notes are some of the paradigm-shifting ideas that Outerside was playing with, as presented by Dr Benjamin:

> *We have a job here at Outerside. The question is, of course, “How can we do our job better?” But more importantly it’s “How can we do it less?” We need to see admission to hospital as a failure. We need to have a shared vision to be able to deliver on that, and we need to look outside the hospital for partners and solutions. Ultimately, we’d really like to put ourselves out of business.*

The year before the ECoP, Outerside's CEO had engaged a management consultancy and the organisation had embarked on the implementation of the consultancy's healthcare improvement program. The primary focus of the methodology was on transforming Outerside's culture from the *"culture of fear"* that Colin had indicated was endemic to healthcare—to a *"culture of safety"*. Like Tea Room, Outerside's version of improvement involved a radical de-medicalisation of the conceptualisation of health service delivery, and a shift from reactively firefighting problems as they arose, to concertedly pre-empting problems that might emerge within the community. Dr Benjamin reiterated strongly the sentiment that had emerged at Big Metro—that more often than not, under the guise of providing 'care' in hospitals, patients are put directly in harm's way:

> *Healthcare is ten times more dangerous than civil aviation, and yet, in general, our risk is extremely poorly managed. Consumers believe they are safe when they enter health services, but that's far from the truth. Hospitals are, in reality, very unsafe places.*

With this, Dr Benjamin brought onto the stage the claim (as Tea Room did, by looking at how the treatment of mental health in ED caused harm) that not only were specific elements of the healthcare system problematic, but there also existed a misleading taken-for-grantedness that healthcare systems as a whole were safe places. Like the more 'principled' interpretation of Lean presented by Colin and operationalised by the Tea Room team, Outerside's new methodology had instilled in them *"an openness to learning".* Importantly, this induced a willingness to share the dark side of their organisational identity on the front stage of the ECoP. Rather than discussing discrete projects (as Malcolm had at the first workshop at Edgeside), or attempting to impart specific methodology-based knowledge (as the policymakers intended), the Outersiders focused on sharing the organisation's struggles. These included the findings of a survey which revealed abysmal levels of trust in the organisation among staff and the local community. The Outersiders also shared how the principles of their new management methodology guided their approach to improvement.

Dr Benjamin explained that Outerside—with these guiding principles and its openness to learning from elsewhere—had radically expanded its view of the patient journey and was trying to develop a public health lens. This would take into consideration individual patients' whole lives and preferences and also the health of the community at large, in order to mitigate future growth in demand. Most strikingly, this saw Outerside engage with non-healthcare businesses and industries as co-producers of preventative and proactive health and care, with the shared

goal being to minimise the need for Outerside's reactive healthcare services (and thereby minimising system failures in the form of hospital admissions). This involved a rhetorical shift, from talking about tweaking internal processes to more divergent 'design thinking' approaches to understanding the lives of their patients and the constraints they faced with regard to their health. As Dr Benjamin explained:

> *We actually don't know anything about who is coming through the system. We don't know our 'users'. We need to tap into alternative sources of information about them and figure out how to tailor services to them, and by services we mean beyond the traditional health services model. For example there is no bike shop in Outerside's local area. None! Where I live, there are dozens. Another example that really shocked me is that Australia Post does not deliver supplements to this geographic area. Which means that the people in our community are not able to become what we're calling 'empowered actives'. Even if they want to. So even if people want to live active and healthy lifestyles, there are physical, commercial and regulatory barriers to them doing so. And this is not stuff we ever think about in the traditional healthcare model.*

Outerside's new strategic plan was to be called 'A Together Future for the Outerside Suburbs' and would be written in genuine partnership with their local council. Outerside now viewed the patient journey as a cycle that began and ended with 'staying healthy at home'. This stood in stark contrast to the usual linear and hospital-centric patient journeys in which the lives of patients either side of admission and discharge were barely considered, and their safety between admission and discharge taken for granted. After Dr Benjamin and his colleague's presentation, the discussions at morning tea in Outerside's modern open-plan 'Innovation Factory' were the liveliest I had seen during any of the workshops.

In an interview with Outerside's director of ED, he talked about an organisational position of desperation to keep up with demand which fostered the openness to learning evident through Dr Benjamin's talk. He told me they had already treated over 150 patients by midday:

> *We are the busiest emergency department in the jurisdiction and we see over 100,000 patients, which is 10% clear of any other health service, and we are the third busiest in the country. There's only two others in the country that are busier, [X] that has 768 beds, more than double [what we have], and [Y] which has 760 beds… So, yeah. We're*

> *number three in the country and we have less than half the beds than the people above us… we're doing some things right, but we are really underdone. So we have to change. (participant 31, veteran hybrid doctor)*

Outerside *had* to change. And, having faced the challenges of rapid growth over the preceding years, they had already become accustomed to rapid adaptation. Their organisational identity had transitioned in very recent times from a community hospital to a huge suburban player and, as a result, they felt that they maintained the unique advantage of a highly cooperative approach that was a legacy of their old community hospital identity:

> *Just… what was it? Just five or six years ago we were seeing 65… 67,000 patients a year. Just the last calendar year we saw 103,000. So we were just a community hospital, not long ago. We have grown astronomically, but we still remember that we were a community hospital and we still have a shoulder-to-shoulder type approach, particularly amongst the leaders of the organisation where we, we don't pretend that it's easy, we don't pretend that things aren't going to be different in three to six months' time and we just get on with it, and accept that change will happen, it's inevitable… It is something unique about us, and it would be something that I would fear a little if I ever went to another organisation… is the hesitance to change and concrete thinking.*

This "*shoulder to shoulder"* orientation helped Outerside to cultivate a 'deference to expertise', a key principle in their new improvement methodology. Similarly to Tea Room, decision-making and ownership of improvement opportunities were devolved to those with the most expertise for that particular decision, regardless of their rank. Dr Benjamin quoted Outerside's CEO's mantra: *"It's just about doing the right thing by patients, day in and day out."* Their collaborative organisational identity and the desperate times they faced enabled Outersiders to push the boundaries of what it meant to 'do improvement'- even further than Tea Room. Their public performance showed the ECoP participants how they had translated their chosen management methodology—not into discrete projects and process 'tweaks', but into an organisational identity which valued vulnerability and openness to learning above all.

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This chapter has illuminated how the presence of various epistemic communities can present *tensions in translation*. Viewed through a practice-based lens, however, these tensions can in fact be seen to be generative (Gherardi, 2009a). My findings show that translating meanings is not merely a matter of trying to reduce interpretive differences, but also of negotiating interests and making trade-offs as participants from different epistemic communities learn to learn together (Carlile, 2004; Wenger, 1998). Participants' translation practices are performative of new ways of thinking and have the potential to effect radical reconceptualisations of the knowledge targeted for mobilisation, and the ongoing formation of collaborative initiatives. Moreover, their translation practices are also performative of new ways of being and new positions in the field. In the next chapter, I explore these issues in greater depth, showing how participants from different epistemic communities worked to reconcile their existing identities with their engagement with process improvement knowledge and their participation in the ECoP.

Table 5.1 Supporting data—Tensions in Translation

Chapter 5: Tensions in translation Epistemic and political negotiations of the 'economies of meaning' in the ECoP.		
Themes	**Sub-themes**	**Data**
Problems of proximity Central epistemic fault line between performance measures and clinical practice.	Performance vs. practice Policymakers and improvement advisors use aggregated 'practice-distant' performance measures to direct clinicians' practice. Efforts to exert control over clinical practice are resisted, and the validity of data produced through process improvement methods is contested on epistemic grounds.	*It might be very black and white that [a clinician] needs to change… And you can provide to them all the data and all the feedback in the world… [but] as frustrating as it is [they have] to make that decision [to change]. (participant 12, veteran improvement advisor)* I observed the policymakers puzzling over why 'mental health' had been highly prioritised as a topic of interest in the ECoP co-design workshop. They thought it was *"too clinical"* an issue, unrelated to access or flow. It was, however, revealed both front and back stage to be a significant, under-resourced problem for ED performance: *Mental health was always, will always, always be a problem for [patient flow in] any ED… [but] I've been here 12 years and I've never had a [mental health] budget… (participant 16, veteran hybrid nurse)*
	Efficiency vs. quality Hybrid clinicians overtly prioritise qualitative	*If I can't see that there's any benefit to the patient or to myself… I'm just not going to do it. And because*

	understandings of improvements in quality—the ‘right’ kind of improvement—over quantifications of efficiency improvements prioritised by policymakers and improvement advisors.	*I'm a senior person it's very hard to make me. (participant 15, veteran hybrid doctor)* *… [we need to be] demonstrating to [clinicians] what benefits this could potentially deliver for our patients, for our communities, as opposed to using... you know, the board up there around the key performance indicators *indicates electronic dashboard*. I don't think that's what really drives them… [it’s] patient outcomes and improving the quality and safety for their patients. (participant 13, veteran improvement advisor)*
	<u>Merging: Efficiency and quality</u> Attempts made to reframe process improvement and the role of improvement advisors in terms that more explicitly prioritise quality. Such attempts are relegated to the ‘backstage’ due to tight circumscription by policymakers of advisors’ official roles and identifications as experts in ‘pure’ (non-clinical) process improvement.	*… it's difficult to engage senior clinicians in this. I don't think it's impossible but… they need to be exposed from all different angles… how does it benefit the patient, how does it benefit the hospital and other people who are also managing the patient… (participant 31, veteran hybrid doctor)* *… [we need to] show more clinicians how these methods can improve quality, and their outcomes. Not just improve productivity and flow and wait times. (participant 21, novice improvement advisor)*
<u>From tweaks to transformation</u> How participants translate what process improvement ‘ought’ to be, unsettle power dynamics and problematise assumptions inherent in health ‘care’ delivery.	<u>Firefighting heroes in a wicked system</u> Translation of process improvement as cultural principles rather than tool—this is used as a lens to problematise the fear of failure endemic in healthcare, to indicate how this results in the need for constant clinical ‘heroics’ to keep patients safe from a villainous system, and how this stifles learning and improvement.	At the final workshop at Outerside, Dr Benjamin spoke about the fear of failure in healthcare: *“That fear is a huge challenge, because we think of ourselves as saviours. Especially doctors. So we aren’t very good at stepping up and pointing out problems because we just get on and keep ‘saving the day’.”*
	<u>Health ‘care’ or harm?</u> Presentations by hybrid clinicians begin to embody a ‘principled’ translation of	Instances of clinicians deploying the philosophy of improvement rather than tools (e.g., to improve relationships rather than performance). At the Big Metro workshop:

	process improvement, showing how such an approach can be reconciled with the desire of clinicians to improve quality of care. Also reveals how relatively low status hybrid clinicians can co-opt process improvement in service of problematising the dominant biomedical model of healthcare.	*"So it comes down to whether the receiving unit trusts ED's feeling. For ED, that obstructiveness is their barrier to flow. So in our new model we've taken that obstruction away from ED and put the responsibility in the hands of the receiving units." (novice hybrid doctor)*
	Real system change Increasing openness to sharing organisational identity and vulnerabilities on 'front stage'. Results in radical translations of what it means to deliver healthcare (less hospital-centric with a much broader public health focus), of what it means to do process improvement, and of what the enterprise of the ECoP ought to be.	At the final workshop, Dr Benjamin openly described negative aspects of Outerside's organisational behaviours and how they were deliberately reflecting on these: *As part of our improvement journey we've taken a good look at ourselves and what we were saying versus what we were doing. We looked at the food served in our organisation for instance. We had ten different types of chocolate biscuits downstairs. Ten! They've changed it and now the cafe has to have 'green' food on that healthy food traffic light system… [we're] trying to promote healthy lifestyles in ways that we've not thought of before.*

Chapter 6: Identity Reconciliation

"[Identity] is the most mundane of things and it can be the most extraordinary… it brings the sociological imagination to bear on the mundane dramas, dreams and perplexities of everyday life."

(Jenkins, 2004, p. 4)

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The findings I present in this chapter address the third research question: *How do actors from different epistemic communities (improvement advisors and hybrid 'targets' of improvement knowledge) reconcile their existing identities with their participation in instrumental collaborative networks?* Wenger's (1998) concept of identity reconciliation and the dialogue between self-identification & external identity regulation (Alvesson & Willmott, 2002; Jenkins, 2004) sensitise my analysis.

I explore identity reconciliation through two key themes. *Epistemic expansion* zooms out temporally to focus on the ubiquitous historical attempts of all participants to incorporate 'other' knowledge and rhetoric, and on the uniqueness of these attempts across epistemic communities. This reveals ongoing epistemic translation work to be a necessary enabler of knowledge mobilisation. *Modes of identity reconciliation* then turns the focus back onto the ECoP. It shows how this epistemic expansion work—and different participants' sensemaking with regard to the 'mandatedness' of the collaborative initiative—influence how participants reconcile their existing identities with their participation in the instrumental ECoP. The findings shed light on how their modes of identity reconciliation influence participants' trajectories of participation (Wenger, 1998). This reveals counterintuitive trajectories, which call into question the policymakers' assumptions about knowledge mobilisation, and about 'their' knowledge brokers.

With the focus largely on private identity work, this chapter draws more dominantly on participants' backstage reflections. I organise the key themes around each of the epistemic communities involved in the ECoP, in order to elucidate their unique *epistemic expansion* and *modes of identity reconciliation*, as well as their divergent trajectories in relation to the ECoP.

6.1 Epistemic expansion

Interviews with participants revealed backstage epistemic expansion efforts that began long before the ECoP. A former physiotherapist, now a full-time improvement advisor at a large suburban hospital, recognised that "*clinician engagement is the key"*. However, she understood from personal experience the struggles that clinicians face as they attempt to incorporate knowledge and practices that are non-native to healthcare into their existing roles and identities:

> *Everyone became clinicians to be caring for patients and as time rolls on… the pressure… is to know the business side of things… [but] no-one went into these jobs wanting to know [that side of things]… me neither. I like it, I find it interesting but I never thought my career would be in data and money and all that sort of stuff. And now people are expected to do that, but I think it's still a bit of a stretch for people on the ground. (participant 9, veteran improvement advisor)*

While epistemic expansion work was common to all of the ECoP participants, the kinds of challenges faced by different epistemic communities in reconciling their existing identities with new knowledge varied. The following sections explore how allied health professionals, nurses and doctors all engaged in different ways with process improvement knowledge, and how and why improvement advisors sought to engage with 'other' forms of knowledge alongside their technical process improvement expertise.

6.1.1 Allied health: Born with it

For allied health clinicians, reconciling process improvement knowledge and practice with their clinical roles and identities appeared to be relatively easy. Allied health were consistently characterised, by themselves, improvement advisors, hybrid nurses and doctors alike, as diligent and engaged improvers. They were *"always super keen"*, according to the improvement advisor from Outerside who told me that her Lean fundamentals training program was always filled predominantly with allied health professionals. She added: *"We do get quite a few doctors through, [though] not as many as I would like." (participant 2, novice improvement advisor).* Likewise, Colin from Big Metro told me: *"… when we advertise internally for our [improvement] secondments, always, they're all physios. And [occupational therapists]. Always."*

Participants suggested that the high level of allied health engagement resulted in part from the fact that improvement training was already part of some allied health clinicians' undergraduate education. As this former physiotherapist turned improvement advisor explained, *"Allied health I think are excellent at it, and I'm a bit biased… [but] when I was in uni, every placement I had, I had to do an improvement project. So none of it was new to me."* Moreover, she described the commonly used 'Plan Do Study Act' cycle as simply another way of representing the diagnosis, treatment and outcome measurement process that clinicians were accustomed to using: *"It's a diagnostic process so it's exactly the same".* This meant that they could easily incorporate engagement with this way of thinking into their professional identities once they were qualified. Unfortunately, her attempts to engage nursing and medical clinicians with this analogy often failed—*"... their minds should work that way, but they don't…" (participant 9, veteran improvement advisor).*

A further explanation for allied health engagement with process improvement provided by participants in interviews was the motivation to ensure that the lower-status allied health professions could better justify their worth in hospitals. As the ex-physiotherapist said, *"[we] have always had to prove [ourselves]… really on a base level to get funding to continue."* An allied health hybrid at Big Metro corroborated this. She explained how the hospital's strong process improvement program had been a boon for her department, since the methodology and its measurement tools offered a way for allied health to evidence their worth in terms of organisational performance. They could use dashboards showing the demand for allied health versus the department's capacity to *"make sure that exec understand that… technically we're always operating below what our EFT is, because we have people on annual leave and sick leave and there's no cover." (participant 3, novice improvement advisor).* By making workforce capacity constraints visible to the executive, they could proudly advertise their finely tuned processes for managing fluctuating demand, but also demonstrate how precarious the balance was and make it plain that allied health was functioning in an under-resourced environment: *"There's always constant re-triaging and re-prioritising for allied health clinicians. Which is great that we do it but I think there's a risk if we just keep doing it… because allied health are generally an easy target for pulling resources... we don't have protected ratios like nursing staff do."* This hybrid manager and other advisors I spoke with were working on figuring out how to turn these data into a way to evidence how a lack of redundancy in allied health staffing could result in delayed discharges and affect performance on KPIs at the hospital level.

Another significant driver of engagement with process improvement stemmed from a different professional challenge—this time at the individual level. The career path for allied health professionals was limited, and this made improvement projects appealing opportunities to move laterally out of clinical roles. As one hybrid doctor said to me in an interview—*"Oh they love [improvement]! I mean if you look around there's a lot of young allied health professionals and a very small number of old ones… most of them go and do something else. And those that stick around do talk about the frustrations of, "I get bored doing the same thing every day." So [they] look for something else." (participant 17, veteran hybrid doctor).* The result was, according to a NUM: *"[Allied health are] really on board. They're very... they're a completely different group of people… they're very adaptable and dynamic and they don't have to be dragged kicking and screaming to change. They are just born that way." (participant 14, veteran hybrid nurse).*

Allied health clinicians' ability to reconcile their professional identities with process improvement practice did not, however, necessarily translate into them being successful leaders of improvement projects, or success as incumbents of dedicated improvement roles (and most of the veteran improvement advisors in the jurisdiction had allied health backgrounds). As Colin told me, allied health clinicians were often *"the best applicants"* for the internal secondment programs at Big Metro in terms of skills, experience, and motivation. They were not, however, always the best choice in terms of their ability to influence beyond their immediate clinical group, and especially to influence higher-status clinical groups such as doctors and surgeons. Colin added: *"Sometimes we need to say, 'Hang on a second, we've had 20 people go through our secondment, 19 of them are physios, maybe we should put a nurse through, or a doctor through, or a surgeon through…'"*

6.1.2 Nurses: Improvement just 'not in their nature'

In contrast to the allied health clinicians who were seen to be 'born' improvers, an advisor at a large suburban hospital lamented that *"that culture is absolutely not there at a ground level [for nurses]." (participant 9, veteran improvement advisor).* A conversation with a veteran NUM of an inpatient ward revealed that nursing leaders also recognised this about their own rank and file professionals: *"Really... it's really challenging [to engage nurses]."* Telling me about a recent project to improve patient flow, she described a lack of initiative and the need to continually role-model behaviour and reiterate process changes:

> *You have to keep going out and doing it and doing it and doing it. That's the tricky part… there's still people that aren't doing what we've agreed that we should do… which is [setting discharge dates], putting in dates, working out minus one [day from discharge], minus two, where they're going, bla bla bla. So I think nurses... I don't understand why they don't do it… it has to be driven by the NUM… every day I'll go out at 11 o'clock to make sure [the meeting] is happening. "We're having [the meeting], ready to start?" [I make sure they] start on time… [make sure they do] one minute per patient… [I have to] oversee that and run it. (participant 14, veteran hybrid nurse).*

In contrast, an ED NUM described just how keen her staff were to do improvement, even on their own time: *"It's improvement. If it's going to make it easier for the staff and the patients they will do it. I said to one of the girls, 'I need someone to do this,' [and she said] 'I'm happy to do it.' That's what they do."* A more junior nurse hybrid provided a possible explanation for the incongruity between the inpatient and ED NUM experience, reflecting that *"EDs are quite different to other departments… [where] there's very much a hierarchy and this is your role and you don't step outside that. I think we've had to adapt in emergency departments because the demand just keeps increasing but nothing is changing elsewhere so we're having to adapt." (participant 16, veteran hybrid nurse)*

She also explained that older nurses were not *"naturals"* when it came to improvement, since the traditional nursing role had been much *"simpler"*. She said that, *"traditionally people would enter nursing and like just have a very traditional role—they go in, clean the patients up… and that's their role and I don't mean to degrade that in any way because we still do that and it's still important, but our scope of practice has grown enormously."* She said that there were *"exceptions, but people are [more] willing to learn because they want to better themselves and I guess that's what [improvement] comes down to." (participant 26, novice hybrid nurse).* An ED medical director also pointed to a low career ceiling: *"Nursing also… lack a bit of… there's things you can do in nursing to extend yourself, but you extend yourself and you extend yourself and you get an extra 50 cents an hour. It just doesn't seem worth it." (participant 17, veteran hybrid doctor).* This incentivised motivated nurses to move laterally into managerial and improvement roles.

6.1.3 Doctors: Deep reservations about non-clinical knowledge

Of the clinical groups I interviewed, hybrid doctors clearly had the most difficulty reconciling their involvement in management practices, which they saw as peripheral to their clinical roles. They provided a number of explanations for the challenge. First, engaging with 'other' kinds of knowledge, especially those related to broader organisational performance measures, meant becoming able to see their roles as part of, rather than separate to, the broader system. A senior hybrid doctor from a large suburban hospital explained:

> *One of the key elements in [doctors] being involved in broader organisational management and development has been trying to create some hook that brings clinicians away from being advocates for individual patients and collegiality, [to] see what they do from a broader organisational or public health perspective. (participant 30, veteran hybrid doctor).*

Envisioning their role as part of a broader system seeking to *"fix crowds of people" (participant 31, veteran hybrid doctor)*—not just individual patients—was, however, particularly challenging for doctors. They were highly autonomous professionals, selected and trained *"to be really independent"* from the moment they entered medical school: *"… we take a bunch of people who are kind of pretty individual thinkers… we select individual thinkers, we train them to value that individual, creative, 'I'm an expert, should learn my own way and take responsibility for it' kind of people". (participant 17, veteran hybrid doctor).*

Moreover, while many allied health clinicians and some nurses actively sought out non-clinical or hybrid opportunities as a result of their relatively limited scope of professional practice and career development, the medical career pathway was different. Training was gruelling and extended for many years, with *"a lot for the junior doctors to take on board just purely from that practical side of what they do…" (participant 15, veteran hybrid doctor).* Doctors rarely tired of their complex professional practice, and financial rewards tallied with education and experience in a way that was not available to allied health and nursing professionals. As an ED director said to me: *"In medicine we're blessed with a really nice career pathway."* As well as this, the *"opportunities to do management... they're not as common… as say with nursing and allied health." (participant 17, veteran hybrid doctor).*

Accordingly, each of the senior hybrid doctors I interviewed spoke of ‘falling into’ their hybrid managerial positions rather than seeking them out. None of them had ever envisioned themselves becoming involved in management, especially not during the early years of their specialist practice. The ED director of a large metropolitan told me that when he had first qualified as an emergency medicine consultant, he *“was trying to stay out of management and politics and all that stuff and just be a doctor.”* This was in part a result of the intellectually challenging and rewarding clinical learning journey and in part due to the *“graduated rewards”* that were part and parcel of a medical career, whereas *“to go and do something like management requires a sacrifice from that [financial] point of view.”*

As well as the lack of structural opportunities and financial incentives to engage with non-clinical practice, an ED director provided insight into the reluctance to expand their roles beyond the clinical:

> *I think partly... from the very first week of medical school… it was nuts and bolts type training back then, very little touchy feely stuff. There was one subject where… they got a chance for all the people who didn't really like doctors to come along. And the health promotion people came and told us how everything you do is worthless and that what's really important is to get people to exercise and stop smoking and that it's all about putting posters up. And you've got the psychologists or something come along and tell you that you're all mentally inadequate people and that you burn out and bully each other and stuff… And I think that sets people up to be a bit suspicious… (participant 17, veteran hybrid doctor).*

This *“little cultural disconnect”* had enduring effects through their professional lives. It translated into resistance to changing their practice and engaging in improvement work with other, especially lower status, disciplines:

> *And then someone comes in, from another craft group particularly, and says, “You should follow this pathway with a nice poster and words that you wouldn't use that I use,” the jargony words, that [say], “This is how you do your job.” And then people get their back up.*

Moreover, conflict between administrators and doctors was culturally ingrained and the move into administrative roles could be troublesome for doctors' professional social capital. An ED director explained that *"stereotypically, a lot of [doctors] believe that these things that we do in management are not the job of the doctor"*, and *"going into a traditional medical administration type role is… well… seen to be going to an organisation that was previously seen as putting a system onto the clinicians… you know… people talk about the colour draining from your eyes [when you become a] medical administrator…"* The idea of engaging with their oppressors resulted in acute internal dissonance, but it was seen to be a necessary sacrifice for the greater professional good: *"To be honest it hurts my clinical soul to talk about joining a college such as [the College of Medical Administrators], but sometimes you need to... if you can't beat them join them!" (participant 31, veteran hybrid doctor)*

Having worked their way through some of these internal struggles, all of the medical hybrids involved in the ECoP were now at least partially 'converted' to the idea of engaging with system improvement. As *'decoupling from the frontline'* in Chapter 4 highlights, these medical hybrids actively sought time away from their clinical work to focus on learning about improvement, whether by taking sabbaticals, or even time out of family holidays. Although their epistemic expansion work was ongoing, the ED director at Outerside explained how he had become *"hooked"* on improvement work: *"[I] quickly realised that I could, in my capacity of working 50% clinical and 50% non-clinical, I could almost vent my clinical frustrations during my non-clinical time and fix the problems with the system that I discovered while I was working with patients." (participant 31, veteran hybrid doctor).*

Vitally, the hybrid doctors told me how they had come to realise, through their experiences, that having a broader systems point of view of performance, as well as structural influence in the organisation, was entirely compatible with their professional commitments to collegiality and quality care. Outerside's ED director continued: *"I very quickly realised that the changes that we were making were making substantial differences to patient care… not just deciding which antibiotic to use or how much fluid to give a certain patient. It was about how long a patient should stay in a particular area, how long a patient should wait for a test, if in fact they should have that test… it was making the patient experience a whole lot better, it was enabling us to assess and manage a larger number of patients more safely, and patients were happier, staff were happier, and that's when I got the bug in emergency management."* Shifting into a 'hybrid' identity involved reconciling the traditional professional perspective (where the individual

patient-doctor relationship was prioritised) with the broader public health perspective more commonly prioritised by lower status clinical disciplines, healthcare administrators and policymakers.

Once they got *"the bug"*, the hybrid doctors had *"sought further training [from] both local and international courses for emergency department leadership and change management".* They did this because it helped them to expand their knowledge about 'softer' issues—which were *"so desperately important to enacting change—particularly to an eclectic group of medical specialists who all have their own professional opinions about what should happen."* With this epistemic expansion work, they started to 'try on' different identities. A senior hybrid doctor from a large suburban hospital described how he was trying to make the shift from leader to follower:

> *I see myself as very much a consumer of initiatives at the moment… I also want senior clinicians to be seen as being consumers, people who see a [knowledge] product and are willing to actually just muck in and make it work… I don't think we need to be seen as leaders... We need to actually demonstrate that we're willing to come in behind other peoples' stuff and support it… in participating in things [like the ECoP], I think it really just allows me to begin to understand how we can support the initiatives on the ground… and how we can conceptualise them to our colleagues to bring them on board. So, I think followership is not a bad concept. (participant 30, veteran hybrid doctor)*

Followership did not come naturally, however. Despite the struggles these hybrids had faced in reconciling 'non-native' knowledge with their clinical identities, many agreed that concerted efforts to broaden the epistemic identities of doctors needed to come earlier in clinicians' training. This, they argued, would help them to understand their own roles and responsibilities as inherently interconnected with others' as part of a broader system of practices and actors: *"Where is there [in formal education] any principles of teaching about what it means if you don't send any patients home then how can you admit any patients, and length of stays and how that can adversely affect outcomes… there's not really any understanding of that, so how do you incorporate it?" (participant 31, veteran hybrid doctor).* They considered incorporating this knowledge at an earlier stage in training vital, so that junior doctors, whose roles were *"quite separate" (participant 15, veteran hybrid doctor)* from the hospitals, would not struggle as much to reconcile their autonomous professional identities with their existence in a broader system characterised by complexity and constraint.

One ED director's vision for how junior doctors could more easily reconcile involvement in managerial activities was by upending the long-held associations of the word 'administration': *"We've got to kind of revolutionise this 'administration' thing and maybe even change the name because administration sounds just so… duffel coat and dusty corridor. It should be about… let's call it 'Emergency Medical Strategy'! That's kind of cool and sexy and really outlines what this is all about." (participant 31, veteran hybrid doctor).*

6.1.4 Improvement advisors: Puppeteers

As earlier chapters have revealed, The Agency—who were making increasingly concerted efforts to direct and monitor the advisors' practice and performance—circumscribed the improvement advisors' official role identities. However, the policymakers' capability building program for the advisors took the form of a *"lowest common denominator approach" (participant 10)*, as one of the veteran improvement advisors put it, with a focus on homogenising skill levels and ensuring all the advisors across the jurisdiction had a basic level of technical knowledge about process improvement. The policymakers understood the crux of these roles to be about building the technical capability of others to do improvement. My fieldnotes reveal that this narrow technical epistemic identity, however, was not fit for purpose for the improvement advisors, whose greatest challenge was *convincing* clinicians to engage with process improvement. Malcolm finally voiced this concern on the front stage at the final ECoP workshop, once participants had become more open to sharing their own weaknesses and willing to point to gaps in the policymakers' knowledge mobilisation program. From my field notes:

> *A group of advisors were huddled around a whiteboard, and one of Neil's colleagues from The Agency was trying to capture what they were saying about the struggles they faced mobilising process improvement knowledge within their hospitals. Malcolm said, to fervent nods of agreement from the others, "I do process improvement. But actually less than half of what it takes is about the process improvement bit." Another advisor agreed, saying, "Some supplementary training for us on behaviour change would be really really good, because that's the actual hard part."*

Backstage conversations with improvement advisors corroborated the salience of this struggle. Being effective in their roles entailed more than simply 'transferring' their technical knowledge

about process improvement, since it was not so easily ‘taken up’ by other epistemic communities in hospitals. There was an abundance of instances in which improvement advisors (especially novice advisors and hybrid nurses) suggested that ‘more and better data’ were what was needed to engage clinicians in improvement. However, many also recognised that their role needed to go *beyond* generating data about practice efficiency. They had to engage and influence others to become open to learning about and doing improvement. They needed to influence ‘upward’, since leadership support for improvement varied widely across organisations, either constraining or enabling their knowledge brokering efforts. And then there was the matter of cross-disciplinary translations to contend with. With exposure to doctors and their epistemic resistance to such data, they had learned not to assume that clinicians would engage without issue. To overcome these problems, they needed to incorporate into their practice forms of knowledge which would enable them to influence others. As an advisor at a large suburban hospital told me:

> *Improvement people can only influence, [we] don't have the ability to actually do. A decision has to be made from those people who have that decision-making ability… so you have to influence and engage. (participant 12, veteran improvement advisor)*

This struggle to influence and engage was borne out in advisors’ everyday work, and most particularly when engaging medical clinicians. Despite Malcolm’s insistence that Dr Jason had followed Lean principles when implementing his new model of care in the Edgeside ED, Dr Jason maintained that he had not, refusing to engage in the conversation when it was framed as a technical management methodology: “*To me, it’s not about using Lean thinking in terms of the word... It almost becomes like ideology type stuff. My clinicians think they’ve done something without Lean so there’s no point... you know the conversation is not about using Lean.”* When it came to ‘his’ clinicians, Dr Jason held ownership over the meanings and language used in the practice of improvement in his department, and this involved the very deliberate excision of Lean language. In these situations, the higher status medical community—who had the power to render their ‘non-native’ knowledge invisible, sidelining the already peripheral improvement advisors—significantly hampered Malcolm and other advisors’ influence.

Improvement advisors felt this peripheral identity acutely. Veteran advisors had experienced it over many years, and novices learnt quickly that their roles were still peripheral in many health services, lacking structural legitimacy in the broader healthcare field, with little social capital in

the community more broadly. This peripherality stemmed, in part, from others' lack of understanding of what the role entailed, and what value these knowledge brokers could provide. Unlike health professionals whose labels were widely understood (*"I'm a doctor"* or *"I'm a nurse"* needs little further explanation), Malcolm explained that he could not reduce his introductions to *"I'm an improvement advisor"* without qualifying the label and justifying its importance: *"When people ask me what I do I say, 'I work in hospitals but I'm not a clinician.' That's sort of the way I describe it. And I say, 'I do process improvement and reduce wait times for patients, improve quality and things like that.' And people just kind of nod politely. That's pretty much what happens."* The precarious nature of the work further entrenched the low-status of process improvement. Short-term contracts, yo-yoing funding from The Agency and health services, and a high turnover merry-go-round—which meant that the advisors constantly needed to find their feet in new organisations—characterised this precarity. All in all, numerous barriers stood in the way of improvement advisors being able to broker their expertise.

To overcome these challenges, advisors made various attempts to expand their epistemic identities and incorporate new knowledge and experience within their advisor identities. For instance, many deliberately made ongoing claims to legitimacy and expanded their roles in different directions, as we saw Malcolm do with his *"sneaky"* foray into Value-Based Health Care. Most commonly, they incorporated the development of education packages into their roles as a way to objectify, legitimise and spread their knowledge. For example, Outerside's designated improvement advisor created an improvement science training package for staff modelled on the Toyota Production System, Malcolm's colleague at Edgeside created a weekly drop-in class about improvement, and Big Metro ran a formal apprenticeship style training program for clinicians interested in improvement.

Another approach to epistemic expansion involved the advisors picking up low-status *"orphan problems"* that professionals refused to engage with. Malcolm reflected:

> *[I became] the father of these little problems… because no-one otherwise would, and the patients were getting stuck at all these points… The doctors refused to do anything about it [saying], 'Well that's not my job to fix this,' … typical 'management' viewed them as more clinical problems, and they're like, 'That's the doctors have to figure this out.'*

This turned out to be a classic problem for improvement advisors. Because of their lack of influence, they were often pulled into the operational 'doing' of improvement rather than facilitating and supporting. An advisor from a large metropolitan hospital explained to me that the *"confusion about what [advisors] do…"* diluted their capacity to influence others to deliver the work. He explained: *"There's always that fight… because we're advisors, there's always a bit of a grey line in terms of sometimes you get pulled into the operational work, whereas we're sort of trying to deliver a strategy". (participant 6, novice improvement advisor).* Their lack of influence, status, and recognisability as a 'real' discipline meant that they often picked up slack that professionals declined to engage with.

Another paradoxical method of dealing with their low-status peripheral identities was to make themselves even *less* visible. This counterintuitive approach involved, as Colin told me, remaining *"off to the side"* and putting clinical leaders front and centre of improvement. He and others found that the improvement advisors were best kept hidden 'in the wings', as described by an advisor at another large metropolitan: *"It's like [clinicians and leaders] are puppets."* He gave the example of how, at a recent improvement project launch, his advisor colleague had played a backstage puppeteering role: *"[She] worded the people up, she did the slides for them, had a one on one meeting with the general manager and [medical] program director and then they just showed up at the right time, said what they had to and then walked off. And she was running all the shots behind the scenes." (participant 6, novice improvement advisor).*

Now, in the ECoP, improvement advisors had the opportunity to reflect on the skills and standing of their epistemic community. Their backstage reflections revealed the workarounds they undertook to improve their effectiveness. Those keen to ameliorate their peripherality, especially novices, also willingly publicly acknowledged that—while they had confidence in their technical improvement expertise—they lacked the ability to effectively translate this knowledge in a way that convinced organisational leadership and clinicians to engage with process improvement. Brokering as understood in the policymakers' terms of transferring technical expertise to clinicians, was a necessary but insufficient conceptualisation of the brokering role and the skill and knowledge requirements of its incumbents. Their main concerns were instead their peripheral subject positions and low status.

6.2 Modes of identity reconciliation

In this final section of the findings in this thesis, I turn the focus back onto identity reconciliation work in relation to participation in the ECoP. I explore three modes of identity reconciliation, through which particular participant groups learnt to be together—though sometimes quite apart from each other (see figure 6.1 below). Through *'distancing', 'participatory engagement'* and *'peripheral lurking'*, I elucidate the perceived comparative costs and benefits associated with ECoP membership for key participant groups, how and why they engaged in different modes of identity reconciliation and how their reconciliation work led to characteristic trajectories of participation which were necessarily entwined with *(per)forming* the ECoP.

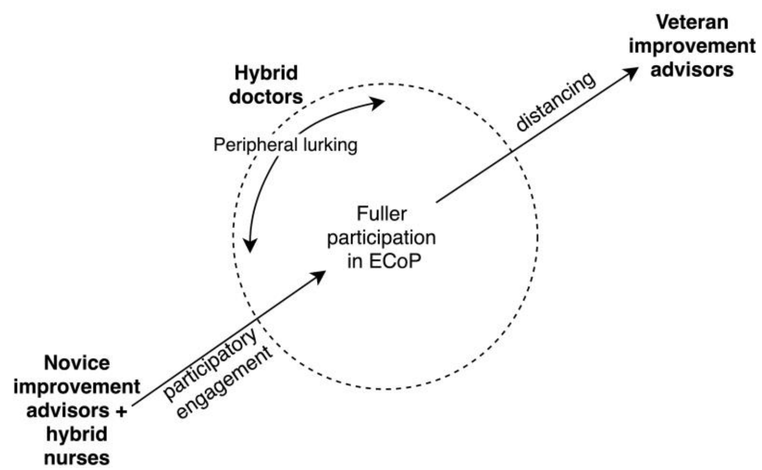

Figure 6.1: Participant trajectories in relation to the ECoP

6.2.1 Participatory engagement: The merits of mandated collaboration for improvement novices and nurses

Novice improvement advisors, as well as both novice and veteran nurse hybrids, expressed appreciation for the relative mandatedness of the ECoP. They felt that it helped ensure organisations took process improvement seriously. A novice advisor from a large regional hospital articulated this:

> *If you leave it up to the health services to arrange people to come and attend you're only going to get people that are motivated and want to align to it. And they're not necessarily*

> *the ones in charge that can actually free up the resources… I think to be successful it needs to be kind of mandated… (participant 18, novice improvement advisor)*

Novice improvement advisors and all of the hybrid nurses engaged strongly with the ECoP. These individuals actively sought out new knowledge, others' experiences, and fresh connections. The novice advisors and junior hybrid nurses in particular were especially enthusiastic about their entrance into the exciting world of improvement. They all wanted to learn how to *become* expert improvers.

6.2.1.1 Improvement novices: Riding the wave

In contrast to the veteran improvement advisors who all had clinical allied health or nursing backgrounds, most novice advisors in the ECoP had only recently joined the health sector. They had gained their process improvement knowledge in non-healthcare sectors (e.g., had come from manufacturing, hospitality or project management backgrounds), and many had formal process improvement or management training (e.g., MBA degrees or formal Lean training). They now sought to use their experience to ride the wave of policy level support for the concerted mobilisation of this knowledge which, like most of them, was 'non-native' to healthcare. It was, as a novice advisor from Big Metro said to me, *"kind of a sexy space for people at the moment, which is great… I mean I feel like I was lucky. I kind of came in just at the right time." (participant 3, novice improvement advisor).*

Others also felt that The Agency's collaborative program, starting with the ECoP's more intensive predecessor The Collaborative the previous year, had been a boon for their careers. Malcolm told me: *"I arrived just when the role for The Collaborative was being advertised… So I joined and eventually realised, well this is a big project I'm going to need some support, so the CEO at the time said, 'Ok well absorb [your colleague]', and then there were two of us doing this work and then there were three, four, now there are seven of us. Thanks in large part to The Agency projects… and [now] they report to me."*

Being new to what participants referred to as the improvement 'merry-go-round' in the jurisdiction meant that the novices often found themselves working in organisations with relatively immature improvement programs. They therefore lacked a community within which to discuss improvement (as discussed in '*Noticing the nexus'* in Chapter 4). A novice advisor at a large regional hospital told me about the various CoPs he had been involved in in his pre-

healthcare life: *"I'm a great supporter of communities of practice… I've been part of the [Regional] Quality Council for eight years…" (participant 19).* He explained that he still engaged with these communities because his networks in healthcare were so limited.

He also did so because *"it's always great to see what other industries are doing."* Novice advisors were particularly open to opportunities for learning from 'others'. They actively looked beyond their organisations for useful ideas and considered non-healthcare industries to be valuable sources of knowledge. A novice advisor relayed to me a recent experience at a cross-industry Lean conference:

> *It was really good recently, we all got an opportunity to go to the Lean conference, like we got free tickets from The Agency. That was great because you were collaborating with people not only from across the country, but in other industries, which was brilliant to me, because I went to a couple of sessions that weren't healthcare related. And people were like, 'You do realise the healthcare session's down the corridor'... I was like, 'Yeah… I actually would like to hear what other industries are doing'... and you know, they were like, 'There was someone who came in before and realised it wasn't healthcare and left again,' and I was like 'No I'm here on purpose, I'm actually wanting to hear outside of healthcare"... We can be so insular. We just think we're all so special and different. Yes healthcare is complex. Yes, you're dealing with sick patients. Yes, you're dealing with this human factor. But the excuse of 'we're special and different' stops us from doing things differently. (participant 2, novice improvement advisor)*

With their external experience and open perspectives, novice advisors were often well-positioned to see that the tools, technologies and methodologies used in healthcare *"tend to be years behind what the rest of the industries are all doing…" (participant 19, novice improvement advisor).* This novice advisor who I spoke with at a large regional hospital was adamant that mobilising 'outside' ideas in healthcare was imperative if the conservative *"cultural thing"* that was holding healthcare back were ever to be addressed. He was optimistic that it was possible. His more experienced veteran colleague, however, took a less confident position: *"[No]... in 2025 we'll still be here…" (participant 18)*—but the novice insisted that healthcare *"just needs a step change."*

As a forum specifically designed to mobilise 'outside' ideas in healthcare, novices considered the ECoP and its formalised and relatively mandated nature to be a catalyst for healthcare to become more open to outside ideas, without which *"We're never going to catch up and we're just going to move further and further behind if we don't actually change the way we look at… [what] is happening out there and being a bit broader." (participant 19, novice improvement advisor).* The novices appreciated the policy mandate for its endorsement of their activity and for the perceived pressure it put on their organisations to support involvement with the ECoP and other Collaboratives. Moreover, they felt that The Agency was continually getting *"better at meeting the needs of the health services" (participant 21)*.

The novice advisors also thought that the mandated nature of the ECoP and other Collaboratives was key to dismantling what they believed was a mythical culture of non-sharing in the jurisdiction. Admitting that the first few workshops of the previous year's Collaborative felt strained, Colin said that, through their attendance, participants quickly realised that there was no problem with sharing: *"Turned out, in my opinion, no one has a problem with sharing. People just thought everyone had a problem with sharing… So we're doing this silly dance when actually there was no problem ever. I don't know. Maybe there was once upon a time. I don't know, but I don't see it now."* This experience of the benefits of mandated collaboration made Colin and other novice improvement advisors hopeful that the ECoP and The Agency's evolving program of collaboratives would continue to enhance knowledge mobilisation across the sector.

Moreover, novice advisors also tended to be optimistic about the possibility and benefits of developing a genuinely shared repertoire of improvement language which crossed clinical/improvement epistemic boundaries. In response to assertions by a doctor that they might more usefully stream the ECoP into disciplinary groups, so that doctors could collaborate directly with doctors across organisations, Malcolm reflected on his support for the cross-disciplinary, cross-organisational collaborative intent: *"Rather than saying, 'Oh no, doctors should be talking to doctors,' I think we should all start to try and speak the same language…"* This optimism led to the hopeful search for new concepts which could address the critical epistemic divide between improvement advisors and clinicians, as we saw in Chapter 5.

6.2.1.2 Novice nurses: Finding their voice, finding their people

Like the novice improvement advisors, the junior hybrid nurses I spoke to also highly valued the policy-level support for process improvement and the associated capability building and

knowledge mobilisation efforts. Until recently, these hybrid clinicians had had very little exposure to management systems, and even less exposure to the broader healthcare system and policy issues. They were, however, keen to solve the problems they experienced on a day-to-day basis in their clinical work. As *'epistemic expansion'* revealed, these were relatively young, driven nurses seeking careers beyond the frontline. Having become proficient in their clinical roles, they were ready for broader systems level knowledge and keen to develop *"a greater appreciation for the other factors that influence all patient care."* They saw having one's *"head wrapped around the clinical side of things"* was seen as a prerequisite to meaningful engagement with improvement and initiatives like the ECoP. As this young hybrid nurse said, it meant that *"you can focus on different things… and you get a wider picture of what's happening." (participant 8).* They perceived the ECoP as a facilitator of this continued identity expansion and the development of this wider perspective, which was what they saw their hybridity to be about.

Now in formal hybrid positions, they felt well-positioned to fruitfully engage with improvement and make meaningful change. They finally believed they had the opportunity to do so: *"I end up having all these ideas with my boss; some viable, some not so viable… getting into the management role… has been really good, because for some reason my voice is louder now in an [associate NUM] position than what it was when I was in that [frontline] senior nurse position."* However, as they entered into these roles, the junior nurse hybrids I spoke with also began to experience the same issues that the novice advisors faced with regard to engaging medical clinicians, and they felt their relatively low status compared with doctors more acutely than they had in their purely clinical roles:

> *For example, I tried to implement [hygiene procedure] stuff for Hygiene Australia, and I tried to implement teaching and stuff for the residents and the interns, and I got kickback from the consultant group. I'm like, 'Okay. I thought ... I'm willing to teach your…' Again, there's that segregation, right? As a nurse, I'm willing to teach… the medical staff, about the patient benefits of hygiene, not to mention the self benefits of hygiene. Yeah, anyway *shakes head*… And I got resistance from that, to the point where my boss was like, 'No, no, no. You've done your part. It is now on them to sort it out.' (participant 8)*

The novice nurse hybrids therefore appreciated the mandated nature of the ECoP, since, like the novice advisors, they saw it as welcome pressure on organisations to take improvement

seriously. Participating in the ECoP gave them a window into other organisations' processes and cultures as a point of comparison. This allowed them to make sense of the worlds they were entering within their own organisations. Seeing and interacting with people from other organisations clarified for them the differences between the levels of organisational support for improvement work at their own organisations compared with others. They could see, for instance, that the senior management at other organisations (e.g., at Big Metro), were much more willing to engage with juniors and their ideas. As one novice nurse hybrid said, *"[My health service] is renowned for [an insular] culture… it's something I'm not proud of, to be part of that aspect of it." (participant 8).* While he described feeling peripheral to decision-making processes regarding improvement in his hospital, he felt that the ED CoP, in contrast, was a broad and inclusive community in which everyone involved in healthcare was welcome as a member: *"Everybody is. Whether you like it or not, your opinion contributes to this community, right? And effectively, from how I see it, it's a healthcare community. The initiative is fantastic, by the way… and I will be involved with it from here on, I can tell you that.'"*

Novice nurse hybrids' participation in the ECoP also opened up opportunities in their hybrid roles at work. This hybrid told me that *"having this position has been really good because I also got to be part of the [Innovation] Committee at work,"* and that *"The Agency thing helped us collaborate or have that group discussion with everybody… we were there to say, 'Yes, this is what we have learnt [from the ECoP]…'"* They highly valued opportunities like this as they were perceived to boost their influence within their organisations.

Moreover, novice hybrid nurses valued the potential of the ECoP to help force the breakdown of hierarchies and silos. Another associate NUM described her *"biggest frustration": "We all work in silos, people won't lend things to other departments and it's such a competition and I just feel, at the end of that, our patients are impacted by these decisions that we make in everyday practice." (participant 26)*. Breaking down silos, both disciplinary and organisational, was of course an explicit aim of the ECoP, and through their participation these novices met people who they perceived to be exemplars of collaborative working and who gave them a voice at a time when they still struggled to find a platform in their own organisations:

> *[the fact that Big Metro's senior management were there] That was really good and they were all very approachable and very keen to get my perspective, being an ANUM in an emergency department, of what I thought about stuff. That was very collaborative in that*

sense because it wasn't like, 'We're upper management. We know better than you.' It was very, "Okay, what do you think?" And really taking on board what I had to say. (participant 8)

Like the novice advisors, the novice hybrid nurses valued the structural legitimacy that they felt that their involvement in an initiative mandated by The Agency could bring them. If the ECoP could prompt the Department of Health to help develop statewide guidelines about service improvement, for instance, this would bolster their ability to push for change within their organisations, and would help them to engage medical clinicians. A junior hybrid nurse commented: *"I love the concept of [the department of health] overseeing it and I love the push towards making statewide guidelines rather than local guidelines and policies… [the ECoP] really showed me that there is work being done around that." (participant 26)*

While they had found themselves with increased structural legitimacy and more influence within their organisations, these novice nurse hybrids' relatively low status still constrained them, as did the lack of organisational support for improvement. Yet, as novices, they maintained enthusiasm, openness, and a willingness to alter the status quo. Through their reflections to me and their participation in the workshops, novice nurse hybrids positioned themselves as in the process of *becoming* proficient improvement practitioners. They perceived their participation in the ECoP to be a pathway toward belonging to a passionate improvement-focused community, alongside *"leaders in their field in terms of leadership, change, innovation, management." (participant 8)*

6.2.1.3 Veteran nurses: Getting on with it, getting out of the box

The veteran hybrid nurses I spoke with were all NUMs of either inpatient wards or EDs, all women, and all had spent their entire careers as nurses. They had also all been at their current organisations, and in their current NUM roles for at least a decade. These were women staunchly dedicated to their profession, organisational units, staff and patients, and their identity was tightly bound up with their work. Over the years, they had been exposed to many management ideas and seen them *"cycle through"* the sector—*"The very start of that… would have been more than 15 years ago, Lean thinking was around then." (participant 14).* As a result, they had already done much of their identity expansion work when it came to reconciling improvement practice with their roles. Moreover, they had not found this particularly challenging since they were so personally invested in their staff and departments. However, they were

largely disinterested in learning to speak the language of any particular methodology or engaging with specific improvement practices as more formally defined by the advisors. What they were most interested in was the legitimacy that their engagement with the ECoP lent them with regard to their existing improvement agendas. Nurses wanted problems within their departments to be acknowledged, and they wanted the support and resources they needed in order to fix them.

Like the novice advisors and nurses, more senior hybrid nurses also perceived the policy level support as sanctioning their own improvement efforts, especially where they felt disconnected from, or unsupported by weak organisational improvement programs. An ED NUM with more than 20 years of experience in her role at an outer suburban hospital described a lack of organisational support for improvement, and an improvement team that was too distant from the frontline: *"They've got Lean... and I know there is something... [a] capability framework… [but] it's not put out there, maybe I'm supposed to research it myself but I just don't have time… I don't even understand [the frameworks] so I don't bother with them... [the improvement people] sit down there, they're not here or not on the wards, they're down there making these learning ladders [and] you think 'For God's sake I'll do my own, thank you.' *laughs*"* She perceived her participation in the ECoP as license to bypass these organisational formalities since she could now say: *"This has come from [the jurisdiction], not from me, not from anywhere else." (participant 16).*

Despite their exposure to improvement methods and long-term management experience, the veteran NUMs in the ECoP were engaging in a significant way with the jurisdiction's improvement program for the first time. They felt that The Agency's support for improvement in the form of the mandated initiatives could legitimise their own improvement activity, and eventually help them build better organisational structures, relationships and support for their work. Even the NUM at Big Metro, which was increasingly renowned for its improvement program, surmised that their emerging success was in no small part due to the mandated policy push for cross-organisational collaboration. She believed that neither would have led Big Metro to the improvement culture it had today without the other:

> *For me, the turning point, for Big Metro, there's probably two things that happened… And I don't know if one would have happened without the other. It was just fortuitous that they both occurred. So, we had a new CEO come in, and that CEO had done a lot of*

> *work in continuous improvement, and all these kind of problem solving, and kind of diving down… all these terms… so, we had a [new] way of looking at problems… Then, she brought in the Improvement Team, and then, at the same time The Agency kind of came into play. So, you know, any one of those could have happened on its own, and there mightn't have been the change. But for Big Metro, those three things, I think, have had the biggest impact. (participant 27)*

While the NUMs I spoke with had decades of experience in nursing management roles, none were conservative in their approach or resistant to change. They advocated for reform and progressive ideas like those emerging from the ECoP, believing that it was important *"to learn to let go of old ways and habits."* The senior nursing hybrids recognised that they could become too inwardly focused within their own units and organisations where they felt that they had the ability to effect change. This meant that they easily fell back on their well-established 'organic' NUM community when they faced challenges. However, engagement with the ECoP helped them to reflect that this organic knowledge mobilisation excluded others who were newer to NUM roles. They realised, as this NUM did, that, *"I may be a constant, but there's lots of new people… And I think [that] opened me up to a different way of problem solving and looking through things." (participant 27)*

Importantly for the NUMs, who spent their lives dedicated to their particular units, another benefit of participating in the ECoP was the opportunity to gather with the broader organisational leadership team. While the ECoP brought novice nurses the opportunity to have a voice and to develop relationships at their organisational leadership tables for the first time, veteran nurses felt that the ECoP enabled them to refresh and further solidify existing relationships that could become neglected over time due to general busyness. With *"the right mixture of people"* in the room, the space that the ECoP created functioned to bring improvement back into a position of organisational priority:

> *Also for my intra-hospital, it brought executive, general managers, and other places that my area, ED, connects into. It brought them into the room, as well, which gave it a level of authority and buy-in [for improvement] from the hospital. (participant 27)*

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While their reflections and reasoning for engaging with the ECoP differed, the novice advisors, novice nurses and veteran nurses were consistent in their *participatory engagement.* They engaged genuinely on the front stage of the workshops and reflected positively on the policymakers' initiative in backstage conversations. These groups easily reconciled their existing identities with their participation in the ECoP, and sought an inbound trajectory toward fuller participation.

6.2.2 Peripheral lurking: Hybrid doctors

Senior doctors had been the most difficult to engage in the preceding ten years of the policy improvement program. For this reason, a core aim of the collaborative initiatives was to improve clinician engagement with process improvement, and to help make the day-to-day knowledge brokering work of The Agency's designated improvement advisors easier. Across the public hospital system, some senior clinicians had in their own organisations begun to engage with and promote the clinical benefits that could come from service improvement. It was these veteran hybrid doctors who policymakers had targeted for membership of the ECoP. They had hoped to forge a common purpose with the advisors. From the policymakers' point of view, the level of engagement of hybrid doctors in the ECoP was to be considered a resounding success. In one of my early meetings with the policymakers, Neil said he believed that *"those clinicians are going to be the success of the ECoP and the other Collaboratives"*.

It was widely felt that ED doctors were a particular case, as a veteran improvement advisor described: *"[They are] a different kettle of fish, and they're much more engaged in this type of thing."* She explained that ED doctors were *"very keen [on improvement because they] feel that they get slammed, because they're the front door." (participant 7).* They bore the brunt of the effects of many hidden problems and substandard processes in organisations and the wider system. While a delay in discharging a patient from an inpatient ward meant an 'easy patient' for ward staff for another day, this could translate into EDs becoming bed-blocked, patients experiencing long wait times, and NEAT KPI 'blowouts'. As a result, the attention on EDs was welcome for hybrid ED doctors.

6.2.2.1 Enhancing doctors' influence

From policymakers' front stage vantage point, the hybrid doctors represented in the ECoP appeared highly engaged. Here, they observed the doctors engaged in discussions and sharing

process knowledge from their clinical perspective. I observed this too—doctors participated enthusiastically and quite often commanded the room. Despite usually being quietly spoken, they occupied the talking space and articulated their ideas well. I noticed that doctors rarely paused when speaking; they were not pushy but they were given the stage and held it well. This was a privilege that their high status afforded them in most walks of life, including in health service management and in the ECoP forum. When I interviewed a senior hybrid doctor one morning at his large suburban hospital, he explained this most effectively by showing me a text message in which he quipped about his own good fortune. He had just sent it to his wife:

> *Just reading about a review of [doctors] in management: "Medical Managers have distinct advantages over their non-medical counterparts, including greater credibility, a deeper knowledge of how healthcare works, and a less trammeled ability to speak out." Sound familiar? :) (participant 30)*

He was not convinced by the line about medical managers having a deeper knowledge of how healthcare works than non-medical managers, but the notion that doctors' professional identity endowed them with credibility and voice was something he had experienced and reflected upon over the years. While the policymakers' optimistic view of clinician engagement in the ECoP was not entirely mistaken, this text indicates that the hybrid doctors' front stage willingness to engage in talk was not necessarily indicative of their engagement with process improvement knowledge or indeed collaborative learning with other disciplines.

The veteran hybrid doctors involved in the ECoP (mostly ED or other departmental directors, and a handful of relatively more junior 'novice' hybrid doctors with some improvement experience or interest) did genuinely and publicly identify with the policymakers' endeavours to mobilise process improvement knowledge. In particular, ED doctors hoped that process improvement would aid the operational efficiency of the busy emergency departments in which they struggled day-to-day.

Hybrid doctors also highly valued the opportunity that the ECoP created to gain more regular insight into the worlds of other organisations and how they were dealing with challenges that were ultimately very similar across organisations. While the veteran doctors, like the veteran advisors and veteran nurses, felt that they already belonged to a strong organic CoP, the ECoP was another sanctioned opportunity in their time-poor schedules to *"catch up with the crew…*

and talk a little bit about what's happening in each department, how we can, I don't know, copy each other." In particular, they emphasised the informal time spaces of the workshops as important for gaining insight into their medical peers' improvement activity. As the ED director at Outerside told me: *"If you knew that something was going on at Metro and they were going to be there… at lunchtime you could slide off with Metro and have a yarn with them about what's happening… I mean, the emergency directors catch up twice a year, but this was another opportunity to catch up." (participant 31).*

As well as a sanctioned opportunity to catch up with hybrid doctor peers, they also interpreted the ECoP as a line of sight into policy activity that affected doctors and their ED departments, and a potential opportunity for upward influence into policy decisions. EDs being highly politicised healthcare arenas, the ED directors already had significant influence. This was evidenced by key political figures including the Minister and Secretary for Health attending their informal dinners. However, further opportunities to have political influence were always a good thing, as this was a perceived pathway to greater resourcing for their busy departments. By having their professional peers in the room with them in this forum alongside policymakers, hybrid doctors could potentially exercise collective influence over policy decisions, as the discussion about variability in flu testing revealed in Chapter 4. At the final ECoP workshop, The ED director of Outerside told Neil and Martina that if they wanted to engage more of the 'unconverted' clinicians (such as the most difficult to engage and highest status surgeons), the solution was to provide them with *"more opportunities to have the minister's ear." (participant 31)*.

6.2.2.2 Alignment issues

Despite the various aspects of their engagement, there was a clear 'alignment issue' with regard to process improvement knowledge, as the findings in Chapter 5 revealed. These 'willing' hybrid doctors still brought their epistemic legacies into the ECoP room with them, and as outlined earlier in this chapter, their epistemic struggles were ongoing. The seeds of mistrust of other disciplines had been planted "*from the very first week of medical school"* and, as such, were not easy to shake. Engaging with the language of improvement was no small part of their epistemic expansion challenge, and there was a general reticence to engage with *"management speak".* An ED director from a large metropolitan hospital (with a highly lauded improvement program) conveyed this in an interview:

> *So there's a lot of management speak... you know people say, "We'll just run it through a few PDA cycles and tweak the PDSA and get some capability uplift," and I just switch off because it just sounds like a lot of bullsh*t at that point. Even though I can step back and go what they're trying to say is, you know, "We're going to try in a structured way to assess what we've done and see if it's any good and improve it…" just the talk, it just grinds me down a little bit so I get a bit switched off. (participant 17)*

While Malcolm, as an enthusiastic novice improvement advisor, expressed that the doctors 'switching off' would be *"a missed opportunity for us to develop a shared language of improvement,"* this was not a challenge to be underestimated. There were plenty of signals that the doctors were continuing to resist engaging with improvement rhetoric in the ECoP. Dr Jason and Malcolm's public contretemps in *'problems of proximity'* was a prime example, with Dr Jason and his hybrid doctor colleague reflexively responding by highlighting that the epistemic machinery of improvement was not to be trusted: *"This tool is not a perfect tool…"* While apparently engaged in discussions in the ECoP, doctors sought to maintain distance from process improvement and its language. They instead sought to maintain loyalty to their medical epistemic community and clinical identity. The ECoP participants were told, for instance, of how Dr Jason *"threw out the management book"* during implementation of Edgeside's new ED model of care—he had deliberately de-labelled the process improvement work so that his clinicians, *"did not think they were doing Lean."* Others sought to avoid the actual doing of improvement entirely: *"I still haven't really got the hang of PDSA cycles and quality improvement processes and so forth and I'll leave it to others probably. I was going to appoint someone else to run those projects." (participant 17)*

Other discussions with hybrid doctors underscored how doctors' wariness of practice-distant improvement advisors and their abstract conceptualisations of improvement stifled the cross-disciplinary collaboration that the ECoP aimed to foster. A novice hybrid doctor from Big Metro told me: *"In the CoP when I'm asking for advice... sometimes how things are phrased… is not work as done, they've misinterpreted, or how they imagine how my job works isn't quite correct."* It was therefore important to him to know *"the context of… who's answering me, in how I interpret... Like is it someone from like exec or [a manager] saying, 'This is how we do our [Daily Operating System] Tier 2 type stuff,' or someone with a change or improvement kind of background—there's a specific kind of language that sits there, or clinicians how they kind of speak to things too."* Trusting that others felt as proximally responsible for the safety of his

patients was difficult, and justified maintaining distance from other disciplinary groups. He felt that 'streaming' the ECoP into disciplinary groups would help because *"... if I know I'm talking to [a doctor] on the shop floor… it adds a bit more authenticity to the advice." (participant 4).*

Despite this wariness, the veteran hybrid doctors saw significant value in providing opportunities for less *"entrenched"*, less cynical junior clinicians to engage with knowledge about the system and its improvement, since, as the ED director of Outerside said: *"The system lets patients down all the time and why... that, to be honest, is a byproduct of perhaps us not teaching people the importance of it." (participant 31).* While none of the veteran hybrid doctors knew how to solve the major tension between enabling the *"poor little intern"* to survive their clinical learning curve and still *"teaching them enough about how we run the place" (participant 15)* there were some early indications that initiatives like the ECoP and The Agency's suite of collaboratives had the potential to engage the future leaders of the medical profession.

In a noteworthy presentation at Big Metro, a relatively young hybrid doctor delivered the only formal presentation by a practising hybrid doctor during the three ECoP workshops. She was a rare kind of early career hybrid doctor, having paused most of her clinical duties to undertake a year-long non-clinical secondment in Big Metro's continuous improvement unit with Colin. Her presentation in the ECoP was most significant not for the project she presented, but for her public expression of gratitude for the opportunity to engage with improvement, and her front stage admission that doctors were dangerously uneducated about the broader system. She said: *"I love that being part of the improvement team drew attention to my ignorance."* Unlike her senior peers who had all 'fallen' into their hybridity, she had actively sought out improvement training to broaden her perspective. This, of course, had only been made possible by the fact that she worked at Big Metro, which had rapidly expanded its improvement program contemporaneously with The Agency's arrival on the scene in the jurisdiction.

Having been *"ranting and raving about [problems] for the last 9 to 10 years since I started working in public hospitals…"* she told the ECoP audience, *"I feel incredibly fortunate to have been given this job… I got to jump into the deep end and I just had no idea what I was doing but I've learnt so much. I learnt terms like SME, standardisation, takt…"* Her presentation was also significant in that it was the only time I observed a doctor willingly using *"management speak"*. Like Colin, her coach, she displayed performance graphs and talked about *"variability"* and *"standard work"* and explicitly connected these to Big Metro's performance on the NEAT KPI.

However, despite this young doctor's willing 'conversion' into a process improvement advocate, and despite Lean jargon rolling off her tongue, she also found herself on a tangent about KPIs as *"corporate violations".* Such violations, she said, put pressure on clinicians to change behaviour despite what is right for a particular patient or clinician in a particular case (surfacing the tension between the 'patients as populations' and 'patients as individuals' perspectives that doctors spoke of in interviews). She made sure to conclude that while standard processes were valuable in framing clinical work, they should *"never touch how we do the doctoring and the nursing".* Her presentation seemed to indicate the possibility that future generations of medical clinicians might more easily engage with process improvement knowledge than their veteran counterparts. Nevertheless, the uneasy tension between abstract performance measures and proximal understandings of practice remained stubbornly evident.

In sum, veteran hybrid doctors' participation in the ECoP was characterised by ambivalence. On the one hand, their past experience of the potential benefits of service redesign and process improvement sufficiently persuaded them to see merit in attending workshops. Moreover, they saw the value of the insight they gained into other organisations, and of the potential for collective influence over policy decision making. On the other hand, however, they struggled to reconcile the 'epistemic' basis of their own professional practice, rooted in scientific evidence, with the seemingly less rigorous basis of process improvement methods. It appeared that younger generations of doctors might be more willing and able to reconcile their clinical identities with the knowledge and language of improvement. Yet, even these enthusiastic younger hybrids made sure that non-medical improvers remained at arms length. In this sense, the hybrid doctors *'lurked'* on the periphery of the ECoP.

6.2.3 Distancing: Veteran improvement advisors

Counter-intuitively, members of the 'veteran' group of advisors had the most difficulty reconciling their existing identities as improvement experts with their membership in the ECoP, despite their being the group the policymakers imagined the ECoP would most help. Worn down by the brokering challenges they had faced over the preceding years, it seemed likely that this group would appreciate the renewed policy level support for their work. Instead, rather than engage with the objectives of the ED CoP, veteran advisors sought ways in which they could distance their identities as experts from it. When talking with veteran improvement advisors, two key

themes emerged. They resisted perceived pressures and attempts at regulation of their role identities and practice by the policymakers, and they reflected on and reverted to their strong organic community of peers.

6.2.3.1 Resisting policy pressure

Critically, veteran improvement advisors had been around for long enough to understand and have experienced firsthand the challenges of attempting to broker improvement knowledge within their organisations. Many veteran advisors on the ECoP invitation list had been in the improvement game for an extended period. Many were, or had been, formally funded as part of the jurisdiction's 'official' cadre of improvement advisors. All of those I spoke with had allied health or nursing backgrounds, and were now highly experienced process improvement practitioners in fully non-clinical roles. Their experience in improvement to date had exposed them to the challenges of engaging across widely varied boundaries, including executive leadership, middle management, clinical leadership, and the clinical frontline. Their extensive experience meant that these veterans did not perceive policymakers' intention to homogenise improvement capability through the ECoP and other Collaboratives as valuable. An improvement advisor from a large suburban hospital with a mature improvement program explained this:

> *I know how challenging it is… [but] one size doesn't fit all and what we need… is going to be very different to what [Edgeside] needs to what Outerside needs. And [The Agency is] trying to accommodate a model to basically really fit the average but because the spread of capability and knowledge and experience is so wide, the average is really low because there's many more at the lower end of capability than there are at the mature end. So they're only at the average, which means there are a few of us who, it's just of no value whatsoever really. (participant 10)*

The improvement veterans did indeed express appreciation for the policymakers' efforts to re-engage with them after the latest restructure and transition from The Department to The Agency, and also for the greater support and opportunity for networking among their peers: *"… there's no question that the collaboratives have reengaged us networking very very differently than we have been, no question. I think everybody would agree…"* However, despite this sentiment, the array of initiatives with which they were expected to be involved in (or not—they weren't sure) also overwhelmed and confused them. How the initiatives fit together, and where

the participants and organisations fit within the broader collaborative picture were hard to grasp. As one of the veterans said to me: "*I'm always confused, is that one of your questions?" (participant 23).*

Moreover, while the improvement advisors themselves struggled to make sense of The Agency's new suite of collaborative initiatives, it also fell to them to marshal the others within their health services who should, could or wanted to be involved in the ECoP or other Collaboratives. Among similar sentiments shared by many participants, the executive sponsor at Edgeside said to me: "*I get confused with all the terminology to be honest... I struggle to keep up to date with even who's who between [another agency] and The Agency… So I just go where I'm told, where [improvement advisor] tells me to go." (participant 5).* It was the advisors' job to convince staff at various levels, from the frontline through to clinical leadership to the executive level, that they should either attend or facilitate others' attendance. Accordingly, veteran advisors shouldering such responsibility experienced a shared sense of overwhelm.

As well as an overwhelming sense of confusion, the ECoP also added an element of perceived pressure to collaborate. Clinicians experienced the mandatedness of the ECoP as a protected opportunity to decouple from the frontline, as well as *"credence"* for improvement work in organisations where it was difficult to garner executive support. Veteran advisors, however, experienced this mandatedness as further pressure to engage with ever-increasing administrative activity associated with their roles. It was clear to the veteran advisors that The Agency was very deliberately attempting to direct the kinds of activities in which they were involved. In a meeting with the policymakers, Martina admitted that her team aimed to be increasingly directive about the kinds of activities that 'their' improvement advisors were involved in, seeking greater oversight and control over the use of these human resources: *"We're trying to flesh out their role. We haven't previously been involved in their onboarding process so we're trying to do that really deliberately and systematically now…"*. Ultimately, The Agency wanted to shift how improvement advisors saw themselves, and how their organisations saw them—from belonging to the health services they worked in, to belonging to their funder. The veteran improvement advisors were acutely aware of this trend, and experienced it as micromanagement and pressure:

> *… what we are increasingly going to be asked to do is I think going to be the most micromanaged role in healthcare… Seriously, what we are going to have to provide to*

> *them. I think they've changed it from quarterly to potentially six-monthly reporting, but I have to prove that I can do my job. I have to provide them with my professional development plan for the year, and demonstrate that it aligns with the capability requirement for my job. I have to send them reports on all of the projects that I'm coaching and working on with quite a detailed list of measures, and where it's up to, and if it's delayed and why, and who, and I have to do that every three to six months. And my executive sponsor has to do a similar thing and basically provide assurance that I am up to the job. (participant 10)*

This perceived pressure sat uncomfortably and indicated to veteran advisors that the policymakers were not genuinely concerned with supporting them: *"They actually are not really interested in how I have a team around me and how that team works, it's actually just about what I do and about what my role is."* The policymakers' desire to reduce the advisors' practice to performance measures (which, ironically, the veterans deemed insufficient to capture the depth and breadth of their professional activities) was unwelcome. The policymakers' distance from the improvement frontline, and lack of expertise in improvement knowledge, did not go unnoticed by the veteran improvers. Veterans recognised this as a gap in terms of their perceptions of the value that policymakers' could bring them: *"I guess the thing for me is none of the people in The Agency have worked in one of these roles in a health service or even worked in the improvement team in a health service… even when they come to visit, they come to talk about one thing and they'll come for an hour and whatever, they have no real knowledge or understanding about what we actually do on a day-to-day basis."* Corroborating such reflections, I observed numerous opportunities for Neil to engage 'on the ground' and understand the internal workings of improvement teams by attending site visits that he rarely took. He chose to remain at a distance from the improvement advisors' work.

Furthermore, the veteran advisors perceived The Agency itself as shambolic and, as this veteran advisor from a large suburban hospital put it: *"... really siloed… you've got like the X Collaborative who's doing something else over here and the Y Partnership over there, Z over here, run by Industry Coaches, who up until recently haven't had any healthcare experience, have come in and kind of tried to teach us how to suck eggs."* My own observation and interactions with the policymakers also upheld this interpretation. Martina told me in a meeting at The Agency that *"It feels like all our different branches are doing lots of projects but there is no overarching program of work… it's all a bit of a mess… there's no oversight anywhere… like*

who is responsible for XYZ isn't clear… and there's so much overlap." As such, it had *"been a bit challenging"* for the veteran advisors to regard the policymakers at The Agency as worthy custodians of the improvement cause.

As a result, some veterans believed this led to front stage engagement that was not necessarily genuine. From his position as an enthusiastic novice advisor, Colin from Big Metro surmised that *"…frankly, the only reason some of the organisations are coming to those Community of Practice events are because they know The Department's there, and they know it's the right thing to do, and I'm not convinced they really, really want to be there."* Colin's comments were a reminder of the hospital which, much to the policymakers' chagrin, had rejected their invitation to participate in the ECoP earlier in the year. The rejecting hospital identified, and was identified by others, as a 'veteran' organisation—a leading figure in process improvement in the jurisdiction and a production line for competent process improvement advisors. Their highly performing CEO had enough standing in the sector to publicly reject participation in the ECoP, but, as Colin's comments suggest, less prestigious organisations may have participated merely to ensure that they were seen to be doing the right thing on the 'front stage', perhaps for fear of the policymakers excluding them from future opportunities.

Also critical to their reticence to engage with the policymakers' program was the fact that veterans typically belonged to organisations with more mature improvement programs, and had often been involved in their development. Through dedicated work over many years, they had begun to build improvement teams, positioned improvement as a strategic priority and been involved in embedding improvement into the organisational structure in a more enduring way than the policymakers' piecemeal efforts at the sector level had enabled. This had been hard and formative slog, and still required constant work, maintenance and learning. Were it not for growing internal organisational support for improvement, they would not have had the opportunity to become 'veterans'. Understandably, they wished to nurture what they had already created over years in the job. They therefore saw shifting their focus away from their internal efforts to engage with poorer performing organisations as a lower priority.

Finally, and importantly, the veteran advisors also interpreted policymakers' activities as concerned with achieving their own targets rather than genuinely helping to facilitate knowledge mobilisation that would help the advisors in their day-to-day work. In an interview with two veterans, one described her impression *"that they're very KPI driven… it sounds like there's*

KPIs regarding how many workshops they hold and how many times people go on [the online forum]... I struggle with—". This advisor's colleague offered to finish her sentence: *"—Forced sharing?"* The first advisor agreed: *"It is, it's forced sharing. And it's like the workshops, I think it's often that… they need to have X number of workshops rather than actually thinking about what do we need, when do we need it, how do we deliver it, so that it suits people that are in the projects." (participant 11).* They took this impression to mean that despite the policymakers' front stage rhetoric about knowledge mobilisation, they lacked genuine concern for the brokers' frontline knowledge brokering challenges. The veterans foresaw that the mounting pressure from policymakers who were disorganised and lacked improvement capability themselves, and who were too distant to understand their frontlines, might eventually run counter to The Agency's aims.

6.2.3.2 Turning to peers

They were under increasing pressure, yet the veteran improvement advisors felt neither isolated nor alone. Because they tended to work in organisations with more mature improvement programs, they were mostly surrounded by teams of people who provided day-to-day opportunities for mutual support. Moreover, they tended to draw on their existing networks across organisations frequently. Veterans acknowledged and appreciated The Department's historical efforts to bring them together. A side-effect was that an enduring 'organic' CoP of improvement advisors had developed. As a veteran said to me in an interview: *"You can't actually underestimate how much of that Community of Practice happens already." (participant 29).* When the original improvement program had shifted from The Department to The Agency, this organic CoP had essentially gone underground. Much of its interaction was now invisible to the policymakers, and taken for granted by the veterans.

Since the ECoP served to bring the existence of these relationships to the fore, veterans—as they reflected on the value of their participation in the ECoP—noted that 'backstage' was where much of the 'real' knowledge mobilisation happened. In fact, veterans felt that The Agency ran the risk that participants would interpret its well-meaning attempts to 'help' mobilise knowledge as paternalistic encroachment on their relational activities. A veteran advisor from one of the large metropolitan services reflected: *"I think that's where The Agency have got to be careful that they don't patronise some of the attendees by saying, 'This is your only opportunity to collaborate.' Because the performance expectations on all of us means that if somebody's got a good idea, we'll go and find it. We're not just sitting back, thinking…"* She felt that the

mandatedness of the ECoP risked participants like them turning away toward existing networks: *“I think the risk… is that people find other ways and forums to engage in.” (participant 29)*

This backstage community was not, however, entirely harmonious nor necessarily welcoming to newcomers. This reconciliation of their veteran identity through distancing was also apparent in the reactions of veteran advisors to newer colleagues who appeared overzealous in their attempts to demonstrate their prowess as improvement experts on the ‘front stage’. In a backstage conversation following Malcolm’s presentation in the first workshop, a veteran was keen to diminish the value of the ECoP for her as a comparative expert: *“Can I be honest with you… I don’t personally find it any value for me going. So I said that to [advisor colleague]... ‘What am I doing there?’ I think it needs to be geared at more people at the ground… Because I’ve heard that guy speak several times before. Like I’ve heard it all before… the first part of that session… yeah, didn’t captivate me.” (participant 9).*

As a result of their high levels of competence, and the maturity of their organisational improvement programs, veterans felt that the kind of knowledge being mobilised within the ECoP was of little value to their development. As the veteran quoted in the opening of this section said: *“... there are a few of us [for whom] it's just of no value whatsoever really…” (participant 10).* Hence, veterans perceived the ECoP as valuable for less experienced ‘others’, including clinicians *“at the ground”* who they believed should increasingly be the doers in improvement work. This would also be true for other groups of improvement advisors who, as a result of their lack of experience, would benefit more from the opportunities created by the formal collaborative initiatives than they would. For instance, a veteran advisor told me that, while metropolitan areas were already relatively well-equipped in terms of improvement capability and resource, *“there is a real opportunity for [The Agency] particularly in engaging rural health services, which I think could be more isolated.” (participant 29).*

Ultimately, the number of veterans improvement advisors attending the ECoP workshops dwindled over time, to zero in the final workshop at Outerside (although their backstage knowledge mobilisation work went on). While the veterans appreciated the policymakers’ goodwill and the ECoP and other Collaboratives as a gesture intended to help them network and broker their knowledge across organisational and clinical disciplinary boundaries, they felt that the policymakers had missed the mark. They remained somewhat skeptical of the conditions surrounding the ‘help’ on offer, which they felt put pressure on them. By the end of

the ECoP, this group had largely adopted a position of distance from the ECoP and had oriented themselves along what appeared to be an outbound trajectory.

***

In this chapter I have elucidated the unique forms of identity reconciliation work of participants belonging to different epistemic communities—both historically and through their participation in the ECoP. I have shown that epistemic expansion work is necessary for engaging with knowledge which is 'non-native' to one's community—an important enabler of knowledge mobilisation that is more or less effortful in the case of different epistemic identities. I have also revealed that modes of identity reconciliation in relation to the ECoP resulted from participants' sensemaking with regard not only to the value of the initiative, but also the extent to which they perceived they were willing participants or, alternatively, obligated to engage. As I will discuss in the next chapter, the trajectories of participation that resulted from participants' identity reconciliation work are likely to have significant performative effects in terms of both the current state and future emergence of the ECoP.

Table 6.1 Supporting data—Identity Reconciliation

<table>
<tr><td colspan="3">Chapter 6: Identity Reconciliation
How participants worked to reconcile their existing identity trajectories with belonging in the ECoP, and how these varied modes of reconciliation resulted in differing trajectories of participation.</td></tr>
<tr><td>Themes</td><td colspan="2">Sub-themes and supporting data</td></tr>
<tr><td rowspan="2">Epistemic translations
Ongoing epistemic expansion common to all participants; struggles faced by different epistemic communities are unique.</td><td colspan="2">Heterogeneous hybrid engagement
Reveals how epistemic broadening is more or less effortful for hybrid clinicians depending on whether engaging with process improvement knowledge is perceived as likely to challenge existing professional and epistemic identities, and attendant status, influence and autonomy.</td></tr>
<tr><td>Allied health
Seen to be 'born with it'.
Deliberately seek out opportunities to engage with improvement for perceived personal and</td><td>Obviously their education and their training, whatever they do is visibly different. It feels different, the communication is different, their adaptability is different, and they just get [improvement] and they just do it. (participant 14, veteran hybrid nurse)

Allied health clinicians at Big Metro were "gagging for the next round of [improvement] secondments… because I think people have seen… the opportunities that you get." (participant 3, novice improvement advisor)</td></tr>
</table>

	professional benefit.	
	<u>Nurses</u> Improvement does not appear to come naturally to rank and file, but changing with newer generations.	*I think nursing does not have any of that… I think even now, you know pulling up a nurse to say, "Look at your falls data over a month and see whether..." that is still not there. It should be there for the NUM, it should be definitely there for the ANUMs because they all have portfolios but how that spreads down, I don't know… it's just not bred [into] them.* (participant 9, veteran improvement advisor)
	<u>Doctors</u> Difficulties reconciling professional autonomy and priority of individual patient care with broader systems and public health perspective.	Epistemic challenge in broadening their perspective from the individual patient to the public health *"pathways and posters"* perspective in which they needed to *"follow guidelines and create a standard way of operating and get rid of unnecessary variation in practice." (participant 17, veteran hybrid doctor)* Trained *"to think of patients as individuals"* but managerial roles required *"thinking of patients as populations. And so there's a real... that is difficult… a constant problem as a [hybrid] manager." (participant 31, veteran hybrid doctor)* Knowledge overload for juniors due to *"endless rotation…"* but doctors recognised a need for *"actually incorporating [improvement] into their continuing medical education… beyond just disease-focused management stuff, but actually talking about what management means and how that leads to efficiency and dealing with scarcity and getting the most value out of what we have." (participant 15, novice hybrid doctor and participant 31, veteran hybrid doctor)* Adding non-clinical *"extras"* a big ask for senior doctors who have *"entrenched ways of doing things… to ask someone to add an extra facet or an extra detail that they have spent 20 years or 25 years never even thinking about is very very difficult."* (hybrid doctor, Edgeside)
	<u>Improvement advisors</u>	
	<u>Peripherality & puppeteering</u> Reveals improvement advisors' ongoing engagement with forms of knowledge	Experienced low status and visibility in organisations: "*So now talking to my girlfriend's friends… they're all doctors [here], they're like 'Ah you're one of those people…' [so I] sort of walk around with a target on my back but... yeah they don't really know about [our improvement team]."* (participant 6, novice improvement advisor)

<table>
<tr><td></td><td>beyond process improvement to generate visibility, legitimacy and become more central within the healthcare field.</td><td>Looked to management theories to help learn to influence more effectively: “[I’m looking to behaviour] frameworks… really interesting stuff [about] diagnosing behaviour… And there's lots more out there so we probably need to take a bit of the initiative as well, stay abreast of the literature and best practices and be the catalysts for the adoption internally.” (participant 21, novice improvement advisor)</td></tr>
<tr><td rowspan="3"><u>Modes of identity reconciliation</u></td><td colspan="2"><u>Distancing, participatory engagement, peripheral lurking</u>
Learning to be together involves reconciling epistemic, political and professional concerns with participation in the mandated collaborative initiative, through sometimes contradictory ‘front’ and ‘backstage’ practices. The three modes of identity reconciliation reveal longitudinal trajectories of participation, shaping the future of the ECoP and knowledge mobilisation activity within it and in the sector more broadly. This takes us full circle to emphasise the processual dialectical ‘reality’ that is the ECoP, in a continual precarious state of becoming through the interaction between the dual processes of participation and reification (Wenger, 1998).</td></tr>
<tr><td><u>Participatory engagement</u>
Novice advisors, novice nurses and veteran nurses appreciated the mandated nature of the ECoP and saw their increasing participation as a pathway to greater engagement and influence in improvement in their organisations and more broadly.</td><td>Novice advisors: Riding the improvement wave
One of the advantages of being part of the collaboratives is that they provide a lot of tools… someone’s gone out, done a bit of research, found a few good ideas and then brought them to us for broader implementation and we've sort of taken them away—‘That's cool that'll work.’ (participant 21, novice advisor)

Novice nurses: Finding their voice
Inspired to belong to the ECoP by presence of perceived “leaders” with “initiative” who they aspired to be like—“at the forefront” of improvement work in the jurisdiction: “Because they want to create change… they're the ones getting information and bringing it back to their organisations and going, ‘This is what we can do.’” Moreover, the fact that the ECoP was “government initiated” was seen as beneficial. (participant 8, novice hybrid nurse)

Veteran nurses: Getting on with it
ECoP perceived as sanction to get on with improvement on their own terms and to innovate—“to learn to let go of old ways and habits”—especially when organisational support was limited. “And with The Agency, looking at all these [collaboratives]. And us seeing it being done in other organisations, and nothing bad happening to anyone. Nothing bad happened to the patient, and nothing bad happened to the staff. It's okay to move, to work a little differently.” (participant 27, veteran hybrid nurse)</td></tr>
<tr><td><u>Peripheral lurking</u>
Veteran hybrid doctors sought insight &</td><td>Veteran hybrid doctors
Willing and able to direct the dialogue and negotiate the ‘economies of meaning’ (Wenger, 1998) within the ECoP due to their high status and their being accustomed to being heard. e.g.,</td></tr>
</table>

	influence into policy decisions but reinforced epistemic boundaries, resisting engaging with improvement rhetoric.	Talking about the challenge for doctors in being open to learning and engaging in a shared repertoire comprising ‘non-native’ language and practices: *Something strange happens to doctors when they become a specialist… for some reason they also start to think that their knowledgeability extends to everything else in life and they have very strong opinions on lots of things that they’re not qualified to have opinions on.* (informal conversation with veteran hybrid doctor)
	<u>Distancing</u> Veteran advisors resisted policy pressure and turned away from the ECoP toward existing peer communities and inward to their own organisational improvement programs.	**Veteran improvement advisors** Resisted the policymakers’ attempts to control improvement advisors: *Like there is pressure from The Agency and the government, and expectation… We've been involved in every single Collaborative, as we need to be, I understand, but, at some point, you're not going to get the results you want out of it.* (participant 29, veteran improvement advisor) Perceived the policymakers as more interested in irrelevant activity-based KPIs: *... it seems to me that there is something around... with their workshops for example, that they need to have x number of workshops per year. That's what it came across as. And they kind of engaged us and said, ‘Oh we need a workshop, we need a workshop,’ but then when it came to, ‘Well, what do you want the workshop for, what do you want us to cover?’ it was, ‘We don't know, we just need a workshop’ type thing… (participant 11, veteran improvement advisor)*

Chapter 7: Discussion

7.1 A process model of collaborative learning

I now turn to addressing the overarching research objective of this thesis:

> *To explore how participants of collaborative networks learn to mobilise knowledge across disciplinary and organisational boundaries, through situated learning and identity work in the healthcare setting.*

Through the findings chapters I have elucidated three meta-processes involved in participants learning across disciplinary and organisational boundaries in the early stages of a collaborative network—*(per)forming, translating* and *reconciling*. The model in Figure 7.1 represents these interrelated parts as a whole, as I observed them in my study of the ECoP. Each brings to the fore aspects of collaborative knowledge mobilisation which have to date been obscured by 'transfer' perspectives or limited by dominant interpretations of situated learning and CoPs.

Through my review of the literature I identified three key areas requiring further investigation in relation to knowledge mobilisation in collaborative initiatives. These concern the formation of organisational 'forms' for collaborative knowledge mobilisation, the challenges of collaboration among different epistemic cultures, and the manner in which participants from different epistemic communities reconcile their identities with their participation in such initiatives. The 'translation' lens and initial bricolage model in Chapter 2 help to focus on these issues, and in particular to address the shortcomings of 'transfer' approaches to understanding knowledge mobilisation. They do so in the following three ways.

First, from an SLT perspective, knowledge mobilisation can be conceptualised as a dual process of learning and of becoming. Second, the concept of epistemic cultures (Knorr Cetina, 1999) helps to avoid the 'romantic trap' of working with the concept of 'community', whereby it is often assumed that learning simply occurs naturally when actors come together. By sensitising the analysis to clashes between epistemic communities, I was able to identify underexplored political negotiations between disciplines and surrounding the mobilisation of 'non-native' process improvement knowledge. Finally, Alvesson & Willmott's (2002) concept of identity

regulation and Jenkins' (2004) internal/external dialectic of identification help to clarify the processes involved in Wenger's (1998) somewhat ambiguous notion of identity reconciliation, and to highlight its embeddedness within broader power relations (Contu & Willmott, 2003; Gherardi, 2009a).

The practice-based methodological approach and processual ontology have allowed me to access these issues by 'following the actors' (Latour, 2005) and analysing the practices involved in the early stages of formation of a collaborative network. Critically, combining the practice-based perspective with interpretation of the empirical findings through the conceptual framework has helped to emphasise the performativity of actors' negotiation practices in the generation of a collaborative network and reveal how knowledge is continually negotiated and translated (Fitzgerald & Harvey, 2015; Swan, Newell, et al., 2016a; Van Grinsven et al., 2016). In turn, this has foregrounded how, in addition to knowledge, individuals also negotiate their through identity participation in collaborative organisational settings (Hultin et al., 2020; Wenger, 1998). This combination of conceptual lenses and practice-based methodological approach has enabled me to reveal particularities of mobilising 'non-native' knowledge and show how the mandated nature of an initiative can influence the collaborative knowledge mobilisation and identity practices of actors from various epistemic communities.

Through my exploration of each of the three meta-processes in this chapter, I build the elements of the model in figure 7.1, using them to help guide the discussion. I show how these are non-linear, mutually intertwined and together help to build on the existing literature and initial sensitising model developed in chapter two (figure 2.3). In this way I shed new light on how participants learn to collaborate and discuss what this means for the practice of knowledge mobilisation in instrumental collaborative networks.

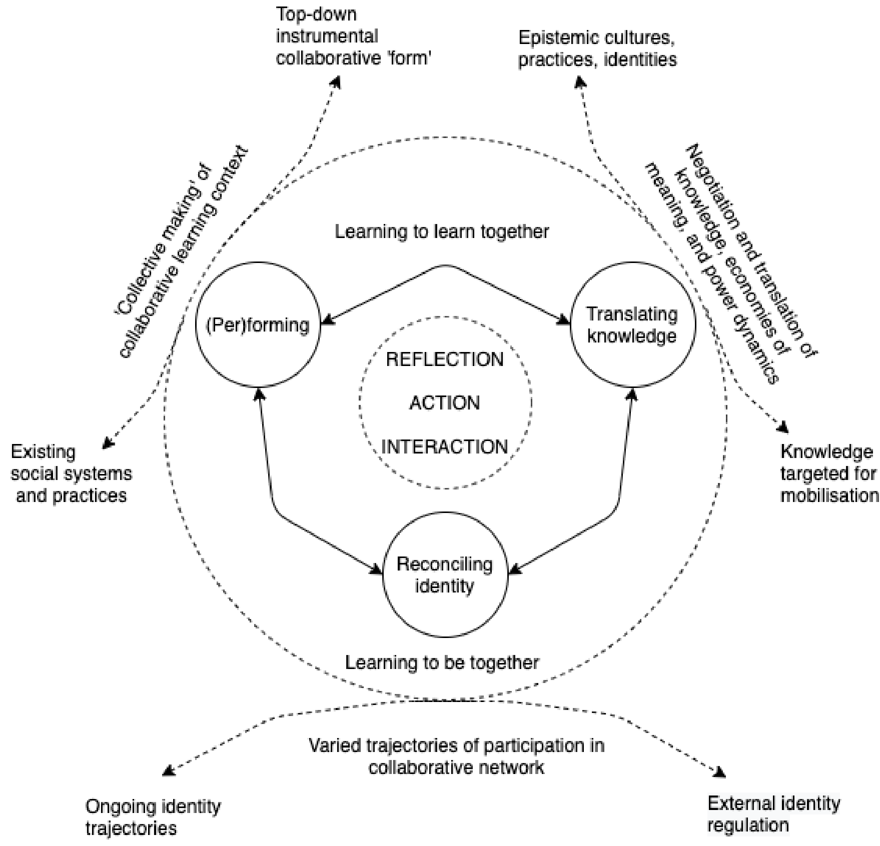

Figure 7.1: A process model of collaborative learning

7.2 (Per)forming

By highlighting the performative aspects of apparently mundane practices, the notion of (per)forming adds to our understanding of how collaborative knowledge mobilisation networks form in healthcare settings. In this thesis, I have sought to contribute to ongoing debates in the literature between analytical accounts which emphasise the organic and spontaneous nature of collaborative learning in CoPs, and instrumental accounts which assume the possibility of deliberately creating CoPs to advance managerial or policy knowledge mobilisation agendas. A major hindrance in progressing this debate has been the ambiguity around the processes involved in the early stages of formation, both in seminal analytical accounts (e.g., Lave & Wenger, 1991; Wenger, 1998) and in the growing literature on instrumental collaborative initiatives (Jørgensen et al., 2019; Kislov et al., 2011, 2012; Kislov, Wilson, et al., 2018; Pyrko et al., 2017).

By deploying the conceptual bricolage in Chapter 2 through a practice-based approach, I focused analytically on the micro-level of formation of the ECoP. By shifting between 'front stage' and 'backstage' views, I was able to use this lens to unveil three practice assemblages generated by the participants*: 'making a space of potentiality', 'comparing: seeing similarity and delineating difference'*, and *'noticing the 'nexus''.* Together, these assemblages reveal how participants collectively *(per)formed* the ECoP into a processual 'reality' through their actions, interactions and reflections. Most importantly, they emphasise a dialectical process of formation; a performative dialogue between top-down instrumental attempts to 'form' a collaborative network, and existing configurations of actors and their practices (as depicted in Figure 7.2 below). I discuss in turn, below, the importance of each of these for advancing our understanding of collaborative network formation.

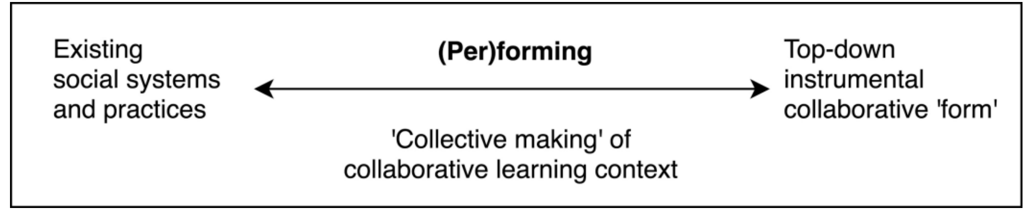

Figure 7.2: *(Per)forming*—a dialectic between existing social systems and instrumental collaboratives

7.2.1 Making a space of potentiality

This practice assemblage revealed how participants constructed the potentiality of the ECoP as they individually and collectively made sense of the policymakers' attempts to label and formalise the network in its early stages. *'Making a space of potentiality'* adds to a substantial body of research suggesting that lack of time is a significant challenge for clinician engagement with process improvement (Jorm, 2016; Solomons & Spross, 2011). It does so by providing more nuanced insight into not only the temporal potentiality but also the spatial and relational potentiality of collaborative networks for the mobilisation of process improvement knowledge. More importantly, my findings from the ECoP reveal how these temporal, spatial, and relational potentialities are collectively made.

Regarding time, my findings highlight how participants reflectively constructed the value of *sanctioned* time away from their frontline work. This sanctioned aspect of time away from work

was of particular importance for clinicians, who constructed it as an opportunity to zoom out on issues beyond their relentless frontlines. At the same time, the findings also reveal the importance of the policymakers' top-down sanctioning of this time. This contrasts with previous research which has found that top-down mandates for clinician engagement tend to invoke resistance (Choi et al., 2011; Glasgow et al., 2012; Pollak, Back, & Tulsky, 2017).

Considered through the lens of identity regulation (Alvesson & Willmott 2002), we might indeed interpret the policymakers' efforts to strongly encourage the engagement of hybrid doctors and nurses with the mandated ECoP as an attempt at normative control over these professionals and, by extension, their rank and file. The hybrid doctors in the ECoP did not, however, interpret this as a challenge to their authority or autonomy, as other studies would suggest they might have (e.g Waring & Bishop 2010). To explain this, we can helpfully characterise the hybrid doctors in the ECoP as 'willing hybrids' (McGivern et al., 2015) for whom engaging with process improvement was not a significant threat to their professional identity (Spyridonidis et al., 2015)—in large part due to their ongoing reconciliation work revealed in Chapter 6. As well as this, ED doctors were considered to be generally more engaged with process improvement than other specialisms—*"a different kettle of fish"*. In addition, the perceived lack of top-level leadership support for process improvement within many organisations represented a significant barrier to the hybrids' willing engagement and to the time available to them to work on improving their EDs, as other researchers have found (Leape et al., 2009; Ovretveit, 2005; Wagner et al., 2001). As a result, the top-down nature of the ECoP provided them with legitimate justification to their organisations to take time away from frontline work. In this way, the hybrid 'targets' of the collaborative network reinterpreted and redeployed its mandated nature as a form of 'micro-emancipation' from organisational constraints (Alvesson & Willmott, 2002). This was part of an ongoing dialectic between existing systems and practices and the instrumental collaborative network, as Figure 7.2 highlights.

Regarding the spatial potentiality of the ECoP, the importance of decoupling from day-to-day work emerged as clinicians—hybrid doctors in particular—reflected on the value of decoupling from the frontline. Their backstage reflections revealed that hybrid doctors already made concerted efforts to learn about improvement by going physically outside of their organisations, as this removed the risk of being pulled back into the frontline fray. Seen through the lens of SLT and its emphasis on the situated and embodied nature of collaborative learning (Lave & Wenger, 1991; Wenger, 1998), the act of physically decoupling from everyday work pressures,

practices and selves also offered a kind of cognitive emancipation. In combination with sanctioned time away, this provided an opportunity to zoom out and think 'away' from the frontline, an aspect of learning which may be critical to what Pyrko et al (2017) has referred to as 'thinking together'. Importantly, reflecting on this valuable aspect of their participation contributed to hybrid doctors' attendance and lively participation on the ECoP 'front stage', helping to generate a warming-up process and 'aliveness' (Sloan, 2018) that was a necessary contributor to the ongoing reification of the collaborative learning context (J. Langley et al., 2018; Wenger, 1998).

Flowing from spatial potentiality was a relational potentiality, which emerged through participants' front and backstage performances. Numerous studies have highlighted the importance of spatial proximity for its ability to trigger social learning (see Amin & Cohendet, 2011; Amin & Roberts, 2008). Regarding the relational potential of cross-organisational collaboratives specifically, scholars have shown how deliberate facilitation can enhance knowledge mobilisation activity within existing intra-organisational improvement communities within such networks (Kislov et al., 2012). The findings from the ECoP also support concerted efforts to promote interaction, but extend previous research by highlighting that serendipitous forms of interaction appear to play a significant role in enhancing or generating intra-organisational relations across disciplines. As a consequence of participants decoupling from their usual places of work, new configurations of actors, and, consequently, new opportunities for actions and interactions, could emerge. As the policymakers hoped, relational encounters during ECoP workshops did have some effect in terms of mobilising relations across organisational boundaries. In addition, participants perceived 'silo-busting serendipitous encounters', not explicit in the intent of the ECoP, as particularly important in terms of dismantling barriers to collaboration within their own organisations. *"Interrupting a certain regularity"* of day-to-day work life (Rodriguez-Barbero, 2018), and being in a new space meant that ECoP participants met others from their home organisations that they otherwise might not have, and experienced *"a momentary sense of connectedness due to the suspension of surrounding ties"* (Mische, 2008). These unanticipated relational encounters may thus be particularly important in participants' construction of the value of such initiatives.

Critically, this sense of interdisciplinary connectedness was not limited to the 'moment' of their performance on the ECoP frontstage, nor to the relationships with specific individuals that developed in the ECoP. Participants carried the experience of these encounters with them

‘backstage’ and into their day-to-day practices, generating more or less durable associations between disciplinary communities (Latour, 1990). By surfacing and interrupting the temporal, spatial and relational ordering of existing social systems, participants’ actions, interactions and reflections played an *“existential”* role (Latour, 1986, p. 268) in (per)forming the potential of the network, and in reconfiguring future relational geographies beyond the ECoP.

7.2.2 Comparing: Seeing similarity and delineating difference

This next practice assemblage reveals how being together in the ECoP instantiated ubiquitous comparative practices. In this, comparing emerged as an indirect but key mechanism underpinning participants’ performances of collaborative knowledge mobilisation. This assemblage highlights three key practices: *‘positioning’*, *‘empathising’* and *‘competing’.*

The first reveals how participants positioned themselves and their organisations in relation to others in the ECoP, and within the broader landscape of process improvement in the jurisdiction’s public healthcare sector. Uncritical readings of Lave and Wenger’s (1991) concept of legitimate peripheral participation would suggest, as indeed the policymakers expected, that organisations and advisors with ‘mature’ improvement capability would tend toward the core of the CoP and willingly take on the role of ‘masters’ within the ECoP (Contu & Willmott, 2003). In contrast, I found in the ECoP that veteran advisors from mature organisations appeared more concerned with buffering against the threat of their displacement as custodians who were in control of the shared improvement repertoire within their own organisations (Contu & Willmott, 2003; Lave & Wenger, 1991). By elucidating participants’ comparative practices, the findings showed veteran advisors to be strategically protecting against external disturbances that might ‘dilute’ their intra-organisational successes in mobilising improvement knowledge to the frontline. This supports previous research that suggests avoiding contact with *“untouchable”* organisational ‘others’ can be a strategic move to avoid the low status that comes with peripherality (Kislov, 2018; Yanow, 2004, p. S18).

My findings show, in contrast, that novice advisors, who often belonged to 'up and coming' hospitals, sensed that they would be advantaged by interacting with ‘other’ interpretations of process improvement (Kislov, Hyde, et al., 2017). Comparing their own relatively ‘immature’ position to those of more mature organisations, these improvement advisors positioned themselves in SLT terms as ‘journeymen’, with much to gain from their peripheral but

increasingly central participation, and also much to give to their even less experienced novice colleagues (Lave & Wenger, 1991; Wenger & Snyder, 2000). Importantly, the ways in which different improvement advisors positioned their organisations in comparison to others influenced how they interpreted the value of learning together in the ECoP. This had implications for their willingness and ability to participate and thus contribute to (per)forming the initiative. This highlights the different tenor of the various ongoing 'conversations' between existing social systems and the top-down nature of instrumental collaborative networks, as depicted in Figure 7.2.

Participants' practices of positioning also highlighted how, within the bounds of the ECoP, they attempted to assign and negotiate roles and responsibilities to particular groups, and, in so doing, also shaped the context for their learning. Jenkin's (2004) internal/external dialectic of identification suggests that the capacity of an individual or group to effectively identify another requires acceptance of the identification. When participants publicly attempted to identify the policymakers as responsible for producing and providing standardised ED flu screening guidelines, for instance, the policymakers contested this designation. This showed how the positioning of participants was also collectively negotiated and performed. Such comparative positioning work is a matter of whose definition of the social situation counts, and therefore always about relations of negotiability and power. The significance of this finding lies in its revelation of how such front stage negotiations of roles, responsibilities, and identifications also give shape to the ways in which participants learn to learn together (Wenger 1998; Lave 1991).

Comparing across organisations in the ECoP also revealed shared struggles, invoking empathy both within and across disciplines. The notion of empathy helps to extend previous research on emotions in collaborative learning contexts. Earlier studies support the role of candid engagement in establishing mutual understanding and building trust, arguing that emotions are important for increasing engagement and understanding in the collaborative context (Currie, Lockett, Finn, Martin, & Waring, 2012; Fischer et al., 2013; Lette et al., 2020; D. C. Spencer & Walby, 2013). However, they do not highlight the role of specific emotions, with the exception of Gabbay et al. (2003). Like those of Gabbay and colleagues, my observations on the ECoP front stage suggest that sharing experiential evidence with which other participants can individually or collectively empathise is important. The findings from the ECoP add to this by emphasising the specific role of empathy as a mechanism underpinning knowledge mobilisation not only *within* unidisciplinary communities but also *across* epistemic communities.

Paradoxically, the positive performative effects of sharing struggles on the front stage were also accompanied by the potential to invoke collective disidentification or 'othering' of those who were not in the room. This finding is similar to the work of Kislov (2018) who shows that the exaggeration of out-group differences with external groups can accompany a focus on shared similarities within a CoP. However, while Kislov (2018) suggests that processes of differentiation are likely to be more acute in groupings with high degrees of collective identification, the findings from the ECoP suggest that such out-grouping may be a risk at even the earliest stages of collaborative formation, where collective identification is likely to be particularly fragile. My findings suggest that as newly acquainted participants seek out commonalities, this may include sharing stories about others with whom they jointly struggle to empathise (e.g., organisational leadership). This may be a key mechanism of achieving collective identification. Jenkins' (2004) concept of the internal/external dialectic of identification helps to explain that the empathy discharged as a result of identification and differentiation work can both act as a motor of knowledge mobilisation (by generating relations of trust and understanding) while simultaneously leading to out-grouping. This may be a significant issue for realising the potential of collaborative networks, as it may hinder relations with important 'others' who remain critical for knowledge mobilisation 'backstage'.

With regard to the third aspect of comparing in the ECoP, competing, this highlighted that the comparative work of positioning one's own and other organisations within the sector sometimes had the unintended effect of making inequities in the system more legible. This served to reify the competitive culture of the jurisdiction's healthcare system—precisely what the policymakers had hoped to address. This finding is consistent with previous research showing that collaboration can be undermined by competition for resources (Kislov, 2014). However, it further underscores the significance of participants' perceptions about the 'mandated' character and top-down nature of collaborative networks. In the ECoP, policymakers' decisions about organisational inclusion or exclusion from collaborative initiatives and about funding support for process improvement lacked transparency. Moreover, their 'co-design' process was largely top-down. As Alvesson & Willmott (2002) suggest, top-down regulation exists in an interplay with various forms of response to such regulation—from acceptance all the way to resistance. The Agency's attempts to manipulate the sector from the top down, through an opaque system of preferential resource distribution, were not lost on many participants. Some, particularly veteran improvement advisors, considered this an attempt to intervene in their organisational

improvement work. Both backstage frustrations and front stage claims about inequitable resourcing clearly shaped actors' future participation and thereby how they collectively (per)formed the ECoP.

Finally, the findings from the ECoP also reveal the importance of the physical manifestations of resource inequities (e.g., velvet curtains in Big Metro's presentation room). Studies have not attended to these in the collaborative knowledge mobilisation literature, and they are likely to be considered irrelevant from a 'transfer' perspective on knowledge mobilisation. Having emerged both on the front stage of workshops and through backstage reflections, we may usefully interpret this finding through the theoretical perspectives offered by ANT and dramaturgical approaches to social life, which see non-human actors to be as important as human actors (Callon, 1986; Goffman, 1969). From this perspective, participants' interactions with physical objects and spaces play a role in the construction of social situations (Doyle McCarthy, 2005). Lending further support to this line of argument, Goffman (1959) outlines links between identification, differentiation and the physical environment. Actors engage with 'impression management' and the 'front' region of their performances is always situated within 'physical confines' (Goffman, 1969) which form part of, and define, the situation for the 'audience'. This suggests that the furniture, decorations, and other such 'props' in collaborative networks set the stage for the performance of organisational identity and for expressing status and position within the field. While the variable quality of furnishings noted within the ECoP was an apparently mundane detail, it did not elude participants and was an inextricable element of the overall performance of the ECoP.

7.2.3 Noticing the nexus

This final practice assemblage in *(per)forming* further highlights the performative interaction between existing social systems and the instrumental collaborative initiative, as seen in Figure 7.2. The notion of *'noticing the nexus'* conveys how participating in the collaborative network (re)materialised in actors' consciousness their existing 'nexus of multi-membership' (Wenger 1998) in which they belong to *"other tangential and overlapping communities of practice"* (Lave & Wenger, 1991, p. 98). Building on previous research which has pointed to the importance of understanding how 'organic' and instrumental CoPs relate to one another (Kislov et al., 2011, 2012), *'noticing the nexus'* helps to elucidate the polyvalent effects of participants reflecting on their existing 'organic' forms of belonging. This helps to explain how and why different

participants interpret what it means to participate in a mandated collaborative network in different ways.

The findings in the ECoP reveal that, for veteran improvement advisors and veteran hybrid doctors, engaging with the ECoP served to (re)materialise and reaffirm their belonging in existing unidisciplinary communities. These participants reflected on the value of existing support that they could access by virtue of their belonging to 'organic' communities which had emerged from and revolved around struggles shared by their professional or role peers, and, in the case of doctors, the level of status and influence they had by virtue of belonging to their professional community. Such well-established unidisciplinary CoPs already appeared to foster cross-organisational knowledge mobilisation prior to the establishment of the mandated collaborative network, as others have found (Fischer et al., 2013; Swan & Scarbrough, 2005). However, veteran improvement advisors and doctors' privilege from pre-existing forms of belonging—within which they were comfortably embedded—constrained their perceptions of the value of the ECoP. As Currie and colleagues (2012) point out, this may be because those who are privileged under existing institutional arrangements have limited motivation to enact change, even though they have the power to do so. Importantly, with limited motivation to engage in 'collectively making' the collaborative learning context (J. Langley et al., 2018), these participants may have limited their contributions to (per)forming cross-disciplinary interactions within the ECoP.

Nevertheless, further explanation is needed to understand the veteran improvement advisors' response, since these were actors with relatively low status in the healthcare field. This would suggest that policymakers' top-down attempts to engage them, and increase their ownership over them, might easily overcome their limited motivation to participate in the ECoP. Alvesson and Willmott's (2002) notion of identity regulation helps to clarify the veteran advisors' response. Having established their own 'organic' CoP over the years, throughout which they had been left unsupported by the policymakers, they now saw the ECoP to be a part of the policymakers' attempt to reassert control over them, and strongly resisted being branded and identified as belonging to The Agency. Unlike their novice counterparts, they were able to resist, to an extent, because they mostly belonged to organisations with mature improvement programs in which their work was already relatively well-supported. In a similar sense, the hybrid doctors also engaged in small verbal 'acts of resistance' on the front stage of workshops as reminders to the policymakers that the ECoP was far from their only opportunity to collaborate. While apparently

contradictory to their own construction of the ECoP as a space of potentiality, these were small nods to the hybrid clinicians' all-important professional autonomy and the existing power and influence bestowed upon them by their belonging to an existing community of high status professionals. They would participate, but on their terms.

In contrast to the veteran advisors and doctors, novice improvement advisors and novice nurse hybrids' participation in the ECoP made their lack of existing community with regard to improvement even more apparent to them. This finding shows that lower-status groups may be more willing participants. In line with Yanow's (2004) observations about those at organisational peripheries, the experience of these categories of participants had been of being prevented from participating fully in organisational and policy-level decision-making. Lave and Wenger's (1991) definition of peripherality is salient in understanding what occurred when these lower-status groups 'noticed their nexus': peripherality entails *"multiple, varied, more- or less-engaged and -inclusive ways of being located in the fields of participation defined by a community"* (Lave & Wenger, 1991, pp. 35–36). Despite already having valuable improvement expertise in terms of their critical 'local knowledge' (Yanow 2004), without an 'organic' community within which to engage on improvement issues or through which form influential connections to broader conversations about improvement, these low-status groups felt alone and undervalued. As a result, they were drawn to what they perceived to be an inclusive forum for participation in the ECoP, one that could ameliorate their alienation within the broader enterprise of process improvement in the sector (Lave & Wenger, 1991).

Finally, previous research highlighting the tension between instrumental and organic perspectives of CoPs has demonstrated the risks of over-formalisation (Bate & Robert, 2002; Kislov, 2014; Pyrko et al., 2017). It has emphasised the need for a delicate balancing act in which knowledge can be captured without 'killing it' (Brown & Duguid, 2000). My findings from the ECoP add to this by showing how overly formalised and directive approaches to collaborative networks risk not only the knowledge mobilisation potential *within* them, but risk also that they may *"really stuff up"* existing informal 'black markets' of knowledge within the broader sector. While the policymakers were focused on the front stage of the ECoP and the intended mobilisation of knowledge from advisors to clinicians, my findings uncover significant background knowledge mobilisation. Informal, often random, and difficult to capture and direct, this was a potentially critical mechanism for the mobilisation of process improvement knowledge across organisations built on well-worn communication channels based on shared

understanding, histories, and trust. Importantly, the findings from the ECoP further emphasise the generative nature of the tension that exists between instrumental knowledge mobilisation initiatives and existing social systems and knowledge mobilisation practices. As participants notice their existing nexus of multi-membership and reflect on this in relation to instrumental initiatives, they continually (per)form both.

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In sum, the notion of *(per)forming* helps to reveal how participants collectively (per)formed the collaborative initiative into a processual 'reality' through an ongoing dialogue between the policymakers' top-down collaborative mandate and existing social systems and practices in the field. *'Making a space of potentiality'* surfaces the temporal, spatial, and relational ordering underlying the social systems involved in the ECoP, and shows how the workshops disrupted the usual configurations of actors, thereby enabling the generation of new chains of associations, particularly across disciplines within organisations (Latour, 1986; Nicolini & Monteiro, 2017). The comparative practices I uncovered in the ECoP are a necessary element of participants learning to learn together—evoking a mix of both positively and negatively valenced effects in terms of the formation of the initiative. Finally, *'noticing the nexus'* reveals how participation in the ECoP occasioned reflections on the value of actors' existing forms of belonging vis-à-vis the perceived value of their participation in the ECoP (Warner, 2006). From a situated learning perspective, these value judgements importantly point toward considerations on the part of participants as to whether and how they might begin learning to learn together. This also takes us forward to how participants might reconcile their existing identities with belonging in the ECoP (Wenger, 1998), the issue taken up in Section 7.4.

7.3 Translating

This second meta-process that my study of the ECoP reveals furthers our understanding of what is involved in participants learning to learn together. It does so by elucidating an ongoing performative tension that emerges as participants from different epistemic communities negotiate and translate the knowledge targeted for mobilisation in instrumental collaborative initiatives (see Figure 7.3). By focusing on the epistemic and political negotiations that go on between different epistemic communities during the early stages of instrumental collaborative initiatives, I help to address the limited attention that accounts working within an SLT

perspective have tended to pay to broader social and power relations as a result of overly romanticised interpretations of 'community' (Contu & Willmott, 2003; Cox, 2005; Gherardi, 2009a; Handley et al., 2006).

The deployment of the concept of epistemic cultures (Knorr Cetina, 1999) alongside SLT sensitised my analysis to conflictual relations between the epistemic communities constituting the multidisciplinary, multi-organisational ECoP, and also to the challenges of mobilising 'non-native' process improvement knowledge. By examining both 'front stage' and 'backstage' practices, I have been able to use this lens to unveil participants' private and public epistemic and political practices, as well as to elucidate how transformations of meaning occur as participants learn how to learn together. Two key narrative themes emerged: *'problems of proximity'* and *'tweaks to transformation'*. In turn, below, I discuss the significance of each of these for advancing our understanding of how knowledge is mobilised across boundaries through participants' situated learning in collaborative initiatives.

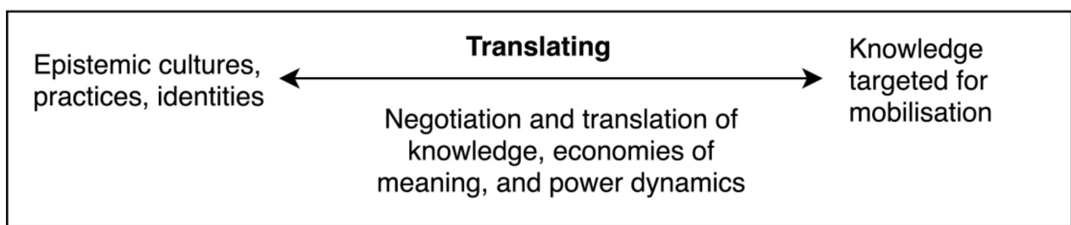

Figure 7.3: T*ranslating* as dialectic between existing epistemic cultures and knowledge targeted for mobilisation

7.3.1 Problems of proximity

The notion of *'problems of proximity'* helps to clarify the nature of the issue of clinician engagement with process improvement. Consistent with the findings of McLoughlin and colleagues (2019), hybrid doctors in the ECoP disputed the validity of data produced by process improvement tools. Viewed through the lens of Knorr Cetina's (1999) notion of epistemic cultures, my findings help to shed further light on the issue. They do this by revealing a central epistemic faultline between those epistemic communities whose practices and tools prioritise abstract 'experience-distant' (Geertz, 1974) measures of healthcare performance (the policymakers, improvement advisors, and some veteran hybrid nurses) and those which prioritise concrete 'experience-near' practice (especially doctors). The data produced by the

lower status epistemic machinery and practices of improvement were argued to be of questionable validity because they could not stand up to the epistemic machinery of ‘science’, with which doctors strongly identify, and which legitimise their work (Sanders & Harrison, 2008). The hybrid doctors’ contestations of attempts to repackage their clinical practices into quantifiable proxies of performance thus highlight the interplay between the knowledge targeted for mobilisation in instrumental collaboratives, and existing epistemic cultures, practices and identities, as depicted in Figure 7.3. Importantly, the findings also show how hybrid doctors used the front stage of the ECoP to perform the ‘scientificness’ of their epistemic identities (Peter Machamer & Osbeck, 2004; Osbeck & Nersessian, 2017), highlighting the interrelatedness of *(per)forming, translating* and the identity work involved in *reconciling*.

The doctors in the ECoP not only contested the validity of performance data—the key ‘tool of the epistemic trade’ of process improvement—but also resisted the ‘tighter rein’ that these represented (Alvesson & Willmott, 2002). Although the doctors in the ECoP can be described as ‘willing’ hybrids (McGivern et al. 2015), the imposition of this foreign knowledge by *“other craft groups”* from the administration domain implied a managerial pattern of identity regulation. This helps to explain the problems which have previously been found to be associated with overly top-down approaches to improvement in healthcare (Devine & Bicheno, 2020). It does so by elucidating how perceptions of managerial regulation triggered deeply ingrained skepticism on the part of hybrid doctors, both of ‘non-native’ process improvement knowledge, and of the ‘non-native’ actors who attempted to use it to expose their practices at increasingly granular levels (Alvesson & Willmott, 2002; Contu & Willmott, 2003). While scholars have documented resistance to increased transparency over clinical work and the circumscription of doctors’ valued professional autonomy (Bejerot & Hasselbladh, 2011; Levay, 2016; Levay & Waks, 2009), my findings highlight how the mobilisation of particular epistemic practices may further embed well-documented political tensions between administrators and doctors.

Further, the findings reveal the normative grounds upon which hybrid doctors may contest process improvement knowledge. In principle, the ‘willing’ hybrid doctors in the ECoP supported process improvement but, as previous scholars have found, they resisted dominant top-down interpretations which they perceived prioritised efficiency over care quality (Fischer et al., 2013; Kitchener, 2002; Waring & Bishop, 2010). The findings from the ECoP extend this previous work by revealing the kinds of performative claims that doctors made, both front and back stage, to justify their disengagement with ‘process improvement as efficiency’. In essence, they argued

that this clashed with their professional duty, and the professional stance ingrained in them through their professional training: to prioritise the quality of care for individual patients over populations of patients. The hybrids reflected backstage, eventually suggesting to the policymakers on the front stage, that explicitly prioritising clinical care over cost containment may help to foster professional legitimation of improvement initiatives.

Importantly, my findings show that the presence of such tensions between existing epistemic cultures and the 'non-native' knowledge targeted for mobilisation had at least two constructive effects for knowledge mobilisation. First, epistemic and political conflicts led to private reflective processes as well as public statements of the kinds of values that process improvement should prioritise and express. This highlighted the negotiability of what Chenhall, Hall and Smith (2017) refer to as the expressive role of measurement systems. These tensions were critical aspects of the negotiation of the economies of meaning present in the ECoP (Wenger, 1998; Contu & Willmott, 2002). They contributed to the process of learning to learn together and, importantly, were valued by participants. Second, these kinds of conflictual relations inspired innovative endeavours to translate process improvement knowledge in ways that had the potential to genuinely address some of the issues underpinning the epistemic and political 'problems of proximity'. As Kislov (2014) has suggested, while conflict may be avoided by keeping epistemic communities apart, such approaches also eliminate opportunities to negotiate epistemic conflicts and develop shared boundaries. The findings from the ECoP show that as they learn together over time, epistemic communities can become motivated to seek creative ways of enhancing this process.

In the ECoP, the novice improvement advisors sought to address the challenges associated with engaging doctors in process improvement. They did so by attempting to find innovative ways of merging efficiency and quality. My findings add to previous research, which has found that such knowledge brokers recognise their low-status position and lack of legitimacy (McLoughlin et al., 2019) by showing how they try to overcome these issues. In the ECoP, the novice advisors attempted to interweave epistemes (Renedo, Komporozos-Athanasiou, & Marston, 2018). They did this, for instance, by reframing improvement in terms that more explicitly prioritised quality. This adds to our understanding of the political work of incumbents of low-status knowledge-brokering roles. Policy and organisational circumscriptions of the improvement advisors' official role identities as experts in 'pure' (non-clinical) process improvement constrained their epistemic practices (Alvesson & Willmott, 2002). However,

through *“sneaky”* backstage endeavours, bold novice advisors acknowledged the performative role of process improvement (Chenhall et al., 2017). They began to search for different concepts, such as VBHC, which had the potential to better *“convince clinicians”* through normative claims about the benefits to patients of their engagement with improvement.

Just as importantly, my findings show that the novice improvement advisors saw that these kinds of ‘merging’ concepts also carried political value for them in terms of ‘proving their worth’ and gaining normative legitimacy in the context of their precarious roles and well-documented hegemonic efficiency narratives within the policy context (Cushen, 2013; Ferlie, 2017). This lends support to previous arguments, which suggest that, in order to be effective in their roles, those designated as knowledge brokers in healthcare need to become more political—taking into account patterns of interests, values and power relations, and looking beyond the 'evidence' to the micropolitics of improvement (Kislov, Hyde, et al., 2017; A. Langley & Denis, 2011). It was ultimately the political palatability of VBHC in terms of its translatability into economic performance measures that led the policymakers to grasp and then mobilise this concept more widely within the sector. This highlights the two-way nature of the translational process in Figure 7.3—the performative dialectic that alters the economies of meaning in an instrumental collaborative, as participants from different epistemic communities negotiate what the knowledge targeted for mobilisation ought to be.

7.3.2 Tweaks to Transformation

7.3.2.1 Negotiating economies of meaning

Alongside these backstage efforts of low-status novice improvement advisors, even more fundamental translations of process improvement knowledge were afoot in the ECoP. Building on previous research, which has found that process improvement takes on a variety of guises in healthcare (Andersen & Røvik, 2015; Benders, Van Grinsven, & Ingvaldsen, 2019), the findings in *‘Tweaks to Transformation’* show that different organisations and epistemic communities did not merely generate semantically different versions of process improvement as a result of their different interpretive lenses or languages (Carlile 2004). Instead, they negotiated the economies of meaning on the front stage of the ECoP over time—negotiating *what counts* when talking about process improvement (Wenger 1998).

A shift was evident over time—from the initial dominance of the policymakers' notions of the kind of knowledge that should be mobilised in the ECoP and the ways in which this should be done (non-clinical 'tweaks' focused on access and flow, 'transferred' through the verbal presentation of projects, managerial discourses, and tools) to later front stage performances and back stage reflections in which participants mobilised more fundamental principles of process improvement. Previous scholars have suggested that 'tinkering' versions of process improvement cannot address the fundamental root causes of problems in the healthcare system if they are not focused on meeting the needs of patients (Bhattacharyya et al., 2019). My findings help to explain why this is so by showing how non-clinical improvement advisors and hybrid clinicians from various disciplines advanced a more 'principled', rather than 'tool-based', interpretation—long promoted in the Lean literature but often unsuccessful in practice (Bhasin & Burcher, 2006; Radnor et al., 2012). By stripping process improvement methodologies back to first principles and emphasising their core as being about fostering a culture of learning, the novice advisor Colin began a collective conversation about the deeply embedded fear of failure in healthcare. This brought to light a pervasive dynamic in healthcare, where 'heroic' clinicians constantly 'save' patients from flawed processes in a system that they described in interviews as conspiring against them. On the front stage, this conversation exposed the behaviours of avoiding failures rather than engaging with their improvement to be inhibitors of organisational and system improvement.

Scholars have previously highlighted a disconnect between professionals and what they perceive as a 'looming system' encroaching on their practice (Jorm, Travaglia, & Iedema, 2006; Wright, Zammuto, & Liesch, 2017). My findings help to extend this work by showing how 'principled' translations of process improvement can generate a greater sense of continuity between clinicians' practices, their identities and 'the system'. Focusing on the underpinning philosophy of process improvement appeared to provide a counter-mechanism and an opportunity for clinicians of all stripes to liberate themselves from this dichotomous perspective (Alvesson & Willmott, 2002; Contu & Willmott, 2003, p. 293). Rather than viewing the system as a conspiratorial, objectified entity that was external and distant to their work, the more integrative perspective set the stage for hybrids to envision their role in addressing the shortcomings of the system and shaping it in ways that aligned more proximally with their own agendas.

The interpretation of Lean at Big Metro, as exemplified through Tea Room, was reminiscent of Andersen and Røvik's (2015) conceptualisation of 'pragmatic' translation in which process improvement is not seen as a fixed method or set of tools but rather as a problem-solving place. My findings add to this notion by suggesting that 'principled' translations of process improvement may provide the flexibility and adaptiveness needed for process improvement to become a place for problem-solving. Moreover, this may contribute to increasingly radical shifts in how problems are conceived and thereby lead to more creative solutions. In the ECoP, deploying the principles underpinning Lean enabled the Tea Room team to embrace and publicly display their organisation's willingness to be vulnerable and open to failure. This enabled them to deconstruct unchallenged assumptions of beneficent 'care', bring to light the harms which resulted from dominant but implicit biomedical assumptions underpinning how health services are designed, and construct a highly innovative solution. Importantly, my findings show how their front stage problematisation actively shifted the economy of meaning in the ECoP from its initial focus on tools and distant performance measures to a fundamental reconsideration of what it means to think about improving the delivery of emergency mental health care, and not merely to tweak existing processes.

7.3.2.2 Negotiating status and power dynamics

The findings from the ECoP regarding the translation of process improvement also add to our understanding of the status and power dynamics in healthcare. The flexible deployment of the principles of process improvement served not only to spark negotiation of the meaning of improvement, but also to destabilise power dynamics. While previous research suggests that the least powerful groups are most likely to become marginalised in multidisciplinary settings (Oborn & Dawson, 2010), this did not appear to be the case in the ECoP. My account of the Tea Room team's performance reveals how this group of relatively low status allied health clinicians and a peer worker employed their innovative approach to improvement in a way that expressly linked medical forms of practice with harm. This unsettled medical dominance and paved the way for negotiating new ways of organising emergency healthcare services. Moreover, they implicitly contested the policymakers' (also implicit) attempts to regulate the economies of meaning within the ECoP (Alvesson & Willmott, 2002; Wenger, 1998). While the policymakers sought to keep the ECoP focused on 'pure' non-clinical issues related to tweaking access and flow, the Tea Room team mobilised a normative argument that made taken for granted ways of working in health 'care' *"begin to shimmy"* through their design of an *"alternate reality" (Knorr Cetina, 1999, p. 251)*. This finding adds to previous research which has shown that hybrid

professional practice and identity is a dynamic negotiated with peers and other professions (Jorm et al., 2006; Sartirana et al., 2019), by demonstrating that lower-status disciplines may be the most willing to engage with the negotiation of this dynamic. This may well be because they may have the least to lose and most to gain from unsettling the status quo (Lockett, Currie, Waring, Finn, & Martin, 2012).

Critically, the backstage reflections of the hybrid doctors revealed a surprising level of support for Tea Room's radical translation of what it means to provide mental health care given that it diminished their own roles, and despite the team's lack of 'hard' evidence. This might be explained in two ways. First, research has shown that lower-status hybrids strategically translate process improvement in line with their interests (Benders et al., 2019; Van Grinsven et al., 2016). My findings add to this work by revealing how they can establish normative legitimacy by selectively performing certain translations of process improvement. As argued by Lockett and colleagues, deploying the patient voice helped to build normative legitimacy and convince other clinicians that their version of improvement was the *"right thing to do"* (2012, p. 361). The Tea Room team's common-sense translation of improvement aligned with the position taken by the hybrid doctors—that quality of care should guide any service redesign. Moreover, by avoiding 'objective' evidence that would have been produced had the team deployed a more tool-based Lean approach, they avoided epistemic resistance from the hybrid doctors—especially since the epistemic cultures of allied health clinicians already rank poorly in the scientific hierarchy (Albert et al., 2008).

Second, the lower-status clinicians could also be seen to buffer potential resistance to their 'alternate reality' by absorbing tasks that the dominant medical professionals would prefer to let go. Kellogg (2014) has previously described how low-status workers can facilitate reform by picking up 'dirty work' that involves professionals acquiring knowledge unrelated to their professional expertise. My findings from the ECoP add to this by showing that high-status hybrid doctors may actively advocate for the *"expanded scope of practice"* of underutilised lower-status disciplines when they perceive change to pose little professional threat. Since acute mental health cases were largely thrust upon EDs due to 'cracks' in the system—and not because ED was the most appropriate place for their care, nor the desired responsibility of ED doctors—the de-medicalisation of services offered by Tea Room did not pose a professional threat. In this way, lower-status clinicians were able to co-opt process improvement knowledge in service both of patient care and of elevating their position in the healthcare field.

This might be considered an instance of 'counter-colonisation' through bottom-up professional activity (Fischer et al., 2013). However, while studies have documented such activity in relation to high-status doctors, it was lower-status clinicians, in the ECoP, who translated the imposed versions of the 'non-native' knowledge in such a way that served both their professional and patients' interests. Similarly to the novice advisors' attempt to use VBHC to translate process improvement knowledge in a way that was more palatable to clinicians, Tea Room was also a kind of integrative translation. Yet, the lower-status clinicians did not experience the same pressure to produce bureaucratically defined measures of performance that were palatable to the policymakers as the advisors did. This meant that they could prioritise the patient's experience in their negotiation of 'what counted' on the ECoP front stage and simultaneously elevate their status through their interpretations of what improvement ought to be—interpretations that were difficult to challenge from a normative perspective. These findings highlight the agency and intentionality involved in collectively negotiating the various interpretations of the knowledge targeted for mobilisation among different epistemic communities in instrumental collaborative networks. Importantly, it underscores how peripheral, lower-status players, a group largely ignored in the literature, may be among the most active translators.

7.3.2.3 Mobilising organisational identity in service of translation

Finally, the findings in *'Tweaks to Transformation'* also add to our understanding of why peripheral players at the organisational level may be most active in trying to negotiate a path between their existing practices and new 'non-native' knowledge in collaborative initiatives. Analysis of Outerside's case highlights organisational identity as playing a central role in how ECoP participants translated and mobilised process improvement knowledge. While Kislov, Hyde and McDonald (2017) call into question the ability of mandated collaboratives to substantially reconfigure boundaries in multifield contexts—especially where there are power differentials at play—my findings suggest that these power differentials may actually facilitate such reconfiguration (Lave & Wenger, 1998; Wenger, 1998). When viewed through the SLT lens, we can see that Outerside's identity as a 'young' hospital struggling under the weight of a rapidly growing population, and a peripheral player in the jurisdiction, underpins their willingness to engage with transformative versions of improvement. Their position appeared to enable even the hybrid doctors there to think beyond the bounds of service improvement in hospitals—to question taken-for-granted notions of health 'care', and the dominant biomedical model of

healthcare, more broadly than even Tea Room had. At a more macro level, Outerside's performance as hosts of the third workshop showed a willingness to deconstruct the hospital-centric assumptions and 'saviour' narrative implicit in a system which they claimed obscured institutionalised harm behind the guise of 'care'. This suggests that organisational identity may play a key role with regard to organisational willingness to challenge top-down policy versions of process improvement in collaborative initiatives, and to be open to enrolling non-healthcare actors (e.g., local councils and commercial interests) into their schemes to *transform,* rather than *tweak,* the future of healthcare.

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Taken together, the findings in relation to the second meta-process, *translating*, show how participants negotiated and translated the process improvement knowledge that the policymakers had targeted for mobilisation. *'Problems of proximity'* highlights the kinds of epistemic boundaries that emerged in the mandated multi-organisational and multidisciplinary ECoP and connects these with broader social and power relations in the healthcare field (Contu & Willmott, 2003). Further, it reveals how these kinds of tensions sparked, in the words of Mengis et al. (2018), *"generative quests of knowledge integration"* that occasioned attempts to 'interweave epistemes' (Renedo et al., 2018), such as those that resulted in the ECoP 'drifting' away from its planned content and structure as defined top-down by the policymakers (Ciborra, 2000). *'Tweaks to transformation'* reveals the collective negotiation of the economies of meaning surrounding process improvement, as well as the negotiation of status and power dynamics in the field. It particularly highlights the willingness of lower-status clinicians and organisations to engage with translations of the meaning of process improvement that unsettle the status quo.

Translating shows that learning to learn together is far from a harmonious process, and that epistemic and organisational cultures, practices, and identities are mobilised in the service of collectively negotiating the economies of meaning in collaboratives. This has the effect of generating various translations of the knowledge targeted for mobilisation, and new transformational (re)imaginings of the future of healthcare (Wenger, 2000). These translations were intertwined with participants' ongoing *(per)forming* of the ECoP. The translations, critically, had the potential to reach beyond the time and space of the ECoP workshops since, as Schatzki (2006) has put it, *"an organization is more than what there is to it in real time".* Most

importantly, the translational practices involved in participants' work of learning to mobilise knowledge together were inseparable from their ongoing identity reconciliation work, discussed next.

7.4 Reconciling identities

In focusing on identity practices, I sought to explain how participants from different epistemic communities reconciled their existing identities with their participation in instrumental collaborative initiatives—how they not only learned together, but learned *to be* together. The findings from the ECoP reveal not only how individuals translated the knowledge targeted for mobilisation, but also how they negotiated and changed their identities through participation in the collaborative organisational setting (Hultin et al., 2020; Wenger, 1998). Figure 7.4 provides a visual representation of the interplay that I found to occur between participants' ongoing identity work and external identity-regulating mechanisms. This interplay emerged analytically through the deployment of Alvesson and Willmott's (2002) concept of identity regulation and Jenkins' (2004) internal/external dialectic of identification. By elucidating what is involved in Wenger's (1998) important but ambiguously defined concept of identity reconciliation, I advance our understanding of how and why actors with different epistemic identities and levels of status engage with 'non-native' knowledge—an important issue which has not been taken up in the literature (Currie et al., 2015; Van Grinsven et al., 2016). Moreover, this lens also helps to maintain a focus on the embeddedness of identity reconciliation practices within broader political relations of control (Contu & Willmott, 2003; Fox, 2000; Gherardi, 2009a).

Exposed through the practice-based lens, my findings reveal participants' ongoing 'epistemic expansion' work through which they reconcile their identities vis-à-vis their engagement with process improvement knowledge, as well as their 'modes of identity reconciliation' in relation to the ECoP. I show how these result in characteristic trajectories shaping the present and potential future of the collaborative network (Wenger, 1998). Analysis of the trajectories calls into question the policymakers' assumptions of 'helping' improvement advisors to broker process improvement knowledge, and sheds further light on the highly nuanced matter of clinician engagement with process improvement.

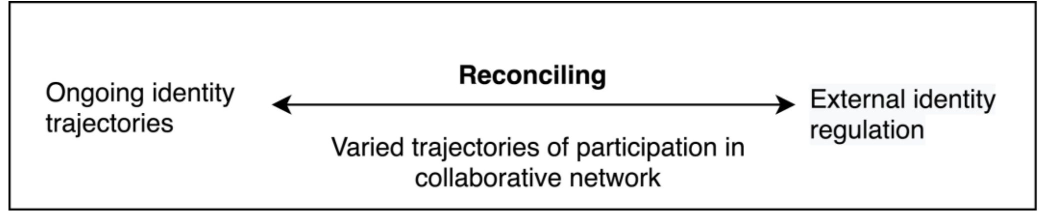

Figure 7.4: R*econciling* as dialectic between existing identity trajectories and external identity regulation

7.4.1 Epistemic expansion

The findings in *'epistemic expansion'* trace how participants' histories and epistemic communities influenced their engagement with, and ability to incorporate, 'other' knowledges and rhetoric into a coherent, livable identity (Alvesson & Willmott, 2002; Wenger, 1998). Epistemic experimentation emerged as a necessary practice through which to broaden the base of knowledge and practice that actors were willing and able to engage with. The backstage reflections of all participants' revealed how they, over time, continually expanded their identities in relation to improvement. The challenges faced by the improvement advisors and various clinical communities were, however, unique.

7.4.1.1 Improvement advisors: Going beyond improvement to find influence

The case of the improvement advisors reveals ongoing engagement with forms of knowledge beyond the boundaries of the technical aspects of process improvement methodologies. As others have shown, the designated knowledge brokers' *"fragile and ambiguous intermediary position"* (Kislov, Wilson, & Boaden, 2017, p. 107), and their struggle for structural, normative and cognitive legitimacy in the healthcare context, (McLoughlin et al., 2019), severely constrained them. Seen through the lens of identity regulation (Alvesson & Willmott, 2002), the findings from the ECoP further this previous research, by showing such external regulation to be a compounding issue for their lack of legitimacy. In the ECoP, the policymakers essentially 'pushed' process improvement knowledge into the system via the improvement advisors, whose capability they defined narrowly in terms of technical process improvement expertise. An unintended effect of this kind of regulation of the advisors' identities was that their disciplinary ways of knowing and their practices ('hard' technical process improvement) were inadequate to enable them to fulfil their roles as designated knowledge brokers, a critical part of which involved engaging organisational leaders and clinicians. As such, the advisors' peripherality and

low status motivated them to engage in attempts to generate visibility and legitimacy for process improvement knowledge, and to create more influential identities that were more palatable for clinicians—especially doctors—to interact with (Yanow, 2004).

Paradoxically, the findings from the ECoP suggest that low-status knowledge brokers may cope with their peripherality in part by making themselves *less* visible. The improvement advisors' 'hid' on the periphery while acting as puppeteers of higher status actors. This adds to our understanding of strategic brokering practices (Van Grinsven et al., 2016), by showing how using higher-status 'willing hybrid' clinicians (McGivern et al., 2015) as the public face of improvement within their organisations was a strategic move that helped to associate low-status process improvement knowledge with higher-status identities (Yanow, 2004). Moreover, the improvement advisors' low-status roles were sometimes 'eroded', resulting in them shifting from enabling improvement to doing more distant 'managing' of improvement, as Kislov and colleagues (2017) have also described. In the ECoP, however, this also appeared to be a deliberate strategic move, as picking up low-status *"orphan problems"* that clinicians did not wish to engage with was employed as a kind of 'buffering' practice to make change more palatable to professionals (Kellogg 2014).

These paradoxical practices point to advisors' epistemic experimentation work through which they attempted to broaden their narrow 'official' identities by incorporating other kinds of knowledge and practice to augment their process improvement expertise (e.g., 'softer' behaviour change, influencing and training skills). These were backstage attempts to expand the formally-defined and funded role scope of improvement advisors beyond patient flow and access, and to push the boundaries of what was defined by the policymakers as 'appropriate' process improvement activity (Alvesson & Willmott, 2002). In conjunction with attempts to integrate concepts that incorporated quality improvement alongside efficiency improvement into their identities, such strategies of epistemic expansion and engagement with influencing skills appeared to be attempts to gain visibility, voice, and, eventually, to find themselves in more certain and stable positions within organisations (Contu & Willmott, 2003). As Kislov et al. (2017) have argued, brokering requires an amalgamation of several types of knowledge and a multidimensional skillset. The identity regulation and identity work lenses in this study show that improvement advisors actively engage in epistemic expansion to (re)construct their own identities in the face of constraining external regulating influences, helping to elucidate more precisely how they might achieve such amalgamation.

7.4.1.2 Lower-status clinicians: Incorporating improvement for influence

The epistemic expansion work involved in incorporating process improvement knowledge within existing identities was more or less effortful for different types of clinicians. Their experience depended on whether they perceived process improvement as challenging to their existing professional identities, status, or other social capital—legacies of their epistemic cultures. Previous researchers have found that allied health professionals tend to experience limited opportunities in professional and managerial career pathways and low wage ceilings (Castro Lopes et al., 2017; Jorm, 2016). However, researchers have not yet explored this in relation to their engagement with process improvement knowledge. The findings in the ECoP add to this research by connecting such professional challenges to their positive engagement with process improvement. For the allied health professionals I spoke with, improvement represented a *"sexy space".* Almost all of the veteran improvement advisors in the jurisdiction had allied health backgrounds and had happily given up their clinical roles to focus on improvement.

Moreover, allied health leaders perceived process improvement methodologies as a political tool at the meso-level to advance the standing of their professions within organisations. They could use the tools of process improvement to make legible—in the quantitative terms preferred by 'experience-distant' executives—the value that allied health services provide for the operational efficiency of hospitals. This had the potential to help them secure resources and enhance their status within the healthcare hierarchy. Finally, there was evidence that their university training programs had already familiarised them with the principles of process improvement. Thus, allied health clinicians felt that diagnosing and treating problems in the system was no different to what they did with their patients. The upshot was that there was little challenging epistemic expansion or identity reconciliation work to do in order to align the practice of process improvement with their professional identities, and considerable benefit to gain from their participation.

As with allied health professionals, participants recognised nursing as limited in its scope in terms of clinical career paths and remuneration. My findings support those of others who have shown that nurses are likely to see managerial careers as an appealing pathway (T. Andersson, 2015). There is some conflict in the literature, however, with regard to the question of whether the professional identity of nurses is easily reconciled with a managerial identity. Andersson

(2015) for instance, suggests that this is the case, while others describe more or less significant identity conflict (Croft et al., 2015; Nordstrand Berg & Byrkjeflot, 2014). My findings from the ECoP also reveal such contradictions, and help to explain them. While it could be challenging for the nursing leaders I spoke with to marshal their rank and file with regard to improvement work—and they felt that the culture of improvement did not come 'naturally' to nurses—it also appeared that nursing was beginning to bear the fruits of an ongoing project of professionalisation. Historically limited to a narrow professional scope and subordinate and dependent mode of practice, there was increasing emphasis on ongoing engagement with new knowledge and greater professional scope, as also reported by Birks et al (2016). In this context, improvement represented a career advancement opportunity for younger nurses. In addition, my findings also underscore the importance of context with regard to the willingness of nurses to incorporate process improvement into their clinical practice. Like ED doctors, participants described ED nurses as particularly adaptable individuals who were more easily engaged with improvement than those on wards. Participants explained that this was a result of their position at the 'front door' of the hospital, where the need to adapt dynamically to increasing demand was an imperative. This further highlights the situated nature of identity reconciliation work.

7.4.1.3 High-status clinicians: Identity conflict

With regard to the epistemic expansion work of hybrid doctors, the findings from the ECoP show that this was a relatively more burdensome task for this higher-status group. This supports previous research suggesting that doctors see themselves as separate to 'the system' and as less likely than other clinical professions to consider managerial roles as appealing (T. Andersson, 2015; Jorm et al., 2006). My findings add to these observations by revealing where this perceived separation between doctors and the system stems from. Participants described junior medical roles as *"quite separate"* from the hospital and made the point that there was little room in the packed medical curriculum for 'extras' like improvement. Moreover, the curriculum itself ingrained a *"suspicion"* of other disciplines, taught doctors to be *"individual thinkers"*, and *"blessed"* them with long, varied and financially rewarding career paths. As a result, my findings suggest that junior doctors start their careers from a position where engaging with non-native process improvement knowledge peddled by non-native 'others' almost necessarily means undertaking challenging and ongoing journeys of identity reconciliation. This explains why none of the senior doctors I spoke with had actively sought out their hybrid roles (Soekijad & Smith, 2011), but rather fallen into them.

As Sartirana and colleagues (2019) have described, hybrid doctors' journeys to hybridity entails familiarising themselves with management, rationalising being a hybrid, and legitimising their role identities. As a result of this identity work, the hybrid doctors in the ECoP had become able, over time, to 'see' beyond the individual patient and zoom out on the bigger picture of their EDs and organisations to engage with the wider system (Jorm et al., 2006). The findings of my study further show how this process of becoming a willing hybrid appears to self-perpetuate. As doctors found their new hybrid identities more 'livable' over time (Wenger 1998), they more easily and actively engaged in further epistemic expansion work, in a kind of virtuous cycle where they sought further non-clinical knowledge and education in business administration or public health. Moreover, they became able to entertain more radical conceptualisations of their own identity—for instance, as 'consumers' of knowledge, 'followers' rather than leaders, and 'advocates' of outside ideas. In this way, they themselves called into question traditional knowledge/power structures in healthcare through their reconciliation work. Such willingness to share power appears, as Spyridonidis (2015) suggests, to be a consequence of the substantial identity reconciliation work in which hybrid doctors had come to a relatively stable sense of self, in which hybrid identifications were no longer perceived as a status threat.

Nevertheless, my findings also show that this struggle was never fully resolved. This resonates with previous research, which has found that doctors experience identifying with non-native practices as a kind of 'heaviness' (*"it hurts my clinical soul" (participant 31))*, even despite their commitment to process improvement (Fischer et al., 2016). Moreover, they also never entirely resolved the perceived dichotomy between the 'the system' and doctors' identities. At times, the hybrid doctors still framed engaging with the system as a necessary evil, an imperative to defend against unchecked managerial or policy imposition. This resulted in a situation where they faced an ongoing tension between the requirements of their professional identities and external attempts to engage them with 'non-native' knowledge and 'non-native' others, which they could only partially reconcile (see Figure 7.4).

Paradoxically, however, while they tried to dis-identify with imposed cultural prescriptions (e.g., by refusing to engage with the language of Lean), these willing hybrids nevertheless appreciated the value of improvement and engaged with process improvement practices to an extent (albeit without labelling them as such), reproducing them and contributing to the regulation of their own hybrid identities (Alvesson & Willmott, 2002; Fleming & Spicer, 2003). At

the same time, they also took great care to perform their identities in ways that were palatable to them—for instance, by talking about their duty and unique ability to administer their departments from the perspective of their patients. This kind of normative framing helped them to reconcile the clinical and managerial aspects of their hybrid identities. They also suggested that this could smooth the way for future generations of doctors to reconcile 'other' kinds of knowledge with their clinical epistemic identities.

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Ultimately, my findings show that trajectories of 'epistemic expansion' span many years leading up to instrumental collaborative initiatives. These trajectories are ubiquitous among all participants involved, but appear to require more or less deliberate effort and are more or less 'effective' in terms of reconciling improvement knowledge with existing identities for different epistemic communities. In the ECoP, being able to engage with process improvement involved not only the cognitive acquisition of knowledge, but also a reconfiguration of participants' epistemic identities. The findings show that such reconfiguration has various and sometimes conflicting effects. Its difficulty depends on whether the identity work challenges existing professional identities and attendant epistemic legacies and status, or whether engagement with process improvement has the potential to bolster status and influence. Epistemic expansion is more or less hard-won, but the struggle appears to be very necessary background work in the lead up to participation in collaborative networks where participants must learn *to be* alongside those from other epistemic communities.

7.4.2 Modes of identity reconciliation

I now turn to consider trajectories of participation *within* the ECoP. In this final part of the discussion, I shed light on how participants learned to reconcile their existing identity trajectories with their involvement in cross-disciplinary, cross-organisational, collaborative initiatives. As the discussion about *(per)forming* already alluded to, actors' existing identities as members of 'organic' disciplinary communities need to be reconciled with their participation in instrumental initiatives. Just as particular groups had more or less difficulty broadening their existing identities to incorporate knowledge that was 'non-native' to their particular epistemic community, groups of actors also experienced more or less difficulty reconciling their membership in the ECoP. Differences in existing professional status, influence, and autonomy played a role in the

ongoing dialogue between their self-identifications and external regulating influences on their identities (Alvesson & Willmott, 2002; Jenkins, 2004). The different modes of identity reconciliation in my findings help to differentiate analytically across groups of participants and explain their characteristic trajectories of participation in relation to the ECoP.

7.4.2.1 Participatory engagement

The novice advisors and lower-status clinicians (both novice and veteran hybrid nurses) sought genuinely to engage with the ECoP. I observed no dissonance in their 'frontstage' and 'backstage' performances, and they easily reconciled their membership in the ECoP with their existing identities. The novice improvement advisors and the nurses found, upon reflection, that they lacked an existing community with which to engage regarding process improvement, and the ECoP provided what they perceived to be a ready-made community with which their epistemic stances were aligned.

The nurse hybrids in the ECoP, especially juniors, suffered from a lack of social and organisational influence. This supports the findings of previous research (Croft et al., 2015; Currie et al., 2015). The findings of this study also reveal, however, how this may be paradoxically beneficial in terms of their engagement in instrumental collaborative networks. This is because they may perceive such networks as potentially enhancing their *"ability, facility and legitimacy to… shape the meanings that matter"* within their own organisations (Wenger, 1998, p. 197). Furthermore, this group perceived the mandated nature of the ECoP and its association with the policymakers as a status token—with which they could obtain a greater level of access to, and influence over, decision-making processes about improvement within their organisations. From a situated learning perspective, the top-down support for process improvement provided nurses with an entry point into the 'regime of competence' of process improvement that they otherwise had little ability to access and negotiate (Wenger, 1998).

The novice improvement advisors perceived the mandate at the jurisdiction level as bolstering the legitimacy of improvement knowledge and practice, and thus their 'subject position' within their organisations and broader healthcare field (Lockett et al., 2012). Moreover, they saw the ECoP as an opportunity for the epistemic expansion they enthusiastically pursued in order to enhance their ability to influence. Their participation was a way for them to avoid becoming too inwardly focused and parochial in their approach to process improvement, and an opportunity to

become future leaders who would be increasingly central to the improvement movement in the jurisdiction.

As a result, my findings from the ECoP showed how improvement novices and hybrid nurses emerged as a sub-community for whom the invitation to participate in the ECoP was a clear opportunity—a perceived window to legitimate peripheral participation in the practice of process improvement (Lave & Wenger, 1991). They easily reconciled this prospective identity with their existing identity, as it had the potential to bring to fruition an imagined shared future (Wenger, 2000) with those they considered *"leaders in the field"*. The interplay between their existing identity work and the external ideo-cultural regulation of the policymakers caused no friction, and set them on an 'inbound' trajectory (Wenger, 1998, p. 154). The prospect of fuller participation represented a valued future identity that would bring them a stronger voice, a supportive community, and greater ability to engage doctors in process improvement.

7.4.2.2 Peripheral lurking

The hybrid doctors participating in the ECoP did not parallel the novices' 'inbound' trajectory as the policymakers had hoped, or as might have been expected based on their increasing willingness to engage with process improvement ideas and collaborative practices resulting from their ongoing epistemic expansion work. For this group, the interplay between their ongoing identity work and the external attempts to engage them in learning about 'non-native' process improvement knowledge from the designated knowledge brokers resulted in them 'lurking' on the periphery of the ECoP.

Research in healthcare has shown that hybrid doctors are—by virtue of their responsibilities to increase organisational performance or ensure high quality and safe care—disposed towards ideas and practices which they perceive will help them meet these goals (Lockett et al., 2012). As a result, much of the healthcare literature sees hybrids' professionality as an enabler of knowledge brokering. However, as Lockett and colleagues (2012) caution, they are, by virtue of their 'subject position', also bound by an interest in preserving the status quo through which their relative organisational power and professional privilege is derived. My findings support this, showing that, in the ECoP, the hybrid doctors' high levels of professional expertise and authority actually resulted in a level of disengagement from the mobilisation of process improvement knowledge—even while they supported the premise of the ECoP and improvement in EDs.

The findings from the ECoP extend our understanding of how hybrid doctors can maintain such a seemingly dichotomous position, by revealing the strategic moves they use to buffer themselves and their peers from managerial intrusion. Even if their actual practices in organisations could clearly be labelled as ‘doing Lean’, hybrid doctors in the ECoP refuted the value of creating a shared repertoire which involved improvement rhetoric (Soekijad & Smith, 2011; Van Grinsven, Sturdy, & Heusinkveld, 2020; Waring & Bishop, 2010). By claiming that mobilising process improvement rhetoric was off-putting to their peers and that improvement needed to be stripped back so that doctors could just ‘get on with it’ and do improvement on their own terms, they stymied any authority that the improvement advisors had accrued. The hybrid doctors’ strategies of reconciling their already tension-laden hybrid identities with their participation in the ECoP ultimately resulted in them tending to mobilise process improvement knowledge in ways which limited any further challenging identity reconciliation work, and preserved rather than transformed the status quo, ensuring that doctors’ could maintain their autonomy and distance from ‘the system’.

The findings importantly add to our understanding of the particular epistemic struggles doctors face in attempting to reconcile their identities in collaborative initiatives. While many others have considered the challenges associated with mobilising clinical research knowledge through collaborative initiatives (e.g. Currie, El Enany, et al., 2014; Kislov, Wilson, et al., 2018; Ovseiko et al., 2015), the ECoP presented a more challenging context in which these high-status actors were encouraged to learn to collaborate with lower-status ‘experts’, and to learn from them about their lower-status ‘non-native’ expertise. Seen through the combined lenses of Alvesson & Willmott’s identity regulation and Knorr Cetina’s epistemic cultures, the interplay between their high-status epistemic identities and the external attempts to engage them with lower-status knowledge was a key tension driving the ‘lurking’ behaviour of the hybrid doctors. The hybrid doctors were not circumspect in articulating their concerns in relation to the evidence base behind improvement methodologies on the ECoP front stage, nor the challenges associated with reconciling the conflicting epistemic stances between the two bodies of knowledge they were attempting to straddle. This was confirmed time and again ‘backstage’ in interviews. In the absence of appropriate scientific evidence, much of the rhetoric of improvement and the resources it sought to deploy could easily sound to the hybrid doctors like *“management speak”*. In contrast, their clinical ways of knowing meant that they saw themselves as experts and should learn in their *“own way and take responsibility for it”* rather than learning from *“other craft groups”* and their *“jargony words” (veteran hybrid doctor, participant 17)*.

Despite their significant epistemic concerns, however, the hybrid doctors also readily articulated the benefits of their involvement, as we saw in the discussion about *(per)forming*. In particular, they valued the ability to interact with like-minded clinicians, the time and space away from their frontline firefights, and the support for attentional and financial resources for ED improvement. Moreover, they considered the ECoP to be an opportunity to present a united front in expressing clinical concerns and advancing ED doctors' interests in relation to improving emergency care at the policy level. From an SLT perspective, the 'lurking' of veteran doctors can be seen as strategic engagement in active boundary management. Since, as autonomous professionals, they did not experience pressure to participate, they constructed their peripheral trajectories *"by choice"* (Wenger, 1998, p. 154).

The finding that hybrid doctors actively manage their intermediate position aligns with the work of scholars who have discovered that willing hybrid medical managers easily discern the status benefits of hybrid roles, as they perceive operating at the interface between profession, organisation, and the state to be a potentially powerful network position (Noordegraaf, 2007; Waring & Currie, 2009). The notion of peripheral lurking adds to this previous research by elucidating more precisely what is involved in hybrids maintaining this interstitial position and identity. It highlights the ongoing internal/external dialectic of identification that involves reconciling professional, political and epistemic issues. We can see lurking on the periphery of the ECoP can be seen as an attempt by hybrid doctors to secure a clear line of sight into what the ECoP was about through their participation, influence its development, and thereby make sure that any outcomes for their own ED departments and professional peers were consistent with their expectations and interests, so that their implications were manageable. Lurking on the periphery also enabled them to participate in the ECoP and keep a watchful eye over policymakers' intentions concerning the improvement of emergency care across the jurisdiction, and collectively exert influence where they deemed it was necessary to protect clinical autonomy.

7.4.2.3 Distancing

Finally, the ECoP case reveals that for veteran improvement advisors, even greater tensions arose in the interplay between their existing identity trajectories and their participation in the ECoP. This finding appears counterintuitive in terms of the existing literature on collaboration and knowledge brokering in healthcare, and was unexpected by the policymakers. Policymakers

expected the veterans to take a lead role in enabling the ECoP to develop. Veterans seemingly had the most to gain from participation since it could provide a hitherto absent formal mechanism for sharing improvement expertise and learning across organisational and professional boundaries. In SLT terms, we might also have expected that the veteran advisors would have, as 'masters' of improvement practice, formed the core of the emerging CoP, and that they would have been enthusiastic about the reproduction of their practice (Lave & Wenger, 1991). Similarly, Lockett and colleagues (2012) suggest that the most effective proponents of service improvement in healthcare are those whose 'subject position' is sufficiently adjacent to the seats of organisational and professional power—to provide the necessary authority and resources to effect change, whilst also being sufficiently tangential—to allow them to envision how the status quo might be transformed. In this sense, we might see the ED CoP as enhancing their subject position by providing policy level backing for their efforts and a forum in which clinicians already disposed towards improvement could be more readily engaged.

However, their experience of the ECoP was characterised strongly by the perception that policymakers were attempting to regulate and control their identities and practices. In response, veteran advisors engaged in identity reconciliation practices that diminished the learning value of the ECoP and distanced themselves from the network and the policymakers. This distancing was most evident when I compared observational data of their 'front stage' performances (where they behaved in the workshops in a manner largely consistent with what might have been expected) with their 'backstage' reflections in interviews. By virtue of their long-term involvement in the program of process improvement in the jurisdiction, veteran advisors already considered themselves experts with regard to process improvement. Many belonged to organisations with mature improvement programs which they had been instrumental in creating. This led to them regarding themselves as the custodians of knowledge (Lamont & Molnár, 2002), both in terms of improvement theory and how it could be applied in practice within their hospitals, accounting for the view that they had *"heard it all before" (veteran improvement advisor, participant 9).* They perceived the ECoP to be of little value to them, and saw it as 'patronising' on the part of the policymakers, of value only for less experienced 'others', and as a threat that could 'dilute' their intra-organisational teachings (Alvesson, 1993; Soekijad & Smith, 2011).

In line with the findings of McLoughlin et al. (2019), the veterans also turned inward to focus on nurturing their own internal organisational programs. The findings from the ECoP may help to

clarify why. The fact that it was policymakers rather than the veterans themselves who exercised ‘ownership of meaning’ (Wenger 1998) in the ECoP, and thus had the ultimate ability to negotiate the prevailing regime of practice, helps to explain their distancing. Consistent with research on expertise, they appeared to distance themselves from the ECoP which seemingly both challenged their identity as experts and their epistemic authority (Kislov, 2014; Lamont & Molnár, 2002). Moreover, the veterans expressed doubt about the adequacy of the policymakers’ understanding of either process improvement or health service operations. They were skeptical of their ‘help’, which they interpreted rather as *“micromanagement” (participant 10)* and control over their roles in service of top-down and seemingly irrelevant policy targets (Alvesson and Willmott 2002). This lends support to the work of Kislov and colleagues (2017) who have likewise argued that top-down performance targets can have an eroding rather than supportive effect on improvement. My findings also lend support to the work of Kislov (2014) who argues that low levels of trust and the over-formalisation of collaborative arrangements can marginalise designated knowledge brokers.

Adding to this previous research, the ECoP findings show how veteran advisors reflected on their already strong cross-organisational relationships with their counterparts. The ECoP was thus a ‘nice to have’ opportunity to catch up, but not necessary in terms of the veterans’ sense of belonging in the field. The findings thus suggest that experienced designated knowledge brokers with existing ‘organic’ communities, under conditions of top-down micromanagement, might deliberately seek autonomy and embark on what Kellogg (2014) refers to as a project of professionalisation to become a brokerage profession. We may see this as a way for veterans to ameliorate the fragility and instability of their peripheral positions in the healthcare field that others have described (Kislov, Wilson, et al., 2017). This contrasts with the doctors’ ability to ‘lurk’, since, as autonomous professionals the doctors did not experience the same sense of pressure to participate as the advisors did. In the case of the ECoP, the upshot was that the veteran advisors paradoxically disassociated from the policymakers, who were indeed trying to help them, but who at the same time were attempting to regulate and direct their practices and identities (Alvesson & Willmott, 2002; Jenkins, 2004). The veteran advisors’ distancing practices in response to these perceived pressures suggest that, in terms of their participation in the ECoP, they were on an ‘outbound trajectory’ (Wenger, 1998, p. 155), struggling or unwilling to reconcile their existing identities with the roles the policymakers intended them to play.

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In sum, the third overarching meta-process, *reconciling*, sheds light on the epistemic expansion work that actors undertake in engaging with forms of knowledge not 'native' to their epistemic communities, and on the identity reconciliation work required to reconcile their existing forms of belonging with their participation in instrumental collaborative networks (Alvesson & Willmott, 2002; Wenger, 1998). The process of identity reconciliation consists of a continuous interplay between participants' existing identity trajectories and external identity-regulating mechanisms, including instrumental collaborative initiatives and the particular types of knowledge targeted for mobilisation within them. My findings highlight that, alongside learning to learn together, participants must learn *to be* together. This involves reconciling epistemic, political, and professional concerns with participation in instrumental knowledge mobilisation collaboratives.

7.5 Learning to learn and learning to be

In this chapter I have articulated how collaborative knowledge mobilisation networks in healthcare are constituted by dual processes of *learning to learn together* and *learning to be together*, inspired by Lave and Wenger's (1991) SLT and Wenger's (1998) work on CoPs. The foregoing discussion leads to a number of conclusions with regard to the aim of this study, which was to better understand how *participants learn to mobilise process improvement knowledge across boundaries in instrumental collaborative networks in healthcare.*

First, *learning to learn together* is an ongoing performative accomplishment. Participants of collaborative initiatives actively make the context for their own learning through their actions, interactions and reflections. This process of participatory 'collective making' (J. Langley et al., 2018) is characterised by various interpretations of the value of collaborating in which actors' existing forms of belonging in 'organic' CoPs form a reference point for comparison. As such, I have shown 'organic' and instrumental CoPs to be both in tension with one another and yet also co-constituting one another. The practice-based lens reveals a dialectical process in which participants' public front stage acts and hidden backstage reflections 'structure' collaborative initiatives as much as top-down attempts to objectify them, showing that *"instrumentality is not enough to hold a CoP together"* (Gherardi, 2009a, p. 520). The 'structure' of collaborative initiatives cannot simply be imposed top-down, nor ever completely stabilised. Instead, the distributed participation and reification practices of the totality of actors involved results in an ongoing collective process which shapes the emergence of collaborative initiatives. In sum, the

notion of *(per)forming* leads us to an ontological shift—from thinking about collaborative initiatives as reified 'forms', to conceptualising them as precarious processes: ongoing performative accomplishments with a relational, collective, negotiated character.

Second, *learning to learn together* is also characterised by epistemic tensions and the transformation of meaning. The discussion in this chapter has clarified how participants within a collaborative knowledge mobilisation initiative negotiate its economies of meaning (Wenger, 1998) around epistemic cultures, practices and identities. I have shown that learning to mobilise knowledge collaboratively is anything but a harmonious process of 'transfer'. It is instead polyphonic and characterised by political and normative conflicts, which emerge as participants dynamically negotiate the joint enterprise of collaborative initiatives, and through their attempts to develop (or sometimes dismantle) a shared repertoire (Contu & Willmott, 2003; Wenger, 1998). These tensions are generative in that they effect various simultaneous translations of the knowledge targeted for mobilisation. All of these versions contribute, to greater or lesser degree, to collective transformations of the economies of meaning that shape the ongoing performance of collaborative initiatives, their broader contexts, and the identities of individuals within them. In this way, the notion of *translating* highlights the epistemic nature of political and professional conflicts that arise when participants from various epistemic cultures are tasked with learning to mobilise particular types of knowledge together.

Finally, alongside the process of *learning to learn together* is an equally critical process of *learning to be together.* This involves reconciling epistemic, political, and professional concerns with participation in mandated collaborative initiatives. Identity reconciliation necessitates actors negotiating an internal/external dialectic of identification in order to achieve a coherent, 'livable' identity (Wenger, 1998). Identity reconciliation practices are fundamentally intertwined with actors' varied perceptions of the collaborative initiative, the knowledge targeted for mobilisation, and the 'others' with whom they must participate. Identity reconciliation work is very likely to be hidden 'backstage', but also to have significant unexpected, and often unintended effects, on the ways in which particular participants engage in collaborative knowledge mobilisation activity. Participants' divergent longitudinal trajectories of participation ultimately influence their *translation* practices and shape how they collectively *(per)form* collaborative knowledge mobilisation initiatives, both in the present and into the future. This has significant practical consequences for the knowledge mobilisation activity within them, and in broader societal contexts.

Chapter 8: Conclusion

If instrumental collaborative networks are to achieve their knowledge mobilisation aims, we need to understand how and why their participants learn to mobilise knowledge across boundaries within them, and the identity work that underpins their situated learning.
This thesis contributes to such understandings by elaborating a process model of collaborative knowledge mobilisation. In this chapter, I summarise the three overarching meta-processes that emerged from my study, which comprise the model. I then outline the theoretical, methodological, and practical contributions that I make in this thesis. I conclude the dissertation with some reflections on the limitations of my study, and offer some directions in which others might further progress the contributions of this research and carry them forward into the future.

8.1 Revisiting the study objective

In this thesis I set out to:

> *Explore how participants of collaborative networks learn to mobilise knowledge across disciplinary, and organisational boundaries, through situated learning and identity work.*

Through the investigation of a collaborative initiative set up to mobilise process improvement knowledge from designated knowledge brokers to frontline clinicians in a public hospital system, I have elucidated three meta-processes and articulated these in the form of a processual model of collaborative knowledge mobilisation. This model enhances our understanding of how and why participants in instrumental multidisciplinary, multi-organisational collaborative networks negotiate and translate the knowledge targeted for mobilisation as well as their own identities. It shows that these micro-level practices shape the evolution of such initiatives at a macro level, and points to how they may influence broader economies of meaning both within and beyond them. The three meta-processes are:

1. *(Per)forming.* This provides a lens through which to see how participants actively and collectively make the context for their own learning. Through participants learning to learn together, collaborative initiatives emerge as ongoing performative accomplishments with a relational, collectively negotiated character.

2. *Translating.* This illuminates the epistemic tensions generated when participants from various epistemic communities learn to learn together. It sheds light on the sometimes subtle and sometimes radical ways in which these tensions influence the mobilisation and transformation of both knowledge and relations of power.
3. *Reconciling.* This elucidates the identity reconciliation work involved in participants learning to be together in instrumental collaborative initiatives. It also provides a view of how different modes of identity reconciliation result in divergent trajectories of participation, and how these in turn influence knowledge mobilisation and the ways in which actors continually *(per)form* such initiatives.

Together, these overlapping and co-constitutive meta-processes provide a 'clearer view' (Tsoukas, 2019) of the practices involved in the early stages of instrumental collaborative knowledge mobilisation networks. The framework helps both practitioners and researchers conceptualise such initiatives as multi-layered processes rather than singular entities, through which participants must both *learn to learn together* and *learn to be together*, and within which there is much more at stake than the simple 'transfer' of knowledge.

8.2 Contributions

The research objective and substantive content of this thesis straddle the healthcare management and generic management literatures. As such, I make a contribution to both fields separately and, importantly, encourage a *"generative dance"* between them (Currie, Dingwall, et al., 2012, p. 273). I discuss specific theoretical, methodological and practical contributions in turn below.

8.2.1 Theoretical contributions

I set out to provide a novel account of how process improvement knowledge is mobilised through collaboration. By *"picking and mixing ideas"* from SLT, epistemic cultures and theories of identity, the practice-based conceptual bricolage I developed enabled me to find common ground between these different approaches, and at the same time to create something new that homes in on the previously underexplored aspects of each (Fox, 2000, p. 857). This generative approach has helped me to challenge simplistic linear models and elucidate a nuanced account of collaborative knowledge mobilisation that is grounded in lived experience. By deploying a

knowledge ‘translation’ lens to understand how knowledge mobilises in collaborative networks, my thesis supports scholars advocating for an alternative to the knowledge ‘transfer’ perspective, which remains dominant in the healthcare management and generic management fields. In so doing, I respond to ongoing calls to replace these linear metaphors and *“radically inappropriate image[s]”* of knowledge ‘flow’ to instead *“describe what are erratic, circular, or abrupt processes…”* (Ferlie et al., 2005, p. 123; Greenhalgh & Wieringa, 2011).

Through the bricolage lens, I have elucidated previously ‘black-boxed’ practices which are involved in participants learning to mobilise knowledge across disciplines and organisations in the healthcare setting. This is an important contribution to this literature, since, despite significant volumes of research into both collaborative knowledge mobilisation and process improvement in healthcare, evidence of their effectiveness remains sparse and equivocal. As a consequence of this predominant focus on inputs and outcomes, understanding *how* and *why* their effectiveness has been limited has been a challenge. The process model produced in this thesis sheds light on these processual issues. By elucidating the formation practices, epistemic and political tensions, and identity reconciliation practices involved in mobilising knowledge collaboratively, the model draws attention to the differing ways in which participants from different epistemic communities engage with instrumental collaborative networks and ‘non-native’ knowledge. This, in turn, helps to clarify how and why ‘non-native’ knowledge is mobilised through collaborative initiatives in the healthcare setting, and therefore provides a way to think about what makes such networks more or less successful.

Following from this is the contribution this thesis makes to debates about the possibility of deliberately ‘setting up’ CoPs. These centre around the tension between analytical accounts of SLT—which emphasise the organic and spontaneous nature of collaborative learning—and instrumental accounts—which assume the possibility of deliberately creating ‘communities’ to advance managerial or policy knowledge mobilisation agendas (Ferlie et al., 2005; Gabbay et al., 2003; Kislov, 2014; Kislov et al., 2012; Li et al., 2009). Despite the endurance of this debate, surprisingly little empirical work has sought explicitly to investigate the formation process of such initiatives, and even less has sought to understand how instrumental cross-organisational and/or cross-disciplinary collaborative networks form. The practice-based approach in this thesis has enabled me to elucidate how participants of collaboratives collectively make the context for their own learning. Instead of assuming that those seeking to instrumentally mobilise knowledge can unproblematically create collaborative networks in a top-down manner, this

approach reveals the particulars of *"how they are made and materialised"* (Meyer & Molyneux-Hodgson, 2010, p. 3). The process model demonstrates that we can more usefully conceptualise instrumental collaborative 'forms' as processes—as ongoing performative, dialectic accomplishments with a relational, collective, negotiated character. It is only by looking more closely at these dynamics that we can seek to understand their importance and perhaps anticipate the challenges they inevitably throw up.

My analysis reveals that pairing Knorr Cetina's epistemic cultures lens with SLT has great utility for exposing ubiquitous epistemic and political negotiations in instrumental collaborative networks—those that dominant interpretations of SLT neglect, and that 'transfer' perspectives miss entirely as a result of their indifference to social processes. This epistemic lens sensitised my analysis to differences between the epistemic practices of various participants, foregrounding the practices of community rather than assuming that a homogenous 'community' existed to begin with (Gherardi, 2009a). This has helped to reveal epistemic politics that emerge when participants negotiate and translate process improvement knowledge. In this way, I contribute to reorienting SLT toward the more 'critical stance' originally intended by Lave and Wenger and (re)embedding analyses within broader relations of power and status (Contu & Willmott, 2003; Fox, 2000).

This thesis thus helps to redress overly *"romantic"* interpretations of the notion of 'community' that characterises much SLT research (Cox, 2005, p. 530) and responds to calls to explicitly capture and analyse knowledge mobilisation strategies and their impacts in collaborative initiatives (Kislov, Wilson, et al., 2018). This leads to a significant contribution to the healthcare management literature and its implicit tendency to assume that knowledge can be 'transferred' unproblematically between actors by bringing them more proximal to one another. It also directs much needed attention to relations of power and status. Moreover, when researchers have previously engaged with a knowledge 'translation' perspective, they have largely focused on issues surrounding the problems of translating clinical research, already 'native' to healthcare, into clinical practice. This study reveals the very particular epistemic tensions that emerge when actors attempt to mobilise 'non-native' process improvement knowledge within a multidisciplinary, multi-organisational, collaborative setting.

The process model also highlights the tensions between the identity practices and politics of different groups. In particular, I have shed new light on the identity practices of non-clinical

communities and allied health professionals. These have to date been under-investigated as, in accordance with optimistic 'transfer' perspectives, much previous research into knowledge brokering in healthcare has tended to assume its beneficial nature. It has largely overlooked the identities of designated knowledge brokers in terms of their analytical importance for understanding knowledge mobilisation (Currie et al., 2015; Van Grinsven et al., 2016). By focusing here, this thesis responds to calls to enhance our understanding of the complex interplay between the historical trajectories and characteristics of knowledge brokers (e.g., their professional backgrounds and status in organisations) and emergent practices developing within complex cross-disciplinary and cross-organisational collaborative settings (Kislov, Hyde, et al., 2017). By exposing how and why actors from different disciplines and with different levels of status and influence become willing and able to mobilise knowledge in collaborative settings, we can better understand how and why divergent trajectories of participation emerge in instrumental collaborative networks, and analyse them in relation to what they mean for the ongoing survival of such initiatives.

Finally, by deploying Alvesson and Willmott's (2002) concept of identity regulation and Jenkins' (2004) internal/external dialectic of identification, I have explicated the processes involved in Wenger's (1998) notion of identity reconciliation (Handley et al., 2006). In doing so, I have shown how considering identity, a foundational concept in SLT, from a processual perspective can enhance our understanding of collaborative knowledge mobilisation. By elucidating how and why participants' from different epistemic communities reconcile their existing identities with their participation in instrumental collaborative initiatives, and the tensions that arise as they engage with external attempts to 'regulate' their identities, I contribute to our understanding not only of how actors *do change* in practice, but also how they *undergo change* (Hultin et al., 2020). Importantly, the practices of identity reconciliation revealed through my thesis suggest that while identity change is hard-won, the struggle may be quite necessary for successful knowledge mobilisation within collaborative networks and beyond.

8.2.2 Methodological contributions

In operationalising the practice-based approach of this study, I deployed ethnographic methods to 'capture' and 'construct' social practices as research objects (A. Langley & Abdallah, 2011). This allowed me to analyse collaboration as a socially constructed, processual phenomenon (Berger & Luckmann, 1991; A. Langley et al., 2013). Through the dual 'front stage' and

‘backstage’ approach, I was able to compare activities and incidents observed in real-time on the ‘front stage’ of the ECoP with the perceptions, reflections, and preoccupations of participants that emerged ‘backstage’ in informal conversations and interviews. This approach helped make legible practices and processes which often remain invisible, and which go uncaptured and unexplored in before/after ‘transfer’ approaches. focusing on these revealed how the ECoP was created through participants’ front stage performances, and equally performative backstage reflections (Lave, 1991). In addition, ‘zooming in and out’ (Nicolini, 2009b) enabled me to aggregate micro analyses of practice at the level of the three interconnected meta-processes, and connect them with what these reveal about broader knowledge mobilisation at the system level.

The nested and layered qualitative research design and practice-based strategies I employed served to guard against the reductive tendencies of methodological approaches in healthcare management research. This dominant focus on inputs and outcomes has resulted in a predominance of point-in-time studies, rather than longitudinal approaches, and the popularity of more ‘objective’ quantitative research methodologies that seek to control, abstract from, or erase social complexity, and questions about *whether* knowledge has been ‘transferred’. Moreover, positivistic orientations have resulted in research viewing phenomena such as collaborative networks *“in a finished form as explicit objective facts”* (Nilsen et al., 2013, p. 8). I have instead highlighted how engaging with practice-based methodological approaches can overcome such limiting perspectives by going beyond questions of *whether* knowledge mobilises. Through a practice-based approach, I was able to ask *how* and *why* actors in collaborative networks participate in particular forms of social engagement, as well as how and why these influence knowledge mobilisation.

Finally, my extended co-presence within the field was critical in revealing and elucidating the processuality and evolution of the initiative, of the knowledge targeted for mobilisation, and of the identities involved. The longitudinal nature of the study enabled me to explore the ‘rhythm’ of the practices and processes involved in community formation, knowledge translation and identity reconciliation over time and from multiple perspectives. This ensured I could address my research objective with rich, contextualised findings (Gehman et al., 2018). It is my hope that the methodological approach taken in this thesis can serve to contribute to elevating more sophisticated qualitative methods from their legitimate peripheral position as a *“minority sport”*

(Wieringa & Greenhalgh, 2015, p. 9) within both the mainstream management and healthcare management literatures.

8.2.3 Practical contributions

While I have problematised overly instrumental approaches to collaboration throughout this thesis, the pragmatic challenges faced by policymakers and managers still have to be recognised. It is clear that from a pragmatic perspective, those seeking to mobilise knowledge to achieve particular aims need to direct and cultivate collaboration to some extent. Moreover, policymakers and managers face particular demands in terms of their own performance goals and professional agendas. Practically, this means that policy and management practitioners may attempt to direct both the 'flow' of particular kinds of knowledge and the roles and identities of those they hope will learn to collaborate with one another.

The processual understanding I offer also lends support to a pragmatic approach in which we might carefully facilitate *(per)forming, translating,* and *reconciling* to address these pragmatic challenges—without running the risk of over-formalising. The process model helps to highlight that the epistemic machinery and identity-regulating efforts of practitioners are not hegemonic one-way narratives. They exist in a dialectical relationship with the epistemic and professional identities and practices of the totality of participants. Together, they individually and collectively negotiate whose definitions count in terms of the collaborative network, the knowledge targeted for mobilisation, and their identities. With this conceptualisation, I extend the developmental perspective put forward by Kislov and colleagues (2012), an approach which represents a pragmatic middle ground between analytical and organic approaches to CoPs. I do so in three ways.

First, I show how actors create their own contexts for learning through their actions, interactions and reflections—both 'front stage' and 'backstage'. While this might appear to undermine the possibility of policymakers and managers facilitating collaboration, it also suggests that practical steps may be taken to facilitate collaborative knowledge mobilisation. Thinking about collaborative initiatives as processes that are *(per)formed* collectively—rather than as reified organisational tools to be created and 'implemented' from the top-down—suggests that prioritising continual co-design processes over point-in-time approaches at the 'beginning' of collaborative initiatives is likely to support their development. Through such ongoing co-design,

participants and the ‘creators’ of collaborative initiatives may find it easier to make implicit negotiations more explicit and intentional. This may facilitate more conscious and collective direction of the ways in which actors *(per)form* initiatives, while avoiding the risks associated with over-formalisation.

Second, while conflict is often considered antithetical to collaboration, this study also shows that conflict can indeed be generative. This suggests that offering more informal opportunities for genuine debate and negotiation of meaning among different epistemic communities, as opposed to traditional formal presentations and other linear approaches to knowledge ‘transfer’, is likely to be helpful. Carefully embracing tension would create more opportunities for meaningful participation, the interweaving of epistemes, innovative translations of knowledge and further reification of the meaning and value of the collaborative initiative itself. This has the potential to leverage the differential power and status of different players to generate ‘aliveness’ in the critical early stages of formation. However, any such approach will need to be taken with caution, and tempered with an awareness of the embeddedness of collaborative initiatives in broader existing relations of power which do not disappear despite the often romanticised rhetoric associated with collaboration and CoPs. Indeed, coming together can rematerialise these dynamics, which can in turn significantly influence the dynamics of participation and the economies of meaning within collaborative initiatives.

Third, this study provides explicit evidence of the role that participants’ identity reconciliation work plays in shaping their participation in collaborative initiatives, and of the effect that identity reconciliation can have on processes of knowledge mobilisation. More frequent and deeper interaction between policy or management practitioners and participants of their collaborative initiatives is likely to surface identity conflicts which would otherwise remain hidden, making them possible to address. However, identities are always ‘at stake’ and activity of this sort requires a delicate, skilled, and open approach from all participants. L*earning to be together* has to date rarely been thought of as a necessary part of the repertoire of instrumental collaborative initiatives.

While I do not intend the process model developed through this thesis to be a prescription for action, it offers two immediate practical uses. First, it provides a lens through which those seeking to mobilise knowledge through collaborative networks may be sensitised to issues that are quite often hidden from them on the ‘front stage’. If managers and policymakers make

decisions and take action based on the best information they have, then it follows that a greater depth of insight into the otherwise hidden or taken-for-granted processes involved in collaboration is a valuable addition to their toolkits. Just as importantly, all participants of instrumental collaborative networks may use the model, both collectively and individually, as a prompt to explicitly consider how they intend to *learn to learn together* and *learn to be together*. Such concerted attention to the situated processes of learning and becoming that underpin collaboration may help participants to engage in more open dialogue and fertile debate about how they can mobilise knowledge together.

8.3 Limitations and further research

The study's primary focus on the 'start-up' stage of instrumental collaborative initiatives could, from a knowledge 'transfer' point of view, be interpreted as a limitation with regard to the conclusions that we might draw about their impact on intended outcomes (such as organisational or health care system performance). The 'cultural proximity' of healthcare management research to the evidence-based medicine movement has led to a preference for 'high quality' studies as defined by large-scale quantitative evidence based on randomised and controlled experimental methods. This has meant that qualitative and narrative forms of evidence, as in my study, struggle to meet the requirements for 'validity' as defined within the hegemonic discourse (Bresnen et al., 2017; Ferlie et al., 2010; Rousseau, 2006). Indeed, the qualitative findings of this study do not provide a way to directly measure the efficacy of collaborative initiatives in terms of their intended knowledge mobilisation effects.

Nevertheless, rich insights into the processes involved in the critical early stage of collaborative networks can almost certainly help to improve their effectiveness. We cannot measure the effectiveness of the mechanisms underpinning knowledge mobilisation in terms of *whether* knowledge as a 'thing' is moved across disciplinary or organisational boundaries, or from one place or mind to another. Instead, it is the effectiveness of participants' collective work of *(per)forming* collaborative networks, *translating* knowledge, and *reconciling* their own identities that enables them to learn together, and thus allows knowledge to mobilise. These insights point to opportunities for future studies to explore in greater depth how we might more effectively facilitate generative formation, translation, and reconciliation practices.

It would be beneficial to apply practice-based methodological approaches similar to that in this study to understand how these insights might apply in other settings. This could include other service-based settings and production settings in which a focus on the technical side of process improvement had predominated, as well as other countries. Future research on mandated collaborative initiatives would also benefit from a focus on identity reconciliation practices at subsequent stages of their development. This might include identifying specific facilitation practices and the points at which these might be most effective in supporting participants to mutually and collectively engage in learning to learn together and learning to be together, in order to support the mobilisation of knowledge.

Finally, while organisational context (e.g., process improvement 'maturity', type of hospital (e.g., regional/metropolitan, size of hospital etc.) appeared to be influential with regard to participants' willingness to engage with the ECoP, I did not systematically analyse this. Moreover, I observed senior organisational leadership to play a critical role in participants' willingness and ability to engage with both the collaborative initiative and the 'non-native' knowledge targeted for mobilisation, but the experiences of this group were not a focus of my analysis. These limitations offer important opportunities for future research, to focus on these contextual and leadership issues and explore how they influence the processes of *(per)forming, translating* and *reconciling.*

Epilogue

Talking with Neil and Martina at The Agency some months after the final workshop, they told me that the ECoP would not continue beyond its first twelve months. Despite the policymakers having initially envisaged it as a low cost mechanism for maintaining collaboration and cross-organisational learning among public health services over the long term, they had found it hard to make the case for its ongoing funding. The qualitative evaluation, which highlighted the relational potentiality of the model, did not make it as far as the boardroom.

The frontline policymakers were ultimately constrained by their sponsors' political desire—or perhaps more accurately their need—for quantifiable measures of the 'effectiveness' of the ECoP. Neil and Martina had known from the outset that improving NEAT performance was an unreasonable expectation of the initiative, especially over such a short period. Even if the NEAT performance of participating organisations had improved, the improvements would have been

impossible to attribute to participation in the ECoP. However, they also knew that short-term political cycles and performance agendas constrained the policy lens: *“Getting the NEAT better is the figure [the sponsors] are interested in. It’s the front page stuff.”*

And yet, were the policy sponsors throwing an impossible to ‘measure’ baby out with the proverbial bathwater? From a ‘transfer’ perspective—perhaps not. If the effectiveness of The Agency’s collaborative networks was to be discerned narrowly, by their ability to improve headline performance measures within a short period of time, then the investment did not (and may never) stack up. If, however, their effectiveness were to be defined in ‘translational’ terms, then the processes of learning how to *learn together* and how to *be together* would be valued for their incremental, albeit highly variable and unpredictable, knowledge mobilisation effects.

While the processes of *learning* and *becoming* were rendered invisible through the policy lens, I was able to observe participants of the ECoP actively creating a context for their own collaborative learning. This process consisted of generative epistemic and political struggles through which participants produced innovative translations of what it means to do service redesign and process improvement, and through which they reconciled their identities in various ways. Without the view opened up by the practice-based translational lens in this study, the policymakers were unable to see—and therefore could not value—these activities. Moreover, they could not see that their veteran advisors were disengaging, that the hybrid doctors were ‘lurking’, or that an unexpected new ‘core’ of engaged participants was emerging.

The question remains—what was the point of evaluating the ECoP in narrow performance terms if these missed the fecundity of the emergent collaborative learning process? This final extract from an interview with Colin, the keen novice improvement advisor at Big Metro, captures the potential pitfalls of the ‘transfer’ approach that the epistemic machinery of the policy domain demanded:

> *It's almost like you wouldn't want to measure it, even if you could. If you can measure it, it means it's probably not working well. Because it's so organic that if you can measure it, it's already too discrete. Does that kind of make sense?*

Colin's words provide food for thought for policy and management practitioners. We would all do well to (re)conceptualise the value of collaborative networks less in terms of outcomes—and more in terms of the learning processes through which they emerge, and which they generate.

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Appendices

Appendix 1: Explanatory statement and consent form

EXPLANATORY STATEMENT FOR ALL PARTICIPANT GROUPS

Project 12931: Translating management knowledge into practice: Clinician engagement and healthcare improvement

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You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the contact details listed above.

What does the research involve?

Improving the efficiency of, and access to healthcare is one of the most pressing challenges for governments around the world. However, service redesign and improvement innovations have had limited system-wide impact to date. Knowledge-sharing about process redesign and improvement within the [state] healthcare system has been limited. Furthermore, clinicians have been particularly disengaged from redesign and improvement activities.

The research aims to understand how different types of clinicians engage with and 'translate' process improvement knowledge, and to investigate whether knowledge-sharing networks may promote system-wide sharing of improvement knowledge, and help to engage clinicians with it.

The research will help develop practical frameworks for implementing and evaluating redesign and process improvement initiatives. This will enable both hospitals and policy-makers to ensure investments in improvement have system-wide healthcare benefits, and economic benefits in terms of efficiency and access.

Participants will be asked to take part in a face-to-face interview, and/or focus group, and/or observation of meetings or other forums related to process redesign and improvement. These activities will usually take place at a suitable venue, for example at participants' place of work, or at venues where meetings/forums related to process redesign and improvement occur.

Interviews will last approximately one hour and will be guided by general themes related to interviewees' experiences, past and current, of The Agency's knowledge-sharing networks, and of process redesign and improvement projects within their employing health service/s. Interviews will be flexibly structured to allow topics that are important to the interviewee to be explored. With participants' consent, the interview will be digitally recorded and transcribed by a professional transcription service. An agreement is in place with the transcription service to ensure that privacy is protected, and a transcription of the interview will be sent to interviewees to review and approve for its inclusion in the body of data to be analysed.

Focus groups, guided by the same general themes as interviews, will last between 60-120min (max). With participant consent, focus groups will be audio recorded, transcribed, and transcriptions sent to participants for their approval.

Observations may also take place—of The Agency network meetings, or meetings, workshops or other forums concerned with process redesign and improvement within the health system, and general observation of redesign and improvement initiatives within health services. With consent, the researcher may audio record, or take photos/videos of activities or artefacts related to redesign and improvement.

Why were you chosen for this research?
You were chosen to participate in this study because of your involvement in The Agency knowledge-sharing networks, or because you have been involved in or invited to be involved in implementing process redesign and improvement initiatives within your health service. We obtained your contact details from [INSERT NAME].

Consenting to participate in the project and withdrawing from the research

Participating in this study is voluntary. If you do wish to participate, the consent process involves signing the consent form that is provided to you by the researcher, prior to the interview.

You may withdraw your involvement at any time. You may withdraw any individual data that you contribute through the interview process up to the point of approval of the interview transcription. You are not obliged to answer any interview question you do not wish to answer.

Possible benefits and risks to participants
The project aims to investigate fundamental challenges for improving healthcare systems, and to develop practical methods of enhancing knowledge-sharing about process redesign and improvement within the sector. Enhancing the capacity of individual health services to innovate and improve service delivery will ultimately result in better public health outcomes in the [state] healthcare system and beyond.

Participation is voluntary, those choosing to participate will have their anonymity and confidentiality protected, and interviews will not explore sensitive or personal themes. We anticipate no risks to participants, and considerable potential benefits for healthcare systems as a result of their involvement in the research process.

Confidentiality

The findings of the research will be shared, for example through the publication of the doctoral dissertation, and other publications such as journal paper submissions, industry or policy briefs. Generic findings may also be shared informally with research participants throughout the course of the research. However, no information that could lead to the identification of individuals will be disclosed at any time, without the individual's explicit written permission. All individuals will be de-identified and referred to through the use of codes or pseudonyms in any published work arising from this project.

In the case of focus groups however, while no research output could lead to the identification of individual participants due to the confidentiality measures described above, the presence of more than one participant at a time means that the researchers cannot guarantee all discussions will remain confidential. The researcher will, however, commence all focus groups with a discussion of expectations related to privacy and mutual respect for other participants.

An agreement is in place with the transcription service to ensure that privacy is protected, and a transcription of the interview will be sent to interviewees to review and approve for its inclusion in the body of data to be analysed.

Storage of data

The body of research data itself will remain secure and will not be openly or publicly available at any time. The data will only be accessible to members of the research team. The data will be stored in accordance with Monash University regulations and kept in a secure format for five years following the completion of research activities related to this project, after which time the data will be destroyed.

Results

Participants and organisations directly involved in the research will receive a summary report of the research findings at their request. The research findings will also be communicated in a variety of forms with the aim of reaching target practitioner, policy and academic audiences. This may include, but will not be limited to, journal articles, conference presentations and industry reports.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC):

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Chancellery Building D,
26 Sports Walk, Clayton Campus
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 99053831

Thank you,

[insert signatures]

Professor Ian McLoughlin
Chief Investigator

Adamina Ivcovici
PhD Researcher

Dr Alka Nand
Co-Investigator

Consent form

Project 12931: Translating management knowledge into practice: Clinician engagement and healthcare improvement
PhD Researcher: Adamina Ivcovici
Chief Investigator: Professor Ian McLoughlin
Co-investigator: Dr Alka Nand

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

I consent to the following / understand that:	Yes	No
I agree to be interviewed by the researcher		
I agree to allow observation of activities by the researcher		
I agree to participate in a focus group by the researcher		
I agree to allow the researcher to audio record unless I inform the researcher otherwise		
I agree to allow the researcher to take photos unless I inform the researcher otherwise		
I agree to allow the researcher to video record unless I inform the researcher otherwise		
My participation is voluntary, and I may choose not to participate in part or all of this project		
I may withdraw my involvement in the project at any stage without being disadvantaged in any way		
Any data the researcher collects for use in reports or published findings will not contain any identifying characteristics without my explicit signed consent		
I may withdraw any individual data I have contributed to the project (e.g., through the interview process) up to the point of approving a transcription of the interview		

No information I have provided that could lead to the identification of any other individual will be disclosed in any reports on the project, or to any other party.		

Participant name:
Participant signature: Date :____________

Appendix 2: Initial interview guide

Topic	**Probes**
Introduction	Confidentiality Permission to record Consent form Introduction to project
Background	What is your background? ● Clinical background ● Organisations ● Previous experience in improvement
Experience of CoP so far	What are your perceptions of the CoP to date? ● Benefits? ● Challenges? ● Have you learnt anything? ● Do you feel it is the right place for you? ● Who do you think should ideally participate? ● How does your organisation decide who to send to this?
Online forum	What do you think of the online forum? Are you likely to use it?
Previous experience with The Agency	Did you participate in the original Emergency Collaborative? Any other interactions with The Agency? What are your perceptions of The Agency's attempts to enhance improvement capability around the system? How do you see your role in relation to The Agency?
Existing networks	Do you have existing networks or communities? When/ how / how regularly do you call upon them? For what reason? Do you use other online networks to share professional knowledge e.g., Twitter?
Spreading improvement knowledge around the system—interviewee's ideas	If you were in charge, what do you think would be the most important issues to improve in the system and how would you go about addressing these?

Conclusion	Anything else? Follow up interview? Transcript to be sent to you Anybody who might be interested to talk to me Thank you!

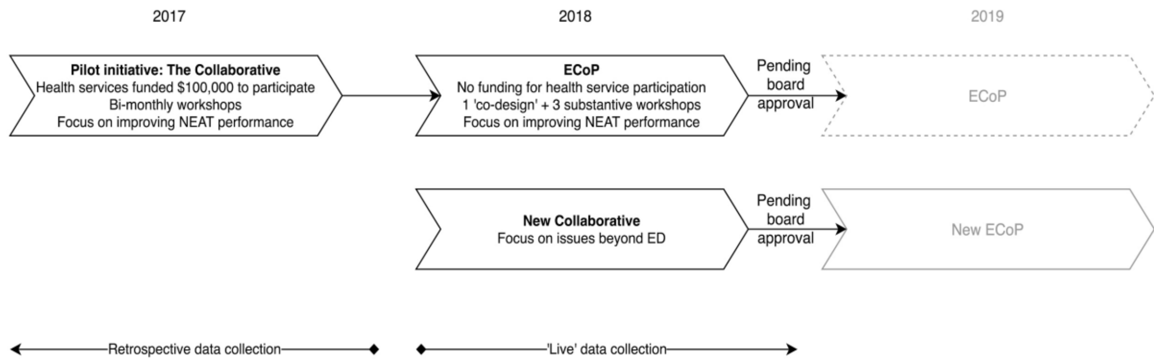
Appendix 3: History of improvement in the jurisdiction

Phases of 'system improvement' policy	Public health policy context	Department of Health / The Agency objectives	Knowledge mobilisation strategy
Mid to late 2000s	The need to improve efficiency of healthcare delivery Devolved governance Introduction of national emergency access targets	Short term improvements in efficiency and performance	Building networks of Lean management practitioners Discrete improvement projects
2009-2013	Healthcare costs continue to rise	Building organisational capability for improvement	Roll-out of trained, funded improvement advisors as designated knowledge brokers Struggle to engage clinicians in improvement
2013-2016	Independent evaluation determines limited efficiency improvements achieved in previous phase	Responsibility for system improvement shifted from The Department to The Agency	Improvement advisors continue to attempt to mobilise knowledge within organisations, with little support from The Department during transition to The Agency
2016-2018	Limited system-wide improvements Popularity of collaboratives and networked governance approaches in other countries recognised by Australian policymakers (e.g., UK, USA).	Shift from individual capability-building to facilitation of cross-organisational knowledge mobilisation and learning	2017 – The Collaborative focused on improving emergency access (participation funded) 2018 – Continuation of The Collaborative as ECoP (participation not funded)

Appendix 4: Comparison of pilot Collaborative and ECoP

	The Collaborative	**The ECoP**
Year	2016-2017	2018-2019
Length of program	15 month trial	12 month trial
Funding for health services	Full time project officer $100,000	No funding for health services
Workshop frequency	Bi-monthly	Quarterly
Organisational participants	High performers and low performers on NEAT target	Same organisational participants except one which withdrew participation, and another redirected to new Collaborative for more intensive support
Type of improvement projects	Specific projects related to access and flow in EDs	No specific projects but focus remained on ED access/flow
Intended ‘core’ participants	Improvement advisors Executives	Improvement advisors ED hybrid doctors and nurses
Level of mandate	‘Invitation’ from health minister, understood by many as mandate	‘Invitation’ from The Agency, understood by many as mandate

Appendix 5: Timeline of The Agency's collaborative initiatives



Appendix 6: Workshop attendance by participant category

	Co-design workshop	**Edgeside workshop**	**Big Metro workshop**	**Outerside workshop**
Improvement advisor	13	5	8	19
Hybrid nurses	1	5	8	3
Hybrid doctors	2	5	5	4
Policymakers	2	5	6	6
TOTAL	**18**	**20**	**28**	**32**

Appendix 7: Interviewee details

Interviewee	Category	Clinical / non-clinical	Novice / veteran	Number of times participant quoted	Pseudonym
1	Hybrid doctor	clinical	novice	6	
2	PIA*	non-clinical	novice	2	
3	PIA	clinical	novice	4	
4	Hybrid doctor	clinical	novice	2	
5	Exec sponsor	non-clinical	veteran	2	
6	PIA	non-clinical	novice	7	
7	PIA	clinical	veteran	1	
8	Hybrid nurse	clinical	novice	6	
9	PIA	clinical	veteran	5	
10	PIA	clinical	veteran	4	
11	PIA	clinical	veteran	2	
12	PIA	clinical	veteran	5	
13	PIA	clinical	veteran	2	
14	Hybrid nurse	clinical	veteran	5	
15	Hybrid doctor	clinical	veteran	5	
16	Hybrid nurse	clinical	veteran	5	
17	Hybrid doctor	clinical	veteran	10	
18	PIA	non-clinical	veteran	2	
19	PIA	non-clinical	novice	2	
20	PIA	clinical	veteran	1	
21	PIA	non-clinical	novice	16	Malcolm
22	PIA	clinical	veteran	2	
23	PIA	clinical	veteran	5	
24	PIA	non-clinical	novice	19	Colin
25	PIA	clinical	veteran	-	
26	Hybrid nurse	clinical	novice	5	
27	Hybrid nurse	clinical	veteran	2	

28	Hybrid doctor	clinical	veteran	12	Jason
29	PIA	clinical	veteran	1	
30	Hybrid doctor	clinical	veteran	7	
31	Hybrid doctor	clinical	veteran	14	
Not interviewed	Policymaker	non-clinical	-	-	Neil
Not interviewed	Policymaker	non-clinical	-	-	Martina
Not interviewed	Hybrid doctor	clinical	veteran	-	Benjamin

*PIA: Process improvement advisor

Appendix 8: Early NVivo codebook

Code name	Number of files code contained in	Number of references to code
Broadening	32	171
Complex system	6	10
Resistance to change	5	8
Clinician engagement	22	214
Accountability	6	30
Excusing docs	6	8
Existing identity	31	165
Epistemic identity	33	223
Hybridity	20	69
Peripherality	15	44
Existing community	24	86
Informal	21	59
Learning across orgs	33	183
Bringing it back	6	10
Giving back	6	9
Learning by doing	27	87
Experimenting	10	21
Learning to be together	28	117
Who belongs	13	34
Learning to learn together	34	163
Learning within orgs	27	293
Motivation	31	158
Networks	19	62
Participating in the CoP	34	106
Expectations	4	5
Setting it up	5	17
Clinical concerns	9	24
Process improvement competence	27	166
Pinning down the data	15	38
Place space time distance	28	79
Politics	24	96
Leadership	19	66
Communication	9	13
Resources	28	153

Time	6	13
Status - power	16	57
Tension between disciplines	31	198
Trust	20	66
Tensions between organisations	12	25
Translating knowledge	36	263
Value of the CoP	34	225
Comparison	5	14
Confusion/uncertainty/ambiguity	26	72
Flowing up to policymakers	8	14
History	3	3
Measuring and evaluating	10	22
Other policy programs overlap	21	75
Specificity	4	4
Standardisation	22	75
Tension with policymakers	27	109

Appendix 9: Sax Institute Knowledge Mobilisation Conference 2018 abstract

Translating Process Improvement Knowledge into Practice: Communities of Practice, Value-creation Narratives and Clinician Engagement

Introduction

Healthcare systems are under pressure. Policy-makers and health managers have turned increasingly to process improvement (PI) knowledge (used extensively outside healthcare) to seek to reduce waste and create value (e.g., by improving patient experience through reduced waiting time).

However, engaging clinicians in process improvement work has proved challenging and how best to nurture and sustain clinician engagement remains an enduring issue. There is an increasing interest in the role of cross-boundary networks (e.g., collaboratives, communities of practice) in fostering engagement within healthcare across a wide-range of stakeholders. This doctoral project explores the role of Communities of Practice (CoP) in mobilising process improvement knowledge across organisational and professional boundaries.

Methods and analysis

Sitting alongside a broader cross-disciplinary parent project, the study will use a qualitative case study design, drawing on 'translation' perspectives rooted in organisation studies and 'value-creation narratives' (Wenger, Trayner & de Laat, 2011), to understand how knowledge is not merely moved from one place to another, but is 'translated' as it is mobilised.

The empirical focus is a sector-level CoP, established in an Australian jurisdiction to mobilise PI knowledge across the public healthcare system. The study will specifically explore: 1) How PI knowledge is 'translated' within the CoP and beyond, 2) implications for how PI knowledge is understood and practiced within health services, 3) how clinicians engage with PI.

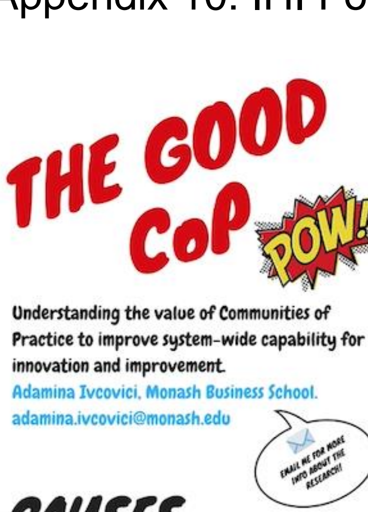
The study will primarily involve immersive observation of the CoP, and interviews with those responsible for its development and participating members. It may also involve interviews with

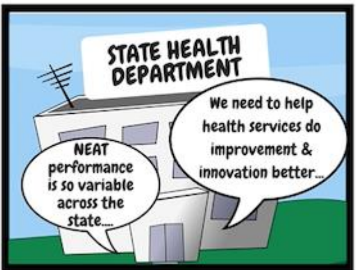
individuals directly involved in PI within health services and observation of PI. An 'abductive' approach will be applied in analysis.

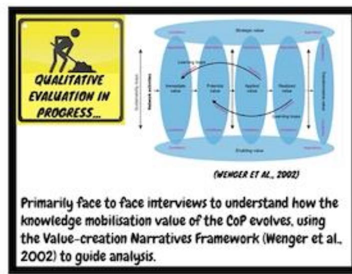
Ethics and dissemination

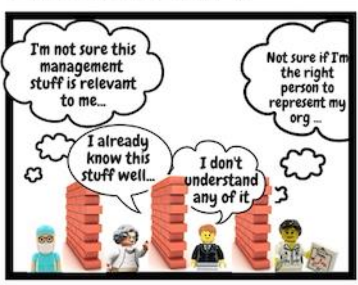
Ethical approval has been granted by the Monash University Ethics Committee. Findings will be disseminated through academic publications, conferences, and policy and industry reports.

Appendix 10: IHI Forum 2018 poster









Appendix 11: EurOMA abstract

Teething or terminally ill? How communities of practice in healthcare get started and survive (or not).

Keywords: Community of Practice, Healthcare, Knowledge Mobilisation (3 only)
Topics: Healthcare Operations Management, Operations Innovation, Operations in the Public Sector
Word count: 999

Background

With ongoing pressures to increase public health service efficiency (Radnor & Johnston, 2012), interest in ideas about improvement and innovation from outside the sector is growing. However, mobilising such 'management' knowledge (eg. Lean management) has proven challenging.

Communities of Practice (CoPs) are increasingly being used as instruments to mobilise these types of knowledge across organisational and professional boundaries in healthcare (Nicolini et al., 2016). However, our understanding of such use of CoPs lacks empirical grounding (Omidvar & Kislov, 2014). The process of CoP formation remains an area of significant ambiguity and debate, and seminal works on the concept advance divergent perspectives on the issue, particularly with regard to the possibility of their being purposefully 'set up' (Cox, 2005; Kislov et al., 2011; Pyrko, Dorfler & Eden, 2017).

Furthermore, little is known about the specific knowledge translation practices of 'members' during CoP formation (Kislov, 2012; Pyrko, Dorfler & Eden, 2017). Finally, most studies of CoPs in healthcare have looked at the mobilisation of clinical improvement knowledge, rather than how 'management' knowledge, often unfamiliar to clinicians, gets mobilised, and translated in the process.

Purpose

This study aims to provide analytical refinement of an under-theorised area of CoPs – that of CoP formation – and enhance our understanding of how 'management' knowledge is mobilised across various professional and organisational boundaries in this complex multi-stakeholder

setting. It does so by describing the micro-practices of CoP members in the early stages of a multidisciplinary, multi-organisational CoP. It also seeks to translate this more nuanced analytic account into practical recommendations for enhancing the likelihood of CoP survival.

Methodology/Approach

A longitudinal case study methodology has been employed to follow in 'real-time' the 'setting up' of a multi-professional and multi-organisational CoP. The CoP was set up by policymakers seeking to enhance the innovation and improvement capability within a healthcare system through cross-organisational knowledge development and mobilisation, under uniquely mature sector-level conditions for innovation and improvement. The early stages of CoP formation were observed, and 27 in-depth semi-structured interviews have been carried out to date, with clinicians, improvement specialists and senior hospital managers involved in the CoP.

To facilitate a nuanced, processual understanding of CoP formation, a 'knowledge translation' perspective is adopted, with a focus on the knowledge translation practices of CoP members. Since "practice always generates sociality" (Nicolini, 2009, p. 1406), this perspective brings to the fore processes of meaning-making of the individuals involved as they come together to share knowledge, as well as the political, social and contextual nature of these processes (Nicolini, 2009; Swan, Newell & Nicolini, 2016).

Data analysis is guided by the CoP Value Creation Framework proposed by Wenger, Trayner and de Laat (2011). This evolutionary framework advances a theory of change for how individual and collective value is generated through social learning in CoPs (Wenger et al, 2011). It provides a useful starting point from which to organise empirically derived practices and help to develop our theoretical understanding of the CoP formation process.

Results

Findings to date suggest that the startup phase is an inherently risky time for CoPs, even under relatively favourable conditions. There appear to be tensions associated with perceptions of 'voluntariness' and 'mandatedness' of CoP membership, and emergent fault-lines between clinicians and those in organisational improvement roles which have threatened the emergence of collective identity. This study documents new insights into the micro-practices of 'members' during CoP formation and shows how members engage in public performances of voluntary engagement and cohesiveness but provide contradictory backstage accounts.

Practice implications

A more nuanced analytical account of the formation phase of CoPs provides insight into the practical process of ‘setting up’ a CoP, and of challenges to anticipate. This has important implications for policymakers and managers attempting to mobilise unfamiliar types of knowledge, both within healthcare and other public sector domains. In particular, acknowledging and attending to divergent identification processes may be vital to ensure that CoPs survive long enough to generate the value they are set up to yield.